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Leicestershire
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Rutland
County Council

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

DATE: TUESDAY, 14 MARCH 2017

TIME: 2:00 pm

**PLACE: Meeting Rooms G.01 and G.02, 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 R Camamile CC

Mrs J A Dickinson CC

Dr R K A Feltham CC

Mr J Kaufman CC

Mrs B Newton CC

Mr T J Pendleton CC

Rutland County Council

Councillor G Conde

Councillor Miss G Waller

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

For Monitoring Officer

Officer contacts:

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

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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

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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.

3. MINUTES OF PREVIOUS MEETING

**Appendix A
(Pages 1 - 12)**

The minutes of the meeting held on 14 December 2016 are attached and the Committee is asked to confirm them as a correct record.

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 (Pages 13 - 282)**

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.

NHS England launched a national consultation on its proposals for the future commissioning of Congenital Heart Disease services on 9 February 2017. This consultation will run until Monday 5 June, closing at 23.59. Extra time has been added to the usual 12 week consultation period to allow those involved in local government elections to have a full opportunity to contribute to the consultation.

The "Proposals to Implement Standards for Congenital Heart Disease Services for Children and Adults in England - Consultation Document" is attached at **Appendix B1 – Page 13**.

This Joint Committee is the appropriate body to be consulted by NHS England on the proposals in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The regulation provides that where the appropriate person (NHS England) has any proposals for a substantial development or variation of a health service in an area they must consult the local authority. Where the consultation affects more than one local authority in an area, the local authorities are required to appoint a Joint Committee to comment upon the proposal and to require a member or employee of the responsible person to attend its meeting and respond to questions in connection with the consultation.

The Regulation does not prevent constituent Councils of the Joint Committee considering the issues separately; but it is the responsibility of the Joint Committee to formally respond to the consultation process.

The Regulations also provide that a Council may refer a proposal to the Secretary of State where:-

- it not satisfied that the consultation has been adequate in relation to content or time;
- it is not satisfied with the reasons given for the change in services; or
- it is not satisfied that that the proposal would be in the interests of the health service in its area.

This referral must be made by the full Council unless the Council has delegated the function to a Committee of the Council. Currently, only the City Council had delegated the powers to refer the NHS proposals to the Secretary of State.

Leicestershire County Council and Rutland County Council would need to approve any referral at their respective Council meetings.

Supporting Information

The following supporting information is supplied to assist the Joint Committee to comment upon the proposals in the Consultation Document.

- a) Minutes of the Meeting of the Joint Committee held on 29 September 2016 when the Joint Committee considered the proposals in the pre-consultation engagement stage. **Appendix B2 (Page 73)**
- b) Letter from Will Huxter responding to issues raised by the Joint Committee on 29 September 2017. **Appendix B3 (Page 85)**
- c) Proposals to implement standards for Congenital Heart Disease Services for Children and Adults in England - Consultation Summary. **Appendix B4 (Page 89)**
- d) Congenital Heart Disease Equality and Health Inequalities Analysis – Draft for consultation. **Appendix B5 (Page 107)**
- d) Congenital Heart Disease Provider Impact Assessment: National Panel Report. **Appendix B6 (Page 155)**
- e) NHS England Congenital Heart Disease Provider Impact Assessment. **Appendix B7 (Page 245)**
- g) Congenital Heart Disease Consultation – Events List. **Appendix B8 (Page 281)**

NHS England will be represented at the meeting by Will Huxter, Regional Director of Specialised Commissioning, London Senior Responsible Officer CHD Commissioning & Implementation Programme, NHS England and Dr Geraldine Linehan, Regional Clinical Director (Midlands & East) Specialised Commissioning, NHS England.

7. **UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST'S (UHL) VIEW ON NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES** **Appendix C (Pages 283 - 296)**

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

8. **OTHER VIEWPOINTS ON NHS ENGLAND'S PROPOSALS** **Appendix D (Pages 297 - 302)**

The following gives further information and viewpoints on NHS England's

proposals and is submitted for the Committee to consider:-

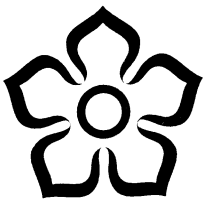
The East Midlands Councils General Meeting considered a report at its meeting on 15 February 2017. The report also summarised the activities of the health overview and scrutiny committees in the region since July 2016.

The recommendations were approved and it was also agreed that unless plans were already in place, that all health scrutiny committees across the East Midlands should be encouraged to actively consider NHS England's proposals relating to UHL Glenfield Hospital; and that the scope and detail of this work be shared to support co-ordination of scrutiny activity and wider lobbying.

9. NEXT STEPS IN RESPONSE TO THE CONSULTATION PROCESS

The Joint Committee is asked to consider the next steps it wishes to take in response to the consultation process based upon its consideration of the previous agenda items and the responses it has received during the meeting.

10. ANY OTHER URGENT BUSINESS



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Appendix A

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

Held: WEDNESDAY, 14 DECEMBER 2016 at 2.00pm

P R E S E N T:

Councillor V Dempster – Chair of the Committee
Dr S Hill CC - Vice Chair of the Committee

Leicester City Council

Councillor T Cassidy
Councillor L Chaplin

Councillor V Cleaver
Councillor D Sangster

Leicestershire County Council

Mrs J A Dickinson CC
Dr R K A Feltham CC
Mr D Jennings CC

Mr J Kaufman CC
Mrs B Newton CC
Mr T J Pendleton CC

Rutland County Council

Councillor G Conde

Councillor G Waller

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13. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Mrs R Camamile CC Leicestershire County Council had nominated
Mr D Jennings to attend as a substitute.

Karen Chouhan and David Henson – Healthwatch Leicester

Councillor Fonseca Leicester City Council

Steven Forbes Strategic Director of Adult Social Care

Councillor M Unsworth Leicester City Council

14. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda.

Councillor Cassidy declared an Other Disclosable Interest as a Trustee of the Carlton Hayes Mental Health Charity.

Councillor Conde declared an Other Disclosable Interest as his daughter worked as Mental Health Nurse for Peterborough and Stamford NHS Trust.

Mrs B Newton CC declared an Other Disclosable Interest as her son and daughter worked in the local health service.

In accordance with the Members' Code of Conduct the interests were not considered so significant in relation to the strategic level of discussion that was likely to take place and it was, therefore, unlikely to prejudice Councillor Cassidy, Councillor Conde or Mrs Newton CC's judgement of the public interest. Councillor Cassidy, Councillor Conde or Mrs Newton CC's were not therefore required to withdraw from the meeting during consideration and discussion on the item.

15. MINUTES OF PREVIOUS MEETING

RESOLVED:

The minutes of the meeting held on 29 September 2016 be confirmed as a correct record.

16. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

17. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations, or statements of case had been received in accordance with the Council's procedures.

18. SUSTAINABILITY AND TRANSFORMATION PLAN

Toby Sanders, Senior Responsible Officer for the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP) provided an overview of the draft Sustainability and Transformation Plan that was released on 21

November 2016.

Also in attendance to answer members questions were:-

Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Tim Sacks	Chief Operating Officer, East Leicestershire and Rutland CCG
Sarah Prema,	Director of Strategy and Planning, Leicester City CCG
Mark Wightman	Director of Marketing and Communications, University Hospitals of Leicester NHS Trust
Nikki Bridge	Finance Director, Better Care Together

The Senior Responsible Officer stated that the Draft STP for Leicester, Leicestershire and Rutland (LLR) was 1 of 44 plans across the country that had been governed by national directives from NHS England and NHS Improvement, in particular. The process was designed to set out health and wellbeing outcomes for the local LLR population over the next 5 year period to address the challenges of:-

- The health and wellbeing gap in terms of health needs and outcomes over the next 5 years.
- Improving care and the quality of service provision to make sure they are of high quality and safe.
- To ensure that services are provided in a way that was affordable within the funds allocated within the NHS system.

The Plan identified the following 5 key priorities for areas which it was considered required fundamental changes over the next 5 years to address the challenges set out above:-

- a) New models of care focused on prevention and moderating demand growth.
- b) Service configuration to ensure clinical and financial sustainability.
- c) Redesign pathways to deliver improved outcomes for patients and deliver core access and quality.
- d) Operation efficiencies.
- e) Getting the enablers right.

These priorities would need to be developed with local authorities, patients and patient groups, community organisations and the voluntary sector etc. The Plan addressed proposals on how to:-

- Improve services provided for particular groups of patients currently presenting challenges in the health service, including improving the home first model supporting discharges from all hospitals to ensure patients, particularly the frail and elderly, are adequately supported at home as early and safely as possible; which leads to better outcomes for patients in re-enablement and recovery.
- Improve Urgent and Emergency Care Services to enable patients in times of crisis to have rapid access to emergency care services in appropriate settings and wherever possible in primary and

community settings in order to reduce pressures and demands on emergency acute services in hospitals and the A&E Department at the Leicester Royal Infirmary.

- Developing integrated teams of community based nursing staff, therapy staff and General Practice Teams working together to support patients, particularly those with long term conditions, to remain healthy and well and manage their own conditions for as long as possible.
- Improving existing pathways and service areas to provide improved services and better patient access and a better patient journey through the system including cancer, mental health, learning disabilities and children's services.

If services were improved and changed in the way they operate to deliver better outcomes to address some of the local safety and quality issues, then that should lead to some implications and changes to the way some services are configured across both acute and community hospital sites and how much capacity is needed in different areas in terms of staff and workforce and inpatient bed facilities. This in turn would impact upon how much physical and treatment capacity and staffing levels were needed in different areas.

The operational efficiencies outlined in the Plan included a number of support services such as:-

- reducing waiting times and delays which were not only frustrating for patients but were inefficient and wasteful in terms of staff time; diagnostic procedures and the time spent by people in in-patient beds.
- workforce efficiencies and workforce skill mix;
- shared IT records and care plans between different organisations and agencies; and
- the way in which the estate buildings were used.

As the draft moved forward next year, it would be strengthened and updated in line with the feedback from the engagement process and further details would be added. There would be some elements of the STP that would require statutory consultation; such as proposals to reduce the number of acute sites from 3 to 2, changes to the community hospital settings and changes to the maternity services configurations. Consultation would start as soon as practical. The two limiting factors upon the consultation were the availability of capital nationally, so that public expectations were not raised on proposals for changes to services that could not be delivered if the capital finance was not available, and the approval of NHS England to start the consultation process.

Following the questions and comments from Members, some of which have been amalgamated below, responses were received follows:-

- a) What would be the impact upon the STP if capital funds were not made available? Also, Members were concerned that the financial case for the STP had not been made public, and Members were being asked to comment on proposals in the STP without the financial details involved.

Response: The STP itself was not totally dependent upon capital resources but there were some elements which could not be built if the capital resources were not provided. However, there were still legacy issues around parts of the estate that would still needed to be addressed at some point regardless of the STP process. Support from Members would be welcomed in discussions and forums to secure additional capital resources.

- b) The 'Care in the Community' initiative in the 1970's had been proposed as providing better care at home for physically and mentally disabled people but became tagged as 'dumping in the community'. It would be essential to convince the public that the proposed services to be provided at home were as good as, or better than, the services provided in hospitals. Assurances would also be needed that a swift adequate level response would be available if a patient required it at weekends or in the early hours of the morning.

Response : Work was progressing in the 'home first model' to ensure that it was a sustainable model going forward. The prime determinant for developing the model was not based upon hospital bed numbers. People were now living longer and there were better health outcomes for individuals if they managed their conditions for longer at home with appropriate support. This would require the current system to be converted from a bed based system to an integrated community care system where teams worked closer with primary care to provide the care and support when needed. This would require a significant shift in current workforce practices. The STP workforce model planned to increase the workforce in primary care by approximately 10% and decrease the workforce in the secondary care workforce by 5% over the next 4 years and this would need to continue in future years.

The Director of Marketing and Communications, University Hospitals of Leicester NHS Trust, who was responsible for the communications issues associated with the STP, indicated that there were no intentions to 'sell' the STP to the public. It was crucial that the public would be made aware of the changes that the clinicians themselves felt needed to be changed. For example, the proposed reduction of acute hospital sites in UHL from 3 to 2 was not being proposed to make financial savings, but had been suggested by clinicians as they had recognised they would not be able to provide a safe and sustainable service in the future; because the specialised workforce needed for the service had been spread too thinly on 3 sites in recent years. The STP provided the opportunity to implement these changes. Also, UHL had said in a number of forums that they would not reduce the number of beds in the acute bed configuration until beds were available in the in community and home settings and were proven to be sustainable.

- c) What plans were in place to retain staff from the European Union (EU) or replace them if there were lost as a result of Brexit?

Response: It was estimated that approximately 500 EU staff were currently employed in LLR and those involved in the workforce planning elements of the

STP we conscious of the efforts needed to protect EU workers' rights to continue to work in the NHS. In addition to those employed in the NHS, there were a number of junior researchers working with universities who also played an important part in the development and delivery of health care.

- d) It was important that the public consultation should be fully accessible and provide really accessible information. It would helpful to have a document written in plain English that clearly explained what was being proposed, which services were being reconfigured and what would be the consequences. The National Guidance that had prevented early publication of the draft STP had not helped public confidence in the process. It was important that the public heard what clinicians, and not administrators, felt needed to change. It was also important that the consultation documents were not structured in such a way as to provide any pre-desired outcome in responses.

Response: Following the current engagement phase on draft plan, formal consultation would begin in early 2017 and would run for 12 weeks. Full supporting plans would be put in public domain at beginning of the consultation period. The Chief Executive of NHS England had recently written to STP local areas inviting proposals for capital investment and it was hoped that the formal announcement of the national allocations of capital for specific projects would be made soon.

It was accepted that the draft STP was technical in nature conforming to a prescribed formula and had not been produced primarily for a public audience. The public summaries produced by the communication team would be critical to the public consultation process.

- e) What would be the impact of the STP on BCT for adult social care and how would it protect social care offer in County, City and Rutland?

Response: Social care was included in the STP and it was recognised that social care was a key risk factor, especially given the recent national funding issues. The STP finances were set out in high level terms and these were constantly changing. Currently the CCGs were negotiating 2 year contracts with UHL and Leicestershire Partnership Trust and the final outcomes of these contracts would also determine future finance plans. Furthermore, UHL had been asked to reduce their current deficit at faster rate than previously required which also affected the financial planning. It was anticipated that there could be a £40m movement in the financial plan since the STP was originally devised. It was for this reason that the finance plan for the STP had not yet been made public.

- f) How can a 12.5% net reduction in bed numbers be proposed when bed numbers have increased over last 12months? What provision would there be to future proof in the event of more beds being needed?

Response: The issue surrounding the number of beds provided by hospitals was complex and more often than not the public perception was that the

number of beds was a form of NHS currency. The STP plan was a document written for the NHS and not public. Clinicians focused on clinical outcomes for patients and sometimes there are better outcomes for patients if they are not in a hospital bed. Over half of patients in geriatric wards were unable to be discharged because they were waiting for work on their homes or for appropriate care packages to be put in place. There was clinical evidence to support the view that an 80 year old patient who stayed in hospital beyond 10 days added 10 years to 'age' as they become 'deconditioned' and effectively left hospital as a 90 year old. Those involved in the care of the elderly agreed that getting people out of hospital and supported in own home was the way forward and was better for patient outcomes; however, it must be done in a safe way. The current BCF was essentially designed to keep people out of hospital for as long as possible and also to get them home as soon as possible following a hospital admission. It was not envisaged that the BCF would cease and it was reviewed regularly to enable it to support the STP strands. There was a joint process each year involving health and social care managers to identify where BCF funds should be spent in order to provide the care needed and it was envisaged this process would not change.

- g) Would the efficiencies include savings of senior managers as well? Why was there a need for 3 CCGs when the aim was to work as one health and care system?

Response: The 3 CCGs were mid-sized with 320-360,000 population. All the CCGs had worked collaboratively since their creation and would continue to do so in order to achieve more savings and to allow project management capacity. Some areas of the country were considering creating a single accountable care organisation. It was also generally accepted that previous re-organisations of the NHS had rarely improved outcomes for patients to the desired effect and the effort required to implement these re-organisations had diverted staff away from other priorities.

- h) Rutland reported that they had already had three public engagement meetings, supported by a public facing document which had been helpful to identify the issues affecting the local population. The meetings had been supported via Healthwatch and other local organisations. Rutland had social workers at both UHL and Peterborough Hospital as 50 % of the population access services in the east.

Response: The STP supported providing care as close to home as possible. 42,000 outpatients for East Leicestershire and Rutland received care at Leicester and Peterborough. There was a real opportunity in the STP to provide services closer to home which reduced the need to travel. There were sound financial reasons for patients in savings in time and travel and it also provided the opportunity for people to be seen early and appropriately locally.

- i) Given the proposals for the changes to Rutland Memorial Hospital under the reconfiguration of community hospitals, what guarantees could be provided that the finances would be found to provide the proposed extra clinics at the hospital?

Response: It was not possible to give any guarantees at this stage for the Rutland Memorial Hospital; but given the philosophy within the STP to provide those services locally there was no reason why these would not be provided. The CCG were currently in advanced talks in relation to providing these additional services and clinics.

j) What would be the impact of the STP on CHD services at Glenfield Hospital?

Response: The impact on CHD services was capital funding at this stage. The CHD Services had to be co-located at LRI because that's where the children's hospital would be and that would be funded by UHL at an approximate cost of £4m.

k) What procedures were in place to ensure that the proposals in LLR STP linked with surrounding counties CCGs STPs proposals and to consider whether there were any consequential or conflicting impacts with other areas CCGs?

Response: The STP was national process which had focused primarily on area based plans and had not included cross area conversations or integrations with neighbouring areas. All areas of LLR have links with services provided across county boundaries. CCGs were now having more active conversations on those issues since the development of the draft plans and whilst it was occurring late in the process, it was a positive step forward.

l) The STP proposals appeared to focus on adult services and not so much on children and young people's health. This was important as young people staying well can have an effect upon services demands in the future. What work was included in the STP for preventative initiatives to keep people healthy for longer.

Prevention work was considered key to reducing the demands upon hospital services especially in relation to information provided to families who could make a considerable contribution in making a difference to the levels of desperation and loneliness experienced by family members. It was important that everyone understood the pathways to GPs and nursing services to receive treatment as a measure to prevent people going to hospital.

Response: Proposals for children and prevention plans were included in the STP but the STP was not about every service. There were other children's and prevention services that were being undertaken through existing services. There were measures being taken to strengthen these existing work services, particularly on how to scale up prevention measures to provide greater benefits in the longer term.

The Director of Public Health also commented that there were challenges in providing public health prevention initiatives when faced with the current

financial pressures. There were considerable resources for health visitors and school nurses to promote prevention measures within the LLR and there were also opportunities within the STP to explore how hospital based nurses and out-reach teams could do to support prevention measures in practical terms.

The Director of Marketing and Communications, UHL, recognised the need to work more closely with public health to make every contact with patients count and to try and impart some message that would contribute to their health and wellbeing. This was not always easy to achieve when staff were often dealing with crisis situations every day.

LPT had contact with approximately a fifth of LLR population. Collectively the NHS and local authorities employed approximately 40,000 staff and this provided an enormous potential to deliver health messages and derive subsequent health benefits.

- m) Some elements of the STP needed formal consultations but who decided which elements and what were they and what opportunities existed for the for public to say we think it should be other –

Response: The elements to be consulted upon were determined by statutory guidance and regulation. Statutory consultation was required where a service ceased to be provided, where services were moved from one location to another or where the change was considered to be a significant key change as opposed to organisational management changes. Statutory consultation would be required on the proposals to reduce the number of acute sites from 3-2, the provision of in-patient beds in community wards and the future of some of those sites and the proposal for moving the maternity services to the LRI with a possible midwifery led birthing pool facility at the Leicester General Hospital.

In addition discussions with scrutiny in the engagement phase may identify other proposals to be considered to be included and also scrutiny may indicate that further clinical evidence is required for the proposals before public consultation.

- n) What was PF2 and which assets would be subject to disposal?

Response: PF2 was an acronym for Private Finance 2. The original Private Finance Initiative had been tortuous process and was not liked by the public sector. PF2 was easier to access funding from private providers on a fairer footing for the NHS. It would be necessary to sell some assets to develop other parts of the estate but no buildings had yet been identified.

- o) What was Vanguard and how did that affect services?

Response: Vanguard was a national programme over an 18month period in 2016/17 to fund vanguard projects which are leading the way and road testing new models of care in different parts of the country. Vanguard projects have included testing out new service models for care homes, green practices for working together, emergency care services and how telephone advice was

provided through NHS 111 to get clinicians advice sooner for patients. UHL had received Vanguard funds to test service models and provide more GPs in the out of hours period to giving advice which had reduced attendance at A&E and ambulance despatches.

'Alliance' was a delivery arrangement between UHL, Leicestershire Partnership Trust and commissioners to provide approximately £20m of elective work and diagnostic services. This included moving services out of acute services to other centre that have theatres and clinics so that some elective surgery can be carried out locally. Alliance was considered to be important vehicle to enable the delivery of operational service changes quickly without incurring additional procurement processes; since these services were already procured within existing services within the Alliance. The Alliance also provided clinical governance arrangements. It was envisaged that the STP would increase the money used through the Alliance to change services in the future. The advantages of the Alliance would allow UHL staff to provide services in LPT estate buildings without the need to recharge each other.

- p) As the population rose in numbers the pressures on admissions also rises and if there were reduced bed numbers at the same time this could increase the pressure to discharge patients too early or late at night. Many patients discharged early were readmitted within 48 hours and this puts an additional strain on the service. The rationale for reducing beds was understood but if the convalescent beds were not available in the community /home settings it would not help the discharge process from the acute hospital beds.

Response: Admission rates were routinely monitored to avoid patients being readmitted within a short period of being discharged. There was no pressure put on clinicians to discharge patients early and this only added to the existing pressures within the system. It was for this reason that health and social care staff were working closely together to break the cycle and ensure that adequate support was available to the patient on returning to home and that discharges were safe.

- q) What could be done to address the issue of GP recruitment and retention?

Response: Leicester University Medical School had the third highest proportion of those completing their qualifications becoming GPs. The Workforce Planning Group was looking at initiatives to address recruiting GPs to replace those retiring and also to attract other health professionals to work in the LLR area. It was recognised that many new GPs currently didn't want to go into a GP partnership and opted to become a locum or sole GP instead. There was a need to make the role of a GP more attractive to provide other work experience for them.

Members asked the STP officers to identify the significant risks to delivery that caused them the most concern if the STP was to be delivered successfully. In

response it was stated that:

- That 5 years was a phenomenally challenging period in which to deliver the massive shift of resources and services required by the STP.
- There were workforce concerns as the STP would essentially require the existing workforce to be acquire new skills and be empowered at the same to deliver new services outside of their of existing working environments and also work in an integrated way to support the cultural change
- Access to sufficient capital funding to allow the investment to achieve the efficiencies that would be required with the existing estate.
- Changing the public expectation of their use of NHS services and gaining their support for the new delivery of services.
- 75% of registered nurses would retire in the next 10 years and replacing them was a challenge.
- Managing patients with complex needs in the community would only be possible if patients that don't need that level of support do not see a GP but see a nurse or pharmacist instead. This was dependent upon the public accepting that they would not receive a worse service but would get a different service which would provide the care and treatment they required at an appropriate and safe level, and this may not always be a GP.
- The challenge of implementing significant changes alongside the existing demands of the day to day job of staff, especially for clinicians who were seeing patients daily.
- A&E was overburdened by the demands placed upon it by the frail and elderly patients due the local pathways being broken and this needed to be changed.
- Given the workforce numbers and the constrained resources there were concerns that services supporting mental health, the frail and elderly may not receive the support that was required.
- It was recognised that the STP had an ambitious plan for capital funding and investment for change.

The Chair thanked the Senior Responsible Officers and his team for attending the meeting and answering Members questions. The Chair also indicated that it was somewhat re-assuring that those leading the STP process shared the same concerns expressed by Members in delivering the proposals within the STP. The whole process was dependent upon the successful delivery of change management. Poor change management usually led to flawed implementation and staff losses. There would be a great deal of detail to unpick in the lead up to the STP implementation. The three Health and Wellbeing Boards in LLR were also looking at the STP process at the strategic level and each one was leading on different areas of the Plan to allow the breadth of changes being proposed to be discussed with the resources available to them.

The Chair suggested that the three scrutiny committees of the LLR should

mirror the approach taken by the Health and Wellbeing Boards and each scrutinise specific parts of the STP whilst recognising that this did not preclude each authority considering any part of the STP if they wished.

AGREED:

- 1) That the officers presenting the STP be thanked for their contribution to the meeting.
- 2) That whilst not precluding each authority to consider any part of the STP if they wished; each individual scrutiny committee of the LLR take the lead role to scrutinise the following areas of the STP:-

	Leicester City	Leicestershire County Council	Rutland County Council
New Models of Care	Primary Care	Integrated Teams	Community Rehabilitation
Service Reconfiguration	UHL acute hospital sites	Community Hospitals (excluding Rutland Memorial)	Rutland Memorial
Other	Mental Health Services	STP proposals of neighbouring CCGs outside the LLR area	STP proposals of neighbouring CCGs outside the LLR area

Rutland County Council representatives indicated that they were already considering the STP in the round and would continue to do so in addition to the specific areas above.

- 3) That each scrutiny committee of the LLR consider their lead areas in early 2017 with a view to sharing their views to a future meeting of the LLR Joint Health Scrutiny Committee.
- 4) That the LLR Joint Health Scrutiny Committee meet again once the formal consultation has started to prepare a formal response to the consultation process in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

19. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

20. CLOSE OF MEETING

The Chair declared the meeting closed at 4.00pm.

Proposals to implement standards for congenital heart disease services for children and adults in England - Consultation Document



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Additional Circulation List	All NHS England Employees, Directors of HR, Directors of Finance, Communications Leads
Description	NHS England is consulting on its proposals to implement national standards for congenital heart disease services for children and adults. This document sets out the background and context for our proposals; explains the proposals in more detail, including their potential impact, if implemented; and how you can get involved in consultation.
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Contact Details for further information	Michael Wilson Programme Director Congenital Heart Disease Programme NHS England Skipton House 80 London Road SE1 6LH www.engage.england.nhs.uk

Document Status

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Proposals to implement standards for congenital heart disease for children and adults in England

Consultation Document

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Foreword

In July 2016, NHS England published a set of proposals regarding the future commissioning of congenital heart disease (CHD) services for children and adults. They describe the actions which we, as commissioners, propose to take in order to ensure a consistent standard of care for CHD patients across the country, for now and for the future.

We propose to do this by implementing national service standards at every hospital that provides CHD services. The effect of our proposals, if implemented, will be that some hospitals will carry out more CHD surgery and catheter procedures, while others, which do not meet the relevant standards, will stop doing this work.

The standards describe services of the highest possible quality. They were developed by patients, and their families and carers, by surgeons and other specialist doctors and nurses, and were formally agreed by the NHS England Board in 2015. We acknowledged then that implementation of them would be a challenge for some hospitals. We also recognised that it might subsequently prove necessary to make tough choices when considering how to put them into practice.

The guiding principle for our work has always been ‘patients come first’. That principle remains at the forefront of our thinking today. It was patients, and their families/carers and representatives, as well as clinicians in the field, who told us – consistently – that the standards were only worth something if they were actually acted upon and met.

Now is the time for decisive action. We have an opportunity to future-proof CHD services, by ensuring that the standards are met. This will enable services to better cope with an increasing number of complex cases and make best use of advances in technology. We must not squander this opportunity. Equally, however, we must ensure that our commissioning decisions are informed by the views of patients and their families and carers, by clinicians and other hospital staff, and by other stakeholders.

We know that if our proposals are implemented, they will have an impact, not just on patients, but on this small number of hospitals, and some of the other services which they deliver, as well as on the staff working in them. We know that some of you are concerned about potentially longer journey times; having to travel greater distances for surgery; the availability of support and accommodation while away from home, and what might happen if there is an emergency. Thankfully, true emergencies in congenital heart disease are incredibly rare, but we recognise your concerns, and have tried to address them later in this document.

This is why we want to hear from you, during this public consultation, so that we can better understand how any changes might affect you and how we might support patients, hospitals and staff, during any future change. Before reading the rest of this consultation document, there are some important points which you might want to consider:

- No decisions about the future commissioning of CHD services have been taken. The proposals published in July were just that – proposals. If you can think of alternative ways in which the standards can be met, then we want to hear from you;
- This is not about saving money. You will already know that money is tight in the NHS, and the NHS has to live within its means. While implementing most of the standards will cost little, or nothing, we expect the overall amount of money spent on CHD care to increase in the future, driven by the growing number of patients living with this condition;
- These proposals are not about closing CHD units. We do not have a fixed number of hospitals providing CHD services in mind. This is about ensuring that every hospital providing a CHD service meets the standards. We have no view about the final number of hospitals which are able to do that;
- This is not about a short-term fix. We are focusing on the long-term resilience and sustainability of CHD services for generations to come.

Finally, we would like to acknowledge the significant time and effort which patients, parents, families, carers, and NHS staff have put into the various pieces of work which have been carried out during the past 16 years, all aimed at improving congenital heart disease services in England. We have all been at this a long time, and we recognise the cloud of uncertainty which hangs over these services as a result.

We need to put an end to this uncertainty, for everybody's sake. So, as you read this document, we hope that you will keep the future long-term stability of these important services in mind, and help us to reach a clear, and long-term, resolution, in the best interests of patients.



Will Huxter
Senior Responsible Officer for
CHD Commissioning and
Implementation Programme &
Regional Director for
Specialised Commissioning



Professor Huon Gray
National Clinical Director for Heart
Disease, NHS England & Consultant
Cardiologist, University Hospital of
Southampton

Background and context

“Sixteen years is a long time to wait. We have lost key consultant staff to posts abroad during that time, as they were not convinced that we were ever going to grasp this nettle. This is our last opportunity to make change happen. If we don’t grasp this opportunity now, we have to accept that ‘adequate’ is good enough”.

Professor Huon Gray

Consultant Cardiologist, University Hospital Southampton NHS Foundation Trust, and National Clinical Director for Heart Disease, NHS England

1. Congenital heart disease (CHD) refers to a heart condition or defect that develops in the womb, before a baby is born. There are many different forms of CHD, some more minor than others. Some people with CHD do not require any form of surgery or interventional procedure in the treatment of their condition; others require surgery before, or immediately after, birth. Thanks to advances in early diagnosis and medical advances, most babies born with CHD grow up to be adults, living full and active lives. CHD is common. It is estimated that between 5 and 9 in every 1000 babies born in the UK is born with CHD – this is around 5,500 to 6,300 babies each year. These figures will continue to increase if birth rates continue to rise, which leads to an increase in the number of operations and interventional procedures carried out on CHD patients each year.
2. Many congenital heart disease services work together in networks, so that neighbouring hospitals have good systems for referring patients, and for passing information back and forth. Networks 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.
3. Services are based around a three-tiered model of care with specialist surgical centres (Level 1) managing the most highly complex diagnostics and care, including all surgery and interventional cardiology. At the next level are specialist cardiology centres (Level 2), which provide the same level of specialist medical care as Level 1, but do not provide surgery or interventional cardiology (except for one, specific minor procedure – atrial septal defect (ASD) closures, more commonly known as ‘hole in the heart’ – at selected hospitals treating adults. These Level 2 hospitals focus on diagnosis, plus ongoing care and management of CHD. At Level 3 will be local cardiology services, which are services in local hospitals run by general paediatricians/cardiologists with a special interest in CHD. They will provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from Level 1 and 2 hospitals. These services are commissioned by local Clinical Commissioning Groups (CCGs), and not by

NHS England. We are working with CCG commissioners to address the need for a more integrated approach to care across the three tiers.

4. Anybody who is familiar with the history of these services will know that publication of NHS England's proposals in the summer of 2016 represented the latest milestone in a very long journey, stretching back 16 years, to the publication of the report of a public inquiry into concerns about the care of children receiving complex cardiac surgery at Bristol Royal Infirmary. This was followed by the Safe and Sustainable review, launched by the Department of Health, in 2008. This review set out recommendations for a CHD service based on networks; with clinical standards for all hospitals designated to provide heart surgery for children, and a reduction in the number of NHS hospitals in England providing that heart surgery. Ultimately, these recommendations were not implemented, following intervention with the Secretary of State.
5. We know, from talking to stakeholders, that the failure to implement the recommendations of previous reviews has created uncertainty for patients and staff, and concerns raised during these, and other enquiries, have remained. However, despite the fact that previous reviews have not resulted in a coordinated programme of change, progress has been made. Outcomes for CHD surgery and interventional procedures across England are good, and compare well with other countries. We also know, from talking to patients and their families and carers in particular, that the quality of CHD care delivered in hospitals is very good. We have heard many, many positive stories about individual patient experiences, and recognise that each of those personal testimonies carries real weight, and shapes how people feel about the NHS service which has cared for, or saved the life of, their loved ones.
6. When NHS England took on responsibility for the commissioning of CHD services in 2013, we were aware of the impact that previous reviews had had, as described above, and were told by patients, families, doctors and nurses alike, that the best way to deal with these issues was through the development of service standards, setting out how a good CHD service should be set up, organised and run.
7. We worked with the different groups of stakeholders for more than two years, as part of the New Congenital Heart Disease Review, to create a set of quality and service standards that covered the entire patient pathway, from diagnosis, through treatment, and on into care at home and end of life care, to make sure that every child, young person and adult with CHD, in every part of the country, would receive the same high standard of treatment.
8. Surgeons told us how many operations should be done by each surgeon every year in order to maintain the surgeons' skills. Similarly, specialist doctors and nurses told us what medical care should be available by the bedside of a patient in a critical condition. Patient representatives led the work in developing the standards covering communication, facilities and bereavement. Additionally, for the first time ever, the transition from children's

services to adult services was included in the standards, to ensure that care is truly joined up.

9. The standards have never been considered as an end in themselves. They were developed in the full expectation that their implementation at every hospital in the country providing CHD services would be the means by which our work would be delivered, i.e:
 - securing best possible outcomes for all patients – not just reducing the number of deaths, but reducing disability caused by disease, and improving people’s quality of life;
 - tackling variation, so that services are consistent in meeting standards, each of them offering 24/7 care, seven days a week, as part of a nationally resilient service;
 - improving patient experience, including provision of better information for patients, plus more consideration of access and support for families when they are away from home.

10. This review has been underpinned by principles of openness and transparency, and a need to engage as widely as possible, bringing patients, families, carers, patient representatives, and clinicians together, in the joint pursuit of an effective and equitable solution, in the interests of patients now, and in the future. Consensus across all groups was achieved on the content of the standards, and it became clear that NHS England, as the sole national commissioner of CHD services had a unique opportunity to drive service improvement, and reduce variation in access and quality, by implementing a set of nationally-agreed standards, governing a truly national service.

The case for change

11. The standards describe how to deliver CHD services of the very highest quality. We believe that implementation of these standards is the only way to ensure that patients are able to access care delivered to the same high standards, regardless of where they are treated. There is currently some variation as to where individual hospitals lie in meeting the standards, so care may vary, depending on where in England you access services.

12. We know, from talking to patients and their families/carers, that some people consider the care that they and their loved ones have experienced at a hospital to be the best there is. We do not wish to detract from that very personal experience, but it is not the same for everyone, and that simply is not fair.

13. Once all hospitals are meeting the standards, we can ensure that patients with CHD will be receiving the same levels of high quality care. For patients, and their families and carers, this means:
 - higher levels of support from specialist nurses and psychologists;

- improved communication and information, so that newly diagnosed patients have a better understanding of their condition; the care provided; treatment options; and how to take part in decisions about their own care;
- better managed transition from children's to adult services;
- improved palliative and end of life care, with specific standards focused on support for bereaved families and carers.

The above were all aspects of care which patients and patient groups told us were important, and are examples of the highest possible quality care, which we think should be available to all CHD patients, regardless of which hospital they attend.

14. For clinicians, and their teams, the broader benefits of meeting the standards will include:

- hospitals caring for people with CHD have the right staffing and skills mix, with no fewer than minimum staffing and activity levels, which support the maintenance of skills and expertise;
- improved resilience and mutual support provided by a networked model of care;
- enhanced opportunities for developing sub-specialisation;
- enhanced training and mentorship; sharing learning and skills; quality assurance and audit;
- elimination of isolated and occasional practice – this is when small volumes of surgery and interventional cardiology are undertaken in hospitals that do not offer specialist expertise in this field.

15. What we have described here are tangible benefits, things that will really make a difference to the care of patients with CHD, and to the teams caring for them. We believe that every patient receiving care for CHD should expect these highest possible standards of care, regardless of where they receive their treatment.

“From my perspective there are three main clinical advantages for having high-volume congenital cardiac surgical centres. Firstly, as an individual surgeon the more I do the better I become. There's lots of evidence for this in other surgical specialties, in particular showing that high volume centres reduce the number of post-operative complications and improving long-term quality of life. This also works for the whole team providing the care: the more the team does, the better they become, and this gives a huge opportunity for people to learn from each other in a large multidisciplinary setting.

And finally, higher surgical volumes enable specialisation in areas such as neonatal, congenital and device treatments. Importantly, these are all important for the next generation of surgeons coming up through the system - they will be less experienced when they become consultants than in the past - and they will need to fit into a large team to nurture them into becoming the surgeons of the future.”

**Mr Martin Kostolony - Head of Clinical Service - Cardiothoracic Surgery,
Great Ormond Street Hospital for Children NHS Foundation Trust**

16. Apart from the benefits achieved by meeting the standards themselves, there are some specific additional benefits associated with implementation of the standards:

1.1 Ending uncertainty

17. The long history of repeated reviews of CHD services has created uncertainty within the specialty, damaging relationships between hospitals; harming recruitment and retention of specialist staff; and reducing the resilience of services. Continued uncertainty affects recruitment and retention of congenital heart disease surgeons, a group in short supply and subject to international demand.
18. The 2014 report on CHD services at Leeds Teaching Hospitals NHS Trust¹ recommended that NHS England should act to dispel the “almost morbid sense of spectatorship and foreboding that hangs over these services”. Clear resolution is now needed to bring the stability the service needs to move forward.

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/.../leeds-review.pdf>

1.2 Ending occasional practice

We have been calling for standards for adult congenital heart disease for many years and it is excellent that this has finally been achieved. Never before have the services for adults been designated and therefore occasional practice has happened. The introduction of these standards has already mainly eliminated that occasional practice and I am confident it will be a thing of the past, providing a much safer level of care and that is what these standards are all about.

Michael Cumper, Vice President, Somerville Foundation

19. Occasional and isolated practice (small volumes of surgery and interventional cardiology undertaken in hospitals without sufficient specialist expertise) has been a big concern, particularly for charities representing adults with CHD.
20. We asked every non-specialist hospital, where the data showed CHD procedures had taken place, to either cease occasional practice or take steps to meet the requirements of the standards, including minimum volume requirements. Most of these hospitals confirmed that the apparent occasional practice 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 specialist Level 1 or Level 2 hospital. Some hospitals confirmed that they wished to be considered as specialist medical centres (Level 2), so we assessed them against the relevant standards
21. Occasional practice has largely been addressed through this process. Where the issue has not yet been resolved, it will be followed up by NHS England's regional teams.

1.3 Resilient, sustainable services

“We know that many people are very nervous about how the standards are moved forward, we must acknowledge those fears and support patients and families affected by any change but if we do not start to implement the new standards soon we will start to see a deterioration in the service.

We know that there are a growing number of children with highly complex conditions travelling through care. It is really important to make sure that there is a really strong service for them from the beginning of their lives, through their childhood and into adult services. They deserve nothing less.

Suzie Hutchinson, Chief Executive and Service Lead, Little Hearts Matter

22. Larger hospitals with bigger teams, more effectively networked with other hospitals, will be more resilient, providing an assurance of full 24-hour, seven- day care and a greater ability to cope with challenging events, for example the loss of a surgeon. We know, from talking to clinicians, that they feel best able to carry out their work when they are part of a team. Surgeons need the support of fellow surgeons, to provide cover for annual leave, and to step in when colleagues fall sick. They also need the support of an expert team around them. It is this kind of set-up that builds resilience in a service, and ensures that patients get access to the best possible care when they need it. The only way we can build this resilience is if we implement the standards.
23. The standards are – rightly – challenging, and it was acknowledged by the NHS England Board, when they were adopted, that it would be difficult for all hospitals to meet them, unless changes were made to the way in which those hospitals work. This is why the timeline for meeting some of the standards differs, as it was recognised that meeting some standards would take longer than others. For instance, the co-location of children’s CHD services with other children’s services might require physical changes to a hospital’s structure or layout.
24. Our proposals are described in detail on page 15. If they are implemented, in future, CHD services will only be provided by hospitals which already meet the standards required, or are likely to meet the standards within required timeframes as a result of the improvement plans they are putting in place.

“We fully support these standards. NHS England must ensure that the standards are applied for the benefit of patients, by ensuring that expertise is concentrated where it is most appropriate. The proposals put forward by NHS England in July 2016 should improve patient outcomes and help address variations in care currently provided”.

Royal College of Surgeons and the Society for Cardiothoracic Surgery (SCTS)

Proposals for consultation

25. At the heart of our proposals is our aim that every patient should be confident that their care is being delivered by a hospital that is able to meet the required standards. In order to achieve this, we propose that in future, NHS England will only commission CHD services from hospitals that are able to meet the standards within the required timeframes.
26. Three specific standards are relevant to our proposals:
- Surgeon working requirements – the number of surgeons at each hospital, and the number of operations they each perform.
 - o The standards require that, for 2016, surgeons work in teams with a minimum of three surgeons, and in teams of at least four surgeons by April 2021. CHD surgeons are each required to carry out no fewer than 125 congenital heart operations a year (the equivalent of about three operations a week), averaged over a three-year period;
 - Service interdependencies, or co-location – the other services CHD patients depend upon, and which need to be on the same hospital site.
 - o The standards require that specialist children’s cardiac services are only delivered in settings where a wider range of other specialist children’s services are also present on the same hospital site. The standards require that certain paediatric specialties are within a 30-minute call to bedside range for April 2016, and co-located on the same site as children’s CHD services by 2019.
 - Interventional cardiology
 - o The standards require that for 2016, interventional cardiologists work in a team of at least three, and by April 2017 in teams of at least four, with the lead interventional cardiologist carrying out a minimum of 100 procedures a year, and all interventional cardiologists doing a minimum of 50 procedures a year.

27. The proposals on which we are consulting are, therefore:

Level 1 (surgical)

Proposal:

Surgery and interventional cardiology for adults would cease at **Central Manchester University Hospitals NHS Foundation Trust**. Central Manchester does not currently undertake surgery for children.

28. The standards require surgeons to be working in teams of three by April 2016, and in teams of four by April 2021. They also require each surgeon to be carrying out a minimum of 125 operations a year. Central Manchester University Hospitals NHS Foundation Trust has only one congenital heart surgeon, carrying out fewer than 125 congenital heart operations a year.

29. Interventional cardiology for adults at Central Manchester University Hospitals NHS Foundation Trust is already performed primarily by interventional cardiologists from Alder Hey Children's Hospital NHS Foundation Trust who travel to Manchester to see patients. Under our proposals, adult patients requiring surgery or interventional cardiology, who currently receive this level of care at Central Manchester University Hospitals NHS Foundation Trust, would be most likely to go to Liverpool Heart and Chest Hospital NHS Foundation Trust for surgery and/or interventional cardiology. All other care, with the exception of surgery and interventional cardiology, would continue to be provided in Manchester.

Proposal:

Surgery and interventional cardiology for children and adults would cease at **Royal Brompton and Harefield NHS Foundation Trust**.

30. The Royal Brompton and Harefield NHS Foundation Trust currently provides surgery and interventional cardiology for children and adults from the Royal Brompton Hospital. The agreed standards require a number of other specified services for children to be co-located by April 2019 on the same hospital site as surgical and interventional cardiology for children are provided from. The Royal Brompton Hospital does not have all of those required paediatric specialties on site, and does not have firm plans to do so. (These services are currently provided to the Royal Brompton's patients by Chelsea and Westminster NHS Foundation Trust). The Royal Brompton is therefore not able to meet that standard.

31. We are continuing to explore two avenues by which the Royal Brompton could continue to provide some, or all, Level 1 services by meeting all of the required standards:
- The hospital trust is exploring ways in which the paediatric co-location standards could be met by the required deadline of April 2019;
 - NHS England has raised with the Royal Brompton Hospital the potential for it to continue to provide Level 1 adult CHD services, including surgery. This would involve the hospital partnering with another Level 1 CHD hospital in London, that meets the required standards and that cares for children and young people. To date, the Royal Brompton Hospital has indicated that it does not support this approach, but it has not said that it would refuse to treat adults alone.
32. If a solution cannot be found then, under our proposals, children and adults who would currently be most likely to undergo CHD surgery and/or interventional cardiology at Royal Brompton and Harefield NHS Foundation Trust would still be able to receive their care in London, but would be most likely to go to Great Ormond Street Hospital for Children NHS Foundation Trust, Bart's Health NHS Trust or Guy's and St Thomas' NHS Foundation Trust if they required surgery and/or interventional procedures.

Proposal:

Surgery and interventional cardiology for children and adults would cease at **University Hospitals of Leicester NHS Trust**.

33. University Hospitals of Leicester NHS Trust performed 326 surgical procedures in 2015/16 which does not meet the minimum number of cases required by the standards. The hospital trust states that it is very close to meeting the requirement for an overall caseload of 375 operations for 2016/17, and has a growth plan in place to reach an overall caseload of 500 operations by 2021. NHS England does not consider these projections to be sound, and needs to see a more robust plan to support delivery of 375 cases now, and 500 cases by 2021. As of mid-January 2017, this plan has not been provided to us by the hospital trust.
34. The CHD service in Leicester lacks the capacity to deliver a full range of services as a fully independent centre, receiving clinical support for complex cases from surgical and cardiology colleagues in Birmingham. It has also transferred cases to Great Ormond Street Hospital for Children NHS Foundation Trust, and to Newcastle Hospitals NHS Foundation Trust. At this point in time, it is difficult to see how the hospital trust will be able to build up its resilience to ensure sustainable services for the future.

