Minutes of the Programme Board held on 08 June 2015

Present:

- John Holden, Director of Policy, Innovation and Partnerships (Chair)
- Professor Sir Michael Rawlins, Chair of Clinical Advisory Panel
- Professor Deidre Kelly, Chair of the Clinicians' Group
- Will Huxter, Regional Team representative, Head of Specialised Commissioning (London)
- Alison Tonge, Regional Commissioner (North)
- Ben Day, Senior Finance Manager, Strategic Commissioning
- Michael Wilson, Programme Director
- Dr Cathy Winfield, CCG representative, NHS Wokingham CCG
- Wayne Bartlett-Syree – (via video-conference) Head of Planning and Delivery (Specialised Commissioning)

Apologies:

- Ian Dodge
- Giles Wilmore
- Chris Hopson
- Mr James Palmer;
- Professor Peter Weissberg

In attendance:

- Nicola Humberstone, Programme Manager

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1	**Welcome and apologies**
	John Holden (Chair) welcomed everyone to the meeting; introductions and apologies were noted.
2	**Note of the last meeting**
	Mr Holden asked for there to be one amendment to the notes: Amendment page 6 point 6 – should read: 'JH summed up the discussion by saying that since there was broad support with no significant concerns it was a basis for the programme to move forward' The notes were then agreed as a true record.
3	**Declarations of Interest**
	No declarations of interest were noted.
4	**Action log**

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	The action log was reviewed and the following decisions made: **Action 61 –** It was agreed that the programme had reviewed its practice against the Independent Review Panel (IRP) recommendations. It was agreed that it may be appropriate to consult the IRP in the future if reconfiguration were to be proposed. This was normal commissioning practice The action was closed. **Action 88 –** The Board discussed workforce. Professor Sir Mike Rawlins and Michael Wilson noted that in order to set a requirement for perfusionists further advice was required and The Society of Clinical Perfusion Scientists of Great Britain and Ireland had been contacted. **Action 92 –** It was agreed that the action would be closed as there was now an agreed pathway for Clinical Commissioning Group involvement. **Action 93 –** To be closed as Alison Tonge, regional commissioner, had joined the Programme Board. **Action 94 –** The risk log had been reviewed and therefore the action was closed. **Action 95–** The action was closed, as the approach for commissioning was now emerging: the provider group had been established and a new specialised commissioning group was to commence on the 10th June 2015.
ACTION	Programme team to close the actions agreed.
5	**Where is the programme now?**
	Michael Wilson advised the Programme Board on programme process since the last meeting. **Where is the CHD review now?'** It was noted that the standards had been at the heart of the programme. They were now being finalised, in preparation for the NHS England Board. The Joint Standards and Clinical Reference Group (JSCRG) had met on the 21st May 2015. The members had conducted a line-by-line review of the standards. Any proposed alterations, additions or amendments that had been suggested in consultation were annotated onto the standards (the information had been gleaned from the consultation independent report conducted by Dialogue by Design, along with the Congenital Heart Disease Review Team's review of responses to the consultation). Changes and recommendations agreed by the JSCRG were then referred to the Clinical Advisory Panel (CAP). CAP's meeting was held on the 4th June 2015; again a line-by-line review of the standards was undertaken to review all the proposed changes. Mr Wilson and Professor Sir Mike Rawlins summarised: Hundreds of comments had been received during consultation re the standards themselves. A large number of changes to the standards were now proposed. Some tightened up the drafting. A few were relatively minor changes and a very few were material changes. The following were highlighted: Surgical changes – 125 cases per surgeon and the number of surgeons per rota. The numbers advised were supported at the JSCRG, but an extension to the implementation deadline was proposed from three years to five years. This was considered appropriate in light of the need to fill posts and the limited availability of CHD surgeons. CAP discussed this recommended extension and agreed the amendment.

