

Leicester
City Council



Rutland
County Council

MEETING OF THE LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

DATE: THURSDAY, 29 SEPTEMBER 2016
TIME: 2:00 pm
PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Committee

Leicester City Council

Councillor Dempster (Chair of the Committee)

Councillor Cassidy

Councillor Chaplin

Councillor Cleaver

Councillor Fonseca

Councillor Sangster

Councillor Unsworth

Leicestershire County Council

Dr S Hill CC (Vice-Chair of the Committee)

Mrs J A Dickinson CC

Dr R K A Feltham CC

Mrs R Camamile CC

Mr J Kaufman CC

Mrs B Newton CC

Mr T J Pendleton CC

Rutland County Council

Councillor G Conde

One Councillor to be confirmed.

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:

Graham Carey (Democratic Support Officer):

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Kalvaran Sandhu (Scrutiny Support Manager):

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey, **Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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PUBLIC SESSION

AGENDA

NOTE:

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<http://www.leicester.public-i.tv>

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<http://www.leicester.public-i.tv/core/portal/webcasts>

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda, and/or indicate that Section 106 of the Local Government Finance Act 1992 applies to them.

3. TERMS OF REFERENCE AND MEMBERSHIP OF THE [Appendix A](#) JOINT HEALTH SCRUTINY COMMITTEE

The Terms of Reference and Working Arrangements of the Joint Health Scrutiny Committee are attached for information.

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, petitions, or statements of case in accordance with the Council's procedures.

6. NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES AT UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST **Appendix B**

To consider NHS England's proposals for the future provision of congenital heart disease services with particular reference to University Hospitals of Leicester NHS Trust.

Following the publication of NHS England's proposals on 8 July 2016 Leicester City Council and Leicestershire County Council considered the issue and extract of their decisions at attached at **Appendix B (Page 5)**. Rutland County Council's Health and Wellbeing Board will consider the issue at its meeting on 27 September 2016.

The City Council's Health and Wellbeing Board received a report from NHS England and a submission from the University Hospitals of Leicester NHS Trust (UHL) at their meeting on 18 August 2016. A copy of the minutes are attached at **Appendix B1 (Page 9)** for information.

Supporting information to the Minutes

- a) Report of NHS England and their Assessment of UHL submitted to the Board and updated to reflect the subsequent meeting held with UHL on 16 September 2016 and the revised high level timetable for the consultation and decision making process. **Appendix B2 (Page 29)**
- b) Letter to the City Council's Deputy City Mayor from NHS England in response to questions asked at the Health and Wellbeing Board. **Appendix B3 (Page 45)**
- c) Evidence base for new standards & specifications in relation to the 125 cases per surgeon that was requested by the Health and Wellbeing Board. **Appendix B4 (Page 49)**

NHS England were invited to attend the meeting and were originally available to attend but are now unable to send a representative as they are all now required to attend a national oversight meeting for all of specialised commissioning that was subsequently arranged for the same day. They have sent a revised report at Appendix B2 above and have stated that they would welcome the opportunity to attend a future meeting of the Committee.

7. UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST'S (UHL) VIEW ON NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES

A representative from UHL will attend the meeting to present their initial view on proposals from NHS England.

8. OTHER VIEWPOINTS ON NHS ENGLAND'S PROPOSALS

Appendix C

The following gives further information and viewpoints on NHS England's proposals and are submitted for the Committee to consider:-

- a) NHS England's press announcement of its proposals.
Appendix C (Page 57)
- b) Report of NHS England's National Panel on Paediatric Cardiac and Adult Congenital Heart Disease Standards.
Appendix C1 (Page 63)
- c) Questions and Answers from NHS England's website on the decision making process.
Appendix C2 (Page 79)
- d) Copy of Will Huxter's blog on the Congenital Heart Disease Implementation Programme issued on 13 September 2016.
Appendix C3 (Page 85)

Will Huxter is the NHS England Senior Responsible Officer for the Congenital Heart Disease Review and his blog can be found at the following link:-

<https://www.england.nhs.uk/2016/09/will-huxter-15/>

The blog will be used to keep everyone up-to-date with activities during the pre-consultation and consultation period on our proposals for meeting the national standards on CHD, and anyone can request to receive it by e-mailing england.congenitalheart@nhs.net

- e) The Leicester City Health and Wellbeing Board also requested the assessments of every other centre currently providing CHD Services. NHS England has published these on their website at the following link:-
<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/>

The link above also has details of the New CHD Review's report, including around two hundred new standards and service specifications which providers of CHD services should meet. These standards came into effect in April 2016.

9. TIMELINE FOR CONSULTATION AND TAKING THE REVIEW OF CONGENITAL HEART DISEASE SERVICES AT UHL NHS TRUST FORWARD

The Committee is asked to consider when the consultation of proposals will be launched and at what stages scrutiny involvement is appropriate.

10. BUSINESS FOR THE NEXT MEETING

The Committee is asked to consider the next steps in taking the review forward.

11. ANY OTHER URGENT BUSINESS

Appendix A

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Working arrangements and Terms of Reference – endorsed by the Joint Committee on 25 June 2007

1. Membership

The Membership of the Committee will total 16 members – 7 members nominated by the County Council, 7 by the City Council and 2 by Rutland Council. In view of the size of the Committee and the range of its responsibilities, it is considered that there should be no co-opted members.

2. Chair and Vice-Chair

The position of Chair will rotate between the County Council and the City Council on a two-year cycle. The Vice-Chair will be from the Authority not holding the Chair. The City Council will nominate the Chair for the period June 2007-2009 and the County Council for the two year period thereafter.

3. Secretariat

The Secretariat will be provided by the Authority nominating the Chair. The Secretariat will liaise with all three authorities in drawing up the agenda. The Constitution/Standing Orders of the Authority providing the Secretariat will apply to the Joint Committee.

4. Policy Support

Both the County Council and the City Council will have an Officer to assist the Health Scrutiny Process – in the case of the County Council this will be a Policy Officer and in the case of the City Council this will be a Members Support Officer.

Both officers will liaise with and assist the Secretariat in drawing up the agenda and undertaking or commissioning research from within their respective Councils on behalf of the Joint Committee. Liaison will take place with the nominated officer(s) from Rutland Council.

5. Agenda Planning and Briefing

The Chair and Vice-Chair will be consulted on the agenda. Arrangements will be made for providing information on agenda items to Rutland at an early stage.

Any member of the Joint Committee will be entitled to ask for an issue to be placed on the agenda. Any such request should be in writing and accompanied by the reason for raising the item. If appropriate, the Secretariat may discuss with the member whether other means of addressing the issue have been explored and the outcome of this (e.g. has it been raised with the relevant Trust and what response was received). The Secretariat may report on such other means and outcomes to the Joint Committee.

A joint briefing arrangement will operate for the Group Spokespersons from the City and County Councils, and one Rutland representative. The briefing meeting will be held on the same day as the meeting, one hour before the meeting is due to start.

In planning agendas, members will bear in mind the purpose of the Joint Committee, namely, to achieve a co-ordinated response from the three authorities on key issues of common interest within the health agenda and to avoid duplication whilst recognizing that authorities may wish to carry out separate scrutiny exercises in the light of the particular circumstances of their areas and priorities of their authority.

These arrangements will be reviewed periodically.

1. Scope of the Joint Committee

- i) To scrutinize the activities of Health Trusts with responsibility for health service functions across the area of the three authorities (i.e. UHL Trust, Leicestershire Partnership Trust, East Midlands Ambulance Service and the Strategic Health Authority).
- ii) To scrutinize and comment on the exercise by all other NHS bodies of functions on a strategic basis or which affect the areas of the three authorities.
- iii) To respond to any consultations by the Health bodies referred to in (i) above, including those which involve a substantial variation in provision of such service.
- iv) To respond to other consultations issued by all the NHS bodies which affect the areas of the three authorities.

[Note:

1. The three Authorities have in place arrangements for co-ordinating scrutiny of functions of bodies falling within (i) and (ii) and to consultations referred to in (iv). Work falling within these will only be dealt with by the Joint Committee if agreement to that effect is reached by all three authorities;

2. The terms of reference allow for issues referred by the PPIFs and/or members of the public to be considered if it is considered appropriate to do so and if there is no other appropriate means for addressing such issues.]

8. Voting

All decisions will be made by a majority vote of Members present at the Committee. In the event of an equality of votes, the chair will have a second and casting vote. Where a casting vote is exercised this will be recorded in the minutes.

A minority report may be prepared and submitted to the relevant NHS body (or Secretary

of State) along with the majority report in the following circumstances:-

- (i) when a majority of members of a particular Authority disagree with the findings; and
- (ii) when at least one quarter of the members of the joint committee disagree.

9. *Referrals*

Referrals to the Joint Committee from individual health scrutiny committees should be carefully monitored and the reasons for the referral should be included in any report.

Referrals from the Patient and Public Involvement Forums (PPIFs) should be looked at critically to avoid overloading the Joint Committee. There is a need to agree a protocol to ensure that referrals are not used as a substitute for other processes.

*The County Council is in the process of consulting PPIFs on a draft protocol in relation to its Health Scrutiny Committee and this may form the basis of the protocol for the Joint Committee.**

It is therefore suggested that all referrals to the Joint Committee should be accompanied by the views of the PPIFs on the matter concerned, the consultation processes undertaken and, importantly, reasons for the referral including what added value the Joint Committee can bring to the issue and what the PPIF expect the Joint Committee to do.

*[*The County Council and City Council at the time of writing this report were in the process of consulting PPIFs on a draft protocol in relation to their respective Health Scrutiny Committees. These may form the basis of the protocol for the Joint Committee].*

10. Media/Publicity Protocol

Where time permits, any press releases or publicity on behalf of the Committee should be undertaken after consulting all Spokespeople. Where this is not possible the Chair and Vice Chair of the Committee will be authorised to issue press releases on the basis that these will be copied/e-mailed to all Group Spokespeople.

Responsibility for public and media relations on behalf of the Committee lies with the Authority responsible for the Secretariat.

LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE 29 SEPTEMBER 2016

Extracts of decisions taken by Leicester City Council and Leicestershire County Council on Children's Heart Surgery at Glenfield Hospital

Leicester City Council passed the following motion at the Council Meeting held on 14 July 2016:-

“This Council strongly supports the work of the Children's Cardiac Services specialist centre of national excellence based at Glenfield Hospital, Leicester and expect the services to be retained, consolidated and further developed to the benefit of the City, County and the Region. That the Health and Wellbeing Board collaborates with other authorities and interested organisations to make representations to NHS England and the Government to oppose the decision to cut these specialist services which are vital to hundreds of children.

This Council resolves to refer this matter to the Health Scrutiny Commission of Leicester City Council and to request that a meeting of the Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee meets to consider this matter and proceeds to make a formal referral to the Secretary of State for Health as per the powers set out in The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.”

Leicestershire County Council's Cabinet considered a report at its meeting on 18 July and the published minute is set out below.

The link to the papers/minutes of the meeting is:-

<http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=4604&Ver=4>

465. Urgent item - Children's Heart Surgery at Glenfield Hospital.

Minutes:

The Cabinet considered an urgent joint report of the Chief Executive and Director of Public Health concerning NHS England's intention to cease the commissioning of children's heart surgery at Glenfield Hospital. The report was urgent because the announcement was made by NHS England after the agenda for the meeting had been published and a response needed to be made at the earliest opportunity. A copy of the report, marked '13', is filed with these minutes.

It was noted that since the report was circulated the NHS had published a rationale for its decision and further communication from the NHS was expected.

Mr. White CC said that NHS England's decision was simply wrong. Glenfield had excellent services and, he believed, would be able to demonstrate some of the best clinical outcomes in the country. He paid tribute to local MPs and Cllr. Palmer (Deputy Mayor of Leicester City Council) who had also voiced concerns. Mr. White said the County Council clearly wished the highest quality services to be provided and evidence showed that Glenfield Hospital was doing this. He reminded members that the County Council could refer such issues to the Secretary of State and noted that the Health Overview and Scrutiny Committee would consider the matter at its next meeting.

Mr. Ould CC, as the Cabinet lead member for children and young people, added his full support for the recommendations as amended.

RESOLVED:

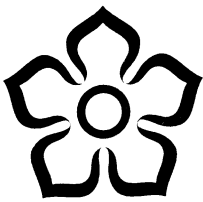
- (a) That the intention of NHS England to cease the commissioning of children's heart surgery at Glenfield Hospital, which will have serious local and regional implications and to do so ahead of NHS England's previously published timetable to address standards by 2021 is deplored;
- (b) That the failings of the communications used by NHS England to inform families, staff and stakeholders of its intention that children's heart surgery will no longer take place at Glenfield are to be regretted;
- (c) That the Cabinet does not believe there is evidence to substantiate NHS England's claim that to cease commissioning is "in the best interests of patients with congenital heart disease and their families";
- (d) That the rebuttal letter sent by the Chief Executive of the University Hospitals of Leicester NHS Trust to NHS England is supported totally;
- (e) That full support is offered to the NHS Trust in fighting NHS England on this matter, if necessary through the courts, and in establishing robust local opposition to NHS England's proposal which, if implemented, would see the end of a world class service;
- (f) That the resolution of the Cabinet be conveyed to local MPs and that their already stated concern at the proposal from NHS England be welcomed;
- (g) That the Health Overview and Scrutiny Committee be requested to consider a report on the implications of the announcement on both the Glenfield Hospital and the wider NHS at its meeting on 14th September 2016.

REASONS FOR DECISION:

To note the announcement made by NHS England, which will have implications on the wider health and care economy of Leicester, Leicestershire and Rutland, as well as the East Midlands as a whole.

The Health Overview and Scrutiny Committee has the responsibility for scrutinising the exercise by health bodies of functions which affect the County and is also able to make reports and recommendations to relevant NHS bodies.

The Director of Public Health has a responsibility to advise the County Council on matters relating to health and he is in agreement with the position taken by UHL.



Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 18 AUGUST 2016 at 4.00pm

Present:

- | | |
|-----------------------------------|---|
| Councillor Rory Palmer
(Chair) | – Deputy City Mayor, Leicester City Council. |
| Karen Chouhan | – Chair, Healthwatch Leicester. |
| Councillor Piara Singh
Clair | – Assistant City Mayor, Culture, Leisure and Sport,
Leicester City Council. |
| Councillor Adam Clarke | – Assistant City Mayor, Energy and Sustainability,
Leicester City Council. |
| Chief Inspector Lou
Cordiner | – Local Policing Directorate |
| Frances Craven | – Strategic Director, Children’s Services, Leicester
City Council. |
| Professor Azhar Farooqi | – Co-Chair, Leicester City Clinical Commissioning
Group. |
| Steven Forbes | – Strategic Director of Adult Social Care, Leicester
City Council. |
| Dr Peter Miller | – Chief Executive, Leicestershire Partnership NHS
Trust. |
| Superintendent Mark
Newcombe | – Adviser to the Police and Crime Commissioner,
Office of the Police and Crime Commissioner. |
| Councillor Abdul Osman | – Assistant City Mayor, Public Health, Leicester City
Council. |
| Sarah Prema | – Director Strategy and Implementation, Leicester
City Clinical Commissioning Group. |
| Councillor Sarah Russell | – Assistant City Mayor, Children’s Young People and
Schools, Leicester City Council. |

- Ruth Tennant – Director of Public Health, Leicester City Council.
- Mark Wightman – Director of Marketing and Communications,
University Hospitals of Leicester NHS Trust

In attendance

- Graham Carey – Democratic Services, Leicester City Council.

* * * * *

16. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

John Adler, Chief Executive, University Hospital of Leicester NHS Trust.
Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime
Commissioner.
Andy Keeling, Chief Operating Officer, Leicester City Council.
Chief Superintendent Andy Lee, Head of Local Policing Directorate,
Leicestershire Police.
Sue Lock, Managing Director, Leicester City Clinical Commissioning Group.
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group.
Trish Thompson, Locality Director Central NHS England – Midlands & East –
(Central England).
Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health
and MRC Senior Clinical Fellow, University of Leicester.

17. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business
to be discussed at the meeting. No such declarations were made.

18. APPOINTMENTS TO THE BOARD

The Board noted that the Council had made the following appointments to the
Board at its meeting on 14 July 2016:-

Councillors

Councillor Piara Clair Singh – Assistant City Mayor, Culture Leisure and Sport.

NHS Representatives

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Healthwatch / Other Representatives

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Steve Robinson-Day, Collaboration Manager, Leicestershire Fire and Rescue Service

A representative of the city's sports community – to be appointed

A representative of the private sector/business/employers – to be appointed

In addition the Chair has also issued a standing invitation to the following to attend meetings as non-voting members of the Board.

Kaye Burnett, Chair, Better Care Together Programme

Toby Sanders, Senior Responsible Officer, Better Care Together Programme

Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust

A representative of the Primary Care Sector – to be appointed.

The Local Policing Unit had also informed the Monitoring Officer that their representative on the Board is now Chief Superintendent Andy Lee, Head of Local Policing Directorate, following Chief Superintendent Sally Healy's retirement. Supt Kerry McLernon has also been nominated to attend the Board in Chief Superintendent Lee's absence.

The revised Terms of Reference for the Board reflecting these changes were received by the Board.

19. MINUTES OF THE PREVIOUS MEETING

AGREED:

That the Minutes of the previous Board meeting held on 6 June be confirmed as a correct record.

20. NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES AT UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NHS England presented a report on their proposals for the future provision of congenital heart disease services with particular reference to University Hospitals of Leicester NHS Trust.

Will Huxter, Senior Responsible Officer for the Congenital Heart Disease (CHD) Implementation Programme and Regional Director of Specialised Commissioning (London), NHS England and Dr Geraldine Linehan, Regional Clinical Director, Midlands and East for Specialist Commissioning, NHS England, attended the meeting to present the report.

The Board also received a copy of the Deputy City Mayor's letter to the Secretary of State on 13 July 2016 requesting the decision to be reviewed and reversed. Copies of the decisions already taken by Leicester City Council and Leicestershire County Council on Children's Heart Surgery at Glenfield Hospital following NHS England's announcement had also been submitted for information.

The Chair welcomed the representatives of NHS England to the meeting, together with Mr E White CC, Chair of Leicestershire County Council's Health and Wellbeing Board and Councillor V Dempster, Chair of the Leicester City Council's Health and Wellbeing Scrutiny Commission.

The Chair invited members of the public to indicate if they would like to contribute to the discussion on this item and four members of the public asked to speak to the meeting.

Mr Huxter, NHS England, thanked the Chair for the opportunity to present the report and to set out the proposals for change and the basis upon which they had been made. He was also keen, as the Senior Responsible Officer for congenital heart disease work across the country; to listen to the Board's and the public's questions and concerns and have the opportunity to address them.

He also introduced Dr Linehan Clinical Director for specialist commissioning for the Midlands and East region. Dr Linehan stated that she was a GP by training, not a specialist in Congenital Heart Disease (CHD); but did have an overall remit for quality of services in the region.

In presenting the report, Mr Huxter stated he wished to set out the context of the proposals and their rationale and then outline the next steps in the debate and consideration of the proposals. During the presentation of the report he made the following comments:-

- a) NHS England had not made any final decision yet on Glenfield or any other providers of CHD.
- b) The proposals were based upon assessments of whether trusts currently met the standards or were likely to do so in the time frame set out in NHS England's standards.
- c) NHS England were meeting University Hospitals of Leicester NHS Trust (UHL) on 16 September 2016 to discuss in detail their assessment and the trust's response.
- d) There would be formal public consultation on the proposals later this year, and NHS England would want to come back to the area to talk to the Joint Health Overview Scrutiny Committee once the consultation was launched.
- e) Much of the debate about CHD services was focused on the standards, their development and how they fitted in with the overall approach NHS

England were taking. After discussions with stakeholders over a wide range of areas, a new CHD review had been established in July 2013. The aims of the review were fundamental to what NHS England were trying to achieve and these were:-

- Secure the best outcomes for all patients. This was not just about the lowest rates of mortality but also about reduced disability and improved opportunity for survivors to lead better lives.
- Tackling variation. To ensure services across the country consistently meet national standards and were able to offer resilient care 24/7; so the care required was available at all times when needed day and night.
- Improve patient experience. To provide information to patients and families and consideration of access and support for families when they are away from home.

The standards can be found on the NHS England website at the following link:-

<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/>

- f) The standards were lengthy but they did demonstrate they were not just focused in the clinical aspects of care; but also about support and services for families. The standards were central to the review and described what constituted an excellent CHD service, and had been used to assess Leicester and other provider centres across the country.
- g) The standards had been developed with the CHD service and experts in CHD, patients, professional bodies and charities. They had received strong consensus before going to public consultation. The standards were formally agreed by the NHS England Board in July 2015. There had been strong representations from patient groups supporting the standards but also supporting NHS England, as the commissioner of services, to ensure the standards were met.

There were three levels of service set out in the paper –

- Specialist Surgical Centres (Level 1)
- Specialist Cardiology Centres (Level 2) - which NHS England was proposing for Leicester in the future
- Local Cardiology Centres (Level 3)

- h) NHS England considered two areas of the standards were particularly important determinants of service, quality and safety. These were:-

- Surgery All surgeons should be at least part of a team of 4 surgeons, with on call commitments no worse than 1 in 3 from April 2016. Each surgeon must undertake a minimum of 125 operations per year and, from April 2021, a minimum on call commitment of a 1 in 4 rota. This was to ensure that there were

surgeons with the right level of expertise and experience across a range of operations which CHD may require. Also making sure that the system had resilience to have staff to cover 24 hrs.

- Surgery from sites having service interdependencies. This was not a technical abstract issue, but was fundamental to having expertise available when patients were very unwell and all services were on the same site 24/7 to be at the bedside when required.
- i) NHS England were convinced that the standards would make a real difference in ensuring that services were safe, of high quality and were available 24/7 by teams of professionals working closely together in an integrated way.
- j) The numbers of operations were not just important for the surgeon but also for the wider clinical team, theatre nursing and other clinical staff, to provide much greater resilience and stability within providers to attract and retain surgical and other clinical staff.
- k) The assessment process had taken some time. The assessment had been based upon on evidence submitted by UHL. NHS England considered that the UHL had not meet minimum 125 operations per surgeon and a total of 375 cases spread across 3 surgeons and did not meet the full range of other services required to be provided on the same site.
- l) After considering the evidence from UHL and all other providers, NHS England were proposing to cease commissioning specialist services (surgery and interventional cardiology) from UHL but were looking to continue to provide level 2 specialist cardiology services in Leicester. It was stressed that there were no proposals to close Leicester as a provider of CHD services, apart from surgery and intervention cardiology. Patients would continue to access services locally in Leicester. NHS England wished all patients across the country to have access to excellent CHD services, and the proposal, if implemented, would transfer some patients currently receiving treatment from Leicester to Birmingham. There were already close links between the two centres and some complex cases were already referred to Birmingham. Most of the care patients received was not surgical and that non-surgical care would continue to be provided at Leicester. NHS England accepted that some patients would have to travel further for surgery and intervention cardiology but considered that people already chose to travel for excellent care; and the greater part of treatment provided for CHD was not emergency surgery but elective planned work.
- m) During the pre-consultation engagement on the proposals, NHS England wanted to talk and listen to concerns and questions from Health and Wellbeing Boards and other stakeholders. NHS England would also be talking to UHL about the proposals and their implications for other

paediatric services within the trust if these proposals were taken forward.

- n) Both ECMO, which is a large and important service within Leicester, and paediatric intensive care services (PICU) were being looked at as part of national reviews being carried out by NHS England to ensure that they took a joined up approach to specialised paediatric services.
- o) The high level timetable was set out in the report; with a final decision after consultation being taken in spring 2017. It was emphasised that nothing would change overnight. NHS England would consult on the proposals and, if agreed, would implement them carefully in a measured way. The primary concern was for patients to have access to best possible services.

In summing up Mr Huxter reiterated that most CHD care would still be provided at Leicester; the proposals solely moved surgery and interventional cardiology to Birmingham and the greater part of CHD work was not emergency but elective surgery. NHS England believed passionately that implementing these standards would deliver better outcomes for children's and adult's CHD services. They were conscious that there had been a long period of uncertainty in CHD dating back to Bristol in 2001, but believed these proposals, if taken forward, would end that uncertainty and ensure there were resilient services available to Leicester, the East Midlands and the area beyond for the future.

The Chair invited, Mark Wightman, Director of Communications, University Hospital of Leicester NHS Trust (UHL) to respond to NHS England's report. Mr Wightman stated that:-

- a) He was representing UHL Trust Board and the 300 staff working in the in East Midlands Congenital Heart Centre unit. He introduced two staff present in the public gallery to answer clinical questions if necessary. Dr Frances Bu'Lock – Consultant Paediatric Cardiologist and Elizabeth Aryeetey, Lead Nurse for the East Midlands Congenital Heart Centre
- b) The East Midland Congenital Heart Centre at Glenfield had made excellent progress over recent years. It had expanded bed numbers and staff, improved outcomes, invested in staffing, created a new adolescent unit and briefed architects to create new single site children's hospital which would meet the NHS England's co-location standard. This had been done against a backdrop of uncertainty following the Secretary of State's statement on the flawed decision to stop surgery in Glenfield 4 years ago.
- c) UHL disagreed that to cease commissioning children's heart surgery in the East Midlands was "in the best interest of patients with CHD and their families." UHL failed to see how leaving the East Midlands as the only region without a specialist centre was equitable.
- d) UHL already provided one of the best performing surgical centres in

England. They were confident that when latest NICOR data was published in October, Glenfield's clinical outcomes for patients would be amongst the best in the country. Despite seeing more children than ever, there had been no deaths within 30 days of surgery for 15 months. The same day cancellation rates and un-planned re-operation rates within 30 days were significantly better than the national average. The patient and families satisfaction rates were currently 99%. This was supported by the CQC's initial feedback of their recent inspection in observing "the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital" UHL felt this should alert NHS England that to implement their decision would be a grave mistake.

- e) UHL were on target to meet surgical numbers. They had carried out 280 surgical cases in 2014/15 and had increased this to 332 in 2015/16. They expected to meet 375 cases per year with 3 surgeons within the next 3 years. This had been achieved by 31% increase in beds, including the adolescent unit and a short stay bay after approx. £1 m investment
- f) UHL felt that the standards they had been consulted upon changed after the clinical engagement exercise from a commitment to achieve 3 surgeons and 375 operations from the introduction of the standards in April 2016 to a retrospective 3 surgeons and 375 operations by APRIL 2016. NHS England had effectively shortened the timescale for delivery by 3 years and must have known that it would exclude Leicester and yet had still stated, in a report to the NHS England National Board, that a major reconfiguration of specialist services with the associated risk and upheaval could probably be avoided.
- g) UHL quoted NHS England's own words that the magical 125 cases per surgeon was "arbitrary". The School for Health and Related Research in Sheffield, had stated that "whilst a relationship between volume and outcome exists this is unlikely to be a simple, independent and directly causal relationship, i.e that no cut-off relating to surgical volume and better outcomes was identified. There was never any indication of the number of minimum or maximum cases which should be done each year by an individual surgeon."
- h) UHL considered that the NHS England were proposing to close a top quality service despite clinicians working in the service being confident to achieve the required number of procedures; and this was compounded by NHS England applying the standards retrospectively. The decision was also based upon an arbitrary number of cases for which the NHS England's own reviewer had said there was no scientific evidence. UHL therefore encouraged NHS England to look again at UHL's outcomes, zero mortality rates and actual results.
- i) EMCHC (East Midland Congenital Heart Centre) supported 12 PICU (Paediatric Intensive Care Unit Service) beds which would be lost if NHS England ceased to commission CHD surgery at Glenfield. Losing the

Glenfield PICU beds would also result in the viability of the Leicester Royal Infirmary PICU beds being compromised, as the paediatric intensivists worked across both units. These specialists were attracted to Leicester by the diverse caseload that working across the two sites offered and this would be lost if more than half the PICU beds disappeared at Glenfield. Glenfield provided 30 % of the PICU capacity across Birmingham, Leicester and Nottingham. The National PIC Directors meeting in July had unanimously expressed the view that the NHS England's proposals made proper evaluation and response impossible and presented a significant destabilising pressure on PIC services; which may be further destabilised through the PIC national review at a time when there was a national crisis in PICU capacity.

- j) There would be a domino effect if Glenfield PICU capacity was lost and LRI's PICU capacity was compromised; as it would have a knock effect on other specialist paediatric services which required intensive care to function safely. This included children's general surgery, ear nose and throat surgery, metabolic surgery, fetal and respiratory medicine (children who received long term ventilated care) children's cancer and neonatal units. In addition, neighbouring hospitals supported by specialist teams in Leicester would not be able to look for support for their more complex patient care from their nearest specialist trust, UHL. This would affect Burton, Coventry, Kettering, Northampton and Peterborough hospitals. Therefore closing Glenfield CHD surgery would ultimately undermine other specialist services across the wider East Midlands.
- k) The ECMO facility at Glenfield was the largest paediatric respiratory ECMO unit in the country and provided 50% of the national capacity. Leicester had pioneered ECMO and the unit was used in the swine flu pandemic in 2010. The Glenfield ECMO unit was the only service to provide a national transport service by stabilising patients before moving them to a specialist centre. The proposals to cease CHD surgery at Glenfield would also result in the loss of the ECMO unit as staff also worked in ECMO and the service would lose decades of staff experience, knowledge and innovation. The standards stressed the importance of numbers, and UHL questioned why this had not been applied to ECMO as well.
- l) UHL felt that if NHS England wanted to support centres they should broker conversations that meant patients are treated in their nearest hospitals and not support the existing system where patients in Northampton are referred to Southampton for no real evident reason. If commissioning took place to the nearest centre, then Glenfield achieving 375-500 cases per year would be simple. Patient choice was not the reason for these apparent perverse patient flows. It was considered that any parent faced with dealing with a very sick child would send them to wherever their referring doctor suggested. They felt this was effectively a clinician choice and not patient choice that was being applied. If patient choice was important to NHS England, UHL questioned why they

were removing that choice from 300 patients a year that considered Leicester as their local centre.

- m) Given all the above views, UHL had been incensed when NHS England had said they would work with Bristol and other centres to achieve the standards in full on the same day they indicated that UHL's CHD service would be closed. Bristol's Children's Heart Unit had triggered an investigation in 1990's when 35 children had died through poor clinical practice and more children suffered poorer outcomes than expected. A further review was carried out in 2014 related to concerns of mortality rates and the second review report for Bristol was published the same day as Glenfield were informed that their unit was identified for closure.
- n) UHL failed to understand why NHS England was responding to a centre with quality concerns elsewhere when indicating to close a service with no concerns.
- o) Many things had changed since the original review of the Bristol unit. There were now 5 fewer centres and mortality data for each centre was published annually, which was better than peer centres in other developed health economies. The mortality rates had halved in the last 10 years for this type of surgery.
- p) UHL considered their position to be uncomfortable and unwelcomed. It seemed that NHS England were offering a new solution to old problem that no longer existed. UHL wanted to continue to do the best for their patients and families. UHL stressed that they were not being parochial in their views but they could not, in all consciousness, let a well performing service be destroyed.

Mr Ernie White CC – thanked the Chair for the invitation to take part in the Board's consideration of this issue. He stated that everyone was determined to fight UHL's case in partnership with the city council and other local stakeholders. He considered UHL's presentation completely demolished NHS England's position. The County Council's Health & Wellbeing Board had met in July which resulted in the County Council's Cabinet passing a strong and robust resolution in support of UHL. He felt it would be helpful if the joint health scrutiny committee could meet soon; as scrutiny had the power to refer decisions to the Secretary of State for Health. He considered that the position taken by NHS England was unconvincing and that they were offering an old solution to problem that had gone away. He felt they had got it wrong and hoped that, by a combined effort of everyone, a change of mind could be achieved.

