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 in Public

TUC, Congress House, 23-28 Great Russell Street
London WC1B 3LS
Wednesday 4 July 2012

Name	**Body/Association**	**Role**
Sir Neil McKay CB	Chair, Joint Committee of Primary Care Trusts	Chief Executive, East of England SHA (Chair)
Rosalind Banks (adviser)	Adviser to JCPCT	Healthcare Analyst, KPMG
Professor Sir Roger Boyle CBE	Clinical Adviser to JCPCT	Former National Director for Heart Disease and Stroke
Andy Buck	Yorkshire and Humber Specialised Commissioning Group	Chief Executive, NHS South Yorkshire and Bassetlaw
Sophia Christie (adviser)	Independent adviser	Former Chief Executive, Birmingham East and North PCT
Jon Develing	North West Specialised Commissioning Group	Chief Officer, North West Specialised Commissioning Group
Deborah Evans	South West Specialised Commissioning Group	Chief Executive, NHS Bristol
Deborah Fleming	South Central Specialised Commissioning Group	Chief Executive, NHS Hampshire
Jeremy Glyde (secretariat)	Secretariat	*Safe and Sustainable* Programme Director
Catherine Griffiths	East Midlands Specialised Commissioning Group	Chief Executive, Leicestershire County & Rutland PCT
Mr Leslie Hamilton (adviser)	Clinical Adviser to JCPCT	Deputy Chair of *Safe and Sustainable* Steering Group and Past President of the Society for Cardiothoracic Surgery in Great Britain and Ireland
Eamonn Kelly	West Midlands Specialised Commissioning Group	Chief Executive, West Mercia Cluster
Paul Larsen (secretariat)	Secretariat	Finance Lead, National Specialised Commissioning Team
David Mason (adviser)	Legal Advice	Solicitor, Capsticks
Teresa Moss	NHS Specialised Services	Director of National Specialised Commissioning
Jonathan Nicholls (adviser)	Independent adviser to JCPCT	Head of Health Research, Ipsos MORI
Brian Niven (adviser)	Independent adviser to JCPCT	Project Manager, Mott MacDonald
Catherine O'Connell	East Midlands Specialised Commissioning Group	Chief Operating Officer, Midlands and East
Anna Quigley (adviser)	Independent adviser to JCPCT	Head of Health Insight Unit, Ipsos MORI
Ann Radmore	London Specialised Commissioning Group	Chief Executive, NHS South West London

Chris Reed	North East Specialised Commissioning Group	Chief Executive, North of Tyne PCT
Dr Sheila Shribman CBE (adviser)	Clinical Adviser to JCPCT	National Clinical Director for Children, Young People and Maternity Services
Ann Sutton	East Coast SCG	Chief Executive, Eastern and Coastal Kent PCT
Dr Tim Wilson (adviser)	Independent adviser to JCPCT	Partner, Health Advisory, PricewaterhouseCoopers

APOLOGIES

None

1. Introductions by Committee members and advisers	The Chair opened the meeting and welcomed members of the Joint Committee of Primary Care Trusts (JCPCT), advisers and the public. The Chair highlighted that the Committee members exclusively would be involved in the decision making. By way of introduction, a video was shown in which Sir Bruce Keogh summarised the background of the Safe & Sustainable (S&S) Review of paediatric congenital heart surgery in England.	
2. Declaration of Interest	There were no declarations of interest.	
Comments and Questions from the Public	Caroline Langridge, Young Hearts, requested that the audience be given the papers for the meeting. John Arnold, a parent and Trustee of the Children's Heart Surgery Fund, highlighted the issue around the impact of patient choice in the North of England, as raised in the PricewaterhouseCoopers (PwC) report. Councillor John Illingworth, Chair of Joint Overview and Scrutiny Committee (JOSC) for Yorkshire and Humber, stated that there had been a democratic deficit in the process. He believed Leeds was optimally placed from a population, travel and access and surgical volumes perspective and he urged that decisions regarding the paediatric and adult services be made simultaneously. Liz Smaje, Kirklees Council, said that assumptions made in the original documentation were contradicted by the PwC report. Between 53% and 73% of transfers would be in excess of the 1.5 hours were Leeds not included in the chosen configuration. She suggested that the gold standard for co-location was that all services should be on one site, as they were in Leeds. Stuart Andrew MP said MPs from Yorkshire and Lincolnshire had been inundated by expressions of concern regarding the potential closure of Leeds. Patient flows and access were of particular importance for the constituents. Andrew Parry, congenital cardiac surgeon, urged that the number of cases per surgeon was the key measure; he urged the Committee not to compromise the standards they had set. Fiona Copeland, Primary Ciliary Dyskinesia Support Group and parent, urged the Panel to consider unintended impacts to other services. Ivan Hollingsworth, a parent, asked the Panel to design the best service for future generations across the whole country; he urged that the opinions of current patients or parents should not drive the Panel's choice on the future service. Dr Duncan McCrae, Paediatric Intensivist at the Royal Brompton Hospital, said that most congenital surgeons had a mixed practice and volumes should be considered in this way. Sharon Cheng, Children's Heart	

	Surgery Fund, asked that the Panel to take into account the 17 networks in Yorkshire, Leeds' co-location, PwC's report and birth rate in Yorkshire. She believed that people in Yorkshire would not be better served by travelling to Newcastle, but more people would be disadvantaged. Gaynor Bearder, parent, urged the Committee to listen to parents' views; parents wanted only the best services but their voices had been 'dismissed' as over emotional in the process to date. A Paediatric Intensivist from the Royal Brompton Hospital endorsed the aspiration to excellence but highlighted that the Central Cardiac Audit Database (CCAD) showed that outcomes were good. As changes to location or surgeon risked increasing mortality rates, she asked whether the decision makers would take corporate responsibility for outcomes in CCAD over the next two years. The Chair explained that the comments would be responded to during the Committee's deliberations. The Committee had chosen not to publish papers in advance in order to allow an unfettered discussion of the issues. However, the papers would be published on the website following the meeting.	
3. Purpose of the Meeting	The Chair highlighted that the meeting was a not a public meeting but a legally constituted meeting in public. Interjections and comments from the floor were not permitted. The Chair summarised the historical context of the Safe and Sustainable review, including Sir Ian Kennedy's recommendations following the Bristol inquiry and James Monro's paper in 2003. He highlighted that at a meeting in 2006 surgical and cardiological representatives from each of the 11 centres providing paediatric congenital cardiac services had reached a unanimous view that there should be fewer and larger centres. In 2007, the Royal College of Surgeons had reiterated the need for fewer larger centres and in 2008 a working group of experts had argued for sustainable services for congenital cardiac children. The Children's Heart Federation had supported the process throughout. The Chair highlighted that the integrity of the Safe and Sustainable review process had been endorsed following a Judicial Review and Court of Appeal hearing. The JCPCT was a legally constituted committee which represented the 152 PCTs in the country and had the power to make decisions. An expert advisory group, the	

