

Safe and Sustainable
**Joint Committee of Primary
 Care Trusts (JCPCT)**



**National Specialised
 Commissioning Group**

**Minutes from the Joint Committee of Primary Care Trusts Meeting
 Dexter House, Royal Mint Court, London, EC3N 4QN
 Wednesday 16 February 2011**

Name	Body/Association	Role
Sir Neil McKay CB	Chair, Joint Committee of Primary Care Trusts	Chief Executive, East of England SHA
Dr Martin Ashton- Key	NHS Specialised Services	Medical Adviser
Ros Banks	KPMG	
Professor Roger Boyle CBE	Department of Health	National Director for Heart Disease and Stroke
Sophia Christie	West Midlands SCG	Chief Executive, Birmingham East and North PCT
Ailsa Claire	Chair, Yorkshire and the Humber SCG	Chief Executive, Barnsley PCT
Jon Develing	North West SCG	Chief Officer
Deborah Evans	Chair, South West SCG	Chief Executive, Bristol PCT
James Ford	Grayling	Managing Director, Public Sector
Jeremy Glyde	Safe and Sustainable NHS Specialised Services	Programme Director
Catherine Griffiths	Chair, East Midlands SCG	Chief Executive, Leicestershire County & Rutland PCT
Mr Leslie Hamilton	President, Society for Cardiothoracic Surgery in Great Britain and Ireland	Vice Chair, Paediatric Cardiac Surgery Steering Group.
Dr Patricia Hamilton CBE	Chair, Paediatric Cardiac Surgery Steering Group	Director of Medical Education, England
Professor Sir Ian Kennedy	Assessment Panel, Safe and Sustainable	Chair of the Assessment Panel
Paul Larsen	Safe and Sustainable NHS Specialised Services	Finance Lead
Dr Lise Llewellyn	Chair, South Central SCG	Chief Executive, Berkshire East PCT
Mr David Mason	Legal Advice	Lawyer, Capsticks
Teresa Moss	NHS Specialised Services	Director of NHS Specialised Services
Sue McClellan	London SCG	Chief Operating Officer
Stephanie Newman	South East Coast SCG	Director, South East Coast SCG
Chris Reed	Chair, North East SCG	Chief Executive, North of Tyne PCT
Hilary Thomas	KPMG	Associate Partner
Paul Watson	Chair, East of England SCG	Chief Executive, North East Essex

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Apologies

Name	Body/Association	Role
Steve Phoenix	Chair, South East Coast SCG	Chief Executive, West Kent PCT

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<p>1. Introductions</p>	<p>The Chair opened the meeting explaining that the meeting was not a public meeting. Questions could not be raised during the discussion, but details of local consultation meetings would be given, at which the public would be able to ask questions.</p> <p>He said that the meeting represented a seminal moment in the long-running debate over safe and sustainable (S&S) children's heart surgery services. The national specialised commissioning team (NSCT) would today set out the case for change and why it proposed consultation should be held as to how these services should be provided in the future.</p> <p>The Chair explained that he was a neutral party, given that the East of England did not have a centre. The Committee was formally constituted and comprised representatives from the various specialist commissioning groups (SCG). PCTs around the country had consented to their views being represented by the Committee today. Other colleagues who had worked on the review were also present, including some from the clinical Steering Group, chaired by Dr Patricia Hamilton, which had also been heavily involved in the process. Hilary Thomas and her team from KPMG had assisted with the technical analysis of the options and David Mason was attending as the legal advisor. Members of the communications team were in attendance. A representative of NHS Wales was also present to observe, as England provided the service to Wales.</p>	
<p>2. Declaration of interests</p>	<p>The Chair declared that from 2002 to 2006 he had been the Chief Executive of Leeds Teaching Hospitals, which included paediatric cardiac surgery. Mr Hamilton said he had trained in Leeds, Belfast, Great Ormond Street Hospital (GOSH) and Birmingham. He had also worked in Newcastle, but was now retired from paediatric cardiac surgery (now adult cardiac surgery and transplantation) and as such he had no vested interests. Professor Roger Boyle had worked in Leeds for three years during his training period.</p>	
<p>3. Purpose of the meeting</p>	<p>Mr Glyde said that the Committee was in receipt of the Pre-Consultation Business Case (PCBC); the outcome of a review that taken just over two years, although the case for change went back considerably further. The case for change would be put to the Committee with regard to how children's cardiac services were planned and delivered, including a proposal to reduce the number of NHS Trusts providing the surgical service. The Committee would be asked to agree the case for change for public consultation. It would receive the proposed quality standards to be met and the proposed model of care and asked to agree both for public consultation. It would also receive a description of the</p>	