35. Similarly, University Hospitals of Leicester NHS Trust is at the margins of having enough interventional cardiology activity for its proposed team of three interventionists to meet the requirements of a lead interventionist carrying out a minimum of 100 procedures a year, and all interventionists doing a minimum of 50 procedures a year. While the hospital meets the April 2016 requirements, we need to see a credible plan which supports the development of a team of four interventionists by April 2017, and the associated activity that goes with that team.
36. Glenfield Hospital, which is part of University Hospitals of Leicester NHS Trust, and which is where the CHD service is located, has access to 24/7 paediatric gastroenterology and paediatric surgery, but does not have either of these services on site. The hospital originally proposed to achieve co-location of relevant paediatric specialties with its paediatric CHD service by 2019, through plans to build a new children's hospital, bringing all children's specialist services together on one site. However, the Trust has since developed an alternative plan that would involve moving paediatric cardiac services to the Leicester Royal Infirmary by 2019. We consider that the Trust's proposal to move paediatric cardiac Level 1 services to the Infirmary site would allow it to achieve full compliance with the co-location requirements, although the Trust would need to ensure that this move is achieved by the required deadline.
37. If we do not receive assurance that the hospital trust will meet the required standards then, under our proposals, children and adults who would currently be most likely to receive surgery and/or interventional cardiology at University Hospitals of Leicester would be likely to choose to receive their care at either Birmingham Children's Hospital NHS Foundation Trust or University Hospitals Birmingham NHS Foundation Trust. Some current Leicester patients would be likely to choose to receive care from Leeds Teaching Hospitals NHS Trust, if this was closer for them than Birmingham.
38. If our proposals are implemented, University Hospitals of Leicester NHS Trust could continue to offer Level 2 specialist medical services to children and adults, and we continue to discuss this option with the hospital trust. If the hospital carried on offering Level 2 CHD services, then the vast majority of patient care would continue to be offered in Leicester, and patients would only be required to travel elsewhere if they required surgery and/or interventional catheters. We continue to discuss this option with University Hospitals of Leicester NHS Trust.
39. It is important to note that change, such as that proposed above, has already taken place in CHD services without any adverse effects on patients. In 2010, Oxford stopped providing CHD surgery following the deaths of a number of babies. The hospital trust was carrying out more than 100 cases a year up until that time. Surgery was moved to Southampton. Surgeons employed at Oxford moved elsewhere, and there was no impact on other members of staff, who were all redeployed elsewhere within the hospital trust. Oxford is now part of a formal children's network, which means that patients can choose either Southampton or a hospital in London for surgery and/or

interventional catheters, but can have all of the rest of their CHD care in Oxford. One of the knock-on effects of the change was that children requiring specialist surgery are now transferred to Southampton, whilst general children's surgery at Oxford has increased, now that it has more capacity.

40. New patients accept referral to Southampton for surgery/interventional catheters as the norm, and, while some patients would prefer that Oxford were still offering Level 1 CHD surgery, the hospital trust Board made it clear that it would not be appropriate for the hospital to continue to provide CHD surgery. We do not use the Oxford illustration in any way to detract from the concerns that you might have about our proposals, but it does demonstrate that change such as this can take place with minimal impact, if well managed.

Surgery and interventional cardiology for adults and children would continue at **Newcastle upon Tyne Hospitals NHS Foundation Trust**.

41. While we are clear that all hospitals providing CHD services must meet the national CHD standards, we have had to propose a time-limited exception, or derogation, in the case of one particular hospital. Newcastle upon Tyne Hospitals NHS Foundation Trust does not meet the 2016 activity requirement and is unlikely to be able to meet the 2021 activity requirement. It also does not meet the 2019 paediatric co-location requirements or currently have a realistic plan to do so by April 2019. The CHD service for both children and adults is located at the Freeman Hospital, which is primarily an adult acute hospital. Relevant children's specialties – paediatric surgery, nephrology and gastroenterology – are located at the Great North Children's Hospital, which is part of the same hospital trust, but is not located on the same site. While the hospital trust meets the co-location requirement for 2016, i.e. bedside access within 30 minutes, it is unlikely to meet the full co-location requirement for 2019 for children's CHD surgery to be on the same site as other children's specialist services.
42. Newcastle upon Tyne Hospitals NHS Foundation Trust has a unique, strategic position in the NHS in England in delivering care for CHD patients with advanced heart failure, including heart transplantation and bridge to transplant. Advanced heart failure amongst people with CHD is increasing as a result of increased life expectancy, and treatment for people with this condition is dependent on CHD surgeons. Adult CHD patients with end stage heart failure have limited access to heart transplantation, and the unit in Newcastle is recognised as delivering more care to this group than other transplant centres nationally. This service is intimately connected to the CHD service and can only be delivered at a hospital providing Level 1 surgical services. No other provider currently has this capability so, while in principle it would be possible to commission these services from an alternative provider, the learning curve would be long and initially outcomes would not be as good.

43. In addition, the hospital trust is one of only two providing paediatric heart transplantation for the UK (the other is Great Ormond Street Hospital for Children NHS Foundation Trust in London).
44. While Newcastle does not meet these required standards now and is unlikely to be able to do so within the required timeframe, its role as one of only two national providers of critical heart transplantation and bridge to transplant services means that we need to consider retaining services at Newcastle despite the fact that it does not meet all the standards at present and is unlikely to do so within the required timeframes. The surgeons who perform CHD operations are the same surgeons carrying out heart transplants. If CHD surgery were moved elsewhere, the transplantation service could not be replaced in the short term without a negative effect on patients. For this reason, we are proposing to retain CHD services at Newcastle upon Tyne Hospitals NHS Foundation Trust.
45. This does not mean that change at Newcastle upon Tyne Hospitals NHS Foundation Trust will not happen in the longer-term. The hospital trust is required to meet the standards in the same way as all of the other Level 1 surgical centres. Timeframes for doing this may differ, but we will be working closely with the hospital trust to ensure that patients receiving CHD care at Newcastle upon Tyne Hospitals NHS Foundation Trust are not compromised in any way.
46. If our proposals were implemented, this would mean that, in future, Level 1 CHD surgical services would be provided by the following hospitals:
- **Alder Hey Children’s Hospital NHS Foundation Trust** (children’s services) and **Liverpool Heart and Chest Hospital NHS Foundation Trust** (adult service)
 - **Birmingham Children’s Hospital NHS Foundation Trust** (children’s services) and **University Hospitals Birmingham NHS Foundation Trust** (adult service)
 - **Great Ormond Street Hospital for Children NHS Foundation Trust** (children’s services) and **Barts Health NHS Trust** (adult service)
 - **Guy’s and St Thomas’ NHS Foundation Trust** (children’s and adult services)
 - **Leeds Teaching Hospitals NHS Trust** (children’s and adult services)
 - **Newcastle upon Tyne Hospitals NHS Foundation Trust** (children’s and adult services)
 - **University Hospitals Bristol NHS Foundation Trust** (children’s and adult services)
 - **University Hospital Southampton NHS Foundation Trust** (children’s and adult services)
47. Changes are also proposed to the provision of Level 2 specialist medical CHD care. In most cases, these proposals involve very small numbers of patients who might be impacted by that change. Whilst those changes are not the subject of this formal public consultation, we are very keen to talk to patients, their families/carers, and staff at affected hospitals, to better

understand the impact of any proposed change, and to hear their views about how we might limit that impact. We will be offering opportunities for stakeholders to talk to us about our proposals in relation to Level 2 services during this consultation period, so that we can discuss how we might support them to adjust to any changes in their care. You can find out about events in your area by visiting our [Consultation Hub](#)

48. If implemented, following our engagement with stakeholders, our proposals would result in the following changes at those hospitals that completed Level 2 self-assessments:

Level 2 (specialist medical services)

Proposals:

Specialist medical care and interventional cardiology should cease at **Blackpool Teaching Hospitals NHS Foundation Trust**

Specialist medical care and interventional cardiology should cease at **Imperial College Healthcare NHS Trust**

Specialist medical care and interventional cardiology should cease at **Nottingham University Hospitals NHS Trust**

Specialist medical care and interventional cardiology should cease at **Papworth Hospital NHS Foundation Trust**

Specialist medical care and interventional cardiology should cease at **University Hospital of South Manchester NHS Foundation Trust**

49. We are continuing to work with Papworth Hospital to consider whether it may be possible for the hospital trust to meet the required standards within the timeframes. At mid-January, there was a significant shortfall in terms of meeting the standards and a robust plan to address this had not been developed. Progress is being made, however. If the hospital trust can demonstrate that it is meeting the standards, or has a robust plan to do so, then we will review our proposal that Level 2 CHD services should cease to be provided at Papworth.

50. If our proposals for the hospitals listed above are implemented, this would mean that, in future, Level 2 CHD services would be provided by the following hospitals:

- **Brighton and Sussex University Hospitals NHS Trust** (adult service)
- **Central Manchester University Hospitals NHS Foundation Trust** (children's services)

- **Norfolk & Norwich University Hospitals NHS Foundation Trust** (adult service)
- **Oxford University Hospitals NHS Foundation Trust** (children's and adult services)

51. We continue to explore the potential for the provision of Level 2 specialist medical services at Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust.

How our proposals were developed

1.4 Meeting the standards

52. The standards were agreed by NHS England's Board in July 2015, following a 12-week period of [public consultation](#). Once agreed, we started to look at how we might put the standards into practice. Patients and their families/carers, and patient representatives, told us early on that, while it was a good thing to have standards, they only really mattered if we ensured that they were met. Otherwise, they were a waste of time. That message is really important and has influenced our thinking throughout this process.

53. Initially we looked at whether the hospitals themselves, by working more closely together, could find new ways of working that would mean that the standards could be met across the country. However, this did not provide us with a solution that would give us a truly national CHD service.

54. It was decided, therefore, to look at each hospital individually, and ask them to complete a self-assessment to assess their compliance against a specific number of the standards. In deciding on which standards to focus on at this stage, we took advice from senior CHD clinicians, and from NHS England's Quality Surveillance Team, which has particular expertise in peer review. Collectively, the advice was to focus on those standards considered to be most closely and directly linked to measureable outcomes, and to effective systems for monitoring and improving quality and safety. This exercise was launched in January 2016, focusing on 14 specific requirements which covered 24 of the standards relating to children's care, as well as the corresponding adult standards.

55. The standards came into force on 1 April 2016. Each standard has an associated timeline for implementation, some of which are immediate, from April 2016, and some of which are longer. The timelines were set by NHS England's Congenital Heart Services Clinical Reference Group (CRG), which is made up of clinicians, patient representatives, commissioners and other experts, who felt that some of the changes required to meet the standards, such as the co-location of children's CHD services alongside other specialist children's services, could not be made overnight. They were also agreed by the NHS England Board in July 2015.

56. We asked each hospital whether it was able to meet the April 2016 standards. Where hospitals indicated that they could not meet that initial timescale, we set out development requirements to see them achieved by the end of the financial year (end of March 2017). These development requirements are being closely monitored via NHS contracts. We did not set out development requirements for Central Manchester University Hospitals NHS Foundation Trust, even though the hospital's assessment indicated that it was unable to meet the standards now, or in the future, as there was mutual recognition that the hospital would not be able to meet the requirements within the stated timeframe and would instead work with us to achieve any necessary changes in service delivery.
57. We considered two aspects of the standards to be of particular importance in terms of not just service quality, but for ensuring the resilience and safety of CHD services both for now, and for the future:

- Surgeon working requirements – the number of surgeons at each hospital, and the number of operations they each perform.

The standards require that, for 2016, surgeons work in teams with a minimum of three surgeons, and in teams of at least four surgeons by April 2021. CHD surgeons are each required to carry out no fewer than 125 congenital heart operations a year (the equivalent of about three operations a week); and

- Service interdependencies, or co-location – the other services CHD patients depend upon, and which need to be on the same hospital site. The standards require that specialist children's cardiac services are only delivered in settings where a wider range of other specialist children's services are also present on the same hospital site. The standards require that certain paediatric specialties are within a 30-minute call to bedside range for April 2016, and co-located on the same site as children's CHD services by 2019.

“125 really is a minimum number. It equates to three operations a week, per surgeon. Practice makes perfect, and 125 operations a year is considered the minimum to ensure that a newly appointed consultant surgeon acquires the skills they need across the differing surgical techniques. Some of the operations we do only come up once or twice a year, so ideally you would be doing at least four operations per surgeon each week, as that would result in 170-200 operations a year.

A surgeon doing too many, or too few, operations is not good. Either way can result in a poor performance when it matters, either through fatigue or a loss of skills. Individuals will, of course, vary in capability, but we must set a minimum standard in order to ensure that a surgeon has an acceptable level of skill refined and maintained through regular practice. Centres need to oversee the distribution of the work fairly, taking account of any specialist skills, to ensure that all surgeons have the opportunity to work at optimum levels.”

Professor David Anderson, Consultant Heart Surgeon and Professor of Children’s Heart Surgery, Guy’s and St Thomas’ NHS Foundation Trust, and President of the British Congenital Cardiac Association (BCCA)

58. Each set of returns from the hospitals was initially evaluated at a regional level by NHS England’s specialised commissioners, and then by a national panel, comprising patient representatives, clinicians, and commissioners, to ensure consistency of approach. The role of the regional and national panels was to assess each hospital’s ability to meet the standards, based on the evidence submitted by that hospital. A [report](#) of the panel’s work, and its assessments, was published by NHS England in July 2016.
59. In summary, the national panel found that as of May 2016, none of the hospitals providing CHD services met all of the standards tested. This was not unexpected, as the standards were aimed at ensuring that all services were brought up to the level of the best of existing practice. They were intended to be stretching, but realistic, and were focused on driving improvement.
60. The panel found that, with respect to Level 1 surgical services:
- Two hospitals – Birmingham Children’s Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust – were very close to meeting all of the requirements, with robust and credible plans to meet the rest within the required timescale, i.e. end of March 2017. They were rated green/amber;

- Seven hospitals² were likely to meet all of the requirements within the required timescale with development of their plans. They were rated amber;
- Three hospitals were unable to meet the requirements now, and were unlikely to be able to do so within the required timeframe. They were University Hospitals of Leicester NHS Trust, Newcastle Hospitals NHS Foundation Trust, and the Royal Brompton and Harefield NHS Foundation Trust. They were rated amber/red;
- One hospital – Central Manchester University Hospitals NHS Foundation Trust – was not able to meet the requirements now, and was unlikely to be able to do so within the required timeframe. 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 these arrangements to be a risk, and rated the centre red.³

61. As the national commissioner of congenital heart disease services, it was the responsibility of NHS England to consider the information provided to it by the national panel, and for deciding what action, if any, should be taken on the basis of that information.

62. The Specialised Services Commissioning Committee met at the end of June 2016, and considered the information provided to members by the national panel. The committee recognised that NHS England needed to take action to ensure that CHD patients, wherever they live in the country, have access to the same safe, stable, high quality services.

63. It was proposed that in future, NHS England would only commission CHD services from hospitals that are able to meet the full set of standards within the required timeframes (with the time-limited exception of Newcastle upon Tyne Hospitals NHS Foundation Trust, for the reasons set out in paragraphs 41- 45), and decided that, subject to appropriate public involvement and/or public consultation, a change in service provision would be appropriate. On the basis of the information received, NHS England then published its proposals on 8 July 2016.

Potential impact of implementing our proposals

64. We know, from talking to patients and their families, and carers; to clinicians and other hospital staff, and to other stakeholders, in the run-up to this consultation, that there are concerns about our proposals, and how implementation of them might affect them personally, or their jobs, or services, and the hospitals as a whole. We acknowledge that these are real

² Alder Hey, Leeds, University Hospitals Birmingham, Barts, Guy's & St Thomas', Bristol, and Southampton

³ Individual assessment reports for each of the CHD provider hospitals were published in September 2016 and can be found at <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/applying/>

concerns and we have listened carefully to all those who have spoken, or written to us during the pre-consultation period. We have tried to answer some very challenging questions as openly and honestly as we could.

65. To better understand these issues, we have undertaken a detailed impact assessment, looking at how, if our proposals are implemented, they might be delivered in practice, and to identify the consequences for patients, providers, commissioners and others.
66. All hospitals providing Level 1 and Level 2 CHD services were asked to review their services in light of NHS England's proposals. Their responses were considered first by NHS England's regional teams, and then a national panel was drawn together to review those submissions. The findings of that panel's review are summarised at Appendix B. A full impact assessment has been published alongside this document.

Pre-consultation engagement and involvement

67. Once the proposals were published, in July 2016, we entered a pre-consultation phase, which ran from July, right up until the start of formal consultation in February 2017.
68. The over-riding objective for NHS England during this period was to engage with hospitals providing CHD services – in particular, with those potentially affected by our proposals – to explore what the key issues were for them, in preventing them from meeting the standards, either for delivery in 2016, or the longer-term. Our aim throughout has been to maintain an open dialogue with the providers, so that we could work together to try and find alternative solutions to meeting the standards.

1.5 Engagement activity

69. Since July 2016, our regional and national teams have met regularly with managers and clinical teams at those hospitals currently providing CHD services and, in particular, with those whose current service will be affected if our proposals were to be implemented. As well as these more regular meetings, we also visited nine hospital trusts to talk specifically about our proposals, meeting with clinicians and managers, and touring the CHD facilities, including paediatric critical care and transplant units. Between July 2016 and January 2017 we visited:

- Royal Brompton and Harefield NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Barts Health NHS Trust
- Newcastle Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust

70. In addition to talking to the hospital clinicians and managers, we have also taken the opportunity – whenever possible – to meet with staff on the CHD units, as well as with patients, families, carers and patient representatives. We met with patients, carers and patient representatives in Leicester and Newcastle-upon-Tyne, and attended a meeting of the North West Adult Congenital Heart Disease Forum in Liverpool. We will be meeting with patients and their families/carers and representatives in London during the consultation period.
71. We have also met with MPs, particularly those whose constituencies include one of the CHD units potentially most affected by our proposals, and have provided a written briefing about our proposals to all local authorities across England, and attended Overview and Scrutiny Committees and Health and Wellbeing Boards where invited.
72. We have responded to a significant volume of correspondence relating to our proposals for CHD services during this period, assessing and re-assessing information provided by the hospitals; answering Parliamentary correspondence and Freedom of Information requests, as well as more general correspondence from stakeholders associated with the hospitals who wrote to us expressing concerns and/or asking for more information about our proposals.
73. The discussions during the pre-consultation period were dominated by the theme of how an individual hospital might achieve compliance with the standards, as well as the level of impact which our proposals – if implemented - might have on a hospital, as well as on its staff and, most importantly, its patients and their families.

Consultation

1.6 Why are we consulting?

74. We know, from talking to patients, carers, patient representatives, hospital staff, and other stakeholders, that our proposals have caused some concern in certain areas of the country. We have tried, during the pre-consultation period, to address those concerns as best we can. However, we know that many of you remain concerned about what the future might look like in terms of your care, or that of your loved ones, or where you carry out your work.
75. Consultation is not a vote on whether or not our proposals should be implemented. Instead, it provides an opportunity for us to listen to people's views about our proposals, so that we can take them into account before any commissioning decisions are made. We have set out in this document some of the areas where we think our proposals could impact, or which people have told us could be impacted e.g. travel times for patients, and other hospital services. There may be other areas that we have not thought of, or alternative ways of meeting the standards which have not yet been explored. We need to hear about those now.

76. Consultation is open to everyone, not just those who have direct experience of CHD services.
77. The consultation is being run in accordance with [Cabinet Office guidance](#)
78. While our focus is on services for patients who are resident in England, we recognise that there are children and adults living in Wales, Scotland, and Northern Ireland, who use CHD services in England. We have agreed with our colleagues in the devolved nations that they will help support our consultation in making people aware of the consultation and how they can respond to it.
79. It is important that as many people as possible, with an interest in CHD services in England, have opportunity to contribute their views about the future of these important services.

1.7 How can I make my views known?

1.7.1 How to get involved

80. During consultation, there will be a number of opportunities for you to have your say about the future commissioning arrangements for CHD services.
81. Information about the different ways in which you can have your say is available at the NHS England [Consultation Hub](#). Consultation materials are also available here. We will be running a number of face-to-face events during the consultation period, which will enable us to tell you more about our proposals and provide you with an opportunity to ask us questions. We will also support charities, patient groups, clinicians, and provider hospitals to run their own events, and can provide materials to support this activity if required. To find out where, and when, your nearest event is taking place, and how to register to attend, please visit the [Consultation Hub](#)
82. Hard copies of the consultation document and response form can be made available. If you require a hard copy, please email us at england.congenitalheart@nhs.net
83. We will also be holding a number of webinars throughout the consultation period, which will enable you to learn more about our proposals, and ask us questions, without having to travel. Details about all of the forthcoming webinars, and how to join them, are available at the [Consultation Hub](#).

1.7.2 How to let us know your views

This is an opportunity to set the standards for the next generation. It has clearly taken a long time, and a lot of discussion, to get to where we are now.

There is a real opportunity to have standards that have been nationally agreed; that have been agreed by clinicians; by providers; by patient groups; and set up services that will benefit children and adults with congenital heart defects over the coming generations.

Jon Arnold
Chief Executive, Tiny Tickers

84. Consultation will run from Thursday 9 February 2017 to Monday 5 June 2017.

85. The full list of consultation questions can be found at Appendix A. For your response to be included in the analysis of this consultation, you need to ensure that we receive your response no later than 23.59 on Monday 5 June.

86. The online response form is located at our [Consultation Hub](#). Alternatively, you can send your response (whether on a response form, or as a letter) to:

Beverley Smyth
 Specialised Commissioning, NHS England
 4N08| Quarry House| Quarry Hill | Leeds | LS2 7UE

When you are replying, please let us know whether you are replying as an individual or whether your views represent those of an organisation. If you are replying on behalf of an organisation, please make it clear who the organisation represents and, where appropriate, how the views of the members were collated.

1.8 What happens next?

87. We have asked an independent company - Participate - to collate all of the responses we receive to the consultation and to produce an analysis of what respondents have said. The analysis will be published in due course and will include information about the number, type and other characteristics of the responses, giving us a good picture of the views expressed.

88. In coming to a decision, NHS England will consider the responses to the consultation and will adjust its proposals if we consider it appropriate to do so. We will take into account and balance all the main factors, including affordability, impact on other services, access and patient choice. Our

recommendations will then be considered by the relevant committees before a final decision is taken by the NHS England Board.

Appendix A: Consultation Questions

It is important, before answering the questions in our consultation survey, for you to ensure that you have read all of the information provided about each of the individual CHD provider hospitals potentially affected by our proposals, so that you understand the potential impact of our proposals on those hospitals, and the way in which service delivery might change, should our proposals be implemented.

Meeting the standards

1. In what capacity are you responding to the consultation?

- Current CHD patient
- Parent, family member or carer of a current CHD patient
- Member of the public
- CHD patient representative organisation
- Voluntary organisation / charity
- Clinician
- NHS provider organisation
- NHS commissioner
- Industry
- Other public body
- Other

If other – please specify:

2. In which region are you based?

- Not applicable/regional/national organisation
- England - North East
- England - North West
- England - Yorkshire and The Humber
- England - East Midlands
- England - West Midlands
- England - East of England
- England - London
- England - South East
- England - South West
- Scotland
- Wales
- Northern Ireland

3. NHS England proposes that in future Congenital Heart Disease services will only be commissioned from hospitals that are able to meet the full set of standards within set timeframes. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

4. Please explain your response to question 3.

Three hospital trusts have been assessed as not able to fully meet the standards within set timeframes. NHS England therefore proposes that surgical (level 1) services are no longer commissioned from:

- **Central Manchester University Hospitals NHS Foundation Trust** (adult service)
- **Royal Brompton & Harefield NHS Foundation Trust** (services for adults and children); and
- **University Hospitals of Leicester NHS Trust** (services for adults and children).

5. Can you think of any viable actions that could be taken to support one or more of the trusts to meet the standards within the set timeframes?

Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust

If Central Manchester and Leicester no longer provide surgical (level 1) services, NHS England will seek to commission specialist medical services (level 2) from them, as long as the hospitals meet the standards for a level 2 service. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

Royal Brompton and Harefield NHS Foundation Trust

6. The Royal Brompton could meet the standards for providing surgical (level 1) services for adults by working in partnership with another hospital that provides surgical (level 1) services for children. As an alternative to decommissioning the adult services, NHS England would like to support this way of working.

To what extent do you support or oppose the proposal that the Royal Brompton provide an adult only (level 1) service?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

Newcastle upon Tyne Hospitals NHS Foundation Trust

7. NHS England is proposing to continue to commission surgical (Level 1) services from Newcastle upon Tyne Hospitals NHS Foundation Trust, whilst working with them to deliver the standards within a different timeframe. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

Travel

We know that some patients will have to travel further for the most specialised care including surgery if the proposals to cease to commission surgical (level 1) services from Central Manchester University Hospitals NHS Foundation Trust (adult service); Royal Brompton & Harefield NHS Foundation Trust (services for adults and children); and University Hospitals of Leicester NHS Trust (services for adults and children) are implemented.

8. Do you think our assessment of the impact of our proposals on patient travel is accurate?
- Yes
 - No

9. What more might be done to avoid, reduce or compensate for longer journeys where these occur?

Equalities and health inequalities

We want to make sure we understand how different people will be affected by our proposals so that CHD services are appropriate and accessible to all and meet different people's needs.

In our report, we have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

- Yes
- No

10. Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Other impacts

We want to make sure that the proposed changes, if they are implemented, happen as smoothly as possible for patients and their families/carers so it is important that we understand other impacts of our proposals.

11. Do you think our description of the other known impacts is accurate?

- Yes
- No

12. Please describe any other impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Any other comments

13. Do you have any other comments about the proposals?

About you

14. Which age group are you in?

- Under 18
- 19 – 29
- 30 – 39
- 40-49
- 50 – 59
- 60-69
- 70-79
- 80+
- Prefer not to say

15. Please indicate your gender

- Male
- Female
- Intersex
- Trans
- Non-binary
- Prefer not to say

16. Do you consider yourself to have a disability?

- Yes
- No
- Prefer not to say

17. Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.

White

- Welsh/English/Scottish/
Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White
background

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian
background

Other ethnic group

- Chinese
- Any other ethnic group

Mixed

- White and Black
Caribbean
- White and Black African
- White and Asian
- Any other mixed
background

Black or Black British

- Black - Caribbean
- Black - African
- Any other Black
background

18. Please indicate your religion or belief

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> No religion | <input type="checkbox"/> Muslim |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Sikh |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Atheist |
| <input type="checkbox"/> Hindu | <input type="checkbox"/> Any other religion |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> Rather not say |

19. Please indicate the option which best describes your sexual orientation

- Heterosexual
- Gay
- Lesbian
- Bisexual
- Prefer not to say

Appendix B: Summary of Impact Assessment

89. The following section summarises key points from the provider impact assessment, and from the equalities and health inequalities impact assessment. It also summarises the likely financial impact on NHS England if our proposals are implemented. Documents setting out this detail in full have been published alongside this consultation document.

1.9 Impact on patients

90. A particular concern for some patients and their families is that they may face longer journeys to access Level 1 CHD services which will be inconvenient, and, they fear, carry a level of risk.

91. Our clinical advisers on NHS England's Congenital Heart Services Clinical Reference Group and Clinical Advisory Panel tell us that true emergencies are very rare. Thanks to advances in antenatal diagnosis, most congenital heart defects are detected while a baby is still in the womb, which enables the mother to give birth either at, or close to, an appropriate hospital providing CHD surgery to children. Even in those cases where CHD is not detected antenatally, and problems are spotted during or after delivery, surgery will often be planned over a period of a few days. If infants need to be moved from one hospital to another for emergency care, then ambulance services, local hospitals and specialist retrieval teams are well able to ensure that patients are stabilised before and during transfer so that the risks of long journeys are negligible.

92. We understand that patients feel safer having a hospital providing CHD surgery close by, but, given the relatively small number of congenital heart disease surgeons in England, this could never be the case for all patients. By implementing the standards, we are able to ensure that patients will receive their surgery in the best possible environment to achieve a good outcome. This is a delicate balance, but we believe that it outweighs the risk of additional journey time, given that emergencies in CHD patients are so rare.

93. Under the proposed model of care different journeys would only be required when patients need to undergo surgery or an interventional or other catheter procedure, and for some admissions. The CRG has advised that the distance travelled for surgery is less important than the distances travelled regularly for ongoing care.

94. Over the course of a lifetime, a person with CHD receives most of their care in an outpatient setting. This should not be affected by the proposed changes since outpatient care can be provided at hospitals providing Level 2 services, those offering Level 3 services, and in outreach clinics. In fact most patient care, apart from admission for a procedure, the pre-admission clinic, and a single follow-up outpatient visit, can be undertaken by Level 2 hospitals.

95. Where patients require more complex diagnostic tests, for most inpatient admissions and for surgery and almost all interventional cardiology procedures, patients and their families/carers will need to travel to a Level 1

hospital. In general we expect that patients would travel to their next nearest Level 1 hospital. For some patients this would mean a similar journey, for others, a longer journey than they would have at present.

96. Our modelling suggests that the impact on average journey times for patients is relatively modest:
- An increase in the average journey time of 11 minutes for adults who use Central Manchester.
 - An increase in the average journey time of 14 minutes for children who use Leicester and 32 minutes for adults.
 - Average journey times would stay much the same for patients who use the Royal Brompton, as most patients would be likely to continue to receive their care from one of the two other Level 1 hospitals in London.
97. Some patients would of course have longer journeys. However 90% of patients who would currently use University Hospitals of Leicester will still have a journey time of less than 1 hour and 45 minutes to their nearest surgical hospital and this is similar to the national picture and shorter than in some other parts of the country (for example the South West peninsula). Similarly, 90% of patients who would currently use Central Manchester University Hospitals would have a journey time of 64 minutes or less to their nearest surgical hospital, and, of the patients who would currently use the Royal Brompton Hospital, 90% will have a journey time of 85 minutes or less to their nearest surgical hospital.
98. We do, however, recognise that it is difficult for families to support patients in hospital at some distance from home. This is a problem faced by many families already, not just in CHD services, but in many other specialist services, which tend to be provided in a smaller number of hospitals across the country. Because of this, and based on the advice of patients and families, a number of standards were developed to make life easier in this situation - providing better information about where to eat and sleep; better facilities to prepare meals; provision of Wi-Fi; ensuring parking is easily accessible and parking charges affordable; and providing overnight accommodation for parents and carers.
99. Our equalities impact assessment showed that three groups of patients would potentially be more affected by the proposed changes:
- children and young people with CHD because most surgical and interventional procedures (around 7 in 10) occur in children and young people;
 - people with CHD and learning disability (LD) because there is a higher likelihood of learning disability amongst people with CHD and people with learning disabilities and especially people with autistic spectrum disorder cope best when things are familiar, so changing settings and changing staff is more of an issue; and

- people of Asian ethnicity with CHD because people who are of Asian ethnicity have a higher incidence of CHD, and may be more likely to have more severe forms of the disease.

100. We will make available materials in different formats to assist people who are part of these groups to participate in the consultation, and will be talking directly to these groups during consultation so that we can better understand the potential impacts of our proposals and any steps we could take to minimise these.

1.10 Impact on CHD services

101. We have modelled the way in which patient flows may change if the proposals are implemented. The modelling assumes that a patient will go to their next nearest surgical hospital. There are clearly limitations to this approach which mean that the results should be treated as a guide rather than an exact representation of what will happen:

Hospital	Additional Operations	% increase
Birmingham - Children's Hospital	180	36%
University Hospitals Birmingham	45	45%
Liverpool Heart and Chest	90	N/A⁴
Leeds - General Infirmary	50	10%
Guy's and St Thomas'	200	40%
Great Ormond Street	220	31%
Barts	85	110%
Southampton	20	5%

102. Under this modelling, there would be little or no change to activity at Newcastle, Alder Hey or Bristol.

103. NHS England is working with the hospitals listed above to ensure that they would be ready and able to manage any increase in activity if the proposals are implemented. In each case we have received an assurance that if the changes go ahead, the hospital would increase its capacity – facilities, equipment, staffing – as necessary to be able to take the extra patients without any fall in service quality or rise in waiting times.

104. The aim of our proposals is to ensure that every provider that we commission to deliver CHD services meets the agreed standards. The standards were set to reflect the best evidence, expert advice and the

⁴ Liverpool Heart and Chest Hospital does not currently undertake CHD surgery.

experience of patients and families about what makes for the best services. We believe that making the changes we have proposed will ensure that no matter where they live, patients and their families will receive excellent care.

105. Services will also be more resilient and sustainable for the future. Under present arrangements services in some hospitals receive significant levels of support from other hospitals. Without this support, at best, these hospitals would not be able to offer their patients a full range of CHD services.
106. Bigger hospitals are generally more resilient. The provision of consistent care at all times of day and night throughout the year is more assured. Bigger teams are better able to cope when one of their number is unavailable or leaves. They are also better able to support the full range of surgical procedures and the development of very specialised practice.

1.11 Impact on other services

1.11.1 Impact on other services: Paediatric Intensive Care

107. Our assessment shows that if our proposals are implemented there will be an impact on paediatric intensive care (PIC) at University Hospitals of Leicester NHS Trust and the Royal Brompton and Harefield NHS Foundation Trust. The proposals affect only adult services at Central Manchester University Hospitals NHS Foundation Trust.

1.11.1.1 University Hospitals of Leicester: Paediatric Intensive Care

108. University Hospitals of Leicester has two paediatric intensive care units (PICUs), one at the Leicester Royal Infirmary and one at Glenfield Hospital (which supports CHD services). While we cannot pre-empt the decisions that NHS England will make on CHD services, or the findings and recommendations of its [Paediatric Critical Care & Specialised Surgery for Children Service Review](#), at this point we expect that Leicester would still provide PICU care for the East Midlands if our proposals are implemented, even if it no longer provides Level 1 cardiac surgery for children. This would be through a single PICU at the Royal Infirmary. We understand that, even if our proposals are not implemented and Leicester continues to provide Level 1 children's cardiac surgery, it plans to move this service from Glenfield to the Infirmary, which would be likely to lead to the closure at the Glenfield anyway (and a corresponding increase in capacity of PICU at the Infirmary). Accordingly, the future of the PICU at Glenfield is uncertain, whether or not NHS England's proposals on CHD are implemented, whereas the provision of the PICU at the Infirmary would be unaffected by the implementation of the proposals. The hospital trust does not share this assessment.

1.11.1.2 Royal Brompton: Paediatric Intensive Care

109. The Royal Brompton's PICU is largely dependent on the hospital's CHD service for children, because CHD accounts for 86% of the admissions. The hospital trust considers that its PICU would no longer be viable if the proposals are implemented, because paediatric cardiac patients are a large

proportion of its work and it would not have enough other patients to stay open. The national panel accepted that this was an accurate assessment. If the PICU at the Royal Brompton were to close, this would be expected to have an effect on their paediatric respiratory services, the only other clinical service for children offered by the Trust (see below).

1.11.1.3 Paediatric Intensive Care: wider implications

110. In order to ensure that there is still sufficient PICU capacity for CHD patients, NHS England will work with the other hospitals where increased paediatric cardiac surgery would be expected if our proposals are implemented (Birmingham Children's Hospital, Great Ormond Street, Leeds General Infirmary, St Thomas' - Evelina Hospital) to undertake the necessary planning and preparation to manage any increase in PICU capacity that would be needed for CHD patients.

111. If our proposals are implemented, there may also be an effect on the wider regional and national PIC system. NHS England has accelerated its Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric intensive care provision and paediatric transport. The critical care review aims to bring forward initial work looking at where paediatric critical care capacity is likely to be needed in future, with the first outputs coming through early in 2017. When the Board takes its decisions on the CHD proposals, it will therefore be able to take into account the impact on PIC for CHD patients in the wider regional and national context. The Paediatric Critical Care & Specialised Surgery for Children Service Review will then be able to pick up and deal with any wider implications for changes in PIC consequent upon the proposed CHD changes, as it considers the required capacity and distribution of PICU across the country as a whole.

1.11.2 Impact on other services: Extracorporeal Membrane Oxygenation (ECMO)

112. Extracorporeal Membrane Oxygenation (ECMO) is a technique that provides cardiac and/or respiratory support for very sick patients. When we use ECMO to support the lungs, supporting individuals with severe, potentially reversible respiratory failure, it is called 'respiratory ECMO'. When it is used to support the heart, it is called 'cardiac ECMO'.

1.11.2.1 Leicester: ECMO

113. Leicester provides cardiac and respiratory ECMO for children and is at present the only provider commissioned to offer mobile ECMO (which allows children to be transferred between hospitals on ECMO). It also provides cardiac and respiratory ECMO for adults. If our proposals were to be implemented, Leicester would no longer be able to provide cardiac or respiratory ECMO for children or mobile ECMO for children. Taken together this would affect around 55 children a year. It would no longer provide cardiac ECMO for adults with CHD. We would expect that Leicester could continue to provide adult respiratory ECMO, in a similar way to other hospitals

where services are supported by adult cardiac surgery services (not congenital cardiac).

1.11.2.2 Royal Brompton: ECMO

114. The Royal Brompton provides cardiac ECMO for children and cardiac and respiratory ECMO for adults. If our proposals were to be implemented, Royal Brompton would no longer be able to provide cardiac ECMO for children. This would affect around 15 children a year. It would no longer provide cardiac ECMO for adults with CHD. Adult respiratory ECMO provision at the Royal Brompton is the subject of a separate current procurement being undertaken by NHS England.

1.11.2.3 Central Manchester: ECMO

115. Central Manchester provides cardiac ECMO for adults with CHD. If our proposals were to be implemented, Central Manchester would no longer be able to provide cardiac ECMO for adults with CHD.

1.11.2.4 ECMO: wider implications

116. NHS England will work with the other hospitals, where increased paediatric cardiac surgery would be expected, if our proposals are implemented, (Birmingham Children's Hospital, Great Ormond Street, Leeds General Infirmary, and St Thomas' - Evelina Hospital) to undertake the necessary planning and preparation to manage any increase in paediatric cardiac ECMO capacity that would be needed for CHD patients.

117. If our proposals are implemented, there may also be a wider regional and national effect on ECMO services. NHS England has accelerated its Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric ECMO. When the NHS England Board makes its decision about the CHD proposals, it should, therefore, have greater clarity about the impact on ECMO for CHD patients in the wider regional and national context. The Paediatric Critical Care & Specialised Surgery for Children Service Review will then be able to pick up and address any wider implications for changes in children's ECMO services, as a consequence of the proposed CHD changes, as it considers the required capacity and distribution of children's ECMO across the country as a whole. We will re-commission appropriate levels of children's respiratory ECMO and mobile ECMO from an appropriate number of providers in the light of the recommendations of that review.

1.11.3 Impact on other services: Specialist paediatric respiratory services

118. As outlined above, the Royal Brompton considers it likely that its PICU would no longer be viable if our proposals are implemented, because paediatric cardiac patients are a large proportion of its work and it might not have enough other patients to stay open. The national panel accepted that this was an accurate assessment. The hospital trust considers that this would have a serious detrimental effect on children's respiratory services which also use the PICU.

119. The national panel considered that there would be an impact on paediatric respiratory services, if paediatric cardiac services and PICU were no longer provided by the Royal Brompton. NHS England's work focusses on congenital heart disease and has not examined paediatric respiratory services. The membership of the panel reflects that focus. Given this, it would not have been appropriate for the panel to undertake detailed assessment of this impact.

120. If a decision is taken that results in closure of the PICU at the Royal Brompton Hospital, NHS England will work with the hospital trust to understand and manage the impact on paediatric respiratory services. This could require a local service change process with further public engagement, potentially including full public consultation. There are alternative providers of specialist paediatric respiratory services in London.

1.12 Workforce Impact

1.12.1 Provider organisations where level 1 services would be provided under the proposals: workforce impact

121. The panel considered that hospitals that would gain more patients if the proposals were to be implemented were well placed to be able to expand their capacity to be able to provide that care. The recruitment of the necessary workforce for this increased activity was seen as potentially challenging for a number of these hospitals. Specifically, the recruitment of the PICU nurses necessary for the additional beds which would be required. The hospitals gaining significant activity believed that although challenging they had a good record of recruiting staff and would be able to recruit the necessary staff as long as they were given sufficient time prior to these proposals being implemented.

1.12.2 Provider organisations where level 1 services would no longer be provided under the proposals: workforce impact

122. Under our proposals some hospitals would no longer provide level 1 CHD services. In some cases this is likely to also affect the future of other linked services. For the staff delivering these services the potential implications include:

- employees being redeployed into other roles;
- the transfer of the contracts of employment of employees from one organisation to another;
- changes to the volume of work carried out by employees (either through increases or decreases in patient activity within the Trust they work for);
- employees working within the service being made redundant; and
- changes to the future workforce requirements to deliver the CHD standards and service specifications across the commissioned centres.

123. One of the key challenges both to current CHD services and to any future configuration is ensuring that there are sufficient staff with the necessary skills and experience to undertake this work across the country.
124. NHS England will work with provider organisations to ensure that staff are supported through any change process and redundancies are avoided wherever possible.
125. The national panel noted that experience at other hospitals where level 1 services have ceased – Edinburgh, Cardiff and Oxford – was that the majority of staff did not transfer to alternative providers of these services, but there were virtually no redundancies, with most staff being redeployed internally. It is reasonable to expect that many staff would seek to take up alternative roles within the relevant hospital trusts, rather than moving to another hospital. However, the panel noted that certain staff, such as CHD surgeons, would look to move to a Level 1 CHD hospital.

1.12.2.1 Impact on workforce at the Royal Brompton Hospital

126. The Royal Brompton identified approximately 430 WTE staff that it considered would be affected by the proposals, including those working as part of their CHD service, paediatric respiratory, paediatric intensive care and other services which will be impacted to a lesser extent. The hospital trust has estimated the cost of redundancies to be approximately £13.5m.
127. The panel was not able to take a view on the likelihood of all these staff being significantly impacted by the proposed changes; however, it was acknowledged that there would be a significant impact on the Royal Brompton's workforce, if the proposals were to be implemented. The panel noted that this impact would be reduced, were the Royal Brompton to continue providing adult-only Level 1.
128. NHS England has reviewed the hospital trust's assessment of the potential level of redundancy. Given that we expect that most patients using the Royal Brompton would transfer to alternative hospitals within three miles of the Royal Brompton with the scope for redeployment that would result, NHS England has a materially different view of possible redundancy costs. Internal redeployment is also likely to make a significant contribution to avoiding redundancy. We estimate that the costs could however be up to £1 – 1.5m. This estimate is highly sensitive to the degree to which staff can be redeployed.

1.12.2.2 Impact on workforce at University Hospitals of Leicester

129. University Hospitals of Leicester identified 153 WTE staff that would be directly affected by the proposals, including administrative and clerical staff, estates and ancillary, medical and dental and nursing and midwifery staff that work solely for East Midlands Congenital Cardiac Service. In addition to the staff directly affected, the hospital trust has also identified other roles, such as those working in theatres, imaging, outpatient care, catheter labs and intensive care that would be indirectly affected. University Hospitals of

Leicester considers it likely that many of its staff would prefer to take up posts elsewhere in the hospital trust if possible.

130. The panel was not able to take a view on the likelihood of all these staff being significantly impacted by the proposed changes; however, it was acknowledged that there would be a significant impact on the hospital trust's workforce, if the proposals were to be implemented. The panel noted that this impact would be reduced, were University Hospitals of Leicester to continue providing Level 2 specialist medical services.

131. NHS England considers it probable that most at risk staff will be redeployed and that therefore the costs of redundancy will be mitigated. We estimate that the costs could however be up to £1m. This estimate is highly sensitive to the degree to which staff can be redeployed.

1.12.2.3 Impact on workforce at Central Manchester University Hospitals

132. The hospital trust did not respond to the request to provide information on the potential impact of the proposals. The panel considered it likely that the impact on staff at Central Manchester University Hospitals would be considerably less than the other two hospitals as the scale of service reduction would be much smaller. Where staff are affected, close working between Central Manchester University Hospitals, Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital should enable Central Manchester to ensure that staff are appropriately supported and that clear plans are made to enable staff who wish to transfer to a Level 1 hospital to do so.

1.13 Financial Impact

1.13.1 Provider organisations where level 1 services would be provided under the proposals: finance impact

1.13.1.1 Confirmation that revenue costs of implementing standards should be covered by increasing income for increasing activity

133. Trusts are paid for CHD services through tariff, which ensures that the money received is linked to patient activity. It is likely that there will be some economies of scale for providers linked with providing a higher volume of activity. As such the trusts which would gain activity under these proposals are confident of being able to fund this expansion through the income which would be associated with this extra activity.

134. The financial assessment undertaken in 2015 at the time the Board agreed the standards showed that additional income to hospital trusts resulting from growth in activity would be sufficient to fund the implementation of the standards. Growth predictions have been refreshed and continue to provide assurance that implementation of the standards will be affordable for providers.

1.13.1.2 Assessment of capital requirements at hospitals that would take additional patients under the proposals and the sources of this capital

135. NHS England asked hospitals providing CHD services whether there would be any capital implications if they were required to take additional patients if our proposals are implemented. NHS England has confirmed that no specific central funds will be made available.
136. Two hospital trusts indicated that they would need to source capital funds to accommodate additional activity: University Hospitals Birmingham (£4M) and Great Ormond Street (£6M). In both of these cases it is expected that the provider would be able to source the capital funding from existing allocations and/or charitable funds. This is being confirmed with NHS Improvement. No other provider indicated any requirement for capital funding, and the risk around capital funding requirement is minimal at this stage.