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	Interventional atrial septal defect (ASD) closure at Level 2 ACHD centres. This had been a controversial issue and had elicited considerable comment in consultation. The original proposals would have had the effect of limiting this procedure to level 1 specialist surgical centres only. Professor Kelly had worked extensively with all the professional groups involved to reach a consensus. This will then permit interventional ASD closure to continue at these centres providing: the centres meet the standards; undertook the level of work required; and work discussed appropriately with the congenital multidisciplinary team (MDT). Professor Kelly asked the group to note that this agreement would improve care and remove occasional practice. Nurse and psychologist staffing – the original standards linked staffing numbers to the number of patients under the care of a centre/network. It was noted that clinicians are not completely sure how many adult congenital heart disease patients were under the care of their individual trusts. Therefore, JSCRG and CAP had agreed the appropriate standards relating workforce to activity and population. Co-location of paediatric CHD surgical services with other specialist paediatrics – the timeframe for this was discussed. It was agreed that the timeframe would not be extended to five years because it was important to signal that providers should not put off work to achieve this standard to an indefinite future date. A development plan would need to be agreed with each trust, with appropriate safeguards put in place in the interim. If a delay occurred, it was agreed that it would be unlikely that the commissioners would decommission the service. A realistic plan effectively delivered was the key. Professor Kelly advised this was a sensible position and the line regarding the delivery of standards should be maintained. Commissioners on the Board advised that three years would be sensible with clear identification of risk mitigation if any delay occurred. The Board agreed that CAP's recommendations be accepted and that the standards and specifications continue through the specialised commissioning assurance process. **Timetable:2015/16** Mr Wilson discussed the timeline for the Programme. Commissioning of the service was discussed by the group. Wayne Bartlett-Syree advised that while April 2016 would be the presumed time for commissioning of the standards - 'go-live' – that the detailed commissioning timetable had not yet been worked up and depended on the success of the work with providers, and 'go-live' could be delayed beyond April 2016. Dr Cathy Winfield advised that this process would offer no surprises to providers or commissioning colleagues, as this was the normal commissioning process. Mr Holden thanked the groups (JSCRG and CAP) for their contribution to the success of the process to-date. It was agreed that a formal letter would be sent to the JSCRG and CAP members.
ACTION	**A letter to be sent to JSCRG and CAP members on behalf of the programme board.**
6	**Responding to consultation**
	How are we responding to consultation? Mr Wilson described the process by which NHS England would develop its response

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	to the consultation. Much of this had already been discussed under the previous item, but the process would culminate in the board decision, expected in July. The board's decisions would need to take account of the consultation responses more widely, not just those relating to individual standards, for example those relating to the model of care and to network working. Will Huxter asked what was the main supporting and opposing points made in the consultation? Professor Rawlins advised that the findings from the consultation did not show much opposition. Mr Wilson considered that the responses had been positive overall, and that most concern focused on implementation and the possible impact of the standards if this resulted in service reconfiguration. Professor Kelly supported those views of responses and advised that the worry for some respondents was that the standards were a proxy for closure of some service provision. Professor Kelly drew attention to the concerns raised about the clarity of roles for the three tiers of the service, described on slide 8. A discussion followed on how the framework had been set up. It was noted that some areas may not have tier 2 centres but that in some areas the level 2 ACHD centres are highly developed with a greater focus on the provision of outpatient work. The number of adults with adult congenital heart disease (ACHD) was increasing and level 2 units would play a part in how the networks developed to ensure service delivery. It was agreed that the framework for delivery may vary according to area and as the models were being developed, communication of them and the countrywide provision would be reviewed by commissioners and other stakeholders. Professor Rawlins advised the group that CAP had considered new evidence that had emerged since the launch of consultation. He had reviewed the new publications; these confirmed the link between higher activity and better outcomes, and did not change the review's direction as this was already known. He advised that CAP had reviewed volumes per centre and surgeon. It had been agreed that a standard of 125 procedures per surgeon was acceptable. CAP had asked the professional societies to look at the issue of counting operations, for example how 'long' operations would be counted for activity levels, and also operations that required two surgeons. The professional societies had advised that they did not want to change from a simple one operation counting once for one surgeon only; they considered that this would prevent any perceived double counting or gaming. Professor Rawlins advised that all the changes proposed by the JSCRG were accepted by CAP. CAP had also made some minor amendments (for example: one standard mentioned caution over tattoos for CHD patients and CAP decided that to ensure consistency by adding in piercings) and clarifications. Mr Wilson described the new evidence from NICOR (National Institute for Cardiovascular Outcomes Research). The first paper provided a full write up of the work undertaken on behalf of the review looking for factors linked to outcomes. It was noted that this paper was not available prior to consultation, only a summary. The final paper was now available to be discussed. The paper had a longer discussion regarding the link between Asian ethnicity and outcomes. The paper also supported other evidence of a link between unit volumes and outcomes but did not show a