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	<p>process as followed by the NSCT over the last two years and the potential recommendations for the reconfiguration of children’s cardiac services. It would be asked to approve the process and the recommended options for public consultation. At the conclusion of the meeting the Committee would be asked whether it felt public consultation should commence as proposed from 28 February until 1 July, and finally agree the process for consultation, including the consultation documentation and questionnaire.</p>	
<p>4. Agree the ‘Case for Change’ for reconfiguration of children’s congenital cardiac services in England</p>	<p>Mr Hamilton emphasised that the review was not a cost-cutting exercise, but about providing the highest quality care. Section 5 of the PCBC detailed the case for change. Since the first successful open-heart procedure had taken place in 1953, mortality had dropped from 75% to less than 5% for all procedures. Currently, there was probably no condition for which surgery could not be offered.</p> <p>Today’s units had been established in an unplanned way, entirely owing to huge enthusiasm and hard work from those involved. It was understood why people felt strongly about their local centres, but for the good of children in future, these interests had to be put aside. 11 units now existed from an original 15. He said that the review was the continuation of a trend that had already begun. It was generally accepted that the configuration of current units was not ideal, given its unplanned nature. The Kennedy Inquiry following a public inquiry in 2001 had made seven recommendations related to paediatric cardiac surgery; three had stated the need for bigger centres, but no action had been taken due to political inertia. James Monro had chaired a working group that had reiterated this recommendation for bigger centres in 2003, but the minister at the time had not been minded to accept the recommendation.</p> <p>Then, in 2006, Professor Boyle and Dr Sheila Shribman (National Clinical Director for Children, Young People and Maternity) had obtained unanimous agreement at a joint meeting of all the units on the need for reconfiguration. In 2007 Professor Sir Bruce Keogh, President of The Society for Cardiothoracic Surgery (SCTS), wrote to the then Secretary of State requesting a review, which he had subsequently been tasked with conducting when he had then become Medical Director of the NHS. Sir Bruce had made the case for change to the NHS management board and the review had then begun. There was unprecedented support for the review from professional bodies and national charities.</p> <p>Regarding the evidence base for change, Mr Hamilton explained that while the Central</p>	

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	<p>Cardiac Audit Database (CCAD) provided arguably the best data in the world, because the numbers per centre were so small, robust analysis could not be conducted, so no evidence to maintain the current service was available. However, the S&S Team had commissioned an external review of the literature and papers, which showed a clear relationship between outcome and volumes in paediatric cardiac surgery. The research evidence did not identify a specified minimum number that any unit should conduct, but this was a matter for discussion, pragmatism and common sense. Evidence from other types of surgical specialities and from paediatric cardiac surgery in other countries suggested higher volumes provided better outcomes. Moreover, larger units with greater numbers of cases would facilitate improved analysis and comparisons between centres. Paediatric cardiac surgery was the most complex type of surgery; the move towards earlier correction made it more complex still. In addition, the professional consensus was that the current service was not sustainable and there was an increasing need for sophisticated post-operational care.</p> <p>Professor Boyle highlighted that paediatric cardiac surgeons worked in highly emotionally-charged and stressful environments; it was not fair to ask surgeons to work in a pair or in threes. Team work was critical and necessary to ensure that trainee surgeons had the chance to work with more senior, experienced surgeons. The service should not depend entirely on recruitment from abroad. Dr Hamilton added that where there was the opportunity to be looked after locally, this was preferable, but that care should take place in specialist centres when this was essential. Trainees' expectations regarding patient safety and role models could not be satisfied in the current service. Mr Glyde advised the Committee that the case for change and proposals for fewer, larger centres, minimum surgeon and procedure numbers and development of networks had been endorsed in September 2010 by the National Clinical Advisory Team (NCAT). Ms Christie queried whether these arrangements would also cover non-congenital heart conditions. Mr Hamilton confirmed that any child with a heart problem would be covered by the service.</p> <p>The Committee agreed the case for change based on Section 5 of the PCBC.</p>	
<p>5. Agree the proposed clinical standards and model of care for children's congenital cardiac services in</p>	<p>Dr Hamilton presented this item. She said that the Steering Group had been set up in 2008 and nine meetings had been held to date. The membership provided broad representation from each of the professional bodies and associations and paediatric nursing, patient groups, commissioners, public health, the Department of Health and Wales had also been represented. The terms of reference had been to agree standards</p>	