Councillor Vi Dempster, Chair of the City Council's Health and Wellbeing Scrutiny Commission, supported Mr White's comments and felt that UHL's statement was a convincing demolition of the argument for ceasing to close the CDH unit at Glenfield. She indicated that she would have discussions with officers to see how members of the public could be best involved in the process of the joint scrutiny health committee.

Karen Chouhan, Chair of Leicester Healthwatch expressed the support of patient groups all over Leicester Leicestershire and Rutland for UHL and the CHD centre. The Leicester Mercury Patient's Panel and other patient groups would fight hard to support UHL and to reverse the decision. Healthwatch would like to see the decision reversed now. They also wished to make sure that the consultation proposed was framed in such a way that it empathised with the patient and not NHS England; as consultations had a habit of being framed in such a way to get the answers wanted by those issuing the consultation. They would like to know that there was independent expertise in framing the questions and patients were involved in that process. They would also like assurances that there would be independent scrutiny of that consultation and no decision would be taken without that. Full reasons of any decision taken in the future should also be made available.

The Chair commented that the Board had a role to understand and analyse the submission made to them. The Board needed to fully understand the 'magic' number of cases; particularly in relation to the validity that some people were placing upon it. This also included understanding the detail of why these were so important and what and where the evidence was to support this case.

In response to the Chair's question on how many current centres across the country met the current April 2016 standards at the moment; Mr Huxter confirmed that none of the centres had met the standards at the time of the assessment by NHS England.

The Chair commented that the basis of the proposals seemed to be a judgement about the trajectory of centres to meet those standards. It was important, therefore, that further clarity was required around the difference in amber/green and amber/red markers that had been used to make that judgement. He felt the clarity about the dividing lines and judgements made were critical in understanding the recommendations because UHL had indicated a strong, credible and ambitious vision for a single site children's hospital with all interdependencies NHS England had outlined and UHL's surgical numbers were on track. Given all the clinical and surgical interdependencies involved, he asked what analysis had been carried out or commissioned by NHS England of the implications for wider children's medical services if the proposals to cease commissioning in these centres were progressed. NHS England could not look at CHD surgery in isolation, and they needed to be mindful of whole breadth of children's medicine services in different parts of the country. The Board would require assurances from NHS England's analysis of how children's medicine services would look in Leicester, Leicestershire and Rutland and the wider East Midlands should the proposals be implemented.

In response to the Chair's comments, Mr Huxter and Dr Linehan stated that:-

- a) Leicester's assessment had been included in the report. The centres in the amber/ green category all had plans to achieve the standards being delivered in this calendar year. This was different to those providers in

the amber/red category. Further details of these could be shared with Board.

- b) The national review around PICU and ECMO services, in advance of going to public consultation, was to understand the potential impact of these proposals on other children's services and other broader services
- c) The standards had taken two years to develop in consultation with large number of experts, patients, parents and different organisations and had been the subject of a huge amount of debate. There was a need to remember that CHD was pretty rare and within it there were rarer conditions which were managed within a centre. It was important, therefore, that the NHS had experts with the breadth of surgical experience to operate and look after those cases.
- d) NHS England's efforts were designed to do the right thing for patients and the objective of the standards was to improve care and deliver excellent care; taking it to an extra level. In order to have a safe and sustainable service it was necessary for surgeons to undertake a good volume of operations.
- e) It was acknowledged that the number of operations per year was arbitrary in the sense that they had been arrived at as a judgement after lengthy discussions. NHS England offered to provide the evidence in support of the standards; including the number of cases per surgeon and total caseload per centre.

The Chair sought an explanation in laymen's terms of how much better a surgeon was in undertaking 125 operations per year compared to one who did 120 operations.

In reply, Dr Linehan stated that specifically in relation to CHD being a rare condition, it was difficult to get enough cases of rare forms of CHD to provide data to prove the number operations that were needed before you had no problems; so there was an element of extrapolation involved. However, it was known in other areas, such as centralised stroke and vascular services, that better outcomes correlated to the number of interventions that were done in a centre. Whilst the number of operations to become expert was unknown, the concept of doing more operations to achieve more expertise was an established principle. The size of teams was also important in having sustainability and to have 'fresh' surgeons to undertake the operations.

Mr Huxter added that sustainability was not just about surgeons but the whole clinical team. Although the minimum standard was 125 operations per year, there were surgeons currently doing more than 200 operations per year. Whilst the 30 day mortality data shows no statistical difference between providers, NHS England believed surgical volumes to be a key assurer of quality and safety.

Councillor Osman felt it was unfortunate that NHS England had issued their

statement in July the day after the Brexit referendum. He reported on a recent meeting of East Midlands Councils which had overwhelmingly expressed support for retaining the services at Glenfield. He felt that having a helipad at Glenfield added to its ability to carry out the services. He also questioned whether the proposed changes to the service were about standards or financial savings.

Councillor Russell commented that if the clinical standards data showed no difference in mortality rates for different levels of operations, what data should the Board be looking at in its consideration of the issue?

The Chair then invited members of the public to address the Board meeting.

Eric Charlesworth, Leicester Mercury Patient's Panel stated that he had been involved with Bristol's inquiry, safe and sustainable, the IRP review and the process for the current standards. When the standards had been approved, there had been no mention of changing the rules afterwards. He also felt that some statements made by NHS England were causing damage in this, and other areas, as they implied that patients did not receive excellent service at the centres identified for closure. He urged NHS England to look again at the evidence and data provided by Glenfield and reconsider their proposals.

He also submitted the following question:-

“In line with Governments requirements for openness candour and patient involvement throughout all change processes and to ensure that you and we avoid the repeated serious flaws highlighted in the safe and sustainable review why have you not listen to what Lord Ribeiro said in his IRP when he made his recommendations which some of them you have not even bothered to take up it would appear. Would you please give the names of the patient and public involvement representatives; can you give me assurance that they have found out local data and have consulted with local people and, by local, I mean the east midlands, before they can contribute to whether the statement that you are making about the mindfulness to withdraw this commissioning has been made? And I would like to know why there has been no apparent recent involvement of PPI when all the previous agreements were that nothing would be done without it coming back for consultation before items were issued or alterations made?”

Heather Rawlings stated that family members had received CHD surgery in October and fully praised the CHD unit at Glenfield. She felt that she had heard an excellent case of why Glenfield should stay open and endorsed UHL's statement. She expressed reservations about the review and asked how much it would cost to close centres. She also felt that the implications for families had been underestimated. Many people were living in austerity, on '0' hour contracts or on benefits, and were facing financial difficulties every day. This impacted upon their ability to travel distances to receive treatment, look after other family children and to keep their employment. These factors also affected the health of individuals.

Ms Sally Ruane – Chair of Leicester Mercury Patient's Panel re-iterated that

NHS England had stated that the 125 figure for operations was not evidence based. She commented that standards were inputs which were designed to achieve the outputs desired for a service. Standards in themselves were not an end, but a means to an end; which were excellent outcomes. She stated that the meeting had heard that Glenfield patients get excellent care at the moment; so it appeared that NHS England wished to close an excellent service on the basis of a non-evidenced based standard. This raised the question of whether the standards were being set deliberately high that they were likely to result in closures somewhere across the country. She felt there was a danger that the public confidence in NHS England would be undermined by these judgements. It was of concern that an announcement had been made that was very destabilising of the service and would have huge knock on effects on other children's services in this area and affecting children across the region; and yet no impact assessment has been undertaken.

Elaine Murray Stated that a petition had already received 26,000 signatures. The Unit was not failing in any shape or form and ECMO, in particular, received world-wide acclaim. She questioned what would happen if Birmingham could not cope with referrals from the East Midlands. The service belonged in Leicester and the East Midlands and felt that the efforts of Keep the Beat and HeartLink and all other research money that had gone into the Unit belonged to Leicestershire and the Unit should stay operational.

In response Mr Huxter stated that:-

- a) There was no requirement to achieve savings in the review and no savings would be achieved. The review was driven by standards.
- b) The information requested by Mr Charlesworth could be provided.
- c) All parties involved had a responsibility to demonstrate transparency and openness.
- d) Details of the public consultation and the PPI involvement could be made available.
- e) The review was not about cost or privatisation of the NHS and the impact on families travelling to obtain intervention surgery was noted.
- f) The Standards had not been set too high for achieving excellent care.
- g) The public announcement was not timed to coincide with the Brexit referendum.
- h) The views expressed at the meeting had been heard and he wanted to listen and to have a debate in Leicester about the proposals. He felt that the meeting had been useful to hear these views and NHS England genuinely believed that the proposals would improve services.

The Chair thanked everyone for their contributions and attendance at the

meeting and for NHS England setting out their proposals and for listening to the views expressed in the meeting.

AGREED:-

- 1) That the given the comments and statements made at the meeting, the Board supports UHL in its challenge to NHS England's proposal to cease commissioning Level 1 CHD services from UHL and that all partners and stakeholders be strongly encouraged to do so as well.
- 2) That NHS England's offer to provide details of the full assessment of all the other centres be accepted to allow the Board to understand the precise methodology used to assess those centres; including the categorisation within the NHS England's traffic light indicators.
- 3) That NHS England provide the Board with an analysis/impact assessment of how children's medicine services would look in Leicester, Leicestershire and Rutland and the wider East Midlands should the proposals be implemented; particularly in relation to ECMO, PICU and the other children's services mentioned in UHL's statement to the Board.
- 4) That NHS England provide further evidence, and details of the analysis and research, around the 125 cases per year for surgeons and that scrutiny be recommended to consider in detail this particular aspect of the review.
- 5) That the joint health scrutiny committee be encourage to meet as soon as possible, in order to exercise its powers in relation to health scrutiny and to provide a further arena for public discussion and accountability.

The Chair adjourned the meeting for 5 minutes at 5.12 pm to allow members of the public and others to leave the meeting if they wished to do so.

The meeting recommenced at 5.17pm.

21. PRIMARY CARE STRATEGY

Professor Farooqi, Co-Chair Leicester City Clinical Commissioning Group (CCG) and Sarah Prema, Director, Strategy and Implementation, (CCG) gave a presentation on the challenges faced by primary care in the city and the plans being developed for a Primary Care Strategy to address these. The strategy would be finalised once the local Sustainability and Transformation Plan was completed in September 2016; which included work around general practice. In addition, it would be informed by the Primary Care Summit that had been organised for 9 September 2016.

During the presentation it was noted that:-

- a) The number of single handed practices in the City had decreased from 26 to 6 in recent years as a result of some GPs retiring and others

merging with other practices.

- b) There were 59 practices in city of which 14 were training practices. The average list size of a practice was 6,531. This was slightly lower than the national average of 7,225.
- c) There were a large number of Alternative Provider Medical Services (APMS) contracts; 13 practices out of the total number of 59 practices in the City. This was in contrast to the county area where there were no APMS contracts. This was an indicator of the difficulty in ensuring services in the City.
- d) More practices in Leicester were rated as good by the CQC compared to the England and Midlands and East averages.
- e) The number of primary sector consultations had increased continually over the last 13 years. Applicants to GP training had dropped by 15% and in 2014 one in ten slots for new GP trainees remained vacant. The number of unfilled GP posts nationally had quadrupled in the last 3 years.
- f) The average funding for a GP in the city was approximately 10% below the national average.
- g) The city had been divided into 4 Health Need Neighbourhoods to enable a locality delivery of primary and community care. These would include extended hours provision, urgent care services (including diagnostics), community nursing and therapy services, social services, voluntary service, self-care and patient education. The focus of the Health Need Neighbourhoods would be on prevention and mobilising community “assets” as well as the development of integrated teams to support patients with the most complex needs.
- h) The CCG were also developing a HUB within 2 Health Need Neighbourhoods to provide patients with access to wider services. The strategy also included a number of initiatives (outlined in the presentation) to improve access to the services.
- i) There was raft of initiatives to improve the recruitment and retention of staff in primary care. These were listed in full in the presentation.
- j) The 59 GP practices were delivered from 60 main premises and 12 branch sites. There were a number of practices operating from converted houses and the CCG supported practices to apply to the NHS England Estates and Technology Fund and 5 developments to the fund were made in 2016.
- k) The CCG supported the development of Federations which supported practices to become more sustainable, combine back office functions, provide uniform delivery of services, share staff across practices and

provide the potential to deliver a wider range of services.

- l) There was a need for some changes in patient expectations as not all services in the future may be provided by one practice and patients may be 'referred' to a HUB for specialist services such as diabetes etc. Also patients needed to understand that minor ailments such as sore throats, colds and flu and sprained ankles etc did not require appointments with GPs; as treatment could be safely provided by other qualified health professionals. This would reduce the burden on GPs time to concentrate on patients with more serious illnesses.

The strategy would continue to evolve and comments were welcomed.

The Chair commented that it would be helpful to have milestones for the initiatives. It was recognised that some solutions were easier than others to implement and some would be more popular than others. It was, therefore essential to develop these through engagement and discussion and the forthcoming Primary Care Summit would provide a good opportunity to begin this process. He also asked what the impact of having 1 federation and Health Needs Neighbourhoods would have on the financial viability of GP practices.

Members of the Board commented that:-

- a) Primary care was critical to the success and sustainability of health services and there was a real challenge in the city to achieve this. A more ambitious strategy to achieve national averages of performance in the primary care services would be welcomed. Given the intention to transfer significant activity from UHL and LPT in the future to the primary care sector through BCT and STP, it would be essential to have a robust primary care sector in place to achieve this.
- b) Integrated teams already made differences to the ways in which patients were presenting to the acute sectors and were transforming services for better patient experiences.
- c) Continuity of care was the prime consideration of patients and this should be linked to BCT and STP

At 5.57pm the Chair was called away from the meeting on other Council business and Assistant City Mayor Piara Singh Clair took the Chair.

In response to the Chair's and Board Members' comments, Professor Farooqi stated that:-

- a) The CCG recognised that the strategy needed to be ambitious and link in with the government's initiative to recruit an additional 5,000 GPs.
- b) Retention of GPs was still challenging. A number GPs recruited from abroad eventually move to Canada, Australia and America after a period of training in the UK.

- c) Providing a portfolio of experiences for GPs would lead to making careers more attractive.
- d) There was a challenge in breaking the circle of heavier workloads for GPs which were exacerbated in some practices by a GP leaving and the practice being unable to recruit a replacement.
- e) There was scope within the integrated teams for UHL and LPT staff to work part time in the community.
- f) Continuity of care was fully recognised and the planning of long term or complex conditions would require stable teams to be in place.
- g) There would be consultation with the public as it was essential for them to be involved in designing the services for the future.
- h) Currently 30% of GPs were aged over 50 years old which could lead to 50 GPs being recruited in the next 5 year to maintain the status quo of current number of GPs.

AGREED:

That Professor Farooqi and Sara Prema be thanked for their presentation and the Boards comments be taken into account in developing the Primary Care Strategy.

22. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public present at the meeting.

23. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

Monday 10th October 2016 – 3.00pm

Thursday 15th December 2016 – 5.00pm

Monday 6th February 2017 – 3.00pm

Monday 3rd April 2017 – 2.00pm

Meetings of the Board were scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

24. ANY OTHER URGENT BUSINESS

There were no items to be considered.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 6.05pm

29 September 2016

Title of the report:	NHS England’s proposals for congenital heart disease services at University Hospitals of Leicester NHS Trust
Author:	Will Huxter, NHS England SRO for the Congenital Heart Disease Review, and Regional Director of Specialised Commissioning (London)
<p>Purpose of report</p> <p>This paper provides a briefing for the Overview and Scrutiny Committee on NHS England’s proposals for the future provision of congenital heart disease services, with particular reference to University Hospitals of Leicester NHS Trust; and the proposed timetable arrangements for public consultation on these proposals.</p>	
<p>Background</p> <p>In July 2015, the NHS England Board agreed new standards and service specifications for congenital heart disease (CHD) services, with the expectation that in future all providers would meet the standards, leading to improvements in service quality, patient experience and outcomes. NHS England is the direct commissioner of CHD services, as prescribed specialised services.</p> <p>The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:</p> <p>Specialist Surgical Centres (level 1): These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology. (Leicester is currently a level 1 centre.)</p> <p>Specialist Cardiology Centres (level 2): These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.</p> <p>Local Cardiology Centres (level 3): Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.</p> <p>The Board agreed a go-live date of April 2016 for implementation of the new standards, embedded in contracts with providers, with a standard specific timetable to achieve full compliance.</p> <p>The Board agreed proposals for commissioning the service and endorsed initial work with providers to develop proposals for ways of working to ensure the standards would be met.</p> <p>Work with providers commenced in April 2015, culminating in submission of proposals in October 2015. Seven submissions were received, some from networks based on a single surgical centre,</p>	

others from new multi-centre networks. Leicester submitted a joint proposal with Birmingham.

The proposals were comprehensively assessed by a commissioner led panel, with clinician and patient/public representation. The panel advised that certain standards were considered particularly important determinants of service quality and safety:

- All surgeons should be part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and that each surgeon must undertake at least 125 operations per year. From April 2021 the aim is a minimum 1:4 rota.
- Surgery must be delivered from sites with the required service interdependencies.

The assessment was discussed at NHS England's Executive Group Meeting (EGM) in December 2015. EGM accepted the panel's assessment that, taken together, the provider proposals did not provide a national solution; and giving more time would not yield a different outcome; and that developing a national solution would require significant support and direction by NHS England. EGM agreed that action should be taken to ensure that the April 16 standards were met as soon as possible, with immediate action to ensure that appropriate short term mitigations are put in place in the meantime to provide assurance of safety. This approach was endorsed by the Specialised Services Commissioning Committee (SSCC) at its meeting in February 2016.

The assessment process

A process to assess compliance with selected standards was launched in January 2016. It focused on 24 paediatric standards (and the matching adult standards) most closely and directly linked to measurable outcomes (including the surgical and interdependency standards previously highlighted by SSCC) and to effective systems for monitoring and improving quality and safety.

Providers of CHD services, including Leicester, were asked to evidence their compliance with the 2016 standards. While the focus was on the 2016 standards, NHS England also took account of the ability of providers to reach the 2021 standards.

Where standards were not met providers were asked to provide plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one that gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective on 1 April 2016.

The process was based on NHS England's standard approach when introducing a new service specification for any specialised service.

Our initial assessment showed that additional information would be needed in order to complete the process. This was requested from all the hospitals involved in March 2016 to make sure that every hospital had the opportunity to supply all the relevant information before we completed our assessment. We gave initial feedback on the findings of the first round at a meeting with clinicians on 18 March, and explained why further detail was being requested. These additional returns were assessed in April 2016.

Each set of returns was initially evaluated at a regional level by the NHS England specialised commissioning team, followed by a national panel to ensure a consistency of approach. The national panel brought together NHS England staff from both national and regional teams with

representatives from the Women and Children's Programme of Care Board and the Congenital Heart Services Clinical Reference Group to provide wide ranging and senior clinical advice and patient and public perspectives.

The panels were asked to concentrate on this assessment of compliance rather than trying to answer the question 'what should NHS England do?' The driver for this work has been to ensure delivery of the standards.

Outcome of the assessment process

All the providers were assessed against the standards, and rated on a scale from Green (meeting all the requirements as of April 2016) through to Red (current arrangements are a risk). Leicester was assessed as Amber/Red (does not meet all the April 2016 requirements and is unlikely to be able to do so).

Leicester was assessed as meeting 8 of the 14 requirements tested, and unlikely to be able to meet all the April 2016 requirements. Specifically:

a) Surgical activity

University Hospitals of Leicester reported a caseload of 331 procedures for 2015-16, an increase of 55 procedures compared with 2014-15. This is insufficient for three surgeons to meet the current minimum activity requirement of 125 cases per surgeon per year. The full standards (effective from 2021) require a team of four surgeons rather than three, and that there was felt to be no realistic prospect of Leicester increasing activity during this period to a level that would allow these requirements to be met.

b) Interventional cardiology rota

The Trust did not demonstrate that they have implemented a 1 in 3 interventional cardiologist rota.

c) Access to specialist services

The Trust does not have access to 24/7 bedside paediatric gastroenterology or paediatric nephrology.

The Trust does not have vascular and interventional radiology services on site.

The national panel report is available on the NHS England website <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/>.

The individual assessment report for Leicester is attached as appendix 1 to this report.

Proposals for change

In line with these assessments, NHS England has set out decisions that it is minded to take in relation to congenital heart disease services, subject to the outcome of public consultation. No decisions have been taken at this time.

The proposal in relation to Leicester is:

- to cease commissioning level 1 (surgical) services from the Trust
- to discuss the potential continuation of level 2 CHD services in Leicester.

If these proposals are approved following public consultation, the closest alternative centre for most patients who currently undergo CHD surgery at Leicester would in future be Birmingham. The majority of care for all patients is non-surgical, and could continue to be provided at Leicester as a level 2 centre.

Engagement and public consultation

NHS England has committed to public consultation on its proposals for change in relation to Leicester and other congenital heart disease providers. This will be for a period of 12 weeks, and will be led nationally with regional support.

Prior to the launch of public consultation, NHS England will undertake engagement with the Trust, local authorities, patient groups and other stakeholders.

Pre-consultation engagement will include an assessment of the potential impact on other services within the Trust in the event that the proposals are approved.

To date, the pre-consultation engagement has included:

- attendance at the Leicester Health & Wellbeing Board on 18 August
- a visit to UHL on 16 September, including a presentation from the Trust management and clinicians, and a meeting with stakeholders.

At the meeting on 16 September, the Trust provided more information in relation to its CHD services, and its assessment of the knock-on impact for other services (in particular paediatric intensive care and ECMO) in the event of the NHS proposals being implemented. The Trust confirmed its commitment to work with NHS England to meet the agreed national standards, and that will be the basis of our further pre-consultation engagement with the Trust.

Both the HWBB meeting and the visit to UHL were helpful in clarifying the issues involved, and the questions and concerns of stakeholders. Alongside the work on the CHD review, NHS England has begun work on national reviews of paediatric intensive care, paediatric surgery, paediatric transfer and ECMO, all of which will inform the approach on CHD.

The discussions and information gathered during pre-consultation engagement will inform the detail of the proposals on which NHS England goes out to consultation, and the way in which the consultation questions are framed. NHS England will commission external independent analysis of the responses to consultation.

Following the HWBB meeting, NHS England wrote back to the Chair with further information. Following the visit to UHL on 16 September, NHS England will clarify with the Trust a number of points in relation to the services provided, and the plans to deliver co-location. NHS England will

also discuss further with the Trust how the Trust could meet the requirements in terms of surgical activity.

Timescale

Subject to advice from Overview and Scrutiny Committees and others during our pre-consultation engagement, NHS England's high level timetable is as follows:

- Pre-consultation engagement: this has now started.
- Public consultation: up to 12 weeks, likely to start in December (date to be confirmed following pre-consultation engagement)
- Written six months' notification to providers of potential decommissioning of their services from April 2017, subject to the outcome of public consultation: 30 September 2016
- Review of the outcome of consultation: April/May 2017
- Final decisions: May/June 2017
- Implementation of the final decisions: June/July 2017 onwards (with an appropriate transition plan for patients and staff).

NHS England would welcome the opportunity to attend a future meeting of the Joint OSC to discuss the proposals further, at an appropriate time during the pre-consultation/consultation process.

Recommendations

NOTE the briefing provided.

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Hospital Trust: University Hospitals of Leicester NHS Trust

RAG RATING: Amber/Red

University Hospitals of Leicester has not demonstrated that it meets all of the requirements assessed and were considered unlikely to be able to meet requirement 2.1 (see below).

Meeting the requirements

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
1. Ensuring that paediatric cardiac / ACHD care is given by appropriate practitioners in appropriate settings.	1.1 All paediatric cardiac and adult CHD surgery, planned therapeutic interventions and diagnostic catheter procedures to take place within a Specialist Surgical Centre (exceptions for interventional and diagnostic catheters in adults noted below).	A9(L1) Paediatric; B8(L1) Paediatric; B12(L1) Paediatric; A9(L1) Adult; B8(L1) Adult; B12(L1) Adult	N	Y – acceptable plan provided	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	1.2 All rare, complex and innovative procedures and all cases where the best treatment plan is unclear will be discussed at the network MDT.	B2(L1) Paediatric; B2(L1) Adult	Y	N	N
	1.3 All children and young people must be seen and cared for in an age-appropriate environment , taking into account the particular needs of adolescents and those of children and young people with any learning or physical disability.	C2(L1) Paediatric	Y	N	N
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake	2.1 Congenital cardiac surgeons must be the primary operator in a minimum of 125 congenital heart operations per year (in adults and/or paediatrics), averaged	B10(L1)Paediatric; B10(L1) Adult	N	Y	Y

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
sufficient practice to maintain their skills	over a three-year period.				
	2.2 Cardiologists performing therapeutic catheterisation in children/young people and in adults with congenital heart disease must be the primary operator in a minimum of 50 such procedures per year (a minimum of 100 such procedures for the Lead Interventional Cardiologist) averaged over a three-year period.	B17(L1)Paediatric; B17(L1) Adult	N	Y – acceptable plan provided	N
3. Ensuring that there is 24/7 care and advice	3.1 Surgical rotas should be no more than 1 in 3.	B1(L1)Paediatric; B9(L1) Paediatric; B1(L1)Adult; B9(L1) Adult;	Y	N	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	3.2 Interventional cardiologist rotas should be no more than 1 in 3.	B1(L1)Paediatric; B15(L1)Paediatric; B1(L1)Adult;	Y	Y	N
	3.3 Cardiologist rotas should be no more than 1 in 4.	B14(L1) Paediatric;	Y	N	N
	3.4 A consultant ward round occurs daily.	B1(L1)Paediatric; B1(L1)Adult;	Y	N	N
	3.5 Patients and their families can access support and advice at any time	B1(L1)Paediatric;	Y	N	N
	3.6 Medical staff throughout the network can access expert medical advice on the care of children with heart disease and adults with congenital heart disease at any time.	A10(L1) Paediatric; B14(L1) Paediatric; A10(L1) Adult;	Y	N	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
4. Ensuring that there is effective and timely care for co-morbidities	4.1 Specialist Surgical Centres must have key specialties or facilities located on the same hospital site. Consultants from the following services must be able to provide emergency bedside care (call to bedside within 30 minutes).	A21(L1)Paediatric; D1(L1) Paediatric; D2(L1) Paediatric; D3(L1) Paediatric; D4(L1) Paediatric; D5(L1)Paediatric; D6(L1) Paediatric; D7(L1) Paediatric; D8(L1) Paediatric; A21(L1)Adult; D1(L1) Adult; D2(L1) Adult; D3(L1) Adult; D4(L1) Adult; D5(L1) Adult; D6(L1) Adult; D7(L1) Adult;	N	Y	Y
	4.2 Key specialties must function as part of the multidisciplinary team.	A21(L1)Paediatric; D1(L1) Paediatric; D2(L1) Paediatric; D3(L1) Paediatric; D4(L1) Paediatric; D5(L1)Paediatric; D6(L1) Paediatric; D7(L1) Paediatric; D8(L1) Paediatric; A21(L1)Adult; D1(L1) Adult; D2(L1) Adult; D3(L1) Adult; D4(L1) Adult; D5(L1) Adult; D6(L1) Adult; D7(L1) Adult;	Y	N	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
5. Assuring quality and safety through audit.	5.1 Specialist Surgical Centres must participate in national audit programmes, use current risk adjustment tools where available and report and learn from adverse incidents.	A21(L1)Paediatric; F4(L1) Paediatric; F7(L1) Paediatric; F9(L1) Paediatric; A21(L1)Adult; F4(L1) Adult; F7(L1) Adult; F9(L1) Adult;	Y	N	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Development plan and mitigation requirements

2.1 University Hospitals of Leicester initially reported a caseload of 321 procedures for 2015-16, an increase of 55 procedures compared with 2014-15. Validated numbers from NICOR are not yet available for this period; however, this is insufficient for three surgeons to meet the activity requirement. They currently have three surgeons who were not projected to achieve the required 125 operations in 2015/16 (122, 95, 43¹ projected procedures). University Hospitals of Leicester provided an updated figure for 2015/16 of 331 procedures but this is still insufficient for three surgeons to meet the activity requirement.

University Hospitals of Leicester is predicting that growth will continue as a result of:

- continuing to develop relationships with level 3 hospitals such as Kettering General Hospital, Peterborough City Hospital and Northampton General Hospital;
- delivering new outreach clinics; and
- expanding their estate, specifically expanding their outpatient department, moving and increasing accommodation for parents and carers, increasing office space for staff and increasing the paediatric cardiology bed provision to provide a short-stay area, cardiac high dependency beds and a separate facility for adolescents (this work is scheduled for completion in August 2016).

University Hospitals of Leicester also described the mitigation it currently has in place including:

- seeking support and advice in complex or unusual cases, particularly from colleagues at Birmingham Children's Hospital; and
- following MDT discussion they have been supported by one of the senior surgeons at Birmingham Children's Hospital on four occasions in the last year.

The panel was concerned about whether these plans were realistic as it is not possible to know if the recent growth will continue. University Hospitals of Leicester must develop a more detailed plan to ensure that all surgeons meet the required numbers during 16/17.

University Hospitals of Leicester must demonstrate that where its plan is based on changes in patient flows this includes agreements with the referring hospitals and the hospitals currently providing a service to that hospital. University

¹ Surgeon started operating in November 2015. A previous surgeon had also performed 61 procedures in 15/16 prior to stopping operating in October 2015.

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Hospitals of Leicester must also monitor surgeon activity during 2016/17 and inform regional commissioners if at any point they consider it likely that one or more of their surgeons will not meet the requirement.

While the predicted growth may in time ensure that the 2016 requirement for a team of three surgeons can be supported, NHS England activity projections suggest that University Hospitals of Leicester will not achieve sufficient activity levels to meet the full requirement for a team of four surgeons by 2021.

2.2 University Hospitals of Leicester reported that it had performed 257 procedures in 2014-15 which would be enough for their interventionists to meet these requirements; however, recently provided figures from NICOR suggest a lower overall activity of 198 procedures (once all procedures which did not qualify had been removed). While NICOR reported activity varies from year to year subject to validation this suggests that University Hospitals of Leicester may be at the margins of having enough activity to meet the requirements for their proposed team of a lead interventionist who performs a minimum of 100 procedures and all interventionists to perform a minimum of 50 procedures for their proposed team of three interventionists. University Hospitals of Leicester must take steps to ensure that they consistently meet the required activity levels to provide sufficient procedures for all their interventionists to meet the required volume.

In order to meet these standards University Hospitals of Leicester plan to reduce the number of interventional cardiologists from seven to three with a fourth cardiologist focussing on EP and implants. The panel considered this an acceptable plan.

University Hospitals of Leicester implemented a 1 in 3 interventional cardiologist rota in April 2016. They must now develop plans to meet the 1 in 4 rota requirement from April 2017.

University Hospitals of Leicester also report an average of 32 procedures each year performed by other staff and trainees for 2013/16. This would appear to be in breach of standard A2(L1) which requires that all congenital cardiac care including investigation, cardiology and surgery, is carried out only by congenital cardiac specialists and standard B12(L1) which requires that all paediatric congenital cardiology must be carried out by specialist paediatric cardiologists (and the equivalent adult standard). The plan described above should address this issue.

University Hospitals of Leicester must take steps to manage interventional workload to ensure that all interventional is undertaken only by congenital

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

cardiac specialists, that all interventional cardiologists meet the required numbers during 16/17 and to monitor interventional activity and inform regional commissioners if at any point they consider it likely that one or more of their interventionists will not meet the requirement.

