Programme Board

23 March 2015

AGENDA

10:00am – 12:00pm
Room 6D1, Skipton House

Members in attendance: John Holden, Director of System Policy (Vice Chair);
Wayne Bartlett-Syree, Assistant Head of Planning and Delivery (Specialised Commissioning);
Dr Mike Bewick, Deputy Medical Director
Ben Day, Senior Finance Manager (deputising for Sam Higginson)
Professor Deirdre Kelly, Chair of review's Clinicians' Group;
Mr James Palmer, Clinical Director, Specialised Services (joining via teleconference);
Professor Peter Weissberg, Chair of the review's Patient and Public Group; and
Michael Wilson, Programme Director.

Apologies: Ian Dodge, National Director: Commissioning Strategy (Chair)
Sam Higginson, Director of Strategic Finance
Chris Hopson, Chair of the review's Provider Group;
Will Huxter, Regional Team representative, Head of Specialised Commissioning (London);
Professor Sir Bruce Keogh, National Medical Director;
Linda Prosser, Area Team representative, Director of Commissioning (Bristol, North Somerset, Somerset and South);
Dr Cathy Winfield, CCG representative, NHS Wokingham CCG;
Professor Sir Michael Rawlins, Chair of Clinical Advisory Panel; and
Giles Wilmore, Director for Patient & Public Voice & Information.

Additional attendees: Nicola Humberstone, Programme Manager
Jennie Smith, Programme Coordinator

Item	Agenda Item	Action	Lead
1.	Welcome and apologies	To note	Chair
2.	Minutes of the previous meeting on 18 February 2015	To agree	Chair
3.	Declarations of interest	To note	Chair
4.	Action log	To discuss	Chair
Programme Process			
5.	From consultation to NHS England Board • Deliverables • Work programme • Milestones	To agree	Michael Wilson

Item	Agenda Item	Action	Lead
	• Risks		
6.	Consultation report	To note	Michael Wilson
Updates			
7.	Engagement & Advisory Group update	To note	Professor Peter Weissberg Professor Deirdre Kelly
8	Risk and issue registers	To agree	Chair
9.	Highlight report	To note	Chair
10.	Any other business	To discuss	All
	Next meeting TBA	To note	

Minutes of the Programme Board, held on 18th February 2015

Present:

- John Holden, Director of System Policy (Vice Chair) **(JH)**
- Professor Sir Bruce Keogh, National Medical Director **(BK)**
- Chris Hopson, Chair of the review's Provider Group **(CH)**
- Will Huxter, Regional Team representative, Head of Specialised Commissioning (London) (**WH)**
- Mr James Palmer, National Clinical Director, Specialised Services **(JP)**
- Professor Peter Weissberg, Chair of the review's Patient and Public Group **(PW)**
- Giles Wilmore, Director for Patient & Public Voice & Information **(GW)** *(via videoconference)*
- Dr Cathy Winfield**,** NHS Wokingham, Clinical Commissioning Group **(CW)**
- Michael Wilson, Programme Director **(MW)**

Apologies:

- Daniel Phillips, Director of Planning, Welsh Health Specialised Services Committee
- Linda Prosser, Area Team representative, Director of Commissioning (Bristol, North Somerset, Somerset & South)
- Professor Sir Michael Rawlins, Chair of Clinical Advisory Panel.
- Ian Dodge, National Director: Commissioning Strategy (Chair);
- Sam Higginson, Director of Strategic Finance;
- Professor Deirdre Kelly, Chair of review's Clinicians' Group
- Wayne Bartlett-Syree, Assistant Head of Planning and Delivery (Specialised Commissioning);

In attendance:

- Nicola Humberstone, Programme Manager (Secretariat) **(NH)**
- Ben Parker, Project Development Manager **(BP)**
- Jane Docherty, Project Manager **(JD)**

Item	Agenda Item
1	**Welcome and apologies**
	John Holden opened the meeting and welcomed attendees, noting apologies. Eleri de Gilbert had now left NHS England. The chair noted the Board's thanks for her contributions to the Board's work.

Item	Agenda Item
2	**Notes of the last meeting**
	The notes of the 4th December 2014 Programme Board meeting were accepted as a true record, with the only outstanding matters forming part of the meeting agenda.
3	**Declarations of Interest**
	No specific interests were declared in relation to the 18th February 2015 agenda.
4	**Action log**

	The action log was reviewed.
	MW and **JH** drew attention to the following actions:
	• **Action 63** – was agreed to be closed.
	• **Action 87** - to be discussed on the agenda.
	• **Action 73** – was still open as further commissioning support was required. Eleri de Gilbert had now retired; John Holden had written thanking her for her contribution to the Board and the wider Programme of CHD work. In considering the programme Board's membership it was suggested that -
	  • representation to be sought from the Clinical Commissioning Groups in the northern region.
	  • specialised commissioning representation to be expanded. Alison Tonge was suggested for nomination
	A discussion followed on governance arrangements for the group, with the potential in the coming phases for the Programme Board transferring to the Specialised Commissioning Oversight Group (SCOG). It was agreed that a formalised plan for clear governance transfer was needed.

ACTION	**MW** to: • agree with Specialised Commissioners a clear plan for transfer of governance transfer from the Programme Board • contact potential new members. **Programme Team**: to close action 63.
5	**Programme Transition, integration and timeline for commissioning services**
	MW advised the group on the current status of the programme. • The consultation report was expected on Friday 20th February 2015. • The CHD team had reviewed all the responses. **MW** then discussed the proposed future timeline, referring to the 'Proposed timeline for response to consultation' slide: • The Joint Standards and Clinical Reference Group (JSCRG), with selected additional members from related Clinical Reference Groups would meet to consider any changes to individual standards needed as a result of the consultation responses.