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England	<p>and define the process. Access, quality and feasibility had been priorities. A sub-group had been convened to consider the evidence where available, and opinion and consensus where it was not. At an early stage the group had decided that network standards and pathway standards were also important. The standards therefore examined networks, prenatal diagnosis, the surgical centres, age appropriate care and issues of transition; information and choice and the family experience.</p> <p>The standards document before the Committee covered some very specific standards, such as four surgeons per centre, which was a standard aimed to ensure the safety and sustainability of the centre, and 400 procedures per centre, to keep up surgeons' expertise. Other standards included having agreed protocols across the networks, the provision of a lead paediatric nurse for each family and family accommodation. These standards had been consulted upon in stakeholder groups and the Steering Group and refined before being finalised.</p> <p>Sir Ian's panel visits had been devised following self-assessment by centres against the standards. The Steering Group retained its involvement, providing input where the JCPCT requested it and continuing to work on the networks, given the Gateway Review had requested further detail on how networks would function. The Gateway Review was a formal process adopted across Government for large-scale projects, where people outside of the NHS and DH scrutinised the work and project management etc.</p> <p>Ms Griffiths commented that she had been impressed by the Steering Group's rigorous consideration of the clinical debate and challenge, and the strong alignment of opinion following such debate. Ms Christie commented that, while there was a requirement for centres to demonstrate arrangements for palliative care and end-of-life care in the standards, there was not the same with regard to local or cardiology centres. Regarding anaesthesia, she noted on page 31 that specialist paediatric anaesthesia was mentioned as a key co-dependency but earlier in the document reference was made only to 'a dedicated paediatric surgical team'. Ms Llewellyn queried the weighting of co-location in the quality standards and whether the Steering Group had felt any further weight should be allocated to co-location. Mr Develing queried whether it would be possible to benchmark the service standards internationally.</p> <p>Dr Hamilton agreed that greater emphasis should be placed on palliative care locally. The standards were aspirational and reflected a gold standard; the colour coding</p>	
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	<p>indicated those standards the Group considered particularly important. However, there was always a balance to be struck and the weighting system could not indicate where one standard outweighed another. Where strict co-location was evidenced, this should be given due consideration, but other equally high-rated standards could hold equal sway in decision making. The critical interdependencies document referenced in the standards defined co-location as onsite or with evidence that services could be delivered from a neighbouring hospital as though they were on the same site, in recognition that physical co-location was not always possible.</p> <p>Mr Hamilton commented that the Steering Group had recently discussed whether it was correct to go beyond the standards and ask for physical co-location. Sir Ian's panel had been asked to look at this specifically during their visits and their comments on this matter were in their report. Regarding anaesthesia, there were no standards for training currently in paediatric cardiac anaesthesia. The S&S Group had challenged the relevant professional associations to convene a group to devise standards to be applied in future.</p> <p>The Committee agreed the proposed standards and the model of care for public consultation.</p>	
<p>6. Agree the process for delivering recommendations for reconfiguration of children's congenital cardiac services in England</p>	<p>Professor Sir Ian Kennedy introduced the first part of this item. He explained that he had been asked to Chair a panel of experts, who were given a brief to assess each centre offering paediatric cardiac surgery by reference to the standards. Each centre had firstly responded to a questionnaire in writing, stating to what extent, if at all, they complied with those standards, given the standards had only come out in March and the visits had taken place in June. They had also been asked what plans they had to comply with the standards if they currently did not, and what plans they had in place in order to meet the number of procedures deemed optimal, 500 or more. Each centre had then been visited by the Panel and assessed based on observations and conversations with stakeholders, again, with reference to the standards. The assessment had been not merely whether the centre was safe, but whether it was able to sustain its level of safety. The panel had met parents, carers, young people who had undergone procedures, nurses, doctors, managers, and non-executives to obtain a full a picture regarding their perceptions, ambition and vision in relation to the standards.</p> <p>Each centre had been assessed in its own right and they had not been compared. The standards had been applied consistently and the panel had then taken a view</p>	

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addressing safety and sustainability by reference to the standards. It had then reported its findings to the Committee, which had taken them forward and applied further consideration to them.

Subsequently, data had been made available on mortality at three particular centres and the panel had been asked whether this affected their opinions. Sir Ian had asked for a separate small inquiry to be carried out by James Pollock, who had reported back to the panel on his findings. The panel had considered his report and decided it had not changed its view, for reasons set out in the paper before the Committee.

Ms Moss asked Sir Ian if he could address how the issue of co-location had been approached, given many questions had been asked about this. Sir Ian said that when the Panel had written its report they had spoken and applied a definition of co-location contained within the Department of Health critical interdependencies document of 2008 and in line with the Safe and Sustainable standards. However, it was for the Committee to decide which approach it deemed to be suitable; the Panel had been given this approach and adopted it.

Sir Neil thanked Sir Ian for the work of his panel.

Ms Thomas presented the remainder of the item. She confirmed she had no interests to declare and explained that KPMG had supported the NSCT on analysis, but had not influenced the process. She summarised that reducing the number of centres from 11 had initially presented 2047 potential configuration options.

