Provider Group Meeting

21 May 2014

1. Introduction from Chris Hopson (Chair)

Chris welcomed attendees and explained that the purpose of the session was to focus on the draft standards and service specifications that would form the basis of the forthcoming consultation, and that it would be helpful to hear from those present about what would make the consultation work most effectively.

Note of previous meeting

In advance of that discussion, Chris asked whether people were happy with the draft note of the previous meeting. It was noted that there had been discussion at the previous meeting of inviting James Palmer to the next (this) meeting.

ACTION: *The new CHD review team undertook to invite James Palmer (or the most appropriate person, reflecting the recently established Specialised Commissioning internal task force) to the next meeting*.

Conflicts of interest

Michael Wilson advised the group that the Programme Board had now completed its forms and that the new CHD review team is now ready to send forms out to members of this group and the other Engagement and Advisory Groups.

The new CHD review team had sent out the form in Word so that it can be completed online and returned.

2. Update from John Holden, Director of System Policy

Engagement

John identified the review team's engagement work since the last meeting and shared some of his personal learning, particularly around:

- the discussions with children and young people – these had been fantastic and got to the real issues for them; and
- what technological advances have meant for people with CHD – and what it means for adult services in terms of increasing activity volumes.

John also noted the meeting with MPs and peers and the webinar.

Pre-consultation assurance

John advised that the new CHD review team is taking its work through the NHS England governance process for Specialised Commissioning. As part of that process the team has been part of conversations about governance, pre-consultation engagement, equalities and affordability.

The new CHD review team is being asked to provide costings that show:

- baseline vs. costs if introduce standards;
- projected increase in demand and costs if do not introduce standards; and
- projected increase in demand and costs if do introduce standards.

We have asked Area Teams for any information they have about spend.

ACTION: *Jo Glenwright, lead analyst, would be in touch with provider units to request any information they have as well.*

Q. It feels like what was a strategic review of cardiac services is now becoming an operational review?

A. It remains a strategic review, but there is a process to get to consultation that includes gathering operational information

Q. We want to make sure that we are focusing on standards and Sir Bruce Keogh's pledge?

A. We are looking at deliverability, affordability and quality. The standards set out what excellent looks like. We will then need to look at how we deliver these with the budget we have.

Q. Are you committed to consulting on best standards?

A. Yes. But we need to recognise that there is not a blank cheque and we will need to look at which standards are for now and which are developmental.

Chris noted that he had been at the last meeting of the Programme Board and that there was a continued commitment to ensure that the review was done well, and that the standards were challenging; but that this needed to be seen as part of the overall piece of work on specialised commissioning.

Q. Please can we see the analysis so far?

A. We want to be able to share information with you and to understand the issues. We have finite staff resources and our focus to date has been on

collecting the information to understand the volume of activity and trends. And on this, we have more information on children than adults. At the next Programme Board, we will provide an update on where we have got to on activity and finance. Chris will be at that meeting and can represent your views in relation to working together.

Q. What can we do outside this group to help?

A. We think that we will have a clearer idea when we get to our Programme Board. Once we have had the discussion there, we will let this group know and flag up where we need help. The new CHD review team is working on the Impact Assessment. This will be the first phase of the Impact Assessment. It will be updated when more data becomes available. Once we have this in a form for sharing, it is likely that Jo will return to the Provider Group.

ScHARR

John advised that the draft report from ScHARR (the University of Sheffield's School of Health and Related Research, who are conducting the literature review) seems to suggest that the evidence does not support a link between volumes and mortality outcomes. The draft report is subject to quality assurance and the final report may differ significantly from the draft.

Great Ormond Street Hospital (GOSH) advised that cardiac services are on the low end of growth in demand. For their institution, over half of the rise in demand for tertiary paediatrics seems to be related to consanguinity and ethnicity. There is an increased need for higher level interventions as a result of:

- greater recognition;
- patient expectations; and
- genetic testing,

and there is no likelihood of this changing.

ACTION: *GOSH to share their findings with Jo Glenwright in the new CHD review team*

One year anniversary

John reminded the group that last June, the new CHD review team had been tasked with coming up with an 'implementable solution' within a year. The team will report to the NHS England Board's sub-group (Task and Finish Group) in July on:

- standards and specifications;
- data activity;
- commissioning and change model; and
- early diagnosis.

Q. What process is going to be used to determine affordability?

A. There is no prescribed right way to do it. We will share our work with providers. We are looking at:

- the baseline;
- cost drivers that are not related to what we are doing; and
- cost drivers that are related to what we are doing.

