Minutes of the Board Task and Finish Group held on 30 September 2013

Present:

- Professor Sir Malcolm Grant (Chair)
- Mr Ed Smith, Non-Executive Director
- Professor Sir Bruce Keogh, National Medical Director
- Mr Bill McCarthy, National Director: Policy

Apologies:

- Ms Margaret Casely-Hayford, Non-Executive Director

In attendance:

- Mr John Holden, Director of System Policy
- Mr Michael Wilson, Programme Director

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1	**Welcome and Apologies**
	The Chair welcomed everyone to the meeting. Apologies were noted. The Chair commended Mr Holden's blog as an innovative means of communicating progress. Mr Holden reported that it was being read by both patient groups and clinicians.
2	**Note of the last meeting**
	The Chair noted that this was a note rather than formal minutes reflecting the nature of the meeting at that time but that in future formal minutes would be produced. The notes of the meeting on 22 July 2013 were accepted as an accurate record.
3	**Action log**
	The Chair noted that all items on the Action Log were either completed or in progress. The Chair requested more information about the engagement groups referred to in action 7. Mr McCarthy replied that a first round of meetings with charities, clinical leaders, front line clinicians and organisational leaders had taken place. These had acknowledged concerns from the judicial review and the Independent Reconfiguration Panel. They had been helpful in explaining that the new review was not simply a re-run of Safe and Sustainable, and reinforcing our commitment that it would put patients first. It would not compromise on standards. He considered that it was the beginning of a process to build trust which was also supported by the blog and other expressions of openness and transparency. These groups were now being incorporated into a more structured system of participation and involvement which would be described under item 7.

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4	**Terms of reference**
	The Chair stressed that the qualities of transparency and openness were paramount for this exercise. Mr Holden confirmed that the agenda, papers and minutes of this and other meetings would be published, as detailed in the publication scheme to be considered under item 6. In addition the blog, with its facility for comment, was an important part of achieving transparency and openness. The task and finish group would report regularly to the NHS England Board (which met in public) and all decisions that affected the commissioning and delivery of CHD services would be taken by the main board in public. The Chair invited the Group to consider whether it was important in the interests of transparency and openness for it to conduct its meetings in public. The Group was of the opinion that it would be normal for a working group of any organisation to hold its meetings in private, subject to it always reporting publicly the substance of its discussions. The Group's meetings would be about the nuts and bolts of the review and transparency and openness would be amply achieved in the ways Mr Holden had described. The proper management of any possible conflicts of interest would be critically important. Mr Holden introduced the terms of reference (TOR) and emphasised that there was a need to be clear about the role of a decision-making group like this one. The Group was a Task and Finish Group acting on behalf of the Board of NHS England in steering and shaping the review, and taking the decisions necessary for that purpose. The Board would receive regular reports, oversee the process and take the necessary substantive decisions. The review's programme board would make decisions on the day to day running of the review and report back to, and make recommendations to the Task and Finish Group. No other groups would make decisions within the review – their roles were advisory and to ensure that a wide range of stakeholders had a voice in the process. It was noted that the membership of the Group was not symmetrical – the chair of the programme board was a member but the chair of the clinical advisory panel was not. If the chair of the clinical advisory panel (CAP) was a member it would then be clear how the CAP's advice was considered by the Group. The Chair agreed that Professor Sir Michael Rawlins should be asked to join the group. With this amendment the terms of reference were agreed.
Action	The chair of the CAP, Professor Sir Michael Rawlins to be invited to join the Group.
5	**Scope and interdependencies**
	Professor Sir Bruce Keogh introduced the paper on scope and interdependencies. He explained that the paper sets out what is being done to resolve the remaining questions. This was for information rather than a decision. Advice would be sought from the CAP and a final decision would be made at the next Group meeting. He explained that the paper showed what is already known about the scope of the review, for example that it should cover the whole pathway, and that some services were out of scope but were still significantly connected to congenital heart disease (CHD) services. An example was paediatric intensive care (PIC). If paediatric CHD surgery were to cease at a hospital this could impact on the viability of the PIC unit and thus affect other clinical services. Michael Wilson explained that such services were not considered to be in scope – it was important to limit the review to the subject at