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	statistically significant association, probably because the sample size was too small. The second paper described changes in outcomes over a ten years period; this showed improvement in the three lower risk categories but not for the highest risk category. The view was that this was because within this category the risk associated with cases had become greater over time. Mr Wilson noted that the paper supported the development of a broader set of metrics because 30 day mortality was now too narrow a measure. This linked clearly to objective 5. The paper indicated that outcomes for the UK were comparable with other countries with similar data. **Function and form** Mr Wilson noted that future projections had been further updated since consultation; based on hospital episodes statistical data (HES) , with minor amendments to procedural codes along with the definition of the episode counting. Mr Wilson commented that predictions for future activity had been made clearer, for example: previous cardiology data had shown a peak in activity; review and reanalysis of this data demonstrated that there had been a change in practice linked to patent foramen ovale (PFO's), which should not reoccur, enabling future activity predictions to be more effective. Overall the modelling had been strengthened but the conclusions of the work were unchanged. Professor Rawlins advised that attempts should be made to assess regional variations in activity growth. He also considered that the review should use the higher growth scenario (Scenario B) in its work. **Interventional ASD closure in adults at the 'other providers'** It was noted that level 2 centres would need to undertake at least 20 ASD (Atrial septal defects) repairs to meet the interventional target of 50 (inclusive of 30 PFO's). A number of units had activity levels well below this, and this would need to cease, being considered occasional practice. **'Surgical activity at the 'other providers'** This data was new to the programme. It included both adult and paediatric data, and was based on HES data as not all the providers for CHD report to NICOR. It was noted that this analysis showed an additional 640 surgical procedures outside the recognised CHD specialist surgical centres. It was noted that it was unclear at this stage whether this was real CHD activity or an issue relating to coding or to the identification rules (IR) used by NHS England to classify CHD activity. The analyst at NHS England would be reviewing the data along with some clinicians who have offered to support the clearer identification of the data. Feedback on this data will be provided to the Programme Board. **What does this mean for surgical activity?** The data discussed, showed that if nothing else changed a number of trusts would not reach 500 cases even with the growth predicted. For this reason NHS England was discussing the advantages of a collaborative network model. Alison Tongue advised that if the surgical activity at the 'other providers' was found to be real CHD activity, the numbers across the slides, once verified, could support network formation. Mr Wilson advised that this information would be analysed but the numbers may not be fully attributable to CHD activity. HES data was known to give higher numbers than NICOR for a variety of reasons.

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	Professor Rawlins added that some work would need to continue at other centres, for example surgery on valves where the original problem was CHD. He advised that clear definitions relating to CHD would need to be followed. Professor Kelly agreed. **Provider Leaders' Subgroup** - The work of the subgroup in developing proposals for models to deliver the standards was discussed. This would support the providers in working collaboratively. The potential for some clinical staff to work in more than one place was noted with the opportunity to support on-call in this way. Other advantages were noted re the 'super networks' including shared protocols, jointly approaches to research and education. Professor Kelly advised that clinicians were anxious about undertaking operations at centres that they were not familiar with, for example - in centres over 50 miles apart. Mr Wilson confirmed that this had never been suggested and was not the intention of NHS England. He recognised that this was a matter of great importance to the surgeons. His thinking was rather about the potential for shared appointments between lower volume centres and higher volume centres as a way of allowing the lower volume centres to create a viable on-call rota, while those surgeons did some of their surgery at the higher volume centre and in that way made sure they had enough experience. The next Provider Leaders' Subgroup was noted to be on the 12th June, with provider networks presenting their progress. Wayne Bartlett–Syree stated that the work undertaken so far to establish standards had been excellent. The real challenge now was to do the standards. Thoughts were now developing on the implementation of the standards. The Provider Leaders' Subgroup had met three times, with Chris Hopson chairing the meeting. The number of units and seniority of attendees had grown. There was recognition that this work was difficult and asked a lot of the providers. The group has been asked to submit their networking plans in the form of an 'expression of interest'. These would be presented on the 12th June. The intention was for commissioners to work collaboratively with providers in exploring solutions. This would be fully worked through and would contribute to the proposals for commissioning of services to be written into the Board paper **'Workforce, education and trainin**g' would be critical for implementing the standards. The professional societies had been approached for assurance about workforce issues. **Developing a commission strategy** Mr Bartlett-Syree noted that the delivery model proposals were developing. A discussion followed on the process to commissioning of services. It was agreed that the providers would continue to work together to support the delivery model. After the board meeting NHS England would take stock of whether this approach should continue. Alison Tonge noted that it would be hard to sustain the process, and important to ensure that all providers continued to receive information whether or not they were actively participating in this process. It was agreed that all providers had the opportunity to engage, but some have chosen to be more involved within the groups of