	Steering Committee, which consisted of eminent clinicians, members of national professional associations and chairs of patient groups, had advised the Committee. It was the role of the Committee to plan services and make decisions to ensure there was a safe and sustainable platform for services in the future. Mr Mason explained that the JCPCT was a national committee and, as such, had to consider issues from a national perspective; the decision concerned services across the country. The consultation was not a matter of 'counting heads' or how many people objected to proposals but how soundly based their objections were. This was not to suggest that the Committee should not consider the strength of opinion expressed; the Committee had a duty to take the output of consultation conscientiously into account and had a Public Sector Equality Duty under the 2010 Equality Act. The JCPCT's task was to take all relevant matters into account and ignore irrelevant ones. The weight it attached to any piece of evidence was a matter for its professional judgment. The Committee should apply its judgement to any advice given to it by advisers or the Secretariat and should not follow any advice 'slavishly'. Mr Glyde advised members that their responsibility was to consider all the evidence submitted to it throughout the process and to weigh the strengths and weaknesses of the options based on that evidence. He outlined that the Committee would be asked to agree a number of recommendations put to it.	
4. Summary of evidence received during public consultation	The Chair noted the comment made regarding parents' feeling their voices were not being heard and promised that the Committee felt parents' views were of paramount importance and would take them into account during the decision making process. Mr Glyde gave a list of evidence that the Committee had received to assist it with its decision and explained that it was referenced where relevant in the Decision Making Business Case, but the limited references to the evidence did not replace the detailed submissions that Members had already considered in detail.	
5. Summary of evidence received at the public consultation events	Professor Boyle explained he had attended all but one of the twelve consultation meetings held in 2011. He said that where centres felt under threat, there had been strong support for local units and testimonials given as to the value of the local service. However, in the areas where there was less uncertainty, debate had focused on how to improve services. Although all the services had been deemed safe, there was room for improvement in every service, pathway and network and it	

	had been accepted in consultation that an important aim of the process was to drive quality improvement. The question had frequently been raised as to whether sufficient emphasis was being placed on quality and the issue of how to balance quality concerns with access/travel had been a challenging one for the Committee. Travel times were not irrelevant he said, but the concerns raised about safety of longer trips had been spurious and not founded in fact. Retrieval services would be a major focus for implementation, regardless of the decision. In order for the Review to remain credible, he suggested that quality had to be the main driver of the Committee's decision. Professor Boyle said that co-location and nationally commissioned services (NCS) had frequently been discussed at consultation meetings. Networks were an important aspect; these had developed to a variable extent across the country, notably between Oxford and Southampton, and Cardiff and Bristol. The proposed Children's Cardiology Centres had been a controversial issue during consultation meetings, with participants questioning their viability, but it was envisaged that Cardiology Centres would have a vital role to play in the new model of care. Challenges regarding workforce issues had been raised at most consultation meetings, but it was not possible to plan for workforce issues until a decision was made as the hypothetical scenarios were too numerous. The impact on Paediatric Intensive Care Units, retrieval services, networks and adult service designation were also important considerations for decision making.	
6. Reports on outcome of public consultation	The Chair welcomed Ms Quigley and Mr Nicholls from Ipsos Mori. Mr Nicholls highlighted the scale of public engagement with the consultation: over 51,000 response forms had been returned in total, including 1,000 from organisations. 22,000 text message responses had also been received. The text message option had been designed to make the consultation as open and accessible as possible. 25 petitions had been lodged and captured in the analysis. Over 20% of the response forms had been sent by Black, Asian and Minority Ethnic (BAME) respondents, where ethnicity was declared, and 11% of response forms had come from under-25s. Ipsos MORI had also reported on more detailed qualitative work involving 25 discussion groups and 18 interviews with service users and parents from South Asian communities, where there was a high relative risk of congenital heart disease. Ms Quigley summarised the findings of the report on the analysis of consultation	

	responses. Mr Nicholls highlighted that no weighting or adjustment had been made to the responses in an attempt to obtain a nationally representative picture; the aim of the report was only to transparently reflect the range and diversity of responses. Individual responses had therefore been presented as one set of data, while organisational response had been presented as another. Similarly, in light of the number of responses from certain regions, the data had been presented in both aggregate and disaggregate form to show the response patterns transparently. Similarly, the petitions had been presented separately from consultation response forms. Ms Griffiths noted the high levels of support for the Glenfield Hospital across the country north of London. Mr Glyde asked for clarification on how professional organisational responses had been identified and defined per Ipsos MORI's process. Ms Quigley responded that Ipsos Mori's approach was not to 'test' the claim that respondents were answering on behalf of a named organisation; Ipsos Mori merely reported how respondents had categorised themselves. She said that no particular weight had been placed on a response from an organisation versus an individual response in the report. Mr Buck noted the high level of responses from BAME communities and asked whether the feedback from BAME groups had differed in any way from that of the rest of the population. Mr Kelly noted that individual respondents had not been convinced that the current service was not safe and sustainable; he urged that it was necessary to clarify the workforce and quality challenges the service was facing. Ms Quigley said that very similar themes had emerged from engagement with BAME groups as during the rest of the consultation, including concerns regarding current patients and more general experience in health services, access and family accommodation. **Members accepted the two Ipsos MORI reports.**	
7. Report on Health Impact Assessment	The Chair welcomed Mr Niven from Mott McDonald. Mr Niven explained that the Health Impact Assessment (HIA) was intended to assist and inform the JCPCT's decision-making process by providing information on how to	

promote and protect the health and wellbeing of communities. It was not a legal duty but was considered good practice. The analysis had to be relevant and proportionate to the proposed changes.

The HIA considered the positive and negative potential impacts of each of the 12 options with regard to health outcomes, existing health inequalities, equality groups, travel and access and carbon emissions. The assessment involved desktop research, data analysis and engagement via regional forums, focus groups and one-to-one interviews with families. Mott McDonald had looked at the scale of each of the potential impacts from reconfiguration, and the likelihood and duration of the impacts.

The conclusion of the HIA work was that all options were viable and that health improvements would result from each option owing to the improved, network-based model of care. There were some adverse potential impacts caused by each option, either through transition or longer term, affecting smaller numbers of patients or families. These adverse impacts could often be reduced or mitigated.

He said that at a population level, the overall impact of all options was small, although at an individual family level the impacts could be significant. Vulnerable groups would not experience any greater impact than other patients or families affected by the proposals, and there were only marginal differences in the impacts across all 12 options. To that extent, all options were viable. Options G and I caused the fewest negative impacts, while Options C, E and J could potentially give 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:

- Monitoring following implementation
- Training the wider clinical network group
- Collaboration with local community groups
- Communication during transition
- Providing travel guidance
- Consideration with other work being undertaken

	Ms Evans said local leadership on implementation would be vital to ensure the networks functioned properly; this would mitigate most effectively any negative impacts of transition. Ms Christie recommended that the HIA be revisited during implementation to ensure action was taken on mitigations and the commentary given in this regard during engagement. She reassured the Committee that population growth in South Asian communities had been considered under the HIA. It had explored the need for services in cities that did not have large BAME populations to adapt the service to cater for these groups, the impact of increased travel costs on economically disadvantaged communities and implications for children with co-morbidities. Actions had been identified for implementation. Mr Glyde noted that concerns had been raised as to why the HIA had not been published prior to consultation. Mr Niven explained that it would not have been possible to complete the HIA prior to consultation as it could only begin once the four options for consultation had been identified, which had happened only shortly before consultation had begun, and that the final HIA should be informed by the responses to consultation. Mr Niven was content that proper process had been followed. **Members accepted the HIA report.**	
8. Report on compliance with Public Sector Equality Duty (PSED)	Mr Glyde advised Members that PCTs in England and the Welsh Specialised Services Committee had confirmed with the secretariat that they had considered their responsibilities and had exercised and discharged their duty under the Act. They had reported that in their opinion there were no issues relating to the Public Sector Equality Duty that rendered any of the options for consultation unviable. PCTs had identified several positive and negative impacts and the mitigations suggested under the PSED matched those identified in the HIA. Ms Griffiths highlighted that the PSED report had also referred to impacts on migrant asylum seekers and additional religious minority groups. **Members accepted the report on compliance with the Public Sector Equality Duty.**	
9. Strategy for implementation	Ms Moss advised Members that there would be a need to incorporate the evidence from the Ipsos MORI and Mott MacDonald reports and the PSED responses in developing a more detailed iteration of the implementation plan. **Members accepted the implementation plan.**	