Item	Agenda Item
	• The Clinical Advisory Panel (CAP) would advise the Task and Finish Group on the review's response to the consultation, taking account of the JSCRG's recommendations, the consultation responses more generally and any new evidence. • Recommendations from CAP will be presented to the Board Task and Finish Group; they will receive the recommendations and accept if appropriate. It was noted that the original timetable for this work envisaged completing this phase of the work before the pre-election restricted period, with a 'pause' proposed until after the election. **MW** advised that this was with a view to presentation of the business case to the NHS England Board in July 2015. **MW** then explained the need for the Programme Board to consider whether this was the appropriate approach bearing in mind the increased sensitivity in the run up to the election. Advice from the Department of Health (DH) was that NHS England should consider the risks of this and alternative courses of action before proceeding. The Board noted that while there could be some media interest in the publication of the consultation report; this was a straightforward report of the responses to consultation, and not of NHS England's response. As such it should be relatively uncontroversial and low risk. Stakeholders were keenly awaiting the report and would be disappointed if publication was held back without good reason. The Board therefore advised that the report should be published as soon as it became available provided that this was before the start of the 'pre-election' period. The Board then discussed whether this should be followed by the planned meetings of the JSCRG and CAP. The risk of not doing so was that this could have an impact on the overall timeline of the review. The risk of proceeding was that moving on to develop NHS England's proposed response to the consultation could prompt a debate with, and between, stakeholders and that because of the restrictions relating to the election the review would not be able to participate in that debate. There was also a risk that this debate could become politicised if it focussed on the inferred impact on individual units. The Board emphasised the need to continue to work openly and in a transparent way, as had been the programmes' ethos. There was therefore no question of holding meetings but not publishing the papers. Concerns were raised about the impact on the overall timeline for the programme if the work 'paused'. **JH** advised the group that NHS England's assurance process needed to be followed. Not to do so would invite criticism. While many stakeholders may feel that the process is slow, cutting corners was not the answer. **BK** advised the group that while a pause was a sensible approach there was a need to plan what could be done to keep the momentum going during the restricted period. **PW** agreed and added that decision-making should be reasonably swift following the restricted period. The Board asked commissioning colleagues if it would be possible to get through the assurance and commissioning process in the given timeline? A discussion followed on parallel tracking of meetings. **JP** advised that as part of the assurance process it was important to understand the analytical, service and financial impact of the proposals. He sought an understanding of the date the service specification and standards would be ready. **MW** advised that while the JSCRG and CAP would make recommendations, the standards and service

Item	Agenda Item
	specifications would not be final until they were agreed by the NHS England Board in July 2015. **JP** advised that further consultation requirements also needed to be considered. Following discussion, it was considered that it would not be necessary to consult on the commissioning model, but that further consultation would need to be considered if commissioning plans envisaged a reduced number of specialist providers. The potential for there to be different approaches to commissioning in different regions was noted. **CH** asked who would be invited to contribute to the commissioning approach and requirements. **JP** advised that the consultation on the procurement phase would be with providers. **CH** went on to share plans developed by the Provider Engagement and Advisory Group. He was writing to all affected provider CEOs and Medical Directors advising of the opportunity to work together regionally to look at a delivery model for the standards and service specifications. If the sub-group developed, as hoped, then this would provide a platform for options for a delivery model to be agreed and presented to commissioners for a potential commissioning model. This option would enable the proposals to be provider-led and reduce the likelihood of any objection. **CH** noted that it was not a foregone conclusion that all providers would want to participate but that he would encourage them to do so, and if necessary would seek support from Programme Board members. **CW** asked how a joined up approach would be managed? There was an opportunity to think of this in 'forward view' terms with accountable care providers run on a regional basis, with a capitated budgeted. **CH** agreed that is work should take this into account. **JP** advised that a peer review process could be a potentially preferable model rather than a commissioning-led process.
ACTION	**CH - to contact all provider trusts to gain commitment to a shared approach to developing a delivery model.** **MW - to clear the Programme Boards recommended approach within NHS England (i.e. to publish the report but to pause further work on NHS England's response until after the election).**
6	**Engagement Groups Update**
	<u>Clinicians' Group</u> – In the absence of Professor Deirdre Kelly – **MW** fed back on the recent Clinicians' Group meeting. The continued high level of interest and attendance at meetings was noted. <u>Patient & Public Group</u> **PW** provided brief feedback, reiterating the need for the programme to continue its momentum and clear communication re timescales for delivery, to ensure all stakeholders are informed. <u>Provider Leaders' Group</u> **CH** had already advised the group on the recent meeting, but commented that support would be required to resource the facilitation and careful work required with providers.

Item	Agenda Item
7	**Consultation response update**
	MW advised the group that there had been 459 responses in total offering a broad range of views. The independent report had taken longer to be delivered than expected. If it was not completed in time this could ultimately mean that it was not be published until after the election, though this was not considered a high risk.
8	**Objective 6 – Antenatal and neonatal detection – Final Report**
	JD introduced her paper on antenatal and neonatal detection and advised the Board this was the first time such information had been brought together and presented in one paper. This would enable the Board to see the extensive amount of work that was taking place around antenatal and neonatal detection as well as to take a view on what additional work may be required. The Board discussed the recommendations set out in the paper. The Board supported the recommendations in principle but **JH** advised that the Board needed to be confident that the impact of the recommendations including any costs had been considered. It would also want to know that all partner organisations / individuals were signed up to the proposals. **JD** was asked to undertake further work in these areas. **JP** noted that the commissioning approach would need to involve Clinical Commissioning Groups (CCGs) through a collaborative commissioning approach. It was suggested that it would be helpful to work with Alison Tonge, Regional Director Specialised Commissioning North, who was leading on co-commissioning. **CW** commented that it would be necessary to consider who commissions each aspect of the pathway, and to ensure that this is obvious to all those organisations that are involved as well as involving linked commissioners, for example, those commissioning ambulance services. J**H** thanked **JD** for the presentation of the paper and advised that an implementation plan was now needed.
ACTION	**JD to** • link with Alison Tonge on co-commissioning project, with support from **WH** and JP. • draw together an implementation plan to support the recommendations for objective 6
9	**Objective 5 – Better Information - Interim report**
	BP introduced his paper on better information. In this first phase of his work approximately thirty possible areas of development had been identified. He was now working to prioritise these, taking account of both the impact of each measure and the practicability of implementation. **MW** advised that he and **BP** had met with the Healthcare Quality Improvement Partnership (HQIP); this had been extremely helpful for understanding the funding mechanism of the National Institute for Cardiovascular Outcomes Research database

