Trust Board Paper R

To:	**Trust Board**
From:	Mark Wightman, (DM&C)
Date:	**29 August 2013**
CQC regulation:	All applicable
Title:	Update on the new Congenital Heart Disease review.

Author/Responsible Director: Mark Wightman Director of Marketing and Communications, (DM&C)

Purpose of the Report:
To brief the Board on recent developments in the national review of Congenital Heart Disease, the process previously known as ‘Safe and Sustainable’.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

The story so far…
On July 4th 2012 the Joint Committee of Primary Care Trusts, (JCPCT) recommended that 7 clinical networks would be established across England, each with a lead surgical centre to cater for children with congenital heart defects. The East Midlands Congenital Heart Centre based at the Glenfield hospital, along with the Royal Brompton and the Leeds General Infirmary were not part of the recommendation.

On the 27th of July the Lincolnshire Health Overview and Scrutiny Committee referred this decision to the SoS.

On the 7th of September the Leicester, Leicestershire and Rutland HOSC also referred the matter.

The SoS then commissioned a full review of the Safe and Sustainable process and proposals. The Terms of Reference for that review were later amended to include a subsequent referral by the York’s and Humber Joint HOSC.

The IRP’s report, made public on June 12th concluded that “the JCPCT’s decision to implement Option B was based on a flawed analysis of incomplete proposals and their health impact, leaving too many questions about sustainability unanswered and to be dealt with as implementation risks.”

As a consequence the SoS in a statement to the House on 12th June said the “proposals cannot go ahead” and the review is “suspended”.

The responsibility for future proposals now rests with NHS England. They have been tasked by the SoS with producing a methodology by the end of July with the intention to announce a new way forward in the autumn, “with plans for implementation within 12 months.”

Most recent developments…

Since the last Board update in June, there have been a series of meetings held between NHS England and the clinical representatives of the Trusts included in the original review and the charities and stakeholder groups from each Trust area.

Overall the feedback from our clinicians and our stakeholders, regarding the tone, content and openness of these meetings has been positive. Although stakeholders and clinicians have pointed out that the proof will be in the pudding there is certainly more faith in the approach that NHSE are taking than in the previous review. (As an indication of the level of openness we recommend that Board members visit the blog by John Holden ‘Director of System Policy’ NHSE, http://www.england.nhs.uk/category/publications/blogs/john-holden/)

Whilst our supporting charities and our clinical teams have been given their voice within the new review there are three of our long term stakeholders who are currently unsure about how they will be involved in future. Healthwatch and both the Lincolnshire and Leicester OSCs have asked NHSE for clarification on how they are to engage in the process going forward. Given the history and the statutory responsibilities of these bodies we would support their view that this is an area which NHSE needs to consider with some haste.

In our letter to Bill McCarthy and Sir Bruce Keogh following our first meeting with NHSE on 21 June 13 we suggested that for the future the review should:

1. Look at the lifetime care of patients, not just children and not just surgery
2. That there should be no predetermination in terms of the numbers of centres
3. That practising clinicians and local stakeholders should be involved in describing what the IRP called a ‘standards driven process’, from day one.
4. Recognise that mortality in the two decades since Bristol has decreased significantly.

We were by no means the only people making these points but it is encouraging that each has been taken on board and each now forms a fundamental pillar of the process.

Specific to the question of the number of centres; NHSE has now advised that ‘there is no number’ and as a consequence we fully expect that any future consideration regarding the quantum of surgical centres will be driven by need and the adoption of agreed clinical standards.

Finally, the Chair of NHS England, Professor Sir Malcolm Grant wrote to the SoS for Health, the RH Jeremy Hunt MP at the end of July. This letter is attached for the Board’s information along with an indicative timeline from NHSE which sets out their current thinking regarding the timescale for drawing these deliberations to a conclusion.

Recommendations: 1. The Board is invited to note the contents of this paper. 2. The Trust Board continues to receive regular updates on the progress of this work	
Previously considered at another corporate UHL Committee? No	
Board Assurance Framework:	**Performance KPIs year to date:**
Resource Implications (eg Financial, HR): To be assessed	
Assurance Implications:	
Patient and Public Involvement (PPI) Implications: We will continue to work with stakeholders until the conclusion of this process.	
Stakeholder Engagement Implications: A/A	
Equality Impact: Will be assessed as part of NHSE work on travel / access	
Information exempt from Disclosure: NA	
Requirement for further review? On-going	

Appendix 1: Letter to Secretary of State from Chair of NHS England

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31 July 2013

Dear Secretary of State

New review of congenital heart disease (CHD) services

In your letter of 12 June about the "Safe and Sustainable" review, you asked NHS England to report back to you by the end of July setting out how we intend to take the process forwards.

I am pleased to enclose the paper which our Board considered at its meeting in public on 18 July, which sets out our thinking on the nature of the problem and the principles which must underpin our approach. In line with our commitment to transparency, a video recording of the Board's discussion is also available, at http://www.england.nhs.uk/2013/07/22/boardvids-180713/. Annex 1 of the Board paper describes an outline timetable for the work.

