BRITISH CONGENITAL CARDIAC ASSOCIATION

BCCA Business Meeting

Minutes

Meeting on: Wednesday 17 November 2010

Time: 1700 - 1800

Venue: Winchester Guildhall, Winchester

1. Welcome (Shakeel Qureshi)

Professor Qureshi welcomed everyone to the meeting, and said that coming up later in the agenda was the issue of the Safe and Sustainable programme, which he intended to open to the floor for much anticipated further discussion.

2. Minutes of last meeting (John Thomson)

Nothing further to add and the minutes were approved and will be available for downloading on the BCCA's website.

3. Council Elections/Voting Process (John Thomson)

Welcome to Mr David Barron and Mr Marcus Haw as the newest Ordinary Members on council. Council also welcomes Mrs Jo Quirk as the new co-opted nursing representative on council replacing Mrs Kerry Cook and Professor Roger Boyle as the co-opted Department of Health representative. Dr Thomson was also re-elected unopposed for a 2nd two year term.

As members will recall there have been two tied votes in elections in the last 18 months (most recently this year between Marcus Haw and Sue Hobbins for the one remaining council place, subsequently re-run with Marcus Haw the successful candidate) which under the current voting system of 'first past the post' have required a complete re-run of the election and have seriously hampered appointments to BCCA Council.

We need a system that allows us to differentiate candidates in the event of a tie at first count. Dr Thomson was charged by BCCA Council to look into alternative voting systems and as subsequently agreed with BCCA Council, the system proposed was that the BCCA adopts the system (Single Transferable Voting – STV – short explanation circulated prior to the Business Meeting to all members) currently used for elections by the BCS.

Single transferable voting: Each voter gets one vote which can transfer from their first preference to second preference and so on as necessary. Candidates need a "quota" of votes to be elected based on the size of the electorate and number of positions to be filled.

If your preferred candidate is elected/has no chance of being elected, your vote is transferred to another candidate in accordance with voting instructions. This ensures votes are not wasted, unlike first past the post where only a small number of votes contribute to the result.

Although the current constitution does not specify how the BCCA's voting system should be run and thus any decision to amend need not be formally proposed, BCCA Council felt that the proposal should be voted upon at the business meeting in the spirit of transparency.

With 64 members in attendance at the meeting, there was a show of hands from the floor, with more than two thirds voting unanimously in favour of the change.

There will be further elections taking place in 2011 with Dr Tometzki's first term as Treasurer (eligible to apply again for a further two year term) coming to an end next November, plus the 2nd term for Dr Simpson expiring and 1st terms for Dr Vettukattil, Dr Stumper and Dr Wilson also expiring. Sara Thorne's term as the ACHD representative ends in March 2011.

4. New Members (John Thomson)

22 new members have been proposed and seconded, all of whom were ratified. The new members come from a range of different modalities and highlight the increasing breadth of the organisation.

- Dr Srinivas Ananth Narayan, SpR Paediatric Cardiology, Glenfield Hospital
- Dr Sonya Babu-Narayan, GUCH Fellow, The Heart Hospital, London
- Miss Anna Barlow, Senior Chief Paediatric and Fetal Cardiac Physiologist, Evelina Childen's Hospital
- Dr Philipp Beerbaum, Consultant Paediatric Cardiologist & Director of Cardiac MRI; Clinical Senior Lecturer, KCL, Evelina Children's Hospital
- Dr Tara Bharucha, Locum Consultant Paediatric Cardiologist, Leeds General Infirmary
- Dr Henry Chubb, SpR Paediatric Cardiology, Evelina Children's Hospital
- Dr Fidelma Flynn, Consultant Anaesthetist, John Radcliffe Hospital
- Mrs Jan Forster, Highly Specialised Cardiac Congenital Sonographer, Leeds General Infirmary
- Dr Margarita Guillén Ortega, Cardiac PICU Consultant, Freeman Hospital
- Dr Tony Hermuzi, ST4 Paediatric Cardiology, Freeman Hospital
- Dr Lindsey Hunter, StR Paediatric Cardiology, Royal Hospital for Sick Children, Glasgow
- Dr Juan Pablo Kaski, SpR Cardiology, Great Ormond Street Hospital
- Dr Shahin Moledina, ST5 Paediatric Cardiology, Great Ormond Street Hospital
- Dr Margaret Morrison, Research Fellow, Paediatric Cardiology, Royal Belfast Hospital for Sick Children
- Dr Tim Murphy, Consultant Paediatric Cardiothoracic Anaesthetist, Freeman Hospital
- Dr Patrick Noonan, Paediatric Cardiology Registrar, Birmingham Children's Hospital
- Dr Shankarnarayana Sadogopan, Locum Consultant Paediatric Cardiologist, Southampton General Hospital
- Dr Jon Spiro, ST5 Cardiology, University Hospitals Coventry and Warwickshire
- Dr Trinette Steenhuis, SpR Paediatric Cardiology, Leeds General Infirmary
- Dr Sampath Sunitha, ST6 Community Paediatrics, Barnsley District General
- Mr Hideki Uemura, Consultant Cardiac Surgeon, Royal Brompton Hospital
- Dr Nana-Akyaa Yao, SpR Paediatric Cardiology, Birmingham Children's Hospital