Item	Agenda Item
	(NICOR). It was noted that HQIP commission NICOR on behalf of NHS England. This information would be useful in the development of data collection. It was understood that principle contacts are national clinical directors connected with the work of the review. **CH** advised that providers would need to feed into the final paper. It was recognised that some had contributed already. **JH** advised that the process for mandating change and data capture process needed to be clear. The Board agreed to continue with phase two of the project.
10	**Objective 2, 3 and 4 Commissioning & Networking**
	MW briefed the Board on progress with work on objectives 2, 3 and 4, was discussed. These objectives all relate closely to the future commissioning of the service. **MW** reported that a summary paper had been sent to the senior management team (SMT) for specialised commissioning (SpecCom) and the Specialised Commissioning Oversight Group (SCOG). SpecCom colleagues had been interested in the relative balance of national and regional commissioning, the timescale for commissioning and the resources available to support the work. **WH** added that it was important for both regional and national teams to SCOG understand the position of the review. **MW** noted that the pre-election restricted period would not prevent preparative work for the assurance process. **CW** advised that the CCGs would need to understand where they fit in to the overall process and advised that a programme management office function would be required to support implementation. The need to think through how the proposed delivery models developed by providers would be assessed was raised. **JP** advised this could be undertaken nationally or regionally on the basis of delivering standards, but this question would need to be understood, once the proposed model was presented, and need answering quickly. It was agreed **JP** and commissioning colleagues would initiate a meeting to look at the national/ regional process required.
ACTION	**JP and commissioning colleagues to initiate a meeting to discuss the national and regional process for response to the delivery model.**
11	**Risk and issue log**
	There were no additions to the risk log.
12	**Highlight report**
	The highlight report was reviewed. The meetings plan was discussed and it was agreed that the joint standards and clinical reference group meeting (JSCRG) was to

Item	Agenda Item
	be delayed; clear communication to be provided to the stakeholders about the revised timeline.
ACTION	Programme Team to: • cancel the JSCRG • communicate to the stakeholders on the revised timeline.
13	**Any other business**
	CH asked if it was possible for the transition process of the programme to specialised commissioning could be communicated to the providers? **MW** advised that the programme was working closely with specialised commissioning around the detail and advised a paper would be provided on this.
ACTION	**MW** and commissioning colleagues to provide a transition paper for stakeholders.
Date of next meeting	Members were asked to note the date of the next meeting of the Programme Board, scheduled to take place on 23rd March 2015.

Action Log: Programme Board

Action no.	Meeting date	Action description	Responsibility	Progress details	STATUS	Date closed
50	16/04/2014	**Discussions to take place with relevant members of the Clinical Advisory Panel regarding the training of anaesthetists and nurses.**	Professor Sir Michael Rawlins and Michael Wilson	In the April 2014 Programme Board, it was agreed that the issue of anaesthetists should be discussed with Dr J P Van Besouw (Royal College of Anaesthetists) and the issue of nursing with Fiona Smith (Royal College of Nursing). Conversations in relation to workforce will be scheduled once work on objective 4 is underway in October 2014.	NOW PART OF ACTION 88	19/11/2014
51	16/04/2014	**Michael Wilson to connect with Jo Lenaghan, Director of Strategy and Planning at Health Education England (HEE) regarding perfusionists, nursing and other technical staff.**	Michael Wilson	Introductory email to Jo Leneghan sent. Will be followed up further when we have a clearer, more comprehensive picture of workforce and training issues in October 2014.	NOW PART OF ACTION 88	19/11/2014
61	13/05/2014	**Seek advice from the Independent Reconfiguration Panel (IRP)**	John Holden	Call to be scheduled at a later point in the review as appropriate.	ON HOLD	
62	13/05/2014	**A note to be prepared on behalf of the Programme Board to Health Education England (HEE) updating them on the potential issues in relation to workforce and training in respect of the early diagnosis work, once they are identified.**	Michael Wilson	This sits alongside action 51. Contact is planned once issues have been fully explored.	NOW PART OF ACTION 88	19/11/2014
73	10/06/2014	**Contact Rosamond Roughton to advise on Area Team, Regional Team and CCG representatives to join the Programme Board.**	Michael Wilson	Two Area Team, one Regional Team and one CCG representatives have joined the Programme Board. A further CCG representative still to be identified.	IN PROGRESS	
75	28/07/2014	**All new members of the review's Programme Board to complete declaration of interest forms and submit to the review team for publication by 8 September 2014.**	Michael Wilson	Declaration of interest forms circulated to all new members. This will be an ongoing process.	IN PROGRESS	
85	23/09/2014	**Different commissioning options will be worked up and tested with providers, clinicians and other stakeholders.**	Michael Wilson	The Provider Leaders' Group is mow establishing contact with all Provider Trusts to establish a group to draft the delivery model for CHD services. A revised timetable is to be proposed at the Programme Board 23.03.15 and communicated to all stakeholder groups.	IN PROGRESS	
86	23/09/2014	**Issues relating to sonographers to be discussed with Health Education England and the NHS England Nursing Directorate.**	Michael Wilson	The new CHD review team have written to HEE to ask for a named contact worker.	NOW PART OF ACTION 88	19/11/2014