Ms Thomas explained that application of the 400-case threshold, the panel's ranking, best geographical fit, and assuming configurations of six or seven sites had reduced potential configurations to 792. As this was still too many to analyse, the lowest scoring site, Oxford, had been excluded, on the basis of it being an outlier in the panel's scores. KPMG had tested whether Oxford's exclusion had an adverse affect in terms of access for the public, by reinstating it in the analysis and ensuring options that excluded it were not disadvantaging the population in terms of access to alternative centres. The highest scoring site had been included in all the options as it was in London and, for geographical reasons, at least one site would need to be London. Two London centres were nominally included at this point, on the basis of scores and access and as there were no sites in Kent, Essex or East Anglia; London's activity levels meant two sites

	<p>was the optimum number.</p> <p>On this basis, 21 potential options had then remained. Applying the ranking from the panel scores, the options had been numbered. Further testing using best fit according to population density maps had shown that two top-ten options had been eliminated as they did not provide a good fit, requiring illogical travel patterns. Five options had been used to retest the assumptions so far: Option 9, as to whether three sites in London provided better access, and 10 and 11, as to whether the Oxford's inclusion provided better access, substituting it for the nearest and next nearest sites. KPMG had tested whether six-sites could provide adequate access and whether an option that had all of the current Nationally Commissioned Services (NCS) in it would provide better access.</p> <p>A shortlist of 13 options had remained to be tested in the first round of detailed access mapping. Oxford's inclusion had not enhanced access and had therefore been eliminated on the basis of its panel scores. It had been established that London should have at least two sites; Birmingham should remain in all options because of its population density, catchment area, very high caseload and high score. At this stage of the process an assumption was made that Bristol and Southampton were mutually exclusive as it was not established that both centres could meet a minimum of 400 procedures a year based on known patient flows; two centres were needed in the North of England, Liverpool and Newcastle or Liverpool and Leeds, based on access and population. This had left 12 potential options, to which two had been added that included all the centres that had scored most highly in the assessment panel visits. This had left 14 potentially viable options.</p> <p>The Chair highlighted that the public would have the opportunity to read the documents and raise queries at their local consultation meetings and that the Committee had already had time to understand and consider the process used in full.</p> <p>Mr Reed asked whether alternative options and views put forward in consultation would be considered. The Chair confirmed that during the process of consultation any proposals made that appeared to be better than those put forward in consultation would be considered. Ms Christie highlighted that the options that included the highest quality grouping as assessed against the standards in Sir Ian's visits included both Bristol and Southampton and queried whether this was to test catchment areas in consultation, given potential changes to patient flows that had occurred since Oxford's surgical</p>	
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	<p>service had ceased. Ms Thomas confirmed that Options 13 and 14 both included Bristol and Southampton; these options had been included to ensure that the findings of Sir Ian's panel were taken into account and reflecting potential new arrangements between Oxford and Southampton. Dr Llewellyn said Oxford had ceased its services and created a new, robust combined model with Southampton; the figures used in the process did not reflect this new pathway.</p> <p>The Committee approved the process so far.</p>	
<p>7. Agree configuration options for consultation</p>	<p>The Chair referred the audience to Section 8 of the PCBC. Ms Thomas said the aim of this section was to present the evidence that supported the scoring of the shortlisted options and produce recommended options for consultation. Referring to the scoring, she explained that 0 meant an option did not meet any elements of a criteria; 1 meant it met some, 2 meant it met most, 3 meant it met all and 4 meant it exceeded the criteria. Options were scored against sub-criteria, with composite scores given for criteria. Evidence to demonstrate compliance against each criteria came from a number of different sources; however the Committee would have to apply its expert knowledge and exercise judgement in weighing the relative importance of the findings to determine an overall score.</p> <p>She presented the 14 potentially viable options. Analysis had been carried out by estimating the number of patients in each postcode district and allocating those districts to the potential future networks. Patients per postcode had been estimated based on referrals in 2009/10, extrapolated to predict referrals in 2025/26, based on the paper written by Dr Ashton-Key. An error rate reflecting fluctuation in the previous 10 years had been applied. Configurations that did not permit the 400-procedure threshold, or, in the case of Birmingham, exceeded an upper limit of 800 cases, had been eliminated as Birmingham had stated that it could not cope with more than 800 cases. This left nine potential options.</p> <p>In line with the conclusions of an expert group convened for this purpose, the JCPCT was advised that options had to include at least three centres capable of providing ECMO, two providing transplant and one providing complex tracheal surgery. Birmingham and Bristol had been deemed capable of providing ECMO services in the future. GOSH and Newcastle provided transplant; Birmingham was also felt capable of providing this service in the future. Only GOSH provided and could provide complex tracheal surgery. Two of the remaining nine options did not include at least three of the</p>	