1.13.2 Provider organisations where level 1 services would no longer be provided under the proposals: finance impact

137. NHS England has assessed for each of the hospitals where it is proposed that level 1 congenital cardiac surgery is no longer provided what proportion of their income comes from caring for patients with congenital heart disease.

1.13.2.1 Impact on finances at Leicester

138. The overall contract value for specialised services at Leicester is approximately £234m. NHS England estimates that the financial effect of the proposed changes would be a reduction in income of around £14m (rather than the £19-20m estimate provided by the hospital trust). This is partly explained by a difference in view on the impact of the proposals on PICU. The hospital trust's estimate is based on an assumption that it would no longer be able to provide PICU services. The panel considered that there was no reason why PICU services could not continue at the Infirmary site even if the PICU currently located at the Glenfield site needed to close.
139. The loss of income to the hospital trust would, on the panel's assessment, represent between 1.6% and 2.2% of the hospital trust's total income, and between 6% and 8% of their total specialised services income. Some of this loss of income could be reduced if University Hospitals of Leicester continued to provide Level 2 specialist medical services. The loss of income to the hospital trust would also, to some extent, be offset by the reduction in the costs of providing the service.

1.13.2.2 Impact on finances at Central Manchester

140. The overall contract value for specialised services at Central Manchester is approximately £348m. The hospital trust did not respond to the request to provide information on the potential impact of the proposals. NHS England estimates that the financial effect of the proposed changes would be

around £1m. The loss of income to the hospital trust would therefore represent approximately 0.3% of their total specialised services income.

141. Some of this loss of income could be reduced if Central Manchester University Hospitals continued to provide Level 2 adult CHD services. The loss of income to the hospital trust would also, to some extent, be offset by a reduction in costs.

1.13.2.3 Impact on finances at the Royal Brompton:

142. The overall contract value for specialised services at Royal Brompton is approximately £226m. NHS England estimates that the financial effect of the proposed changes would be around £35m excluding the impact on paediatric respiratory services. The hospital trust's estimate of a £47m loss in income when paediatric respiratory services are taken into account appears to be broadly in line with NHS England's own estimate. The hospital trust estimates that the loss resulting from these proposals would be approximately 13% of its total income and 21% of its total specialised services income, which represents a significant financial and business challenge. The scale of loss reflects the impact on PICU and the potential impact on paediatric respiratory services.
143. Some of this loss of income could be reduced if the Royal Brompton continued to provide adult-only Level 1 surgical services, in partnership with a Level 1 paediatric hospital. Whilst adult Level 2 services to be provided at RBH would lessen the financial impact of the proposals on the Royal Brompton to a limited degree the vast majority of its CHD income relates to inpatient activity linked to a surgical or interventional procedure and therefore the Royal Brompton have identified just over £3m income from CHD activity not relating to surgery or catheter interventions. However, this almost totally related to paediatric services and as such if the Royal Brompton were to only offer adult Level 2 services, it is unlikely this would provide significant income to the Trust
144. The loss of income to the hospital trust would, to some extent, be offset by a reduction in costs. Data supplied by the Royal Brompton indicates that its provision of CHD services results in an overall net loss, and therefore although the loss of income is significant it may be that in the long term no longer providing these services is in the best financial interest of the hospital trust. The Royal Brompton has, however, stated that owing to the stranded costs associated with this service they estimate an adverse impact of over £7m per year to its bottom line if these proposals are implemented. The financial impact of the changes could be reduced if the Royal Brompton provided Level 1 services for adults.
145. We note that the Royal Brompton is an active partner in the North West London Sustainability and Transformation Planning process and has identified a number of potential areas for partnership working which could potentially contribute to the mitigation of any financial losses if our proposals are implemented.

1.13.2.4 Finance impact: NHS England

146. The cost of the CHD service to NHS England has been estimated at £175m pa (based on 2013/14 figures). Activity is projected to increase whether or not the new standards are implemented. As a result, we forecast that – in today's prices - by 2025/26 expenditure on CHD services will be between £186m and £207m depending on the level of activity growth. We therefore expect that the challenge for us as commissioners will be in meeting the costs of activity growth rather than any costs arising from meeting the standards, or costs arising from the proposed changes. There are no current plans to reduce the CHD budget (per capita or overall).
147. As commissioners of CHD services we pay hospitals for the majority of these services using the national tariff (price) per unit of activity. Were we to change the number of centres where care is provided, this would therefore have no impact on our expenditure on patient care. NHS England finance experts have advised that it is logical to assume that an improvement to clinical outcomes and the clinical, operational and administrative efficiency and geographical/estates consolidation that would result from implementation of our proposals should lead to reduction in unit cost of this service for providers.

Equalities and Health Inequalities

148. The CHD standards are intended to ensure that everyone with CHD gets the best possible care within available resources. Earlier analysis and engagement indicated that any proposed service change may differentially impact some Black and Ethnic Minority (BME) patients (those of Asian ethnicity), and those with a learning disability. In addition, services for CHD are of particular interest to children, and to the families and carers of children. We will be carrying out specific engagement activities with these groups during the consultation period.
149. We asked hospitals providing CHD services about any equalities or health inequalities as a consequence of our proposals being implemented. All responses submitted by the hospitals can be found in the Equalities and Health Inequalities Impact Assessment which has been published alongside this document.

1.14 Age

150. Our analysis shows that there has been an increase in demand for adult CHD care. More children now benefit from advances in treatment for CHD, and are therefore reaching adulthood. As more people survive with this condition, it is likely that the service will move from one that is centred on children, to one that is, in addition, treating a growing number of young people and adults. This has consequences for the way in which services are planned and delivered.

151. Most surgery and interventional cardiology for CHD happens early in life so our proposals, if implemented, will affect where care for children and young people will be delivered and will therefore impact children and young people. We will be talking directly to children and young people during the consultation period, and have also developed an Easy Read version of the consultation document to help younger children better understand our proposals.

1.15 Disability

152. Children and adults with CHD are at an increased risk of developing further difficulties. Many children with CHD experience delays in their development, for instance, taking longer to walk or talk. Some children will have a learning disability. Around 50% of children with Down's Syndrome have a congenital heart defect and around 60% of those children will require treatment in hospital.
153. Change for people with learning disabilities or on the autistic spectrum is more difficult. Any service change for this population can be more difficult and needs to be managed well. This is not unique to the CHD proposed service change; however careful consideration should be given to the management of change for these patients. The particular concern has been around the practical elements of change like travelling to a new location, and patients being treated by clinical teams in a location that they are not familiar with. For example, people with learning disabilities who allow clinicians that they know to work with them are more likely than people without learning disabilities to refuse the same treatment in an unfamiliar surrounding by unfamiliar people.
154. During consultation we will make special arrangements to gather the views of people with learning disabilities and their families and carers. We have also produced an Easy Read version of this consultation document to help parents and carers explain the proposals to people with learning disabilities. As part of our consultation we are asking people about the impact implementation of the proposals would have on people with learning disabilities and their families and carers and also for advice on dealing with any concerns.

1.16 Gender reassignment

155. We have not identified any specific evidence relating to gender reassignment (including transgender) and CHD. The standards and service specifications do not alter access or delivery of these services to people with this protected characteristic.

1.17 Marriage and civil partnership

156. We have not identified any specific evidence relating to marriage and civil partnership and CHD. (We do not think it appropriate or justified to assume that people who are married or in a civil partnership are more likely to be the parents or carers or in a family with a person with CHD). The standards and service specifications do not alter access or delivery of these services to people with this protected characteristic.

1.18 Pregnancy and maternity

157. Two distinct groups in this category may be affected by the proposed changes.

- Women with CHD who are pregnant
- Women who are pregnant carrying a baby with CHD

158. In both cases most maternity care is delivered through local maternity services at a hospital close to the woman's home. Arrangements will be made for the delivery of the baby that take account of the needs of both mother and child. This may be at the local obstetric unit or at an obstetric centre at or close to the specialist surgical centre. For some women, if the proposals are implemented it will mean that delivery will take place at an obstetric unit further from home

159. We believe that the proposed standards will have a positive impact on the experience and outcomes of women with CHD who are considering pregnancy, are pregnant or are receiving maternity care and on women who are pregnant carrying a baby with CHD. For the first time services will be nationally commissioned using common service specifications.

1.19 Race

160. Ethnicity is known to relate to the prevalence of certain diseases. The relationship between ethnicity and CHD is complex and may be confounded by cultural and religious factors. Research dating back to the 1980s⁵ and 1990s⁶ demonstrated higher prevalence among Asian communities in various UK cities including Manchester and Leeds, and in the West Midlands.

161. We looked at the recorded ethnicity of CHD patients at the three affected level 1 hospitals. All three trusts have a higher prevalence of South Asian patients than the average for the population and higher than the CHD patient group at other level 1 CHD hospitals:

⁵ Gatrad AR, Reap AP, Watson GH Consanguinity and complex cardiac anomalies with situs ambiguous, *Arch. Dis Child* 1984; 59: 242-5

⁶ Sadiq M, Stumper O, Wright JGC, de Giovanni JV, Billingham C, Silove ED Influence of ethnic origin on the pattern of congenital heart defects in the first year of life *Br Heart J* 1995; 73: 173-176

- CMFT has the highest prevalence of Asian population of the three providers that will be impacted by the service change at 15.9% compared to the average of 11.2% of all hospital trusts.
- UHL has a prevalence of 12.6% compared to the average of 11.2% of all hospital trusts.
- Royal Brompton has a prevalence of 12.1% compared to the average of 11.2% of all hospital trusts.

The data above shows that the changes will affect more people of Asian origin than the general population because of the higher incidence of CHD amongst people of Asian origin.

It is not straightforward to assess whether the proposed changes will affect people of Asian ethnicity differently from other groups. Implementation of the standards will ensure that everyone benefits from services provided to a consistent standard across the country. The consultation process will enable us to better understand the impact of the proposed changes by engaging with BME groups, and we will make special arrangements to gather the views of people of Asian ethnicity with CHD during the consultation period. We have produced a summary version of this consultation document in a number of Asian languages and the full document can be translated on request. We heard that religion and belief and culture could make it difficult for some people to engage with us in an open forum, and will therefore ensure that there are opportunities for people to engage with us on a one-to-one basis, via telephone interview, during the consultation period.

1.20 Religion or belief

162. We do not have any evidence that shows a particular impact of the proposed changes on people of differing religions and beliefs. It is envisaged that hospitals that would be expected to provide care for more patients, under our proposals, will review ethnic, religious and cultural mix of patient information in light of the standards and feedback of the communications, engagement and the independent consultation report

1.21 Sex or gender

163. We do not anticipate that the proposed changes will have a differential impact either by sex or gender of patient or carer.

1.22 Sexual orientation

164. We do not anticipate that the proposed changes will have a differential impact depending on sexual orientation.

1.23 Asylum seekers and/or refugees

165. We have not identified any specific evidence relating to asylum seekers and or refugees and CHD. Access to healthcare, understanding of the English health system and communication difficulties and cultural differences may be

relevant differences for asylum seekers and refugees but would not be specific to CHD services or the proposed changes.

1.24 Carers

166. We have heard how important it is for parents and carers to be supported, particularly when they are away from home. They told us about difficulties with finding their way around new hospitals, finding accommodation and eating balanced meals. They also told us about problems with car parking. These effects may be amplified if parents and carers have to travel to a new hospital. We also heard about the importance of having support for end of life for both children and adults. This means having identified support structures that encourage and enable open and honest communication with families and carers at that time. We have developed specific standards to address these issues.

Consultation will seek views from families and carers as well as from people with CHD. The consultation questions include open ended questions where families and carers will have the opportunity to share their experiences and concerns. This may include families and carers who would have compounded impacts of the proposed service changes.

1.25 Those living with mental health issues

167. In addition to medical problems, people living longer with CHD face psychological, sociological and behaviour challenges⁷. Since people with CHD are surviving longer into adulthood, the increasing population of adults with CHD also means there will be an increasing percentage of adult CHD patients that have mental health issues such as anxiety and depression.

168. We do not have any data to understand the percentage of people with mental health issues and CHD that would be impacted by the changes. However, we have heard during the 2016 preliminary stakeholder engagement that people with mental health issues may be differentially impacted by the proposed service changes. This will need further exploration during the consultation to understand the specific impact.

1.26 Other groups

169. We have not identified any specific evidence relating to the following groups and CHD:

- Alcohol and/or drug misusers
- Ex-service personnel/veterans
- Those who have experienced Female Genital Mutilation (FGM)
- Gypsies, Roma and travellers
- Homeless people and rough sleepers

⁷ [Int J Cardiol.](#) 2013 Dec 5;170 (1):49-53. doi: 10.1016/j.ijcard.2013.10.003. Epub 2013 Oct 11.

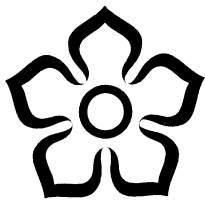
- Sex workers
- Trans people or other members of the non-binary community

Glossary

Adult Congenital Heart Disease	ACHD	This is also known as “grown-up congenital heart disease”, or “GUCH”.
Atrial Septal Defect	ASD	Most common type of ‘hole in the heart’
Bridge to heart transplant		The use of a ventricular assist device (VAD), or other form of circulatory assistance, to support the pumping action of a failing heart until a donor heart becomes available for transplantation. The technique is known as ‘bridge to transplant’.
Cardiologist		A doctor who specialises in investigating and treating diseases affecting the heart and some blood vessels.
Cardiothoracic:		Conditions affecting organs within the thorax, such as the heart, lungs and oesophagus.
Clinical Commissioning Groups	CCG	Groups of GP practices responsible for buying the majority of hospital and community-based health services for patients within their local communities
Clinical Reference Group	CRG	Groups of clinicians, patient representatives, commissioners and other experts, covering the full range of specialised clinical services, (such as cardiac), and providing clinical advice in support of NHS England’s direct commissioning function.
Clinician		Any health professional who is directly involved in the care and treatment of patients, for example, nurses, doctors, therapists, and midwives.
Co-location / service interdependencies		The other services required to provide optimum care of the whole patient, particularly when their conditions are complex or complications arise, and which need to be on the same hospital site.
Commissioning:		The process of buying health services, involving the assessment and understanding of a population’s health needs; the planning of services to meet those needs; securing services on a defined budget, and then monitoring of the services. Commissioning in the NHS in England is managed locally by CCGs, and nationally by NHS England.
Congenital Heart Disease	CHD	Refers to a range of birth defects that

		affect the normal workings of the heart.
Consultant		A senior doctor who is a specialist in a particular area of medicine
Diagnostics		Medical tests used to identify a medical condition or disease.
Extracorporeal Membrane Oxygenation	ECMO	A complex technique that provides cardiac and/or respiratory support for very sick patients
Gastroenterology		Area of medical specialism which deals with disorders of the abdomen, particularly the stomach and intestines.
Interventional cardiology		Various non-surgical procedures for treating cardiovascular disease, such as coronary angioplasty (inserting a tube with a balloon on the end to treat a narrowing or blockage in an coronary artery) or cardiac valve intervention.
Nephrology		Area of medical specialisation that deals with the physiology and diseases of the kidneys.
NHS England Board		The Board is the senior decision-making structure in NHS England and consists of a Chair and eight non-executive directors and four voting executive directors.
NHS England Clinical Advisory Panel	CAP	A group of experienced clinicians that is part of the CHD Review's governance structure.
Paediatric		A branch of medicine providing care for infants and children.
Paediatric Critical Care and Specialised Surgery for Children service review		NHS England national service review which will consider the provision of paediatric Intensive Care and paediatric transport in England
Paediatric Intensive Care	PIC	A highly specialist hospital ward that provides sick children with the highest level of medical care.
Referral		Sending a patient to a specialist, or between specialists, for expert care.
Service Standards		Sets out how NHS services should be set up, organised and run
Specialist		A clinician whose work is concentrated on a particular area of medicine.
Stakeholder		All individuals, parties or organisations with a particular interest in the organisation and delivery of particular clinical services, etc.
Sub-specialisation		Surgeons and cardiologists train generally in their specialty and, at the end of their training, will qualify as a

		consultant. Many will then sub-specialise in an area of particular expertise. These areas are known as sub-specialties.
Surgeon		A clinician who is qualified to practice surgery.
Time limited derogation		NHS England will put in place time limited exceptions (or derogations) allowing hospitals to continue providing essential quality services for their patients whilst working to meet more rigorous service specifications.
Whole time equivalent	WTE	A measure of staffing that takes account of both full time and part time workers.



Leicester
City Council

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

Held: THURSDAY, 29 SEPTEMBER 2016 at 2.00pm

P R E S E N T:

Councillor V Dempster – Chair of the Committee
Mrs J A Dickinson CC - Vice Chair of the Committee for the Meeting

Leicester City Council

Councillor T Cassidy
Councillor L Chaplin
Councillor M Unsworth
Councillor V Cleaver
Councillor L Fonseca

Leicestershire County Council

Mrs R Camamile CC
Dr R K A Feltham CC
Mr S Sheahan CC
Mr J Kaufman CC
Mr T J Pendleton CC

Rutland County Council

Councillor G Conde
Councillor G Waller

* * * * *

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr S Hill CC (Vice Chair of the Committee) and Mrs B Newton CC.

Leicestershire County Council had nominated Mrs J A Dickinson CC as Vice Chair for the meeting and Mr S Sheahan CC was attending as a substitute for Mrs B Newton CC

2. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business

on the agenda.

Councillor Cassidy declared an Other Disclosable Interest as a trustee of Carlton Hayes Mental Health Trust.

Dr R K A Feltham CC declared an Other Disclosable Interest as a hospital manager at Northampton General Hospital.

In accordance with the Council's Code of Conduct the interests were not considered so significant that it was likely to prejudice either Councillor Cassidy's or Dr Feltham's judgement of the public interest. Councillor Cassidy and Dr Feltham were not therefore required to withdraw from the meeting during consideration and discussion relating to NHS England's proposals for the future provision of congenital heart disease services.

3. TERMS OF REFERENCE AND MEMBERSHIP OF THE JOINT HEALTH SCRUTINY COMMITTEE

Members noted the Terms of Reference and Working Arrangements of the Joint Health Scrutiny Committee which had been previously circulated with the agenda.

In response to a Member's question it was noted that the Joint Committee was the appropriate body to be consulted by NHS England on the proposals in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The regulation provides that where the appropriate person (NHS England) has any proposals for a substantial development or variation of a health service in an area they must consult the local authority. Where the consultation affects more than one local authority in an area, the local authorities are required to appoint a Joint Committee to comment upon the proposal and to require a member or employee of the responsible person to attend its meeting and respond to questions in connection with the consultation.

It was also noted that this did not prevent constituent Councils of the Joint Committee considering the issues separately; but it was the responsibility of the Joint Committee to formally respond to the consultation process.

The Regulations also provided that a Council may refer a proposal to the Secretary of State where:-

- it not satisfied that the consultation has been adequate in relation to content or time;
- it is not satisfied with the reasons given for the change in services; or
- it is not satisfied that that the proposal would be in the interests of the health service in its area.

This referral must be made by the full Council unless the Council has delegated

the function to a Committee of the Council. Currently, only the City Council had delegated the powers to refer the NHS proposals to the Secretary of State. Leicestershire County Council and Rutland County Council would need to approve any referral at their respective Council meetings.

4. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, petitions, or statements of case had been received in accordance with the Council's procedures.

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

The Chair commented that this would be the first of a series of meetings to consider NHS England's proposals for the future provision of congenital heart disease services (CHD) with particular reference to University Hospitals of Leicester NHS Trust. It was not intended to cover every aspect of the proposals during the meeting; particularly as the process was currently in the pre-consultation engagement stage. There would be further opportunities at a later date to discuss the issues once the formal consultation process had started.

Members had received the following information prior to the meeting:-

- a) Extracts of decisions taken by Leicester City Council and Leicestershire County Council following the publication of NHS England's proposals on 8 July 2016.
- b) Rutland County Council's Health and Wellbeing Board considered the issue at its meeting on 27 September 2016.
- c) Minutes of the City Council's Health and Wellbeing Board meeting held on 18th August which received a report from NHS England and a submission from the University Hospitals of Leicester NHS Trust (UHL). The minutes were supported by the following documents:-
 - i) A report of NHS England and their Assessment of UHL submitted to the Board which had been updated to reflect the subsequent meeting held with UHL on 16 September 2016. It also included a revised high level timetable for the consultation and decision making process.
 - ii) A letter to the City Council's Deputy City Mayor from NHS England in response to questions asked at the Health and Wellbeing Board.

- iii) NHS England's evidence base for new standards & specifications in relation to the 125 cases per surgeon that had been requested by the Health and Wellbeing Board.

NHS England had been invited to attend the meeting and had originally indicated that they were available to attend, however, a national oversight meeting for all of specialised commissioning had subsequently been arranged for the same day as the Joint Committee. Consequently, NHS England staff involved in the review were now unable to attend or send a representative as they were all required to attend the national oversight meeting. They had, however, submitted a revised report and had stated they would welcome the opportunity to attend a future meeting of the Committee.

Councillor Conde reported that the leader and portfolio holder for health at Rutland County Council had both issued strong statements in support of retaining current CHD services at Glenfield Hospital.

In response to a question relating to the outcomes envisaged for the Joint Committee meeting, the Chair stated that she hoped the Joint Committee would be able to support a strong message to NHS England that, having considered the information supplied to them and also taking into account the views of UHL and the public, the proposals should be abandoned now to avoid wasting any further public funds. If that was not possible and the consultation process went ahead, then the Joint Committee should agree to meet again; with NHS England representatives present to explain their proposals.

The Chair invited Members for their initial views on the proposals and the following comments were made:-

- a) It was disappointing that NHS England had not attended the meeting
- b) The arbitrary figure of 125 operations per surgeon was not supported by tangible evidence.
- c) Place based planning was a requirement for the development of Sustainability and Transformation Plans but place based planning did not appear to be applied in NHS England's proposals.
- d) The rationale for sending patients in the region to London and Southampton was questioned not only in relation to the costs to the families involved, but also on the grounds that if NHS England did not support sending patients with the region to the nearest specialist centre then, by default, they were contributing to Glenfield Hospital not hitting the required targets.
- e) UHL's neonatal services currently provided services to the East Midlands region and the unit's viability could be jeopardised by the current proposals.

- f) The additional travelling time from Leicester to Birmingham in an emergency was considered to be totally unacceptable.
- g) Patients already travelled from Boston to Leicester for care and this journey would be further exacerbated if services were then transferred to Birmingham.
- h) A number of statements had been made by NHS England in relation to patient choice being the reason for cases of CHD being treated outside of the region and, if this was the case, Members felt they should be provided with the number of patients and locations involved.
- i) Councils in the East Midlands and East Anglia regions should be contacted to see if they have any evidence that would be helpful in responding to the proposals.
- j) Some scepticism was expressed at the timetable for the review process and whether this allowed for a realistic consideration of the responses to the consultation. The 12 weeks consultation period would start in December 2016 and end in March 2017. The review of the consultation outcomes would start in April/May 2017. Letters to NHS Trusts giving them 6 months' notice of NHS England's intention to cease commissioning services from them, subject to the consultation outcomes, would be issued on 30 September 2016 with the six months' notice expiring on 31 March 2017. The timetable was considered to be cynical and intimidating and suggested the outcomes were predetermined.
- k) The current review appeared to present the same outcomes of the previous Safe and Sustainability Review in 2012, which was successfully challenged through a referral to the Secretary of State. This had resulted in the Independent Reconfiguration Panel recommending that the Safe and Sustainable Review be abandoned. Glenfield Hospital was still considered to be delivering excellent outcomes for patients and no concerns had been expressed in recent years about the Hospital's performance for CHD services. Members queried what evidence, if any, NHS England had found to suggest that CHD services were not safe and should not be carried out in Leicester.
- l) Glenfield provided an excellent facility and was well placed to serve Lincolnshire, Derbyshire, Nottinghamshire and Northamptonshire. Removing CHD services from Glenfield would result in the East Midlands being the only region in the country without a Level 1 specialist centre.
- m) Strong concerns were expressed that the announcement had already had a destabilising and unacceptable effect upon Glenfield's reputation and could affect more people deciding to choose treatment elsewhere in the country; further destabilising Glenfield's position during the pre-engagement and consultation periods.

- n) MP's in the region and the extended region under the proposed parliamentary boundary reviews should be encouraged to support the continuation of Level 1 services at Glenfield.

The Chair invited Members of the public to comment on the proposals:-

- a) Karen Chouhan, Chair of Leicester Healthwatch stated that NHS England had confirmed that the consultation process would be conducted on a national basis which did not favour Glenfield Hospital. Healthwatch in Leicester Leicestershire and Rutland were proposing to organise local consultations on the proposals.
- b) Sally Ruane, Chair of the Leicester Mercury Patient's Panel felt that the Joint Committee should invite interested parties to submit formal written and oral evidence and to advertise future meetings more widely.

The Chair commented that it had not been intended to involve the public at this first meeting but future meetings would be widely publicised. She further stated that any referral to the Secretary of State would be supported by robust and detailed evidence.

AGREED:

- 1) That the comments made by Members be endorsed.
- 2) That a letter be sent on behalf of the Joint Committee to NHS England outlining the Joint Committee's initial concerns and asking for the proposals to be withdrawn.
- 3) A further meeting of the Joint Committee be arranged once the any formal consultation process begins on the proposals and that NHS England be required to be represented at the meeting under Regulation 27 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

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

Mark Wightman, Director of Communications, University Hospital of Leicester NHS Trust (UHL) attended the meeting to present UHL's initial view on proposals from NHS England. He introduced Aidan Bolger, Paediatric Cardiologist and Head of Service for East Midlands Childrens' Heart Centre (EMCHC) and Claire Westrope, Consultant in Paediatric Intensive Care and Clinical Lead for Paediatric Intensive Care Unit who could provide clinical responses if required.

UHL were grateful for the support of the Joint Committee and the opportunity to provide evidence to enable the Joint Committee to make a qualified and

evidence based decision. UHL had always maintained that if the EMCHC had given them cause for concern or was not providing its patients with excellent outcomes they would have a different viewpoint on the proposals, however, they felt that the proposed changes were not right for their patients.

UHL's initial views on the proposals included the following:-

- a) The proposal to conduct the consultation process on a national basis was of concern to UHL as the local perspective could become diluted since other areas of the country were unlikely to comment upon the proposals because they would not have any particular interest in the issues affecting the East Midlands. There was a concern that NHS England would use the national consultation to suggest that both the Glenfield and the Royal Brompton Hospitals should cease to provide Level 1 CHD services because there would be no overwhelming support in the national consultation to support them continuing.
- b) The proposals also raised concerns relating to the knock on effect upon other services such as ECMO and paediatric intensive care services in the East Midlands. There was also concern that NHS England had subsequently announced they were fast tracking two national reviews on ECMO and Paediatric PICU provision to inform the review of CHD services. There was a strong view that these reviews should have undertaken before the CHD proposals were announced and not as an apparent afterthought.
- c) UHL felt they had now reassured NHS England on the colocation of all services in one building and had explained the plans in place to move to 24/7 access to services. UHL were confident that they could give the necessary assurances to NHS England on this.
- d) The remaining issue for UHL was the arbitrary figure of 125 operations per surgeon per year. The advisor to NHS England had never indicated a minimum or maximum number of operations and NHS England had determined the number of 125 operations per surgeon.
- e) If all patients in the East Midlands area were treated at Glenfield, then the 500 operations per year could be achieved. There were currently 502 cases in the East Midlands but a number were treated out of the area. NHS England promoted 'patient choice' as being enshrined in the NHS constitution but, in reality, it was the referring clinician that was leading the 'patient choice' to go to other centres. It was felt that NHS England could provide stronger leadership in requiring centres in the East Midlands to refer patients to Glenfield in the first instance, unless there were compelling reasons for not doing so.

Following questions from Members the representatives from UHL stated:-

- a) That 'patient choice' was effectively driven by longstanding established clinician networks based upon personal relationships. It was felt that

with the various reorganisations in the NHS over recent years these relationships should be reviewed to see if they were still appropriate and relevant.

- b) Patients from Northamptonshire, Cambridgeshire and East Norfolk were referred elsewhere for treatment and when this was raised with NHS England their response had been that this was patient choice being exercised. UHL felt that patients were not being made aware of Glenfield as a specialist centre when being referred elsewhere.
- c) The number of patients diagnosed with CHD before birth was increasing and this also determined where patients were treated. For example, patients in Peterborough had historically been referred to London for treatment and patient choice is not discussed in these clinics.
- d) UHL would refer patients to other centres if it was felt that better services or treatment were available at that centre, or if the patient felt they had previously had a bad experience at Glenfield, or if being treated at Glenfield would result in a delay in them receiving treatment. UHL had raised the issue of other centres in the East Midlands referring patients elsewhere and had generally received unsupportive replies and an unwillingness to discuss the issue further.
- e) UHL had raised the factual inaccuracies in NHS England's assessment of CHD services at Glenfield during their visit to Leicester on 16 September 2016 and these had been accepted by NHS England. UHL had subsequently written to NHS England requesting that their assessment should be amended in view of these inaccuracies. UHL felt that their initial assessment of meeting 8 out of the 14 core standards should rise to 10 or 11 out of the 14 core standards. The highest score in the original assessments of all centres had been 12 out of 14 and the lowest had been 6 out of 14. It appeared that colocation of services and performing 500 operations per year outweighed the other standards in NHS England's assessment process. UHL would be raising these inconsistencies within the assessments with NHS England.
- f) UHL was currently on target to achieve the 125 operations per surgeon with 3 surgeons. If they moved to 4 surgeons now this would undermine their case to continue to provide Level 1 CHD services as they would not achieve this benchmark; unless more cases were referred to UHL from the East Midlands area instead of being referred elsewhere. In addition, recruitment had also been affected by NHS England's announcement of the proposals, which had cast a shadow of uncertainty over the future provision of CHD services at Glenfield and this would not encourage prospective applicants to want to work in the unit.
- g) UHL had originally suggested a two site East Midlands' network centre solution, with treatment being shared between Leicester and Birmingham, in response to the previous safe and sustainability review proposals. This had been suggested again to NHS England in the

preliminary stages of this current review, but had not received any favourable support.

- h) UHL had obstetricians working at Kettering Hospital and the arrangement worked well. The same offer had been made to Northampton Hospital and had been rebuffed.
- i) UHL were working closely with both Liz Kendal MP and Nicky Morgan MP; who were both supporting UHL's position.
- j) Pregnant women diagnosed with foetal heart conditions would not be treated by their GP's but by obstetricians in hospitals. The recognised pathways for treatment for these cases were Oxford and London.

Members asked for the following to be supplied to them:-

- a) Evidence of why patients chose to receive treatment at other centres and why patients chose to have treatment at Glenfield.
- b) A copy of UHL's plan to demonstrate that it will meet the standards in the required timescale.
- c) A copy of UHL's response to NHS England following the visit to Leicester on 16 September 2016.
- d) A copy of the upgraded assessment of Glenfield CHD services when this had been received from NHS England.

UHL's agreed to share the documents requested.

The Chair invited members of the public to make comments and observations:-

Eric Charlesworth, Leicester Mercury Patient's Panel made the following comments:-

- He thanked the Councils for arranging the meeting and for the opportunity for the public to make their views known.
- He noted that NHS England had agreed to attend a meeting with Rutland County Council on 31 January 2017.
- He felt NHS England had failed to comply with a number of recommendations made by the Independent Reconfiguration Panel (following their review of the Safe and Sustainability Reviews proposals in 2012) in the current review.
- There was concern that the proposals could mean the loss of the ECMO unit and this provided a valuable health asset for both adults and children living in the East Midlands.

- Councillors should raise the implications of the NHS England's proposals in their own localities and wards at every opportunity.

Shirley Barnes – a parent of a child with congenital heart condition stated that if Glenfield lost its Level 1 services, there would not be a specialist centre on the eastern side of the country between Newcastle and London. The East Midlands would be the only region in the country without a specialist heart centre. Patients could only travel to Birmingham Children's Hospital if there were beds available, otherwise patients in the East Midlands would have to travel long distances to other centres for treatment such as Liverpool, Newcastle, Southampton or London. It was felt the additional travelling time to Birmingham would be dangerous in instances where emergency treatment was required, particularly as there were regular occurrences of traffic congestion on the M6 motorway to Birmingham.

Mrs Barnes was organising a petition at Glenfield Hospital to support the on-line petition at <https://petition.parliament.uk/petitions/160455>. The paper petition was being signed by the elderly and those that did not access to the internet. It was important to spread the awareness of the review as widely as possible as it affected every child in the country.

Members made the following suggestions:-

- a) UHL should make all GP's in the East Midlands aware of the services offered by the EMCHC at Glenfield as it appeared that they were unaware of its existence, especially in Northampton and Cambridgeshire.
- b) The current petition had received 33,000 signatures and more publicity on the issue was needed to get this figure to over 100,000 so that it triggered a parliamentary debate.
- c) Engagement should take place with all the MPs in the East Midlands area and for the new proposed parliamentary constituencies which went further south than at present.
- d) UHL should continue to make approaches to Northampton Hospital on the issue of referrals.
- e) The letter to NHS England agreed in the previous item should also be copied to the Secretary of State for Health.

The Chair thanked everyone for their participation in and effective discussion which had raised a number of points to be included in the letter to NHS England. It was important to put these views to NHS England now rather than wait for the formal consultation to start.

It was also important to use the period before the start of the consultation process to engage with other authorities and organisations and undertake further research of the issues, including the practicalities of patient choice.

As soon as the date of the formal consultation was known there would be a minimum of two further meetings. There would be a meeting with NHS England and one involving interested parties including parents, carer groups, young people, and representatives of the wider public to put forward their views.

AGREED:

- 1) That the Chair and Vice Chair prepare the letter to be sent to NHS England and circulate it to members of the Joint Committee for comment and approval before it is sent to NHS England and copied to the Secretary of State.
- 2) That UHL provide copies of the documents requested earlier in the meeting.
- 3) That further details be provided to the Committee as to why the two site East Midlands' network centre was rejected by NHS England.

8. OTHER VIEWPOINTS ON NHS ENGLAND'S PROPOSALS

Members received the following information and viewpoints on NHS England's proposals:-

- a) NHS England's press announcement of its proposals dated 8 July 2016.
- b) The report of NHS England's National Panel on Paediatric Cardiac and Adult Congenital Heart Disease Standards.
- c) Questions and Answers from NHS England's website on the decision making process.
- d) A copy of Will Huxter's blog on the Congenital Heart Disease Implementation Programme issued on 13 September 2016.

Note: 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 would be used to keep everyone up-to-date with activities during the pre-consultation and consultation period on NHS England's proposals for meeting the national standards on CHD, and anyone can request to receive it by e-mailing england.congenitalheart@nhs.net

- e) Leicester City's Health and Wellbeing Board had also requested the assessments of every other centre currently providing CHD Services. NHS England had subsequently published these on their website at the following link:-

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

Note: 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 considered this item during discussion of previous agenda items.

10. BUSINESS FOR THE NEXT MEETING

The Committee considered the next steps in taking the review forward during discussion of previous agenda items.

11. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business to be discussed.

12. CLOSE OF MEETING

The Chair declared the meeting closed at 4.00pm

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Mr Kalvaran Sandhu (Scrutiny Manager)
Joint Health Scrutiny Committee (Leicestershire, Leicester, Rutland)

Dear Mr Sandhu

RE: Congenital Heart Services Review (Glenfield Hospital)

I refer to the minutes of the meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee meeting on 29 September 2016 and to your email to me dated 6 February 2017, which attached those minutes.

You will be aware that we are planning to launch our formal consultation on the level 1 proposals shortly. We will be publishing in the consultation document and supporting materials the detail of our current thinking on the issues raised in the minutes. I am also looking forward to discussing these proposals with the Joint Committee in March. In the meantime, let me provide you with the following preliminary responses.

125 operations

The Standards were approved by NHS England's board in July 2015, following extensive consideration and full public consultation, and their contents are not now up for debate. The number of operations required per surgeon was agreed following NHS England's engagement with all the surgeons on our clinical reference panel on this issue and analysis of validated data provided by NICOR. The surgeons who participated in our standards review have been unanimous in their belief 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. The number of operations performed is measured per surgeon to ensure that each surgeon maintains their expertise by frequently practising and refreshing their skills.

Patient flow

University Hospitals Leicester (UHL) submitted a surgical growth plan which they consider would result in them achieving the minimum level of activity required to ensure four surgeons are able to perform a minimum of 125 procedures per year by 2021. The projected increase in activity depends on population growth, technical advances, and changes to patient flows (which UHL state would be helped if NHS England supported the flow to the Trust of all patients for whom it is the closest centre). NHS England has previously stated that it does not intend to mandate patient flows because it does not consider it appropriate to override clinical judgement and patient choice. This remains our view.

UHL's performance

It is essential that all patients receive the same standards of care, wherever they are in the country. Therefore all providers of CHD services must meet the standards set following work with the different groups of stakeholders for more than two years, as part of the New Congenital Heart Disease Review, to create a set of quality and service standards that covered the entire patient pathway, from diagnosis, through treatment, and on into care at home and end of life care, to make sure that every child, young person and adult with CHD, in every part of the country, would receive the same high standard of treatment. Patients, and their families/carers and representatives, as well as clinicians in the field, have told us – consistently – that the standards were only worth something if they were actually acted upon and met.

The standards have never been considered as an end in themselves. They were developed in the full expectation that their implementation at every hospital in the country providing CHD services would be the means by which our work would be delivered and would bring an end to variation in service based

on location.

IRP/Safe and Sustainable review

We have borne the IRP carefully in mind throughout the CHD review process. See for example our published report setting out how the new congenital heart disease review has sought to learn lessons from the Safe and Sustainable review and specifically the recommendations raised by the IRP¹. We continue to do so.

Travel times

We are aware of and have taken on board patient concerns regarding travel times where it is proposed that services are decommissioned. If our proposals are implemented, UHL could continue to offer Level 2 specialist medical services to children and adults, and we continue to discuss this option with the hospital trust. If the hospital carried on offering Level 2 CHD services, then the vast majority of patient care would continue to be offered in Leicester, and patients would only be required to travel elsewhere if they required surgery and/or interventional catheters. Our modelling suggests that the impact on average journey times for patients is relatively modest: an increase in the average journey time of 14 minutes for children who use Leicester and 32 minutes for adults. Thankfully, true emergencies in congenital heart disease are incredibly rare.

Some patients would still, of course, have longer journeys. However 90% of patients who would currently use University Hospitals of Leicester would still have a journey time of less than 1 hour and 45 minutes to their nearest surgical hospital and this is similar to the national picture and shorter than in some other parts of the country (for example the South West peninsula).

We do, however, recognise that it is difficult for families to support patients in hospital at some distance from home. This is a problem faced by many families already, not just in CHD services, but in many other specialist services, which tend to be provided in a smaller number of hospitals across the country. Because of this, and based on the advice of patients and families, a number of standards were developed to make life easier in this situation - providing better information about where to eat and sleep; better facilities to prepare meals; provision of Wi-Fi; ensuring parking is easily accessible and parking charges affordable; and providing overnight accommodation for parents and carers.

UHL's neonatal service

Last October we wrote to each of the Trusts as part of our impact assessment process, seeking information in relation to the impact of our proposals on a range of factors, including on CHD services, other interdependent services and the Trust as a whole. UHL was therefore provided with an opportunity to raise the impact on neonatal services and information supplied by the Trusts has been included in our Impact Assessment report. We have also taken the information provided by the Trusts into account in developing our consultation document.

Inaccuracies in UHL assessment

We have amended our view on paediatric co-location in the light of the information provided by UHL, and this will be reflected in our consultation document.

ECMO/PICU knock-on effect

NHS England is carrying out a Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric intensive care provision, paediatric transport and paediatric ECMO. UHL has two paediatric intensive care units (PICUs), one at the Leicester Royal Infirmary and one at Glenfield Hospital (which supports CHD services). While we cannot pre-empt the decisions that NHS England will make on CHD services, or the findings and recommendations of its Paediatric Critical Care & Specialised Surgery for Children Service Review, at this point we expect that UHL would still provide PICU care for the East Midlands if our proposals are implemented, even if it no longer provides level 1 cardiac surgery for children. This would be through a single PICU at the Royal Infirmary. We understand that, even if our proposals are not implemented and UHL continues to provide level 1 children's cardiac surgery, it plans to move this service from Glenfield to the Infirmary, which would be likely to lead to the closure at the Glenfield anyway (and a corresponding increase in capacity of PICU at the Infirmary). Accordingly, the future of the PICU at Glenfield is uncertain, whether or not NHS England's proposals on CHD are implemented, whereas the provision of the

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/11/5-chd-34-nchdr-lessons-learnt.pdf>

PICU at the Infirmary would be unaffected by the implementation of the proposals. The hospital trust does not share this assessment.

Timetable

We know, from talking to stakeholders, that the failure to implement recommendations from previous reviews has created uncertainty for patients and staff. At the same time, we are committed to following due process throughout the review, ensuring that sufficient time and consideration is given to each stage of the process and to make sure relevant stakeholders are able to participate and contribute effectively. The consultation period is in line with standard practice and provides a sufficient amount of time for patients, their families and carers, clinicians, organisations and other stakeholders to provide their opinions and any extra information or evidence as they wish.

I am happy to correct the suggestion that the outcomes of the review are pre-determined; no decision has been taken and any decision will be taken only following appropriate engagement and consultation.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Will Huxter', written in a cursive style.

Will Huxter

Regional Director of Specialised Commissioning (London Region)

SRO, CHD Programme

Proposals to implement standards for congenital heart disease services for children and adults in England - Consultation Summary



Proposals to implement standards for congenital heart disease for children and adults in England

Consultation Summary

First published: 9 February 2017

Prepared by: Specialised Commissioning, NHS England

Classification: OFFICIAL

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Summary

1.1 Introduction

1. In July 2016, NHS England published a set of proposals regarding the future of congenital heart disease (CHD) services for children and adults. They describe the actions which we propose to take in order to ensure a consistent standard of care for CHD patients across the country, for now, and for the future.
2. We propose to do this by implementing consistent national service standards at every hospital that provides CHD services. The standards cover the entire patient pathway from diagnosis, through treatment, and on into care at home and end of life care. The effect of our proposals, if implemented, will be that some hospitals will carry out more CHD surgery and catheter procedures, while others, which are not meeting the relevant standards, will stop doing this work.
3. This means that those patients who would currently be likely to receive surgery and/or interventional catheter procedures at a hospital where we are proposing to stop that activity will, in future, be likely to receive that surgery and/or catheter procedure at a different hospital. For some patients this will mean travelling further for surgery/catheter procedures, and for one appointment both pre, and post-surgery. However, most follow-up appointments, and ongoing monitoring and care can still be done closer to home.
4. What will also change is the level of care which all CHD patients can expect in the future. If we implement the national standards in full in every hospital providing CHD services across England, we will be able to ensure that every patient receiving treatment for CHD will be getting care delivered to the same high standards, regardless of which hospital they are attending. This means consistent and equitable high quality treatment for all.

1.2 Background

5. The national CHD standards were developed in the wake of a series of reviews and enquiries, starting with a public inquiry into concerns about the care of children receiving complex cardiac surgery at Bristol Royal Infirmary, published in 2001.
6. The standards were developed by people with a direct interest in CHD services – patients, families, carers and patient representatives – in collaboration with those delivering the services – the surgeons, cardiologists, specialist nurses, and others. Consensus across all groups was achieved, and the standards were approved by NHS England's Board in July 2015. It was clear that NHS England, as the sole national commissioner of CHD services, had a unique opportunity to drive service improvement, and reduce variation in access and quality, by implementing a set of standards which would govern a truly national service.

7. The standards describe how to deliver CHD services of the very highest quality. They are – rightly – challenging, and it was acknowledged by the NHS England Board that it would be difficult for all hospitals to meet them, unless changes were made to the way in which they work. The timeline for meeting some of the standards differs, as it was recognised that it would take longer to meet some of them, such as the co-location of children’s CHD services with other children’s specialist services, which might require physical changes to a hospital’s structure or layout.
8. Once all hospitals are meeting the standards, all patients with CHD will be receiving care of the highest possible quality. This means that they, and their families/carers, will get higher levels of support from specialist nurses and psychologists; improved information and communication, so they will have a better understanding of their condition and treatment options; and a better managed transition from children’s to adult services. Clinicians and other specialist staff will be working in an environment which has the right staffing levels and skills, which means the service is resilient and better able to cope with sickness and holiday/emergency cover. They will also have more opportunities for training and sharing learning, and surgeons will have more opportunity to practice and maintain their skills, because they are carrying out more operations and interventional procedures.
9. We think all of these elements make a real difference to patients, and to their families and carers, and to health outcomes, as well as benefitting the teams caring for them. We believe that every patient with CHD should have access to care delivered at the same high standards, regardless of where they receive their treatment.