5. President's Report (Shakeel Qureshi)

Revalidation

We need to think carefully about whether there is a need for a knowledge based assessment for revalidation. Dr Robin Martin with support from Dr Joseph Vettukattil is drafting a paper based on the RCPH approach, which should be completed in time for the next BCCA Council meeting in February 2011.

Engaging with the Department of Health (DH)

Professor Roger Boyle has been co-opted as the Department of Health representative onto BCCA Council. Professor Boyle's input has been very helpful and has proved to be a useful conduit to communicate with the higher echelons at the Department of Health.

Communications

All council members who attend a meeting are encouraged to report back with a written report as a matter of good practice and keep everyone informed. Just a reminder that when BCCA members are attending meetings, they are representing their own interests, not those of the BCCA unless they are specifically invited to do so.

As always we are keen to improve our communications to the membership. Thank you to Dr John Thomson for being proactive with the regular emailings to all but likewise members should be encouraged to do the same and inform us of their activities.

To conclude, BCCA have had a very busy year and been proactive in developing various guidelines and producing statements in response to high levels of media attention (eg. Fetal Cardiology Standards – published March 2010; BCCA statement regarding recent press releases relating to reconfiguration of services, issued May 2010; BCCA statement in response to a Telegraph article on paediatric surgical outcomes, issued September 2010; joint Statement with the Society for cardiothoracic surgery (SCTS) and the Central Cardiac Audit Database (CCAD) relating to recent media coverage of Paediatric surgical outcome data for the attention of those involved with the "Safe and sustainable" surgical services review), issued September 2010.

There are still challenging times ahead for all with perhaps the main issue being the Safe and Sustainable programme, which will be discussed later on in the agenda.

6. Treasurer's Report (Andrew Tometzki)

Preparation of finance information is still in progress having inherited archive material from the previous treasurer, Dr Jo De Giovanni. Professional advice will be taken as how these accounts should be kept up to date, but ultimately, the intention will be to produce a full report for the last two years and a review of the accounts as far back as possible, by the end of this financial year (31 March 2011).

Overview of bank accounts/finances
- Treasurer's Account for receipts and payments, £9,500.48
- Business 30 day account for savings, £54,624.89

Total of £64,125.37

Known/potential liabilities

Still have a shortfall of subscription arrears of approximately £3,500. It has been noted that there are some delegates at this meeting who have membership fee arrears and letters have been prepared to be personally handed to them during the meeting, and hopefully that will reconcile some of these issues!

Points for discussion
- review whether NHS Trusts can pay for council members travel expenses – some will and some won't which is the problem!
- recommend only book 1st class travel tickets if this works out cheaper than a normal 2nd class return bought on the day of travel.

Income from the BCCA Annual Meetings
Propose that there should be proper accounts prepared and presented to BCCA Council within 6 months of the meeting.

Formula for apportionment of any profits to the local organising team and the BCCA. At the last meeting, Council agreed that the profits should be split 50/50. We are just awaiting confirmation from Liverpool over how to allocate profit of approximately £8k.

...and finally
Just a reminder to those of you who still have outstanding membership subscription payments, and have not yet completed and sent back a direct debit form, please can you do so as soon as possible. If you also have a standing order set up under the old system with the BCCA, this should be cancelled with immediate effect, as we will instead take your payment by direct debit.

