Annex C: Notes of meeting between Liverpool and Manchester Hospitals

Email from Professor Huon Gray

Dear Colleagues,

It was very good to meet with you all on October 23rd. I felt the discussion was constructive and a helpful step forwards in understanding how the North West Congenital Heart Disease network will work in future.

I have attached here the notes of the meeting and would also like to thank the Manchester team for following up with us so promptly on the interventions they would like to consider undertaking as a level 2 service.

The NHS England Board will take into account our discussions as they make their decisions, in public, on the November 30th. I can confirm that we will be providing them with the reassurance that in the North West the providers will be working together to establish a robust network with strong level 1 and 2 centres providing ACHD and paediatric cardiac care to patients in the North West.

Specifically, I believe we reached an agreed view on maternity care for women with CHD, with services continuing in both Manchester and Liverpool, and the network MDT involved in decisions about appropriate care for women with complex needs.

We also agreed that there would be support for continuing ACHD interventions in Manchester, within the level 2 standards, and that we would look at the specific procedures that Manchester wished to undertake. Having received a list of the proposed procedures following our meeting I am advised that all but one fall within acceptable Level 2 service standards, subject to the usual MDT oversight. The exception is intervention for de novo aortic coarctation, which would be expected to be undertaken within a level 1 centre.

I hope these agreements now form the basis for planning implementation of these services, subject to the Board's deliberations on 30th November. We agreed at the meeting that joint workforce planning would be key to re-establishing and developing CHD services across the network, starting with providing a full outpatient service on both sites so that additional patient travel can be minimised as soon as possible.

I am very aware of the challenges experienced by colleagues in the North West and I am grateful to you for your continued efforts to ensure that your network can once again offer patients a full range of CHD services. Please do get in touch if there is any further help that I or the team can offer.

Kind regards,
Your sincerely,

Professor Huon Gray
National Clinical Director for Heart Disease, NHS England

NHS England CHD Programme: NW Region

Action notes from the meeting held on 23 October 2017

Present

- Professor Huon Gray, National Clinical Director for Heart Disease, NHS England (Chair)
- Professor Robert Pearson, Medical Director, Manchester Foundation Trust
- Dr Jane Eddleston, Associate Medical Director, Manchester Foundation Trust
- Darren Banks, Director of Strategy, Manchester Foundation Trust
- Dr Raphael Perry, Medical Director, Liverpool Heart and Chest Hospital
- Adam Bateman, Chief Operating Officer and Director of Strategy, Alder Hey Children's Hospital
- Mr Rafael Guerrero, Consultant Congenital Cardiac Surgeon, Alder Hey Children's Hospital
- Dr Vishal Sharma, Consultant Cardiologist, Royal Liverpool and Broadgreen University Hospital
- Robert Cornall, Regional Director of Specialised Commissioning North, NHS England
- Dr Michael Gregory, Regional Clinical Director for Specialised Commissioning North, NHS England
- Helen Ashcroft, Local Service Specialist, North of England Specialised Commissioning Team, NHS England
- Michael Wilson, CHD Programme Director, NHS England
- Claire McDonald, CHD Communications and Engagement Lead, NHS England

1. Introduction / Aims and Objectives

Professor Gray described the background to his involvement in the development of CHD services for the North West of England. As National Clinical Director for Heart Disease he had been asked by the Board of NHS England, as it approaches its decision on 30 November 2017, to seek assurances that, if they were to proceed with their proposed approach, providers in the NW understood what would be required to reshape services accordingly, and had a plan to deliver the necessary changes in a timely way. Equally important within that were that level 1 ACHD care was delivered in Liverpool and level 2 ACHD care was delivered in Manchester.

He acknowledged that the continued uncertainty had led to challenges and that it had been difficult to create plans without knowing the final decisions of the NHS England board. He asked for the meeting to focus on the present and future.

Dr Perry, on behalf of the Liverpool Trusts, confirmed that they wanted to see a strong network of CHD provision and saw MFT as a crucial part of that service, providing strong level 2 services. That would be key to providing a service that fit the NW and meeting the national standards.

Professor Pearson, on behalf of MFT, said that they wanted to see patient pathways at the centre of any plans. They were seeking assurance that implementation of the national standards would not compromise patient safety.

Dr Gregory, for NHS England, North Region, confirmed that while NHS England was committed to commissioning services that met the standards, this was to build up not degrade the services that patients receive.

2. Maternity care for women with CHD

Professor Gray said that the national Clinical Advisory Panel had considered the impact of the proposed changes on maternity care. Their view was that the proposals would affect only a very small number of women (those who might need acute peri-partum intervention or surgery) but that in other cases the pattern of care would be expected to remain largely unchanged, with plans for delivery in individual cases being the subject of relevant MDT discussions.

Both Liverpool and Manchester representatives agreed that the current provision for patients works very well. Most women with CHD deliver their babies in their local maternity unit. Most of those who need a higher level of specialist obstetric or ACHD support deliver either in Liverpool or Manchester depending on patient preferences and geographical referral patterns.