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	<p>centres identified, and had therefore been eliminated, leaving seven options. Options were also to meet minimum requirements for retrieval set out by the Paediatric Intensive Care Society (PICS), which meant that Bristol had to be included in all reconfiguration options, owing to retrieval times from Truro, South Wales and parts of Cornwall. One further option from the seven remaining had therefore been excluded.</p> <p>The six remaining options had then been scored for access and travel times. Based on increased travel times for elective surgery, Options six and ten had the greatest negative impact, while Option 2 had the smallest negative impact. Options 8, 12 and 14 had been amber-rated. A similar picture had emerged when the total absolute numbers of patients whose travel time increased had been explored; Option 2 had caused the smallest negative impact, while option 14 had resulted in an increase to the greatest number of patients. Considering these tests together, Option 2 scored 4, Options 8 and 12 scored 3 and the others had all scored 1.</p> <p>The second sub-criteria in access and travel times was retrieval times. Mr Glyde said the options had been assessed using road time data and average journey times from journeys across three times of day. The outcome of the analysis was in the appendix to the PCBC; Option 1 had been found unviable against the retrieval standards of the Paediatric Intensive Care Society standards.</p> <p>Ms Thomas explained that, based on retrieval times, all the options were comparable. In the composite scores for access and travel times, scores for elective admissions therefore had the most impact.</p> <p>Dr Ashton-Key clarified that all potential service providers had been asked to say if they were willing to provide any NCS and give evidence in support of this. Not every provider had indicated that they wanted to do so, hence, where Birmingham and Bristol were deemed capable, this did not mean others were not, but rather they had not wanted to. Ms Christie queried whether options with Bristol and Newcastle had provided a best fit from an access perspective. Ms Thomas confirmed this: Option 2 had the least impact in terms of travel times for patients and their families. Options 6 and 10 also included Bristol and Newcastle but did not have Leeds and therefore required unusual networks to enable Newcastle's catchment to be viable.</p> <p>The first sub-criteria under quality was the quality of service, for which individual centres'</p>	
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scores from Sir Ian's assessments had been added and totalled for each configuration. For options with different London centres, a range was presented in accordance with the different scores for London. Average scores ranged from 446 to 472. The six-site options included a seventh score, which was the average taken across the whole of the six-site options, to create comparable figures. On quality, Option 14 scored the highest with 4, but the range was still narrow; all other options scored 3 and even the lowest scoring option scored over 95% of the potential score.

The second quality sub-criteria was innovation and research. All centres had completed a submission to demonstrate compliance with the standard and the assessment panel had been convened to score them out of 5 on their written submissions and the panel's visits. Again, individual centres' scores had been totalled for each option to give an innovation score and again, the number varied for options with two London sites depending on which centres were included. All options included a centre with maximum score of 5 as each included two centres in London and Evelina and GOSH had both scored 5. Similarly every option included Liverpool, which had a minimum score of 2. The variation was therefore minimal across the options, although Options 6 and 8 had a slightly lower total score as they were six-site options. Option 14 scored 4, while all the others scored 3.

The final quality marker related to manageable networks. KPMG had worked with specialised commissioning groups (SCGs) on likely future networks. Option 14 was amber-rated, as in order for Southampton to achieve 400 cases patients from Redhill, Brighton, Hemel Hempstead and Slough postcodes would have to be part of its network. Clinical networks were deemed viable in all the options, but Option 14 had scored a 3 because of this issue.

Ms Thomas summarised that total scores for quality showed remarkable concordance, but Option 14 emerged as the best.

The Chair asked Mr Hamilton to explain why clinical outcomes had not featured in the assessment. Mr Hamilton said there was no risk-stratification process in paediatric cardiac surgery, so no allowance could be made for the differing case mix between units. It had therefore been felt unfair to use mortality outcomes, especially given the small numbers involved. Ms Griffiths asked for an assurance to be given that the viability of the network that included Bristol and Southampton would be tested in