1.3 Meeting the standards

10. Once the standards had been agreed, we first looked at whether hospitals currently providing CHD services could work together, in networks, to deliver services which met the required standards. This approach did not provide a national solution to meeting the standards. We therefore asked the hospitals to complete a self-assessment, to assess compliance against a specific number of the standards. We took clinical advice about which standards we should ask the hospitals to look at, and opted for 14 requirements in total, which were those most closely linked to measureable outcomes and to improving safety and quality.
11. Three specific standards are relevant to our proposals:
 - Surgeon working requirements – the number of surgeons at each hospital, and the number of operations they each perform.
 - o The standards require that, for 2016, surgeons work in teams with a minimum of three surgeons, and in teams of at least four surgeons by April 2021. CHD surgeons are each required to carry out no fewer than 125 congenital heart operations a year (the equivalent of about three operations a week), averaged over a three-year period;

- Service interdependencies, or co-location – the other services CHD patients depend upon, and which need to be on the same hospital site.
 - o The standards require that specialist children’s cardiac services are only delivered in settings where a wider range of other specialist children’s services are also present on the same hospital site. The standards require that certain paediatric specialties are within a 30-minute call to bedside range for April 2016, and co-located on the same site as children’s CHD services by 2019.

Interventional cardiology

- o The standards require that for 2016, interventional cardiologists work in a team of at least three, and by April 2017 in teams of at least four, with the lead interventional cardiologist carrying out a minimum of 100 procedures a year, and all interventional cardiologists doing a minimum of 50 procedures a year.

1.4 Proposals for consultation

12. The information submitted by the hospitals was considered by a national panel, which included patient representatives, clinicians and commissioners. The panel assessed each hospital’s ability to meet the standards and found that at the time none of them met all of the standards tested. This was not unexpected, as the standards were expected to ‘stretch’ the hospitals, and bring all services in all hospitals consistently up to the level of best practice.
13. The majority of the hospitals were either very close to meeting the requirements, or were considered to be likely to meet them within the required timescales, with further development of their plans. They were rated green/amber, or amber.
- Three of the hospitals - University Hospitals of Leicester NHS Trust, Newcastle upon Tyne Hospitals NHS Foundation Trust, and the Royal Brompton and Harefield NHS Foundation Trust - were unable to meet the requirements for April 2016, and were considered unlikely to be able to do so within the required timeframe. They were rated amber/red.

One hospital – Central Manchester University Hospitals NHS Foundation Trust – was not able to meet the requirements now, and was unlikely to be able to do so within the required timeframe. 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 these arrangements to be a risk, and rated the centre red.

14. At the heart of our proposals is our aim that every patient should be confident that their care is being delivered by a hospital that is able to meet the required

standards. In order to achieve this we propose that in future, NHS England will only commission CHD services from hospitals that are able to meet the standards within the required timeframe. The effect of our proposals, if implemented, will be that some hospitals will carry out more CHD surgery and catheter procedures, while others, which do not meet the relevant standards, will stop doing this work.

15. In practice, this means that, in future, if our proposals are agreed:

- Surgery and interventional cardiology for adults would cease at Central Manchester University Hospitals NHS Foundation Trust, and patients requiring such procedures would be most likely to go to Liverpool Heart and Chest Hospital NHS Foundation Trust. Patients requiring all other forms of treatment, i.e. anything other than surgery and/or interventional cardiology may still be able to receive their care in Manchester. We continue to discuss this option with the hospital trust.
- Surgery and interventional cardiology for children and adults would cease at Royal Brompton and Harefield NHS Foundation Trust, and patients requiring such procedures would be most likely to continue to receive their care in London, at Great Ormond Street for Children NHS Foundation Trust, Bart's Health NHS Trust, or Guy's and St Thomas' NHS Foundation Trust. There is a possibility that the hospital trust might continue to provide surgery and interventional cardiology for adults only. This option remains open for discussion.
- Surgery and interventional cardiology for children and adults would cease at University Hospitals of Leicester NHS Trust, and patients requiring such procedures would be most likely to receive their care at either Birmingham Children's Hospital NHS Foundation Trust, University Hospitals Birmingham NHS Foundation Trust, or Leeds Teaching Hospitals NHS Trust, as closer for some patients than Birmingham. There is a possibility that the hospital trust might continue to provide CHD services for children and adults other than surgery and interventional cardiology. This option remains open for discussion.

16. Newcastle upon Tyne Hospitals NHS Foundation Trust was also given an amber/red rating, in the same category as both University Hospitals of Leicester NHS Trust and Royal Brompton and Harefield NHS Foundation Trust. However, Newcastle has a unique role in delivering care for CHD patients with advanced heart failure including heart transplant and bridge to transplant and this could not be replaced in the short term without a negative effect on patients. On balance therefore our present view is that it is better to continue to commission level 1 CHD services from Newcastle. CHD surgery and the transplant programme involve the same surgeons so the two are tied up together.

17. This does not mean that change at Newcastle upon Tyne Hospitals NHS Foundation Trust will not happen in the longer-term. The hospital trust is required to meet the standards in the same way as all of the other Level 1 surgical centres. Timeframes for doing this may differ, but we will be working closely with the hospital to ensure that patients receiving CHD care at

Newcastle upon Tyne Hospitals NHS Foundation Trust are not compromised in any way.

1.5 What would be the benefit of implementing these proposals?

18. We believe that implementation of the national standards for CHD is the only way to ensure that patients are able to access the highest possible quality care, regardless of where they are treated. There is currently some variation in terms of where hospitals are in meeting the standards so care may vary, depending on where in England you access services.
19. The NHS has been trying to improve care for CHD patients for almost 20 years and, while we have learned much from previous reviews and enquiries, we know that there remains a cloud of uncertainty hanging over these services which has damaged relationships between hospitals; harmed the recruitment of staff; and reduced the resilience of these services. We need to create a stable, resilient and sustainable national CHD service for the future, by introducing certainty and consistency of approach across the country.

1.6 Potential impact of implementing our proposals

20. We know, from talking to patients and their families/carers, clinicians, and other hospital staff, that there are concerns about our proposals and how implementation of them might affect them personally, or their jobs, or other services in the hospitals affected. We acknowledge these concerns, which is why we are holding a full public consultation, so that we can talk to you in more detail about our proposals, and learn more from you about how you think implementation of the standards might impact you, your family, or where you work. It is important to note that, even if our proposals are implemented, change will not take place until early 2018, and we will be working closely with all hospitals involved to ensure that patient care is not interrupted or unduly affected.
21. We know, from talking to people during the pre-consultation period, that patients, in particular, are concerned about where their care will take place in the future. If our proposals are implemented, journey times will increase for some people when they need to attend their new hospital for surgery or a catheter procedure. We expect the average rise in journey times to be fairly small, although we know for some patients it will be more substantial. While we acknowledge that this extra journey length will be difficult for some, we think that patients will ultimately benefit from being treated at a hospital which is meeting the national standards in full.
22. Fortunately, the vast majority of admissions to hospital for CHD surgery are planned, and there are very few true emergency admissions for CHD patients. Even in those cases where CHD has not been diagnosed in the womb, and surgery is required soon after birth, that operation will be planned over a period of a few days, and newborns are stabilised and transported to a surgical centre by expert and highly skilled children's transport teams. The same goes for adult patients.

23. We also know that there is concern about the impact of our proposals on other hospital services, such as paediatric intensive care, and on the wider hospitals and their staff. Formal **impact assessments**, which set out what implementation of our proposals might mean for each of the hospitals affected, have been carried out as part of our planning for public consultation.

1.7 How can I make my views known?

24. During consultation there will be a number of opportunities for you to have your say about the future of CHD services. We want to hear from anybody with an interest in these important services, and have set out a number of questions which we want to ask you about our proposals. The answers to these questions will be independently analysed, and will be considered by the NHS England Board before a decision is made.

25. We will be holding a number of events, such as public meetings, webinars and Twitter chats, so there will be lots of different ways for you to ask us questions, and hear more about our proposals.

26. The consultation questions, and all other information about this public consultation, can be found at our [Consultation Hub](#). The consultation questions are attached at Appendix A for ease of reference. If you would prefer to send us your responses to consultation by post, please answer the questions on the form attached, and post it back to us at:

CHD Consultation
c/o Beverley Smyth (Specialised Commissioning)
NHS England
4N08| Quarry House| Quarry Hill | Leeds | LS2 7UE

27. If you cannot find the information you are looking for, or have any other questions relating to this consultation, please contact us at england.congenitalheart@nhs.net

Appendix A – Consultation questions

Meeting the standards

1. In what capacity are you responding to the consultation?

- Current CHD patient
- Parent, family member or carer of a current CHD patient
- Member of the public
- CHD patient representative organisation
- Voluntary organisation / charity
- Clinician
- NHS provider organisation
- NHS commissioner
- Industry
- Other public body
- Other

If other – please specify:

2. In which region are you based?

- Not applicable/regional/national organisation
- England - North East
- England - North West
- England - Yorkshire and The Humber
- England - East Midlands
- England - West Midlands
- England - East of England
- England - London
- England - South East
- England - South West
- Scotland
- Wales
- Northern Ireland

3. NHS England proposes that in future Congenital Heart Disease services will only be commissioned from hospitals that are able to meet the full set of standards within set timeframes. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

4. Please explain your response to question 3.

Three hospital trusts have been assessed as not able to fully meet the standards within set timeframes. NHS England therefore proposes that surgical (level 1) services are no longer commissioned from:

- **Central Manchester University Hospitals NHS Foundation Trust** (adult service)
- **Royal Brompton & Harefield NHS Foundation Trust** (services for adults and children); and
- **University Hospitals of Leicester NHS Trust** (services for adults and children).

5. Can you think of any viable actions that could be taken to support one or more of the trusts to meet the standards within the set timeframes?

Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust

If Central Manchester and Leicester no longer provide surgical (level 1) services, NHS England will seek to commission specialist medical services (level 2) from them, as long as the hospitals meet the standards for a level 2 service. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

Royal Brompton and Harefield NHS Foundation Trust

6. The Royal Brompton could meet the standards for providing surgical (level 1) services for adults by working in partnership with another hospital that provides surgical (level 1) services for children. As an alternative to decommissioning the adult services, NHS England would like to support this way of working.

To what extent do you support or oppose the proposal that the Royal Brompton provide an adult only (level 1) service?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

Newcastle upon Tyne Hospitals NHS Foundation Trust

7. NHS England is proposing to continue to commission surgical (Level 1) services from Newcastle upon Tyne Hospitals NHS Foundation Trust, whilst working with them to deliver the standards within a different timeframe. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

Travel

We know that some patients will have to travel further for the most specialised care including surgery if the proposals to cease to commission surgical (level 1) services from Central Manchester University Hospitals NHS Foundation Trust (adult service); Royal Brompton & Harefield NHS Foundation Trust (services for adults and children); and University Hospitals of Leicester NHS Trust (services for adults and children) are implemented.

8. Do you think our assessment of the impact of our proposals on patient travel is accurate?
- Yes
 - No

9. What more might be done to avoid, reduce or compensate for longer journeys where these occur?

Equalities and health inequalities

We want to make sure we understand how different people will be affected by our proposals so that CHD services are appropriate and accessible to all and meet different people's needs.

In our report, we have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

- Yes
- No

10. Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Other impacts

We want to make sure that the proposed changes, if they are implemented, happen as smoothly as possible for patients and their families/carers so it is important that we understand other impacts of our proposals.

11. Do you think our description of the other known impacts is accurate?

Yes

No

12. Please describe any other impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Any other comments

13. Do you have any other comments about the proposals?

About you

14. Which age group are you in?

- Under 18
- 19 – 29
- 30 – 39
- 40-49
- 50 – 59
- 60-69
- 70-79
- 80+
- Prefer not to say

15. Please indicate your gender

- Male
- Female
- Intersex
- Trans
- Non-binary
- Prefer not to say

16. Do you consider yourself to have a disability?

- Yes
- No
- Prefer not to say

17. Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.

White

- Welsh/English/Scottish/
Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White
background

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian
background

Other ethnic group

- Chinese
- Any other ethnic group

Mixed

- White and Black
Caribbean
- White and Black African
- White and Asian
- Any other mixed
background

Black or Black British

- Black - Caribbean
- Black - African
- Any other Black
background

18. Please indicate your religion or belief

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> No religion | <input type="checkbox"/> Muslim |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Sikh |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Atheist |
| <input type="checkbox"/> Hindu | <input type="checkbox"/> Any other religion |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> Rather not say |

19. Please indicate the option which best describes your sexual orientation

- Heterosexual
- Gay
- Lesbian
- Bisexual
- Prefer not to say

**Congenital Heart
Disease Equality and
Health Inequalities
analysis – Draft for
consultation**



**National Standards and Service Specifications for Congenital Heart Disease
Equality and Health Inequalities analysis – Draft for consultation**

Version number: V2

First published: May 2015, Updated: January 2017

Prepared by: Congenital Heart Disease Programme Team

Classification: OFFICIAL

Draft for consultation

PART A: General Information
1. Title of the project, programme or work:
Congenital Heart Disease Equality and Health Inequalities Analysis
2. What are the intended outcomes?
<p>This review is an extension of the equality and health inequality impact assessment conducted in May 2015 on the standards by:</p> <ul style="list-style-type: none"> • Refreshing the Equality Impact Assessment conducted in 2015 with new available data; and • Undertaking an equality impact assessment on the proposals to cease the commissioning of level one and level two services at particular centres. We will consider whether the proposals would have a differential impact on any group with protected characteristics. <p>The National CHD Programme Team intends to review the Equality Impact Assessment periodically to ensure that ongoing feedback is included.</p>
3. Who will be affected by this project, programme or work?
<p>The following section addresses (i) who will be affected by the CHD service review and (ii) who would be affected by the proposed service changes.</p> <p>3.1 Who will be affected by the CHD service review</p> <p>It is estimated that across England and Wales between 5 and 9 in every 1,000 pregnancies are associated with some form of congenital heart disease (CHD) based on information collected by the British Isles Network of Congenital Anomaly Registers (BINOCAR¹). It is noted that the number of babies born with CHD will increase if the total numbers of babies being born continues to rise². Future birth rates are very difficult to predict. In their 'principal' projections, the Office of National Statistics (ONS) predicts that birth rates will fall over the next 10 years rates. But under their 'high' projections, ONS recognises that birth rates could rise.³</p> <p>Because of improvements in treatment, people with CHD can now expect to live longer than ever before. Between 1979-1983 and 2004-2008, the number of deaths from CHD in children under 15 years fell by 83% in the UK⁴. As a result, the number of people living with CHD is rising. This means that in the future we are likely to see the service moving from one that has been centred on children, to one that is treating a growing number of young people and adults. Advances in paediatric cardiology, intensive care medicine, and cardiac surgery mean that the number of children with</p>

¹ Table 1.1 and 5.1, "Congenital Anomaly Statistics 2011, England and Wales", BINOCAR, September 2013, found at: http://www.binocar.org/content/Annual%20report%202011_FINAL_040913.pdf

² ONS Population Estimates 2002-2010 available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-269171>

³ ONS Population projection 2012-2037 available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-318453>

⁴ *Mortality with congenital heart defects in England and Wales, 1959-2009: exploring technological change through period and birth cohort analysis* Knowles RL, Bull C, Wren C, Dezateux C (2012) Arch Dis Child, 2012 Oct; 97(10): 861-5

congenital heart disease (CHD) surviving into adulthood continues to increase. Hence, adults will constitute an ever-growing population⁵, who will continue to have (often complex) health needs. For many congenital defects treated in childhood, further problems can develop later in life that require medical care or further surgery⁶. As well as people with CHD, this work will affect: their families and carers; all members of the multidisciplinary teams who support patients with CHD; and hospitals, in particular those with specialist CHD units. Paediatric cardiac services also care for children with acquired and inherited cardiac diseases (although CHD accounts for most of their work).

The standards and specifications produced will ensure that services are provided to a consistent standard across the country and by doing so will reduce inequalities in CHD service provision and optimise outcomes.

3.2 Who would be affected by the CHD proposed service changes?

Patients who are currently receiving treatment in providers offering level 1 or 2 services, whose level of provision may be decommissioned would be impacted by the proposed service changes as at least some of their care would be transferred to another provider. The families and carers of patients with CHD affected by the changes would also be affected. Future patients and their families and carers who would have been treated at those centres and who will now be treated at a different centre will also be affected.

If level 1 services cease at the three centres proposed it is possible that level 2 services may continue (this is one aspect being explored in consultation). If this were to be the case the majority of care for those patients could continue to be provided at their existing centre except for any operations or cardiology interventions, and one pre-procedure and one post-procedure outpatient appointment.

We have outlined the providers that would be impacted by the proposed service change in section 3.3.

The next round of consultation is proposed to take place in December 2016 through to March 2017 and will be focused on understanding the impact of the proposed service changes. NHS England will not make a final decision until the consultation has concluded and the responses analysed.

The aim of the proposed service change is to provide a better service overall by ensuring that every patient receives their care from a centre that is able to meet the service standards and specifications. We do not anticipate that there should be a negative impact on the quality of services provided by centres that remain in operation: the principal impact will come from the reduction in the number of centres with the result that some patients will live further from their centre of choice. However, in the period during which change may be happening, there may also be transitional effects that may impact some patients more than others (most obviously, patients receiving treatment from centres that may cease providing the services they currently receive).

Patients who are currently at centres that will see increased volumes due to the proposed decommissioning of services may also be impacted. To understand the estimated volumes of CHD surgery per year moving to other providers if the suggested services are suspended two options have been modelled in table 1 and 2.

- In both scenarios a majority of patients from the Royal Brompton would attend Great Ormond Street Hospital should the proposed closures go ahead.
- In both scenarios a majority of patients from CMFT would attend Liverpool Heart and Chest

⁵ *Delivery of care for adult patients with congenital heart disease in Europe: results from the Euro Heart Survey*, Moons et al (2006) *European Heart Journal* 27, 1324–1330

⁶ *Care and Treatment for congenital heart defects* (2011) American Heart Association
<http://heart.org/HEARTORG/Conditions/CongenitalHeartDefects>

should the proposed closures go ahead.

- In both scenarios a majority of patients from UHL would attend University Hospitals Birmingham should the proposed closures go ahead.

Table 1: Scenario 1 of estimated volumes of CHD surgery/ year moving to other providers

Receiving Trust	Patients/year From Royal Bro			Patients/Year From CMFT			Patients/year From UHL			Grand Total		
	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1		-	-		8	8	-	9	9
BARTS HEALTH NHS FOUNDATION TRUST	77		77		-	-	1	1	1	78	-	78
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		5	5		-	-		174	174	-	179	179
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		228	228		-	-		4	4	-	232	232
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	30	173	203		-	-		4	4	30	177	207
LEEDS TEACHING HOSPITALS NHS TRUST	1	-	1	4	-	4	10	37	47	15	37	52
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1	96	-	96	-	-	-	97	-	97
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		-	-		-	-		-	-	-	-	-
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	6	11	17		-	-		1	1	6	12	18
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	2		2		-	-	49		49	51	-	51
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	3	2	5		-	-		2	2	3	4	7
Total	120	420	540	100	-	100	60	230	290	280	650	930

Data sources:

Volumes of Surgery : 1314 NICOR

Proportional use of centres : HES data 0607 to 1415

Table 2: Scenario 2 of estimated volumes of CHD surgery/ year moving to other providers

Receiving Trust	Patients/year From Royal Bro			Patients/Year From CMFT			Patients/year From UHL			Grand Total		
	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1		-	-		8	8	-	9	9
BARTS HEALTH NHS FOUNDATION TRUST	90		90		-	-	1	1	1	91	-	91
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		4	4		-	-		174	174	-	178	178
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		201	201		-	-		4	4	-	205	205
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	36	153	189		-	-		4	4	36	157	193
LEEDS TEACHING HOSPITALS NHS TRUST	1		1	4	-	4	8	37	45	13	37	50
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1	85	-	85	-	-	-	86	-	86
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		-	-		-	-		-	-	-	-	-
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	7	9	16		-	-		1	1	7	10	17
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	3		3		-	-	37		37	40	-	40
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	4	2	6		-	-		2	2	4	4	8
Total	142	370	512	89	-	89	46	230	276	277	600	877

Data sources:

Volumes of Surgery : 1415 NICOR

Proportional use of centres : HES data 0607 to 1415

Providers have also been asked to assess the impact on their services as a result of the proposed closures. From this information we understand the patient choice has not been factored into the modelling of where patients will go should the decommissioning of centres go ahead. Rather, the model looks at proposed new catchment areas. The impact on time travel is analysed in section 8.

The equality impact assessment aims to understand whether there will be a differential impact on any group with protected characteristics as a result of the proposed service change. The consultation will also provide a more detailed perspective on the impact of the proposed changes on patients.

3.3 Proposed changes to providers offering level one services

NHS England is currently minded to make changes at centres that provide level 1 (surgical) services:

- Surgery and interventional cardiology for adults should **cease** at Central Manchester University Hospitals NHS Foundation Trust (CMFT). CMFT does not undertake surgery in children.
- Surgery and interventional cardiology for adults and children should **cease** at Royal Brompton & Harefield NHS Foundation Trust.
- Surgery and interventional cardiology for children and adults and children should **cease** at University Hospitals of Leicester NHS Trust.

This means that the following centres would continue to provide level 1 services:

- Alder Hey Children's Hospital NHS Foundation Trust (children's services)
- Liverpool Heart and Chest Hospital NHS Foundation Trust (adult service)
- Birmingham Children's Hospital NHS Foundation Trust (children's services)
- University Hospitals Birmingham NHS Foundation Trust (adult service)
- Great Ormond Street Hospital for Children NHS Foundation Trust (children's services)
- Barts Health NHS Trust (adult service)
- Guy's and St Thomas' NHS Foundation Trust (children's and adult services)
- Leeds Teaching Hospitals NHS Trust (children's and adult services)
- Newcastle Hospitals NHS Foundation Trust (children's and adult services)
- University Hospitals Bristol NHS Foundation Trust (children's and adult services)
- University Hospital Southampton NHS Foundation Trust (children's and adult services)

3.4 Proposed changes to providers offering aspects of level two services

The following changes are proposed at centres that provide level 2 (medical) services

- Specialist medical care and interventional cardiology should **cease** at Blackpool Teaching Hospitals NHS Foundation Trust
- Specialist medical care and interventional cardiology should **cease** at Imperial College Healthcare NHS Trust
- Specialist medical care and interventional cardiology should **cease** at Nottingham University Hospitals NHS Trust
- Specialist medical care and interventional cardiology should **cease** at Papworth Hospital NHS Foundation Trust
- Specialist medical care and interventional cardiology have **already ceased** at University Hospital of South Manchester NHS Foundation Trust based on the recommendations of the Review.

This means that the following centres would continue to provide level 2 services:

- Brighton and Sussex University Hospitals NHS Trust (adult service)
- Central Manchester University Hospitals NHS Foundation Trust (children's services)
- Norfolk & Norwich University Hospitals NHS Foundation Trust (adult service)
- Oxford University Hospitals NHS Foundation Trust (children's and adult services)

NHS England is discussing the potential for the provision of level 2 medical services at hospitals where level 1 care would cease. The National CHD team is interested in the support for this approach and will test this as part of the consultation. This possibility relates to:

- Central Manchester University Hospitals NHS Foundation Trust (adult service)
- Royal Brompton & Harefield NHS Foundation Trust (children's and adult services)
- University Hospitals of Leicester NHS Trust (children's and adult services)

4. Which groups protected by the Equality Act 2010 and/ or groups that face health inequalities are very likely to be affected by this work?

The proposed standards are intended to ensure that everyone with CHD gets the best possible care within the available resources. Earlier analysis and engagement, has indicated that the impact of the proposed service change may differentially impact some Black and Minority Ethnic (BME) patients (those of Asian ethnicity) and those with a learning disability. In addition, services for CHD are of particular interest to children and the families and carers of children. We hope to build our understanding of the nature of the impact through the proposed December 2016 – March 2017 consultation. Therefore, the consultation considers the impact of the proposed changes on these

groups.

We do not believe that the work would undermine compliance with the Public Sector Equality Duty or section 11 of the Children Act 2004 which requires NHS England to make arrangements for ensuring that its functions are discharged having regard to the need to safeguard and promote the welfare of children; and that any services provided by another person pursuant to arrangements made by NHS England are provided having regard to that need.

4.1 Summary of response from providers regarding equality and inequality impact as a result of the proposals

The CHD Implementation Programme team asked providers to supply information about any equalities or inequalities consequences of the proposals. A number of hospitals responded to the request, however most centres did not identify any significant equality or health inequalities impacts associated with the proposals.

One centre stated that the reduction in services available in the East Midlands may create a geographical inequality in their ability access CHD care. Another centre suggested that a greater number of economically disadvantaged patients would find it harder to access outpatient clinics. All the responses submitted by the centres were considered in more detail and the analysis can be seen in section 7.1 (geographic variation).

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

5.1. Age

5.1.1 Review of literature and data

Mortality from CHD has decreased over the past 30 years; between 1979-1983 and 2004-2008, absolute numbers of deaths from CHD in children under 15 years declined by 83% in the UK⁷. As the birth prevalence of CHD is thought to have remained more stable over this time period⁸, it can be inferred that a large part of this decline in mortality is due to improved survival. Knowles *et al.* found that while deaths rates in the first year of life have been reducing throughout the period studied, drops in mortality in all age groups has only been observed for birth cohorts originating after 1989⁹.

There is a suggestion from our own analysis (table 3) and what we have heard that there has been an increase in demand for adult congenital heart disease care, not just among people in their twenties (i.e. birth cohorts originating after 1989).

Table 3: CHD related episodes by age and as percentage of total (2013/14 HES data)

Age band	Age	Episodes	% total
Neonate	0 to 30 days	1081	11%

⁷ *Mortality with congenital heart defects in England and Wales, 1959-2009: exploring technological change through period and birth cohort analysis* Knowles RL, Bull C, Wren C, Dezateux C (2012) Arch Dis Child, 2012 Oct; 97(10): 861-5

⁸ *Temporal variability in birth prevalence of cardiovascular malformations* Wren C, Richmond S, Donaldson L (2000). Heart; 83: 414-9

⁹ Op. cit.

Infant	31 to 364 days	1930	20%
Child 1 -15	1 to 15 years	3741	38%
Child 16-18	16 to 18 years	815	8%
Adult 19-64	19 to 64 years	1654	17%
Adult 65+	65 years+	588	6%

Note: includes all episodes with a procedure (excluding electrophysiology) in NHS England providers for all patients resident in England.

In the past, mortality rates were higher in the early days and months, now more children in the UK with CHD benefit from advances in paediatric cardiac surgery and intensive care, and receive treatment and reach adulthood. The greatest decline in deaths from congenital heart disease has occurred in those aged less than one year.

This means that in the future, as more people survive, we are likely to see the service moving from one that is centred around children to one that is in addition treating a growing number of young people and adults, who will continue to have (often complex) health needs. This has consequences for the way in which services are delivered and what sort of services are delivered, for both children and young people (and their different needs and expectations) through to transition for young people into adult services.

For many congenital defects treated in childhood, further problems can develop later in life which then requires medical care or further surgery¹⁰.

In *Children and young people: Statistics 2013*¹¹, the British Heart Foundation notes: 'Treatment of adults with congenital heart disease is relatively new as more children with congenital heart defects receive treatment and reach adulthood. As a result of the success of paediatric cardiology and cardiac surgery over the last four decades, it is thought that more adults with congenital heart disease will require medical care than children'¹² (page 15). The report authors go on to highlight the importance of ensuring that facilities are adequate at transition.

5.1.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

¹⁰ *Care and Treatment for congenital heart defects* (2011) American Heart Association
<http://heart.org/HEARTORG/Conditions/CongenitalHeartDefects>

¹¹ *Children and young people: Statistics 2013* (2013) Townsend N, Bhatnagar P, Wickramasinghe K, Williams J, Vujcich D, Rayner M, British Heart Foundation: London

¹² *Task force on the management of grown up congenital heart disease of the European Society of Cardiology* (2003) *European Heart Journal*; 24: 1035-1084

Typically we hear most from the families of children and young people with CHD. However, we have made efforts to ensure that we hear directly from children and young people with CHD themselves (and from adults with CHD too). We will continue to do so in this consultation. In creating the standards we took the time to listen to children and young people and what mattered most to them. We learned that their concerns were different from those of their parents or those who run services.

Young people told us:

- They want doctors and nurses to talk to them and not just to mum and dad; to be honest; and to communicate in a way that is appropriate for the individual taking account of their age and any disabilities.
- Even very young children quickly become expert on their condition and this needs to be acknowledged.
- They want to understand what's going to happen but not be scared by it.
- They want better information on living with CHD as a young person including on sex, drugs, alcohol, relationships, contraception, the possibility of children – and this needs to be away from parents completely.
- They would like there to be more specialist nurses, psychologists, counsellors.
- Getting to know and being known by hospital staff makes hospital life easier so keeping the same consultant/surgeon is very important.
- They would really like Wi-Fi as they are dependent on devices to keep in touch with the outside world.
- They want facilities including entertainment and play for all the different age groups.
- Everyone wants to improve transition so that the move from children's to adults' services is smoother; and transition needs to be individualised - there can't be an age limit – each patient is different – some should move early, others late, others never; and
- While they are in hospital children and young people want to maintain some level of normality, for example eating with their family, exercising/playing sports, seeing friends; keeping up with school; and having access to social media/internet/online resources.

Many of these concerns are directly addressed by the standards. We believe that our proposals to ensure that every patient can be confident that they will receive their care from a centre that meets the standards will have a very positive impact for children and young people.

In consultation in 2014/15, we heard that there is a need for increasing capacity in adult congenital heart disease services and that some centres were expanding facilities and recruiting new staff. We heard from patients, families and carers that services needed to be age-sensitive and that effective transition was vital. This related to effective and appropriate communication, but also to the facilities provided.

Young people told us that they would like more information about the implication of CHD on sex and relationships. They also recommended that this needed to be away from parents, since many teenagers are uncomfortable speaking about this in front of their parents, some didn't even don't like the idea of speaking with their regular doctors.

During consultation we spoke with individuals as well as organisations; this included: children, young people and adults, including service users' families and carers. Information provided during consultation guided us to review elements such as transition and collocation of services to support families who have multiple generations with congenital heart disease that require treatment.

5.1.3 Potential impact of the proposed service changes

We know that most surgery and cardiological interventions for CHD happen in early life. Because the proposals particularly affect where this sort of care will be delivered, children and young people (and

their families and carers) will be more affected than adults with CHD.

They can be expected both to gain more (the changes particularly focus on assurance that centres are able to meet the activity volumes required for best practice by surgeons and interventional cardiologists, and on the interdependencies required for children's cardiac services) and also to be more affected by change and by different journeys to the level 1 CHD centre when needed. Some children and their families will live further away from centres that will be continuing to make provision than they do from a centre that may cease provision. Some journey times will increase. Some families may find it harder to visit a child who is receiving in-patient care.

To understand the breakdown of children and young people and adults that would be impacted by the proposed changes we looked at the prevalence of children and young people (CYP) who were admitted to the Royal Brompton, Central Manchester Foundation Trust and University Hospitals of Leicester NHS Trust over a three year period (2013/14 to 2014/16). From table 4 we can see that there more CYP admitted than adults with the prevalence being 59%, 57% and 75% respectively.

Table 4: Inpatient admissions with CHD diagnosis 2013/14 to 2015/16

Inpatient Admissions with CHD diagnosis 13/14 to 15/16									
Provider	#patients (3yrs)	#patients (1yrs)	total admissions	#CYP	%CYP	#Asian	%Asian	#LD	%LD
RT3: Royal Brompton & Harefield NHS Foundation Trust	3,672	1,224	4,939	722	59%	8	1%	0	0.03%
RW3: Central Manchester University Hospitals NHS Foundation Trust	1,158	386	1,416	219	57%	55	14%	0	0.1%
RWE: University Hospitals of Leicester NHS Trust	1,217	406	1,584	304	75%	43	11%	1	0.2%

Source: NCDR SUS

CYD includes patients aged <19 at date of admission

Section 8 provides detailed information about the impact of travel. Children who currently receive treatment at Leicester and Royal Brompton would be impacted by the proposed changes. Average time travel would increase by 14 minutes for children who attend Leicester and 2 minutes for children use the Royal Brompton.

5.1.4 Proposed actions to mitigate the impact of the proposed service changes

The proposed standards emphasise, in several places, the importance of open, honest communication in ways that are appropriate to the patient's needs. In addition we have also developed specific standards on:

- communication with patients;
- transition; and
- pregnancy and contraception.

The standards specifically address a number of age related life course elements including birth, transition from paediatric to adult services, recognition of the increasing number of adults living with CHD and end of life.

We have commissioned the development of a survey to measure patient reported experience. The questions to be asked have been guided by the concerns of patients and their families including children and young people. This will mean that from next year we will be directly measuring and reporting on the experience of children and young people and will be able to track and address any changes that arise as a result of the proposed changes if they are agreed.

5.1.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

During consultation we will make special arrangements to gather the views of children and young

people. We have also produced an EasyRead version of this consultation document to help parents and carers explain the proposals to children.

As part of our consultation we are asking people about the impact implementation of the proposals would have on children and young people and also for advice on dealing with any concerns. This will include gathering qualitative evidence on the impact on young people through open ended questions.

5.2. Disability

5.2.1 Review of literature and data

Children and adults with congenital heart disease are at an increased risk of developing further difficulties. Many children with congenital heart disease experience delays in their development. For example, they may take longer to start walking or talking. They may also have lifelong problems with physical coordination.

Some children with congenital heart disease also have learning disabilities, which are thought to be caused by a poor oxygen supply during early life, which affects the development of the brain.

Natural intelligence is usually unaffected, but some children often perform well below the academic level they would be expected to reach. This is because of problems such as:

- impaired memory;
- problems expressing themselves using language;
- problems understanding the language of others;
- low attention span and difficulty concentrating;
- poor planning abilities; and
- poor impulse control – acting rashly without thinking about the possible consequences.

Recent research has found that children who have had surgery for transposition of the great arteries have significant problems related to a concept known as theory of mind (TOM). TOM is the ability to understand other people's mental states and recognise that they may differ from your own. In other words, to recognise that everyone has their own set of desires, intentions, beliefs, emotions, perspective, likes and dislikes. In simple terms, TOM is the ability to see the world through another person's eyes. An inability to recognise other people's mental states can lead to problems with social interaction and behaviour in later life.

Congenital heart disease as a complication of Down's syndrome

Around 50% of children with Down's syndrome have a congenital heart defect and around 60% of children with Down's syndrome who are born with a heart defect require treatment in

hospital.

Septal defects account for 9 out of 10 cases of congenital heart disease in people with Down's syndrome. (A septal defect is a hole inside one of the walls that separate the four chambers of the heart, often referred to as a 'hole in the heart').

Less common but serious types of congenital heart disease in people with Down's syndrome include:

- tetralogy of Fallot (accounts for 6% of cases); and
- patent ductus arteriosus (accounts for around 4% of cases).

As noted above in relation to age, it is possible that in complex congenital heart disease cases, further problems (which could include a disability) will develop later in life that will require medical care or further surgery¹³.

Congenital heart disease as a complication of 22q11 Deletion Syndrome (22q11DS)

22q11DS is a deletion of 1.5 to 3Mb on the long (q) arm of chromosome 22. It is the most common autosomal deletion in humans. The prevalence is 1 in 2 to 4000, and at least 1 in 6000. In the UK and Ireland, of a population of 66 million, approximately 150 to 200 infants are born each year with 22q11DS. Between 50 and 85% of individuals with 22q11DS have congenital heart disease¹⁴.

Therefore people with Down's Syndrome and 22q11DS may be more affected by the proposed service changes.

Prevalence of Learning Disability as a secondary diagnosis of CHD patients

The incidence of learning disability is 2.9% amongst children in England and Wales and 2.17% amongst adults¹⁵. We cannot make an exact estimate of the number of people with CHD who also have LD, but based on the evidence quoted above we can assume that it will be more than found in the general population. Using the incidence of learning disability we calculated the number of adults

¹³ *Care and Treatment for congenital heart defects* (2011) American Heart Association

<http://heart.org/HEARTORG/Conditions/CongenitalHeartDefects>

¹⁴ *Consensus Document on 22q11 Deletion Syndrome* Max Appeal

http://www.maxappeal.org.uk/downloads/Consensus_Document_on_22q11_Deletion_Syndrome.pdf

¹⁵ *People with Learning Disabilities in England*, Public Health England, 2013

http://www.improvinghealthandlives.org.uk/securefiles/161107_1231//People%20with%20learning%20disabilities%20in%20England%202013.pdf

and children with a learning disability that may be impacted by the proposed service change in each provider in table 5.

Table 5: Inpatient admissions with CHD diagnosis

Inpatient Admissions with CHD diagnosis 13/14 to 15/16, and pro rata NICOR 1415											
Provider	Group	#patients (3yrs)	total admissions	Patients/year	#Asian	%Asian	#LD	%LD	NICOR 1415	Est Asian patients/year	Est LD/year
RT3: Royal Brompton & Harefield NHS Foundation Trust	Adults	1,506	1,621	502	61	12.1%	11	2.17%	142	2	-
	Paeds	2,166	3,318	722	87	12.1%	21	2.90%	370	-	<1
RW3: Central Manchester University Hospitals NHS Foundation Trust	Adults	502	565	167	27	15.9%	4	2.17%	89	6	-
	Paeds	656	851	219	35	15.9%	6	2.90%	-	-	<1
RWE: University Hospitals of Leicester NHS Trust	Adults	305	352	102	13	12.6%	2	2.17%	46	3	<1
	Paeds	912	1,232	304	38	12.6%	9	2.90%	230	27	<1
Source: NCDR SUS											
CYP includes patients aged < 19 at date of admission											
#Patients and total admissions includes records where Ethnic category is 'Not Stated', 'Not Known' and NULL											

Note: refer to appendix 2 for the list of diagnosis used in the learning disability calculation

5.2.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

We heard about the importance of ensuring the standards respect the needs of people with disabilities.

We have proposed standards that address the needs of all patients and have included particular standards that relate to learning disability, for example in relation to:

- communication with patients; and
- transition.

We heard about the difficulties that individuals and carers have when caring for someone with a disability and CHD during consultation. For example the relation to the actual and perceived age of the individual with a learning disability; the need for staff to be trained in caring for those with specific special needs and the importance of the carer in this role. (Relating to the Carers Act 2014)

5.2.4 Potential impact of the proposed changes

Change for people with learning disabilities or on the autistic spectrum is more difficult. Any service change for this population can be more difficult and needs to be managed well. This is not unique to the CHD proposed service change; however careful consideration should be given to the management of change for these patients.

We asked charities that work with people with both CHD and learning disabilities about the potential impact of our proposals on people with learning disabilities. They told us that:

- People with learning disabilities and especially people with autistic spectrum disorder cope best when things are familiar, so changing settings and changing staff is more of an issue. 60% of those with any form of Q22 deletion will have an anxiety disorder of some kind, and this makes change and new experiences (as well as everyday experiences) particularly traumatic.
- We will need to be able to let patients and their families / carers know what is going to happen very clearly including the practical details.
- Travel for people using wheelchairs or supportive aids is difficult. Children with autistic spectrum disorders often can't use public transport easily. So the issue of access and travel needs extra attention and support for people with learning disabilities and their families / carers
- The impact of a cancellation on a family of a learning disabled patient can be huge – so capacity at centres taking additional patients will need to be sufficient that cancellations can be minimised.
- Care and attention needs to be paid to any successful change and transition - visits with familiar staff to new units, new staff coming to meet a patient on familiar ground, arranging for visits prior to surgery or interventions to see where things will happen, what the ward looks like etc. can help.
- Discharge needs better planning and organisation so that travel doesn't mean that patients are arriving at their destination very late at night, and out of their regular schedule.
- Parents and carers need to be included in the planning each patient's needs.

The particular concern has been around the practical elements of change like travelling to a new location, and patients being treated by clinical teams in a location that they are not familiar with. People with learning disabilities allow clinicians that they know to work with them and may refuse the same treatment in an unfamiliar surrounding by unfamiliar people.

- If our proposals are agreed we will ensure that these concerns are addressed in the planning and preparation for any changes that follow.

The proposed service changes may also result in patients receiving care split at two centres (level one and level two) rather than all at the same centre. This may be disruptive for all patients and especially those with a learning disability. Clinical team should be encouraged to communicate to make the transition as smooth as possible. We anticipate that the network model of care will encourage good communication between clinical teams. It is also expected that the regional networks will work in a coordinated manner to ensure equality and standardisation of care throughout the NHS.

The standards address the particular needs of people with learning disability for example in requiring appropriate facilities, appropriate communication and individualised transition to adult services. There is also a requirement to work with the learning disability team and for CHD health professionals to include training on meeting the needs of people with learning disability in their continuing professional development. Many other aspects of the standards will have a positive effect on the experience of people with learning disability and their families.

5.2.5 Proposed actions to mitigate the impact of the proposed service changes

Consideration has been given to the 'target audience' for documents and information, and whether proactive publication in any alternative languages and / or formats is appropriate.

Documents and information published by NHS England, as well as corporate correspondence, should be as accessible as possible to as many people as possible as stated by the [NHS England Accessible Information Standard](#). This does not mean that multiple formats or versions of every document should always be produced; rather that accessibility should be built into the development of 'standard' versions and consideration should be given to the most appropriate approach to alternative language and format provision as part of preparing for publication. - *Therefore, information can be made available in formats, such as easy read or large print, and may be available in alternative languages, upon request.*

Previously we listened and responded to this in consultation; producing easy read material; offering different forms of media, as well as face-to-face at consultation events; translating material and being available to answer queries via email or phone. We will continue to do this for the proposed December 2016 consultation.

From preliminary conversations with stakeholders we found that ensuring there is a learning disability team in Trusts is crucial. Reasonable adjustments are also already being made at providers across the country. This may include scheduling patients with a learning disability during the beginning or end of the day when the hospital is quieter. It is important that best practice is shared between trusts and that clinical teams are communicating the needs of patients. We believe that the network model will encourage communication between centres which is especially important for vulnerable groups.

We will also encourage providers to communicate with parents, carers and patients about the changes and what practical implications will arise. This would help lessen concerns and enable enough time to make alternative arrangements. When service change does happen the National CHD Team should seek to assure patients that communication will be smooth and that patients will have change managed well.

Standards around family support, transportation and accommodation will become even more important for patients that are moved to new centres. The implementation of the standards will also take into account capacity at units in order to minimise cancellations.

5.2.6 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

The consultation should specifically consider the impact on people with learning disabilities and understand the best way to create continuity for people with learning disabilities. This will aim to minimise the disruption of change and make the transition period smoother.

During consultation we will make special arrangements to gather the views of people with learning disabilities and their families and carers. We have also produced an EasyRead version of this consultation document to help parents and carers explain the proposals to people with learning disabilities. As part of our consultation we are asking people about the impact implementation of the proposals would have on people with learning disabilities and their families and carers and also for advice on dealing with any concerns.

5.3. Gender reassignment

We have not identified any specific evidence relating to gender reassignment (including

transgender) and CHD. Additionally we have not heard anything on this topic in pre-consultation or consultation. The standards and service specifications do not alter access or delivery of these services to people with this protected characteristic.

5.4. Marriage and civil partnership

We have not identified any specific evidence relating to marriage and civil partnership and CHD. Additionally we have heard nothing on this topic both pre-consultation and during consultation. (We do not think it appropriate or justified to assume that people who are married or in a civil partnership are more likely to be the parents or carers or in a family with a person with CHD). The standards and service specifications do not alter access or delivery of these services to people with this protected characteristic.

5.5. Pregnancy and maternity

Two distinct groups in this category may be affected by the proposed changes.

- Women with CHD who are pregnant
- Women who are pregnant carrying a baby with CHD

In both cases most maternity care is delivered through local maternity services at a hospital close to the woman's home. Arrangements will be made for the delivery of the baby that take account of the needs of both mother and child. This may be at the local obstetric unit or at an obstetric centre at or close to the specialist surgical centre. These requirements are described in the standards in sections J and K.

5.5.1 Review of literature and data

While cardiac disease is a leading cause of maternal death in pregnancy¹⁶ there is evidence that this is acquired rather than congenital heart disease and outcomes for pregnant women with CHD are good.

The Royal College of Obstetricians and Gynaecologists (RCOG) published a Good Practice guideline in 2011 which noted that pregnancy carries increased risks for women with congenital heart disease and particular efforts should be made to prevent any unwanted pregnancies. In particular teenage girls with congenital heart disease should have access to a specialist who can advise on contraception and later in life on preconception counselling. RCOG also noted the importance of ensuring that women with CHD:

- who go to their GP or midwife for advice are referred promptly to an appropriate high-risk pregnancy and heart disease team; see a cardiologist to establish how well the heart is working; and discuss how pregnancy may impact their health.
- who want to become pregnant or who are pregnant visit their obstetrician and ideally should talk to them jointly with a cardiologist.

5.5.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

We heard choices in care delivery are offered and these choices must be clearly defined and shared, including positive and negative outcomes, support in both circumstances must be offered. We heard

¹⁶ Royal College of Obstetricians and Gynaecologists (2011)

that there is a possibility that increased fetal diagnoses could in some cases increase terminations and reduce activity. But in other cases, it could increase the chance of survival and increase activity.

We also heard that as a consequence of better care for people with congenital heart disease, more are going on to have their own children. This means that it is very important that there are close links between maternity services and Adult Congenital Heart Disease services, and that deliveries are planned for safety.

We heard comments on the standards relating to maternity care for women with CHD – for example the specific request for earlier diagnosis; the wording of the standards in relation to choice, options and access to procedures and care how such services would be implemented and monitored.

In 2014/15, we undertook a separate piece of work to improve fetal diagnosis of congenital heart disease. An implementation project group commenced to ensure early diagnosis and improved standards of detection, with partner organisations such as Health Education England, Public Health England, societies and charities. We developed specific standards on:

- pregnancy and contraception (section J); and
- fetal diagnosis (section k).

5.5.3 Potential impact of the proposed changes

We believe that the proposed standards will have a positive impact on the experience and outcomes of women with CHD who are considering pregnancy, are pregnant or are receiving maternity care and on women who are pregnant carrying a baby with CHD. For the first time services will be nationally commissioned using common service specifications.