A very small number of women, perhaps 1 or 2 a year, need to deliver at the level 1 centre because of the potential need for intervention or surgery at or around the time of delivery. This has been in Manchester. Under the proposals this would change to be Liverpool. However there was concern from MFT that changing provision in this way would provide a less good service because obstetrics, ITU, neonatal care and specialist ACHD care were on different sites in Liverpool.

Professor Gray said that place of birth for women at higher risk should be discussed and determined at the NW network MDT. This could mean a bespoke arrangement to ensure that all aspects of care were 'wrapped around' the patient at whatever site was most appropriate for the delivery.

Liverpool and Manchester representatives agreed that the decisions should be made, for each individual woman, at the MDT.

Liverpool representatives confirmed that this could include the relevant ACHD support being provided at the St Mary's site if that was the most appropriate place for the woman to deliver. This should be possible for the small number of women likely to have this requirement, but noted that they could not commit to this being a more routine arrangement because of the impact on the provision of 24/7 care at the level 1 centre.

Michael Wilson confirmed that the arrangement as described is not at odds with the standards.

3. Workforce

Liverpool and Manchester representatives agreed that the limited available workforce within the NW was a critical issue in delivering services, both currently and in the future. They agreed that it was a shared problem and that it needed to be addressed with a shared approach.

MFT expressed concern that despite commitments to a joint approach, appointments were being made in Liverpool that were apparently not network appointments.

There was agreement that existing staff needed certainty about their own future, and shared HR policies should be developed. It was agreed that retaining present workforce was vital, particularly as other organisations would be looking for this skill set.

Some staff who were currently based in Manchester would, under the proposals, be likely to need to shift their centre of gravity to the level 1 centre in Liverpool, and TUPE would be expected to apply, but it would be unhelpful for there to be competition between the Trusts for these staff.

A variety of approaches were discussed including joint appointments and developing the network as a joint vehicle able to employ staff. There was concern about the practicality of joint appointments, but agreement to work together to create contracts that would describe roles and expectations best designed to serve the region as a whole. Providing there was a shared approach, the employing organisation was less important.

Two groups were seen as particularly important: ACHD cardiologists and specialist nurses.

There was agreement that appointing more ACHD cardiologists was the key to establishing the new service in the NW, and that it would be necessary to expand the number of posts, both to meet the standards, and to meet patient need. While the minimum staffing required by the standards to support effective rotas would mean at least six ACHD cardiologists across the level 1 and level 2 service, meeting the needs of the known patient cohort could require eight or nine.

MFT described how they had flexed job plans for some of their staff to give more capacity to the ACHD service, and Professor Gray and Professor Perry supported this sort of inventive approach as helpful during the initial phase of assuring a safe service in the NW.

The ACHD specialist nurses would also need additional members added to the team to increase capacity to match patient's needs. Specialist nurses were also in short supply and were considered less likely to be mobile than consultant medical staff.

4. Interventional Cardiology

Professor Pearson confirmed that MFT's aspiration was to be able to provide cardiological interventions for ACHD patients beyond the closure of PFOs and ASDs described in the national standards. Their view was that this practice would be safe because the need for surgery after intervention in these cases is rare.

Michael Wilson confirmed that under the standards:

- The only ACHD interventions permitted at a level 2 centre were PFO and ASD closures
- That the network service would need a lead interventionist who undertook at least 100 interventions each year
- That the level 1 centre would need a team of at least four interventionists, providing 24/7 cover, each of whom undertook at least 50 ACHD interventions each year and that any interventionist based at the level 2 centre would also need to undertake at least 50 ACHD

interventions each year. In each case however, there is no requirement that all the interventions are undertaken at a single site, so joint working would be possible across the network.

Mr Wilson also suggested that if practice beyond the level expected at a level 2 centre were to be contemplated, that standards beyond those for level 2 should also be expected to apply. Many of the standards for level 1 centres were designed to provide the appropriate staffing, environment, facilities and back-up needed for complex interventional cardiology patients, and not just the availability of CHD surgeons.

There was discussion about the nature of the cases that MFT would want to undertake. This information was not available for the meeting and MFT representatives agreed to make it available to the group.

Professor Gray said that the priority was to re-establish a safe effective ACHD service in the NW. The NHS England Board would, in its decisions, continue to support the standards, so in the first instance this would mean level 1 and level 2 services as described by the standards. If the future model of care agreed for the network included an interventionist based at MFT undertaking PFO and ASD closures, they would be able to undertake more complex ACHD interventions in Liverpool at LHCH. Decisions about the appropriate site for any individual patient's interventions should be made by the network MDT.

MFT representatives said that they were trying to work with the NHS England proposals but could not support an inflexible approach to applying the standards if a flexible approach would not worsen outcomes or patient experience. Professor Gray acknowledged their aspirations but said that he would not want this single issue to hinder the NW developing an effective NW service. The first priority was to establish a service for the majority of patients, much of which involves better outpatient services in both Liverpool and Manchester, and these issues which would be likely to involve small numbers of patients should be deferred until that was achieved.

5. Concluding remarks

Finally it was stated that goodwill and willingness to work together that had been expressed at the meeting would be needed to proceed to creating the service in the North West everyone wanted to see.