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	<p>consultation, as some of the flows appeared counterintuitive.</p> <p>Mr Glyde said the consultation period would include a process for testing the assumptions under Option 14, both around where patients would travel based on their nearest centre and with regard to understanding implications to patient flows in South Central England following suspension in Oxford. Mr Watson reiterated that a patient flow from Hertfordshire to Southampton seemed counterintuitive. Dr Ashton-Key commented that the experience of trying to reconfigure services nationally showed that clinically-led and trust-led changes were more successful; it was worthwhile to consider the work that Oxford and Southampton had begun. He urged that patient flows could not be proven until tested; patient choice also influenced flows counter-intuitively.</p> <p>Ms Thomas explained that the deliverability criteria related firstly to provision of NCS, then to PICU and other interdependent services. All options would be affected by workforce issue but this could not be addressed until implementation. All centres' transition plans were fully supported by their SCGs, so it was not possible to differentiate options according to transition plans. In all cases, the optimum recommendation against this specific criterion (and without prejudice to the JCPCT's final recommendations) was therefore to retain NCS where there currently were. Option 2 retained Newcastle and Leicester and all three ECMO services and therefore had the highest score. Options 8 and 12 contained neither Newcastle nor Leicester and were red-rated, and Options 6, 10 and 14 were amber, as they contained Newcastle but not Leicester.</p> <p>The Safe and Sustainable team had asked for analysis to be conducted regarding the risk to PICUs. All remained viable under the new reconfiguration options, with three exceptions: Leicester, Newcastle and the Royal Brompton. However, the impact of the loss of these to the national network was low risk as they exist primarily to support children with cardiac problems. Potential risks remained with regard to the destabilisation of other PICUs, however. If de-designated, Bristol's patient numbers would fall and Leeds and Southampton would face the same issue. Options with Bristol and Leeds were green-rated, those with just Bristol were red-rated and those with Bristol and Southampton were amber-rated.</p> <p>Options 2 and 14 had the highest composite scores for deliverability and Options 8 and 12 had the lowest.</p>	
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Ms Moss said that the challenges around deliverability were not underestimated; they would impact many of the services, hence the need for national coordination and careful management.

Activity levels were the first sub-criteria of sustainability. Activity levels under all seven-site options fell within acceptable parameters. Under Option 8, Leeds would receive a significant increase in activity against historical levels so Option 8 had been marked amber. In options with three London sites, activity numbers decreased in the London sites, but under Option 12 Leeds had higher activity again. Option 14's figures had been looked at based on Southampton activity figures with or without the postcodes for Brighton and Redhill or with postcodes for Hereford and Worcester allocated to Bristol. Currently in both those options, Southampton was slightly below the 400-case threshold.

All options achieved the minimum caseload, apart from Option 1. Options 6 and 10 scored most highly, followed by 2, then 8 and 12. Scores had not been given for recruitment and retention of newly qualified surgeons, as this was an issue for implementation. The total scores for sustainability were therefore 3 for Options 2, 6 and 10 and 2 for Options 10, 12 and 14. Ms McLellan queried whether maximum case numbers could be explored during consultation. Mr Hamilton said that definition of 'case' varied and it was very problematic to determine a maximum. Ms Christie said her concern was the issue raised in Sir Ian's feedback regarding the experience for children and families in very large centres; it was difficult to quantify but could be explored in consultation. PICU sustainability was a potential challenge when numbers rose; hence the ceiling imposed in Birmingham. Ms Moss said that providers had been invited to provide maximum numbers; these had been included in the development of the potential criteria.

Referring to the absolute scores, Ms Thomas explained the scores had been weighted according to consultations held in summer 2010. When this weighting was applied, an overall score for each option was obtained. Option 2 scored the most highly, followed by Option 14. Options 6, 10, 8 and 12 were lower but relatively similar. A second version of the overall scoring had been produced as a sensitivity check, which assumed equal quality scores for each option. Option 2 then scored relatively higher and Option 14 scored below 6 and 10 but above 8 and 12.

Ms Thomas explained that of the six remaining options, four had two sites in London and two had three sites in London. Those with three sites were assumed to have the same out-of-London configuration as the two-site centres. In three-site options all London sites could reach the minimum caseload of 400, but not the ideal of 500. The JCPCT had asked KPMG to apply the same process to London centres as for the other options. Looking at the same criteria and sub-criteria, there was no difference between the three London centres on access and travel times. Under quality, based largely on the impact of innovation and research, the Royal Brompton scored 2, Evelina scored 4, and GOSH, 3. Under deliverability, GOSH scored highest, followed by Evelina and then the Royal Brompton. All designated sites could perform at least 400 procedures; there had been no reason to differentiate them. Using weighted composite scores, Evelina scored 364, GOSH scored 347 and the Royal Brompton scored 264.