Outstanding payments can be reconciled through direct debit, which the British Cardiovascular Society manage on behalf of the BCCA. Since subscriptions are essentially the BCCA's only source of income, it is therefore important that issues are finally sorted out, which has meant that only 71% of subs have been collected in the last few years. If you have any further enquiries, please contact Azeem Ahmad, BCCA Administrator at the British Cardiovascular Society, email: bcca@bcs.com, tel: 020 7380 1918.

7. SAC Chair's Report (Robin Martin)

This has been a busy year for the SAC mainly relating to changes in the curriculum and also the work of PMETB has now been subsumed into the GMC.

The 2010 paediatric cardiology curriculum is now on the JRCPTB website.

There are 8 subspecialty areas which can be taken in modular fashion:
- Adult congenital heart disease
- Fetal cardiology
- Advanced imaging (CT/MRI)
- Diagnostic and therapeutic catheterisation
- Invasive electrophysiology and pacing in children and adults with congenital heart disease
- Pulmonary hypertension
- Heart failure and cardiac transplantation
- Advanced echocardiography

Trainees wishing to develop a special interest should aim to achieve basic competence in that area during the first three years of the training programme. Trainees who enter a specific sub-specialist training post will spend a much greater proportion of clinical and research time devoted to the special interest after the general 3 year training programme has been completed. In the majority of cases only one special interest should be developed, although in certain circumstances two compatible special interests may be accommodated in the training programme (eg. CT and MRI with advanced echocardiography)

Those current trainees who want to stay on the 3 years curriculum can do so or alternatively, switch over to 5 years.

Other key issues:
- Training days have gone well and have been of a high standard. Grateful to Dr Dom Hares and everyone's help. These are mandatory training days, and we need to encourage attendance.
- A form of a KBA will be introduced at some stage.
- Workforce planning – currently fairly well balanced and do not have plans to reduce paediatric cardiology trainee numbers unlike other specialties.

8. BCCA Annual Meeting 2010/2011 (James Gnanapragasam/Shakeel Qureshi)

Dr Gnanapragasam will be speaking later on at the Gala Dinner. On behalf of the BCCA, thank you to Dr Gnanapragasam and the Southampton team for all of their hard work in organising this year's meeting.

Dr Alan Magee is the organiser of next year's meeting hosted by Royal Brompton Hospital,
22 – 23 November 2011, Royal College of Surgeons of England, London.

2012 – venue to be confirmed but we have received interest from Oxford and Belfast.

We are mindful of our relationship with industry and perhaps need to formalise the organisation of future meetings, but this should not be seen to be taking away responsibility from the local centres. Comments from the floor:

- BCCA should open a separate conference bank account so as to promote transparency. Yes that is a valid point worth considering.
- So as to maximise any income generated from annual meetings, switching to a higher interest account than is currently being used.
- Possibility of BCCA applying for charitable status.

9. BCCA membership categories (John Thomson)

Those present at last year's business meeting will remember that Dr Thomson proposed the removal of the "associate membership" category and bring those members (effectively all medical trainees) into the full membership category. Dr Thomson also proposed removing the term "primary interest" from the descriptor of an ordinary member as this simply is not the case for the increasing numbers of general paediatricians with an interest in congenital heart disease in the UK who are either already full members or are being encouraged to join BCCA. Despite a vote in favour from those present, these amendments could not be implemented til the following year due to a clause in the constitution.

To summarise, the total membership figure is 330.

There are currently 257 Ordinary members, 42 Associate members, 17 Corresponding members, 4 Commercial members and 10 Retired members.

An audit of the membership was carried out. In reality, there is a considerable portion of medical trainees already classified as "ordinary members" and also a proportion (now consultants) have remained as associate members.

As a result this has created problems with the current membership system:

- Unnecessary complication when collecting subscription fees (£15.00 difference per annum) between Ordinary and Associate membership categories.
- Potential voting anomalies where some trainees who class themselves as Ordinary Members and thus are eligible to vote whilst others class themselves as Associate Members and thus are not eligible to vote.
- Trainees have as much vested in the future of the speciality and therefore should be treated the same as anyone else.

The potential downsides of the removal of the associate category entirely and switch everyone to full ordinary membership would mean that:

- Trainees could stand for office, but would they want to? Speaking on behalf of the trainees. Dr Hares said that trainees are happy with the current situation of having one co-opted trainee representative on council, and therefore, does not envisage that there will be a problem.
- Loss of members resulting from a £15.00 increase in their membership subscription fees.