For some women, if the proposals are implemented it will mean that delivery will take place at an obstetric unit further from home. These issues are dealt with in section 8.1 below.

5.5.4 Proposed actions to mitigate the impact of the proposed changes

We believe the standards published in 2014/15 that specifically consider maternity and pregnancy mitigate any impact of the proposed standards. We do not think that the proposed service changes for 2016/17 will impact pregnancy and maternity.

5.5.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

Pregnancy and maternity do not have implications on the 2016/17 consultation.

5.6. Race

5.6.1 Review of literature and data

Ethnicity is known to relate to the prevalence of certain diseases. The relationship between ethnicity and CHD is complex and may be confounded by cultural and religious factors.

We looked at hospital activity data in comparison to the population to see whether some ethnic groups receive a greater than expected level of hospital care.

The data (appendix 2) appears to show higher levels of inpatient activity for congenital heart disease amongst BME groups than would be expected on a strict population basis amongst children, but not

amongst adults. This data does not tell us whether the incidence of CHD is higher in these groups – higher levels of inpatient activity may reflect a similar incidence but a greater proportion of serious disease, or may reflect other factors leading to higher admission rates.

Ethnicity and prevalence

Research dating back to the 1980s¹⁷ and 1990s¹⁸ demonstrated higher prevalence among Asian communities in various UK cities including Manchester and Leeds, and in the West Midlands.

Research conducted at the Birmingham Children's Hospital indicates there is a higher prevalence of Asian infants with congenital heart disease. The prevalence for Asian infants is estimated to be 9.45 per 1000 and 4.56 per 1000 for non-Asian infants. The difference between these two groups is highly statistically significant¹⁹.

In the 1980s research links were made between CHD and consanguinity in the Asian Muslim population. More recently in *Consanguinity and the risk of congenital heart disease*, (2012)²⁰ found that the majority of studies support the view that consanguinity increases prevalence of CHD, but found only three population-based studies controlled for potential socio-demographic confounding. The results suggested that the risk for CHD is increased in consanguineous unions in the studied populations, principally at first cousin level and closer.

For more precise risk estimates a better understanding of the underlying disease factors is needed. It has been suggested that we should consider whether and how to raise awareness of the risk of CHD within these communities. This is discussed in more detail under proposed actions in section 5.6.4.

The national census 2011²¹ shows that 7.5% of the population of England and Wales has Asian ethnicity including Indian 2.5%, Pakistani 2%, Bangladeshi 1.5% and white and Asian 0.6%. Based on the evidence already presented we would expect that there would be a higher proportion of people with Asian ethnicity amongst CHD patients.

We looked at the recorded ethnicity of CHD patients at the three affected level 1 centres. From the data in table 6, we can see that all three trusts have a higher prevalence of South Asian patients than the average for the population and higher than the CHD patient group at other level 1 CHD hospitals.

- CMFT has the highest prevalence of the three providers that will be impacted by the service change at 15.9% compared to the average of 11.2%.
- UHL has a prevalence of 12.6% compared to the average of 11.2%.
- Royal Brompton has a prevalence of 12.1% compared to the average of 11.2%.

Table 6: Ethnicity prevalence in CMFT, Leicester and Royal Brompton

¹⁷ Gatrad AR, Reap AP, Watson GH Consanguinity and complex cardiac anomalies with situs ambiguous, *Arch. Dis Child* 1984; 59: 242-5

¹⁸ Sadiq M, Stumper O, Wright JGC, de Giovanni JV, Billingham C, Silove ED Influence of ethnic origin on the pattern of congenital heart defects in the first year of life *Br Heart J* 1995; 73: 173-176

¹⁹ Sadiq M, Stumper O, Wright JGC, de Giovanni JV, Billingham C, Silove ED Influence of ethnic origin on the pattern of congenital heart defects in the first year of life *Br Heart J* 1995; 73: 173-176

²⁰ [Am J Med Genet A](https://doi.org/10.1002/ajmg.a.35272). 2012 May;158A(5):1236-41. doi: 10.1002/ajmg.a.35272. Epub 2012 Apr 9.

²¹ Ethnicity and National Identity in England and Wales, ONS 2011

<http://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11>

RW3: Central Manchester University Hospitals NHS Foundation Trust	RWE: University Hospitals of Leicester NHS Trust	RT3: Royal Brompton & Harefield NHS Foundation Trust	All Trusts Grand total	Ethnic Category_
70.6%	75.8%	72.6%	74.1%	A: British
0.8%	0.3%	2.4%	0.5%	B: Irish
2.6%	3.6%	4.8%	4.7%	C: Any other white background
0.9%	1.4%	0.4%	0.8%	D: White and black Caribbean
0.7%	0.1%	0.0%	0.4%	E: White and black African
0.6%	0.4%	0.4%	0.7%	F: White and Asian
1.3%	1.0%	0.4%	0.9%	G: Any other mixed background
15.9%	12.6%	12.1%	11.2%	H: Asian
0.7%	0.6%	0.8%	0.7%	M: Caribbean
2.6%	0.9%	3.2%	2.2%	N: African
0.5%	0.9%	0.0%	0.9%	P: Any other black background
0.7%	0.3%	0.8%	0.6%	R: Chinese
2.2%	2.1%	2.0%	2.3%	S: Any other ethnic group

Source: NCDR SUS 13/14 to 15/16

Selection criteria: primary diagnosis from CHD 'pure' list

'Not known' and 'Not stated' excluded (4672 of 26605 records)

Furthermore we looked at inpatient admissions for people with a CHD diagnosis for Royal Brompton, CMFT and UHL to determine the number of patients from Asian groups that would be impacted by the proposed service change.

From Table 7, we can see that CMFT has the largest Asian patient population and therefore the proposals would have the largest impact on Asian patients at CMFT

Table 7: Inpatient admissions with CHD 2013 to 2014

Inpatient Admissions with CHD diagnosis 13/14 to 15/16, and pro rata NICOR 1415											
Provider	Group	#patients (3yrs)	total admissions	Patients/year	#Asian	%Asian	#LD	%LD	NICOR 1415 Est Asian patients/year	Est LD/year	
RT3: Royal Brompton & Harefield NHS Foundation Trust	Adults	1,506	1,621	502	61	12.1%	11	2.17%	142	2	-
	Paeds	2,166	3,318	722	87	12.1%	21	2.90%	370	-	<1
RW3: Central Manchester University Hospitals NHS Foundation Trust	Adults	502	565	167	27	15.9%	4	2.17%	89	6	-
	Paeds	656	851	219	35	15.9%	6	2.90%	-	-	<1
RWE: University Hospitals of Leicester NHS Trust	Adults	305	352	102	13	12.6%	2	2.17%	46	3	<1
	Paeds	912	1,232	304	38	12.6%	9	2.90%	230	27	<1
Source: NICOR SUS											
CYP includes patients aged < 19 at date of admission											
#Patients and total admissions includes records where Ethnic category is 'Not Stated', 'Not Known' and NULL											

Ethnicity and outcomes

We asked NICOR to examine whether there was any link between ethnicity and the 30-day outcome after paediatric surgery. The NICOR²² analysis showed that Asian ethnicity is associated with poorer outcomes (30-day post-operative mortality). This association does not prove that Asian ethnicity causes poorer outcomes. Other factors beyond simple ethnicity may play a factor in this finding, such as deprivation and a higher incidence of consanguinity which is associated with more complex congenital heart disease and therefore less good outcomes. More work will be needed to understand this association.

5.6.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

During the 2014/15 pre-consultation we heard that BME groups would need to be contacted to ensure that they were aware and engaged within the process. We made every effort to ensure that this happened.

5.6.3 Potential impact of the proposed changes

The data above shows that the changes will affect more people of Asian origin than the general population because of the higher incidence of CHD amongst people of Asian origin.

It is not straightforward to assess whether the proposed changes will affect people of Asian ethnicity differently from other groups. Implementation of the standards will ensure that everyone benefits from services provided to a consistent standard across the country.

Language barriers can cause challenges when being offered or receiving treatment.

The consultation process will enable us to better understand the impact of the proposed changes by engaging with BME groups.

5.6.4 Proposed actions to mitigate the impact of the proposed changes

Language barriers can cause challenges when being offered or receiving treatment. Support for people for whom English is not their first language is addressed in the standards:

H8(L1): Specialist Children's Surgical Centres must demonstrate that arrangements are in place for parents and carers, children and young people to be given an agreed, written

²² (Sonya Crowe, Kate L. Brown, Christina Pagel, Nagarajan Muthialu, David Cunningham, John Gibbs, Catherine Bull, Rodney Franklin, Martin Utley, Victor T. Tsang, **Development of a diagnosis- and procedure-based risk model for 30-day outcome after paediatric cardiac surgery**, The Journal of Thoracic and Cardiovascular Surgery, Volume 145, Issue 5, May 2013, Pages 1270-1278, ISSN 0022-5223, <http://dx.doi.org/10.1016/j.jtcvs.2012.06.023>)

management plan in a language they can understand, that includes notes of discussions with the clinical team, treatment options agreed and a written record of consents.

H18(L1): Copies of all correspondence for GP and local centres must be copied to the parent/carer/young person (as appropriate) in plain language to retain in the patient's personal record in accordance with national guidance.

H16(L1): Where patients do not have English as their first language, or have other communication difficulties such as deafness or learning difficulties, they must be provided with interpreters/advocates where practical, or use of alternative arrangements such as telephone translation services and learning disability 'passports' which define their communication needs.

5.6.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

During consultation we will make special arrangements to gather the views of people of Asian ethnicity with CHD. We have produced a summary version of this consultation document in a number of Asian languages and the full document can be translated on request. As part of our consultation we are asking people about the impact implementation of the proposals would have on people of Asian ethnicity with CHD and also for advice on dealing with any concerns.

5.7. Religion or belief

5.7.1 Review of literature and data

Please refer to section 5.6 for information on CHD and consanguineous unions.

5.7.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

We heard that religion and belief and culture could make it difficult for some people to engage with us in an open forum.

During the 2014/15 consultation, we heard that when a fetal diagnosis is made, how the options of terminating or continuing the pregnancy are delivered, can be difficult if a patient has religious beliefs, or their culture pre-disposes them to not entering discussion on such matters.

We also heard that sometimes parental accommodation is unsuitable for Muslim women because of the possibility of contact with men, for example in shared communal areas such as kitchens. This issue is not specific to CHD services and is not tackled by the new standards. There is no evidence that this would become a greater issue if our proposals were to be implemented.

5.7.3 Potential impact of the proposed changes

We do not have any evidence that shows a particular impact of the proposed changes on people of differing religions and beliefs.

The standards recognise the need for communication and information giving to be culturally sensitive.

It is envisaged that hospitals that would be expected to provide care for more patients, under our proposals, will review ethnic, religious and cultural mix of patient information in light of the standards and feedback of the communications, engagement and the independent consultation report.

5.7.4 Proposed actions to mitigate the impact of the proposed changes

The impact on people of different ethnicity (which may be linked to religion and culture or with different beliefs) will be explored further during the consultation. We will explain the method of doing this in section 5.7.5.

5.7.5 Implications for the 2016/17 consultation on the proposed service change as part of the CHD Commissioning and Implementation Programme

As part of our consultation we are asking people about the impact implementation of the proposals would have on groups protected characteristics and also for advice on dealing with any concerns

5.8. Sex or gender

5.8.1 Review of literature and data

Data was reviewed to identify if there was any specific correlation between gender and hospital episodes relating to CHD.

Table 8: CHD-related episodes by gender and as percentage of total

Gender	%	%
Paediatric cardiac	Episodes	Patients
Male	55	54
Female	45	46
ACHD	Episodes	Patients
Male	47	47
Female	53	53

Source: 2013/14 HES data

Note: includes all episodes with a procedure (excluding electrophysiology) in NHS England providers for all patients resident in England.

From table 8 we can see that in terms of activity levels, there are more episodes for males than females in paediatric cardiac procedures but more episodes for females than males in adulthood.

In terms of outcomes, there is no evidence that outcomes differ by gender – based on analysis by NICOR – no statistical association between 30-day mortality and patient gender has been identified²³. However, *Children and young people: Statistics 2013* (2013) notes that in children under five years of age, 3.5% of all deaths in boys and 4.8% of all deaths in girls are from congenital heart disease.

5.8.2 What we heard during pre-consultation and consultation during the CHD Review

²³ Source: NICOR

Programme in 2014/15

During consultation we spoke with both genders and received comments only in relation to pregnancy and maternity as already discussed within the paper.

5.8.3 Potential impact of the proposed changes

We do not anticipate that the proposed changes will differentially impact this pregnancy and maternity.

5.8.4 Proposed actions to mitigate the impact of the proposed changes

None

5.8.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

None

5.9. Sexual orientation

5.9.1 Review of literature and data

We have not identified any specific evidence relating to sexual orientation and CHD.

5.9.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

Young people have told us that they would like more information about sex and relationships and this need to be away from parents – many teenagers are uncomfortable speaking about any of these things in front of their parents and some don't even like the idea of speaking with their regular doctors.

We did not hear specific concerns on sexual orientation during the consultation. However, we believe that the standards will have a positive impact on the experience and outcomes of children and adults with differing sexual orientation who have CHD.

5.9.3 Potential impact of the proposed changes

We do not anticipate that the proposed changes will have a differential impact depending on sexual orientation.

5.9.4 Proposed actions to mitigate the impact of the proposed changes

Our standards emphasise, in several places, the importance of open, honest communication in ways that are appropriate to the patient's needs.

5.9.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

None

6. Implications of our work

Implications for our work has been included in discussion of each of the protected characteristic groups

6.1. Alcohol and / or drug misusers

One study found that rates of substance abuse among patients with CHD are either comparable or lower than comparable samples of similarly aged peers.²⁴

We do not believe that the proposed service change will have a differential impact on patients who are alcohol and/ or drug misusers.

6.2. Asylum seekers and /or refugees

We have not identified any specific evidence relating to asylum seekers and or refugees and CHD.

Access to healthcare, understanding of the English health system and communication difficulties and cultural differences may be relevant differences for asylum seekers and refugees but would not be specific to CHD services or the proposed changes.

We will ensure if the proposals are approved that enhanced communication and support is available for any patients and families with CHD who are refugees/asylum seekers.

6.3. Carers

6.3.1 Review of literature and data

It will be important to ensure that parents and carers of children and adults with CHD have access to the information and any psychological support they might need.

6.3.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

We heard how important it is for parents and carers to be supported, particularly when they are away from home. They told us about difficulties with finding their way round new hospitals, finding accommodation and eating balanced meals. They also told us about problems with car parking. These effects may be amplified if parents and carers have to travel to a new centre.

We also heard the importance of having support for end of life for both children and adults. This means having identified support structures that encourage and enable open and honest

²⁴ [Congenit Heart Dis.](https://doi.org/10.1111/j.1747-0803.2007.00161.x) 2008 Jan-Feb;3(1):16-25. doi: 10.1111/j.1747-0803.2007.00161.x.

communication with families and carers at that time.

We have developed specific standards on:

- facilities; and
- palliative care and bereavement
- networks and integration of care provision
- support groups.

The difficulties for carers were identified e.g. juggling family responsibilities while caring for an individual with CHD; being able to participate in the care of the individual while they are in hospital.

6.3.3 Potential impact of the proposed changes

We aim to understand the impact of the proposed changes on carers through the consultation process.

6.3.4 Proposed actions to mitigate the impact of the proposed changes

It has been proposed that level one centre(s) consider whether the number of hotel facilities available for carers reflects the volume of care they provide.

6.3.5 Implications for the 2016/17 consultation on the proposed service change as part of the CHD Commissioning and Implementation Programme

Consultation will seek views from families and carers as well as from people with CHD. The consultation questions include open ended questions where families and carers will have the opportunity to share their experiences and concerns. This may include families and carers who would have compounded impacts of the proposed service changes. This would include parents and carers with disabilities, from particular religious observations and some characteristics that are not protected but would bear considering, e.g. single carers, those on low income.

6.4. Ex-service personnel / veterans

We have not identified any specific evidence relating to ex-service personnel or veterans and CHD

6.5. Those who have experienced Female Genital Mutilation (FGM)

We have not identified any specific evidence relating to those who have experienced FGM and CHD.

6.6. Gypsies, Roma and travellers

We have not identified any specific evidence relating to Gypsies, Roma and travellers and CHD.

6.7. Homeless people and rough sleepers

We have not identified any specific evidence relating to homeless people and rough sleepers and CHD.

6.8. Those who have experienced human trafficking or modern slavery

We have not identified any specific evidence relating to those who have experienced human trafficking or modern slavery and CHD.

6.9. Those living with mental health issues

6.9.1 Review of literature and data

In addition to medical problems, people living longer with CHD face psychological, sociological and behaviour challenges²⁵. Since people with CHD are surviving longer into adulthood, the increasing population of adults with CHD also means there will be an increasing percentage of adult CHD patients that have mental health issues such as anxiety and depression.

Some studies show that female patients and patients with complex forms of CHD are more prone to worse psychological adjustment and to psychopathology. Patients with complex forms of CHD need regular care, which restricts social contact with peers and family and regular social integration. Furthermore, patients who had undergone surgery showed worse quality of life as they often have long hospital stays, during which social activities are restricted, making it more difficult for them to develop a good social support network²⁶.

Evidence highlights the importance of multi-disciplinary teams with specialised follow up to manage these complex patients²⁷. The multi-disciplinary team may include clinical psychologists or councillors to help patients living with CHD transition into adulthood. It is important to highlight the need for social support as it plays a crucial role in buffering stress and promoting patients' adjustment.

6.9.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

People with mental health conditions and CHD were not covered explicitly in the pre-consultation and consultation on the standards.

6.9.3 Potential impact of the proposed changes

We do not have any data to understand the percentage of people with mental health issues and CHD that would be impacted by the changes. However, we have heard during the 2016 preliminary stakeholder engagement that people with mental health issues may be differentially impacted by the proposed service changes. This will need further exploration to understand the specific impact during the consultation.

6.9.4 Proposed actions to mitigate the impact of the proposed changes

The consultation will help inform any proposed actions to mitigate the impact.

6.9.5 Implications for the 2016/17 consultation on the proposed service change as part of the

²⁵ [Int J Cardiol.](#) 2013 Dec 5;170 (1):49-53. doi: 10.1016/j.ijcard.2013.10.003. Epub 2013 Oct 11.

²⁶ *Revista Portuguesa de Cardiologia, Volume 32, Issue 9, September 2013, Pages 657-664*

²⁷ [Eur J Cardiothorac Surg.](#) 2009 Jul;36(1):105-11; discussion 111. doi: 10.1016/j.ejcts.2009.03.023. Epub 2009 May 12

CHD Commissioning and Implementation Programme

The consultation process should help us gather more information about the nature of the impact on people with mental health issues.

6.10. Sex workers

We have not identified any specific evidence relating sex workers and CHD

6.11. Trans people or other members of the non-binary community

We have not identified any specific evidence relating to Trans people or other members of the non-binary community and CHD

6.12. The overlapping impact on different groups who face health inequalities

6.12.1 Review of literature and data

A study in Sweden has found that deprived areas have higher rates of CHD by 23%²⁸. Level of deprivation may influence risk of CHD through a number of general mechanisms, including unfavourable health-related behaviours of women during pregnancy. However, the association did not seem to be independent of individual- and family-level characteristics.

We have not identified any specific literature around CHD and the compounded impact on carers or people from a disadvantaged social economic standing.

6.12.2 What we heard during pre-consultation and consultation on the standards

This was not covered in the pre-consultation and consultation on the standards.

6.12.3 Potential impact of the proposed changes

The proposed changes may have a compounded impact on several groups:

- carers of vulnerable people such as those with a learning disability or from BME groups;
- travel for people using wheelchairs or supportive aids can be more difficult; and
- carers of people from a disadvantaged social economic standing.

We have heard that carers might find the changes difficult as they will have to manage the impact on vulnerable people. We have heard the concern that some carers may not be willing to travel further to visit patients in hospital. This may lead to social isolation and make vulnerable people less likely to want to travel. Confounding factors such as poverty would also make travel more difficult.

The consultation process should help us gather more information about the overlapping impact of carers and social economic status on people with CHD.

6.12.4 Proposed actions to mitigate the impact of the proposed changes

²⁸ *Int J Behav Med.* 2016 February; 23(1): 112–120. doi:10.1007/s12529-015-9488-9
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4808140/pdf/nihms766685.pdf>

The consultation will help inform any proposed actions to mitigate the impact.

6.12.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

The consultation process should help us gather more information about the nature of the impact on health inequalities.

7. Other groups that face health inequalities that we have identified.

Draft for consultation

7.1 Geographical variation

7.1.1 Review of literature and data

The analysis on geographical variation was structured to understand two factors: activity and time travelled to a different centre under the proposed new structure. To understand these factors we conducted the following analysis:

First, relative activity was calculated to understand the number of patients who would be impacted by the proposed service change.

- CHD-related episodes by area to understand whether there could be quality issues by geography;
- Mapping of relative activity by geography to determine relative activity in each area; and
- Modelling the estimated volume of CHD surgery per year moving to other providers if suggested services are suspended.

Second, to understand the time travelled by patients as a result of the new proposed catchment areas we calculated the time patients would have to travel as a result of the new catchments. This was done in two steps:

- Impact of the proposed service changes on provider catchment area
- Time travel analysis as a result of the proposed service change on surgical patients

We then used this information to understand the impact of the proposed changes on travel time.

Relative activity across the country

While not a protected characteristic, we have looked at CHD-related episodes (specialist inpatient activity) by area as percentage of total, and episodes per head of population (2013/4 HES data). This was done to test whether there could be geographic quality issues.

Table 9: Variation in CHD relative activity

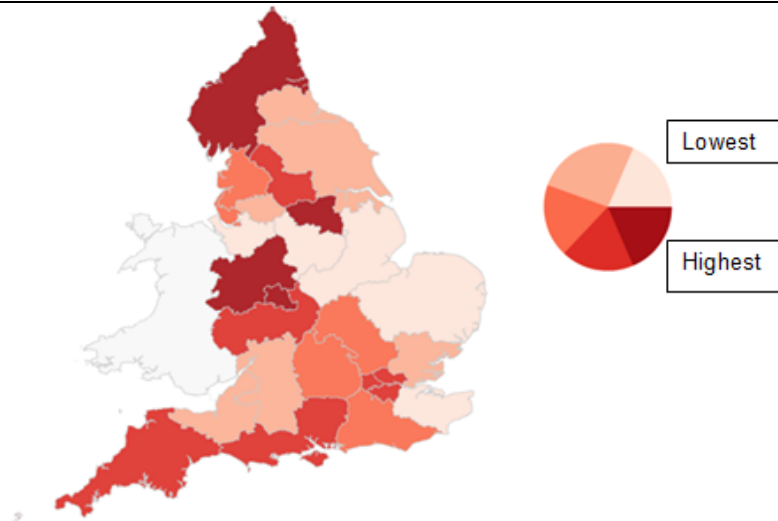
Area Team of patient residence	% of all specialist inpatient episodes	Specialist inpatient episodes per 100,000 (0-18) population	Specialist inpatient episodes per 100,000 (19+) population
Durham, Darlington and Tees	2%	58.3	4.2
Cumbria, Northumberland, Tyne and Wear	4%	69.9	4.4
Lancashire	3%	61.3	6.3
Greater Manchester	5%	57.0	5.5
Cheshire, Warrington and Wirral	2%	50.9	5.9
Merseyside	3%	59.0	11.5
West Yorkshire	5%	69.0	3.9
South Yorkshire and Bassetlaw	3%	73.4	5.0
North Yorkshire and Humber	2%	54.7	2.8
Leicestershire and Lincolnshire	3%	50.5	5.7
Hertfordshire and The South Midlands	5%	61.0	5.4
Derbyshire and Nottinghamshire	3%	52.2	4.3
Birmingham and The Black Country	6%	79.8	6.2
Shropshire and Staffordshire	3%	74.0	7.1
Arden, Herefordshire and Worcestershire	3%	66.0	3.5
East Anglia	4%	51.7	5.8
Essex	3%	58.5	5.2
London	17%	69.3	4.9
Kent and Medway	3%	45.2	4.7
Surrey and Sussex	5%	58.9	7.0
Thames Valley	4%	60.2	5.5
Wessex	5%	67.0	4.9
Bath, Gloucestershire, Swindon and Wiltshire	3%	57.4	8.0
Bristol, North Somerset, Somerset and South Gloucestershire	2%	54.8	5.7
Devon, Cornwall and Isles Of Scilly	3%	62.9	4.4

Note: includes all episodes with a procedure (excluding electrophysiology) in NHS England providers for all patients resident in England.

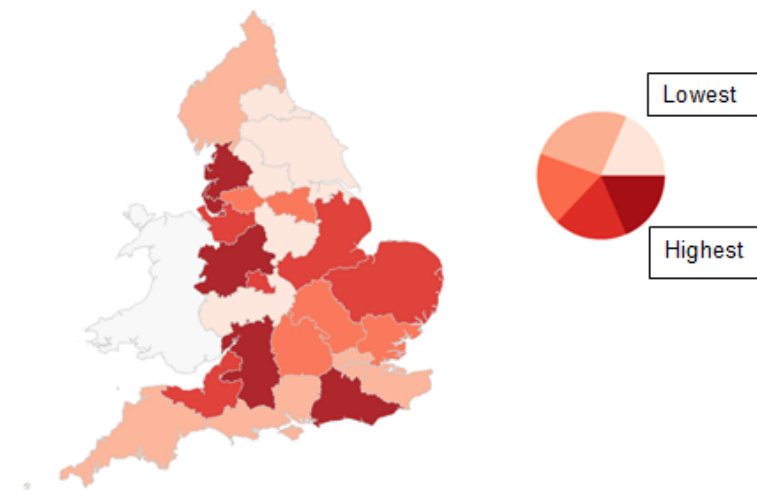
The HES data in table 9 indicates that there is considerable variation across the country in terms of relative activity. The episodes per 100,000 population (age 0-18) show some differences from Kent and Medway at 45.2 to Birmingham and the Black Country at 79.8. In the case of adult services, the episodes per 100,000 population show differences from North Yorkshire and Humber at 2.8 to Merseyside at 11.5.

This is demonstrated in the maps (image 1 and 2); the darker the colour the higher the relative activity in that area. The reasons for this variation are unclear.

Image 1: Paediatric specialist inpatient episodes per 100,000 population, by Area Team



ACHD (19+) 2013/14 HES specialist inpatient episodes per 100,000 population, by Area Team of patient residence (activity per head so controlled for different population sizes)



Impact of the proposed service changes on volumes of surgery

We have modelled two scenarios, one with 2013/14 NICOR data and one with 14/15 NICOR data to understand the potential volumes of CHD surgery moving to other providers if suggested services are suspended. This analysis will help build an understanding of the number of patients that would be impacted in each geography by the service change.

From the 2014/15 data we can predict that the following number of patients would be impacted by the changes to level one services:

- 142 adults and 370 children who previously received treatment at the Royal Brompton;
- 89 adults who previously received treatment at CMFT; and
- 26 adults and 230 children who previously received treatment at UHL.

Table 10: Estimated volumes of CHD surgery per year moving to other providers if suggested services are suspended (using 2013/14 NICOR data)

Receiving Trust	Patients/year From Royal Brom			Patients/Year From CMFT			Patients/year From UHL			Grand Total		
	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1		-	-		8	8	-	9	9
BARTS HEALTH NHS FOUNDATION TRUST	77		77		-	-	1		1	78	-	78
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		5	5		-	-		174	174	-	179	179
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		228	228		-	-		4	4	-	232	232
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	30	173	203		-	-		4	4	30	177	207
LEEDS TEACHING HOSPITALS NHS TRUST	1	-	1	4	-	4	10	37	47	15	37	52
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1	96	-	96	-	-	-	97	-	97
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		-	-		-	-		-	-	-	-	-
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	6	11	17		-	-		1	1	6	12	18
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	2		2		-	-	49		49	51	-	51
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	3	2	5		-	-		2	2	3	4	7
Total	120	420	540	100	-	100	60	230	290	280	650	930

Data sources:
 Volumes of Surgery : 1314 NICOR
 Proportional use of centres : HES data 0607 to 1415

Table 11: Estimated volumes of CHD surgery per year moving to other providers if suggested services are suspended (using 2014/15 NICOR data)

Receiving Trust	Patients/year From Royal Brom			Patients/Year From CMFT			Patients/year From UHL			Grand Total		
	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total	Adult	Paeds	Total
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1		-	-		8	8	-	9	9
BARTS HEALTH NHS FOUNDATION TRUST	90		90		-	-	1		1	91	-	91
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		4	4		-	-		174	174	-	178	178
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		201	201		-	-		4	4	-	205	205
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	36	153	189		-	-	-	4	4	36	157	193
LEEDS TEACHING HOSPITALS NHS TRUST	1		1	4	-	4	8	37	45	13	37	50
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1	85	-	85	-	-	-	86	-	86
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		-	-		-	-		-	-	-	-	-
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	7	9	16		-	-		1	1	7	10	17
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	3		3		-	-	37		37	40	-	40
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	4	2	6		-	-		2	2	4	4	8
Total	142	370	512	89	-	89	46	230	276	277	600	877

Data sources:
 Volumes of Surgery : 1415 NICOR
 Proportional use of centres : HES data 0607 to 1415

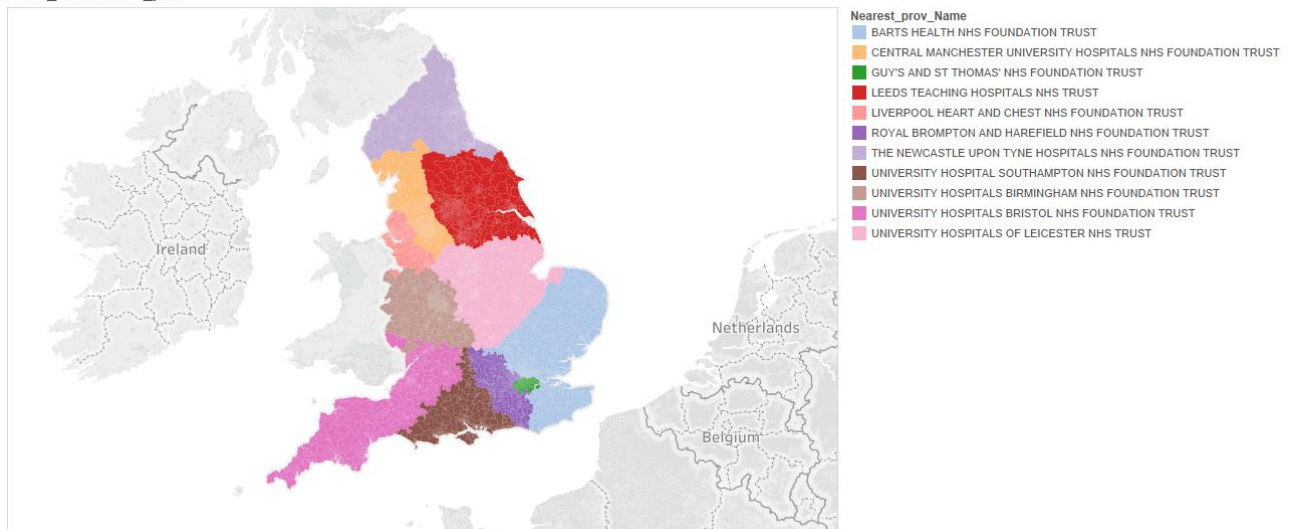
Impact of the proposed service changes on provider catchment area

The two maps (image 2 and 3) show the proposed catchment areas change for adult and paediatric CHD services. Both the adult and paediatric catchment areas have become larger as a result of the proposed service change.

Adult

Image 2: Adult catchments before the proposed service change

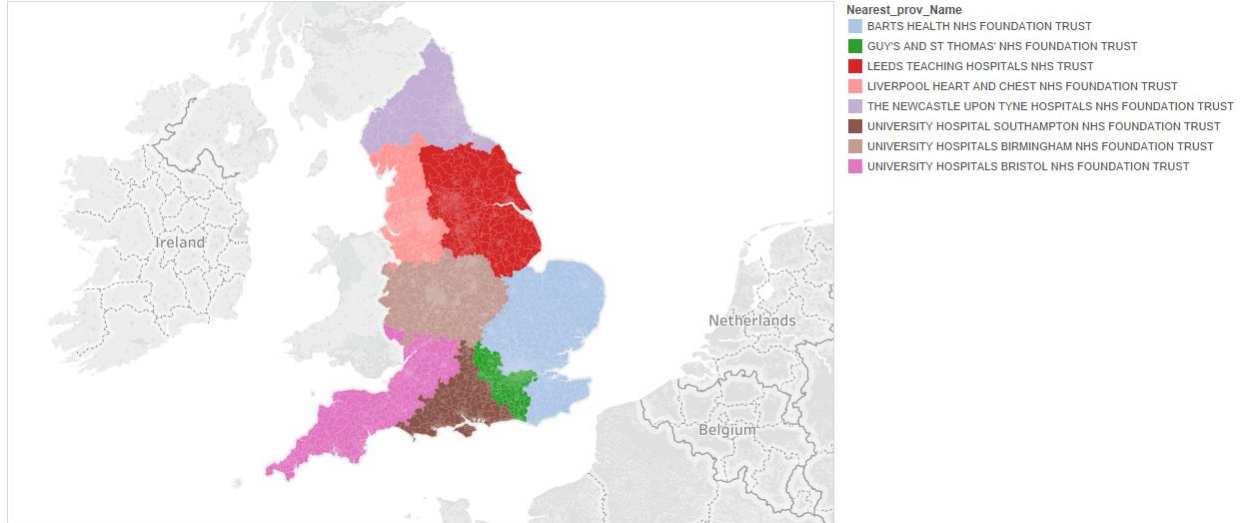
Adult_catchments_pre



Map based on average of Longitude and average of Latitude. Color shows details about Nearest_prov_Name. Details are shown for Msoa and PolygonID (Detail). The data is filtered on Scenario and Grp. The Scenario filter keeps Pre. The Grp filter keeps Adult.

Image 3: Adult catchments after the proposed service change

Adult_catchments_post

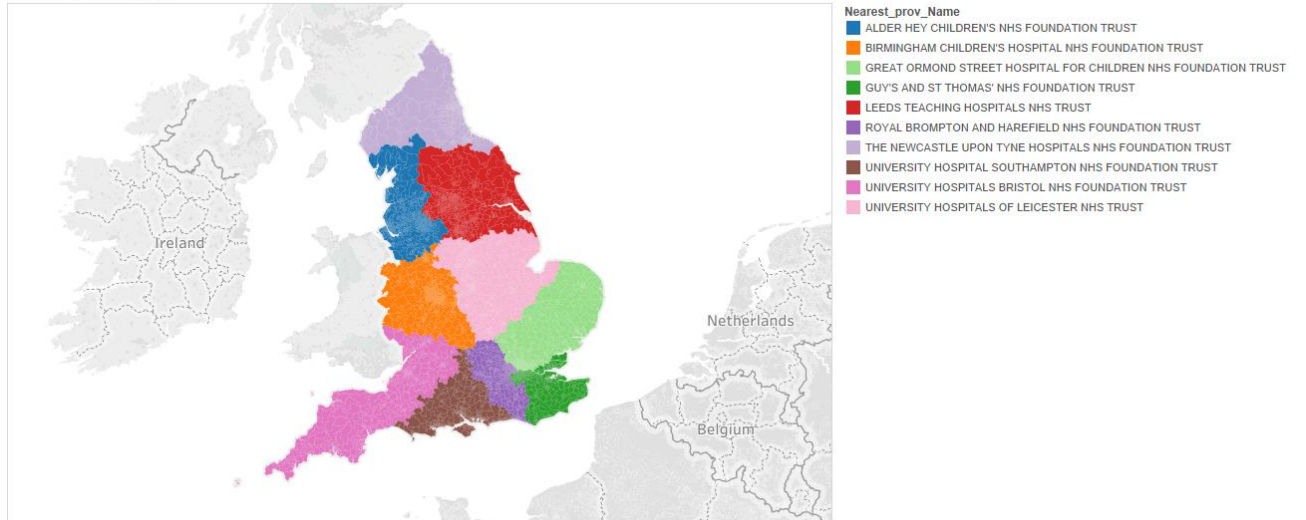


Map based on average of Longitude and average of Latitude. Color shows details about Nearest_prov_Name. Details are shown for Msoa and PolygonID (Detail). The data is filtered on Secnario and Grp. The Secnario filter keeps Post. The Grp filter keeps Adult.

Paediatric

Image 4: Paediatric catchments before the proposed service change

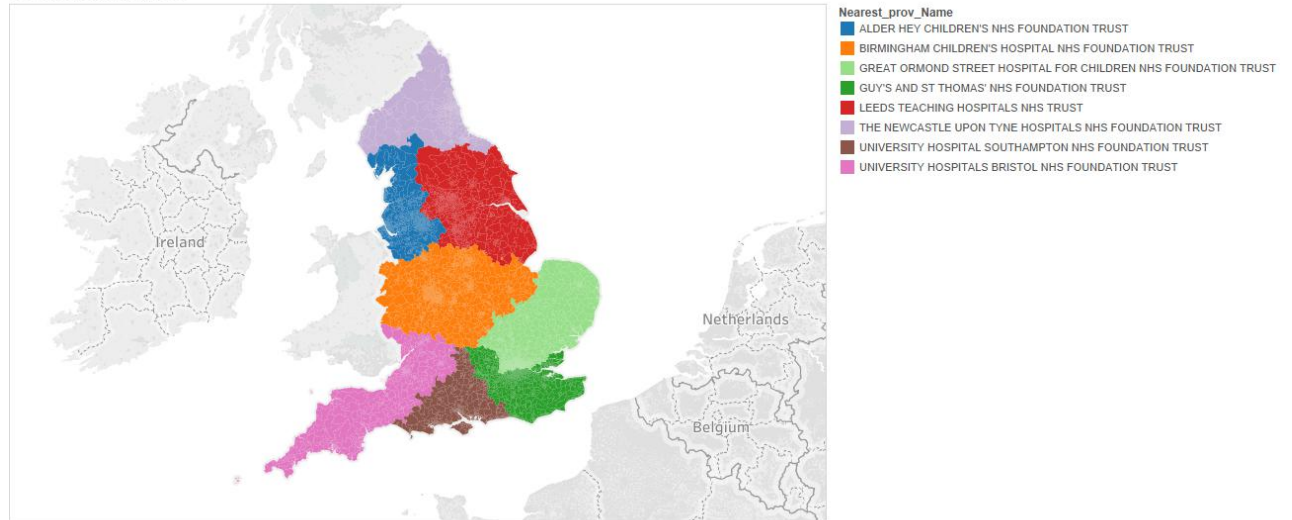
Paeds_catchments_pre



Map based on average of Longitude and average of Latitude. Color shows details about Nearest_prov_Name. Details are shown for Msoa and PolygonID (Detail). The data is filtered on Secnario and Grp. The Secnario filter keeps Pre. The Grp filter keeps Paeds.

Image 5: Paediatric catchments after the proposed service change

Paeds_catchments_post



Map based on average of Longitude and average of Latitude. Color shows details about Nearest_prov_Name. Details are shown for Msoa and PolygonID (Detail). The data is filtered on Scenario and Grp. The Scenario filter keeps Post. The Grp filter keeps Paeds.

To understand the impact of the new catchment areas on patients we have conducted travel time analysis.

Time travel analysis as a result of the proposed service change on surgical patients

The table 12 and 13 show the median and maximum time travel before and after the proposed decommissioning. From the analysis it can be determined that while journey times will increase for some people when they need to attend their level 1 centres, especially for those living close to the hospitals whose services are changing. We expect the average change in travel times will not significantly increase as a result of new catchment areas, although a small number of patients will experience a significant increase. Our modelling suggests an average increase of:

- 14 minutes for children who use Leicester and 32 minutes for adults;
- 11 minutes for adults who use Manchester; and
- 2 minutes for children and a reduction in one minute for adults who use the Royal Brompton.

Table 12: Median and maximum travel times before decommissioning

Patients going to	Median Travel time	Max travel time for 90% of patients
CMFT Adults	00:29:05	00:59:19
Royal Brompton Adults	00:47:50	01:43:40
UHL Adults	00:41:10	01:18:28
Adults National pre decommissioning	00:41:18	01:25:55
Royal Brompton Paeds	00:43:00	01:37:19
UHL Paeds	00:45:40	01:54:46
Paeds National pre decommissioning	00:43:41	01:53:27

Table 13: Median and maximum travel times after decommissioning

Patients previously going to	Median Travel time	Max travel time for 90% of patients
CMFT Adults	00:40:06	01:04:18
Royal Brompton Adults	00:46:15	01:22:35
UHL Adults	01:13:18	01:44:19
Adults National post decommissioning	00:49:30	01:25:33
Royal Brompton Paeds	00:45:15	01:24:42
UHL Paeds	00:59:01	01:41:04
Paeds National post decommissioning	00:45:34	01:50:24

Note: The calculations in the table 'Before Decommissioning' are based on data which include a number of patients who travelled very long distances (from out of logical catchment) to the three centres. In the 'after decommissioning' data these have been redirected to their nearest provider. While patients previously very close to the decommissioned services would have to travel further to an alternative centre (and hence increase average travel times) mathematically the redirection of the patients travelling long distances reduces the estimated maximum travel time for 90%. These estimated reductions are marginal (22 seconds for adults and circa 3 minutes for paediatrics).

7.1.2 What we heard during pre-consultation and consultation during the CHD Review Programme in 2014/15

The evidence we have received in relation to geographical variation has been limited. Where geography has been raised it has been in relation to how services are delivered now and how they might be delivered in the future. The focus has been on whether existing units will meet the standards and what it means to staff and patients if not; and travel times now and in the future.

During consultation we heard that people were concerned that depending on where you live you may have a CHD service on your doorstep, or it could potentially be 2-3 hours' drive away. However we have also heard that the main impact of the changing centres is not the time travel, rather the aspect of change and patients and families having to adjust to travelling to new centres. This was discussed earlier under disability.

7.1.3 Potential impact of the proposed changes

We recognise that it is more difficult for families to support patients in hospital at some distance from home and that this is a common problem already. Based on the advice of patients and families, a number of standards were developed to make life easier in this situation.

NHS Choices has guidance on claiming or getting travel costs refunded under the Healthcare Travel Costs Scheme. This scheme can help with travel costs if three conditions are met: meeting the eligibility criteria of the NHS Low Income Scheme, having a referral from a health care professional, and the appointment is separate to when the referral was made. The schemes can apply to children, dependents and carers.

The scheme and conditions are explained in detail on the NHS Choices webpage:
<http://www.nhs.uk/nhsengland/healthcosts/pages/travelcosts.aspx>

7.1.4 Proposed actions to mitigate the impact of the proposed changes

To make this situation easier for patients, carers and families we have developed standards – for better information about where to park, eat and sleep; better facilities to prepare meals; providing Wi-Fi; ensuring parking charges are affordable; and providing overnight accommodation for parents and carers.

7.1.5 Implications for the 2016/17 consultation on the propose service change as part of the CHD Commissioning and Implementation Programme

The consultation will specifically ask about the impact of longer journeys and seek suggestions for dealing with any concerns.

Draft for consultation

PART C: Promoting integrated services and working with partners

Short explanatory notes: Integrated services and reducing health inequalities.

8. How can this work increase integrated services and reduce health inequalities?

We believe that implementing the standards will have a positive impact on the experience and outcomes of all children, young people and adults with CHD. We have given full consideration to the health outcomes, experiences and access to health care services to different population groups. All of which has been evidenced previously in this document.

For the first time services will be nationally commissioned and regionally delivered using common service specifications across all ages. As the sole National Commissioner, NHS England will need to ensure monitoring of the duty as part of contract management with service providers.

The first set of standards - category A – The Network Approach, will help to integrate CHD services. We are proposing that across the country services should be organised according to a three tier model (level 1, 2 and 3), with clear roles and responsibilities 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

PART D: Engagement and involvement

9. Engagement and involvement activities already undertaken.

A three month consultation on the proposed standards and specifications for CHD services for children and adults ran until the 8th December 2014 (there was already a set of standards and a service specification in place for children's services but standards only existed in draft form for adults).

The consultation was an open process, enabling groups, organisations and individuals to respond. Information captured was reviewed on an individual basis, enabling all information to be captured and thereby avoiding the creation of a voting process on what the majority said.

The review team visited twelve locations across the country, to provide information through a variety of media forms and enable people to discuss face-to-face their concerns, worries or queries.

People were able to fill in their responses on-line, by post and could seek help in completion of a response if required. Translated material was available, with further translations available on request. This included 'easy' read to support those who may have disabilities and for those that wanted a version that was easy to read, providing the essentials of the consultation material. This version was tested with appropriate charities and support groups.

Support in ensuring widespread communication of the consultation was sought by the review team from groups who had mechanisms already established to reach those groups classed as 'hard to reach'.

The communication and engagement report contains further detail on consultation and the independent report on consultation prepared by 'Dialogue by Design' provides further information on the numbers of responses, the type of response and their origin.

The proposed standards were central to our engagement and involvement work from the outset and informed the development of the draft service specifications. We sought to address any gaps in evidence across all protected characteristics during the engagement process of

developing these standards, testing all our work, with experts and service users (particularly through our engagement and advisory groups - clinicians, patients and the public and provider and organisation representatives).

As well as regular meetings of formal engagement and advisory groups, we have visited all the specialist units; these visits were led by Professor Deirdre Kelly, previously Chair of the Clinician Group. During these visits, members of the new CHD review team had an opportunity to speak to clinical staff, patients and their families and carers. Nine dedicated events for children and young people were held around the country.