Mr Larsen presented the financial assessment criteria for the potential configuration options. In 2009/10, NHS commissioners had spent £98 million on these services, less than 0.2% of NHS Budget. Regarding set up costs to deliver extra numbers, each option's capital costs would be between £12 million and £25 million. Those centres who had submitted their returns suggested they were committed to that spend and planning it. Capital costs were one-off and came out of capital budgets. HR costs through training, moving etc. were estimated at around £2 m per centre, so a total cost of £9 million to £11 million. Legacy costs impacted providers and included fixed costs left with a centre once they had lost an income, e.g. unsupported spend for theatre space. This came to between £9 million and £16 million. In total the impact in terms of capital cost and revenue to the provider was between £30 million and £50 million, which was still a small proportion of total budgets of the centres impacted; less than 1%, and arguably manageable. Commissioners would also have implementation costs in setting up networks. Over two years this would cost £600,000. Each network would also need a dedicated director-level post, which would cost £1.8 million to £2 million per option, which was a very small proportion of total commissioning spend. Ranked by implementation cost, Option 2 necessitated the lowest increase in funding. Mr Larsen explained that options 6a and 6b differed according to the envisaged networks.

However, long-term ongoing costs were also involved for the providers, especially with regard to increasing numbers of paediatricians with an expertise in cardiology, and these costs were very similar across each option, at around £4 million. This

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represented a 4% increase in cost, but economies of scale should also result once fewer, larger centres were in place. Other aspects to be considered were tariffs and local impacts, which were likely to be disproportionate across the country. An increase in 'spells' under the networks would mean increased tariff charges to the commissioner, as there would be increased transfers from surgical centres to cardiology centres or District General Hospitals (DGH) before returning home. Tariffs could be split between the surgical centre and local centre to mitigate this, or the surgical centre could buy the service from the local centre. Local PICU prices varied currently; this would need to be addressed prior to implementation. The market forces factor related to local cost; if centres were moved from low-cost to high-cost areas there could be an impact on commissioners. A risk-sharing agreement could be implemented across commissioners to mitigate this. Mr Larsen concluded that all the options were affordable, although Option 2 necessitated the lowest increase in funding. Once a recommendation was made, a full cost-implementation agreement and sharing plan would be drawn up. Based on costs, the options were ranked thus: 2, 14, 6, 8.

The Chair asked how many more cardiologists £2.9 million would fund. Mr Larsen said he believed this would fund about 30. Dr Llewellyn welcomed the suggestion that these figures be explored further during consultation; she thought some of the costs that had been attributed had not reflected comments made in the quality report with regard to changes necessary in some of the units. Mr Reed added that Mr Larsen's work was based on the assumption that efficiency changes could be ringfenced to allow reinvestment in these improvements. This would need to be tested. Dr Ashton-Key urged that staff appetite for relocation be tested with centres during consultation. The Chair urged that cardiology in DGHs versus specialist centres in terms of manpower be clarified with regard to the financial assessment. Ms Moss commented that the Steering Group was continuing to develop the standards for paediatric cardiology centres and the DGHs.

The Committee endorsed the progress of the financial assessment, noting it was not finalised.

The Committee endorsed the process that had been followed to deliver options for consultation.

The Committee agreed the following options for public consultation: A (Option 2),

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	<p>B (Option 14), C (Option 6) and D (Option 8).</p> <p>Mr Reed reiterated that in presenting four options the Committee was inviting views about the quality of the analysis and suggestions of other options.</p>	
<p>8. Agree proposal for recommendations for monitoring outcomes in children’s congenital cardiac services in the future</p>	<p>Mr Glyde commented that pages 92 and 93 set out the recommendations for improving the process of monitoring clinical outcomes in the future. Professor Boyle explained that the monitoring process currently relied on very hard work by a small number of people in centres, who entered cases onto a database. Each centre then was subject to validation through visits to ensure no cases were omitted, by reference, for example, to theatre log books. Case notes were also sampled to ensure that data entered to the database tallied. It was a time-consuming process and relied upon a single individual with volunteers travelling around the country. Data was collected on 149 procedures were collected and analysing that data took time; this also was conducted largely by one individual. The recommendations aimed to improve the process, especially with regard to timeliness to provide more up-to-date data to the public.</p> <p>The Chair asked whether centres could decline to participate. Professor Boyle said that the process was practically mandated, but naming hospitals that did not submit data or that submitted data of a lower quality was a powerful lever. However, the process was the most complete of any in the world and widely admired.</p> <p>Mr Watson suggested the Committee recommended participation as a requirement in future contracting. It was confirmed that the new commissioning should provide that opportunity. The Committee was happy with the proposals in the PCBC, with the addition suggested by Mr Watson.</p> <p>The Committee agreed for public consultation the recommendations for monitoring outcomes in the future.</p>	
<p>9. Agree consultation strategy</p>	<p>Mr Ford explained that it was proposed that consultation would run for four months; one month above the statutory requirement, given the scope of the review and public holidays. People had to be made aware of the consultation, informed about the proposal and the need for change. The Committee had to listen to questions, suggestions and comments that would be fed back to them by an independent third party. The following day a registration site would be made available that would list the consultation events. On 28 February consultation materials would be provided and</p>	