87	23/09/2014	**Recommendations to improve early detection rates of congenital heart disease to be received by the Programme Board in December 2014.**	Michael Wilson	A paper was presented to the February 2015 Programme Board; an implementation plan, sign-off and agreement is required for the May 2015 Programme Board. Direct individual links with commissioners to be established	IN PROGRESS	
88	23/10/2014	**Workforce and training issues related to anaesthetists, nurses, perfusionists, sonographers and other technical staff - highlighted across the programme by actions 50, 51, 62 and 86.**	Michael Wilson	Clinical workforce issues will be discussed by CAP and recommendations brought forward under objective 3.	IN PROGRESS	
90	18.02.15	**James Palmer and commissioning colleagues to initiate a meeting to discuss the national and regional process to the delivery model.**	James Palmer	Note this is also linked to action 85	IN PROGRESS	
91	18.02.15	**Programme Team and Commissioning colleagues to provide a transition paper to stakeholders**	Michael Wilson	Commissioning Oversight Group. However the new timeline will need to be factored into this.	IN PROGRESS	

Programme Board

New Congenital Heart Disease Review

23/03/15

NHS England

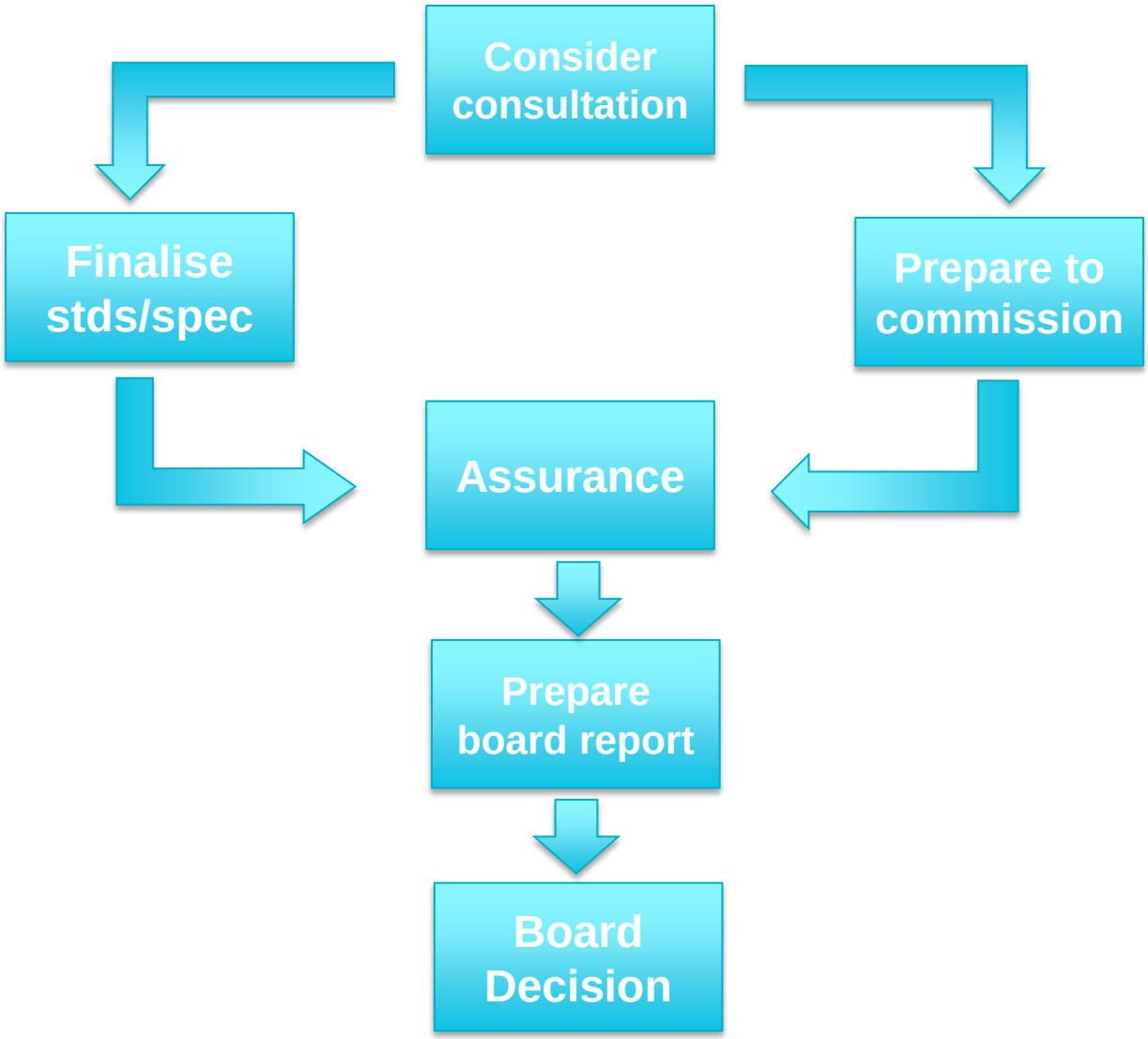
Item 5

From consultation to NHS England Board

NHS England

Item 5

From consultation to board decision



NHS England

Item 5

Consider consultation

- Independent report by Dialogue by Design
- Review of all responses by team*
- Prepare analysis of responses by standard
- Prepare analysis of wider issues raised

*including late responses where relevant

NHS England

Item 5

Finalise standards and specification

Joint standards and CRGs

- Consider responses by standard
- Recommend to CAP any necessary amendments to standards and any necessary additional standards and future developments
- Develop revised specification

Clinical Advisory Panel

- Consider JSCRG recommendations
- Consider new evidence
- Consider wider issues raised in consultation
- Advise TAFG