The CHD Commissioning and Implementation Programme continues to adopt an approach of openness and transparency and all the previous CHD review programme papers are published on the NHS England Congenital Heart Disease Review website and included within John Holden's blog.

The CHD Commissioning and Implementation updates are now provided through Will Huxter's blog.

10. Which stakeholders and equalities and health inclusion groups were involved?

During 2015, we worked with a wide range of stakeholders to develop the proposed standards. These included:

- children and young people with CHD along with their families and carers;
- adults with CHD and their families and carers;
- groups representing people with CHD;
- clinicians and other members of the multidisciplinary team;
- providers; and
- local authorities and Healthwatch.

During the proposed December 2016 to March 2017 consultation we will focus on patients that are residents in England. Whilst we recognise that there are patients living in Wales, Scotland and Northern Ireland who use CHD services in England, we have agreed with colleagues in other countries that they will make people aware of the consultation. We will welcome all responses. We have specifically designed questions to understand the impact of the proposed changes on vulnerable groups or people with protected characteristics.

11. Key information from the engagement and involvement activities undertaken.

During the 2015 pre-consultation we gathered evidence from stakeholders on:

- the network approach;
- level two specialist cardiology centres;
- level three local cardiology centres and local hospitals;
- staffing and skills;
- facilities;
- interdependencies;
- training and education;
- organisation, governance and audit;
- research;
- transition;
- pregnancy and contraception;
- fetal diagnosis;
- palliative care and bereavement;

- dental; and
- any other issues.

A full report detailing the information gathered at these events and concerns expressed by stakeholders is available on the NHS England (<https://www.england.nhs.uk/wp-content/uploads/2014/07/chd-cap-6.pdf>). Stakeholders were broadly supportive on the new standards and service specifications as they will increase the quality of care within the available resources.

12. Stakeholders were not broadly supportive but we need to go ahead.

N/A

13. Further engagement and involvement activities planned.

Another round of consultation will potentially start during the week of 12 December 2016 and run for 14 weeks, with additional time added in recognition of Christmas and New Year holidays; and therefore ending 19 March, 2017.

The purpose of the consultation is to understand the various perspectives on the changes to level one services that were set out in the July announcement. These changes will be set in the context of NHS England's whole programme of work in this field.

The consultation document will provide a rationale for the proposal in respect of each centre, summarising the case for change and pointing to the more detailed analysis where relevant. The rationale will include:

- Impact on service quality
- Impact on patients, including transport
- Transition plans
- Impact on health inequalities
- Impact on groups sharing a protected characteristic
- Impact on patient choice
- Cost implications

In the proposed consultation December 2016 to March 2017 we seek to understand the impact of the proposals on each local health economy. This includes the proposal to cease commissioning some level one and level two centres as indicated previously. During the consultation we will be keen to understand:

- whether patients support the proposals that every patient is able to receive a service that is able to meet the standards;
- whether patients support the proposed new commissioning models;
- whether patients agree that the implementation of the service will reduce health inequalities;
- whether patients think implementation of the proposal would have an impact on any group sharing a protected characteristic that has not already been considered;
- whether the proposals relating to paediatric services will safeguard and promote the welfare of children;
- whether the proposals promote and safeguard the welfare of children;
- whether patients have any suggestions for dealing with concerns; and
- and whether there are any suggestions that would help us make sure that the proposed changes are agreed happen as smoothly as possible for patients and their families.

Question time events

In the three cities where most change is proposed an event will be organised following the 'Question Time' format with an independent facilitator. Questions should be pre-submitted to the facilitator. The events should be ticketed to ensure that the size of audience can be matched to the capacity of the venue, with free registration taking place on the NHS England events system. For these to be successful we will need to work closely with campaigners, charities, providers and democratically elected representatives to ensure a representative panel and audience. It will also be important to ensure that all parties work together to ensure that large numbers of people without tickets do not attend.

WebEx Seminars

Web enabled seminars will be offered and provide an important tool in reaching targeted audiences.

Targeted engagement

Targeted engagement will be used to elicit the views of groups known to be more affected by CHD including people with learning disabilities and their families and carers; people of Asian origin (this work would be inclusive of people for whom English was not their first language); children and young people. We will work with relevant charities and support groups in undertaking this engagement, and where necessary engage specialist agencies to undertake work on our behalf.

PART E: Monitoring and Evaluation

14. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work

Stakeholder Engagement

Evidence to support the review of CHD services has come from a range of sources. Key sources of evidence for the review in general, and the standards in particular, have been advised from:

- patients;
- clinicians;
- provider leaders;
- academics and other experts; and
- the wider public through correspondence and responses to our blog.

During 2014/15 we gathered evidence from:

- our patients and public, providers' and clinicians' engagement and advisory groups;
- the groups that have developed the CHD standards;
- the Clinical Advisory Panel;
- a formal review of academic literature undertaken by ScHARR (see below);
- visits to 13 Trusts with specialist CHD units where we had the opportunity to meet staff and patients;
- nine meetings across England with children and young people;
- twelve consultation events;
- consultation responses.

An independent report was commissioned by NHS England and written by Dialogue by Design

entitled 'Consultation on draft standards and service specifications for congenital heart disease services' published on the 2nd March 2015.

This enabled us to understand and take account of the views of a much wider range of stakeholders.

Furthermore, the CHD team is proposing to conduct another round of engagement from December 2016 to March 2017 to understand the patient perspective on the proposed service change.

Literature Review

A report that summarises some of the evidence is available at on the NHS England (<https://www.england.nhs.uk/wp-content/uploads/2014/07/chd-cap-6.pdf>). This paper summarises views expressed during the 2014/15 pre-consultation period. In particular it reflects views from the CHD review's children and young people events, visits to CHD services across England and Wales, discussions with the CHD review's three engagement and advisory groups and discussions at the CHD Clinical Reference Group.

In 2014/15, to inform our thinking on standards and the other objectives of the CHD Review Programme, we put in place other pieces of work to gather evidence. This has been done in parallel with the work of the review's lead analyst who has been progressing work on Objective 2 (including interrogating Hospital Episodes Statistics (HES) data).

We also commissioned a systematic literature review; and asked the National Institute for Cardiovascular Outcomes Research (NICOR) to investigate their data.

The independent systematic literature review, undertaken by The University of Sheffield, School of Health and Related Research (SchARR) on our behalf, aimed to understand how organisational factors may affect patient outcomes focusing on:

- What is the current evidence for the relationship between institutional and surgeon volume and patient outcomes, and how is the 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 paediatric intensive care)?

During the 2016 refresh of the equality impact assessment new research was conducted on the protected characteristics to understand if new studies have been conducted. During this process, our thinking was tested with a few key stakeholders, prior to wider consultation. The data collected from consultation will be analysed by an independent firm experienced in the analysis of consultation.

Data analysis

The National Institute for Cardiovascular Outcomes Research (NICOR) was asked to examine its data and to advise on what this showed about service factors that could influence outcomes. NICOR ran the Congenital Heart Disease Audit using patient information collected by the Central Cardiac Audit Database (CCAD). We asked them to consider whether the information collected could be used to further understand the relationship between certain organisational or patient factors and patient outcomes. NICOR have helped us understand better the association between 30-day mortality rates in relation to ethnicity and social deprivation.

Further data analysis has been conducted to understand the projected impact of ceasing to commission some level one and level two centres. This work has been summarised in the section B and C.

15. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?

Covered in the section 16

16. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:

- important equalities or health inequalities data gaps or
- gaps in relation to monitoring and evaluation?

Yes

No

No – we will explore some factors in more details such as travel that may have an impact on inequalities.

17. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

We have taken action to ensure that the consultation process is accessible to as many people as possible and has a wide reach. We have done this through the following steps:

- Consultation document is available through the consultation hub website.
- Hard copies of the documents will be distributed to charities and patient support groups.
- The consultation documents will be emailed to all stakeholders and available at all events.
- Translated versions of the consultation document and other materials will be made available on request.
- An easy read version of consultation document will be available. While principally developed to support the participation of people with learning disabilities this version may also be helpful for younger children and for people for whom English is not their first language.
- Foreign language summary of consultation proposals have been translated into most common non-English languages and Welsh.
- Video summary of consultation proposals is available via the consultation hub website and will be shown at events.
- Talking head videos support key aspects of the proposals and the standards underpinning them. These will be available through the consultation hub website and

will be shown at events.

- The standards available on NHS England website.
- A report of national panel and detailed centre reports will also be available on NHS England website.

Throughout the CHD Review Programme in 2014/15 we heard that work is needed to develop the information provided to both patients and commissioners about the performance of congenital heart disease services. The primary outcome measure used to monitor congenital heart services is 30 day postoperative mortality measured over a three year rolling period. As survival rates improve there is a need to develop other quality measures and pay more attention to adult congenital heart services. The CHD team has recommended the following actions to improve the quality of data.

Adult data recommendations

- NICOR to publish a non-risk adjusted report on whole centre adult mortality alongside their paediatric mortality reports
- NICOR to begin developing case mix adjusted reporting on the outcomes of adult interventions

Process recommendations

- NICOR to implement a web based system for providers to submit their data
- NICOR to provide written guidance to providers to include information on responsibilities, data submission, reporting and what will happen if alert/warning limits are breached
- Health Quality Improvement Partnerships to update their policy on the detection and management of outliers to include a step to inform the Accountable Commissioner for the Congenital Heart Services Clinical Reference Group (CHS CRG) and the HQIP contract manager of any outliers
- NHS England to develop a consistent process for responding to any outliers

Communication of information recommendations

- NICOR to produce their annual report on paediatric and adult mortality within six months of the end of the year it has reported
- NICOR to report both paediatric and adult risk adjusted mortality on a quarterly basis
- NICOR to improve the design and publication of audit data, with specific targeted communication for; Patients/Public, Providers (Clinical Teams/Units), Commissioners and Trust Boards. This will also include the establishment of a communication strategy for informing stakeholders when reports have been published
- The Clinical Operational Research Unit (CORU) to complete its project to develop, test, and disseminate online resources for families and carers affected by congenital heart disease in children, the public and the media to facilitate appropriate interpretation of published mortality data following paediatric cardiac surgery
- The CHS CRG to review the outcome of the CORU project looking at disseminating online resources to determine if it provides any learning regarding how to better communicate information on congenital heart disease outcomes

Expanded mortality data

- NICOR to report on 90 day mortality alongside 30 day mortality
- NICOR to review the 56 procedures against which mortality information is provided to ensure as many as possible are included within this list
- NICOR to report outcomes by diagnosis as well as procedure
- The CHS CRG information sub-group to add measures to the dashboard relating to out of hospital mortality for high risk procedures
- The CHS CRG to review the outcome of the CORU project looking at long term

outcomes to determine if it provides any learning regarding how to report on longer term outcomes by diagnosis.

Quality

- To improve the information on quality of care, NHS England has established the Transition Dashboard and the Quality Dashboards across congenital heart services.
- Public Health England has also established the National Congenital Anomaly and Rare Disease Registration Service (NCARDRS) which started having national coverage in April 2016. This will include all patients diagnosed with congenital heart disease and may provide a useful way of recording any presenting information on long term quality of care.

Morbidities

- The CHS CRG information sub-group will develop a meaningful way of reporting surgical complications via the Quality Dashboard.
- Information will be collected and analysed on ten morbidities. These have been agreed by a panel of clinicians and patient representatives to establish whether or not these provide useful and comparable information. Upon completion of the projects the CHS CRG will review the findings to determine whether these indicators should be reported on nationally by the Quality Dashboard or NCHDA.

Long term outcomes

- The Clinical Operational Research Unit is looking at long term outcomes, this and developing metrics relating to monitoring them. This information should enable patients to better understand the long term impacts of specific conditions and reveal variation in long term outcomes.

Service measures

- NICOR has also been commissioned to identify a small number of Clinical Service Quality Measures (CSQMs) for congenital heart disease which can be used by commissioners and patients to provide a high level view of areas of concern at any of the specialist centres

Dashboards

- NHS England has commissioned the development of a portal which will enable NHS staff to access the dashboard information and submit data to it. Following this a Quality Surveillance Portal will be established as a public facing portal where dashboard information can be viewed by members of the public

Patient Experience

- Metrics which report on patients' experience of care are seen as an important marker of the quality of the service and help to establish that the patient is at the centre not just of the care they receive but of the way the quality of their care is measured
- The expansion of patient centred outcome measures (PCOMS) may provide congenital heart disease with an opportunity to collect information on patient outcomes in a different way.
- Procure a service to develop paediatric PREMS surveys, validate the existing adult survey, create a web based portal for completing the surveys and provide ongoing analysis to centres of the results of these surveys. Explore whether the PREMS survey will capture information about protected characteristics.

PART F: Summary analysis and recommended action		
18. Contributing to the first PSED equality aim.		
Can this work contribute to eliminating discrimination, harassment or victimisation?		
Yes	No	Do not know
If yes please explain how, in a few short sentences		
The standards state that providers should ensure that facilities meet the appropriate requirements of the Equality Act 2010.		
19. Contributing to the second PSED equality aim.		
Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.		
Yes	No	Do not know
If yes please explain how, in a few short sentences		
<p>All groups should benefit since the standards state that the Networks should form seamless pathways of care for patients. It is expected that the networks will work in a coordinated manner to ensure equality and standardisation of care throughout the NHS, eliminating regional variation that might have an indirect negative effect on equality and opportunity.</p> <p>The standards should also ensure a better and more consistent service for people with CHD, hence improvement in their health and wellbeing. This also means they can participate more in public life and therefore the standards could have a secondary impact of advancing equality of opportunity.</p>		
20. Contributing to the third PSED equality aim.		
Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.		
Yes	No	Do not know
If yes please explain how, in a few short sentences		
This work can contribute to fostering good relationship between groups through the network model. Good communication is encouraged through the standards and will be important in providing a good service in the network model.		
21. Contributing to reducing inequalities in access to health services.		
Can this policy or piece of work contribute to reducing inequalities in access to health services?		
Yes	No	Do not know
If yes which groups should benefit and how and/or might any group lose out?		

All groups should benefit since that the Networks should form seamless pathways of care for patients. There will be regular collaboration to ensure equality and consistency of care throughout the health service. Furthermore, it is expected that the networks will work in a coordinated manner to ensure equality and standardisation of care throughout the NHS.				
22. Contributing to reducing inequalities in health outcomes.				
Can this work contribute to reducing inequalities in health outcomes?				
Yes		No		Do not know
If yes which groups should benefit and how and/or might any group lose out?				
All groups should benefit since the standards state that the Networks should form seamless pathways of care for patients separate Congenital Heart Networks will not work independently of each other. There will be regular collaboration to ensure equality of care throughout the health service. Furthermore, it is expected that the networks will work in a coordinated manner to ensure equality and standardisation of care throughout the NHS.				
23. Contributing to the PSED and reducing health inequalities.				
How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.				
Implementation of the standards and service specifications by all providers is expected to contribute to improvements in health inequalities and public health outcomes. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria.				
24. Agreed or recommended actions.				
What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?				
The consultation will provide qualitative information on the impact of the proposed standards and any concerns relating to the equality and health inequalities. This will be taken into account by the NHS England board in reaching its final decisions.				
Action	Public Sector Equality Duty	Health Inequality	By when	By whom
PART G: Record keeping				
25.1. Date draft circulated to E&HIU:	25/10/2016			
25.1. Date draft EHIA completed:	28/10/2016			
25.2: Date final EHIA produced:	04/01/17			
25.3. Date signed off by Director:				

25.4: Date EHIA published:		
25.5. Review date:		
26. Details of the person completing this EHIA		
Name	Post held	E-mail address
Sophie Solti	Senior Policy Manager	Sophie.solti@nhs.net
27: Name of the responsible Director		
Name:	Directorate:	
Michael Wilson	Specialised Commissioning	

Draft for consultation

Draft for consultation

Congenital Heart Disease Provider Impact Assessment: National Panel Report

Draft for consultation



OFFICIAL

Congenital Heart Disease Provider Impact Assessment: National Panel Report

First published: 9 February 2017

Prepared by: Specialised Commissioning, NHS England

Classification: OFFICIAL

Draft for consultation

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Draft for consultation

1 Introduction

1. In July 2015, NHS England Board agreed the proposed CHD standards and service specifications relating to three levels of CHD service provision that had been collaboratively developed with and agreed by all stakeholders. A 'go-live' date for commissioning of the standards and the service specification was agreed for April 2016.
2. Starting in April 2015 NHS England supported an initial provider-led process to consider how hospitals might work together in order to meet the standards. On 9 October 2015 submissions from networks were received by NHS England and assessed. Overall it was considered that this work had not produced an acceptable solution, in the best interests of patients, and nor was it likely to do so even if the hospitals were given more time. NHS England concluded that developing a nationally coherent delivery model would require it to provide significant support and direction¹.
3. Between January and April 2016 hospitals providing CHD services were assessed against key selected standards by a national commissioner-led panel with clinician and patient/public representation. The panel's role was to assess each hospital's ability to meet the selected standards, based on the evidence submitted by the individual hospital trusts. The panel was not responsible for deciding what action to take as a result of that assessment. That responsibility sits with NHS England as the single national commissioner of CHD services.
4. This assessment² demonstrated that some hospitals met most of the standards and were likely to be able to meet the remainder by April 2017, and that others should be able to meet the requirements with further development of their plans. NHS England has since been working with those hospitals as they progress towards full compliance. Other hospitals were not meeting or likely to meet all of the relevant standards within the required timescales. Some presented a clinical and governance risk. Since then, we have been working with them to look for ways to bring them into full compliance. This has not (so far) been possible.
5. The panel's assessment was considered by NHS England's Specialised Services Commissioning Committee, at the end of June 2016. The Committee recognised that the status quo could not continue and that NHS England needed to ensure that patients, wherever they lived in the country, had access to safe, stable, high quality services. The Committee also recognised that achieving this within the current arrangement of services would be problematic.

¹ The full report of this work is available here: <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/quick-links/>

² The full report of this assessment is available here: <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/>

6. The Specialised Services Commissioning Committee determined that, subject to appropriate public involvement and/or consultation, a change in service provision was appropriate. As a result it was proposed that in future NHS England would only commission CHD services from hospitals that are able to meet the standards within the required timeframes.
7. Proposals for service change were announced on 8 July 2016. Subject to public consultation, if implemented, our proposals would mean that in future CHD level 1 (surgical) services in England would be provided by the following hospitals:
- **Alder Hey Children’s Hospital NHS Foundation Trust** (children’s services) and **Liverpool Heart and Chest Hospital NHS Foundation Trust** (adult service)
 - **Birmingham Children’s Hospital NHS Foundation Trust** (children’s services) and **University Hospitals Birmingham NHS Foundation Trust** (adult service)
 - **Great Ormond Street Hospital for Children NHS Foundation Trust** (children’s services) and **Barts Health NHS Trust** (adult service)
 - **Guy’s and St Thomas’ NHS Foundation Trust** (children’s and adult services)
 - **Leeds Teaching Hospitals NHS Trust** (children’s and adult services)
 - **Newcastle Hospitals NHS Foundation Trust** (children’s and adult services)
 - **University Hospitals Bristol NHS Foundation Trust** (children’s and adult services)
 - **University Hospital Southampton NHS Foundation Trust** (children’s and adult services)
8. If implemented, our proposals would result in the following changes at hospitals that currently provide level 1 (surgical) CHD services:
- Surgery and interventional cardiology for adults should cease at **Central Manchester University Hospitals NHS Foundation Trust (CMFT)**. CMFT does not undertake surgery in children.
 - Surgery and interventional cardiology for children and adults should cease at **Royal Brompton & Harefield NHS Foundation Trust**.
 - Surgery and interventional cardiology for children and adults should cease at **University Hospitals of Leicester NHS Trust**.
9. Changes are also proposed to the provision of level 2 specialist medical CHD care. While not the subject of the forthcoming consultation they will be described in our consultation materials and stakeholders invited to provide us with their views. We will also be conducting specific further engagement with patients and others who would be affected by implementation of the proposals.
10. If implemented, our proposals would mean that in future level 2 (specialist medical) CHD services in England would be provided by the following hospitals:
- **Brighton and Sussex University Hospitals NHS Trust** (adult service)

- **Central Manchester University Hospitals NHS Foundation Trust** (children's services)
 - **Norfolk & Norwich University Hospitals NHS Foundation Trust** (adult service)
 - **Oxford University Hospitals NHS Foundation Trust** (children's and adult services)
11. NHS England is exploring the potential for the provision of level 2 medical services at hospitals where level 1 care would cease. We are interested in the degree of support for this approach and will test this as part of the consultation. This possibility relates to:
- **Central Manchester University Hospitals NHS Foundation Trust** (adult service)
 - **University Hospitals of Leicester NHS Trust** (children's and adult services)
12. NHS England has raised with the Royal Brompton the potential for it to continue to provide level 1 adult CHD services, including surgery, by partnering with another level 1 CHD hospital in London that is able to provide care for children and young people with CHD, and which meets the required standards. To date, the Royal Brompton Hospital has indicated that it does not support this approach, but has not said that it would refuse to treat adults alone. NHS England believes that it has sufficient merits to be explored further. The Royal Brompton is also exploring with partners ways in which it could achieve compliance with the standard for paediatric co-location, but to date no plan and timetable for this to be achieved have been shared with NHS England.
13. If implemented, our proposals would result in the following changes at hospitals that currently provide level 2 specialist medical CHD care (subject to further local engagement as appropriate):
- Specialist medical care and interventional cardiology would cease at **Blackpool Teaching Hospitals NHS Foundation Trust**
 - Specialist medical care and interventional cardiology would cease at **Imperial College Healthcare NHS Trust**
 - Specialist medical care and interventional cardiology would cease at **Nottingham University Hospitals NHS Trust** Specialist medical care and interventional cardiology would cease at **Papworth Hospital NHS Foundation Trust**
 - Specialist medical care and interventional cardiology would cease at **University of South Manchester NHS Foundation Trust**
14. NHS England is continuing discussions with **Papworth Hospital NHS Foundation Trust** about its plans to meet the requirements to continue to provide specialist medical care and interventional cardiology. If the hospital trust demonstrates that it now either meets the standards or has a robust plan to do so, NHS England will review its proposal that Level 2 CHD services should cease to be provided.

2 Part One: The impact assessment

15. NHS England has undertaken a detailed impact assessment considering the impact on patients and their families, on CHD services and other clinical services, and on hospital trusts, including financial implications, if our proposals were to be implemented. This paper reports the work of NHS England's regional teams and the National Panel in assessing the impact on hospitals providing CHD services.

2.1 Approach

16. The aim of this impact assessment was:

- to understand how NHS England's proposals could be delivered in practice;
- to identify the consequences of implementing the proposals for patients, provider hospitals, commissioners and others; and
- to support planning of mitigations that may be needed to counter risks or address potentially negative consequences arising from implementing the proposed changes.

17. All level 1 and level 2 CHD hospitals were asked to review their services in light of NHS England's proposals under the following headings:

- CHD activity
- CHD capacity
- Impact on other interdependent services and facilities
- Financial and business impact
- Workforce implications
- Equality and health inequalities

2.2 The process

18. Requests were issued on 21 October 2016 with responses due by 7 November 2016. Responses were received from all providers except for Central Manchester University Hospitals NHS Foundation Trust³.

19. At the same time as undertaking the impact assessment, NHS England gave the Royal Brompton and Harefield NHS Foundation Trust and University Hospitals of Leicester NHS Trust an opportunity to provide further information in relation to their ability to meet the relevant standards that have to be implemented by a future date, including in particular the interdependency/co-location requirements

³ Central Manchester University Hospitals NHS Foundation Trust considered that its impact assessment could only be undertaken once the clinical service model for the North West has been described. It further stated that insufficient notice had been given for the request to be met.

that come into effect in 2019 and the surgical volume standards that come into effect in 2021.

20. Throughout October NHS England also undertook its own analysis of activity and expenditure using SUS data⁴. This included some analysis of other services used by patients with CHD, to understand the proportion of that service's activity which relates to CHD patients.

21. Both sets of data were considered first by specialised commissioning teams from the relevant NHS England region during the period 10-15 November 2016. This allowed for a review of both sets of data and for consideration of any wider regional implications. The impacts were then considered by a national panel drawn together to review the submissions, to moderate the regional assessments and to take a national overview.

22. The national panel met on 18 November 2016 and consisted of the following members:

Chair

Will Huxter, Chair of Women's and Children's Programme of Care Board, NHS England and Programme SRO;

Patient and Public Voice

Jon Arnold, CRG Patient Representative;

Suzie Hutchinson, CRG Patient Representative;

Clinical

Dr Jacqueline Cornish, National Clinical Director for Children and Young People, NHS England;

Professor Deirdre Kelly, Chair of the CHD Implementation Group;

Dr Trevor Richens, Chair, Congenital Heart Services Clinical Reference Group;

Specialised Commissioners (national team)

Natalie Brazhda Mejia, National Lead Commissioner for congenital heart services, NHS England;

Cathy Edwards, Operational Delivery Director (National), Specialised Commissioning NHS England;

Sally Edwards, Head of Quality Surveillance Team, NHS England;

⁴ The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. It is run on behalf of the whole NHS by NHS Digital. When a patient or service user is treated or cared for, information is collected which supports their treatment. This information is also useful to commissioners and providers of NHS-funded care for 'secondary' purposes - purposes other than direct or 'primary' clinical care - such as healthcare planning, commissioning of services and development of national policy.

Kieran McHugh, Senior Finance Manager, Financial Strategy & Allocations, NHS England;

Michael Wilson, CHD Programme Director;

Ben Parker, CHD Programme - Project Development Manager.

Specialised Commissioners (regional)

Robert Cornall, Regional Director, Specialised Commissioning, NHS England, North;

Hazel Fisher, AD Programme of Care & NW London Locality Lead (London)

Dr Vaughan Lewis, Regional Clinical Director, Specialised Commissioning, NHS England, South;

Dr Geraldine Linehan, Regional Clinical Director, Specialised Commissioning, NHS England, Midlands & East;

23. In their assessment of impact at hospitals which would no longer be commissioned as level 1 CHD hospitals under the proposals, the panel considered the following:

- Impact on CHD services including:
 - the activity that would need to be transferred to different hospitals;
 - the potential for Level 2 CHD services to be offered if Level 1 CHD services ceased to be offered.
- Impact on other interdependent services if Level 1 CHD services cease;
- Impact on the hospital trust, including financial, business and reputational considerations;
- Impact on staff;
- Risks and mitigation of any potentially negative impacts.

24. In their assessment of impact at hospitals which would continue to be commissioned as level 1 CHD hospitals under the proposals, the panel considered the following:

- Impact on CHD services including the additional activity that would need to be managed;
- Development of plans to care for additional patients;
- Facilities including availability of capital if needed;
- Workforce;
- Risks and mitigation of any potentially negative impacts.

2.3 Impact on patient flows

25. Under the proposals there would be a requirement for a number of CHD hospitals to provide additional CHD services. In the impact assessment we have used surgical procedures to indicate the volume of activity which will be required to be undertaken in these hospitals; however, the additional activity which will be required will also include some additional diagnostic, catheter interventions and outpatient care dependent in part on the patient pathways and whether Level 2 services are retained at the hospitals activity is transferring from. Undertaking this additional activity will require a number of hospitals to expand their capacity in a number of areas, including theatres, catheter labs, wards, intensive care provision and interdependent services.
26. If the former Level 1 hospitals retain Level 2 services the majority of the CHD diagnostic and outpatient activity would be able to be retained by these hospitals, with the exception of any invasive diagnostic procedures and a single pre-operative and post-operative visit to the Level 1 hospital. Level 2 hospitals also may retain some inpatient activity where this is not related to a surgical or interventional procedure. However, if these hospitals do not provide Level 2 care most CHD activity relating to diagnosis and outpatient care would also need to be transferred to other hospitals.
27. We have modelled the way in which patient flows may change if the proposals are implemented. The modelling assumes that a patient will go to their next nearest hospital⁵, calculated as car journey time. The results of this modelling are

⁵ The modelling included in this analysis has used the following data sources:

- NICOR – volumes of CHD surgery by group (adult/paediatrics) and provider hospital. Published data for financial years 2013/14 and 2014/15 used.
- HES – volumes of CHD surgery by MSOA, group (adult/paediatrics) and provider hospital. Data covers financial years 2006/07 to 2014/15.
- Travel times – NHS England reference file (generated via Google API) (with amended London logic, see below)

Each middle layer super output area (MSOA) was linked to its nearest provider hospital (adult/paediatrics separately) based on the travel time from MSOA to the hospital indicated by the NHS England reference data (above). For those patients who currently go to the Royal Brompton, University Hospitals of Leicester or Central Manchester University Hospitals from London the following amendments were made to their predicted flows –

- Adult patients from MSOAs south of the Thames attend Guys and St Thomas' even if travel time to Bart's is shorter
- Adult patients from MSOAs North of the Thames attend Bart's even if travel time to Guys and St Thomas' is shorter
- Paediatric patients from MSOAs south of the Thames attend Guys and St Thomas' even if travel time to GOSH is shorter
- Paediatric patients from MSOAs north of the Thames attend Bart's even if travel time to Guys and St Thomas' is shorter

HES data combined with MSOA/travel time reference data (as above) was used to establish, for those patients attending Central Manchester University Hospitals, University Hospitals of Leicester and Royal Brompton (split by

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intended as a guide rather than an exact representation of what will happen. The results of this modelling are shown in tables 1 and 2 below

Table 1: Changes to surgical patient flows under our proposals based on 2013/14 NICOR data

Receiving Trust	Patients/year From Royal Brompton			Patients/Year From CMFT			Patients/year From UHL			Grand Total	
	Adu It	Pae ds	Tota l	Adu It	Pae ds	Tota l	Adu It	Pae ds	Tota l	Adu It	Pae ds
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1		-	-		8	8	-	9
BARTS HEALTH NHS FOUNDATION TRUST	77		77		-	-	1		1	78	-
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		5	5		-	-		174	174	-	179
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		228	228		-	-		4	4	-	232
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	30	173	203		-	-		4	4	30	177
LEEDS TEACHING HOSPITALS NHS TRUST	1	-	1	4	-	4	10	37	47	15	37
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1	96	-	96	-		-	97	-
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		-	-		-	-			-	-	-
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	6	11	17		-	-		1	1	6	12
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	2		2		-	-	49		49	51	-
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	3	2	5		-	-		2	2	3	4
Total	120	420	540	100	-	100	60	230	290	280	650

Data sources:

Volumes of Surgery : 1314 NICOR
 Proportional use of centres HES data 0607 to
 : 1415

adult/paediatrics), which the nearest provider hospital would be (excluding Central Manchester University Hospitals, University Hospitals of Leicester and Royal Brompton).

These proportions were then used to estimate, pro rata, the number of cases per year which would go to each 'receiving' provider by multiplying the proportion calculated above by the quantum of surgery indicated by the NICOR data.

Table 2: Changes to surgical patient flows under our proposals based on 2014/15 NICOR data

Receiving Trust	Patients/year From Royal Brompton			Patients/Year From CMFT			Patients/year From UHL			Grand Total		
	Adu It	Pae ds	Tot al	Adu It	Pae ds	Tot al	Adu It	Pae ds	Tot al	Adu It	Pae ds	Tot al
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1		-	-		8	8	-	9	9
BARTS HEALTH NHS FOUNDATION TRUST	90		90		-	-	1		1	91	-	91
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		4	4		-	-		174	174	-	178	178
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		201	201		-	-		4	4	-	205	205
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	36	153	189		-	-	-	4	4	36	157	193
LEEDS TEACHING HOSPITALS NHS TRUST	1		1	4	-	4	8	37	45	13	37	50
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1	85	-	85	-	-	-	86	-	86
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST			-		-	-			-	-	-	-
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	7	9	16		-	-		1	1	7	10	17
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	3		3		-	-	37		37	40	-	40
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	4	2	6		-	-		2	2	4	4	8
Total	142	370	512	89	-	89	46	230	276	277	600	877

Data sources:

Volumes of Surgery :

1415 NICOR

Proportional use of centres :

HES data 0607 to 1415

28. If the proposals were implemented our modelling suggests that approximately 900 surgical procedures would need to be transferred to other hospitals. Up to

1300 interventional cardiology procedures would similarly need to be transferred. The likely impact on surgical volumes at each centre is summarised in table 3 below:

Table 3: Additional operations at hospitals that would continue to undertake CHD surgery under our proposals⁶

Hospital	Additional Operations	% increase
Birmingham Children's Hospital	180	36%
University Hospitals Birmingham	45	45%
Liverpool Heart and Chest	90	N/A ⁷
Leeds - General Infirmary	50	10%
Guy's and St Thomas'	200	40%
Great Ormond Street	220	31%
Barts	85	110%
Southampton	20	5%

29. Under this modelling, there would be little or no change to activity at Alder Hey, Bristol or Newcastle.

30. This analysis was supplied to provider hospitals to inform their thinking about the impact of the proposals.

3 The panel's assessment of impact

31. The panel's role was to assess the likely impact of NHS England's proposals on each hospital and its services. Individual impact assessments reflecting the panel's conclusions are appended to this report. The panel was not responsible for deciding what action to take as a result of that assessment. That responsibility sits with NHS England as the single national commissioner of CHD services.

32. Since the panel completed its assessment in November 2016, NHS England has continued to maintain a dialogue with the affected hospitals as a result of which new or revised information has been provided and further analyses undertaken. NHS England's own impact assessment, current to January 2017, which is

⁶ Modelling based on NICOR validated surgical activity for 2013/14 and 2014/15, averaged and rounded. Assumes patients attend their nearest centre assessed as car journey times.

⁷ Liverpool Heart and Chest Hospital does not currently undertake CHD surgery.

informed both by the national panel's work, and by this subsequent work, is reported separately.

3.1 Summary of the impact at hospitals which, under the proposals, would not continue to be commissioned as Level 1 CHD hospitals

3.1.1 Royal Brompton and Harefield NHS Foundation Trust

33. Under the proposals the Royal Brompton would no longer perform surgical or interventional cardiology on people with CHD. The panel considered that the scale of this change was especially significant to the Royal Brompton's provision of paediatric services but could be reduced if it provided adult-only services at level 1 or level 2.
34. The panel accepted the Royal Brompton's view that the loss of level 1 CHD services for children would make the PICU at the Royal Brompton unviable. The panel accepted that this would therefore impact the hospital trust's ability to offer paediatric respiratory services and paediatric cardiac ECMO.
35. The panel viewed the potential financial loss to the Royal Brompton as a significant proportion of the hospital trust's overall income; however, noted that according to the financial information submitted by the hospital trust, the costs associated with providing this service were greater than the income the hospital trust received. The Royal Brompton stated that owing to the stranded costs associated with this service, they estimate an adverse impact of over £7m per year to the hospital trust's bottom line if these proposals are implemented. The panel again noted that the financial and reputational impact of the changes could be reduced if the Royal Brompton provided level 2 adult services or level 1 adult services.
36. The Royal Brompton identified approximately 430 WTE staff that would be impacted by the proposals. The panel was not able to take a view on the nature of the impact on all the staff identified but accepted that it would have a significant impact on the Royal Brompton's workforce. It considered that this impact could be reduced through collaborative working with other hospital trusts in London and the Royal Brompton continuing to provide either level 2 adult services or level 1 adult services.
37. The panel considered that the proposals would have a significant impact on the hospital trust's finances and reputation. Whilst the reputational impact will be lessened by the continued provision of a wide range of specialist services at the Royal Brompton, the financial impact of losing CHD Level 1 activity would be significant for the Royal Brompton.

3.1.2 University Hospitals of Leicester NHS Trust

38. Under the proposals University Hospitals of Leicester would no longer perform surgical or interventional cardiology on people with CHD. The panel considered that the scale of this change for the hospital trust would not be as significant as for the Royal Brompton due to the greater number of services which University Hospitals of Leicester provides. The panel also noted that this impact could be reduced if the hospital trust continued to provide level 2 services.
39. The panel accepted that the proposals would make the PICU at the Glenfield Hospital unviable but did not accept that they would result in the cessation of PICU services at Leicester Royal Infirmary. The panel also considered that the proposals would result in University Hospitals of Leicester no longer being able to provide paediatric cardiac or respiratory ECMO services. The panel noted that this would impact approximately 55 children each year.
40. The panel viewed the potential financial loss to University Hospitals of Leicester as less significant than that at the Royal Brompton due to the projected income which would be lost being smaller and the higher overall income of the hospital trust. The panel noted that the financial and reputational impact of the changes could be reduced if the hospital trust provided level 2 services.
41. University Hospitals of Leicester identified over 150 WTE staff that would be directly impacted by the proposals and a further set of roles which would be indirectly impacted. The panel was not able to take a view on the nature of the impact on all the staff identified but accepted that it would have an impact on the hospital trust's workforce. It considered that this impact would be reduced if University Hospitals of Leicester continued to provide level 2 services.
42. The panel considered that although the proposals will undoubtedly impact the hospital trust's finances and reputation, the scale of this impact is reduced by the wide range of specialised and non-specialised services which will continue to be offered by the hospital trust.

3.1.3 Central Manchester University Hospitals NHS Foundation Trust

43. Under the proposals Central Manchester University Hospitals would no longer perform surgical or interventional cardiology on adults with CHD. The panel considered that the scale of this change would be considerably less than at the Royal Brompton or University Hospitals of Leicester due to the significantly lower number of surgical or interventional procedures which are undertaken at Central Manchester. The panel also noted that this impact will be reduced if Central Manchester continues to provide level 2 services as part of the overall CHD service provision in the North West.

44. The panel did not consider that these proposals would have a significant impact on any other services within the hospital trust.
45. The panel viewed the potential financial loss to Central Manchester as much less significant due to the overall income the hospital trust currently receives for level 1 CHD services being much lower than other hospitals which would lose activity as a result of these proposals. The panel noted that the financial and reputational impact of the changes will be reduced if Central Manchester continues to provide level 2 services.
46. The panel considered that the proposals will have some impact on the hospital trust's finances and reputation, but that this will be offset by the establishment of a new model for the delivery of CHD services in the North West. The impact on Central Manchester as a hospital trust would be very limited, as it has only been undertaking a relatively low volume of CHD surgical activity.

3.1.4 Summary

47. In summary, the national panel's view was that there would be a significant impact at each of the hospital trusts where it was proposed that current level 1 or level 2 services should cease, with the greatest impact seen at the Royal Brompton, a lesser but still significant impact at University Hospitals of Leicester, and a less significant impact at Central Manchester University Hospitals.
48. The panel remained confident that the proposals could be implemented and that these risks could be reduced or mitigated through ongoing work with hospital trusts. Whilst the financial impact of these proposals was likely to be material for the Royal Brompton and University Hospitals of Leicester, the panel did not consider them sufficient to threaten the viability of the hospital trusts or their ability to continue to provide a wide range of services.
49. Detailed planning of the changes and an appropriate implementation timetable were considered important for effective management of the changes needed.

3.2 The impact at centres which, under the proposals, would continue to be commissioned as Level 1 CHD centres

3.2.1 Alder Hey Children's Hospital NHS Foundation Trust

50. No significant increase in surgical activity is expected at Alder Hey as a result of the proposals. The direct impact on Alder Hey will therefore be minimal.
51. However, under the proposals Alder Hey will form a joint level 1 centre with Liverpool Heart and Chest Hospital NHS Foundation Trust, which has not previously undertaken CHD surgery. The panel considered that Alder Hey would therefore need to act as the senior partner in the transition of Level 1 services

from Central Manchester to Liverpool Heart and Chest Hospital in order to provide assurance for the continuation of the service at Central Manchester University Hospitals and support Liverpool Heart and Chest Hospital in the development of its service.

3.2.2 Barts Health NHS Trust

52. The proposals are likely to result in increased activity at Barts Health NHS Trust. While the number of patients involved is relatively small, this still represents a doubling of activity for the hospital trust. The panel considered this scale of increase to be a significant challenge for Barts. Other factors noted by the panel as contributing to the risk posed by this change were:

- Barts only took on responsibility for delivering Level 1 CHD services for adults at the new Barts Heart Centre in 2015, following comprehensive reorganisation of cardiac services across North Central and North Central London between UCLH and Barts.
- Barts is currently in financial special measures.
- Barts had not clearly demonstrated that it had quantified the additional staff it would require.

53. As such the panel considered there to be a moderate risk associated with its ability to provide Level 1 CHD services for the increased number of patients envisaged under these proposals. The panel considered the most significant risk associated with Barts increasing its capacity to be in relation to the additional workforce they would require.

54. Barts is part of a joint level 1 centre with Great Ormond Street Hospital for Children NHS Foundation Trust. The panel considered that Great Ormond Street would therefore need to act as the senior partner in the scaling up of Level 1 services at Barts in order to provide assurance of the development of its service.

3.2.3 Birmingham Children's Hospital NHS Foundation Trust

55. The proposals are likely to result in significantly increased activity at Birmingham Children's Hospital. The number of patients involved is relatively large and represents a proportional increase in activity for Birmingham Children's Hospital of 36%.

56. Birmingham Children's Hospital is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided very good evidence of having understood the scale of what would be required and of plans to increase capacity.

57. Birmingham Children's Hospital identified that in order to provide the extra activity required by these proposals it would need additional PICU and ward beds. It has identified a number of options for providing this additional capacity and is

currently in the process of appraising these options. It is confident it would have this additional capacity in place by early 2018 but notes the significant challenge there will be in recruiting the necessary PICU nurses for this expansion.

58. The panel did not consider there to be any significant risks associated with Birmingham Children's Hospital increasing its capacity to meet the activity required by the proposals but did note the challenges associated with the recruitment of staff, most notably PICU nurses, and the need for sufficient lead time.

3.2.4 Great Ormond Street Hospital for Children NHS Foundation Trust

59. The proposals are likely to result in significantly increased activity at Great Ormond Street Hospital. The number of patients involved is relatively large and represents an increase in activity for Great Ormond Street of 31%.

60. Great Ormond Street Hospital is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided good evidence of having understood the scale of what would be required of it and of its plans to increase capacity.

61. Great Ormond Street identified that in order to provide the extra activity required by these proposals it would need additional PICU beds. It plans on providing this additional capacity through its new "Premier Inn Clinical Building" which will be completed in September 2017. If Great Ormond Street is required to provide extra capacity prior to this, it stated it would be able to utilise vacant capacity on its current PICU and NICU in the short term.

62. The panel did not consider there to be any significant risks associated with Great Ormond Street increasing its capacity to meet the activity required by the proposals, but did note the challenges associated with the recruitment of staff, most notably PICU nurses, and the need for sufficient lead time.

63. Great Ormond Street is part of a joint level 1 centre with Barts Health NHS Trust. The panel considered that Great Ormond Street would therefore need to act as the senior partner in the scaling up of Level 1 services at Barts in order to provide assurance of the development of its service.

3.2.5 Guy's and St Thomas' Hospitals NHS Foundation Trust

64. The proposals are likely to result in significantly increased activity at Guy's and St Thomas'. The number of patients involved is relatively large this represents a proportional increase in activity for the hospital trust of 40%.

65. Guy's and St Thomas' is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided good evidence of having understood the scale of what would be required of it and of its plans to increase capacity.
66. Guy's and St Thomas' identified a need for both additional ward and PICU capacity in order to provide the additional activity modelled under these procedures. It has not identified the number of additional PICU and ward beds required because it is confident that the extra capacity to be provided under its planned expansion scheme will be sufficient. This will provide up to eleven ward beds and up to ten PICU beds by December 2017.
67. The panel noted that as the surgical work undertaken by Guy's and St Thomas' on behalf of Northern Ireland moves to Dublin (currently expected to happen at the end of 2017) this would free up existing capacity.
68. The panel did not consider there to be any significant risks associated with Guy's and St Thomas' absorbing the activity required by NHS England's proposals. However, the panel did note that the most significant risk related to the workforce implications of the proposals on Guy's and St Thomas' and its ability to recruit the appropriate staff, most notably PICU nurses.

3.2.6 Leeds Teaching Hospitals NHS Trust

69. The proposals are likely to result in increased activity at Leeds Teaching Hospitals. The number of patients involved is relatively modest and represents a small proportional increase in activity for Leeds of 10%.
70. Leeds Teaching Hospitals is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided good evidence of having understood the scale of what would be required of it and of its plans to increase capacity.
71. Whilst the panel had some concerns relating to the trust's ability to increase capacity in its cardiac ward, PICU and theatre, they did not consider that these posed a significant risk to its ability to provide services for these additional patients.

3.2.7 Liverpool Heart and Chest Hospital NHS Foundation Trust

72. Liverpool Heart and Chest Hospital currently provides Level 2 CHD services. Under the proposals the hospital trust would begin performing Level 1 services including surgery and interventional cardiology on adults for the first time. This will mean a significant change in the cohort of patients and activity levels.

73. The panel considered the scale and nature of this change to be a significant challenge for Liverpool Heart and Chest Hospital and the most significant risk amongst hospitals gaining activity as a result of the proposals.
74. Liverpool Heart and Chest Hospital would be providing adult Level 1 CHD services for the first time having previously been a Level 2 centre. As a result of this it will not simply be doing more of the activity it has already been undertaking (as is the case with other hospitals gaining activity) but rather starting to undertake a type of activity it has not previously done. This increases the risks.
75. In addition, the panel was concerned that Liverpool Heart and Chest Hospital had not clearly quantified the additional capacity and workforce it would require to provide this additional activity in its submission. Therefore it could not provide convincing assurances about how and when this would be provided. These risks were seen as more significant due to Liverpool Heart and Chest Hospital's current breaching of referral to treatment waiting times (RTT) specifically in relation to cardiac surgery.
76. Under the proposals Liverpool Heart and Chest Hospital will form a joint level 1 centre with Alder Hey Children's Hospital NHS Foundation Trust. The panel considered that Alder Hey Children's Hospital would therefore need to act as the senior partner in the transition of Level 1 services from Central Manchester University Hospitals to Liverpool Heart and Chest Hospital in order to provide assurance for the continuation of the service at Central Manchester and support Liverpool Heart and Chest Hospital in the development of its service.
77. Managing the risk of this change will require close working between Central Manchester University Hospitals, Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital to ensure that they have a clear understanding of the activity Liverpool Heart and Chest Hospital will be required to undertake and the systems, facilities, staffing and capacity needed to manage this activity.