According to the constitution, the current definitions of Ordinary and Associate membership categories are:

"**ORDINARY MEMBERSHIP** shall be given to medical practitioners of consultant or equivalent level, and others, whose primary interest is in the practice or research of congenital heart disease in the adult or heart diseases in the fetus or child, who are resident in the United Kingdom and the Republic of Ireland at the time of the application."

"**ASSOCIATE MEMBERSHIP** will be given to individuals engaged in any aspect of training in congenital heart disease in the adult or heart diseases in the fetus and child. Such members will be ineligible to vote or hold office."

Proposed amendments highlighted in brackets:

"**ORDINARY MEMBERSHIP** shall be given to medical practitioners of consultant or equivalent level, [delete] and others, whose primary [delete] interest is in the practice or research of congenital heart disease in the adult or heart diseases in the fetus or child, who are resident in the United Kingdom and the Republic of Ireland at the time of the application."

"**ASSOCIATE MEMBERSHIP** will be given to individuals engaged in any aspect of training in congenital heart disease in the adult or heart diseases in the fetus and child. Such members will be ineligible to vote or hold office." [Remove completely]

With 64 members in attendance at the meeting, there was a show of hands from the floor, with more than two thirds voting unanimously in favour of the amendments to be implemented with immediate effect.

10. CCAD and Payment By Results 2011-2012 (Rodney Franklin)

CCAD

All colleagues should have received a copy of the Congenital CCAD newsletter either from CCAD itself or via the BCCA (Dr Thomson) to ensure wider circulation.

In response to feedback from our data contributors and other stakeholders , important changes have been made to the way that survival data is analysed on the public portal. A clear explanation of these changes will be posted on the portal.

Other key messages are:
- Separating adults and childrens data. When the portal is updated in the near future, separate funnel plots for children (under 16 years old) and for adults will be given.
- Deadline for complete 2010-11 data submission. In the past July 1st has been used as the CCAD's deadline for complete data submission for the preceding financial year. The Care Quality Commission are recommending the earlier date of 31st May 2011 for the other cardiac audits for this year's data.
- The next congenital CCAD open meeting will be held Friday 4th February 2011, Royal College of Surgeons. Agenda to follow nearer the time. Suggestions for discussion items welcome. As usual, a surgeon, a cardiologist and a data manager representing each centre would be ideal. Attendance is encouraged from representatives of all centres.

Payment By Results 2011-2012

After considerable consultation and analysis within the organisation, a letter from the BCCA has been sent to Mr David Flory, Director General, NHS Finance, Performance and Operations, Department of Health, regarding the impact of Payment by Results 2011-12 Sense Checking draft tariffs on the care of patients with Congenital Heart Disease. The BCCA entirely supports the position of other Specialist Children's Hospitals and strongly urges DoH to modify the proposed reduction in Children's Specialist Top-up. The BCCA suggest that at the very least that this reduction is phased in over a 2-3 year period, reanalysing the reference costs on a year by year basis with appropriate adjustments to the actual tariff, so that an optimum and clinically sound end point can be reached. The BCCA suggest an initial reduction to 55% would be appropriate for 2010-11.

A response is currently awaited from the Department of Health.

11. Safe and Sustainable paediatric cardiac surgery (Shakeel Qureshi)

Much has been happening this year and everyone will be aware of the ongoing safe and sustainable cardiac surgery review and stakeholder meetings taking place and visits to centres from Ian Kennedy's team over recent months. Recommendations were due at the end of September 2010, but due to various issues 3 units showing as historical outliers in the 10 year CCAD dataset, these are not expected til January 2011. There will be a series of potential configurations presented by the S&S team, followed by a 3 month period of public consultations including a series of open meetings around the country (probably in February 2011) to discuss the options and their implications. This will be a key period for all units to feedback. The final recommendations are expected in Autumn 2011, but we have little idea of timescale for implementation of any recommendations.

As mentioned earlier under the President's Report (Item 5), in view of increasing media attention relating to reconfiguration of services, the BCCA have also issued and collaborated with other groups on statements relating to reconfiguration of services.