10. The need for change	The Chair asked Mr Hamilton to describe the case for change. Mr Hamilton explained that paediatric cardiac surgery was a very young specialisation and the current pattern of units had developed in an unplanned way. Surgery had become much more complex since the beginning of the specialty but it was not possible to provide this complex service with one, two or three surgeons in a centre. Surgical expertise and team expertise was spread too thinly around the country. Of the 198 recommendations made by Sir Ian Kennedy in the Bristol report, only seven had related specifically to paediatric cardiac surgery. However, three of those comments had related to the need for larger centres. In 2006, all units had met and agreed that change was needed. He said that there was evidence that higher case volumes led to better results and the Steering Group advised that training, recruitment, retention and succession planning would be improved by having larger, fewer centres. The Steering Group believed that the case for change was compelling and it was urgently necessary that a decision be made and for implementation to begin to overcome the planning blight caused by uncertainty. Professor Boyle reiterated the need for increased numbers of surgeons per centre to improve training across such a wide range of procedures, through joint operating. Ms Radmore asked the clinical advisers for their view regarding the level of risk involved in reconfiguring the service against the benefits it would bring. Mr Hamilton responded that ‘no change’ was not an option. Other countries were facing the same issues and had already reconfigured their services. It was important to recognise and work to mitigate the risks involved and the professional bodies had a large part to play in bringing their members along and mitigating risks. Mr Glyde confirmed that nearly all the national professional bodies that had responded to consultation had supported the need for change. **Recommendation 1: Mr Glyde asked Members to agree that the need for change to the way in which children’s congenital heart services in England are planned and delivered remains compelling, and that the case for change supports the proposals set out in the Decision Making Business Case.** **Members agreed.**	

11. Key principles	Mr Glyde explained the five key principles that underpinned the S&S Review: 1. The need of the child comes first 2. All children in England and Wales needing heart surgery must receive very high standards of NHS care 3. The same high quality of service must be available to each child, regardless of where they live or which hospital provides their care 4. The care that every congenital heart service delivers must be based around the needs of each child and family 5. Other than surgery and interventional procedures, all relevant cardiac treatment should be provided by competent experts, as close as possible to the child's home. Ipsos MORI had reported that there had been strong overall agreement with the five principles in consultation, but slightly less with the fifth principle. Some respondents had been concerned that surgical and interventional procedures had been excluded from that commitment in light of potential travel issues. These issues would be explored later in the agenda. **Recommendation 2: Mr Glyde asked Members to agree that there is overall support for the key principles that underpin the development of proposals for change.** **Members agreed.**	
12. Model of care	The Chair asked Mr Hamilton to explain the proposed model of care. Mr Hamilton explained that the Steering Group had discussed the model of care at length, which currently varied across the country. The new model of care was based on networks, a concept deemed to be key to improving the quality of care. There would be larger, fewer, surgical centres, in which all interventional procedures would be carried out. This would ensure that surgical cover was available where cardiologists were undertaking interventions. The majority of non-surgical care would be carried out closer to home. 85% of children only needed one intervention, so it was unnecessary for children to travel back to surgical centres for follow-up care. He explained that cardiology centres would work closely with surgical centres to	**L Hamilton**

	provide this more local expertise and also undertake pre-surgical investigations, including diagnostic cardiac catheterisation. There were currently models in the country, such as Cardiff/Bristol and Oxford/Southampton, where this appeared to work well. Paediatricians with Expertise in Cardiology (PEC) would play a vital role, providing cardiology expertise close to home. Specialist Cardiac Nurses would be responsible for linking all the tiers of the service. Each family were to have a named nurse to support and facilitate their journey through the care pathway. 77% of the personal respondents and 85% of organisations in consultation had supported the model of care. He said that the Steering Group was convinced as to the viability of the proposed model and advised the Committee to accept the recommendations in the Decision Making Business Case. Mr Glyde summarised that the JCPCT had consulted on a three-tier model of care consisting of district children's cardiology services led by PECs, children's cardiology centres (CCCs), providing tertiary complex non-interventional care (but not diagnostic catheterisation) and specialist surgical centres. There had been a very strong level of support for the creation of specialist surgical centres, and overall support for cardiology centres. However, there had been concerns that the proposal for CCCs was not sufficiently developed to be sustainable, and at the proposal that diagnostic catheterisation would not take place at CCCs. Mr Hamilton explained that the CCC issues raised during consultation had been debated at length by members of the Steering Group and the British Congenital Cardiac Association (BCCA). The Steering Group had concluded that CCCs would be viable, albeit with some risks that needed to be mitigated, which were set out in the DMBC. Mr Glyde read the five recommendations given to the Committee by the S&S Steering Group regarding the proposed model of care, which included amending the proposed model of care to allow diagnostic catheterisation to be carried out in the CCCs, in light of advice given to the Steering Group by Professor Shakeel Qureshi, President of the BCCA at the time. Professor Boyle noted that the PECs could also provide a useful liaison point and assist with bringing patients back into the system for follow-up. Mr Kelly sought to clarify that the district children's cardiology services would be based in large or medium-sized District General Hospitals (DGH). Mr Glyde confirmed this. Mr Buck asked if further guidance could be given as to how CCCs differed from district	

services. Mr Hamilton explained that they would provide diagnostic services, feed into the surgical centres by referral and would take part in the multidisciplinary team meetings at the surgical centres. Mr Buck asked for clarification regarding the safety of diagnostic catheterisation. Mr Hamilton explained that the original recommendation by the Standards Working Group had been that diagnostic catheterisation should not be undertaken at CCCs. Subsequently, the BCCA had looked in detail at the issue and determined it was reasonable for CCCs to carry out this work, and the surgical advisors had agreed. However, interventional cardiology and catheterisation were restricted to the surgical centre as they might require surgical backup.

Ms Moss highlighted there had been improvements achieved in antenatal diagnosis since the CCC in Cardiff had been set up. Mr Hamilton explained that electrophysiology (EP) was another specialised service that the Steering Group believed could be provided in a CCC provided the right arrangements were in place, per the DMBC.

Recommendation 3: Mr Glyde asked Members to agree that the proposed model of care is viable and should be implemented in England; this will involve establishing a number of congenital heart networks in England; a reduction on the number of hospitals that provide heart surgical services for children; and the development of District Children's Cardiology Services and Children's Cardiology Centres for which standards will need to be developed.

Members agreed.

Recommendation 4: Mr Glyde asked Members to agree that Children's Cardiology Centres must not provide interventional cardiology services but may provide diagnostic catheterisation.

Members agreed.

Recommendation 5: Mr Glyde asked Members to agree that electrophysiology services may be provided in dedicated children's services outside of a specialist surgical centre provided the congenital heart network had developed clear protocols.