- 4.1 University Hospitals of Leicester does not have access to 24/7 bedside paediatric gastroenterology.

The panel was concerned about whether the proposed mitigations (24/7 support from general paediatrics and paediatric surgery based at Leicester Royal Infirmary to provide first line care for gastroenterological emergencies with next day advice from a paediatric gastroenterologist) were acceptable. The recruitment of an additional Consultant Paediatric Gastroenterologist was approved in May which they state will enable 24/7 30 minute to bedside paediatric gastroenterology care by the end of 2016.

- 4.1 University Hospitals of Leicester does not have vascular and interventional radiology services on site as required by Standard D7(L1)Adult.

The service is provided by Leicester Royal Infirmary with a site to site journey time under 30 minutes but evidence was not provided to demonstrate that this service is available 24/7 or of a commitment to 30 minute call to bedside care. The panel noted that this service is due to be moved to Glenfield Hospital in February 2017.

University Hospitals of Leicester must provide further evidence to demonstrate that this standard is met or that effective mitigations are in place. NHS England's regional commissioning team will review and agree the plans and monitor implementation of the plan.

Other requirements

- 1.1 University Hospitals of Leicester has reached an in principle agreement with Nottingham University Hospital that they will provide oversight of their activity as a Level 2 centre including ASD closures. A decision regarding Nottingham's continuation as a Level 2 centre is required prior to any decisions being made regarding the University Hospitals of Leicester proposals regarding its role in providing supervision. If this arrangement proceeds, University Hospitals of Leicester would need to provide additional information on their arrangements for overseeing ASD closures at Nottingham University Hospitals following their meeting which was held during April and July 2016. Regional commissioners would then determine whether any further plans or mitigations were required.

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

- 4.1 University Hospitals of Leicester does not have paediatric surgery or gastroenterology located on site. While the 2016 requirements state that bedside care needs to be available within 30 minutes the standards require that by 2019 these services are co-located. University Hospitals of Leicester have made arrangements to meet the 2019 requirements through their building of a new children's hospital.
- 5.1 University Hospitals of Leicester working with Birmingham Children's and University Hospital Birmingham will also continue to develop their wider pan-midlands network in line with commissioner requirements due to be confirmed during 16/17.

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9 September 2016

Councillor Rory Palmer
Deputy City Mayor and Chair, Leicester Health & Wellbeing Board
3rd Floor
City Hall
115 Charles Street
Leicester
LE1 1FZ

Dear Rory

Congenital Heart Disease services

Thank you for your letter of 25 August, following the meeting of the Health & Wellbeing Board on 18 August.

I was pleased to have the opportunity to attend the Board, and to provide information for members and the public on NHS England's proposals for change in relation to congenital heart disease services at Glenfield Hospital.

I thought it would be helpful to confirm a few key points in relation to the standards, the approach we are taking, and our discussions with UHL:

- The national standards that NHS England is using to assess providers against were developed with expert advice from clinicians from the CHD community, including from Leicester, and with charities, patients and stakeholders. They command wide support, and set out the key elements of an excellent service, that will be resilient and sustainable for people across the country now and into the future.
- We have made no final decisions about our proposals. We are now undertaking pre-consultation engagement, and public consultation will follow; decisions will be taken after the conclusion of consultation.
- Our assessment of UHL, based on the evidence that they have provided, is that the Trust does not now meet all of the standards, in particular in relation to surgical activity (in total and by surgeon) and paediatric co-location; and the Trust has not provided us with a plan demonstrating that it will meet these standards in the required timescale.

- We are talking to UHL about how the standards can be met, including a meeting we have scheduled for 16 September.

As mentioned in your letter, I committed to provide some additional information that was requested at the meeting. To take each of these in turn:

- Evidence in support of the standards: a briefing on this is attached, from the meeting of the NHS England Board (held in public) in July 2015.
- Patient and public involvement representatives on the national panel: a list of all members of the national panel is included as an appendix to this letter.
- Public consultation arrangements, including PPI involvement: these are still being worked up, informed by pre-consultation engagement.

I hope this is helpful.

Best wishes

Yours sincerely



Will Huxter
Regional Director or Specialised Commissioning (London)

Appendix 1: Members of the National Panel

The members of the panel that carried out the assessment are listed below. Their role was to assess each hospital's ability to meet the standards. They were not responsible for deciding what action to take. That decision (which is a minded decision not a final decision) was taken by NHS England.

Panel Chair

- Will Huxter, Programme SRO, NHS England

Patient and Public

- Michael Cumper, Nominated CRG PPE representative
- Suzie Hutchinson, Nominated CRG PPE representative

Clinical

- Professor Deirdre Kelly, Chair, Clinician Engagement and Advisory Group
- Dr Jackie Cornish, Women and Children POC Board
- Dr Trevor Richens, Chair, Congenital Heart Services CRG

National Commissioning / Programme (NHS England)

- Anthony Prudhoe, Accountable Commissioner
- Ben Parker, CHD Programme Team
- Cathy Edwards, Operational Delivery Director (National), Specialised Commissioning
- Michael Wilson, Programme Director
- Richard McMahon, Quality Surveillance Team
- Teresa Fenech, Director Of Nursing for Specialised Commissioning

Regional Commissioning (NHS England)

- Dr Alison Rylands, Regional Clinical Director for Specialised Commissioning (North)
- Catherine O'Connell, Regional Director Specialised Commissioning (Midlands and East)
- Hazel Fisher, AD Programme of Care & NW London Locality Lead (London)
- Dr Vaughan Lewis, Regional Clinical Director for Specialised Commissioning (South)

Appendix 7: Evidence base for the new standards & specifications

The development of standards has been at the heart of the review; they describe how services should be organised, both adult and paediatric, at each of three levels of the service. Few of these standards are informed by direct clinical evidence, but represent the best advice from expert clinicians and patient representatives.

“In my experience, the amount of quantitative scientific evidence available to guide us in deciding how best to organise health services is often much less than we would like. In these circumstances we rely heavily on the views of experts, both specialist clinicians and those who are expert because of their experience of using the services in question. The views of experts, while qualitative rather than quantitative, are also valid and an important source of evidence in our deliberations.”

Professor Sir Michael Rawlins, Chair, new CHD review Clinical Advisory Panel

We commissioned a review of the international literature¹ conducted by SchARR at Sheffield University. Their report focused on two questions:

- What is the current evidence for the relationship between institutional and surgeon volume and patient outcomes and how is that relationship influenced by complexity of procedure and by patient case mix?
- How are patient outcomes influenced by proximity to/co-location with other specialist clinical services (e.g. co-location of services such as specialist cardiac paediatric intensive care)?

Good data on CHD activity and outcomes is also available from the National Congenital Heart Disease Audit run on behalf of NHS England by the National Institute for Cardiovascular Outcomes Research (NICOR). NICOR was asked to examine its data and to advise what this showed about service factors that could influence outcomes. We have also had extensive support from NHS England analysts, working with a range of data supplied independently, and from CHD clinicians and patient groups.

We have good data on post-operative mortality internationally and on 30 day mortality in this country, but the best data relates only to children’s services, and we have little information about longer term outcomes, morbidity or patient experience. Some believe that it is the lack of broader measures that hinders us in being able to show the benefits of larger scale services, arguing that 30 day mortality is a relatively insensitive indicator of good care. Without the data we cannot know the truth of this argument, but one of the review’s six objectives has been to develop proposals for a

¹ Turner J, Preston L, Booth A et al, What evidence is there for a relationship between organisational features and patient outcomes in congenital heart disease services? A rapid review, School for Health and Related Research (SchARR), University of Sheffield, 2014

wider range of relevant timely metrics other than just 30 day mortality, to inform commissioners and support patient choice. These proposals will form part of the report we are bringing to the Board in July.

The evidence from published literature can guide our thinking on the scale of services. But the arguments for size of surgical teams, individual surgeon caseload and our approach to subspecialisation are inferred, and relate to the resilience and reliability of systems rather than to outcomes.

Overall then, there is a body of evidence to support most of the challenging standards, some of it from academic studies, some inferential, some based on expert advice. The nature of the evidence is such however that it does not give precise answers to questions about the organisation of the service, or show what size is too small or what size is big enough, and neither can this data be extrapolated to show what improvements in outcomes might be expected. As a result it cannot tell us whether the benefits gained would outweigh the risks of change – the upheaval, the cost, the upset, specialist care delivered further from some patients' homes², the risk of destabilising some units or other services linked to or dependent upon CHD services. This has informed our thinking in seeking to develop solutions that give many of the benefits of working as part of a larger team, without the disruption of reconfiguration.

To avoid one of the pitfalls of *Safe and Sustainable* we have been very open about the limitations of the evidence base, and where we have therefore had to rely on judgement, and what the basis for that judgement is. We have published the minutes of every substantive discussion, bringing the debate into our various engagement groups. As a result, the vast majority of the proposed standards are uncontroversial and widely endorsed. But we readily concede that those standards where there has been most contention have been developed by listening to expert advice and argument, not by proving that there is sufficient weight of evidence from research. Our stakeholders know this and would expect us to be able to show the audit trail for any new proposals we now bring forward.

Evidence for the relationship between unit size and outcomes

The SchARR literature review³ identified a substantial number of studies reporting a positive relationship between volume and outcome and concluded that while the evidence demonstrates a relationship between volume and outcome in the majority of studies, this relationship is not consistent. The relationship is stronger for single complex conditions or procedures. It remains unclear whether the impact of volume

² SchARR reported that two studies examined the relationship between distance from a specialist cardiac centre and mortality and both found no relationship between distance and mortality. NICOR found no association was shown with distance from home

³ Ibid

on outcome is largely a consequence of higher volume units organising and providing a complex service with all the “right” components, or whether it remains an independent factor directly related to the advantages of dealing with a larger number of cases⁴. The lack of any UK studies to contribute to the review indicates a serious gap in evidence relevant to service provision in the NHS.

Two additional publications⁵⁶ on volume and outcomes were brought to the attention of the review. They were not included in the ScHARR review because they had not been published at the time it was written. Reviewing these studies CAP concluded that they confirm that generally, greater volumes are associated with better outcomes. They do not, though, conflict with the findings of the ScHAAR review; nor should they lead to changes in the volumes contained within the current set of standards. The study by Kansey et al was however notable in that it was based on European rather than American data.

The ScHARR review confirmed the findings of an earlier literature review⁷ carried out for *Safe and Sustainable* which found that the literature confirmed the association of volume with in-hospital mortality, but that precise recommendations on volume thresholds were difficult. This review also found that the relationship was stronger with increasing complexity.

While the data linking larger units with better outcomes is widely accepted, it is not clear over what range this relationship holds. Most of the published evidence comes from the US where units operate across a much wider size range. As a result of the banding of centres into small, medium and large, units bigger than 350 operations per year are classified as large. This means that while studies show better outcomes at larger centres, it is not possible to determine whether even bigger centres would be better still. Much of the published evidence considers only paediatric volumes, and it is also unclear how these numbers should be applied to services that deliver both paediatric and adult services. Our smallest units are currently undertaking around 300 operations annually (240 paediatric operations)⁸.

As a result of stronger regulation and a centralised national health service, the UK is already in a far better position than both the US and many European countries in

⁴ The evidence is equivocal – some studies found lower complication rates in high volume centres; others found no association between volume and complication rates. Two studies found low volume centres were associated with longer length of stay. Two studies also assessed costs and both found a relationship of higher costs associated with low volume centres.

⁵ Kansey A , Ebels T, Schreiber C et al Association of Center Volume With Outcomes: Analysis of Verified Data of European Association for Cardio-Thoracic Surgery Congenital Database. *Ann Thorac Surg* 2014;98:2159–64

⁶ Karamlou T et al. Surgeon and Center Volume Influence on Outcomes After Arterial Switch Operation: Analysis of the STS Congenital Heart Surgery Database. *Ann Thorac Surg* 2014;98:904–11.

⁷ Ewart E, The relationship between volume and outcome in paediatric cardiac surgery, PHRU Oxford, 2009

⁸ Sources: National Congenital Heart Disease Audit, NICOR data for 2013-14; NHS England analysis.

having a consolidated paediatric CHD surgical service – a striking change since the original Kennedy Report, when the surgical centre in Bristol had been undertaking around 47 paediatric operations per year. At the time of the Munro report in 2003, six centres in England and Wales were doing fewer than 200 cases a year and two were doing fewer than 100. Since that time the paediatric surgical service at Oxford has closed, and in the past year surgical practice has ceased in Belfast.

In the context of the NHS in England, while published evidence gives support to the view that units should undertake at least 350 operations per year, interpretation of this is complicated by analysis of UK outcomes which showed no significant association between annual centre volume and 30-day survival outcome⁹. This complexity was recognised in our consultation document¹⁰ where we stated that “the evidence did not tell us the best size for a specialist surgical centre. As a result our Clinical Advisory Panel told us that ... the evidence was broadly supportive of the relationship between volumes and outcomes, but did not provide a compelling argument for change.”

Evidence for four surgeons in a team

UK surgeons agree that teams of four surgeons are ideal, and some leading individual surgeons have argued passionately in our meetings for this to be the requirement. But the consensus view of the profession¹¹ is that three rather than four should be the minimum. This appears to be a change from the position during the *Safe and Sustainable* process when there was a consensus for teams of at least four and which is therefore reflected in the current service specification, in use today. This position was supported by the IRP in their recommendations¹²:

‘Patients should receive congenital heart surgery and interventional cardiology from teams with at least four full-time consultant congenital heart surgeons and appropriate numbers of other specialist staff to sustain a comprehensive range of interventions, round the clock care, training and research.’

The arguments in favour of larger teams are inferential rather than directly taken from research evidence. They relate to the pressure on individual surgeons working in smaller teams and the vulnerability of such services to the absence of one member of the team. Larger teams are also more able to subspecialise to handle rare, complex and innovative procedures.

⁹ Using data from 13 paediatric surgery centres, NICOR’s analysis of 12,186 episodes of care in paediatric heart surgery from April 2009 to March 2012 inclusive showed no significant univariate association between annual centre volume and 30-day survival outcome.

¹⁰ Proposed congenital heart disease standards and service specifications: a consultation, NHS England, 2014

¹¹ Personal communication from David Barron, Society of Cardio Thoracic Surgeons

¹² Independent Reconfiguration Panel, Advice On Safe And Sustainable Proposals For Children’s Congenital Heart Services, 2013

The combination of professional, annual and study leave will mean that members of 3 surgeon teams will spend almost half the year working a 1:2 on call. The Royal College of Surgeons, the Royal College of Anaesthetists, the Royal College of Paediatrics & Child Health and the Royal College of Nursing all told our Clinical Advisory Panel that this was not acceptable. Norman Williams (then president of RCS) advised that the pressures this placed on individual surgeons could potentially jeopardise patient safety.

Despite this, surgeons who argue the case for larger surgical teams are not usually motivated by concerns about out-of-hours arrangements or work life balance. Rather, the number of surgeons is used as a proxy for the scale of the unit – perceived advantages being greater sub-specialisation within surgical teams, better supporting facilities and staffing, more attractive units for recruitment, and greater opportunities for training and research. These are not seen as ends in themselves, but as vital contributors to higher quality services that will improve outcomes.

Most of the evidence on the volume/outcome relationship comes from studies that examine centre volumes. Some studies have also examined individual surgeon volumes and most found decreased mortality with increasing surgeon volumes for complex procedures^{13,14}. Some English centres, because of their size, see only low numbers of complex cases so that individual surgeons may do only one or two of each per year. Our proposals aim to improve this situation by ensuring that surgeons work in teams of at least four (with at least 500 cases between them, so that each team has higher numbers of complex cases) and by an explicit approach to sub-specialisation aimed at concentrating this work in the hands of fewer surgeons. So our proposed standard maintains the current requirement rather than lowering the bar to a “minimum of three”. However, by proposing four surgeons per team, rather than per unit, we create the potential for some flexibility in implementation, which is missing from the current standard.

