**Briefing on the New Congenital Heart Disease Review for Specialised Commissioning**

## Executive summary

This paper describes the work of the new congenital heart disease review, including proposals for implementing the review's recommendations through commissioning. It is presented to the specialised commissioning SMT prior to consideration at SCOG to inform the initial stages of the 'long handshake' process of managing the handover from the review to specialised commissioning. A number of issues are highlighted for discussion and resolution including risks to the delivery timetable, the potential for streamlining the assurance process, the need for appropriate expert support, stakeholder involvement and reporting.

## 1. Introduction

In June 2013 the Secretary of State announced that he accepted the recommendations of the Independent Reconfiguration Panel (IRP), and was therefore setting aside the outcome of the "Safe and Sustainable" review of children's congenital heart surgery. He asked NHS England, as the organisation now responsible for commissioning these services, to undertake a new review, learning the lessons of experience to date, including Judicial Review findings and the report of the IRP. The board of NHS England recognised that a new review was a vital opportunity to secure lasting improvements for some of the most vulnerable NHS patients. It also considered that reviewing such a high profile and sensitive service would be seen as a test of the way in which the emergent NHS England conducted itself, and our commitment to patient and public engagement, clinical leadership in every aspect of our work, and evidence-based decision making. The board recognised the difficulties of conducting the review in a climate where trust had broken down and relationships needed to be rebuilt, but was nonetheless concerned about the risks to the congenital heart service due to continuing uncertainty and "limbo". The new review, in contrast to earlier work has considered not only children's congenital heart surgery, but also fetal and adult care and care in local settings as well as in specialist centres.

The following six objectives were agreed for the review:

> **Objective 1:** to develop standards to give improved outcomes, minimal variation and improved patient experience for people with congenital heart disease;
> **Objective 2:** to analyse the demand for specialist inpatient congenital heart disease care, now and in the future;

**Objective 3:** to make recommendations about the function, form and capacity of services needed to meet that demand and meet quality standards, taking account of accessibility and health impact;
**Objective 4:** to make recommendations on the commissioning and change management approach including an assessment of workforce and training needs;
**Objective 5:** to establish a system for the provision of information about the performance of congenital heart disease services to inform the commissioning of these services and patient choice; and
**Objective 6:** to improve antenatal and neonatal detection rates.

The Board Task and Finish Group, overseeing the work of the review on behalf of the board, recently expressed NHS England's continued commitment to implement the standards through a commissioning approach. This is confirmed in 'The Forward View Into Action: Planning For 2015/16' which states 'In the light of the current consultation, NHS England will finalise the standards [for congenital heart disease services], and implement in full from April 2016.

The Board Task and Finish Group also affirmed the need for that approach to support and promote collaborative working between centres, with a focus on whole system achievement of the standards rather than on individual units. The group also noted that strong leadership and collaborative working between provider units would be essential for success, keeping the patients' best interests at the heart of all that was done.

Although the review started 18 months ago, it aligns strongly with the Five Year Forward View (5YFV) proposed new care model for specialised care, with an innovative approach for patients to benefit from scale through networks of services, and with consolidation of services (in ACHD where there is evidence of a considerable number of providers undertaking low levels of activity, and potentially also in paediatrics if services cannot meet the specification requirements). The review also has a specific aim of reducing variation in the quality of care while raising the bar for everyone – it is expected that every provider will need to improve in order to meet all the proposed standards. The review is also working with partners inside and outside NHS England to improve the range and availability of data to inform patients and to support improvement by clinicians and commissioners.

## 2. Standards and Specifications

Proposed new standards (and the associated service specifications – one for children's services, one for adult) for congenital heart disease services have now been subject to full formal public consultation. Over 450 responses were received and these are now being analysed by an independent specialist company Dialogue by Design. The need for amendment of the proposed standards and specifications

will be considered in light of the consultation response. This process will involve the groups that originally drafted the standards and the Clinical Reference Group. The review's Clinical Advisory Panel (CAP) will then consider the consultation responses and the views of these groups in making recommendations to the NHS England Board. CAP's recommendations will then be subject to assurance both through the review's own governance arrangements (two groups).

Our current plan is to complete the review's consideration of the consultation response by March 25th. Work on final agreement of the standards would then pause until after the election, at which point the standards, revised in light of the consultation, would enter the specialised commissioning assurance process (which includes review by up to six groups) leading to consideration by the Board in the summer, with an expectation that services will be commissioned against the new specifications and standards from April 2016.