	Members agreed.	
13. Co-location of services	Mr Glyde explained that the issue of co-location was three-fold: **1. Co-location requirements per the framework of Critical Interdependencies** Mr Glyde referred Members to the relevant section of the Decision Making Business Case, including a report on the approach of Sir Ian Kennedy's panel in applying the term 'co-location' as defined by the *Framework of Critical Interdependent Services*. Ms Griffiths asked why ENT services at Glenfield Hospital had been 'singled out' as an issue. She highlighted that Glenfield Hospital delivered an outpatient service at the hospital and there was an option to provide a more comprehensive ENT service on the site in the future. Professor Boyle explained that ENT was an important service from an emergency perspective for ventilation and airway; these services were very close at the Royal Brompton Hospital and in Newcastle, whereas in Leicester the services were located on the other side of the city. An outpatient service was not sufficient to meet the co-location requirements for ENT. Dr Shribman endorsed the Kennedy panel's interpretation of 'co-location' as being consistent with that applied by the *Framework of Critical Interdependencies*; in her view the co-location issues had been carefully considered throughout the review. **2. Co-location of other services not identified by the *Framework*** Mr Glyde referred Members to the relevant section of the Decision Making Business Case. Mr Buck noted that the issue of keeping mothers and babies together was a major concern and it was important to seek to reduce the instances where this would be necessary during implementation. The Chair endorsed this approach; he noted that the networks would need to describe means of minimising separation wherever possible. **3. Co-location of paediatric heart services with adult services** Mr Glyde referred Members to the relevant section of the Decision Making Business Case. Mr Hamilton noted that the national congenital heart patient charities and the Grown	

	Up Congenital Heart (GUCH) Patients' Association had publicly advised in 2010 that the separate reviews of adult and paediatric services should not be combined owing to the concern that this would further delay progress on both. **Recommendation 6: Mr Glyde asked Members to accept the advice of Professor Sir Ian Kennedy's panel about the panel's application of the term 'co-location' as defined by the Framework of Critical Interdependencies.** **Members agreed.** **Recommendation 7: Mr Glyde asked Members to accept the requirements for the co-location of services as stipulated in the Safe and Sustainable standards.** **Members agreed.**	
14. Patient choice	Mr Glyde referred Members to the relevant section of the Decision Making Business Case. He suggested that there had been concern and confusion among some respondents regarding a perceived tension between the proposal to establish clinical networks and the principle of patient choice. Some respondents had questioned the impact of patient choice on the analysis of patient flows and the assumptions about the viability of networks. Ms Radmore emphasised that patient choice was enshrined within the NHS constitution and commissioners wished to be assured both that high quality services would be available in every location and that choice would be retained. Professor Roger Boyle explained that quality and choice were both key deliverables of the Review. The Chair emphasised that, as the network concept was crucial in delivering quality improvement, commissioners would expect referrals to be made according to the network. However, patient choice was a recognised right which would be exercised from time to time. **Recommendation 8: Mr Glyde asked Members to agree that the proposed model of care is consistent with the principle of patient choice.** **Members agreed.**	
15. Services for adults with congenital heart	Professor Roger Boyle highlighted that a parallel process reviewing adult congenital heart disease was underway, and a national consultation was planned in 2013. A	

disease	three-tier model was recommended and clinical networks were a critical element. Mr Glyde explained that many respondents had put to the Committee that a combined review should have been carried out owing to the commonalities between the two services. There had been calls for a moratorium on a decision for paediatric designation until the adult review was completed. He advised that the JCPCT's powers did not extend beyond children's services, but members could opt to delay the decision on paediatric services until the adult service review was completed in 2014. The DMBC set out submissions from Royal College of Surgeons, the Royal College of Paediatrics and Child Health, the Royal College of Nursing and Little Hearts Matter, focusing on the urgent need for change in paediatric services as distinct to adult services. Clinical members on the Steering Group had endorsed the need for a separate review in 2008 in consideration of the urgent need in paediatric services. Professor Boyle commented that the service could not afford a delay of another year. There was a planning blight in the area and he strongly recommended taking a decision that day. Mr Glyde highlighted that the BCCA had written to the Committee in December 2011 explaining that, notwithstanding its view regarding the desirability of a combined review, the *Safe and Sustainable* review should be brought to a conclusion as soon as possible. The Chair suggested there was also a moral and leadership imperative to completing the review. **Recommendation 9: Mr Glyde asked Members to agree that there is an urgent need to conclude the review of children's congenital cardiac services in England, and that this necessitates the JCPCT making a decision before the separate review of services with congenital heart disease has concluded.** **Member agreed.**	
16. Standards	Mr Hamilton described the rationale for, and the process for development of, the clinical standards. Mr Glyde reiterated that consultation responses had showed very strong support for the standards. 89% of individual respondents and 93% of organisations had supported the proposal for the minimum and ideal caseloads and number of surgeons per centre. The only negative comments had related to the evidence	

	behind the numbers proposed; however, 52% of individual respondents and 70% of organisations had agreed with the statement that there was a relationship between higher volumes and better clinical outcomes. Mr Glyde said the Steering Group advised the Committee to accept the additional standards set out in Appendix B, on patent ductus arteriosus (PDA). This standard stipulated that it was permissible for neonate with PDA to receive surgical ligation in the referral neonatal intensive care unit provided the visiting surgical team was despatched from the designated surgical centre. Mr Glyde also advised Members to accept the additional standard that would require the designated units to publish the *Safe and Sustainable* standards Mr Reed highlighted the need to ensure the implementation of the standards that concerned improving information, communication and support for families as these had been an important issue raised during engagement and consultation. Mr Glyde highlighted that the terminology in Appendix C, the standard relating to antenatal screening, had been updated to reflect recent work by the British Congenital Cardiac Association and the NHS Fetal Anomaly Screening Programme. **Recommendation 10: Mr Glyde asked Members to agree each of the 156 standards together with the 4 additional standards set out in Appendices A and B of the Decision Making Business Case.** **Members agreed.** **Recommendation 11: Mr Glyde asked Members to agree the revisions to the proposed standards relating to antenatal screening as set out in Appendix C of the Decision Making Business Case.** **Members agreed.**	
17. Data reporting and monitoring outcomes	Mr Glyde referred Members to the relevant section of the Decision Making Business Case. Professor Boyle explained that the Central Cardiac Audit Database is the best database of its kind in the world. However, improvements were still necessary,	

	especially with regard to timeliness of information. It was proposed that every unit should have robust audit cycles and processes and that the CCAD should include information on mortality by procedure groups to enable the identification of issues in performance and outlier status in a timely fashion. **Recommendation 12: Mr Glyde asked Members to agree the proposals for improving the collection, reporting and analysis of outcome data as set out in the consultation document.** **Members agreed.**	
18. Evaluating configuration options	Mr Glyde reminded Members that the scoring of the options was an important part of the evidence but it was not determinative. Ms Banks listed the criteria used to score the options, explaining that it had been elaborated through discussion and engagement with all relevant stakeholders: • **Access and Travel Times**, with a weighting of 14: o Elective travel times o Retrieval times • **Quality**, with a weighing of 39: o High quality service o Innovation and Research o Managed Clinical Networks • **Deliverability**, with a weighting of 22: o Provision of nationally commissioned services (NCS) o Impact on PICU and other interdependent services o Sub criteria relating to implementation *(not scored)* • **Sustainability**, with a weighting of 25: o Minimum of 400, ideally 500 procedures o No centre would exceed capacity o Recruitment and retention of appropriately qualified staff *(for implementation and not scored)*	
ii. Assumptions to be applied to identify viable options	Ms Banks explained the assumptions that had been applied by the secretariat to test the viability of potential options. Mr Glyde explained at length the assumptions	

around the viability of options that include both Bristol Children’s Hospital and Southampton General Hospital, and around the non-viability of options that include the John Radcliffe Hospital. Mr Glyde advised Members on the proposed changes to the networks for options that include Bristol Children’s Hospital and Southampton General Hospital as set out in Appendix Q of the Decision Making Business Case.