Q. In Greater Manchester a process has been going on in relation to standards. The National Clinical Advisory Team (NCAT) undertook a review and gap analysis. Following that, there was a commissioner-led process to look at options to deliver. They have worked with 10 hospitals, looking at the options first and then affordability against the options. Is the new CHD review team planning to work with providers to consider options?

A. We are following the same sort of process as described. We are at the stage of defining what excellence looks like and the next part of the process will be to see how close we are to excellence. That will be after consultation. In the meantime, we are being asked to work out affordability while recognising that we cannot give a full account at this stage.

Q. Has the new CHD review team approached the leads for adult CHD units? Clinicians have information and can cross reference.

A. The new CHD review team will take this away. We are not going to be able logistically to pursue every lead, but if we can get something that will help, that is good.

3. Update from Michael Wilson, Programme Director

Trust visits

Michael thanked everyone for their help on the visits. A key benefit has been in ensuring that as many as ten times more people will have heard about the new CHD review from the team and will have been able to ask questions and to inform our thinking. The visits were about information sharing and we are writing up the experience.

Standards

Michael went on to give an overview of the standards and then focused on specific issues that have been raised by the Clinical Reference Group (CRG) responsible for developing the service specifications. He invited the group to help with the thinking.

Networks

The CRG talked about networks and the challenge of putting them in place. The CRG has requested that the new CHD review team express more clearly the distinction between what we mean by networks and what already exists, how these relate to clinical pathways and how they will be supported (both in leadership and administration).

Q. In the past there were operational delivery networks that worked across boundaries. What we are looking at here is more about sharing and learning to drive quality. In light of recent reviews, we need to look for ways of reporting quality, as well as mortality. We could describe quality-driven relationships.

A. This may not be in the standards, but it could be elsewhere. The standards cannot be too prescriptive but we will be promoting consistent pathways and protocols feeding into surgical centres.

Workforce

The standards set down proposals for numbers of different members of staff working in multidisciplinary teams (MDTs). It would be good to talk about the staff supply and where the issues are specifically for CHD or more generally. The following points were made about workforce:

- Attracting cardiologists into Tier 2 services is challenging.
- The CRG talked about this. Some people are convinced that Tier 2 is unsustainable in the long term. There are others who think it will become more essential in the future. We are not sure how to resolve this issue.
- There may be different staffing issues in and outside London. Retention seems much more difficult in London – it is more difficult to fill vacancies at lower pay bands in London. It may be easier to fill clinician vacancies in London.
- The draft standards propose new requirements for psychologists. We recognise that there is huge variability in availability. It may not be an issue always of numbers, but could be an issue of budgets.
- There may be an issue with ECHO as training has changed and people don't have the same skill set. There is a four year gap because of *Modernising Scientific Careers* – need to look at numbers going in to training as well as bandings.
- Competition between units will lead to more staff moves, as some posts are on higher Agenda for Change bandings than others. There needs to be a dialogue about bandings.

- There has been little investment in adult services and so it is proving difficult to fill vacancies. This is exacerbated by the fact that there are no standards for adult congenital heart specialists.

- Need to look at what happened with nursing ten or fifteen years ago - need to link to universities nationally to deliver an adult congenital course.

- We need to identify what the new review can and should do. The new CHD review team could talk to HEE about the increasing demand for specialists at a time when the move is towards generalised services. May be opportunity to introduce a new training module to Modernising Scientific Careers.

Communications

Michael remarked that the standards can set expectations but not behaviours. It was noted that Somerville do a survey with patients in adult centres to check that services are addressing expectations. This could be used for children. A patient survey for each unit would help

Q. The Leeds review and other reviews have done a lot of work on feeling and culture. The families are keen that lessons are learned and that this work informs future thinking. Would it be valuable to share it with the group?

A. It would be good to see this now and to reflect this – when we consult we can test back whether those families feel like we have followed the findings. We recognise that Bereavement and Palliative Care are the most difficult areas. Bristol have asked if they can use the draft standards now – we could get feedback and see if they work in practice.

ACTION: *Units to let us know if they are using the draft Bereavement and Palliative Care standards and to let us have feedback if they do*

Interdependencies

This has been one of the most controversial areas. The ideal would be to have children's and adults' congenital and other services co-located. However, there is some debate about the importance of responsiveness times – and whether location is always more important than how well services work together.

Q. Is co-dependency with fetal cardiology not in the standards now?

A. It is still in the standards

Q. What is happening about existing DH standards?

A. We decided that we needed to have our own conversation, so our proposals are not completely aligned with the DH document.

Q. Was there any objective analysis from clinicians? Remarkable how close interdependencies are with the DH document.

A. We have not applied a numerical assessment and the data from the National Institute for Cardiovascular Outcomes Research (NICOR) or the literature review has not helped. Any data is good but we need to check out association and causality.