Evidence for 125 cases per surgeon

Maintaining regular operative experience is fundamental to any surgeon, especially in technically demanding specialties like CHD. Two studies suggest a relationship between individual surgeon volumes and outcomes for adults with CHD - one study found outcome was associated with surgeon volume. Another found a similar association with adult procedure volume indicating the influence of expertise on outcome. The requirement in the proposed standards for a minimum of 125

¹³ Turner J, Preston L, Booth A et al, What evidence is there for a relationship between organisational features and patient outcomes in congenital heart disease services? A rapid review, School for Health and Related Research (SchARR), University of Sheffield, 2014

¹⁴ Karamlou T, Jacobs M, Pasquali S et al, Surgeon and Center Volume Influence on Outcomes After Arterial Switch Operation: Analysis of the STS Congenital Heart Surgery Database, *Ann Thorac Surg* 2014;98:904–11

operations per surgeon has been strongly supported by the Society for Cardiothoracic Surgery, by the community of congenital cardiac surgeons themselves, and by the Royal College of Surgeons.

Inevitably the setting of standards involves ‘picking a number’, and in the absence of data with a clear inflection point, this number will be arbitrary. That is sometimes the source of criticism but this of course ignores the fact that any number would be arbitrary. Similar numbers have been recommended by earlier reviews: the European Association for Cardio-Thoracic Surgery report¹⁵ recommended that each surgeon should perform 126 cardiac surgical procedures on adults or children; the *Safe and Sustainable* review¹⁶ recommended a minimum of 100 paediatric and ideally 125 paediatric operations per surgeon. Job plans for consultant surgeons include between 1.5 – 2.5 operating days a week and we would expect every surgeon to deliver a minimum of 42 weeks clinical work per year. Thus, even at the most conservative end of the spectrum (and including a minimum of emergency work) a consultant surgeon should expect to do 150 cases minimum¹⁷.

Surgeons have been unanimous in saying that they feel that individual case numbers are the single most important statistic to apply in terms of ‘numbers’, and there is very little argument against 125 being a helpful and achievable minimum standard.

Evidence for four interventional cardiologists in a team /no. of cases per cardiologist
The studies identified in both literature reviews related exclusively to surgical practice. Most studies of catheter procedures have been small in scale and as such the available evidence base on which to make recommendations for treatment is limited. The new proposed standards are based on current professional guidelines¹⁸ and the advice we received from clinicians.

Evidence for paediatric CHD co-location with other paediatric services
The SchARR review¹⁹ found no evidence on the effects of proximity of other services other than PICU, so the proposed standards are based on expert opinion.

Our clinical advisers strongly supported co-location with other paediatric services, even though they recognised that not everyone agrees. The Clinical Advisory Panel²⁰ considered that this brought the standards for CHD services into line with expectations in other specialist children’s services. They noted that while

¹⁵ Optimal Structure of a Congenital Heart Surgery Unit in Europe, Congenital Heart Surgery Committee on behalf of the European Association for Cardio-Thoracic Surgery, 2003

¹⁶ Safe and Sustainable: A new vision for children’s congenital heart services in England, NHS Specialised Services, 2011

¹⁷ Barron D, Personal communication, 2014

¹⁸ Recommendations for therapeutic cardiac catheterisation in paediatric heart disease, British Congenital Cardiac Association, 2012

¹⁹ Ibid

²⁰ Minutes of CAP, 18 June 2014 <http://www.england.nhs.uk/ourwork/qual-clin-lead/chd/meetings/cap/>

responsiveness was important, it was not the only thing that mattered – the interaction between teams on a daily basis was also important. They considered that it was not safe to care for children with complex conditions and co-morbidities (a high proportion of whom will need input from other specialties) in settings where other paediatric services were not on site.

In consultation²¹, the majority of respondents supported our proposals (albeit with comments and suggestions). Patients told us that they need good access to these services, and that there need to be good working relationships between clinical teams, making sure that services work together in the patient's best interest. Some consider that the best way to achieve this is to have all the services on the same site.

Evidence for paediatric CHD and adult CHD interdependency

The new proposed standards require that within a surgical service, adult and paediatric CHD services have a close relationship, and that surgeons and interventionists are able to respond with a call to bedside time of no more than 30 minutes (whether the adult and paediatric services are on the same site or not). This recognises the interdependency and shared staffing of the two parts of the service but does not require co-location. This standard is based on the clinical advice we received.

²¹ Consultation on draft standards and service specifications for congenital heart disease services, *Dialogue by Design*, 2015.

Congenital Heart Disease: NHS England takes action to deliver consistent and high quality services now and for the future

8 July 2016 - 00:01

Patients with complex, sometimes life-threatening congenital heart disease will benefit from action to ensure core standards of quality and sustainability apply across all specialist services announced today (Friday 8th July) by NHS England.

Congenital heart disease (CHD) services have been the subject of a number of reviews since the public inquiry at Bristol Royal Infirmary in 2001, with the outcome of a further review of a number of children's heart surgery cases at Bristol published last week.

In 2015, NHS England published new commissioning standards for CHD services following extensive consultation with patients and their families, clinicians and other experts.

Since then, hospital trusts providing CHD services have been asked to assess themselves against the standards, which came into effect from April 2016, and report back on their plans to meet them within the set time frames.

As a result of these assessments, and following further verification with providers, NHS England intends – subject to necessary engagement and service change process in relation to this assessment – to take the following actions to ensure all providers comply with the set standards.

With regard to providers of specialist surgical (Level 1) services:

- Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with Alder Hey Children's Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust to safely transfer CHD surgery from Central Manchester University Hospitals NHS Foundation Trust. Specialist medical services may be retained at Central Manchester.
- Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with University Hospitals of Leicester NHS Trust and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD

surgical and interventional cardiology services to appropriate alternative hospitals. Neither University Hospitals Leicester or the Royal Brompton Trusts meet the standards and are extremely unlikely to be able to do so. Specialist medical services may be retained in Leicester.

- NHS England will work with Newcastle Hospitals NHS Foundation Trust to ensure progress is made towards meeting the standards and the strategic importance of the link of CHD surgery to the paediatric heart transplant centre is sustainable and resilient.
- NHS England will support and monitor progress at University Hospitals Bristol NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, University Hospitals Birmingham NHS Foundation Trust, Barts Health NHS Trust, Guy's and St Thomas' NHS Foundation Trust, and University Hospital Southampton NHS Foundation Trust to assist them in their plans to fully meet the standards. In the case of Bristol this will also include addressing specific recommendations set out in the independent report published last week.
- Birmingham Children's Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust will continue to be commissioned, with ongoing monitoring, as they currently meet all or most of the standards.

NHS England remains concerned as to the level of occasional and isolated practice in specialist medical (Level 2) services, and intends to take the following actions:

- NHS England will work with Blackpool Teaching Hospitals NHS Foundation Trust, University Hospital of South Manchester NHS Foundation Trust, Papworth Hospital NHS Foundation Trust, Nottingham University Hospitals NHS Trust and Imperial College Healthcare NHS Trust to cease occasional and isolated specialist medical practices. Plans will be put in place to transfer services to other appropriate providers.
- NHS England will support and monitor progress at Liverpool Heart and Chest hospital to develop Level 2 and Level 1 services in line with standards and Oxford to assist them in their plans to fully meet the standards.
- Norfolk & Norwich University Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust will receive ongoing monitoring of their progress towards meeting the standards.

In addition, a small number of hospital trusts not recognised as a specialist centre, but which responded to the self-assessment that they undertook occasional practice/interventions, have been instructed to make arrangements for such patients to be cared for at a specialist centre in future. This process has now all-but

eliminated occasional practice, with follow-up action to be taken against providers if they continue.

Dr Jonathan Fielden, NHS England Director of Specialised Commissioning and Deputy National Medical Director, said: “Patients, families and staff need to be assured of sustainable, high quality services now, and into the future.

“There has been a great deal of uncertainty over the future of congenital heart disease services over the past fifteen years. We owe it to patients, families and staff to end that uncertainty, and to provide clear direction for the safety and quality of this specialist area of medicine going forward.

“A great deal of work has gone into achieving consensus across the board on the standards that providers should meet. We are determined to take all actions necessary to ensure that those standards are met, so that patients get the high quality and safe services that they expect and deserve.

“This is further proof that NHS England as the national commissioner of specialised care is stepping up decisively on behalf of patients now and to sustain quality care for the future.”

Professor Sir Ian Kennedy, who was the chair of the public inquiry at Bristol Royal Infirmary, said: “These are vital services and we have waited 15 years to arrive at a solution which delivers quality and consistency for current and future generations. It is good news for patients that there is finally a clear consensus on the standards that need to be met, and that we are now seeing decisive action to make those standards a reality for every patient in every part of the country.”

Miss Clare Marx, President of the Royal College of Surgeons, said:“Improvements to care for children undergoing heart surgery continue to be needed in spite of improvements since the Bristol Royal Infirmary public inquiry report in 2001. The Royal College of Surgeons strongly supports today’s plans and we hope these changes will now finally happen for the ultimate good of patients. “Units need to be the right size to enable surgical teams to be familiar and skilled in all conditions, treating these patients on a regular basis to maintain their experience and expertise. It’s absolutely critical that teams are sufficiently staffed to provide secure on-call rotas, disseminate new techniques, and train the next generation of specialists.

“The proposals set out today represent a consensus view of what consistent, high quality care should look like across the country. As a profession we are confident

these standards will help reduce variation in care and improve outcomes. Any further delay or obstruction by local parties will prolong uncertainty for the very ill patients who need this surgery.”

Congenital heart disease (CHD) affects up to 9 in every 1,000 babies born in the UK, with differing types of CHD and levels of severity. Some of the more common CHDs include:

- septal defects, commonly referred to as a “hole in the heart”;
- coarctation (or narrowing) of the aorta,
- pulmonary valve stenosis, where the valve controlling blood flow to the lungs is narrower than normal, and;
- transposition of the great arteries, where the pulmonary and aortic valves and the arteries they’re connected to have swapped positions.

Services and surgery – the provision of which is clustered in a small number of specialist centres across England – have progressed significantly over the last few decades, and around 80% of those born with a CHD now survive into adulthood.

However, there has been uncertainty over their future configuration. In an effort to address this uncertainty, in July 2013, after discussions with key stakeholders, NHS England established the New Congenital Heart Disease Review.

The Review had the following aims:

- Securing the best outcomes for all patients – not just lowest mortality but reduced disability and an improved opportunity for survivors to lead better lives;
- Tackling variation – ensuring that services across the country consistently meet national standards, and are able to offer resilient 24/7 care, and;
- Improving patient experience – including how information is provided to patients and their families, and consideration of access and support for families when they have to be away from home.

On 23 July 2015 the NHS England Board received the review’s report and around two hundred new standards and service specifications which providers of CHD services should meet. These standards began in April 2016, with a five-year trajectory to full compliance.

In order to establish which providers do or can meet the standards in the set time frame, all providers were asked to complete a self-assessment process, the results of which have now been processed and form the basis of the actions set out today.

In 2014/15, the last year for which reliable data exists, the number of operations performed by CHD services was 4,354, and the number of interventional procedures was 3,793.

While some patients will have to travel further to access specialist services as a result of these changes, emergency admissions are rare, and ongoing work aims to ensure that more of a patient's long-term care can be delivered closer to home, meaning fewer trips to specialist centres.

Where the transfer of services goes ahead, NHS England will work with the hospital trusts to ensure that staff are supported.



**Paediatric Cardiac and
Adult Congenital Heart
Disease Standards
Compliance Assessment:
Report of the National
Panel**

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

Contents	4
1 Introduction	5
2 The assessment process	6
3 Specialist Surgical Centres (level 1).....	7
3.1 Overall assessment.....	7
3.1.1 Minimum volumes of surgical / interventional activity for individual consultants and the minimum size of a surgical or interventional team.	8
3.1.2 Availability of advice, care and support from interdependent clinical services	9
3.2 Other issues	10
4 Level 2 centres and occasional practice.....	13
5 What happens next?	14
6 Ongoing approach to assuring standards compliance	15

1 Introduction

NHS England is the direct commissioner of congenital heart disease (CHD) services, as prescribed specialised services. On 23 July 2015, the NHS England Board agreed new standards and service specifications for CHD services, with the expectation that in future all providers would meet the standards, leading to improvements in service quality, patient experience and outcomes. The Board agreed a go-live date of April 2016 to begin implementation of the new standards, embedded in contracts with providers, with a standard-specific timetable giving up to five years to achieve full compliance.

The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:

Specialist Surgical Centres (level 1): These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology.

Specialist Cardiology Centres (level 2): These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.

Local Cardiology Centres (level 3): Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.

The Board agreed proposals for commissioning the service and endorsed initial work with providers to develop proposals for ways of working to ensure the standards would be met. This work with providers commenced in April 2015, culminating in the submission of proposals in October 2015. Seven submissions were received, some from networks based on a single surgical centre, others from new multi-centre networks. The proposals were comprehensively assessed by a commissioner led panel, with clinician and patient/public representation. The panel advised that certain standards were considered particularly important for service quality, safety and sustainability:

- Surgeons should be part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and that each surgeon must undertake at least 125 operations per year. From April 2021 a minimum 1:4 rota will be expected.
- Surgery should be delivered from sites with the required service interdependencies. The standards specify which services should be on the same site, and the level of responsiveness required from these and other services. Some of the requirements for co-location are new, so hospitals have until April 2019 to meet them.

NHS England accepted the panel's assessment that, taken together, the initial provider proposals did not provide a national solution and giving more time was unlikely to yield a different outcome.

It was decided therefore that action should be taken to ensure that the April 2016 standards were met as soon as possible, with immediate action to ensure that appropriate short term mitigations are put in place in the meantime to provide assurance of safety. The process reported in this paper was endorsed by NHS England's Specialised Services Commissioning Committee (SSCC).

2 The assessment process

A further process to assess compliance with the standards was launched in January 2016. It set out 14 requirements organised into five themes:

1. Ensuring that paediatric cardiac / ACHD care is given by appropriate practitioners in appropriate settings
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake sufficient practice to maintain their skills
3. Ensuring that there is 24/7 care and advice
4. Ensuring that there is effective and timely care for co-morbidities
5. Assuring quality and safety through audit

Within the 14 requirements, this assessment covered 24 paediatric standards (and the corresponding adult standards) considered to be most closely and directly linked to measurable outcomes (including the surgical and interdependency standards previously highlighted) and to effective systems for monitoring and improving quality and safety.

Providers of CHD level 1 & 2 services were asked to provide evidence of their compliance with the April 2016 standards. As the standards are being introduced in a phased way to allow hospitals longer to prepare for the more demanding standards, consideration was also given to the ability of providers to reach the later requirements.

Where providers could not demonstrate that standards are met, they were asked to describe their plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one that gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective.

This process was closely based on NHS England's usual approach when introducing a new service specification.

Additional information was needed in order to complete the process and this was requested in March 2016. These additional returns were assessed in April 2016.

Each set of returns was initially evaluated at a regional level by the NHS England specialised commissioning team, followed by a national panel review to ensure a consistency of approach. The national panel brought together NHS England staff from its national and regional teams with representatives from the Women and

Children's Programme of Care Board and the Congenital Heart Services Clinical Reference Group to provide wide ranging and senior clinical advice and patient and public perspectives. NHS England then gave each provider organisation the opportunity to comment on the factual accuracy of its assessment, so that the provider's comments could be taken into account before the assessment was finalised.

This report of the national panel's findings represents NHS England's assessment of compliance with the standards and the action it is proposing to take, subject to appropriate public involvement and/or consultation.

3 Specialist Surgical Centres (level 1)

3.1 Overall assessment

The detailed assessment of each centre, based on the evidence submitted is summarised here.