Ms Banks presented the proposed 12 viable options for scoring, explaining that six had been added as a result of responses to consultation. Option I was a combination of options A and B. Under Option I both Birmingham Children’s Hospital and Bristol Children’s Hospital would not reach 400 unless the upper error of margin was accepted.

Mr Reed suggested that Members discuss whether the weightings that had been applied to the criteria required adjustment in light of consultation responses. Mr Buck and Ms Christie noted the Committee had extensively discussed the respective weightings given to quality and access. Members were persuaded by the strong themes reported by Ipsos MORI around the importance of quality. Mr Buck added that the crux of the matter was the distinction between safety and the aspiration towards world-class services now and in the future. Dr Shribman highlighted that in her clinical experience families were prepared to travel in order to obtain the highest quality service for their child and prioritised quality above all other considerations. The Chair highlighted that the weighting had originally been chosen based on discussion with clinicians and all other stakeholders and was reasonable in this regard too. Mr Reed highlighted that the impact of the weighting would also be explored.

Ms Banks explained that a scale of 0 to 4 had been applied when scoring the options, where ‘0’ meant no elements of the criteria had been met and ‘4’ meant the option exceeded the criteria.

iii. Scores for each option against the agreed criteria

Access and Travel Times

Ms Banks presented a proposed scoring system as set out in the Decision Making Business Case.

Quality

Ms Banks presented a proposed scoring system as set out in the Decision Making Business Case.

Mr Glyde explained that Leeds General Infirmary and Glenfield Hospital had suggested that there had been factual inaccuracies in the Kennedy report and asked for a reconsideration. The Committee had asked Sir Ian’s panel to consider the submissions and the panel had reaffirmed its report and not recommended a rescoring of those centres.

Following consultation feedback, a proposed revised methodology was proposed for scoring the high quality service sub criteria, based on their inclusion or not of centres that had scored highly or less well according to the Kennedy panel’s scores. Only Options B and G had included all the three top-scoring centres. Options D, F, G, K and L included all three bottom-scoring centres. Option B scored 3 as it included all three top-scoring centres and only one of the three bottom-scored centres.

Mr Buck noted that the proposed scores for B and G were 3 and 2 respectively and the only difference was the presence of Leeds General Infirmary. Ms Banks confirmed this; Leeds General Infirmary had scored less well than the Freeman Hospital in the Kennedy assessment, which was the reason for this result. Mr Glyde explained that the report was in the public domain but the Committee had decided not to consider the sub scores. The next agenda item would explore the submissions put to the Committee by respondents to consultation on the relative strengths of the Leeds service compared to the Freeman Hospital.

Ms Banks reminded the Committee that the Kennedy panel had been reconvened in November 2011 to rescore centres for compliance with the standards relating to ‘research and innovation’ based on consultation submissions. The only changes had been an increase in RBH’s score from a 2 to a 3 and an increase in Oxford’s score from a 1 to a 2. Options B, G and I included the five centres that had scored most highly for Research and Innovation.

Ms Banks explained that manageability of clinical networks would be further covered by the PwC report. The networks for Newcastle had been identified as riskier from a manageability perspective and it was therefore appropriate to score options that included Newcastle slightly lower. These were options A, B, C, E, H, I and J.

Overall it had been felt that the high quality sub criteria was the most important aspect of the Quality criteria based on consultation feedback so the score for this sub criteria had been used to score for Quality overall.

Deliverability

Ms Banks presented a proposed scoring system as set out in the Decision Making Business Case.

Ms Griffiths queried why options that required the movement of ECMO had been scored 3, given the risk of moving these services. Ms Moss noted that it was recognised that there were risks in moving ECMO services and these would need to be mitigated. However, the Secretariat had sought not to introduce fixed points into the analysis unless absolutely necessary and there were risks involved in the reconfiguration of the service on the whole.

Ms Christie suggested that this was an appropriate juncture to discuss the challenges and advice that had been received regarding ECMO and transplant services. She said that Glenfield Hospital had been very supportive in assisting Birmingham Children’s Hospital in building up capacity and capability in light of the flu pandemic and there was strong clinical confidence in the ability of Birmingham Children’s Hospital to take on ECMO work.

Ms Moss explained that there were three nationally commissioned services that could be impacted by the review: children’s transplant, ECMO, and complex tracheal surgery. The Committee had received consistent advice from many bodies and groups throughout the review that to achieve the necessary configuration of children’s congenital cardiac services one or more of the services might need to be moved. Transferring any of the services posed a risk, but the magnitude of that risk was considerably greater for transferring transplant than it was for ECMO. While it was recognised that all of the nationally commissioned services were delivering excellent quality, and the expert panel had concluded that it was desirable the services remain where they were if possible, it was acknowledged that this should not be an absolute restriction when designing the best configuration overall. The expert panel had considered that three ECMO services, two transplant and one complex tracheal service was needed in the new configuration.

After analysing submissions by current providers to take over these services, the expert panel had concluded that only Birmingham Children's Hospital was able to develop transplant services. University Hospitals of Birmingham NHS Foundation Trust delivers an adult transplant service which would satisfy the requirement for the paediatric service to be closely linked with an adult cardiothoracic transplant service. Regarding ECMO, both Birmingham Children's Hospital and Bristol Children's Hospital had been deemed capable of delivering ECMO services. However, Birmingham Children's Hospital had confirmed that it would not be able to take on both ECMO and transplant services were an option chosen that excluded both the Freeman Hospital and Glenfield Hospital, as it would be unable to address the complex risks sufficiently in the required timeframe if this were to happen. No other submissions had been made for complex tracheal work. The National Advisory Group on National Specialised Services (AGNSS) had been advising the JCPCT on nationally commissioned services but had not advised the JCPCT on scoring or consideration of options.

Sustainability

Ms Banks presented a proposed scoring system as set out in the Decision Making Business Case.

Low activity numbers were envisaged at Birmingham Children's Hospital and Bristol Children's Hospital under Option I, and it had therefore scored poorly for sustainability. Mr Glyde said that the Secretariat proposed the viability of Option I with some reluctance on the basis that the centres could perhaps reach the minimum of 400, but it was also possible that the activity could decrease. Options had been scored on the basis of the number of centres in them which would achieve the ideal number of 500 procedures or more per year. Options A, H and L had scored slightly lower as they included fewer centres that exceeded 500 procedures a year. As no options caused centres to exceed their capacity, the overall score for sustainability was based on ability to meet the minimum activity requirements.

Ms Banks also presented a number of sensitivity tests that had been applied by the secretariat to test the conclusions of the scoring process.