Jeremy Glyde, S&S team has recently sent a draft statement to Professor Qureshi relating to the S&S process of ACHD services as opposed to the potential outcomes, requesting endorsement by BCCA for inclusion on the S&S and BCCA's respective websites. Further to urgent email discussions amongst council members, there was a strong general agreement that the BCCA could not endorse the statement as there was a majority voice from the BCCA membership and from GUCH clinicians and surgeons that the GUCH review should be linked to the paediatric review. The fact that it was not has caused continuing concern with clinicians and patient groups for paediatrics and adults, and is a missed opportunity that may lead to a configuration of services that disadvantages adults with congenital heart disease. BCCA Council have continued to relay the BCCA's concerns direct to the S&S team, and also Professor Boyle has also been taking a very close interest in discussions, and has too explained the depth of feeling to the S&S team. The S&S team have accepted that it is not possible for the BCCA to endorse the statement as it stands. The key message to still highlight to S&S is GUCH interdependency. Currently, a GUCH Steering Group is being set up to feed into the S&S process. Other proposals will be clearer over time shortly.

Professor Qureshi and Dr Salmon had a meeting with the S&S team (Patricia Hamilton, Jeremy Glyde and Teresa Moss) at the Department of Health on 28th October 2010, to discuss concerns raised by members of the BCCA. Following this meeting, it was felt that there needed to be further dialogue between the S&S team and BCCA members, although BCCA members would have attended the S&S public events. A special meeting to be held on 13 December 2010 was agreed, with the proposal to be discussed at the BCCA Council and Business meetings. All BCCA members will have received an invitation by now. BCCA Council have recommended that 3 representatives (one paediatric cardiologist, one surgeon and one intensivist or anaesthetist) from each UK centre plus 3 paediatricians with expertise in cardiology are invited for to the open discussion. The venue has limited capacity, hence the recommendation for 3 representatives only. BCCA Council hope that this will be a useful meeting. A separate meeting with the paediatric cardiology nurses will be taking place in January 2011. Respective unit representatives details should be forwarded to the S&S team as soon as possible for the venue's security purposes.

As always BCCA Council are happy to hear the views of BCCA members which they do take on board.

- Surgical survey

Mr Barron presented the results of a surgical survey into the S&S process. A total of 36 surgeons in the UK were surveyed with only 9 responses received (4 positive – complete support and 5 negative – varied comments).

Some of the concerns included:

- Questionnaire poorly thought out
- Not enough emphasis on research/academic
- Not enough emphasis on ECMO/Tx/Tracheal
- Surgeons may be asked to work on split sites
- Spiegelhalter data analysis flawed because based on historical data*
- Disconnection of GUCH services from S&S
- Ranking has been based on subjective decisions not related to the standards – lack of transparency

- Decision will be taken by managers
- Timeline too tight**

* But 2 others asking for outcome data to be given more weight
** But another asking for tighter timeline

Criticisms:
- Criteria are being changed
- Preconceived agenda
- Bias against certain centres
- Concern over Sir Bruce Keogh's comments
- Leaks

Positive feedback comments:
- 4 out of the 9 respondents were in complete support
- 24 out of 33 respondents chose not to comment
- Called for the importance of speaking with one voice
- Concern that the politicians may ultimately not have the appetite for this
- Concern that this is not the time to undermine the process
- Concern that BCCA runs risk of losing its credibility

12. AOB

BCCA website

Currently being revamped as there is a feeling that though the website is functional, it needs to be better coordinated with more relevant information provided about the areas of work BCCA have an interest in. Dr Simpson and Azeem Ahmad are working on this project.

BCCA guidelines

- Flying/Exercise

As agreed at an earlier council meeting, Dr Graham Stuart has produced a draft BCCA guidance document on sports and exercise for children with congenital heart disease. Further discussions need to take place before guidance can be finalised.

- ACHD transcatheter intervention guidelines

Agreement still not reached with the Joint Committee of the BCCA, BCS and BCIS guidelines committee. Professor Qureshi is arranging a meeting of the committee in mid January 2011. 2 papers are being prepared, one by BCCA and the other by BCIS.

Scheduling of future BCCA Annual Meetings

BCCA Council and regional unit organisers will bear in mind scheduling future meetings so that they do not clash with the American Heart Association's. Next year's BCCA Annual Meeting does not pose any problems.

As there was no further business, the meeting closed at 18.10.