	Green	Green / Amber	Amber	Amber / Red	Red
	Meets all the requirements as of April 2016.	Meets most of the requirements as of April 2016 and has good plans to meet the rest within max. 12 months.	Should be able to meet the April 2016 requirements with further development of their plans.	Does not meet all the April 2016 requirements and is unlikely to be able to do so.	Current arrangements are a risk.
North			Alder Hey Leeds	Newcastle	Central Manchester
Midlands and East		Birmingham Children's	UH Birmingham	Leicester	
London		Great Ormond Street	Barts Guy's and St Thomas'	Royal Brompton	
South			Bristol Southampton		

We found that none of the centres met all the standards tested. This was not unexpected, as the standards were designed to ensure that all services were brought up to the level of the best of existing practice - to be stretching and drive improvement without being unrealistic.

The differences we found between centres, particularly between those rated green/amber and those rated amber/red were starker than the ratings alone may

imply. Those rated green/amber scored 12 out of 14 with only quite small and easily achievable improvements needed to move to a 100% rating. This contrasts strongly with the centre rated red which met only 6 of the 13 areas tested and where the required improvements would be extensive, and considered by the national panel not to be realistically achievable. Indeed it is this - our assessment of whether it is realistic to expect the providers rated amber/red to be able to meet those requirements where they fall short - that separates them from those providers rated amber (rather than a simple assessment of how many of the requirements are met).

The national panel's assessment confirmed that two elements of the April 2016 standards present a particular challenge and this was reflected in the assessments of those centres rated red and amber/red:

3.1.1 Minimum volumes of surgical / interventional activity for individual consultants and the minimum size of a surgical or interventional team.

During the process to develop the standards, surgeons told us that the number of operations they each carried out was the most important factor in achieving good surgical outcomes. Bigger teams are more resilient and better able to support the development of subspecialty practice. The standards require that each surgeon undertakes a minimum of 125 operations per year. This is a minimum threshold rather than a target. They also require that from April 2016 surgeons are part of a team of at least three, and from April 2021 part of a team of at least four. Although some centres significantly exceed the minimum required activity to support the required surgical teams, the national panel found that others (Manchester, Newcastle and Leicester) had not demonstrated that they met the minimum requirement:

- Manchester has fewer than 100 operations annually undertaken by a single surgeon, with interventional cardiology provided on a sessional basis. Appropriate 24/7 surgical or interventional cover is not provided. The national panel considered this to be a risk, and rated the centre red.
- Newcastle reported insufficient activity for three surgeons in 2014-2015. At the time of the national panel's assessment, Newcastle predicted that it would not perform 375 operations annually until 2016 - 2017. The national panel noted that the full standard (effective from 2021) requires a team of four surgeons rather than three, and considered that there was no realistic prospect of this being achieved during this period. Newcastle's response to the fact check indicated that activity in 2015 - 2016 had been higher than expected and had taken its activity to a level sufficient to support a three surgeon team. This is provisional data (as it is not yet validated by NICOR) but if confirmed, and sustained beyond one year, and if the activity was distributed appropriately between three surgeons, would meet the April 2016 requirement.
- Leicester reported insufficient activity for three surgeons in 2014-2015 and 2015-16. Leicester's response to the fact check indicated an expectation that the April 2016 requirement would be met over the three year period 2016-2019 and that it considered it was on target to achieve it in 2016-2017, though no additional data was supplied. Although Leicester described plans to increase activity, the national panel considered that this did not provide sufficient assurance to be confident that the requirements would be met during the next 12 months. The national panel noted that the full standard (effective

from 2021) requires a team of four surgeons rather than three, and considered that there was no realistic prospect of sufficient activity to support this requirement being achieved during this period.

While activity is expected to rise overall across the country, and repatriation of interventional activity from non-specialist centres will provide modest help, this will not resolve the problem that there is not enough activity nationally to support the number of centres now delivering the service.

3.1.2 Availability of advice, care and support from interdependent clinical services

The standards require that a range of other specialists needed by children with CHD must be able to deliver care at the patient's bedside at any time of day, seven days a week and 365 days a year. This is because many children with CHD have multiple medical needs. Co-location of specialised paediatric services is also considered important because it allows much closer working relationships to develop between paediatric cardiology specialists and the wider specialised paediatrics team. For hospitals where all of these services are not provided on the same site, this is more challenging:

- Leicester delivers care for children from a mainly adult hospital and the national panel found that assurance of 24/7 bedside care from a full range of paediatric specialists was lacking. Leicester's response to the fact check indicated an expectation that for a number of these the April 2016 requirement would be met by April 2017. The national panel noted that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time. Leicester does not currently meet these requirements and the national panel considered that it would not realistically be able to do so by 2019.
- Royal Brompton delivers care for children from a mainly adult hospital. While the national panel found that assurance of 24/7 bedside care from a full range of paediatric specialists was lacking, Royal Brompton submitted additional evidence in response to the fact check which provided this assurance. However, the national panel noted that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time. Royal Brompton does not currently meet these requirements and the national panel considered that it would not realistically be able to do so by 2019.
- Newcastle provided evidence to show that it is able to meet the April 2016 requirements. The national panel noted, however, that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time, and that the current arrangements at Newcastle would not meet these requirements.

3.2 Other issues

Care by CHD specialists

The standards require that surgery and interventional practice for CHD patients must only be undertaken by CHD specialists. Some level 1 centres told us in their submissions that this is not always the case, and doctors who are not recognised specialists in the care of CHD are sometimes involved. Some of the centres argue that this represents a legitimate approach because of their specialist skills. This needs to be urgently addressed with those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

Surgical and interventional practice

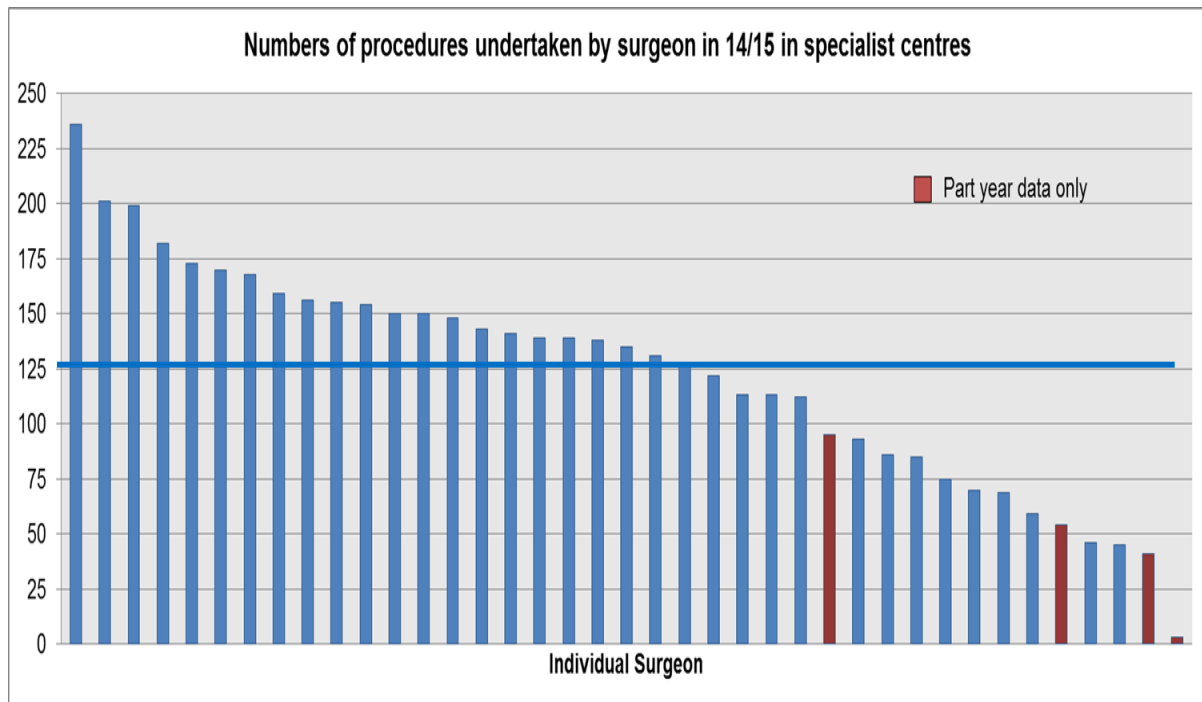
From the data supplied by the level 1 centres (figure 1 below) we can see that there are some surgeons whose activity levels fall below, and in some cases well below stated requirements. This is not just an issue for centres with low activity levels. It also occurs when centres have chosen to have too many practitioners or not to distribute activity in a way that achieves compliance with the standards. This needs to be urgently addressed by those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

Sometimes low activity was seen because of a change of staff, for example a cross-over between a retiring surgeon and their replacement. This is not considered a problem.

Taking the requirements for individual surgeon activity and for team size together, the implication of this is that in order to meet the standards each surgical centre will need a case load of at least 500 operations annually as a minimum. The Clinical Reference Group has previously advised that more than 500 cases would be needed at each centre because it would be operationally challenging to ensure that all surgeons reached the minimum activity required and every patient received their care from an appropriate surgeon if the unit's total activity was exactly 500 or only slightly above.

The evidence supplied shows that it is quite possible for surgeons to undertake 200 or more operations annually, emphasising the point that 125 operations per year is a minimum not a maximum. This is important in considering the efficient use of scarce resources as well as for consistency of outcome.

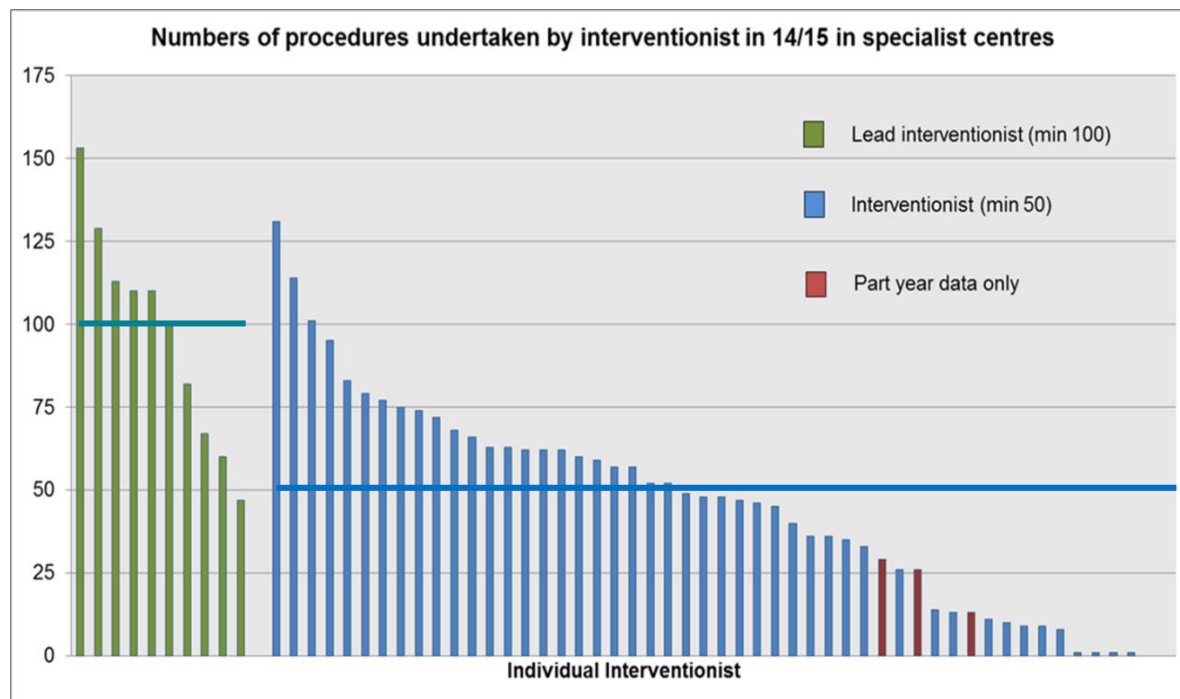
Figure 1: Number of procedures undertaken by individual surgeons in level 1 specialist surgical centres (2014-15)



From the data supplied by the level 1 centres¹ (see figure 2 below) we can see that these challenges are even more pronounced for interventional cardiology practice. There are many interventionists whose activity levels fall below, and in some cases well below, our requirement that lead interventionists undertake at least 100 procedures and other interventionists at least 50 procedures. As with surgery this results from a combination of factors including centres with too little activity, centres with too many practitioners and from poor distribution of activity within a centre. This needs to be urgently addressed by the centres concerned and NHS England regional commissioners will follow this up directly with the providers concerned.

¹ The individual interventionist activity numbers used here are those reported by each centre. Comparison with NICOR data shows that some of these include procedures which cannot be counted towards the volume required by the standards. While it is not possible from the data available to produce an absolutely definitive view of the number of procedures undertaken by each interventionist, whichever data source is used we see that a significant number of interventionists do not meet the minimum activity levels required by the standards. This is addressed in more detail in the individual centre reports.

Figure 2: Number of procedures undertaken by individual interventional cardiologists in level 1 specialist surgical centres (2014-15)



Ensuring there is 24/7 care and advice

The standards include adult care as well as children's services in order to ensure that excellent care is delivered to all age groups. Information from a number of centres showed that 24/7 care – both on-call and seven day working – is less robust for adult patients than for children. This needs to be addressed by those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

The evidence supplied revealed that in a number of centres clinicians are on more than one duty rota at the same time. The national panel considered that while there could be circumstances when it would be acceptable for a clinician to be on more than one rota, this was not always the case. The key test was the likelihood that being on one rota would prevent the clinician from discharging their duties on the other rota. The national panel had particular concerns about out of hours arrangements that would require a member of staff with responsibilities for patient care on one site to leave that site to attend a CHD patient on a different site. The national panel considered that where these arrangements involved more than one organisation this added to the risk that duty doctors could be faced with conflicting priorities.

While all centres described arrangements to provide advice 24/7 to patients, families and other health professionals, only some described clearly how they made sure staff knew how to handle requests for information and advice. Similarly only some centres had systems in place that ensured those seeking advice (patients, their families and other health professionals) knew how to obtain it.

An age appropriate environment

Around 80% of procedures (surgery and interventional) are undertaken in children so it is important to provide their care in an age appropriate environment where paediatric CHD care is delivered alongside other paediatric services – on the same site and with the ability to meet challenging response times. The evidence supplied showed that this is challenging for providers that deliver paediatric CHD care from specialist hospitals mainly focussed on adult services.

Many centres also found it challenging to articulate how they provided an appropriate care environment for patients with physical and/or learning disability, suggesting that this is an area where sharing best practice could be helpful.

Governance and improvement

The development of formal network governance arrangements and oversight of level 2 centres undertaking interventional cardiology in adults with CHD is a new requirement and progress so far is patchy. There is more to do for providers in establishing these arrangements and for NHS England in establishing which centres will continue to practise at level 2.

Many centres were able to describe clinical governance, audit and improvement activities though evidence of learning and action resulting from this activity was sometimes not available. As networks develop we expect this area to improve as the standards require networks to develop a robust and documented clinical governance framework that includes clinical audit; regular network meetings to discuss patient pathways, guidelines and protocols, mortality, morbidity and adverse incidents.

4 Level 2 centres and occasional practice

The standards do not permit occasional and isolated practice (small volumes of surgery and interventional cardiology being undertaken in institutions that do not offer sufficient specialist expertise in this field). Occasional and isolated practice has been of particular concern to patients and their representatives.

Our analysis showed that surgery and interventional cardiology procedures in CHD patients may have been happening at a number of non-specialist centres. The standards only permit this to continue in very specific circumstances². Most non-specialist centres were not expected to wish to meet these requirements.

We asked all these centres to confirm whether CHD procedures had taken place and if they had, either to cease occasional practice or to take steps to meet the requirements of the standards, including minimum volume requirements. Most providers confirmed that the apparent occasional practice revealed by analysis of HES data was due to coding errors. In other cases, the practice had already stopped or steps were being taken to move this activity to an appropriate level 1 or level 2 centre.

The issue has not yet been resolved at a number of providers, either because no response has been received or because an application to work as a level 2 Adult

² Closure of atrial septal defects (ASDs) by interventional cardiology at level 2 ACHD centres can continue providing individual operators meet minimum volume requirements and the centre meets all the level 2 ACHD standards.