We have set ourselves the hugely ambitious challenge of an implementable solution within a year. This does not mean we think the job is easy; on the contrary, it is exceedingly difficult. We have a duty to patients now and to future generations to ensure the best possible quality of care within the available resource. That means best outcomes, a positive patient experience, and consistently high levels of safety.

We do not see this as a competition between providers to find "winners" and "losers". Instead, we want a single national service which sets high standards for the delivery of care, which are uniformly available to all NHS patients in England, wherever they live. Beyond this aspiration for a national service underpinned by national standards, we do not profess to know yet precisely what the answer is. We are very clear that the Independent Reconfiguration Panel's (IRP) report requires us, amongst other things, to look at children's and adults' services together, to look afresh at the demographic and other relevant data, to describe the entire pathway, and to properly involve all stakeholders throughout the work. So, we need a new process. Although the *Safe and Sustainable* conclusions cannot be implemented, there has nonetheless been some very good work during the past five years, with extensive involvement from clinicians and patient groups, to develop standards and proposals for networks. As IRP suggests, this work needs to be completed. Once validated it will give us a platform for future work, but it does not in any way require us to reach the same conclusions as the previous process.

As we continue our initial discussions over the next few weeks, and begin to develop a proposition for debate in the autumn, there is bound to be speculation about the “answer” we have in mind. But having promised that we will listen before we act, I can assure you that we have no such prejudice. I welcome your support in reiterating this message.

We are still in an extended period of listening and we regularly publish the notes from our meetings to open the debate as widely as possible. I have established a committee of the Board to give this topic the focus it deserves, and Professor Sir Mike Rawlins will chair a clinical advisory panel to support our medical director Professor Sir Bruce Keogh in obtaining excellent clinical engagement and advice.

We are absolutely committed to achieve the service change required for these very vulnerable patients. We will exploit the full potential of NHS England as the sole national commissioner, and do so in a way that properly engages all interested parties, but at sufficient pace to mitigate the risks of further delay.

Yours sincerely

Professor Sir Malcolm Grant
<u>Chair</u>

Appendix 2: The proposed timeline form NHS England (lifted from NHSE Board Paper and referred to in the letter to the SoS)

Annex 1: Programme Plan

Our indicative timetable is as follows:

Phase 1 – up to October 2013

Co-design a process for the work going forward

- Take advice from external experts to help shape listening exercise *[done]*
- Review previous stakeholder input in order not to lose what has already been achieved; and check its continuing relevance with stakeholders *[under way]*
- Begin communications as per stakeholders preferences, eg blog, shared resources on webpage/sharepoint *[under way]*
- Agree approaches to participation, identify preferred communications channels

Establish the programme

- Establish governance, advisory and stakeholder arrangements *[under way]*
- Develop programme plan, update Board, secure agreement, update Secretary of State *[under way]*
- Identify resources *[underway]*

Initial work on how to achieve programme aims of higher quality services

- Agree with stakeholders what should be taken forward from previous processes
- Complete work on proposed paediatric cardiology standards *[underway]*
- Bring together adult and children's standards and agree process for approval and adoption *[underway]*
- Develop proposals for testing/implementing formal network arrangements *[underway]*
- Work with stakeholders to identify any fixed points and how these would influence service design. This is likely to include (but not be limited to) discussion of the provision of transplant services, the need for children's heart surgery and other tertiary paediatrics to be provided on the same site, and the need for children's and adults' surgery (and interventional cardiology) to be provided in close proximity
- Develop a "proposition" – not a list of sites, but a straw man of what a high quality and sustainable service looks like for adults and children, unconstrained by current configuration – the optimal model
- Consider and weigh, with legal advice, possible approaches for a managed process to translate these fixed points into firm proposals for structuring services, test with stakeholders, outline agreed process
- Establish the required capacity of the service in future years
- Set an ambitious timeline to have completed the work and be ready to implement.

Phase 2 – up to February 2014

Develop, test and revise the proposition

- Using multiple channels, including local and national clinically led events, engage on the clinical appropriateness and user acceptability of the proposition
- Benchmark existing provision against the proposition – considering access as well as service quality

- Test any emerging alternative proposals
- Review dependencies – eg for children, neonatal and paediatric intensive care (PICU) and retrieval services, extracorporeal membrane oxygenation (ECMO). While the IRP recommended that decisions about the future of transplant services and respiratory ECMO should be contingent on final proposals for congenital heart services, in practice the level of interdependency may mean that they need to be considered together
- Weigh alternative implementation approaches: early thinking suggests that some fixed points could constitute ‘hurdle criteria’ for potential providers within a commissioner led standards driven approach, however alternative approaches need to be considered including option appraisal and designation and provider led regional solutions.
- Agree revised proposition with clinical and patient groups

Phase 3 – up to June 2014

Preparation for implementation

Work in this phase will of course be dependent on the nature of the proposition developed and the measure of agreement with that approach.

- If the solution is for a national plan in which current centres continue/cease to provide surgery, then – subject to legal advice - there may need to be further full formal consultation. This could take the timeline for implementation beyond one year.
- If the solution is a commissioning approach to enforce a set of national standards which invites providers to cooperate to provide the service, any consultation could be undertaken sub-nationally as part of the development of tenders. Assuming local resolution and provider cooperation, the focus of this period would be on developing the tender exercise.

ENDS MW 22/8/13