	Recommendation 13: Mr Glyde asked Members to agree the assumptions that have been applied to identify viable options. **Members agreed.** **Recommendation 14: Mr Glyde asked Members to agree the proposed criteria for the evaluation of options, and the weightings applied to each criteria.** **Members agreed.** **Recommendation 15: Mr Glyde asked Members to agree the proposed scoring of options against the weighted criteria.** **Members agreed.** **Recommendation 16: Mr Glyde asked Members to agree that option B is consistently the highest scored option when sensitivity tests are applied.** **Members agreed.**	
19. Evaluating configuration options	Mr Glyde reiterated that the scoring process was not determinative; it was important for the Committee to consider the strengths and weaknesses of the options against the other evidence available to it. Mr Glyde and Ms Banks presented section 12 of the Decision Making Business Case: **i. Quantitative analysis of consultation responses** Ipsos MORI had reported that Options A and B had received the most support during consultation. Members were asked if they had any further questions to put to Ipsos MORI regarding consultation responses. There were no questions. **ii. Considerations of quality** As already explained, Ipsos Mori has reported that consultation responses had indicated that quality should be the Committee's main concern. Option B offered the five centres outside of London scored highest by the Kennedy panel; all three centres	

in London had received high scores. An alternative option, comprising all top seven centres as assessed by the Kennedy panel, had been tested (a three-London-centre), but this had been found not to be viable as it left only one centre in the North of England, which was not sufficient.

Some respondents had suggested that co-location of services had not been sufficiently weighted as an aspect of quality. Ms Banks explained that this had been tested by reweighting the scores given for critical interdependencies by the Kennedy panel, giving them a maximum weighting which was equivalent to the other highest weighted category in the scores. The impact on the overall scores of this revised weighting was that the Freeman Hospital became one of the bottom scoring three centres overall, replacing Alder Hey Children's Hospital. Option B still contained all the highest scoring centres and only one of the lowest scoring centres, but so did Option G, which meant that both of the options were scored 3 for quality overall. In the overall weighted option scores, Option B remained the highest scoring option, but Option G's second place score was closer to that of Option B.

The weighting of the other sub criteria in the quality score had also been tested. If all three sub criteria were equally weighted, options B and G scored 3 as both received two 3s and one 2, which was higher than the other options. Weighted overall scores showed Option B was highest scored, closely followed by Option G.

Mr Buck asked why Option B still outscored Option G overall when that sensitivity was applied. Ms Banks explained that this was owing to the deliverability criteria.

iii. Access and travel times

Mr Glyde noted that a reduction in the number of centres inevitably caused increased journey times for some children. Much emphasis had been given to travel and population density by some respondents to the consultation, while other respondents had encouraged the JCPCT to disregard issues of convenience, in line with Sir Ian Kennedy's original recommendations in 2001. Under Option B, 92 more families in or around Yorkshire and Humber would experience an increased journey of over an hour compared to under Option G. The issue of quality had been reported by Ipsos MORI as the most frequently mentioned issue for respondents, both on options and specific centres. Members were therefore invited to conclude that the significant quality benefits of Option B outweighed the relatively limited impact to elective travel times. This was not to say that the impact to individual families who experienced an increase to their travel time was not significant. The next iteration of the implementation plan would focus on the potential mitigations to these increases in elective travel times. Mr Buck highlighted that the model of care itself would go a long way to mitigate the concerns.

iv. Population density

Mr Glyde advised Members that the Yorkshire and Humber JOSC and Children's Heart Surgery Fund had submitted that the JCPCT had been inconsistent in its approach to population density considerations. The Secretariat advised that the approach had been consistent: in respect of Alder Hey Children's Hospital and Birmingham Children's Hospital the JCPCT had concluded that two units were needed in the North and that one should be Alder Hey Hospital, based on projected caseload and patient flows and the knock-on impact to Birmingham Children's Hospital if Alder Hey ceased surgery. Leeds General Infirmary had a smaller caseload than Alder Hey and the networks that would exist in the North and the Midlands if Leeds General Infirmary were to be cease surgery would mean that Birmingham Children's Hospital would be less impacted, hence it had been concluded that Alder Hey could not be removed from the national service but Leeds General Infirmary could be removed without impacting significantly on other centres. In addition, the proposal to have at least two surgical units in London was based on population density in the South East. The submission of inconsistency with regard to including Bristol Children's Hospital in all options had been addressed earlier in the agenda, with regard to retrieval times.

v. Impact to health outcomes, health inequalities and vulnerable groups

Mr Glyde asked whether the Committee wished to address any aspects of the Health Impact Assessment having completed the scoring of the options, bearing in mind that the impacts upon vulnerable groups had been shown to be marginal across the options. Ms Fleming sought to confirm that Option G had less impact on vulnerable groups than Option B. Mr Glyde responded that page 84 of the Decision Making Business Case set out the comparative impacts of both options with regard to vulnerable groups, e.g. 24% of the total population in question would be referred to a new network under Option B compared to 23% in Option G, which was a marginal difference of 65 patients. He summarised that the impacts to individuals were important but the absolute numbers affected were low.

vi. Carbon emissions

Mr Glyde advised that the impacts of carbon emissions were set out on pages 82 and 83 of the DMBC. Carbon emissions were highest under Option A, lowest under Option G and middling under Option B. No option was unviable in this regard. The difference between all the options was marginal on carbon emissions.

vii. Population projections

Ms Banks explained that whilst activity had remained fairly steady over the past few years, modest growth of 13.7% was anticipated by 2025. 3,990 procedures were forecast for services in England in 2025 and all options had been assessed using the projected activity numbers and all options indicated that no centre would exceed its maximum stated capacity using those future projections of activity. Mr Develing queried whether there was any unmet need. Mr Hamilton said that it was not believed there was currently any unmet need but it was not possible to know whether improved fetal diagnosis would have an impact on termination rates or whether cardiologists would undertake more interventions but less surgery. Mr Kelly queried whether national level projections were sensitive to potential higher rates of growth in parts of the country with larger Black and Minority Ethnic populations. It was important to ensure this would not impact on the capacity of any centre to cope with growth outwith of the projections. Ms Banks noted that the analysis indicated that while some pockets would experience a slightly higher birth rate, this would be very marginal in terms of overall future procedure numbers.

viii. Viability of proposed networks

Mr Glyde advised Members that they could not decide upon Option B unless they were assured that the Newcastle network was viable and deliverable. This had been questioned repeatedly during consultation by respondents from Yorkshire and Humber. Mr Glyde advised that these responses were set out in the Decision Making Business Case. In order to test the viability of the networks and the assumptions made in consultation, the Joint Committee had commissioned PwC to interview key consultees in this regard.

The Chair welcomed Tim Wilson of PwC who outlined the activity conducted under three separate work streams. Clinicians from the surgical centres had been consulted, a survey had been sent out to referring clinicians (153 had responded) and three focus groups had been run to explore the patient flow issue. PwC had also surveyed parents and received 172 responses, which was approximately a 25% response rate, which was a good rate for this type of survey. 21 in-depth telephone interviews had been held with parents and focus groups had been held with 102 members of the public, recruited from the 22 contentious postcodes.

PwC had explored options A to D, reflecting the consultation document. Parents and the public had not agreed completely with the patient flows envisaged by the options. In particular a larger number of people had queried the patient flows envisaged for the Newcastle network in options A, B and C. When asked for initial preferences it had emerged that many people from the contentious postcodes envisaged as part of Newcastle’s network had preferences to attend Alder Hey Children’s Hospital or Birmingham Children’s Hospital for surgical services. Parents and the public had then been asked what would influence parents in their choice of centre. The key factor reported to PwC had been reputation, which related to quality, and which Mr Wilson suggested was a further endorsement of the importance of quality to parents and the public. The second most influential factor had been recommendation from health care professionals. Mr Wilson said that travel considerations had not emerged as one of the top four influencing factors on choice of centre.