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	hand, but it would be important for the review to recognise the interdependency and be clear how the connections would be managed. Sir Bruce explained that there were other areas where it is less clear whether a service or aspect of a service should be considered to be in scope. It would be important to consider the interdependencies and any knock on effects of change on other services. The Group considered that criteria needed to be developed to shape decisions about what was in and why. The proposed process involved seeking the advice of the Congenital Heart Services clinical reference group (CRG). Also the papers for this meeting of the Group had been published on the web site and views were being sought from any interested party by this route. A number of stakeholders had already expressed opinions. These responses would be collated and used to inform the CAP as it considered its advice for the Group. The CAP's advice would be shared publicly before TAFG took its decision. The review needed to ensure an appropriate balance between clinical expertise and public opinion. It was important that the CAP was clinically led. The Chair noted that the paper presented the question of scope as a binary choice – in scope or not. But the reality was more of a spectrum.
Action	CAP advice on programme scope to be published on the NHS England website and views invited before Group makes its decision.
6	**Proposed governance and decision making**
	Mr McCarthy explained that the paper and diagram showed how the proposed arrangements link together and the proposed reporting line. Decisions affecting the commissioning and delivery of CHD services would be taken by the main Board at its public meetings. The Chair asked for the review to be a standing item on the Board agenda. Mr Holden stated that it was important to note that only three groups made decisions – the Board of NHS England, the Group and the programme board. Mr McCarthy drew attention to the governance diagram. The CAP and the CRG were the formal advisory groups. The clinician group, the patient and public group and the provider group were a systematic means of ensuring input from these key stakeholders; they ensured that the review had the necessary channels for regular engagement and gave the review team an opportunity to test its thinking. Mr Holden explained that NHS England had nominated independent chairs for each group, who could act as an honest broker as well as represent the views of the group. Questions were raised: (1) whether the provider group should feed into the clinical advisory panel as well as the programme board. This was not considered essential given the specific focus of the provider group (eg on organisational, financial and workforce issues) and the provider group's direct representation on the programme board. (2) what the relationship between the three engagement groups would be, and whether it could be helpful for there to be some joint working. Mr Holden replied that some attendees at the various stakeholder groups which had met to date were aware of each others' meetings (through reading meeting notes etc) and had in some instances referred to the notes/outputs of each other's

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	discussions. But these three new, consolidated panels would need to be more systematically kept abreast of each other. Mr Wilson added that while it could be impractical to bring all the groups together on every occasion there would be occasions when it would be helpful to bring them together. The Group agreed that it would be important that the arrangements should make it possible to hear smaller groups and those whose voices were sometimes crowded out. Patients and parents who had a poor experience or less good outcome were an important group with a lot to teach us.
Action	The new CHD review to be added to the main Board agenda as a standing item.
	Programme Board (including proposed terms of reference) Mr McCarthy stated that while the Group acted on behalf of the main Board of NHS England in steering and shaping the review, the programme board was responsible for running the programme of work necessary to bring the review to a successful conclusion including the management of risk. It did this work on behalf of this Group and following its direction. It was agreed that Professor Rawlins should be invited to join the programme board. With this amendment the Group were content to convey the terms of reference to the programme board for its consideration and approval.
Action	The chair of the CAP, Professor Sir Michael Rawlins to be invited to join the programme board.
	Clinical Advisory Panel (including proposed terms of reference) Sir Bruce stated that having reflected on the panel's membership he now considered that an anaesthetist should be added to the group. Even with this addition, he noted that there would be comment about the membership of the CAP. It was not intended that every geography or professional interest group was represented. The review had other mechanisms for that, through the clinical group and the clinical reference group. Members of the CAP had been selected for their personal expertise. With the proposed amendment to membership the Group were content to convey the terms of reference to the CAP for its consideration and approval.
Action	An anaesthetist to be invited to join the Clinical Advisory Panel.
	Managing conflicts of interest The Chair emphasised the importance of the review's approach to managing conflicts of interest. He welcomed the paper but considered that it should be tightened up even further so that less formal associations were also registered. Everything should be in the open.
Action	The proposed approach to managing conflicts of interest should be further developed to ensure that informal associations were also declared.
	Publication scheme for the review The publication scheme was welcomed as an important contribution to the review's approach to openness and transparency.

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7	**Proposed stakeholder participation and engagement arrangements**
	Mr McCarthy explained that this paper complemented item 6 by showing how each stakeholder group would be able to participate in the review's work. Mr Wilson emphasised that it did not present a complete communications and engagement plan; this was being developed. The Chair asked about the plan for working with overview and scrutiny committees (OSCs). Was there an intention to establish a joint national OSC? Mr McCarthy agreed that this would be a very helpful development, since this was a national review of a national service. Nonetheless some local councillors had expressed concerns or questioned the feasibility of such an approach. The Chair agreed to explore the issue with the chair of the Local Government Association, Sir Merrick Cockell.
Action	Sir Malcolm Grant to discuss the potential for joint local government engagement, overview and scrutiny.
8	**Developing the proposition**
	NHS England had committed to a deliverable proposition by June 2014. The Chair asked whether it would be possible to meet the deadline. Mr Holden replied that the paper defined an implementable solution as a specification for children's and adult congenital heart disease (CHD) services together with a recommended commissioning and change management approach, including an assessment of workforce and training needs. This was achievable for June 2014. But the process was not without risk, and while there were good reasons for seeking to deliver the review at pace, this needed to be balanced against the need to ensure comprehensive engagement and alignment in support of the proposals, which of course was not guaranteed. The Chair stated that it would be important for NHS England to support providers of CHD services to work together in developing a national approach.
9	**Highlight report**
	The highlight report was noted. The Chair affirmed that the review was a whole organisation priority and the Group agreed the importance of ensuring that the organisation's resources were mobilised to support the review.
10	**Any other business**
	There was no other business.
Date of next meeting	29 October 2013 – Maple Street, London W1T 5HD