3.2.8 Newcastle upon Tyne Hospitals NHS Foundation Trust

78. No significant increase in surgical activity is expected at Newcastle upon Tyne Hospitals as a result of the proposals. The impact on the hospital trust will therefore be minimal.
79. While noting that the proposals posed a minimal risk, the panel considered that real risks did arise because Newcastle upon Tyne Hospitals does not meet the 2016 activity requirement and is unlikely to be able to meet the 2021 activity requirement. It also does not meet the 2019 paediatric co-location requirements or have a realistic plan to do so by April 2019.
80. The panel considered that these shortfalls could not be ignored and that if there was to be derogation, the issues needed to be resolved by the end of the period

of derogation. This would require a plan for the future of advanced heart failure services currently provided at Newcastle upon Tyne Hospitals.

3.2.9 University Hospitals Birmingham NHS Foundation Trust

81. The proposals are likely to result in increased activity at University Hospitals Birmingham. The number of patients involved is relatively modest although this represents a 40% increase in activity for the hospital trust.
82. University Hospitals Birmingham is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that the hospital trust had provided good evidence of having understood the scale of what would be required of it and of its plans to increase capacity.
83. The panel did not consider that there was any significant risk associated with University Hospitals Birmingham absorbing this additional activity.
84. Due to the size of its overall adult cardiac service, including ITU provision, the level of activity it would absorb as a result of the proposed changes is not considered to be significant, and the panel was therefore confident that any transition of activity would be able to be undertaken in a timely manner.

3.2.10 University Hospitals Bristol NHS Foundation Trust

85. No significant increase in surgical activity is expected at University Hospitals Bristol as a result of the proposals. The impact on Bristol will therefore be minimal.

3.2.11 University Hospital Southampton NHS Foundation Trust

86. The proposals are likely to result in a small increase in activity at University Hospital Southampton. The number of patients involved is modest and represents a small proportional increase in activity for the hospital trust of 5%.
87. The hospital trust is confident of its ability to increase its capacity sufficiently to provide the extra activity required by the standards.
88. The panel did not consider that there was any significant risk associated with University Hospital Southampton absorbing this additional activity.
89. The panel considered that it had provided good evidence of having understood the scale of what would be required and of its plans to increase capacity. Work is already underway to expand PICU.

3.2.12 Conclusion

90. The panel considered that hospitals that would gain more patients if the proposals were to be implemented were well placed to be able to expand their capacity to be able to provide that care.
91. All the hospitals which would gain additional activity under the proposals indicated that they were able to increase capacity in order to meet this increased demand.
92. Detailed planning of the changes and an appropriate implementation timetable were considered important for effective management of the changes needed.
93. All hospitals are confident of their ability to provide high quality CHD services to these additional patients and the risks which remain largely relate to ensuring that sufficient lead in time is given to any changes, and to the detailed work of understanding the precise nature of that change. Thus the specific requirements on these hospitals has been undertaken prior to these proposals being implemented.

4 National themes

94. The national panel noted a number of themes which emerged during its assessment. Some of these related to the current services and some to what would be required were the proposals to be implemented.

4.1 Workforce

95. One of the key challenges both to current services and to any future configuration is ensuring that there are sufficient staff with the necessary skills and experience to undertake this work across the country.
96. The proposals would have a significant impact on the workforce with a number of staff currently providing Level 1 CHD services, no longer providing these within their current hospital trust and other hospitals requiring additional staff in order to accommodate the additional activity. The recruitment of the necessary workforce for this increased activity was seen as potentially challenging for a number of these hospitals, specifically, the recruitment of the PICU nurses necessary for the additional beds which would be required.
97. Those hospitals which would gain additional activity under the proposals, all stated a desire to work with the hospitals which would no longer be commissioned, to provide Level 1 services in order to maximise the possibility of retaining these skilled staff and minimising the impact of any changes.

98. NHS England would support TUPE arrangements to enable staff affected by change to transfer to other Level 1 hospitals requiring their skills.
99. Experience from previous CHD service changes shows that a number of staff, perhaps most, would prefer to be re-deployed within their current hospital trust, though in some cases staff may transfer in accordance with TUPE regulations. This may create an additional challenge both for the hospitals gaining activity, which may find it more difficult to recruit the necessary staff for the additional activity, and for the hospital trusts no longer commissioned to provide Level 1 services which may not have appropriate roles for this workforce to move into.
100. The hospitals gaining significant activity believed that, although challenging, they had a good record of recruiting staff and would be able to recruit the necessary staff as long as they were given sufficient time prior to these proposals being implemented. We also expect that some PICU nurses will transfer to these hospitals with patients. In London, where the Royal Brompton would no longer have a PICU, and where the distances between hospitals are smaller, this may make a particularly important contribution. Whilst this does represent a significant challenge to CHD services the panel anticipated that this could be managed with good planning, appropriate policies agreed between affected provider hospitals, and sufficient lead times prior to changes being made, as well as appropriate structures to support and protect staff affected by these changes.
101. A priority will be the development of a framework across organisations to ensure the best possible outcome for staff. The national panel advised that all units are resourceful and where there is a shortfall in the staff available they were confident they will continue to find ways to recruit the necessary staff, including international recruitment where necessary.
102. Sufficient experienced staff within the service is key to good patient outcomes across the care pathway. Were these proposals to be implemented, significant work would be required to ensure every effort was made to retain experienced staff, and ensure that every Level 1 hospital maintained a highly skilled and experienced workforce.

4.2 The resilience of surgical teams

103. Specific concerns were raised as part of this impact assessment over the resilience of the surgical teams at several hospitals. There is a concern that some current surgical teams are not sufficiently robust, due either to an over reliance on locums or on key individuals. There is concern that in a number of these hospitals there is a lack of clear succession planning which creates a significant risk to the service if an experienced CHD surgeon stopped working within that hospital.

104. The panel recommended that NHS England should ensure that each hospital's implementation planning ensures that appropriately robust surgical teams are in place with clear succession plans.

4.3 Managing patient flows

105. NHS England has undertaken patient flow modelling based on the assumption that patients who currently attend one of the Level 1 hospitals which may no longer be commissioned would attend their nearest hospital. This will not always be the case as patients may decide to attend a different unit for a wide range of reasons.
106. During planning and preparation for implementation, the panel recommended that further modelling may be required to explore other flows which may occur for example using public transport travel time or the pattern of referrals for other specialised paediatric services.

4.4 Communication

107. Communication of service provision and service change is paramount to the continuity of the service for patients and staff. The uncertainty which has surrounded CHD services for a number of years is extremely unhelpful for both patients and staff.
108. The panel recommended that the NHS England CHD programme should continue to offer open communication on the stages of the programme and seek to support the patients in understanding the changes and the associated timelines proposed.
109. Key to this communication is a clear articulation of the staged approach to meeting the standards which explains both the timelines which are stated within the standards and the rationale behind these.

4.5 Finance

110. The money required for the CHD service is provided through tariff which ensures that the money received is linked to patient activity. It is likely that there will be some economies of scale for providers linked with providing a higher volume of activity. As such the hospital trusts which would gain activity under these proposals are confident of being able to fund this expansion through the income which would be associated with this extra activity. The panel accepted this.

111. Two hospitals indicated that they would need to source capital funds to accommodate additional activity: University Hospitals Birmingham NHS Foundation Trust (£4M) and Great Ormond Street Hospital for Children NHS Foundation Trust (£6M). In both of these cases it is expected that the hospital trust would be able to source the capital funding from existing allocations and/or charitable funds.

4.6 PICU

112. The proposed changes would result in a loss of approximately 23 commissioned PICU beds (7 from University Hospitals of Leicester and 16 from the Royal Brompton). This includes beds not used by CHD patients.

113. The hospital trusts expected to undertake additional activity identified that if required they would be able to make available an additional 24 beds (Guy's and St Thomas' 10, Southampton 5, Birmingham Children's Hospital 5, Great Ormond Street 3⁸, Leeds 1). These numbers represent the capacity that hospital trusts are planning to develop including planned expansions in PICU beds, not just those beds needed to respond to additional CHD activity.

114. The panel was assured that the proposed number of PICU beds exceeded the current capacity.

115. If these proposals were to be implemented, ongoing monitoring would be required to establish the actual patient flows and case mix going to each hospital. Staffing was noted to be an issue for many PICUs.

116. The panel noted that the national paediatric critical care review is considering the overall requirement for PICU beds in future across the country and for all patient groups.

4.7 Advanced heart failure

117. NHS England's CHD Programme did not specifically consider the provision of services relating to advanced heart failure (including paediatric and adult heart transplantation services).

118. The panel noted concerns about Newcastle upon Tyne Hospital's ability to meet the CHD standards and that if Newcastle could not meet the standards, a clear plan would be needed either to move the advanced heart failure service, or deliver it under a different model. A phased, planned transition supported by the Newcastle team would be the ideal if the service needed to move. This would

⁸ GOSH also stated that it had vacant capacity on its PICU/NICU wards that could be utilised in the short-term and would be able to create additional PICU capacity in its Premier Inn Clinical Building by converting some beds which had been allocated as HDU beds into PICU beds.

minimise the risks. The panel also considered that succession planning would be an issue for the service in Newcastle.

119. The panel recommended that NHS England would need to undertake specific work on the future of advanced heart failure services in England, to ensure their ongoing provision and resilience. If this were to result in the development of an alternative model for advanced heart failure services for CHD patients then a review of the long term future of Level 1 CHD services in Newcastle would also be enabled.

4.8 ECMO

120. The optimal national model for provision of children's ECMO in the future will be considered as part of NHS England's review of paediatric critical care services. The maintenance of good outcomes will be a key consideration. The review is expected to consider the appropriate number of providers of children's ECMO, the case for minimum activity levels and the appropriate number of mobile ECMO providers.
121. The panel considered it possible that this review will produce a new model for the provision of these services which may not require a link to CHD surgeons.

4.9 Support

122. In order for these proposals to be implemented there will need to be a high level of hospital to hospital support. This is already clearly evident in certain areas of the country such as the North West where there are ongoing discussions between Central Manchester University Hospitals, Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital, and in London where the panel recommends that Great Ormond Street Hospital supports Barts.
123. It will also be necessary for clear protocols to be established between Level 1 and Level 2 hospitals to ensure that care is provided in appropriate environments and patients are cared for closer to home as much as possible. In addition to this, hospitals will need to collaborate to ensure that there is clear understanding of the "ask" of those hospitals gaining activity and that appropriate services and capacity are in place. The timing of any changes is extremely important and will work better for patients where this is agreed between all affected hospitals.
124. NHS England remains committed to promoting collaborative working and will continue to work with hospitals to facilitate these conversations.

125. In addition to this, once final decisions have been made, money will be available to pump prime the formation of networks, in line with the approach to other Operational Delivery Networks for specialised services.

4.10 Level 2 services and the impact of the end of Commissioning through Evaluation for Patent Foramen Ovale (PFO)

126. Under the proposals Oxford University Hospitals NHS Foundation Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust, Brighton and Sussex University Hospitals NHS Trust would be commissioned to provide Level 2 services. Both Brighton and Sussex and Oxford intend to continue to perform catheter ASD closures.
127. Following the end of Commissioning through Evaluation for PFO closures, it may now prove more difficult for these hospitals to meet the minimum requirement of 50 ASD / PFO closures per annum. Further monitoring will be required to determine whether these hospitals are able to continue performing these procedures.
128. Where hospitals are not able to perform ASD catheter closures they may still choose to provide Level 2 CHD services in the same way as Norfolk and Norwich Hospital.

4.11 Equality and health inequalities

129. Most hospitals did not identify any significant equality or health inequalities impacts associated with the proposals.
130. All responses submitted by the hospitals were considered in more detail as part of our Equality and Health Inequalities Assessment.

5 Part Two: Further assessment against the standards

5.1 Introduction

131. Assessment of the additional information submitted by University Hospitals of Leicester and the Royal Brompton in respect of standards with a future implementation date was undertaken by the national panel at the same time as the Impact Assessment.

5.1.1 Paediatric interdependency requirements

132. The standards state that by 2019 the following specialties or facilities must be located on the same hospital site as Specialist Children's Surgical Centres. They must function as part of the multidisciplinary team. In addition, consultants from the following services must be able to provide emergency bedside care (call to bedside within 30 minutes).

- Paediatric Cardiology;
- Paediatric Airway Team capable of complex airway management (composition of the team will vary between institutions);
- Paediatric Intensive Care Unit (PICU);
- High Dependency beds;
- Specialised paediatric cardiac anaesthesia;
- Perioperative extracorporeal life support (Non-nationally designated extracorporeal membrane oxygenation (ECMO));
- Paediatric Surgery;
- Paediatric Nephrology/Renal Replacement Therapy;
- Paediatric Gastroenterology.

5.1.2 Surgeon minimum activity levels and surgical team size

133. The standards state that congenital cardiac surgeons must be the primary operator in a minimum of 125 congenital heart operations per year (in adults and/or paediatrics), averaged over a three-year period. Only auditable cases may be counted, as defined by submission to the National Institute for Cardiovascular Outcomes (NICOR). They must work in teams of three by April 2016 and teams of four by April 2021.

5.2 University Hospitals of Leicester NHS Trust

5.2.1 Paediatric interdependency requirements

134. University Hospitals of Leicester stated that all paediatric specialist services, including paediatric cardiac services, will be co-located at Leicester Royal Infirmary by 2019 and they will therefore be fully compliant with the co-location requirements. This plan no longer depends on the building of a new children's hospital.
135. The panel considered whether the hospital trust's proposal to move paediatric cardiac Level 1 services to the Infirmary site would allow it to achieve full compliance with the requirements. However, the panel considered that University Hospitals of Leicester needed to set out its plans in more detail to be fully reassured that this move could and would be achieved by the required deadline.
136. University Hospitals of Leicester provided assurances that the project will not require external capital funding, as it will be funded using a combination of the hospital trust's Capital Resource Limit and charitable donations. It will be designed as part of (but is not dependent upon) the wider Children's Hospital Project, to ensure the integration of paediatric services to create a defined Children's Hospital in Leicester.

5.2.2 Surgeon minimum activity levels and surgical team size

137. University Hospitals of Leicester's surgical activity in 2015/16 was 326 procedures. 2016/17 activity data was not available to the panel.
138. The hospital trust submitted a surgical growth plan which it considers would result in it achieving the minimum level of activity required to ensure four surgeons are each able to perform a minimum of 125 procedures per year by 2021.
139. The projected increase in activity depends on population growth, technical advances, and changes to patient flows. NHS England has repeatedly stated that it has no intention of mandating patient flows and as such the panel remained unconvinced that the changes to patient flow required to achieve the necessary growth are likely to occur.
140. University Hospitals of Leicester reported that it has successfully established a complete lifetime referral pathway with Kettering General Hospital and had positive discussions with two other network hospitals to establish lifetime referral pathways. University Hospitals of Leicester suggested additional surgical cases from these partners as demonstrated in the table below:

Table 4: UHL estimated additional future referrals

Year	Partner 1	Partner 2	Partner 3
2016/17	0	0	0
2017/18	4	6	4
2018/19	8	11	7
2019/20	11	17	11
2020/21	15	22	14

141. To date these arrangements have not been established and as such, the hospital trust does not expect to see any additional activity from these until 2017/18.
142. University Hospitals of Leicester did not provide any evidence of formal agreements having been established or any basis for its assertions over the amount of additional activity it would receive from these networks.
143. The changes to referral pathways described by the hospital trust were not considered sufficient to bring about the level of growth required for it to meet the 2021 requirements. In order for these requirements to be met the hospital trust's activity would need to increase by 53% from 2015/16 levels in five years, when the previous five years have only resulted in a total growth of 24%.
144. Applying national predicted growth rates to University Hospitals of Leicester's surgical activity, and factoring in the additional referrals cited above (though evidence for these has not been provided), NHS England has estimated that the hospital trust's surgical activity in 2020/21 will be approximately 398 operations.
145. University Hospitals of Leicester's growth estimate assumes growth will continue at the rate seen at the hospital trust between 2014 and 2016 as well as technical advances and changes in its network. The basis for these assumptions, and their impact within the hospital trust's modelling, is not fully explained. One difference between the hospital trust's model and NHS England's is that University Hospitals of Leicester assumes the most recent, and higher, growth rate at the hospital will continue, while NHS England has taken a longer run perspective informed by growth rates seen across the country.
146. The panel considered it likely that University Hospitals of Leicester would reach activity levels sufficient to support a team of three surgeons each undertaking 125 operations per year, but that it was not clear when this would happen. The hospital trust's own most recent estimate was that this would be achieved by 2017/18.

147. The panel considered that University Hospitals of Leicester had not provided sufficient evidence to provide confidence that it would achieve the minimum surgical activity requirements by 2021.

5.2.3 Summary

148. Following the hospital trust's latest submission the panel considered that:
- University Hospitals of Leicester had demonstrated that it could meet the April 2019 co-location requirement though more detailed plans were required to be fully reassuring;
 - The hospital trust had not demonstrated that it met the April 2016 requirement of three surgeons each performing a minimum of 125 procedures per year;
 - While University Hospitals of Leicester had not provided sufficient information to know when the April 2016 requirement would be met, it was likely that this requirement would be met; and
 - The hospital trust had not set out a convincing plan as to how it will meet the April 2021 requirements of four surgeons each performing a minimum of 125 procedures per year.

5.3 Royal Brompton and Harefield NHS Foundation Trust

5.3.1 Paediatric interdependency requirements

149. The Royal Brompton has previously demonstrated that it meets all of the co-location requirements with the exception of paediatric surgery and gastroenterology.
150. The hospital trust did not provide any additional information or evidence as to how it plans to meet the 2019 requirements to co-locate its paediatric CHD service with other key specialties.
151. Royal Brompton stated that although the hospital trust does not have paediatric surgery or paediatric gastroenterology co-located on site, it provides these services through its partnership with Chelsea and Westminster whose staff participate in MDTs and ward rounds and provide out of hours cover as required.
152. The hospital trust stated that it did not consider that 2019 requirements should be a part of this assessment process or that decisions should be made on the basis of these.

5.3.2 Summary

153. Following the hospital trust's latest submission the panel considered that:
- Royal Brompton had not demonstrated that it could meet the April 2019 co-location requirement for paediatric gastroenterology or paediatric surgery.

6 Conclusion

154. The panel did not consider that any of the potential impacts or risks identified through this process was sufficient to require the proposals to be altered.
155. The panel noted that if the affected hospital trusts were to continue to provide appropriate level 2 services (or in the case of Royal Brompton, adult only level 1 services, the impact would be reduced.
156. The panel was confident that those hospitals required to provide additional Level 1 services, were these proposals to be implemented, would be able to provide sufficient capacity for this.
157. The panel concluded that the additional evidence submitted did not alter their original assessment of the three trusts (Central Manchester University Hospitals – red; University Hospitals of Leicester – red/amber; Royal Brompton and Harefield – red/amber).
158. The panel considered that while the proposals would have a material impact on the hospital trusts no longer providing Level 1 services, especially the Royal Brompton and University Hospitals of Leicester, it did not consider it to be likely that these would be sufficient to threaten either their continued viability or their continued ability to provide a wide range of specialised services.

7 Next steps

159. This is a high level impact assessment intended to identify the risks associated with the proposals as they currently stand; test the plausibility of the proposals, and inform NHS England's assurance processes prior to the launch of public consultation. Whilst there remain a number of unknowns relating to the implementation of these proposals, as well as a number of risks which will require managing, there is nothing highlighted within this document which seems likely to make the proposals unviable.
160. No commissioning decisions have yet been made, as the public consultation is pending, and therefore it is not appropriate to produce a detailed implementation plan at this stage. This will be produced after commissioning decisions have been taken by the Board of NHS England, following the completion of public consultation. Throughout the consultation period and beyond NHS England will continue to work with provider hospitals to understand the impact of the changes which are being proposed and refine the impact assessment we have completed to date.

Appendices: Individual centre impact assessments

CHD impact assessment – Alder Hey Children’s Hospital NHS Foundation Trust

1. Overview

NHS England’s modelling suggests that Alder Hey Children’s Hospital would receive fewer than ten additional procedures per year as a result of these proposals. In light of this, the panel considered that there are no new risks to Alder Hey. Under the proposals there would be a surgical team which would operate on children and adults at Alder Hey and Liverpool Heart and Chest Hospital respectively.

2. Impact on CHD services

The additional activity that would need to be managed

Alder Hey’s current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult ⁹	Total
2013/14	389	7	396
2014/15	372	4	376
2015/16	343	5	348

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	230	10	240
2014/15	253	14	267
2015/16	308	22	330

NHS England’s modelling suggests that Alder Hey would receive fewer than ten additional procedures per year as a result of these proposals.

3. Development of plans to care for additional patients

Alder Hey stated that although no plans were required due to a low level of predicted increase, should Birmingham Children’s Hospital’s increase in activity be greater than it can accommodate, Alder Hey would be willing to consider growing its capacity.

4. Facilities including availability of capital if needed

None required as a result of these proposals.

5. Workforce

No increase required as a result of these proposals.

⁹ NICOR adult procedures include anyone aged 16+

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>As a result of these proposals the Trust has completed its impact assessment assuming it does not receive a material increase to its CHD activity. This creates an operational risk that a higher than expected number of patients receives their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>

Draft for consultation

CHD Impact Assessment – Barts Health NHS Trust

1. Overview

The proposals are likely to result in increased activity at Barts. NHS England's modelling indicates that the CHD surgical activity at Barts may increase to over double its current activity. Whilst this would represent a significant increase in its CHD activity the panel noted that there is available capacity in the PFI-financed Cardiac Centre on the St Bartholomew's site and that further development of cardiac services is in line with the hospital trust's strategic aims.

Barts took on responsibility for delivering Level 1 CHD services for adults at the new Barts Heart Centre in 2015, following comprehensive reorganisation of cardiac services across North Central and North Central London between UCLH and Barts. UCLH had previously provided Level 1 CHD services for adults. Barts is currently in financial special measures. As such the panel considered there to be risk associated with their ability to provide Level 1 CHD services for the increased number of patients envisaged under these proposals.

The panel considered the most significant risk associated with Barts increasing its capacity to be in relation to the additional workforce it would require. This risk was increased as a result of their failure to clearly demonstrate that they had quantified the additional staff they would require.

Barts was confident of being able to provide the additional capacity necessary to provide services to these additional patients. In conjunction with Great Ormond Street Hospital for Children, it has begun discussions with Guy's and St Thomas' and University Hospital Southampton to discuss what a network solution might look like which ensured that all hospitals met the 2021 requirements of surgeons working in teams of four who perform a minimum of 125 procedures a year.

Barts should continue to work closely with Great Ormond Street Hospital for Children to ensure that its CHD service continues to develop and that appropriate steps are made to ensure that the appropriate capacity is in place for any additional activity.

2. Impact on CHD services

The additional activity that would need to be managed

Bart's current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Adult
2013/14	85 UCLH
2014/15	69 UCLH
2015/16	60 Barts /4 UCLH

Catheter Procedures

Year	Adult
2013/14	142 UCLH
2014/15	2 Barts /129 UCLH
2015/16	164 Barts / 12 UCLH

NHS England's modelling of potential patient flows suggest that Barts would receive an additional 75-95 adult patients requiring surgical interventions. Barts have based its analysis of the capacity required on an assumption that it will receive an additional 90 surgical cases and 100 interventional cases each year. It has produced two projections one based on outpatient activity also transferring to Barts and one on it not.

3. Development of plans to care for additional patients

Barts currently provides four inpatient ward beds for its CHD service. In order to expand its capacity it has identified that it would need an additional four ward beds. Barts also has two critical care beds available for CHD which it believes would need to increase by one bed in order to provide care for these additional patients.

Barts has also identified the additional theatre sessions, catheter lab days, outpatient clinic appointments and diagnostic procedures which would be required for this additional activity. The additional diagnostic and outpatient capacity are impacted significantly by whether or not the outpatient activity transfers to Barts.

4. Facilities including availability of capital if needed

In order to provide the additional services identified Barts is relying largely on better utilisation of current facilities.

Currently there is a weekday catheter lab and operating theatre capacity available and business cases have been submitted to fund support services for additional capacity. In addition to this in order to meet additional future demands Barts is proposing extended three session operating days and seven day working which will provide capacity expansion possibilities.

Barts proposes making additional inpatient bed capacity for both ward and critical care areas through protocolled in-patient pathways which reduce the length of stay and improve efficiency.

Depending on whether or not outpatient activity transfers to Barts there may also be a need for greater outpatient capacity. Barts state that there is some outpatient capacity available and that more capacity can be generated by extended three session days and seven day working. It also proposes expanding current outreach specialist CHD clinics in regional hospitals if required.

The panel considered there to be some risks associated with Barts' proposals. It was noted that much of the additional capacity required was going to be achieved through utilisation of existing capacity and greater efficiency. Whilst this may be achievable the panel was concerned that there was risk that these efficiencies would not be achieved and did not feel assured that Barts had a plan for increasing its capacity if they were not. This risk was increased by the strain which Barts services currently seemed to be in under as demonstrated by currently being in financial special measures.

5. Workforce

Barts is confident that its current workforce plans/job planning will enable it to recruit experienced staff to support its additional catheter lab, theatre, outpatient and diagnostic activity.

If there were to be a significant growth in outpatient and diagnostic activity Barts currently have echo capacity restraints mainly due to physiology team skills mix. Its CHD physiology team are junior and in-training therefore all scans are full / detailed studies of 45 minutes duration. Recruiting experienced CHD physiologists is difficult due to a shortage of physiologists across the UK, especially those with skills in CHD. The recruitment of appropriately experienced consultant CHD cardiologists to support the expected levels of outpatient and diagnostic activity would also require targeted recruitment both within UK and EU.

In both scenarios the recruitment of ACHD Clinical Nurse Specialists (CNS) would be a challenge. CNS are crucial for ACHD services, however, there are very few who are experienced in this field. Barts has mitigated these recruitment problems by appointing experienced cardiac nurses with provision of an in-house training programme in CHD within the Barts Heart Centre.

In order to meet these challenges Barts has submitted business plans to the hospital Trust Board outlining resource requirements for implementing NHSE proposals. It is confident that through utilising its existing recruitment strategy and campaigns for nursing and allied health professionals it would continue to attract the necessary staff.

The panel was concerned that despite recognising the challenge which Barts was likely to face in terms of workforce development it had not quantified the growth which would be required in order to provide this additional activity.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>In order to provide the additional capacity the hospital trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive.</p>	<p>The Trust to quantify the staff required for its additional activity. The Trust to work with other hospitals to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. Commissioners, providers and Health Education England work together to plan for future CHD workforce provision NHS England to ensure that sufficient lead time is given to enable workforce planning.</p>
<p>As a result of these proposals the Trust has completed its impact assessment based on an increase of approximately 80-90 surgical procedures per year. This creates an operational risk that a higher than expected number of patients receives their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>
<p>The Trust requires additional intensive care and ward beds in order to increase its CHD activity. This creates an operational risk that an insufficient number of the new intensive care/ward beds are made available for the CHD service. This could result in last minute cancellations, delays to procedures and increased waiting times.</p>	<p>The Trust to do further more detailed planning to ensure that it has identified the number of ward/intensive care beds which are likely to be developed and ensure that a sufficient number of these new beds are allocated to CHD. NHS England to ensure that sufficient lead time is given.</p>
<p>As a result of these proposals the Trust has completed its impact assessment based on an increase of approximately 80-90 surgical procedures per year. This creates a financial risk that a lower than expected number of patients receives their care from the Trust following the implementation of the proposals. This would result in a financial loss to the hospital trust and the potential need for downscaling of provision including loss of staff and potential redundancies.</p>	<p>The Trust to develop contingency plans to provide care for a smaller number of patients.</p>

CHD Impact Assessment – Birmingham Children’s Hospital NHS Foundation Trust

1. Overview

These CHD proposals are likely to result in a significant amount of additional activity at Birmingham Children’s Hospital. Although the normal risks relating to growing capacity would exist, the panel is satisfied that Birmingham Children’s Hospital would be able to increase its capacity in order to meet this additional demand.

Birmingham Children’s Hospital was confident of being able to provide the additional capacity necessary to provide services to these additional patients. Its primary concern was over its need to develop additional PICU capacity and recruit the necessary nurses for the extra beds.

2. Impact on CHD services

The additional activity that would need to be managed

Birmingham Children’s Hospital current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	504	11	515
2014/15	480	8	488
2015/16	491	5	496

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	432	29	461
2014/15	465	35	500
2015/16	545	21	566

NHS England’s modelling of potential patient flows suggests that Birmingham Children’s Hospital would receive approximately 180 additional patients requiring surgical interventions. Using this figure Birmingham Children’s Hospital estimated that 80% of University Hospitals of Leicester’s activity would transfer to them were the proposals to be implemented. It also worked on the assumption that the majority of outpatient activity would continue to be provided by University Hospitals of Leicester.

The panel considered that these assumptions were appropriate to be used as a basis for Birmingham Children’s Hospital’s impact assessment whilst noting that it will be necessary for Birmingham Children’s Hospital to consider what the impact of providing all the outpatient activity would be.

3. Development of plans to care for additional patients

NHS England currently commission 30 PICU beds from Birmingham Children's Hospital. If the proposals were to be implemented Birmingham Children's Hospital has estimated that it would require an additional five PICU beds and twelve cardiac ward beds. In addition Birmingham Children's Hospital also stated that it would need to create additional consulting rooms and expand capacity within the heart investigations unit. It will need an additional three echo machines to be able to manage the growth in activity - one extra machine in the Heart Investigations Unit, one additional machine in theatres and an additional echo machine for the expanded cardiac ward.

4. Facilities including availability of capital if needed

The hospital trust is already investing in a major site redevelopment as part of the Next Generation project and this will be finalised in late 2017. The completion of this project is extremely important as it enables a large amount of inpatient space to be decanted and transferred into the new building when it opens thereby providing vacant estate for the cardiac inpatient, PICU bed base and additional consulting rooms to expand into.

As part of Birmingham Children Hospital's planning it has identified three potential locations that will be vacated and could support the required cardiac/PICU expansion. The Director of Estates and Chief Strategy Officer are leading an options appraisal to identify the preferred option and will be developing the business case for converting these into the additional cardiac and PICU estate required. Birmingham Children's Hospital is confident this will ensure that there is adequate capacity to be able to take the additional 380 admissions per year and also manage the increased outpatient requirements.

In terms of potential scheme value Birmingham Children's Hospital has not at this stage got final redevelopment costs but its initial scoping has indicated that this will be a significant capital investment. The existing space would become available in late 2017 and Birmingham Children's Hospital plans to commence the building programme with completion in early 2018.

In terms of funding the required level of estate development Birmingham Children's Hospital will need additional capital funding. The hospital trust's preferred capital financing route for the additional investment required for cardiac services would be via the issue of Public Dividend Capital. It understands that transformative schemes such as this could be prioritised as part of allocation of the Department of Health Capital Departmental Expenditure Limit (CDEL) process.

However, the business case that Birmingham Children's Hospital would internally develop to gain internal approval for taking this forward would look at a number of downside cases that would assume either part PDC / part loan via the Independent Trust Financing Facility (ITFF) and full loan funding via the ITFF. Its initial expectation is that to fund the latter they would model over a ten year period at current rates (with some degree of sensitivity in this to cover interest rate risk). The assumption is that the ongoing revenue funding via tariff would allow the servicing of a loan (repayment of principal and interest) or PDC (dividend payment to the DH).

The panel is satisfied that Birmingham Children’s Hospital has a clear plan for establishing the capacity required for the additional activity it would be likely to receive if NHS England’s proposals were to be implemented. However, this capacity appeared to be dependent on capital spend and as such there remains a risk that if this to not progress as outlined by Birmingham Children’s Hospital it would not be able to sufficiently increase its capacity. This risk would be increased if NHS England does not provide Birmingham Children’s Hospital sufficient lead time to implement changes.

5. Workforce

The projected growth in activity will result in the need to expand the existing workforce across a number of areas, including cardiac and PICU nursing, cardiologists, cardiac nurse specialists, psychologists and staff within the Heart Investigation Unit.

Birmingham Children’s Hospital has estimated that it would need the following staff:

- Cardiologist workforce – 2 WTE consultants, 2 WTE middle/junior grades and an increase the number of cardiac liaison nurses and Advanced Nurse Practitioners;
- PICU and Cardiac ward nursing – 55 WTE nurses made up of 37 WTE Qualified PICU nurses and 18 WTE cardiac ward nurses; and
- 5 WTE clinical support workers.

Birmingham Children’s Hospital considers the growth in PICU and ward nursing staff represents a significant challenge, especially if TUPE transfer is not applied. To increase staff numbers at this level will require a significant recruitment programme and does risk destabilising units elsewhere through potentially poaching existing PICU and cardiac nursing staff. Birmingham Children’s Hospital considered that it was critical that it is able to work with the NHS England team nationally to ensure there is an integrated and structured approach to this issue.

The panel recognised the challenge faced by Birmingham Children’s Hospital in recruiting the necessary staff. It acknowledged the risk of destabilising other units through Birmingham Children’s Hospital’s recruitment of additional nursing staff; however, remained confident that with sufficient lead time and planning it was likely that this risk could be reduced.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>In order to provide the additional capacity the Trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive.</p>	<p>The Trust to work with other hospitals to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. Commissioners, providers and Health Education England work together to plan for future CHD</p>

Risk	Mitigation
	workforce provision NHS England to ensure that sufficient lead time is given to enable workforce planning.
<p>The Trust is undertaking a new building programme which will provide additional space for intensive care/ward beds. There is a risk of delays/problems with the building programme which increases the operational risk that sufficient ICU/ward capacity is not available. This could result in last minute cancellations, delays to procedures and increased waiting times.</p>	<p>Birmingham Children's Hospital to continue developing plans to reduce the risk of delays occurring. Birmingham Children's Hospital also to ensure there is enough slack in the plan to allow for delays.</p> <p>Birmingham Children's Hospital to develop a contingency plan for how additional capacity could be created without this building work being completed.</p> <p>NHS England to ensure that sufficient lead time is given.</p>
<p>In order to provide the additional capacity the Trust will need to recruit additional staff. There is a risk that Birmingham Children's Hospital's recruitment of staff results in under staffing in other hospitals in the region.</p>	<p>Birmingham Children's Hospital to work with other hospitals and NHS England to develop a co-ordinated approach to recruiting the necessary staff</p> <p>Commissioners, providers and HEE work together to plan for future CHD workforce provision</p>
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 180 additional surgical procedures. This creates an operational risk that a higher than expected number of patients receives their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 180 additional surgical procedures. This creates a financial risk that a lower than expected number of patients receives their care from the Trust following the implementation of the proposals. This would result in a financial loss to the Trust and the potential need for downscaling of provision including loss of staff and potential redundancies.</p>	<p>The Trust to develop contingency plans to provide care for a smaller number of patients.</p>

CHD Impact Assessment – University Hospitals Bristol NHS Foundation Trust

1. Overview

These CHD proposals are unlikely to result in any significant amount of additional activity at University Hospitals Bristol. The most significant risk for University Hospitals Bristol remains that it fails to achieve the minimum activity required for four surgeons to perform 125 procedures each year by 2021.

NHS England's modelling suggests that Bristol would receive fewer than ten additional procedures per year as a result of these proposals. There are therefore no new risks to University Hospitals Bristol.

2. Impact on CHD services

The additional activity that would need to be managed

University Hospitals Bristol current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	306	94	400
2014/15	306	110	416
2015/16	327	125	452

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	220	178	398
2014/15	188	168	356
2015/16	336	293	629

NHS England's modelling suggests that Bristol would only receive fewer than ten additional procedures per year as a result of these proposals

3. Development of plans to care for additional patients

University Hospitals Bristol stated that as the projected increase was within range of year to year variance it can be accommodated without additional support.

4. Facilities including availability of capital if needed

None required as a result of these proposals

5. Workforce

No increase required as a result of these proposals

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
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Risk	Mitigation
<p>As a result of these proposals the Trust has completed its impact assessment assuming it does not receive a material increase to its CHD activity. This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>

Draft for consultation

CHD Impact Assessment – Central Manchester University Hospitals NHS Foundation Trust

1. Overview

Central Manchester University Hospitals did not complete an impact assessment. However, following publication of NHS England's proposals there have been constructive conversations between Central Manchester University Hospitals, Liverpool Heart and Chest Hospital and Alder Hey Children's Hospital regarding the appropriate configuration of Level 1 and Level 2 CHD services in the North West.

Whilst the proposals will have some impact on the Trust's finances and reputation, this will be offset by the establishment of a new model for the delivery of CHD services in the North West. The risk to Central Manchester University Hospitals as a Trust is very limited, as it has only been undertaking a relatively low volume of CHD surgical activity.

2. Impact on CHD services

2.1 The activity that would need to be transferred to different providers

Were Central Manchester University Hospitals to no longer be commissioned as a Level 1 CHD hospital, it would cease performing any surgical or catheter procedures on people with CHD. This activity would need to be transferred to other hospitals with the majority of the adult activity transferring to Liverpool Heart and Chest Hospital as shown in the table below.

Receiving Trust	Patients/year From CMFT		
	Adult	Paediatric	Total
LEEDS TEACHING HOSPITALS NHS TRUST	4	-	4
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	96	-	96
Total	100	-	100

The most recent activity as reported by the National Congenital Heart Disease Audit is displayed in the tables below. The 15/16 activity is as yet unvalidated.

Surgical procedures

Year	Adult
2013/14	99
2014/15	89
2015/16	88

Catheter Procedures

Year	Adult
2013/14	85
2014/15	88

Year	Adult
2015/16	180

2.2 The potential for Level 2 CHD services to be offered if Level 1 CHD services ceased to be offered.

Level 2 hospitals represent a significant part of the model of care described by the standards for CHD services. They are able to provide the vast majority of the ongoing CHD care required by patients with the exception of any care requiring surgical intervention and the majority of that which requires catheter intervention.

Central Manchester University Hospitals currently provide Level 2 CHD services for children and are currently exploring the possibility of providing these services for adults. This would enable the majority of adult patients in and around Manchester to receive most of their care closer to home with only care relating to a surgical or interventional procedure requiring a Level 1 hospital.

3. Impact on other interdependent services if Level 1 CHD services cease.

Due to the relatively low volume of Level 1 CHD activity undertaken at Central Manchester University Hospitals, the panel did not expect the proposals to have any significant impact on other services within the hospital trust.

4. Impact on the hospital trust including financial, business and reputational considerations

Financial impact – Central Manchester University Hospital's overall income for 2015/16 was £967m and the value of its contract for specialised services is approximately £348m. While the panel accepted that the proposed changes would have a financial impact the contract value of the hospital trust's CHD activity is approximately £1m.

The financial value of Central Manchester University Hospital's CHD activity therefore represents 0.1% of the hospital trust's total income and 0.3% of its total specialised services income. The financial loss would be smaller than this if the hospital trust continues to provide Level 2 specialist medical CHD services.

Reputational impact

The panel accepted that the loss of Level 1 CHD services would have a reputational impact on Central Manchester University Hospitals. Being one of only ten centres to offer these services enhances the hospital trust's reputation as a hospital providing high quality specialist services; impacts on its ability to recruit and retain staff; and increases its ability to be involved in specialist research. The reputational impact would be reduced if Central Manchester University Hospitals was to continue to provide Level 2 services in partnership with Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital.

The panel noted that the reputational impact of these proposals must be considered in the light of Central Manchester University Hospital's overall provision of specialised services. The hospital trust would continue to offer a wide range of

specialised services and as such the panel was confident that the hospital trust would continue to be a highly valued hospital within the NHS.

5. Impact on staff

Due to the relatively low volume of surgical and interventional CHD activity at Central Manchester University Hospitals, the impact on staff is significantly lower than on other hospitals which would no longer be providing Level 1 services under the proposals.

The members of the panel considered that in their experience of service change, the majority of staff do not transfer over to alternative providers of these services from the centres which are decommissioned. Whilst Central Manchester University Hospital's CHD surgeon is likely to move to a Level 1 CHD hospital, the panel considered it reasonable to expect that many staff currently providing Level 1 services at Central Manchester University Hospitals would seek to take up alternative roles within the hospital trust, rather than moving to another hospital. This would become more likely if Central Manchester University Hospitals was to provide Level 2 services, as more CHD roles would be retained within the hospital trust. Detailed discussion about this will continue as the North West model develops.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
The loss of Level 1 CHD activity affects a significant number of staff currently working in this service. This creates a risk of disruption to staff and potentially redundancies.	Central Manchester to work closely with staff impacted by the change to ensure that staff are given the appropriate support. Ensure appropriate policies and processes are in place to support workforce affected by change. Ensure that sufficient lead time is given to enable workforce planning.
Disruption to staff including redundancies as a result of the loss of Level 1 CHD activity	NHS England to develop contingency plans to reduce the impact if this was to occur. Central Manchester to continue working with Liverpool Heart and Chest Hospital and Alder Hey Children's Hospital to ensure the appropriate configuration of services in the North West. Central Manchester to monitor vacancy rates and inform NHS England should there be any indication that services are under threat due to staff vacancies.
As a result of no longer providing Level 1 CHD services the Trust will lose income it receives for the associated procedures and care through tariff. This creates a financial risk to the Trust.	Seek to minimise the financial impact through ensuring appropriate costs are saved as a result of not providing Level 1 services and that the maximum revenue is maintained through the provision of Level 2 services.

CHD Impact Assessment – Great Ormond Street Hospital for Children NHS Foundation Trust

1. Overview

The CHD proposals are likely to result in a significant amount of additional activity at Great Ormond Street. Although the normal risks relating to growing capacity exist, the panel is satisfied that Great Ormond Street would be able to increase its capacity in order to meet this additional demand.

Great Ormond Street Hospital is confident of being able to provide the additional capacity necessary to provide services to these additional patients. It has begun discussions with Guy's and St Thomas' and University Hospital Southampton regarding what a network solution might look like which ensured that all centres met the 2021 requirements of surgeons working in teams of four who perform a minimum of 125 procedures a year.

2. Impact on CHD services

The additional activity that would need to be managed

Great Ormond Street's current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	VADs ¹⁰	Total
2013/14	704	15	4	719
2014/15	678	9	18	687
2015/16	655	8	14	663

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	335	30	365
2014/15	329	22	351
2015/16	465	43	508

NHS England's modelling of potential patient flows suggest that Great Ormond Street would receive an additional 205-235 paediatric patients requiring surgical interventions. However, Great Ormond Street completed this assessment on the basis of receiving additional activity based on 154 paediatric surgical cases on the assumption that a larger amount of activity from the Royal Brompton would go to Southampton. Great Ormond Street confirms that if required it would be able to take approximately 200 additional cases at short notice.

¹⁰ VADs are Ventricular Assist Devices and these operations are countable under the standards. The numbers shown are based on data submitted to NICOR but not validated or reported by them

3. Development of plans to care for additional patients

Great Ormond Street's cardiology ward currently consists of 16 beds (eight of which are for CHD). In addition, it also has eight beds in its cardiology HDU (four for CHD) and six beds in its day care ward. In order to expand capacity Great Ormond Street has identified that it would need an additional 2.2 cardiology ward beds, 1.1 HDU beds and 2 day care beds. Great Ormond Street has a 21 bedded PICU (11 for CHD) which it believes it would need to increase by 3.1 beds in order to provide care for these additional patients. In 15/16 their PICU and ward utilisation was 92-93%.

Great Ormond Street has also identified the additional theatre sessions, catheter lab days, outpatient clinic appointments and diagnostic procedures it would require for this additional activity. It does not envisage any issues with meeting the additional requirements for theatre sessions, diagnostic activity, catheter labs or outpatient provision.

4. Facilities including availability of capital if needed

In September 2017 the new Premier Inn Clinical Building is opening at Great Ormond Street, which will provide additional inpatient beds plus operating theatre capacity.

There is some flexibility in how Great Ormond Street allocate these beds, with beds which were originally proposed as HDU beds able to be converted into ICU beds, if required. There would be a capital cost associated with this. Early indicative costs associated with this work are in the region of £6 million. Any necessary work to convert HDU beds to ICU beds would not be able to start until May 2017. However Great Ormond Street confirmed that there is vacant capacity on its PICU/NICU wards that could be utilised in the short-term.

As a result of this Great Ormond Street have modelled on the basis that it would receive additional patients from April 2018.

5. Workforce

Great Ormond Street considers itself able to recruit and retain high quality staff. It recognises nurse recruitment as one of the key challenges associated with expanding activity and would hope that many nurses who work at the Royal Brompton would want to transfer to Great Ormond Street which would retain these essential skills within London.