Task and Finish Group

- Ratify amended standards and specification
- Agree to proceed to assurance

NHS England

Item 5

Prepare to commission

- Provider group develops delivery model proposals
- Assess proposed delivery model
- Preparing for the commissioning of the delivery models, work up to include: baseline market assessment; analysis of current contract; activity and expenditure analysis and forecast; consider alternative payment/funding models; consider legal issues; describe alternative commissioning strategies; financial appraisal and capital investment requirements
- Agree commissioning and change strategy
- Determine resource requirements to deliver
- Develop communications and engagement approach

NHS England

Specialised Commissioning Assurance

Item 5

Programme of Care Board	• Considers congruence with other related services; equalities assessment; engagement and governance of process.
Clinical Priorities Advisory Group	• Considers relative priority and assures compliance with agreed processes.
Specialised Commissioning Oversight Group	• Considers affordability, priority, and commissioning strategy.
Service Reconfiguration Oversight Group*	• Considers impact of proposals on service configuration.
Specialised Commissioning Board Sub-Committee	• Approves proposals for board consideration.

* Not on critical path

NHS England

Item 5

Preparation of Board Report

Board Report

Report will cover the whole work of the review. This will include proposals for:

- A new model of care describing the function and activities of tiers 1-3, outreach and retrieval services
- Mechanisms to optimise outcomes for rare and complex procedures
- New standards and specifications
- A system for monitoring and managing standard compliance
- An assessment of workforce and training needs to meet the standards and service specification
- Recommendations on the commissioning and change management approach to be adopted
- Factors to be taken into account when commissioning including capacity requirements, access and provider affordability
- A plan to provide better information for commissioners and patients, including performance, financial and activity
- A clear programme of action to improve antenatal detection actions

NHS England

Timetable: 2015/16

2015-16

April – September 2015

Deliver review objectives

Agree standards

Co-design commissioning model

October 2015 – March 2016

Commissioning

Specialised commissioning; finance; comms & engagement; analytics

April 2016 onwards

Live

Contract & performance management

Transition from review to SpecCom

NHS England

Item 5

Governance transition

Phase 1 **To consultation**	Phase 2 **To board decision**	Phase 3 **To implementation**
• Task and Finish Group	• Task and Finish Group	• Specialised Commissioning Oversight Group
• Programme Board	• Programme Board *with additional SpecCom and ClinCom representatives*	• Implementation Working Group
	• Transitional arrangements: *regular reporting to SCOG; establish Implementation Working Group*	

NHS England

Risks to delivery

Risk	Proposed mitigation
Volume of material to be considered by JSCRG/CAP	Detailed meeting preparation including work with chairs
Scheduling of SpecCom assurance groups	Work with Richard Jeavons and James Palmer to resolve
Successful completion of all assurance requirements at first attempt	Work with chairs and secretariat to ensure expectations are understood
Impact of specialised tariff cap on affordability	Refresh finance impact assessment. Providers to factor into delivery model
Development of delivery model is delayed or does not meet requirements	Set clear requirements. Provide facilitation. Appropriate commissioner involvement.
Programme team lack technical skills to complete pre-procurement work up	Seek specialist support from SpecCom
Programme team capacity	Define discrete tasks and seek support within Commissioning Strategy
Commissioning cannot be completed in time for go-live Apr 2016	Timescales developed jointly between Review, SpecCom and Providers
Providers cannot meet specification without reconfiguration	Include scenario in assessment framework. Regional lots allows multi-track approach.

NHS England

Item 6

Consultation responses

The Report

- NHS England commissioned *Dialogue by Design* to receive and analyse consultation responses on their behalf.
- This involved setting-up and maintaining the response channels, processing, analysing and reporting on the responses received.
- Report published 02/03/15

THE CONSULTATION PROCESS

- An overview of who responded, and how
  - 459 submissions: 280 online, 102 email, 77 on paper form
  - 365 from individuals, 92 from organisations (2 not specified)
  - 220 from people with CHD or their family/carer: 124 from people working directly or indirectly with people with CHD: 17 from charity/support group for people with CHD
  - Broad age range, including 55 ‘under 12’
  - Most identified as Welsh/English/Scottish/Northern Irish/British (285)
  - 87 self-identified as having a disability

DIALOGUE by DESIGN

RECURRING THEMES

Positive views

- Collaboration, supporting improvements to quality of care
- Improved access to care resulting from network approach
- Opportunities for knowledge transfer and skills development provided by model of care

Concerns

- Challenges of implementation, particularly adequacy of funding
- Potential for regional variations in quality of care
- Sufficient specialists with the right expertise to staff the model?

SOME OF THE THINGS YOU SAID…..

I think the proposals are well thought out and should help provide seamless consistency for all CHD and cardiac children/families (Individual)

Your proposals are extremely dated and many areas have developed services beyond those outlined in the documentation produced (Individual)

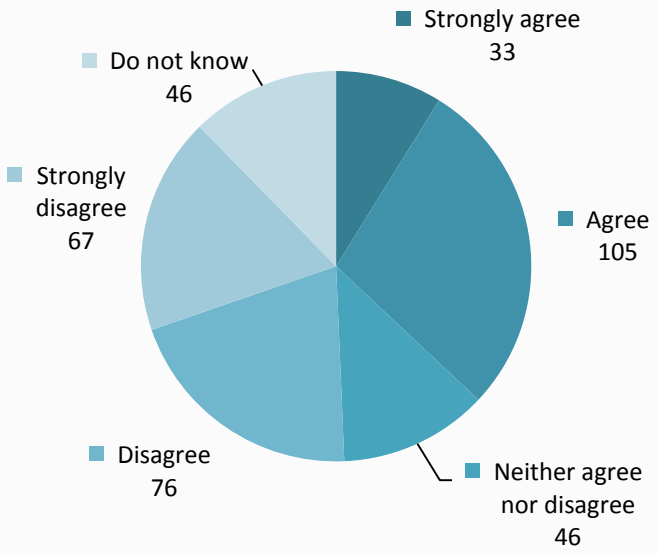
There is an inconsistent approach to the proposed model of care [...] The proposal that some parts of the country will operate with Level 1 and Level 3 centres, while other parts of the country will have Level 1, Level 2 and Level 3 centres appears to be inconsistent with the aim of tackling variations across the country. (Organisation)