CHD centre is unlikely to be agreed. These will be followed up by NHS England regional commissioners to ensure that occasional and isolated practice is eliminated.

Some centres confirmed that they wished to be considered as level 2 (specialist adult CHD medical centres). Centres wishing to work in this way were assessed at the same time as the level 1 centres against the corresponding standards.

The detailed assessment of each centre, based on the evidence submitted, and after the fact check process described above had taken place, is summarised here.

	Green	Green / Amber	Amber	Amber / Red	Red
	Meets all the requirements as of April 2016.	Meets most of the requirements as of April 2016 and has good plans to meet the rest within max. 12 months.	Should be able to meet the April 2016 requirements with further development of their plans.	Does not meet all the April 2016 requirements and is unlikely to be able to do so.	Current arrangements are a risk.
North			Liverpool Heart & Chest		Blackpool; South Manchester
Midlands and East	Norwich & Norfolk*			Nottingham	Papworth
London					Imperial
South		Brighton	Oxford		

* Norwich & Norfolk was assessed as a medical only centre – it does not offer interventional ASD closures

NHS England's regional commissioners will discuss the arrangements at those providers assigned an amber/red or red rating with a view to ensuring that in future patients requiring ASD closure receive their care from an appropriate provider.

5 What happens next?

The issues we are grappling with are complex, but as commissioners we intend to see them through with a view to securing the best outcomes for all patients, tackling service variations and improving patient experience. That includes ensuring that all hospitals providing CHD care are able to meet the standards, or get as close as possible to them with satisfactory safeguards in place.

When we launched this assessment process with providers in December 2015 we advised them about how we intended to respond to the findings:

'...the outcome of the assessment may be one of the following:

- *NHS England continues to contract with a provider without conditions;*
- *NHS England will contract with a provider on the basis of a ‘derogation’ from the service specification (a time-limited agreement that providers can operate outside of the service specification, with an action plan to achieve compliance);*
- *If a provider does not meet the specification and is unlikely to be able to do so, we would need to discuss future service provision.’*

This report was considered by the Specialised Services Commissioning Committee (SSCC), a sub-committee of the NHS England Board, at the end of June. SSCC has recognised that the status quo cannot continue and that we need to ensure that patients, wherever they live in the country, have access to safe, stable, high quality services. SSCC also recognised that achieving this within the current arrangement of services would be problematic.

SSCC has determined that subject to appropriate public involvement and/or consultation, a change in service provision is appropriate and we expect that any such changes will be part of a managed process and that continuity of care for patients will be a high priority.

While the ability to meet the standards is an extremely important consideration as we seek to ensure that all patients benefit from the same high quality of care, it is not the only consideration. The NHS England board recognised this when it agreed the standards in summer 2015, setting out an intention to take into account and balance all the main factors, including: affordability; impact on other services; access; and patient choice; and not to treat the standards as though they existed in isolation.

Heart transplant services were not covered by the CHD standards as they have their own separate service specification. The national panel considered that the potential impact of any changes to CHD services on paediatric heart transplant and bridge to transplant services (which are only delivered by two providers - Newcastle and Great Ormond Street) would need careful consideration. In addition, adult CHD patients with end stage heart failure have limited access to heart transplant. The unit in Newcastle is recognised as delivering more care to this group than other adult heart transplant centres nationally.

For those providers where our assessment has shown that improvements are needed, we expect that agreed development plans and mitigations will become contractually binding by incorporation in provider Service Delivery Improvement Plans (SDIPs). NHS England regional service specialists will set out clearly the evidence required from providers to demonstrate that individual milestones of the agreed action plan have been met, and will meet with providers regularly to monitor progress, at least quarterly.

6 Ongoing approach to assuring standards compliance

We have a comprehensive process for ensuring that providers will meet all of the standards:

- CHD networks will be established with a specific focus on quality and improvement both operational (for example through the network MDT for rare, complex and

innovative procedures) and developmental (through network audit and improvement activities and clinical governance meetings). Patients and families will have an important role in the operation of the new CHD networks.

- Where providers need more support to achieve the standards we will facilitate arrangements to give access to support and advice from other providers. Where appropriate commissioners will provide project support.
- Our work with the CRG on the clinical dashboard and with NICOR on the national audit, and the new patient reported outcome measurement (PREM) tool we have commissioned will make available a much broader range of information about services to guide improvement activities and performance management.
- Regional commissioners will work through STPs and CCOGs to ensure that level 3 services are appropriately commissioned and play a full part in networks.

Meanwhile we are continuing to deliver a very active programme of work to support the implementation of the standards, including a new implementation group. This new group brings together clinicians from across the service with an interest in CHD, service and network managers, patients and their representatives and commissioners to work together on the challenges of meeting the whole span of standards, and to share best practice.

Questions and Answers

The decision making process

Who are the members of the Panel making your decision?

The members of the panel that carried out the assessment are listed below.

Their role was to assess each hospital's ability to meet the standards, based on the evidence submitted by the Trust. They were not responsible for deciding what action to take as a result of that assessment. At this stage, no final decisions have been taken by NHS England. Final decisions will be taken by the NHS England Board after appropriate engagement, up to and including public consultation.

Panel Chair

- Will Huxter, Programme SRO, NHS England

Patient and Public

- Michael Cumper, Nominated CRG PPE representative
- Suzie Hutchinson, Nominated CRG PPE representative

Clinical

- Professor Deirdre Kelly, Chair, Clinician Engagement and Advisory Group
- Dr Jackie Cornish, Women and Children POC Board
- Dr Trevor Richens, Chair, Congenital Heart Services CRG

National Commissioning / Programme (NHS England)

- Anthony Prudhoe, Accountable Commissioner
- Ben Parker, CHD Programme Team
- Cathy Edwards, Operational Delivery Director (National), Specialised Commissioning
- Michael Wilson, Programme Director
- Richard McMahon, Quality Surveillance Team
- Teresa Fenech, Director Of Nursing for Specialised Commissioning

Regional Commissioning (NHS England)

- Dr Alison Rylands, Regional Clinical Director for Specialised Commissioning (N)
- Catherine O'Connell, Regional Director Specialised Commissioning (Mid and E)
- Hazel Fisher, AD Programme of Care & NW London Locality Lead
- Dr Vaughan Lewis, Regional Clinical Director for Specialised Commissioning, (S)

In your assessments why are outcomes not the decisive factor?

Only a single measure of outcome is currently available – 30 day post-procedure mortality. We heard from parents that they are looking for more than just survival now. They want to know about the quality of life their children can look forward to and the quality of care they will receive. We do not consider it sufficient to rely solely on a retrospective measure of a single outcome to provide assurance of every aspect of the quality and safety of a service. We have therefore set out a comprehensive range of standards to create a service that can deliver the outcomes throughout life that these patients deserve. While it may be possible to achieve good outcomes without meeting all of these standards, centres that meet the standards are the ones where we as commissioners, acting on behalf of patients, have the greatest assurance that good outcomes will be consistently achieved. We are also ensuring that in future a much wider range of outputs and outcomes are measured and we would be happy to supply further information about our work in this area if required.

How quickly will these changes happen? I'm worried about whether my booked appointment / surgery will go ahead.

We want to reassure patients and families that things are not going to change overnight.

Any change to services in the future will be managed carefully, and will be carried out in partnership with current service providers, and with patient groups and advocates. We will keep you informed every step of the way.

If the proposals are accepted, does this mean units are going to close?

Whether or not the proposals are carried out will be subject to the outcome of public consultation, which will begin later this year. If accepted, it would mean those hospitals no longer provide level 1 CHD services – the most specialist services including surgery and most interventional cardiology. However, if it is decided to implement this proposal, this would not necessarily mean the end of congenital heart disease services at the affected hospitals.

NHS England is keen to work with management and clinicians to explore whether it would be possible to continue to provide level 2 medical CHD services – the majority of specialist medical care. That would mean that CHD patients could still receive their ongoing care and more minor interventions at those hospitals. Patients would then need to travel elsewhere only for the most specialist care, including surgery

Why is there a requirement for children's cardiac services to be provided in a place where other specialist children's services are also provided?

The standards were set following a country wide comprehensive consultation and they follow the advice we received from doctors, nurses, patients and their families. The standards require other children's services to be in the same place as congenital heart services because they are the services that doctors told us are most likely to be needed by the bedside when a child is critically ill, as many children with CHD will have conditions that affect systems and organs other than the heart. This is especially important for the sickest children. The close working relationship between different specialties that develops when they work side by side on a daily basis is particularly important.

Why is it so important that a surgeon does 125 operations?

The standards were set following a country wide comprehensive consultation and they follow the advice we received from doctors, nurses, patients and their families. The standards require consultant surgeon to undertake at least 125 operations a year because congenital heart disease surgeons told us that this was the most important standard in terms of assuring excellent outcomes, and that the number of 125 is a minimum, not an aspiration. We know this is realistic because the evidence supplied by hospitals during the self-assessment exercise shows that some surgeons are already doing many more than 125 operations, which, after all, only equates to three operations per week. 125 surgeries means that surgeons maintain their skills across a range of procedures, which is particularly important in a specialty with a large number of different procedures, and when surgeons are on call.

Commonly asked questions and answers about the implementation of the CHD Standards are set out below – this page will be updated as the programme develops and to reflect additional questions raised by the public and stakeholders.

What is the aim of all this? Outcomes are good so why are you making changes?

Congenital heart disease services in England are very good – they have surgical outcomes comparable with best in the world. Hospitals where we intend to transfer services from have not failed. They and the staff within them deserve great credit for their work – they are rightly proud of their hospitals, and we understand that change is not always easy.

This is about ensuring high quality, consistency and sustainability for the future through common standards. These standards were agreed by clinicians, other

experts and patient and public voice representatives as being the best way to make sure every patient can benefit from the same excellent care.

What is the over-riding concern?

There has been a history of reviews into congenital heart disease services, each making recommendations; but without a national programme of systematic implementation, this has created uncertainty within the speciality, which has damaged relationships between centres, harmed recruitment and retention, and reduced the resilience of services.

It is important now that by implementing the standards we bring that uncertainty to an end and give the service the stability it needs to be able to provide excellent services to patients with CHD and the resilience to be able to plan for the future.

Have you spoken to patient groups and parents about what is going to happen now?

All our patient and public stakeholders have been informed about the proposals we have announced. We have an on-going programme of communication and engagement with patient groups, working with over 30 organisations on a regular basis. They have been involved over the past 2 years creating the standards and ensuring the patients they represent have had opportunity to contribute to the standards creation and the consultation on standards. We will continue to work with patients, their families and patient organisations, and where change is proposed, we will make sure that patients have an opportunity to have their say on them.

Do you actually think that services are unsafe now, but you don't want to panic people?

We know from the data that we receive that services are safe, but we do believe that care can be improved, which is why the standards and their implementation is important. Any changes proposed to a service will be made safely and any changeover is carefully managed with patients.

Are the numbers of people with CHD going up?

Our estimates show that the number of CHD patients using services is going up and this is due to a number of reasons:

- The population is increasing and therefore the number with CHD is increasing
- The number of people living longer with CHD is increasing

Our ability to treat people with CHD is improving and therefore the number of procedures we are doing is rising.

Are we just talking about children’s CHD services or adults as well?

The new CHD standards apply to the entire lifetime of patients with CHD, encompassing maternity and antenatal care, neonatal, childhood, transition between children’s and adult services, adult services and end of life care.

Are the standards the same as the ones used in the Safe and Sustainable review?

Some of the standards that were developed for safe and sustainable were agreed to be very good, so they were kept and built upon. We heard from clinicians and patients and families that there were areas that needed to be covered that hadn’t been. So we developed standards that covered adult care and areas such as communication, end of life care and dental.

What makes you think that the approach you are adopting this time around will work? Isn’t it the same as Safe and Sustainable?

We heard from stakeholders that rather than looking at units and locations we should start with standards. A great deal of work has gone into achieving consensus across the board – clinicians, patients and families, providers and other stakeholders – on the standards that providers should meet to ensure that services are high quality and consistent, now and into the future. This process is now about applying those standards to our decision as commissioners of specialised care, based on Trusts’ own assessments of whether or not they do and can meet them.

We are clear that these decisions remain subject to the outcome of service change processes in relation to each of the proposed changes. This will include further local public engagement – in each case the process will be appropriate for the scale of the change proposed, up to and including full public consultation.

What is the timetable for this?

We will aim to have improvement plans agreed with Trusts very quickly, and where substantial changes to services are proposed, run a full public consultation so that people can have their say. We currently expect that this will start in the autumn, allowing us to make a final decision in late spring / early summer of next year.

Are there any cost implications to this?

All the standards have been developed to be able to be delivered within the current tariff.

What is the difference between level 1 and level 2?

The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:

Specialist Surgical Centres (level 1): These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology.

Specialist Cardiology Centres (level 2): These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.

Local Cardiology Centres (level 3): Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.

Will these changes affect care for heart attacks and strokes at these hospitals?

Our proposals for change are for children's cardiac and adult congenital heart services only.

Next steps to meeting new national standards – Will Huxter

13 September 2016 - 16:24

Welcome to my latest blog about the CHD implementation programme.

I will be using this blog to keep everyone up-to-date with activities during the pre-consultation and consultation period on our proposals for meeting the national standards on CHD, so if you want to receive a blog alert email england.congenitalheart@nhs.net

There has been much written about the proposals that we have made for CHD services and we thought it would be helpful to be clear on some of the facts.

First, no final decisions on CHD services have been made. Rather, following an assessment of current services based on information provided by current providers, NHS England has made a series of proposals about how services should be offered in the future. Final decisions on surgical services will not be made until we have carried out full public consultation.

We are now working with providers and stakeholders to explain and discuss our proposals, and to listen to concerns. This will help us to plan the consultation which we expect to launch later this year.

We expect the NHS England Board to make its decisions, following public consultation, in the first half of next year. But even when decisions have been made, services for patients will not change overnight. If the decision is to make changes like the ones proposed, it will be a steady and carefully planned transition of care and the CHD clinicians that you know will work to ensure care is transferred well. If you have any concerns about this please speak to your cardiologist.

While we are in the pre consultation phase we are responding to invitations from local authority Health and Wellbeing boards and Overview and Scrutiny committees, where we can talk through the proposals and answer any questions and we will continue to do this wherever we are able to. We are also planning to visit hospitals to discuss proposals with teams at the units.

We have updated the [questions and answers page](#) with questions that we have been asked and will continue to add questions and answers. One question we have been asked several times is who was on the panel that carried out the assessment. You can find that answer on our Q&A page, but in brief the assessments were made by a panel of made up of clinicians and patient representatives drawn from the Clinical Reference Group and the Programme of Care Board and commissioners drawn from NHS England's regional and national teams. Professor Kelly, the long serving chair of our clinicians' group was also part of the panel. I chaired it, in my role as the programme's SRO. See the [full list of who was on the panel](#).

The [reports of NHS England's assessment of each CHD centre](#) (both level 1 and level 2) are now also available. These reports give the national panel's assessment of the evidence provided by the units for each

of the requirements examined, which reflect 24 paediatric standards and the matching adult standards. These final reports take into account the comments from each provider organisation on the factual accuracy of its assessment, and so differ from the initial reports shared with providers earlier in the process. Each report details whether the evidence provided shows that the requirement has been met, and then sets out what that provider needs to do to meet those standards that have not yet been met. Each unit is also given a summary rating. An overview of the assessment process, the findings and the ratings for every unit are described in the [overview report of the national panel](#).

We want to reassure patients that published outcomes from all our current providers show that they are safe, but we believe that care can be improved and risks further reduced by ensuring that patients receive their care only from centres that meet the standards. Any changes made to any service will be made safely, and will be carefully managed with patients.

We are also planning for our next CHD Implementation workshop for the clinical and patient & public representatives who have been working on implementing the standards, which will be focusing on transition to adult services, psychological support, engaging young people and how we share best practice.