The combined effect of this comprehensive approach to assurance is that the earliest date possible for a board decision is at its meeting on July 23rd. This is the best case and assumes that work is not delayed by concerns about sensitivities prior to the election, the optimum alignment of meeting dates where these are yet to be set, and that all groups pass the work on to the next group without further delay or requirements for additional work.

## 3. Networks

The proposed standards are based on a network approach to the provision of services. Early attention focussed on hub and spoke networks (Operational Delivery Networks). Subsequently discussions have focussed on the potential benefits of regional multi-centre networks, which include:

- the opportunity for surgical centres to work more closely together to develop innovative approaches to meeting the standards, for example with shared surgical teams that individual centres might not be able to meet working alone;
- an enhanced opportunity to develop subspecialisation ensuring that the vast majority of patients can receive their care within the network;
- increased opportunity for mutual challenge and support, including
    - enhanced training opportunities,
    - sharing learning and skills,
    - mentorship,
    - quality assurance and audit and
    - increased research opportunities.

Prior to and during consultation some providers have argued that NHS England should mandate network boundaries and in so doing 'guarantee' a large enough

catchment for every centre to undertake 500 operations annually. This is a potentially unattractive option for NHS England in that it would inevitably lead to some patients being asked to travel to a surgical centre that was not their closest, something which was strongly opposed in the Safe and Sustainable proposals, and which would also compromise patient choice. Multi-centre networks with a larger natural catchment area and promoting joint working could provide an alternative approach to this difficult issue, while maintaining patient choice.

Leading such networks will be a significant challenge. Good leadership with effective support will be a key determinant of success. Although multi-centre networks would be larger, this may be advantageous in developing a multi-skilled network leadership team, and making best use of scarce resources. A suitable funding mechanism for hosting and funding such a network would need to be part of the commissioning and funding system developed for the service.

## 4. Commissioning challenges

### 4.1 Funding

We face a challenging financial situation. However, given the board's commitment to the delivery of the proposed standards, the challenge is to design a commissioning and payment approach that will deliver this outcome in a way that is affordable for NHS England and fair to providers.

Scenario planning undertaken by the review shows that under the 'do nothing' scenario, activity within the specialty can be expected to rise. For paediatric cardiac services this is predicted to result in an activity rise between 0.4% and 1% each year, as a result of increasing births, increasingly successful intervention and medical advances. For adult CHD services an activity rise between 0.7% and 4% each year is predicted, principally as a result of increasing life expectancy for CHD patients. There is little opportunity to reduce activity levels through prevention.

The financial assessment undertaken prior to consultation suggested that implementation of the standards could be achieved by providers using the increased income that would flow as activity rose, but at no extra cost[1]. More recently Monitor has proposed that for specialised services, increased activity above 2014/15 levels should be reimbursed at 50% rather than full tariff. Application of this approach to congenital heart services could destabilise the implementation of the new standards, so the use of an exception is proposed, at least in the short term, for this speciality, to continue full tariff payment.

[1] The review takes 'at no extra cost' to mean that implementation of the standards should not add to the cost to commissioners beyond the increase in costs that can be expected even if the standards are not implemented. Many of the new standards are already included in the existing service specification, and are not new in that sense.

Average provider costs could be expected to rise as the standards are implemented if there is no change in the way the service is provided. Some of these costs are already accounted as the costs of the existing specification and in the rising income that will follow rising activity. Changes in costs to providers and changes to income for providers can be assumed to be unevenly distributed. The impact on reference costs will be ameliorated because these are an average, and offset by the tariff deflator. In addition, the review does not assume that services will continue to be provided in the same way. The impact of networked working or changes to the number and scale of units providing the service would also affect costs overall and need to be taken into account. While modelling such changes is prudent, the implementation of the standards through a commissioning approach means that the way in which the service is provided in future cannot be known in advance (including the number and scale of units providing the service). This will emerge through the commissioning process from the bids made by providers, NHS England's assessment of whether these bids meet its requirements for access, capacity, choice, quality and price, and any subsequent negotiations. Attempting to second guess the outcome of this process would be prejudicial to the process.

The review will work with providers to address the challenge of how to implement the standards at no extra cost, but this will not involve asking individual providers to assess the financial impact because this would again be the wrong question, and would simply result in an unaffordable 'shopping list' from providers. Our approach will be to seek their assistance in developing an approach that delivers the standards at no extra cost (to commissioners).