PwC had also asked referrers if they would refer in line with the new network configurations envisaged by the options and the extent to which they would need to change their referral patterns. 93% of referring clinicians had stated they would refer in line with Option D, whereas changes of referral pattern were most common in Option C, with 59%. However, the level of agreement from referring clinicians regarding referring within a network was over 90% for all four options tested. There had been some variation in the level of change required to referring patterns, although it had not been very notable. Mr Wilson advised that the concept of managed clinical networks had emerged as critical to the success of reconfiguration during the focus groups, both with parents and clinicians. Good communication, continuity of care and personal contact with the surgeon prior to an operation and for a follow-up session had also been raised as highly desirable.

Asked the extent to which the networks were already in place for each option, the key aspect identified had been the need for more PECs and the delivery of non-interventional care. Mr Wilson advised that respondents were of the view that no current networks were significantly more developed than others. The active management of networks, especially at the initial stage of creation, had been identified as critical by clinicians.

The Chair noted that some submissions made during consultation did not support PwC's advice about the viability of the Newcastle network. Mr Wilson advised that more people interviewed had queried the patient flows envisaged in this network than those in other networks but he cautioned that PwC had not asked respondents for an absolute view on the Newcastle network. He said that PwC's advice was that parents would be driven by the perceived quality of the surgical unit and the advice of referring clinicians. PwC advised that if networks were properly managed residents of Yorkshire would no doubt be content to go to the Freeman Hospital over time. The Chair asked if the Newcastle network could be made viable if necessary. Mr Wilson said that, if properly managed, PwC believed it could work based on the findings of this work.

Mr Buck urged that the scale of challenge to ensure the network function was considerable and it would require sustained clinical and managerial leadership during implementation and thereafter. He said that putting that leadership in place soon after the meeting would be an imperative, in the event that Newcastle was designated.

Members accepted the PwC report.

Ms Banks presented further sensitivity tests, which were designed to test the viability of the Newcastle network. The Leeds, Wakefield, Sheffield and Doncaster postcodes fell in the Newcastle network under Option B. The issue in Newcastle could be viewed from either a sustainability or clinical network perspective. Under sustainability, if it was assumed that three-quarters of the patients from the four postcodes travelled to centres other than Newcastle, under options A, H, I and J, Newcastle would be unable to meet the minimum 400 procedures per year, owing to the presence of Leicester. However, under other options, Newcastle did meet the caseload minimum. The impact on scores across the options saw Option B remaining the highest scored option, followed by Option G.

The second sensitivity, under Quality, (Manageability of Clinical Networks), only made a difference to the scores if all Quality sub criteria were equally weighted. The options that included Newcastle were already slightly down-weighted for clinical networks, but if they were further downgraded to a 1 for this sub criterion, Option B remained the highest scoring option, but Option G's score was much closer to that of Option B.

Mr Glyde highlighted that some respondents had queried the viability of the Southampton network under Option B (as proposed in Appendix Q), specifically with regard to Guildford and Redhill postcodes. The secretariat had set out good reasons why the network was viable in Appendix Q, but Mr Glyde advised Members that were they minded not to accept this, Option G would have to be disregarded for the same reason. Option J was the next highest-scoring option, and scored highly in most sensitivity tests.

ix. Arrangements for the retrieval of critically ill children

Mr Glyde explained that a significant number of respondents had raised concerns about the emergency retrieval of children in Yorkshire and Humber under Option B. The consultation had used a worst-case scenario when measuring compliance with the Paediatric Intensive Care Society standards. Mr Glyde referred Members to the submission from Dr Marriage, the Chair of the Paediatric Intensive Care Society's Acute Transport Group. Dr Marriage had advised that there were potential risks to longer travelling times, but that the available research evidence suggested that the distance travelled by patients to access emergency paediatric critical care did not seem to affect outcomes. Although Dr Marriage included a caveat about the application of these findings to the longer journey times envisaged by option B he advised that the most time critical aspect of retrieval was stabilisation by an appropriate specialist team at a local hospital. The duration of the transport was then of secondary importance.

Mr Hamilton said surgery for babies with 'blue baby' syndrome was time critical and the network in Cardiff had developed a successful model for these babies, but most babies with CHD required rapid stabilisation rather than surgery. Mr Glyde added that the Association of Paediatric Anaesthetists of Great Britain had advised that no problems were insuperable in this regard and that the solution would depend on the final configuration. The Steering Group advised that all the options would require larger numbers of critically ill patients to be transferred over longer distances but this did not present increased risk to the child provided the options complied with the maximum journey time thresholds set out in the Paediatric Intensive Care Society standards, and that the evidence was that those distances were not associated with increased risk.

Mr Glyde summarised that the analysis presented had concluded that all options complied with the three-hour threshold. Also, the Committee had assessed the worst-case scenario and had assumed for this purpose that children in Yorkshire and Humber would receive a specialist retrieval team from the Great North Children's Hospital in Newcastle when in fact the local dedicated paediatric retrieval team, 'Embrace' based in Barnsley would continue to retrieve cardiac children. This would considerably reduce the retrieval times than those considered by the JCPCT. Ms Evans noted that Embrace had noted that extra resource would be required to take on the paediatric service and it was important to plan and finance this increased capacity in retrieval services.

x. Paediatric cardiothoracic transplant services and paediatric bridge to transplant services

Ms Moss referred Members to the advice received from the Advisory Group for National Specialised Services and from Birmingham Children's Hospital around the risks involved in moving the paediatric cardiothoracic transplant service and the paediatric 'bridge to transplant' service from the Freeman Hospital to Birmingham Children's Hospital. Option B would avoid these risks by retaining these services at the Freeman Hospital.

xi. Extra-corporeal membrane oxygenation for children with severe respiratory failure

Ms Moss advised Members that Glenfield Hospital delivered the majority of respiratory ECMO services in the country and that although the professional associations had advised that the service could be safely moved, there were potential risks in moving the service to Birmingham Children's Hospital. She said that the challenge for implementation was to reduce these risks by supporting the relocation of Glenfield's ECMO team and the transfer of its skills to Birmingham Children's

Hospital if Option B was selected. In response to concerns about capacity at Birmingham Children’s Hospital Ms Moss reported that the Chief Executive had provided reassurance about the potential for increased capacity to enable ECMO to be safely transferred. She said that Great Ormond Street Hospital and the Freeman Hospital were also to increase PICU capacity and should be able to assume additional ECMO activity.

xii. Impact to paediatric intensive care services

Mr Glyde advised Members that the consultation document had informed respondents that implementation of Option B would render the PICUs at the Royal Brompton Hospital and the Glenfield Hospital unviable as they predominantly supported cardiac paediatric patients. He said that the PICUs at the John Radcliffe Hospital and Leeds General Infirmary would remain viable as cardiac patients accounted for around 35% of admissions to PICU. However, work would be needed to mitigate the potential risks to the PICU in Leeds; the National Specialised Commissioning Team was actively implementing work streams to strengthen PICUs around England.

xiii. Capacity

Mr Glyde said that Glenfield Hospital had suggested during consultation that the population of the Midlands necessitated two centres as its population was comparable to London. Mr Glyde advised Members that the analysis undertaken during the review did not support this claim; the Midlands represented 19% of the country’s population, whereas the proposed London networks represented 35% of the population. Glenfield Hospital had also queried the ability of Birmingham Children’s Hospital to increase PICU capacity. Ms Moss had spoken to this issue and Mr Larsen would also comment on capacity in his presentation.