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	<p>face-to-face events would take place between March and June. Updates would be sent to all involved via a newsletter during consultation and the consultation would close on 1 July. Anybody was welcome to comment on the consultation but the key audiences to be engaged included parents with children with congenital heart disease, young people, scrutiny committees, NHS staff and providers. Politicians and stakeholders would be provided with written briefings in the next week or so. Materials such as the consultation document and questionnaire would be directly sent to as many people as possible. The communications team would also be keen to work with trusts, the NHS and parent groups to ensure the materials reached the target audiences.</p> <p>Media had been informed regarding the recommendations today; on 28 February they would be reminded of the launch of the consultation and prior to each consultation event the media would be informed again to ensure the target audiences had the opportunity to engage with the process.</p> <p>12 consultation events were planned; 11 in England and 1 in Wales. Information would be provided as to how each option would impact the particular area concerned. Professor Boyle had agreed to be present at each event along with a panel of experts from the Steering Group. Each event would be independently chaired and transcribed so that all feedback could be provided to the Committee. Staff events would also be held with the trusts, organised by the SCGs.</p> <p>Ms Christie urged that electronic communication an online consultation be considered, given the access issues and the target audience for the consultation.</p> <p>The Committee agreed the consultation strategy as set out in Section 14 of the PCBC.</p>	
<p>10. Agree consultation document and questionnaire</p>	<p>The Chair said that the detail of these documents would not be discussed; the drafts were still works in progress but the content was contained in the PCBC. These would be finalised within the next 14 days and then published when consultation launched on 28 February. The questionnaire was designed to focus views but not to organise responses; it was a guide only.</p>	
<p>11. Approval to proceed to public consultation</p>	<p>Mr Glyde summarised the discussions, and sought formal approval from Committee members to proceed to public consultation.</p> <p>Committee members formally approved to proceed to public consultation on the</p>	

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	basis set out in the pre-consultation business case and supporting documents.	
12. Health Impact Assessment	<p>Ms Evans explained that she had worked at the Bristol Royal Infirmary for two years over 20 years ago, and noted that this should be declared as a potential interest. The purpose of the Health Impact Assessment (HIA) was to consider the positive and negative impacts of each option in terms of the health outcomes and existing health inequalities, especially with regard to equalities groups as defined by legislation, deprived populations and travel and access for vulnerable groups. The NHS was endeavouring to be greener in the future, so a carbon footprint assessment of each option would also be conducted. The group convened to guide the HIA included parent representatives and professionals with wide geographical spread, the membership of which was published on the website. Copies of the Scoping Report, which was the first part of the HIA, were available at the meeting; it identified some vulnerable populations, considered the evidence and ways in which more data could be collected, including interviewing each regional director of public health across the country. Once complete, the HIA would then be reviewed in the light of issues that were raised during consultation. It was then the role of the HIA to assimilate this information and feed into the Committee's decision-making process, as well as consider how any negative impacts could be mitigated prior to implementation. The HIA work would proceed alongside the consultation process. The Scoping Report would also be published on the website. The Chair invited the JCPCT to send comments on the scoping report to Ms Evans.</p>	
13. Any Other Business	There was no other business	
14. Summary	<p>The Chair summarised that this was a massively important issue and a real opportunity to provide a truly world-class system based on networks, with paediatric cardiac surgery centres at their hearts. He hoped that the objective and analytical basis of the process had been made clear. The case for change was clear and the process had been lead by clinicians, patient groups and parents. The consultation exercise would be challenging; the strength of feeling regarding local centres was understood and he hoped people from nearby centres would attend the consultation events with questions and challenges. The Chair said that the Committee was open-minded about the outcome of the consultation.</p>	

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Questions and Answers

A participant asked whether the consultation dates could be altered as it was felt that Monday night was often problematic for stakeholders. The Chair asked for issues with specific dates to be raised; if it was possible to change dates, this could happen. If not, another event could be arranged for a different day.

A participant asked whether the impact on cystic fibrosis services would be taken into account. The Chair said the impacts on other services had been considered and that the options offered were intended to be deliverable in that instability could be mitigated or managed. However if it was clear from consultation that something would not work, the Committee would review this during consultation. The review was not intended to destabilise other services to the benefit of children's heart surgery.

A participant asked, given the interdependencies in designation, whether the adult congenital heart population would be integrated in the process. Mr Glyde responded that the consultation was inclusive; however, they could not formally consult on adult designation. The Chair added that any review could not have an unlimited remit.

A participant asked whether the scoring of all the sections would be included in the consultation document. The Chair confirmed that detail would be included to explain the decisions, but a balance had to be struck between detail and ease of comprehension.