While dealing with the inherent inflationary pressures is not one of the objectives of the review, we will examine the opportunities for savings within the specialty (from both a commissioner and a provider perspective) that might accrue from reducing variation (for example in local agreements on payments and on lengths of stay).

In order to successfully design a commissioning and payment system that will deliver the standards at no extra cost the review will need to draw on the expert commissioning, procurement and payments skills available within NHS England and beyond. Joint working between the review team and specialised commissioning is now developing, and will need to increase as part of the ‘long hand-shake’ approach to hand over within the organisation.

### 4.2 Commissioning approach

The approach to commissioning providers to deliver the CHD service against the new specification needs to be carefully designed to ensure that it facilitates the behaviours and outcomes that are sought and minimises the risk of unintended consequences.

The approach should:

- Ensure that all patients, regardless of where they live, will benefit from services that meet the new standards;
- Encourage positive relationships between providers in the patient interest;
- Be flexible enough to accommodate new entrants if necessary;
- Take account of the impact of any changes to service configuration on other services, on providers and on access to services for patients;
- Minimise the risk of provider default and the need for derogation;
- Give the space for the emergence of new provider models if appropriate;
- Be congruent with geography of provision and
- Be reproducible for other specialties.

An independent literature review confirmed that while bigger units are associated with better outcomes and the relationship is stronger in studies of single complex conditions or procedures, the evidence does not tell us the best size for a Specialist Surgical Centre. As a result our Clinical Advisory Panel told us that while the evidence was broadly supportive of the relationship between volumes and outcomes, by itself it did not provide a compelling argument for change. The review has been clear from the start that it did not have a pre-conceived idea of the right number of specialist surgical centres. It remains the review's view that what is important is that all patients receive care from services that meet the standards rather than the number of units. The number of units, and the way they work together in future will emerge from the commissioning process and will depend on the ability of providers to work together to find ways of meeting the standards.

The review has established strong relationships with provider organisations through its provider engagement and advisory group, chaired by Chris Hopson, Chief Executive, NHS Providers. Provider organisations have welcomed the opportunity to be actively involved in the review process (which they contrast with having things done to them). While respecting NHS England's role as a commissioner, providers have sought an opportunity to be involved in the design of the commissioning process. The review has invited providers to develop proposals for models of provision that would ensure that the proposed standards are met. This innovative approach should be welcomed because it provides an opportunity for the development of solutions owned by providers. Given the need for closer working relationships between provider organisations and their clinical teams, this is better developed from the inside than an attempt by NHS England to impose it from the outside. Providers are aware that if they decline to accept this opportunity, or their proposals do not provide a robust solution to the challenges, NHS England would move to a procurement based approach which would impose solutions on them. They understand clearly that meeting the standards is non-negotiable.

For some providers it appears unlikely that they could meet all of the standards while continuing to work as isolated units. While the system could be expected to be able to cope with further consolidation of units (Oxford ceased to provide surgical services during the Safe and Sustainable period and new networked arrangements with Southampton emerged; Leeds was closed temporarily in 2014 and patients were successfully diverted - albeit for a short period; Safe and Sustainable would have closed three units and plans to achieve this were quite well advanced) the impact would be considerable – on access to CHD services (depending on which units were affected); on other services dependent on CHD services; on the national paediatric intensive Care (PICU) system; on transplant services. In light of this, if it is possible for all providers to meet the standards by working in new and different ways, raising the overall quality of care, without closures, this is an attractive outcome for NHS England.

The development of multi-centre networks may offer a possible approach to achieving this. Further discussion is needed to determine what the appropriate geography is for each network, and whether this would be reflected in separate lots being offered relating to each network. The question of whether NHS England's regional boundaries should determine the geography of networks and of commissioning lots has also been raised. Patient flows and network relationships seem likely to be more important determinants, but this does not rule out a network model that is aligned with NHS England's regions.

For NHS England further work will be needed to establish the roles of the national and regional teams in commissioning the service. Maintaining a consistent approach to standards and moving to consistent national funding suggest a continued role for a national team, but relationships with providers should continue be managed through regional teams and their hubs.

### 4.3 Communications and engagement

Stakeholder engagement, building ownership and transparency have been important aims for the review. Having established a high level of engagement and communications and an unusually transparent approach (unusual for the NHS) it is unlikely that stakeholders would accept a dramatic change of approach during the commissioning phase of the work. It is therefore important for NHS England to consider what the appropriate level of stakeholder engagement is and communications through the commissioning period, recognising that to some extent the approach taken with CHD will set a precedent for other services too.