xiv. Benefits of a six-site option

The highest-scored options, B and G, were seven-site options. Mr Glyde advised Members that six-site options arguably offered greater sustainability and increased financial benefits from the concentration of activity, but they risked losing high quality centres and destabilising PICUs. He advised that no firm conclusions could be drawn regarding the respective benefits on six-site versus seven-site options, as it depended on the centres included. The Steering Group had advised that six-centre options were less resilient and Ipsos MORI had reported limited support for those during consultation.

xv. London, South East and Eastern England

Mr Glyde spoke in detail to pages 103 – 108 of the Decision Making Business Case. He advised that it was not possible for three surgical units in London to each attain 500 surgical procedures; three units in London could each reach the lower threshold of 400 procedures but these options had scored low in the scoring process; he advised that there were reasonable grounds for concluding that two centres in London could each meet the higher threshold of 500 procedures.

Mr Glyde referred Members to the Pollitt report on the impact to paediatric respiratory services at the Royal Brompton Hospital and to the report from London SCG on the outcome of engagement with users of paediatric respiratory services at the Royal Brompton Hospital. The panel’s summary advice was that although there would be an impact on a range of activity at the Royal Brompton, paediatric respiratory services would remain viable in the absence of an onsite PICU, although alternative arrangements would have to be made for a small range of children. Ms Radmore advised Members that London Specialised Commissioning Group was currently leading an engagement process with users of paediatric respiratory services at the Royal Brompton Hospital, in its role as commissioner of paediatric respiratory services in London. She highlighted that the engagement work was not complete, but emerging themes were around research, the sustainability of rotas and the importance of collaboration between centres. Chelsea and Westminster Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust had confirmed that they believed they could sustain paediatric respiratory services in London if necessary. The Chair suggested that there was no evidence available to the JCPCT that suggested that the Pollitt recommendations could not be implemented. Ms Radmore agreed. Ms Evans noted that the Royal Brompton Hospital had been concerned about the impact to its respiratory research programme. Professor Boyle said that collaboration with other centres should be advantageous to the Royal Brompton’s research programme.

Ms Banks advised Members that they would be required to decide which NHS Trusts should be designated as surgical units in London if they decided on option B or any other option that proposed two units in London. She advised that the same criteria

	would be used to score London centres as had been used to score the options. Members were referred to the detailed analysis in section 13 of the Decision Making Business Case. Ms Banks proposed that the Evelina Children's Hospital scored highest against the criteria, followed by Great Ormond Street Hospital. She proposed that the Royal Brompton Hospital was scored third even when sensitivity tests were applied. **Recommendation 18 (as numbered in the Decision Making Business Case): Mr Glyde asked Members to agree the designation of the Evelina Children's Hospital and Great Ormond Street Hospital for Children as providers of paediatric congenital cardiac surgery in the event of the JCPCT deciding an option with two surgical units in London.** **Members agreed.** **Recommendation 19 (as numbered in the Decision Making Business Case): Mr Glyde asked Members to accept: the findings of the Pollitt report; that paediatric respiratory services will remain viable at the Royal Brompton Hospital in the absence of a viable paediatric intensive care unit, though alternative arrangements would have to be made for a small number of children.** **Members agreed.**	
20. Report on finance and capacity	Mr Larsen referred Members to the capacity and finance reports. He advised Members that although the review was not about making financial savings, the JCPCT had to take account of the affordability of its chosen configuration and whether it could be managed by providers. He said that only 0.2% of the total commissioning budget was spent on paediatric cardiac surgical services each year. He reported that all providers had capital programmes in place to meet the cost of transition and implementation to deliver the standard and activity levels. Workforce costs were estimated to be between £7 million and £11 million, which was relatively small overall. Fixed costs to de-designated centres were likely to be a very small percentage of turnover but there	

	were financial constraints in the NHS and providers were required to make savings. However, the proposed changes to paediatric surgery were deemed manageable to providers by NHS commissioners. Additional costs for providers would arise from the proposed appointment of new Network Directors and Clinical Leads. Investment would be needed in developing and training Paediatricians with Expertise in Cardiology; the estimated cost of £2.9 million per annum was based on 130 trained paediatricians spending one day a week on paediatric cardiac care. A total cost of approximately £7 million had been estimated to enable trusts to meet the improved quality standards, but this was considered to be a pessimistic view. Capital charges were a total additional cost of around £12-14 million for each configuration option. A central project management team would be required to manage the cost to commissioners over the first two years. Providers were expected to offset their increase in costs through the extra income received for the service they provided, which would be provided at marginal rates. Mr Larsen advised the JCPCT that the total cost of the service in the future should be roughly that which it was currently and that the new configuration was affordable to commissioners and manageable to providers. Capacity risks increased the potential to have a greater number of spells, owing to the care being given at various different locations. To manage this, there was an option of splitting the tariff to ensure the right income could be directed to the right place. PICU places were currently charged at different rates across the country, which posed the risk of increased costs when transferring patients from low-cost PICUs to high-cost PICUs, which had to be managed. The market forces factor was a supplement paid to providers to cover the additional cost of the location and this should also be kept in mind when moving activity. Providers had also raised the issue that high costs to providers for what was a low-activity service might put pressures on local economies of health. This also had to be borne in mind during implementation. Mr Larsen concluded that the configuration options were affordable to commissioners and manageable by providers, but it was important that a cost implementation be drawn up as soon as possible post the decision, with a robust commissioning strategy to control costs. Options G and B were the most cost-effective based on points per million pounds, but there was little differentiation between the options.	

	Ms Griffiths highlighted that throughout the day the need to revisit issues during implementation had been mentioned many times and the new implementation costs should be reflected in the financial presentation. The Chair endorsed the need for robust financial planning in the implementation plan. **Recommendation 20 (as numbered in the Decision Making Business Case): Mr Glyde asked Members to agree that the JCPCT's proposals are affordable and that providers have demonstrated realistic plans to increase capacity.** **Members agreed.**	
21. Members will be asked to agree for implementation the number and location of Congenital Heart Networks in England	Before putting the final recommendation to Members, Mr Glyde asked Members whether they required further evidence from any of the advisers present. Members responded that they did not. **Recommendation 17 (as numbered in the Decision Making Business Case): Taking into account all of the evidence submitted to and considered by Members, Mr Glyde asked Members to agree for implementation the designation of congenital heart networks led by the following surgical units:** • **Newcastle Upon Tyne Hospitals NHS Foundation Trust** • **Alder Hey Children's Hospital NHS Foundation Trust** • **Birmingham Children's Hospital NHS Foundation Trust** • **University Hospitals of Bristol NHS Foundation Trust** • **Southampton University Hospital NHS Foundation Trust** • **Great Ormond Street Hospital for Children NHS Foundation Trust** • **Guy's and St Thomas' NHS Foundation Trust** **Members agreed option B for implementation.**	
22. Close	The Chair emphasised that the implementation plan would need to be elaborated following the decision to ensure it covered retrieval, PICU capacity issues, mitigation of impacts, migration paths for NCS and the implementation of the networks. He urged all the designated centres to work closely with their stakeholders to consider how the decision could be implemented for the benefit of children with congenital heart conditions.	