Q. Services can be next door to each other and not speak to each other – it is about having positive relationships. If this is about a strategic review, we need to be going for best. If triple location is ideal, why can't we make it clear that that is what we are working towards?

A. This section in the standards is broken into categories depending on the sort of responsiveness needed:

- Co-location is ideal
- Ways in which services work together
- However the services are configured, responsiveness is very important

and this needs to inform long-term planning.

Surgical issues

Numbers of surgeons and caseloads have continued to be controversial. The new CHD review team would welcome any suggestions as to how these standards might be written to get beyond the block.

The surgeons we have spoken to have been more concerned about activity over the number of surgeons in the team. We are trying to understand better the out-of-hours rotas and whether a surgeon can do what is needed in an emergency.

Request for help

Michael asked if it would be possible to put measures in place to make it easier for surgeons to move between institutions. The group noted it would be possible to look at getting a passport. In addition, it may be possible to reach agreement for surgeons along the lines of locums in the standards. Michael noted that effective networking should reduce the problem.

John asked if this group could agree a set of requirements.

Proposals for consultation products

- Small and easy-to-read consultation document that we will test with PPVAG
- Materials for providers to have meetings with staff

The group noted that it will be important to engage with clinical commissioning groups (CCGs) who will need to understand interdependencies and the pathway.

Meeting of all engagement and advisory groups

Michael noted that work was underway to find a date that works but that it had been difficult to find a date that worked for all three chairs. If there is an event, this is likely to be in July.

In the meantime, the new CHD review team proposed a further three meetings of the Engagement and Advisory Groups, starting with the Provider Group in July 2014.

ACTION: *New CHD review team to send invitations for meeting of Provider Group in July 2014.*

ACTION: *New CHD review team to share communications products – early set.*

What do providers need from the new CHD review team to support them?

The group asked for communications materials to support consistency of message:

- Slides
- Audio material
- Video that can be played at every session

And a focus on:

- What to do
- Where to do it
- How to do it

Michael asked everyone to provide a named communications link person to the new CHD review team (may or may not be Comms).

ACTION: *New CHD review team will provide 2 sides of A4 for corporate communications.*

Michael fed back initial thoughts on engagement during consultation:

- Initial plan was a further four engagement events during the consultation but that some members of the Patient and Public Engagement and Advisory Group had suggested more events and had proposed the IRP process as the best.
- Michael advised that the new CHD review team was considering more structured events where representative people could have a two-way conversation in a smaller and more controlled environment.

The group suggested:

- events could be held where there are high population densities; and
- something via internet across all units (live simulcast).

4. Any other business

Chris asked the group if they wished to do any work outside that of the Engagement and Advisory Group either in relation to service development or in relation to more effective operational working.

If the group wanted to take further action to progress particular issues, e.g. workforce, it would need to be something that all units could sign up to and would need to be agreed at Chief Executive level in units.

Attendance

Name	Title	Organisation
Chris Hopson (Chair)	Chief Executive	Foundation Trust Network
Ian Atkinson	Deputy Chief Operating Officer and General Manager	Alder Hey Children's NHS Foundation Trust
Helen Sanderson	Paediatric Cardiology Network Manager	Alder Hey Children's NHS Foundation Trust
Darren Banks	Director of Strategic Development	Central Manchester University Hospitals NHS Foundation Trust
Robert Burns	Director of Planning and Information	Great Ormond Street Hospital for Children NHS Foundation Trust
Bryan Gill	Consultant in Children's Hospital, Neonatal Medicine	Leeds Teaching Hospitals NHS Trust
Tony Wilding	Chief Operating Officer	Liverpool Heart and Chest Hospital NHS Foundation Trust
Liz Bailey	Directorate Manager: Cardiothoracic Services (Heart and Lung)	Newcastle upon Tyne Hospitals NHS Foundation Trust
Claire Tripp	Director of Operations	Papworth Hospital NHS Foundation Trust
Lawrence Mack	General Manager	Royal Brompton and Harefield NHS Foundation Trust
Fiona Walker	Adult Cardiologist	University College London Hospitals NHS Foundation Trust
Stephen Williamson	Divisional Director of Operations	University Hospital Southampton NHS Foundation Trust
Jonathan Vaughan	Group Manager - Cardiac Services and Vascular Surgery	University Hospitals Birmingham NHS Foundation Trust

Name	Title	Organisation
Michael Wilson	Programme Director	NHS England
John Holden	Director of System Policy	NHS England
Penny Allsop	Project Manager	NHS England
Jennie Smith	Project Co-ordinator	NHS England