## 5. Change management challenges

While the focus of the review has been on delivering change through commissioning, the Board Task and Finish Group recently identified the important role of behaviours

in the success of implementation and in particular the key role of leaders in providers. We need to consider how to support leaders in affected providers and to foster good relationships between staff of neighbouring providers.

## 6. Information for commissioning

The review's fifth objective is 'to establish a system for the provision of information about the performance of CHD services to inform the commissioning of these services and patient choice'.

We have divided this into three main groups:

a. Activity and Finance
b. Outcomes
    i. Mortality
    ii. Morbidities
    iii. Quality of life
    iv. Patient Experience
c. Standards Compliance

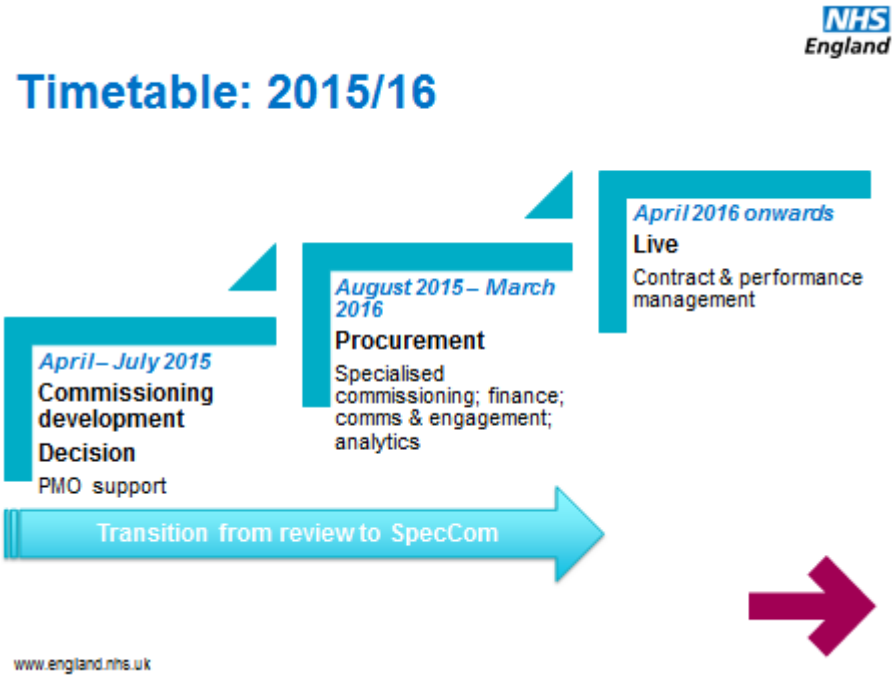
We have had discussions with a wide range of individuals and organisations, including people involved in CHD services in other countries, and are building a picture of what further information is needed, what systems already exist that might be used more widely and what is still in the realms of R&D. We will produce a report on the discussions to date and key areas of information which could be developed, and use as a basis to:

- Seek views on prioritisation
- Discuss practicalities
- Agree a plan

We will produce recommendations as part of the overall business case.

## 7. Handover

A 'long handshake' approach to handing over the work from the review to specialised commissioning is proposed. Between now and the summer when board decisions are expected, we will work closely together to design the appropriate approach to commissioning and change. The programme team will support the proposals through to decision making after which the locus of control is expected to move to specialised commissioning to implement the board's decisions, commissioning the service against the new specification with a view to new contracts taking effect in April 2016.




## 8. Resources

A bid for continued funding through programme budgets has been made through the Commissioning Strategy directorate. If agreed, this would provide funding for a small dedicated team to continue the work through 2015/16 (including running a procurement exercise) but assumes high levels of support are made available (at no cost) from across the organisation, for example from analytics, comms and finance.

## 9. Recommendations

This paper is presented to the specialised commissioning SMT prior to consideration at SCOG to inform the initial stages of the 'long handshake' process of managing the handover from the review to specialised commissioning.

Specialised Commissioning colleagues are asked to:

- Note the briefing
- Agree the approach proposed for developing implementation of the review's recommendations through commissioning
- Consider whether there may be opportunities to streamline the assurance process for the proposed service specifications

- Ensure that appropriate expert resource is made available in a timely way to support the development and delivery of the commissioning of CHD services
- Discuss and agree appropriate arrangements for continued stakeholder involvement through the commissioning process
- Agree appropriate reporting arrangements for SCOG during this period

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