The overall model of care is good and will maximise opportunities for as much care as possible to be provided close to home, whilst ensuring that patients have access to highly specialist care at the times in their pathway that they need it. (Individual)

DIALOGUE by DESIGN

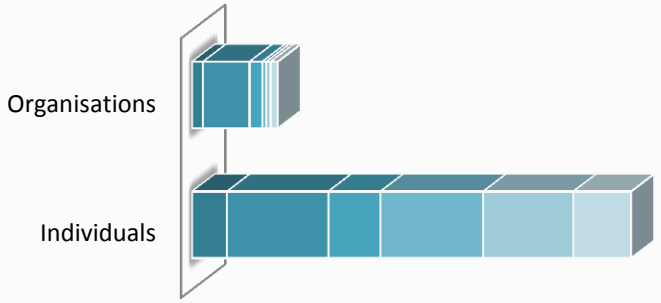
VIEWS ON THE PROPOSALS OVERALL (373 RESPONSES)

Will the draft standards and service specifications meet the aims [of the new CHD review]?



Similar numbers agree that draft standards and service specifications will meet the aims of the new CHD review as disagree, with slightly more disagreeing.

Will the draft standards and service specifications meet the aims [of the new CHD review]? Responses by organisation and individual.



	Individuals	Organisations
Strongly agree	25	8
Agree	72	33
Neither agree nor disagree	37	9
Disagree	73	3
Strongly disagree	64	3
Do not know	41	5

Organisational respondents are more likely than individual respondents to agree that the proposals would meet NHS England's aims.

DIALOGUE by DESIGN

MODEL OF CARE

Many support this, a few unconditionally though most with caveats.

Positives

- Promoting consistent standards across regions
- Bringing care closer to home
- Joining up care

The overall model of care is good and will maximise opportunities for as much care as possible to be provided close to home, whilst ensuring that patients have access to highly specialist care at the times in their pathway that they need it. (Individual)

Concerns

- Would lead to additional travel time for patients and families
- Care could become fragmented and inconsistent

There is an inconsistent approach to the proposed model of care [...] The proposal that some parts of the country will operate with Level 1 and Level 3 centres, while other parts of the country will have Level 1, Level 2 and Level 3 centres appears to be inconsistent with the aim of tackling variations across the country. (Organisation)

DIALOGUE by DESIGN

LEVEL 2 SPECIALIST CARDIOLOGY CENTRES

Views are mixed

Positives

- Similar to those identified for overall model of care
  - Reduced travel time, increased access, quality and consistency of care

It provides a better clinical governance structure by mandating the MDT decision must be made and will build stronger centres of excellence due to the increased throughput. (Organisation)

Concerns

- Staff retention
- Dilution of skills, impacting on quality and consistency of care
- Need for level 2 centres in every location – or at all?

The needs of patients or healthcare professionals will not be met here if these centres are seen as little more than training grounds.

DIALOGUE by DESIGN

NETWORK APPROACH

Many support this, often with reservations. Few oppose the standards explicitly.

Positives

- Value of collaboration – contributes to knowledge transfer, high quality and consistent care
- Opportunities for staff development
- Reduced regional variation in access to care

Concerns

- Implementation will be challenging without proper management or adequate funding
- Whether some centres will not be included in networks and have to close

DIALOGUE by DESIGN

STAFFING AND SKILLS

Many support this, often with reservations. Some oppose the standards explicitly.

Positives

- Supporting improvements in quality of care
- Increased support for patients
- Increased access to specialist care
- 24/7 on call support

Concerns

- Availability of resource to cover cost of additional staff and training
- Availability of expertise to staff the proposals
- Recruitment and retention at different levels of the network
- Strictness of standards

DIALOGUE by DESIGN

MINIMUM 4-SURGEON TEAMS, MINIMUM CASELOAD OF 125 OPERATIONS PER SURGEON PER YEAR

Positives

- Cover for absence
- Promotion of safety and quality
- Exposure to wide range of different cases

Concerns

- Potential for competition between surgeons striving to meet caseload quota
- Surgeons unable to meet caseload quota
- Perceived lack of evidence for standard size team, operations quota
- Regional variation in demand

DIALOGUE by DESIGN

SERVICE INTERDEPENDENCIES AND CO-LOCATION

Many support this, some with reservations. A few oppose the proposed standards.

Positives

- Patient-centred
- Efficient allocation of resources
- Improved patient safety

Concerns

- Cost and time-scale for implementation
- Potential for co-location to lead to the closure of some centres
- Queries over whether the evidence base supports the proposed approach

DIALOGUE by DESIGN

IMPLEMENTATION

Broad support for approaches to implementation. Some concerns and mixed views

Positives

- Quality dashboard
- Peer review
- Network governance

Concerns / mixed views

- Whether a rigid or flexible approach to implementing standards is preferable
- Ensuring consistent quality of care over the long term
- Role of commissioners
- Funding/resourcing for implementation

DIALOGUE by DESIGN

OTHER STANDARDS

Few respondents comment on sections of the consultation which have no associated question: most agree broadly with proposals, and some suggest improvements or alternatives.

- Facilities
- Training and education
- Organisation and audit
- Research
- Communication with patients
- Transition
- Pregnancy and contraception
- Fetal diagnosis
- Palliative care and bereavement
- Dentistry
- Transplant services
- Learning disabilities

DIALOGUE by DESIGN

SOME OF THE THINGS YOU SAID…..