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	the programme than others. It was noted that providers had worked in a collaborative way at the provider subgroup meetings. Relationships were healthier with some joint project working, but some of the challenges posed by the standards were very difficult. Professor Kelly asked if the meetings included Clinical Commissioning Groups (CCGs), as patients were cared for by level 3 centres, whose services were commissioned by CCGs. Dr Winfield advised it was essential for both, that there was engagement by the level 1 centres with local hospitals and by NHS England with CCG commissioners, so that the review and its impact were understood. Mr Bartlett-Syree noted that the commissioners involved in the Provider Leaders' Subgroup had been NHS England representatives and further collaboration with CCGs would be needed. Providers were asked about their approach to wider engagement, as part of their submissions. It was noted that Professor Kelly had been asked to attend the Provider Leaders' Subgroup on the 12th June 2015, to support the process. **Supporting improvement, delivering change** – it was noted that commissioning was only one part of a larger improvement and change management process; Change drives the delivery of the standards. **Commissioning vs the standards** – It was noted that providers had been briefed on the commissioning and standards requirements; It was reasonable to assume that there were some changes would be needed in the system to be able to deliver the standards and that this may take some time, for example to achieve the co-location requirements. Providers would need to ensure that the proposals made financial sense. It was noted that commissioners were not trying to drive efficiencies through the standards, but would need to assure good value. It was noted that all services including CHD would need to show efficiencies in the long term, given the NHS' financial constraints. **Commissioning development / Affordability and innovation** Commissioners in NHS England had been briefed at a workshop on the 13th May on the progress of the programme and the co-development of the delivery model with providers. A new group had been set-up following this – the CHD Implementation Group which was due to meet on 10 June 2015. The need to include CCG representatives needed further discussion as the terms of reference were finalised. **Handover to Specialised Commissioning.** The transition from review to commissioning of services had been termed the long-handshake. It had been agreed that the joint process would continue until after the Board decision. Professor Kelly asked how the clinical group would be involved in implementation. Mr Bartlett-Syree advised that in the first instance NHS England would expect to work with existing groups like the Clinical Reference Group (CRG). Professor Kelly noted that there had been very good clinical engagement so far and this should not be lost. The CRG might not be the only vehicle needed for this. Consideration of a future role for the existing groups or professional societies should be considered. Mr Wilson noted that there was a clear distinction to be drawn re commissioning and the implementation, and the arrangements for engaging clinicians could well be

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	different for each phase. Commissioning of local services was discussed further. It was noted that events focussing on level 2 and 3 centres would be held after the NHS England Board. Dr Winfield suggested that there could be a role for lead provider or alliance contracting. If that were the case there would be a need for innovative commissioning. Ms Tonge agreed that there were potential links to the work on new care models, and that drawing out those links would be very interesting. Professor Kelly advised the group that a lot of work had been undertaken on network leadership by the Clinical Implementation Advisory Group associated with Safe and Sustainable and that much of it would still be applicable and useful. This work could be shared further, if required, with providers. Mr Holden advised the Board that the review team would continue to support the work through the transition period, and that resources were available for the rest of the financial year.
ACTION	**Programme team to** - **review the activity data by region using the upper limits for growth** - **analysis of the surgical activity of 'other providers'** - **advise on the development of the CHD Implementation Group**
7	**Business proposal**
	Mr Wilson reminded the group that the NHS England Board would consider the whole work of the review, not simply the standards. There would in addition be recommendations for : - the model of care (MOC) - commissioning - better information and early detection The NHS England Board would review and agree (if they thought applicable) the standards and service specification and discuss any other recommendations. However the NHS England Board would not be asked to agree any networks, or configuration. The work of the Provider Leaders' Subgroup would simply inform the commissioning approach.
8 & 9	**Risk and issues register, Highlight report**
	Mr Holden asked the Board to note the highlight report; it covered the items discussed during the meeting, with some notable dates for the governance process. He also advised that a programme blog would be sent out soon. The Board noted the highlight report and the risk and issues register.

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10	**Any other business**
	There was no other business.
Date of next meeting	Members were asked to note the next scheduled date of the Programme Board, 30th June 2015.