The staff have to be towards top of the agenda, at the end the service or good quality service will not exist without these highly skilled and sought after staff (Individual)

Please think carefully about keeping all the skills in a few places. I have two grandchildren with CHD. I can't travel to the other end of the country to visit, neither can their parents. Please be mindful of geography. (Individual)

There needs to be provision for the whole family to be treated as a unit in one location regardless of age, with shared appointments and investigation, diagnosis and treatment (Charity/support group)

The proposed network and 3 levels of centres seem sensible but resources, funding and procedures/operations should be located in areas of highest local patient demand for services based on published current and predicted future demand. (Several individuals)

Fears about the funding of the service, the availability of highly qualified, experienced staff and the length of time it will take to meet the newly agreed standards is an ongoing and as yet unanswered concern. (Charity)

New congenital heart disease review: Programme Risk Register

Risk Owner	Risk Ref	Potential Risk Description	Current Risk Score (note 1)			Mitigating Actions in Place	Further Mitigating Actions	Completion Date for Actions	Anticipated Risk Score Following Mitigation (note 2)		
			Impact	Likelihood	RAG Status	Systems and processes that are in place and operating that mitigate this risk	Additional actions required to mitigate this risk further	For each further mitigating actions a completion date must be provided	Impact	Likelihood	RAG Status
Programme Risk Register											
National Director: Commissioning Strategy Supported by: National Medical Director	1	**There is a risk that continued uncertainty may compromise the safety, quality, resilience and viability of services until the future configuration of the service is established.**	4	3	AR	1. NHS England has worked with providers to develop a 'transition dashboard' and this is now being rolled out across the country to give early warning of any emerging concerns and to allow commissioners and providers to respond promptly whenever concerns arise. 2. NHS England continues to drive an ambitious timeline to bring the period of uncertainty to an end as soon as possible.	Continue to progress the review at pace whilst being as open as possible, and maximising opportunities for engagement. The programme board and task and finish groups were updated on the transition dashboard in June. Further discussions will be held in relation to the potential to share this data in future. Advice will be sought and continued communication , where possible will ensure work progresses.	ongoing	3	3	A
National Director: Commissioning Strategy Supported by: National Medical Director	2	**There is a risk that continued uncertainty for patients, families and staff may lead to concern about the future of particular units and the implications for individuals.**	3	3	A	1. Ensuring good communication and stakeholder engagement are at the heart of the review and that stakeholders are informed about the process, it's aims, objectives and ways of working and are enabled to participate in that process in a way that suits them. 2. Bi-monthly meetings of the engagement and advisory groups continue and a joint meeting of all 3 groups took place in July 2014. Visits to all paediatric surgical centres along with an opportunity to engage with local patient and public groups have taken place. Visits have also been made to three adult centres. 3. Detailed plans are now underway for engagement during consultation and an update will be provided to the Programme Board at their meeting on 8 September 2014. 4. A detailed communications grid and briefing packs have been developed for the lead up to consultation and are ready to go once consultation launch is approved.	Ongoing revision and development of stakeholder communications and engagement plan must be carried out to ensure all stakeholder groups are identified and well informed. Public consultation concluded in December 2015, following 12 nationwide consultation events , supported by other local events . A joint engagement and advisory meeting is planned for 09/03/15 with further events following the pre-election restricted period.	ongoing	2	3	AG
National Director: Commissioning Strategy Supported by: National Medical Director	5	**There is a risk that the review will not achieve the required level of stakeholder engagement and ownership of the processes and proposals of the review leading to mistrust of or opposition and delaying needed service improvements for patients.**	4	3	AR	1. Continuing to work closely with colleagues in the Patients and Information Directorate. 2. Communications and engagement plan drafted and considered by the Programme Board at its meeting on 21 October 2013. 3. A further update was presented to the programme board in February 2014 to advise of the detail of the engagement currently taking place and planned.	The stakeholder communications and engagement plan to be constantly reviewed and updated following dialogue with stakeholders - reflective of how they want to be engaged. Publications of material continue to be open and transparent,; stakeholders advised of the pre-election restricted period that may cause a pause in certain communications.	ongoing	3	3	A
National Director: Commissioning Strategy Supported by: National Medical Director	6	**There is a risk that any proposed solutions will be formally challenged, for example through judicial review or referral to Secretary of State, delaying needed service improvements for patients.**	3	3	A	1. Open and transparent approach - bi-weekly blogs, new congenital heart disease (CHD) webpages, publishing all meeting papers etc. 2. Supplementary publication scheme for the new review approved by the Programme Board at its meeting on 21 October 2013. 3. Ensure both the new standards and specifications are created in collaboration with all established programme engagement groups and all established NHS England specialised commissioning groups.	Progress work to ensure that all information / documents are published in line with the agreed supplementary publication scheme. Continue to maintain an extensive plan of engagement and communications activity with all stakeholder groups. Advice has been taken from the NHS England Legal team. Areas of the commissioning process which may require legal advice have been identified and will be progressed as the commissioning and change model work develops.	ongoing	3	2	AG
National Director: Commissioning Strategy Supported by: National Medical Director	7	**There is a risk that if a challenge was raised against the programme (see risk 6) it could be successful if best practice in all processes has not been followed.**	3	2	A	1. Reflecting on the lessons learned from the challenges brought against the safe and sustainable process. 2. The new review is taking into account the recommendations made by the Independent Reconfiguration Panel (IRP) in their report and the Judicial Review. 3. Commitment has been made by NHS England to not leave all the key decisions until to the end of the process wherever possible. 4. The NHS England specialised commissioning process for the development of new service specifications is being followed and best practice standards will be consulted on and agreed before consideration is made as to how these can practically be applied. 5. Stakeholders are being engaged at every stage in an open and transparent way to allow input to the process in addition to the content of the review. 6. All appropriate stakeholders have had the opportunity to input pre-consultation and all appropriate governance groups have signed off the relevant materials. A full report is to be provided to the Programme Board at their meeting on 8 September 2014. 7. An equalities analysis has been undertaken, assured by the NHS England Equalities team and published on the NHS England website after review by key stakeholders.	Seek expert advice on the review's processes (e.g. Legal, Monitor, scrutiny) - as part of increased focus on Objective 4 (commissioning & change model).	ongoing	2	2	AG

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			Impact	Likelihood	RAG Status	Systems and processes that are in place and operating that mitigate this risk	Additional actions required to mitigate this risk further	For each further mitigating actions a completion date must be provided	Impact	Likelihood	RAG Status
National Director: Commissioning Strategy Supported by: National Medical Director	8	**There is a risk that as NHS England is not the commissioner for the third tier in the proposed service standards, this may result in extended timescales to deliver change, or an inability to fully implement the new service model and standards.**	4	3	AR	1. Resource now identified to lead the engagement with Area Team commissioners and providers (update June 2014).	NHS England to work closely with CCG's to ensure that changes can be implemented across the pathway. Programme team to continue to engage more closely with specialised commissioning colleagues following initial meetings, to ensure handover to commissioning is seamless and that expert commissioners are advising on the implementation of standards for service areas outside of NHS England's direct commissioning reach. Commissioning colleagues are now members of the Boards, as well as codirecting the Programme.	Ongoing	4	2	A
National Director: Commissioning Strategy Supported by: National Medical Director	9	**There is a risk that the new standards and specifications result in higher cost services which will conflict with current work underway to reduce costs across all specialised service areas, which may result in the funding being unavailable to implement required changes.**	3	4	AR	1. An initial financial impact assessment has been carried out assessing areas of cost pressure within the standards and current delivery costs. This initial assessment contains a much higher level of detail including modelling potential financial impact of all standards and has been assured by the CPAG financial advisor and NHS England strategic finance.	Consideration later in the review process will need to be made as to the likely cost of implementation of best practice standards by working closely with providers to understand costs, undertaking further financial assessment of the new standards, understanding the relationship and trade offs between higher standards, number of centres/access, payment systems and risk sharing and the impact of rising activity levels. The timing of this work will be carefully considered alongside the planning of the commissioning approach. Further consultation may be required. Commissioning colleagues to advise.	Mar-15	3	3	A
National Director: Commissioning Strategy Supported by: National Medical Director	12	**There is a risk that a need to replicate a similar governance process to that required to launch consultation, prior to providing a formal public response to the consultation, will result in a delay to responding until after the general election. This in turn could lead to a delay in implementation.**	3	3	A	The governance process has been reviewed.	The programme plan has taken into account the pre-election restricted period, with the associated timings of all the assurance processes necessary to meet the reviews objectives. Publications of material have been discussed with the Department of Health and NHS England's senior team, along with advice form communication personnel. All work undertaken by the programme will follow a specific governance route to remain open and transparent with all stakeholders.	Jul-15	3	3	A
National Director: Commissioning Strategy Supported by: National Medical Director	15	**There is a risk that the work undertaken by the new CHD review is not sufficiently aligned with the broader programme of work being developed across specialised commissioning. This may result in commitments made that do not align with those being made across other services.**	3	4	AR	1. Representatives from across specialised commissioning have now joined the programme board and are working with the team to define the next steps and the commissioning process which will follow the consultation on standards and specifications.	Director of Specialised Commissioning briefed and joining TAFG. Briefing provided for SpCom SMT and SCOG. Specialised commissioning colleagues attending provider group. Process for development of commissioning is being reviewed, with provider input	Mar-15	3	3	A
National Director: Commissioning Strategy Supported by: National Medical Director	16	**Changes proposed may need support from other stakeholders e.g., Public Health, Societies, to name a few- which will require a greater time period than the programme is able to support; to ensure and assure the delivery of the changes, given the proposed demand and capacity.**	3	3	AR	Working in partnership with other organisations/stakeholders to influence change.	Programme Board to ensure that recommendations result in continuing NHS England involvement and influence on delivery following the completion of the Review.	Mar-15	3	2	AG

HIGHLIGHT REPORT to the PROGRAMME BOARD 23/03/15

SRO: Professor Sir Bruce Keogh, National Medical Director

Programme Director: Michael Wilson

KEY UPDATES SINCE LAST MEETING OF PROGRAMME BOARD:

Governance meetings

- No governance meetings have been held since the last Programme Board. The Joint Standards and Clinical Reference Group meeting was cancelled.

Engagement meetings

- Engagement & Advisory Group Meeting was held on the 09/03/15; the group discussed the findings from the consultation response; received updates on objective 5 and 6, whilst helping to establish what was a priority for data capture

Reports

- The Dialogue by Design report on the review of consultation responses was published on the 02/03/15 and presented to the Engagement & Advisory Group meeting by the CEO of Dialogue by Design.

Literature

- John Holden's blog with reference to the review programme, has been updated with the latest being the 39th version - http://www.england.nhs.uk/category/publications/blogs/john-holden/. The next one is due to be published on Friday 20th March 2015

KEY RISK:

Description	Current residual risk rating
1. Reference risk 1 - Timeline for the commissioning of the CHD services, following consultation and the publication of documents along with the limitations enforced by the pre-election restricted period, inclusive of governance. 2. Reference risks 9 and 15 - Future commissioning of services is being developed. Related actions - 85 & 90.	AR

ISSUES:

Description
No issues at this time.

NEXT STEPS:

Communication & Engagement:

- No meetings. Planning work will still continue.

Future key meetings:

- The next Engagement and Advisory Meeting will be held in June 2015, due to the pre-election restricted period.
- It is envisaged that the provider leaders' subgroup will meet in April/May to draft a delivery model.

SUPPORT REQUIRED:

The Programme Board is asked to:

- provide advice on further actions relating to the review and response to the consultation report;
- review and advise on the programme's next steps; and
- advise on the governance and decision-making for the review.