They have estimated the following additional WTE staffing requirements:

- **Nursing**
 - ICU - 22.4
 - Ward (Inc. HDU) - 10.6
- **Consultant Cardiologists**
 - (Ward cardiologist, general cardiologist, CMR consultant) - 3
 - CICU Consultants - 2
 - Interventional Cardiologist - 1
 - Junior Doctor - 5
- **Support Staff**
 - Echo Tech (Band 7) - 2
 - Physiologists (Band 6) - 2
 - Catheter Lab Nurses - 3

- Cardiac Radiographers - 2
- Perfusionist - 1

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>In order to provide the additional capacity the Trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive.</p>	<p>The Trust to work with other Trusts to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. Commissioners, providers and HEE work together to plan for future CHD workforce provision NHS England to ensure that sufficient lead time is given to enable workforce planning.</p>
<p>As a result of these proposals the Trust has completed its impact assessment assuming a 16% increase of surgical procedures and a 42% increase of other CHD services. This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>
<p>The Trust requires additional intensive care and ward beds in order to increase its CHD activity. This creates an operational risk that an insufficient number of the new intensive care/ward beds are made available for the CHD service. This could result in last minute cancellations, delays to procedures and increased waiting times.</p>	<p>The Trust to do further more detailed planning to ensure that it has identified the number of ward/intensive care beds which are likely to be developed and ensure that a sufficient number of these new beds are allocated to CHD. NHS England to ensure that sufficient lead time is given.</p>
<p>As a result of these proposals the Trust has completed its impact assessment assuming a 16% increase of surgical procedures and a 42% increase of other CHD services. This creates a financial risk that a lower than expected number of patients receive their care from the Trust following the implementation of the proposals. This would result in a financial loss to the Trust and the potential need for downscaling of provision including loss of staff and potential redundancies.</p>	<p>The Trust to develop contingency plans to provide care for a smaller number of patients.</p>

CHD Impact Assessment – Guy’s and St Thomas’ NHS Foundation Trust

1. Overview

These CHD proposals are likely to result in a significant amount of additional activity at Guy’s and St Thomas’. Although the normal risks relating to growing capacity exist, the panel is satisfied that Guy’s and St Thomas’ would be able to increase its capacity in order to meet this additional demand.

Guy’s and St Thomas’ is confident of being able to provide the additional capacity necessary to provide services to these additional patients. It has begun discussions with Great Ormond Street/Barts and Southampton to discuss what a network solution might look like which ensured that all centres met the 2021 requirements of surgeons working in teams of four who perform a minimum of 125 procedures a year.

2. Impact on CHD services

The additional activity that would need to be managed

Guy’s and St Thomas’ current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	431	81	512
2014/15	424	68	492
2015/16	414	85	499

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	201	145	365
2014/15	247	151	351
2015/16	262	174	508

NHS England’s modelling of potential patient flows suggests that Guy’s and St Thomas’ would receive an additional 190-210 patients requiring surgical interventions. However, Guy’s and St Thomas’ completed this assessment on the basis that it would receive additional activity based on 186 surgical cases, on the assumption that a larger amount of activity from the Royal Brompton would go to Southampton. Guy’s and St Thomas’ also included a reduction of 83 paediatric patients in their projections, due to the current plans for the patients which are currently referred to Guy’s and St Thomas’ for surgery from Belfast to be referred to Dublin in the future. As a result of this Guy’s and St Thomas’ has projected a 16% increase in paediatric surgical activity and a 42% increase in other paediatric services (which would previously have been provided by Belfast) and adults.

The panel considered that these assumptions were appropriate to be used as a basis for Guy’s and St Thomas’ impact assessment.

3. Development of plans to care for additional patients

Guy's and St Thomas' currently has access to 14 inpatient paediatric cardiology ward beds (including six HDU beds). In addition is also has access to 66 inpatient adult cardiology beds plus 6 CCU beds. Guy's and St Thomas' has a 20 bedded PICU (seven of which are dedicated cardiac beds) and 54 adult critical care beds.

Guy's and St Thomas' identified that it would need to provide an additional ten surgical cases a month and that this would require additional theatre sessions; however, for all other areas it did not quantify the additional capacity which it would require to provide the additional activity. Guy's and St Thomas' has not identified the additional capacity it would need (with the exception of theatre capacity) but rather identified the additional facilities it will have available as a result of its capital expansion.

4. Facilities including availability of capital if needed

Guy's and St Thomas' capital expansion includes an additional:

- four paediatric cardiology ward beds (from Jan 2018);
- three adult cardiology ward beds (from April 2017);
- ten additional four hour paediatric MRI and catheter lab sessions (from October 2018);
- ten PICU beds (from March 2018);
- eleven adult ICU beds (from Dec 2017 – awaiting business case);
- three additional paediatric clinic rooms (end of 2017);
- three additional adult diagnostic and clinic rooms (March 2017).

Guy's and St Thomas' have estimated that in order to perform the additional surgical procedures an additional ten cases per month will be required. It will perform these procedures through an additional four sessions of four hours each, which are available on Wednesday afternoons every month and through increasing its weekend surgical lists from two to four per month.

As a result of this additional capacity Guy's and St Thomas' will have available it does not expect there to be any significant issues with increasing its capacity in order to provide Level 1 services for the additional patients suggested by NHS England's modelling.

The panel is satisfied that there is sufficient capacity within Guy's and St Thomas' facilities to provide CHD services for the additional patients suggested by NHS England's modelling. However, a clearer demonstration of the proportion of this Guy's and St Thomas' additional capacity which would be required for this group would reduce the risk that the appropriate facilities are not made available to provide these additional CHD services.

5. Workforce

The recruitment of the necessary staffs is an integral part of Guy's and St Thomas' capital expansion with staff recruitment, induction and training phased to the opening of additional facilities. Guy's and St Thomas' has a good record in staff recruitment and retention, with regular experience of responding successfully to the increased staffing needs of new facilities. Guy's and St Thomas' also stated that it considers

that TUPE is likely to apply and want to work with partner organisations as soon as possible to attract as many existing CHD staff to the Trust as possible, ensuring they all have clear options and that none of these very valuable staff are lost to the service.

The panel was reassured to hear that the recruitment of the workforce was an integral part of their expansion it would have been further assured had the staffing required for this increase in CHD activity been quantified. Given the challenges faced by all trusts in recruiting staff, specifically nurse specialists, assurance that the scale of the requirement is understood by those centres receiving activity is seen as an important first step in minimising this risk.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>In order to provide the additional capacity the Trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive.</p>	<p>The Trust to quantify the staff required for its additional activity. The Trust to work with other Trusts to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. Commissioners, providers and HEE work together to plan for future CHD workforce provision NHS England to ensure that sufficient lead time is given to enable workforce planning.</p>
<p>As a result of these proposals the Trust has completed its impact assessment assuming a 16% increase of surgical procedures and a 42% increase of other CHD services. This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This is particularly significant due to the risk that the activity from Northern Ireland does not all move to Dublin prior to the proposals being implemented This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>
<p>The Trust requires additional intensive care and ward beds in order to increase its CHD activity. This creates an operational risk that an insufficient number of the new intensive care/ward beds are made available for the CHD service. This could result in last minute cancellations, delays to procedures and</p>	<p>The Trust to do further more detailed planning to ensure that it has identified the number of ward/intensive care beds which are likely to be developed and ensure that a sufficient number of these new beds are allocated to CHD.</p>

Risk	Mitigation
increased waiting times.	NHS England to ensure that sufficient lead time is given.
As a result of these proposals the Trust has completed its impact assessment assuming a 16% increase of surgical procedures and a 42% increase of other CHD services. This creates a financial risk that a lower than expected number of patients receive their care from the Trust following the implementation of the proposals. This would result in a financial loss to the Trust and the potential need for downscaling of provision including loss of staff and potential redundancies.	The Trust to develop contingency plans to provide care for a smaller number of patients.

As part of the fact check exercise Guy's & St Thomas' provided assurances that they had undertaken the necessary action to mitigate the risks identified within this assessment.

CHD Impact Assessment – Leeds Teaching Hospitals NHS Trust

1. Overview

These CHD proposals are likely to result in some additional activity at Leeds Teaching Hospitals. Although the normal risks relating to growing capacity would exist, the panel is satisfied that the hospital trust would be able to increase its capacity in order to meet this additional demand.

Leeds Teaching Hospitals NHS Trust is confident of being able to provide the additional capacity necessary to provide services to these additional patients. The most significant risks related to the hospital trust's ability to expand its cardiac ward, PICU and theatre capacity.

2. Impact on CHD services

The additional activity that would need to be managed

Leeds Teaching Hospitals' current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	390	93	483
2014/15	373	118	491
2015/16	390	104	494

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	198	134	332
2014/15	215	145	360
2015/16	441	244	685

NHS England's modelling of potential patient flows suggests that Leeds Teaching Hospitals would receive an approximately 50 additional patients requiring surgical interventions per year. The hospital trust used this figure as the basis for the growth in catheter interventions, diagnostic activity and outpatient services it would be likely to experience.

The panel is satisfied that this is an appropriate basis for its impact assessment; however, acknowledged that the outpatient and diagnostic activity assumptions may change if UHL was to provide Level 2 services.

3. Development of plans to care for additional patients

Leeds Teaching Hospitals currently has ten paediatric cardiology ward beds, six HDU beds and 16 PICU beds. In addition to this it has 17 adult cardiology beds and 15 adult ICU beds.

The panel noted that in the information provided by Leeds Teaching Hospitals, some months showed its cardiac ward running at 99% occupancy. In addition, regional commissioners noted that the hospital trust's PICU capacity had been under strain this year.

In order to meet the demands of the additional activity indicated by NHS England's modelling Leeds Teaching Hospitals has identified that it would require an additional cardiac ward bed and an additional PICU bed. An additional MRI session, catheter lab session and outpatient clinic each week would also be required.

4. Facilities including availability of capital if needed

Leeds Teaching Hospitals indicated that the one additional cardiac ward bed required can be accommodated by adaptations on the ward and that PICU provision could increase by four beds from 16 to 20 if required. The hospital trust also hopes to develop day case pathways in the medium term for some diagnostic and intervention procedures.

The adult ward is a combined cardiac and vascular ward with a total capacity for 28 patients. Currently, 15 beds are designated for adults with acquired and congenital heart disease, but Leeds Teaching Hospitals could look to review this if demand required. Critical care is based on cardiac ICU wards with 15 beds. The hospital trust considers this to be adequate capacity and will keep this under review.

Leeds Teaching Hospitals also states that the additional theatre activity can be supported through productivity gains.

The panel was satisfied that Leeds Teaching Hospitals would be able to develop sufficient capacity to provide CHD services for the additional patients suggested by NHS England's modelling. However, the panel is unclear whether the hospital trust would be able to increase its ward capacity by more than one bed, if this was to be required. The risk associated with this was considered to be more significant due to the high occupancy rates within the cardiac ward. In addition, there is a risk associated with theatre capacity if this relied on productivity gains. More details on the nature of the productivity gains and a contingency if these were not achieved would reduce this risk.

5. Workforce

Leeds Teaching Hospitals has established a Cardiac Surgery Improvement Programme Board, led by an Executive Director. The programme board has various work streams including a focused group delivering workforce planning. The hospital trust also confirmed that it would welcome applications from any staff displaced by the proposed changes.

The panel was reassured to hear that Leeds Teaching Hospitals had a clear focus on workforce planning for cardiac surgery. However, it would have been further assured had the staffing required for this increase in CHD activity been quantified. Given the challenges faced by all trusts in recruiting staff, specifically nurse specialists, assurance that the scale of the requirement was understood by those centres receiving activity was seen as an important first step in minimising this risk.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>The Trust has identified that it requires one additional intensive care bed in order to increase its CHD activity by the amount indicated by NHS England's modelling. This creates an operational risk that an insufficient number of the new intensive care beds are made available for the CHD service. This could result in last minute cancellations, delays to procedures and increased waiting times.</p>	<p>The Trust to make contingency plans for situations where more than one additional ward bed is required. NHS England to ensure that sufficient lead time is given.</p>
<p>The Trust has identified productivity gains in its theatres which can be achieved to accommodate the addition activity indicated by NHS England's modelling. This creates an operational risk that fails to achieve sufficient productivity gains in its theatres. This could result in last minute cancellations, delays to procedures and increased waiting times.</p>	<p>The Trust to make contingency plans for situations where sufficient productivity gains are not achieved. NHS England to ensure that sufficient lead time is given.</p>
<p>In order to provide the additional capacity the Trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive.</p>	<p>The Trust to quantify the staff required for its additional activity. The Trust to work with other Trusts to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. Commissioners, providers and HEE work together to plan for future CHD workforce provision NHS England to ensure that sufficient lead time is given to enable workforce</p>

Risk	Mitigation
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 50 additional surgical procedures. This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>planning.</p> <p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 50 additional surgical procedures. This creates a financial risk that a lower than expected number of patients receive their care from the Trust following the implementation of the proposals. This would result in a financial loss to the Trust and the potential need for downscaling of provision including loss of staff and potential redundancies.</p>	<p>The Trust to develop contingency plans to provide care for a smaller number of patients.</p>

As part of the fact check exercise Leeds provided assurances that they had undertaken the necessary action to mitigate the risks identified within this assessment.

CHD Impact Assessment – Liverpool Heart and Chest Hospital NHS Foundation Trust

1. Overview

Liverpool Heart and Chest Hospital currently provides Level 2 CHD services and under the CHD proposals would begin providing Level 1 services including surgery and interventional cardiology on adults. This is a significant change in its activity and the panel has concerns over its understanding of all the capacity which will be required to provide these services and ability to meet this. The risks associated with this are seen as more significant due to Liverpool Heart and Chest Hospital's current breaching of referral to treatment waiting times (RTT) specifically in relation to cardiac surgery

These risks can be reduced through ongoing close working between Central Manchester University Hospitals, Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital to ensure that Liverpool Heart and Chest Hospital has a clear understanding of the activity it will be required to undertake and the facilities, staffing and capacity associated with this activity.

Liverpool Heart and Chest Hospital is confident of being able to provide the additional capacity necessary to provide services to these additional patients. Due to the new nature of the activity it would be undertaking, the panel considered it to be of increased importance that the changes required have been clearly understood and quantified and that plans are in place to ensure that the necessary capacity and workforce is in place to provide Level 1 adult services.

2. Impact on CHD services

The additional activity that would need to be managed

Liverpool Heart and Chest Hospital's current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Adult
2013/14	23
2014/15	19
2015/16	11

Catheter Procedures

Year	Adult
2013/14	139
2014/15	96
2015/16	67

NHS England's modelling of potential patient flows suggest that Liverpool Heart and Chest Hospital would receive an additional 75-90 adult patients requiring surgical

interventions. Liverpool Heart and Chest Hospital has based its modelling on receiving an additional 86 surgical cases and 97 ACHD interventions which the panel considered to be a reasonable basis for their impact analysis.

Liverpool Heart and Chest Hospital does not currently have a level 1 adult CHD service and will need to establish a new service supported by Alder Hey and Central Manchester.

Although the table shows CHD surgery at Liverpool Heart and Chest Hospital most of the procedures concerned were either aortic surgery (patients referred to an aortic specialist surgeon including referrals from CHD surgeons) or cases that do not require a CHD surgeon (based on the definitions of adult CHD surgery established before NHS England's work in this area).

3. Development of plans to care for additional patients

Liverpool Heart and Chest Hospital has not been providing Level 1 CHD services prior to this and so did not provide evidence of any current capacity with the exception of outpatient clinics. Liverpool Heart and Chest Hospital has stated that it will require one critical care bed and two or three cardiology beds. It acknowledges that these estimates will require validating once more data is available on current activity undertaken by Central Manchester University Hospitals. Liverpool Heart and Chest Hospital will also require four hours of theatre time and one catheter lab session each week.

Liverpool Heart and Chest Hospital has also identified an additional four to six outreach clinics would be required; but would require information on outreach clinics currently delivered at other sites across the North West.

The panel recognised that there was still a significant level of uncertainty around the capacity which Liverpool Heart and Chest Hospital would require to begin delivering Level 1 CHD services. This increased the risk of sufficient capacity not being available at Liverpool Heart and Chest Hospital if the proposals were to be implemented. This risk could be reduced through ongoing discussions between Liverpool Heart and Chest Hospital, Alder Hey and Central Manchester University Hospitals to provide greater clarity over the capacity required.

4. Facilities including availability of capital if needed

Liverpool Heart and Chest Hospital stated that the North West Partnership has agreed a business case in relation to the additional capacity requirements. It confirmed that the additional capacity could be operationalised within 6 to 9 months of a commissioning intention being confirmed.

Whilst the panel is reassured by the fact an agreed business case was in place, it remained concerned that the extent of the capacity is not yet clear and that the details of the business case were not provided. It was therefore not possible to get assurance that the necessary facilities would be in place to provide this additional activity if the proposals were to be implemented

5. Workforce

Liverpool Heart and Chest Hospital identified that it would require an additional cardiac surgeon who would work across both the paediatric and adult centres and two ACHD cardiologists.

In addition, Liverpool Heart and Chest Hospital intends to recruit cardiac anaesthetists and cardiac nurse specialists, but the required number of these has not been established. The hospital trust intends to receive the necessary cardiac anaesthetist cover from Alder Hey until it has recruited its own. It stated that the recruitment although some of these posts may be recruited through TUPE arrangements; however, it is confident that these could be recruited were this to not be possible.

The panel is concerned that the workforce requirements have not been clearly quantified and recognised the need for sufficient lead time to be given to minimise the risk of Liverpool Heart and Chest Hospital failing to recruit the necessary workforce.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>In order to provide Level 1 CHD capacity the Trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive. In addition this could result in Liverpool Heart and Chest being unable to provide Level 1 services</p>	<p>The Trust to work with other Trusts to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. Commissioners, providers and HEE work together to plan for future CHD workforce provision NHS England to ensure that sufficient lead time is given to enable workforce planning.</p>
<p>The Trust requires additional theatre, cath lab, intensive care and ward capacity in order to increase its CHD activity. This creates an operational risk that insufficient capacity is made available for the CHD service. This could result in last minute cancellations, delays to procedures and increased waiting times. In addition this could result in Liverpool Heart and Chest being unable to provide Level 1 services</p>	<p>The Trust to do further more detailed planning to ensure that it has identified the number of ward/intensive care beds which are likely to be developed and ensure that a sufficient number of these new beds are allocated to CHD. NHS England to ensure that sufficient lead time is given.</p>
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 80-90 additional surgical procedures. This creates a financial risk that a lower than expected</p>	<p>The Trust to develop contingency plans to provide care for a smaller number of patients.</p>

Risk	Mitigation
<p>number of patients receive their care from the Trust following the implementation of the proposals. This would result in a financial loss to the Trust and the potential need for downscaling of provision including loss of staff and potential redundancies.</p>	
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 80-90 additional surgical procedures. This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>

As part of the fact check exercise Liverpool Heart and Chest Hospital provided assurances that they had undertaken the necessary action to mitigate the risks identified within this assessment.

CHD Impact Assessment – Newcastle upon Tyne Hospitals NHS Foundation Trust

1. Overview

The CHD proposals are unlikely to result in any significant amount of additional activity at Newcastle upon Tyne Hospitals. The most significant risks for the hospital trust remain that it fails to achieve the minimum activity required for four surgeons to perform 125 procedures each year and that it fails to meet the requirement for co-location of key paediatric services by 2019.

NHS England's modelling suggests that Newcastle upon Tyne Hospitals would not receive any additional procedures as a result of these proposals. There are therefore no new risks to the hospital trust.

2. Impact on CHD services

The additional activity that would need to be managed

Newcastle upon Tyne Hospital's current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	VADS ¹¹	Total
2013/14	248	71	43	362
2014/15	237	63	23	323
2015/16	261	67	9	337

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	136	74	210
2014/15	140	54	194
2015/16	285	132	417

NHS England's modelling suggests that Newcastle upon Tyne Hospitals would not receive any additional procedures per year as a result of these proposals

3. Development of plans to care for additional patients

Newcastle upon Tyne Hospitals stated that it had internally modelled various scenarios of CHD activity growth and anticipated that additional capacity could be provided; assuming that suitable notification of any expected growth was given.

4. Facilities including availability of capital if needed

None required as a result of these proposals.

¹¹ VADs are Ventricular Assist Devices and these operations are countable under the standards. The numbers shown are based on data submitted to NICOR but not validated or reported by them

5. Workforce

No increase required as a result of these proposals.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>As a result of these proposals the Trust has completed its impact assessment assuming it does not receive a material increase to its CHD activity (as per NHS England's modelling). This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust has developed contingency plans which model how they would provide care for a larger number of patients.</p>

Draft for consultation

CHD Impact Assessment – Royal Brompton and Harefield NHS Foundation Trust

1. Overview

If implemented, these proposals will have a significant impact on the hospital trust's finances and reputation. Whilst the reputational impact will be lessened by the continued provision of a wide range of specialist services at the Royal Brompton the financial impact of losing CHD Level 1 activity would be significant for the Royal Brompton.

The Royal Brompton considers the proposals to pose significant risks to it as a hospital trust. It considers that the financial implications of these proposals to be sufficient to destabilise the hospital trust's financial position.

The panel considered that the financial risks are more significant at the Royal Brompton than at any other hospital trust that would be affected by implementation of the proposals, due to the proportion it represents of its overall income and the impact the changes are likely to have on other services, specifically paediatric services within the hospital.

2. Impact on CHD services

2.1 The activity that would need to be transferred to different providers

Were the Royal Brompton to no longer be commissioned as a Level 1 CHD hospital, it would cease performing any surgical or catheter procedures on people with CHD. This activity would need to be transferred to other hospitals and NHS England's modelling suggests that the majority of this would transfer to one of the other Level 1 hospitals within London. The table below describes the potential additional patients received by different hospitals were the Royal Brompton to no longer perform CHD surgery.

Receiving Trust	Likely Patients/year From RBH		
	Adult	Paediatric	Total
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		1	1
BARTS HEALTH NHS FOUNDATION TRUST	77		77
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		5	5
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		228	228
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	30	173	203
LEEDS TEACHING HOSPITALS NHS TRUST	1	-	1
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	1		1
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	6	11	17
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	2		2
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	3	2	5
Total	120	420	540

The most recent activity as reported by the National Congenital Heart Disease Audit is displayed in the tables below. The 15/16 activity is as yet unvalidated.

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	412	125	537
2014/15	370	142	512
2015/16	390	132	522

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	255	86	341
2014/15	303	242	545
2015/16	424	342	764

Diagnostic Activity

The Royal Brompton also stated that it performed the following diagnostic activity in 2015/16

	Paediatrics	Adults	Total
Outreach Clinic Echo procedures	6739	108	6847
Outreach Neonatal Echo procedures	98	N/A	98
Fetal Echo scans	2966	N/A	2966
Paediatric Sleep Studies (CHD & non-CHD)	1243	N/A	1243
Paediatric Bronchoscopy procedures (non-CHD)	188	N/A	188
CT	277	217	494
Exercise Tests	515	368	883
Flouroscopy Tests	546	312	858
Holter Monitor Tests	892	206	1098
MRI	329	495	824
Nuclear Medicine Tests	38	54	92
Ultra Sound Tests	439	71	510
Bone Density Tests	24	4	28
Paediatric Lung Function (CHD [3%] and non-CHD)	425	N/A	425

Outpatient activity

The Royal Brompton also stated that it performed the following outpatient activity in 2015/16:

	Paediatrics	Adults	Total
Outpatient Visits	10829	3527	14356
Outreach Clinic Visits	7094	108	7202
Outreach Neonatal Visits	171	N/A	171 ¹²

2.2 The potential for adult only services to be offered

Level 2 hospitals represent a significant part of the model of care described by the standards for CHD services. They are able to provide the vast majority of the ongoing CHD care required by patients with the exception of any care requiring surgical intervention and the majority of that which requires catheter intervention. Although these have not been designated as Level 2 hospitals prior to the standards being agreed, Oxford University Hospitals and the University Hospital of Wales (Cardiff) have been operating successfully, providing Level 2 services in partnership with proposed Level 1 provider hospitals University Hospital Southampton and University Hospitals Bristol respectively.

¹² Due to the way outpatient appointments are coded it has not been possible for NHS England to validate outpatient activity using the data available to it.

The Royal Brompton stated that the definition of Level 2 services is unclear especially in the context of other Level 1 services being provided in London. It doubted that it would be in the patient's interest for them to attend one hospital for an interventional procedure and then another in the same city for other admissions, appointments, follow up care and diagnostic assessments.

The panel noted that the Royal Brompton would not be able to provide paediatric Level 2 services without a PICU.

The panel considered that if Level 1 services ceased it would be possible for adult Level 2 services to be provided at the Royal Brompton. As a Level 2 centre for adults the Royal Brompton may be able to retain their adult ASD and PFO catheter closures, of which they performed 81 procedures last year. It may also retain a large proportion of their diagnostic and outpatient activity as well as some inpatient activity where this was required for patients not undergoing surgical or interventional activity.

This would enable patients currently receiving their CHD care from the Royal Brompton the opportunity to continue receiving the majority of their care from this centre, and potentially enable some patients receiving level 1 CHD services from another provider to receive much of their care closer to home. Interdependent services would also be more likely to retain a higher volume of the activity they provide to people with CHD under this model as the majority of their care would remain at the Royal Brompton.

Whilst this would lessen the financial impact of the proposals on the Royal Brompton to a limited degree the vast majority of its CHD income relates to inpatient activity linked to a surgical or interventional procedure and therefore the Royal Brompton have identified just over £3m income from CHD activity not relating to surgery or catheter interventions. However, this almost totally related to paediatric services and as such if the Royal Brompton were to only offer adult Level 2 services, it is unlikely this would provide significant income to the hospital trust.

The panel noted that both NHS England and one of the CHD charities have asked Royal Brompton to consider the potential for it to continue to provide level 1 adult CHD services, including surgery (by partnering with another level 1 CHD hospital in London that is able to provide care for children and young people with CHD that meets the required standards). To date, the Royal Brompton Hospital has indicated that it does not support this approach, but it has not said that they would refuse to treat adults alone. The panel considered that such a proposal would reduce the impact of the changes on patients and reduce the financial impact on Royal Brompton though not the knock on effect on other paediatric services.

3. Impact on other interdependent services if L1 CHD services cease.

The Royal Brompton considers the loss of Level 1 CHD services as likely to have a significant impact on a range of other services within the hospital trust. The two services they believe will be most impacted are its PICU and respiratory provision.

3.1 PICU and HDU

The Royal Brompton has a PICU with 16 beds which is primarily used by its paediatric cardiac patients. According to both the data the hospital trust submitted

and the data NHS England extracted from PICANet, approximately 86% of all activity within their PICU relates to cardiac patients and therefore it seems unlikely that they would be able to sustain a PICU if Level 1 CHD activity is no longer commissioned from them.

In addition, the Royal Brompton has eight paediatric HDU beds which would also become unviable, as most of the work requiring these beds again relates to cardiac patients.

The panel considered that the loss of Level 1 CHD services at the Royal Brompton is highly likely to make their PICU unviable and that this would impact the Royal Brompton's ability to offer other specialist paediatric services within the hospital.

3.2 Specialist respiratory services

While common paediatric respiratory conditions are managed in local hospitals or primary care settings, complex and rare conditions (including for example difficult asthma, primary ciliary dyskinesia and bronchiectasis) are managed in conjunction with a specialist paediatric respiratory centre. Much of the specialist work is done on an outpatient basis.

Specialist paediatric respiratory services are provided by a number of other hospitals in England, including for example Great Ormond Street Hospital in London.

The Royal Brompton considers it likely that its PICU would no longer be viable if our proposals are implemented, because paediatric cardiac patients are a large proportion of its work and it might not have enough other patients to stay open. The panel accepted that this was an accurate assessment. The Trust considers that this would have a serious detrimental effect on children's respiratory services which also use the PICU.

The Royal Brompton's specialist paediatric respiratory service is the largest in the UK and provides services for a range of patients including:

- Cystic Fibrosis (305 patients)
- Difficult Asthma (150 patients)
- Primary Ciliary Dyskinesia (135 patients)

The panel considered that there would be an impact on paediatric respiratory services, if paediatric cardiac services and PICU were no longer provided by the Royal Brompton. It considered that adult respiratory services would be less affected but that it was likely there would be some effect on patient numbers without the feed into adult services from children's services.

The panel noted that while it might be possible to provide some aspects of paediatric respiratory services at the Royal Brompton, this might not be desirable given that without PICU or paediatric cardiac services this would be the Brompton's only paediatric service.

The panel noted that it was unable to make a detailed assessment of the impact on respiratory services because NHS England's work has focussed on congenital heart

disease and has not examined paediatric respiratory services and the panel's membership therefore reflected that focus.

3.3 Other services

Royal Brompton also identified a number of services as potentially impacted by these proposals. These are listed below. Although a high level summary of the impact was provided more work is needed to better understand, and corroborate, the scale and nature of any impact on these services.

The panel considered that there would be an impact on the other adult specialist services offered by the Royal Brompton but considered that these reductions were likely to be a small proportion of the overall activity within these services. The impact may also be smaller if the Royal Brompton continues to offer level 1 adult CHD services..

The panel considered that there would be a significant impact on the other paediatric specialist services offered by the Royal Brompton.

Paediatric

- Lose expertise needed for general paediatric cardiology services including specialist imaging and specialist services (such as for Kawasaki disease);
- Paediatric electrophysiology – they do not believe that offering these services would be in the best interest of patients were they not also performing the interventions. Also they do not believe they would be able to staff this without those staff also having exposure to invasive procedures. In addition the lack of intensive care and surgical backup would make some of their more complex activity unsafe;
- Fetal cardiology – Service would be lost due to the integration of this work and the Royal Brompton's CHD activity;
- Anaesthetic services – They estimate they will lose at least 2 WTE posts.

Adult

- Pulmonary hypertension – They state that 60% of workload from CHD and 50% of workforce and that therefore this service would not be viable and close;
- Pregnancy and cardiac disease service at Chelsea and Westminster – They state this would not be viable as they need access to cardiac surgery, ITU and ECMO;
- Complex adult EP – They estimate they would lose 2 WTE consultants;
- Complex imaging – They believe that they would lose the whole team;
- Inherited cardiac conditions – Reduced activity as they would not be able to deal with whole families who are diagnosed and treated at the same time due to lack of PICU;
- Research and training and education opportunities would reduce.

4. Impact on the Trust including financial, business and reputational considerations

The panel considered a number of risks associate with these proposals in relation to the Royal Brompton.

Financial impact – The Royal Brompton’s overall income for 2015/16 was £370m and the value of their contract for specialised services is approximately £226m. NHS England’s original estimate if the CHD activity is lost was £35m; however, the panel considered it reasonable to include the loss of other specialised paediatric activity and therefore the Royal Brompton’s estimate of £47m was considered more reasonable. The table below shows the estimated financial impact using both data submitted by the trust and analysis by NHS England

	Trust Submitted	SLAM data	SUS data
CHD Services		27,711,373	16,205,846 ¹³
PICU		7,641,020	
Total income lost	47,571,142 ¹⁴	35,352,393 ¹⁵	

The loss of revenue to the hospital trust would therefore represent approximately 13% of the hospital trust’s total income¹⁶ and 21% of its total specialised services income.¹⁷ The panel noted that although there was a significant loss of income as a result of these proposals the Royal Brompton’s figures reported that the overall these services brought in a total income of just over £47.5m but cost the hospital trust almost £53m. As a result they presented an overall loss of almost £5.5m per year from these services. The hospital trust stated that owing to the stranded costs associated with this service they estimate an adverse impact of over £7m per year to the Trust’s bottom line if these proposals are implemented.

Reputational impact

The panel accepted that the loss of Level 1 CHD services would have a reputational impact on the Royal Brompton. Being one of only ten hospitals to offer these services enhances the Royal Brompton’s reputation as a specialist heart and lung hospital and impacts on its ability to recruit and retain staff and increases its ability to be involved in specialist research.

The Royal Brompton’s reputation would also be impacted if they were no longer able to provide specialist paediatric respiratory services.

The panel noted that the reputational impact of these proposals largely related to its reputation for providing specialist paediatric services and that its reputation as a specialist adult hospital should not be significantly impacted by the proposals. As such the panel was confident that the Royal Brompton would continue to be a highly valued hospital within the NHS offering a wide range of adult specialised services.

¹³ Based on spells relating to people with CHD at national tariff (excluding devices)

¹⁴ Include all paediatric non cardiac and paediatric cardiac which is not CHD.

¹⁵ Based on all the income from all services accessed by people who had been treated for CHD

¹⁶ This is based on the total income lost as submitted by the Trust divided by their entire income.

¹⁷ This is based on the total income lost as submitted by the Trust divided by the value of their specialised services contract.

5. Impact on staff

The Royal Brompton considers that these proposals would have a wide ranging impact on its workforce. It has specifically identified a range of staff including Paediatric CHD, Paediatric Respiratory, Paediatric Intensive Care, Long Term Ventilation (LTV), Primary Dyskinesia Ciliary (PCD), Adult CHD, Morphology Unit and Pulmonary Hypertension which totals to approximately 430 WTEs.

The Royal Brompton states that if the current proposals proceed, the affected colleagues will consider offers and opportunities outside the UK as well as domestic opportunities.

The panel considered that the potential for staff to move to other hospitals within the same city providing this work increased the likelihood of this workforce transferring to new providers. In addition, a number of these roles may not be specific to CHD and therefore work should be done with other provider hospitals in London (for example through STPs) to determine other vacancies and opportunities within London for this workforce.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
As a result of no longer providing Level 1 CHD services the Trust will lose income it receives for the associated procedures and care through tariff. This is likely to be approximately £47m. This creates a financial risk to the Trust.	Seek to minimise the financial impact through ensuring appropriate costs are saved as a result of not providing Level 1 services
The loss of Level 1 CHD activity affects a significant number of staff currently working in this, and interdependent, services. The Royal Brompton estimates this to be approximately 430 WTE staff. This creates a risk of disruption to staff and potentially redundancies.	Royal Brompton to work closely with its workforce to ensure those impacted by the change are given the appropriate support. Ensure appropriate policies and processes are in place to support workforce affected by change. Ensure that sufficient lead time is given to enable workforce planning. Work collaboratively with other trusts in London to ensure that local opportunities are identified for all staff.
No longer providing Level 1 CHD services makes the paediatric respiratory services at the Trust unviable. As a result of this there is likely to be a reduction in activity in the Trust's adult respiratory service. This creates an operational and financial risk.	The Royal Brompton to work with NHS England and other trusts to develop appropriate patient pathways. The Royal Brompton to monitor activity rates and inform NHS England should there be a significant risk of it becoming unviable.
Losing Level 1 CHD services has an impact on the reputation of the Trust. This creates a	NHS England to develop contingency plans to reduce the

Risk	Mitigation
reputational risk which may impact on its ability to recruit staff	impact if this was to occur. The Royal Brompton to monitor vacancy rates and inform NHS England should there be any indication that services are under threat due to staff vacancies.

Draft for consultation

CHD Impact Assessment – University Hospital Southampton NHS Foundation Trust

1. Overview

The CHD proposals are unlikely to result in any significant amount of additional activity at University Hospital Southampton. The most significant risk for the hospital trust remains that it fails to achieve the minimum activity required for four surgeons to perform 125 procedures each year by 2021. This risk has been reduced in part through the ongoing collaborative working between Southampton, Great Ormond Street and Guy's and St Thomas'.

If University Hospital Southampton gained sufficient activity to meet the standards it would be able to establish a more robust service. Whilst the normal risks of workforce recruitment would exist if the hospital trust was to grow its activity, there is no significant risk that it would not be able to increase its capacity to provide Level 1 CHD services for these additional patients.

The modelling provided did not suggest that University Hospital Southampton would receive a high number of additional CHD patients requiring surgical interventions. However, it completed this assessment on the basis of receiving the additional activity required to meet the standard relating to surgical activity. The hospital trust is confident that it would be able to increase its capacity by enough to provide Level 1 services for this larger cohort of patients.

2. Impact on CHD services

The additional activity that would need to be managed

University Hospital Southampton's current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	309	78	388
2014/15	289	76	365
2015/16	323	67	390

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	188	103	291
2014/15	180	102	282
2015/16	223	126	349

The modelling produced by NHS England suggests that University Hospital Southampton would perform fewer than 20 additional surgical procedures each year under the proposals were patients to go to their nearest hospitals. However, in order to meet the standards University Hospital Southampton would require over 100 additional procedures. Therefore, in the interests of ensuring that the impact of

meeting the standards has been considered, it has based its impact assessment on a 30% increase of their activity.

3. Development of plans to care for additional patients

University Hospital Southampton's children's cardiac ward currently consists of 20 beds (reducing to 16 staffed beds over the weekend). In order to expand their capacity to meet the minimum surgical requirements of 500 procedures the hospital trust has identified that it would need an additional 2-4 high care beds which would take the total number of beds to 23. It believes this would be achievable by late 2017. It would also need to expand their young adult ward from 11 beds to 17.

University Hospital Southampton has a 14 bedded PICU, which it believes it would need to increase by a minimum of one bed in order to perform these additional procedures. This seems lower than is likely to be required to provide the level of care required for the additional patients; however, the hospital trust currently has an agreement and funding for an additional two PICU beds and has earmarked space to allow a further three bed expansion. The hospital trust has agreed this in principle if demand exists. Also, two new HDU beds are planned for child health and will be operational in April 2017. This will release capacity in PICU, especially to allow the early discharge of long-term ventilation patients.

University Hospital Southampton currently performs all CHD surgery in one theatre, five days per week running at about 85% utilisation. It believes by increasing its utilisation to 100% it can perform the additional surgeries required to meet the standards. Whilst this does pose a risk to the hospital trust's ability to provide this care without it having a detrimental impact on patient care and waiting times, it is possible that this could be improved by performing non-emergency CHD surgery on weekends.

University Hospital Southampton does not envisage any issues with meeting the additional requirements for diagnostic activity, catheter labs or outpatient provision.

4. Facilities including availability of capital if needed

University Hospital Southampton's expansion plan does not require new-build capital expenditure.

The PICU expansion of further two beds has already been completed. The hospital trust has agreed in principle further PICU expansion into adjacent areas, if demand exists. The children's cardiac ward requires internal changes only and has space to expand within its existing footprint. It is confident that their own charity (Wessex Heartbeat) will fund the internal changes required. The Young Adult Ward already has the existing beds and extra capacity. Expansion in staffing numbers will be funded by the income generated by the extra work performed.

University Hospital Southampton also has a plan to expand children's cardiac outpatient facilities by developing two new areas. The first is the refurbishment of an old building (Wordsworth House and Normand House) on the UHS site. Some non-cardiac children's outpatient services will be moved to the new site to release capacity within the children's outpatient department. University Hospital Southampton states that this will be operational late 2017 or early 2018. The second area lies

adjacent to their children's cardiac ward and will house three new consulting rooms and a counselling area. The funding has been donated from charitable funds; plans have been drawn up and these expanded facilities are due to be available by late 2017.

5. Workforce

University Hospital Southampton considers itself able to recruit and retain high quality staff. It would welcome staff from centres which are no longer commissioned to provide Level 1 services and would hope to be able to transfer some staff from London in order to help it recruit the workforce required to expand its activity. Some of the staff have a long lead time to employment after recruitment begins and the hospital trust would therefore not expect to have attracted all the necessary staff until the end 2017 or mid-2018.

They have identified the following additional staffing as being required:

- 1 Congenital Cardiac Surgeon;
- 1 Paediatric Cardiology Interventionist;
- 1 Paediatric Cardiologist (Imaging specialist);
- 2 Cardiac Anaesthetist ± ODA;
- 2 Cardiac nurse specialists;
- Children's CHD ward nurse expansion (phased to 12 depending on in-patient growth);
- PICU nurse expansion;
- Theatre team expansion;
- Allied staff expansion.

More work is needed to quantify the number of PICU nurses required as the recruitment of these is a challenge for all trusts. The theatre team expansion required should also be quantified.

6. Risks and mitigation of any potentially negative impacts

University Hospital Southampton does not have any significant risks associated with expanding its capacity to meet the standards. There are some risks associated with its ability to recruit the appropriate workforce for this expansion. In addition, a number of the risks associated with increasing its capacity would be increased were it not given an appropriate lead time including the risks associated with PICU and ward capacity, workforce recruitment and theatre capacity. However, the most significant risk associated with these proposals is that the hospital trust fails to meet the 2021 standards requirements of having four surgeons who all perform a minimum of 125 procedures per year. This risk has been reduced in part through the ongoing collaborative working between Southampton, Great Ormond Street and Guy's and St Thomas'.

CHD Impact Assessment – University Hospitals Birmingham NHS Foundation Trust

1. Overview

These CHD proposals are likely to result in a significant amount of additional adult activity at University Hospitals Birmingham. Although the normal risks relating to growing capacity would exist, the panel is satisfied that University Hospitals Birmingham would be able to increase its capacity in order to meet this additional demand.

University Hospitals Birmingham is confident of being able to provide the capacity necessary to provide services to these additional patients. Whilst the growth was significant in terms of University Hospitals Birmingham's CHD activity it would only make up a small proportion of their overall cardiac work and therefore many of the risks associated with facilities including critical care capacity were reduced.

2. Impact on CHD services

The additional activity that would need to be managed

University Hospitals Birmingham's current surgical and interventional activity is displayed in the tables below:

Surgical procedures

Year	Adult
2013/14	137
2014/15	86
2015/16	60

Catheter Procedures

Year	Adult
2013/14	50
2014/15	20
2015/16	112

NHS England's modelling of potential patient flows suggests that Birmingham Children's Hospital would receive approximately an additional 40-50 patients requiring surgical interventions. Using this figure University Hospitals Birmingham created a number of scenarios for catheter interventions, depending on whether UHL remained as a Level 2 centre or not and whether ASD and PFO closures also transferred to University Hospitals Birmingham. It used these scenarios to calculate the additional diagnostic and outpatient activity which would be required as well.

The panel consider that these assumptions are appropriate to be used as a basis for University Hospitals Birmingham impact assessment.

3. Development of plans to care for additional patients

University Hospitals Birmingham has the largest ITU in the country with the ability to flex up at short notice if required. The notional capacity for its CHD activity includes 32 cardiology ward beds, 36 cardiac surgery ward beds and 12 critical care beds. They also have four hours of theatre time and eight hours of catheter lab time for CHD each week as well as eleven CHD clinics per week.

If University Hospitals Birmingham was to receive the projected activity it has estimated that it would require an additional two ward beds, two ITU beds, between two and four hours of catheter lab provision each week and four hours of theatre capacity each week.

4. Facilities including availability of capital if needed

University Hospitals Birmingham stated that it was currently under significant pressure due to increasing emergency medical admissions, and increasing demand for complex and non-complex surgery. This increase in demand has resulted in capacity constraints for both inpatient and critical care beds.

University Hospitals Birmingham considered the inpatient bed requirements for the additional work to be relatively small and anticipated that this could be absorbed into the Level 1 bed capacity across cardiology and cardiac surgery if small improvements in length of stay can be achieved.

The additional critical care activity would require up to an additional two beds, and University Hospitals Birmingham does not think it would be possible to absorb this into existing capacity. University Hospitals Birmingham considers that the additional beds could be accommodated within the footprint of its existing critical care but equipment and associated staffing would be required. As a result a lead time of 6-12 months would be required to recruit and fully train critical care nurses.

University Hospitals Birmingham has stated that its catheter labs are reaching maximum capacity and theatres are capacity constrained. In order to increase this capacity University Hospitals Birmingham is considering developing a hybrid theatre which would allow both the surgical work and any interventional work to be accommodated. It stated that some external capital support would be required for this and estimate the cost of developing this theatre to be £4-5m.

The panel is satisfied that the scale of the increased activity for University Hospitals Birmingham would be able to be absorbed within its current estate as long as sufficient lead time is given to open additional beds and recruit the necessary staff. The panel is concerned about University Hospitals Birmingham's statement that external capital would be required to expand their theatre/catheter lab capacity; however, the panel does not consider that the relatively modest increased demand on these facilities would alone be sufficient to require the development of this new facility.

5. Workforce

The anticipated increase in activity would require additional resource including consultant PA's. With respect to surgical activity the Trust anticipates that this could be delivered through increases in existing job plans and therefore deliverable within a

relatively short timeframe. University Hospitals Birmingham is currently recruiting an additional ACHD consultant. It is anticipated that following appointment cardiology consultant manpower would be available to meet the increase in activity.

The additional resource required by other staff groups would be added to existing staff groups and the Trust does not anticipate any delays in providing this additional capacity.

The panel is satisfied the University Hospitals Birmingham would be able to recruit the necessary staff to increase their CHD activity. It would however, have been more assured had the other additional staff, including ITU nurses, been quantified by University Hospitals Birmingham.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>The Trust is exploring the construction of a hybrid theatre in order to provide additional cath lab and theatre capacity. There is a risk that the Trust fails to secure funding for this which would have an operational impact. There is a risk that the Trust may not have sufficient capacity for the additional activity. This could result in last minute cancellations, delays to procedures and increased waiting times.</p>	<p>The Trust to either develop plans for providing the additional activity without the hybrid theatre or provide confirmation that the capital for this has been secured. NHS England to ensure that sufficient lead time is given.</p>
<p>In order to provide the additional capacity the Trust will need to recruit additional staff. There is a risk that the Trust fails to recruit the required workforce which could result in an overstretched workforce, a lack of bed capacity and a reduction in the quality of care patients receive.</p>	<p>The Trust to work with other Trusts to ensure appropriate policies and processes are in place to support workforce affected by change The Trust to develop/provide evidence of a recruitment strategy to ensure sufficient staff are in place when required. NHS England to ensure that sufficient lead time is given to enable workforce planning.</p>
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 50 additional surgical procedures. This creates an operational risk that a higher than expected number of patients receive their care from the Trust following the implementation of the proposals. This could result in the CHD service being under unexpected strain.</p>	<p>The Trust to develop contingency plans to provide care for a larger number of patients.</p>
<p>As a result of these proposals the Trust has completed its impact assessment on an increase based on approximately 50 additional surgical procedures. This creates a financial risk that a lower than expected number of patients receive their care</p>	<p>The Trust to develop contingency plans to provide care for a smaller number of patients.</p>

Risk	Mitigation
from the Trust following the implementation of the proposals. This would result in a financial loss to the Trust and the potential need for downscaling of provision including loss of staff and potential redundancies.	

Draft for consultation

CHD Impact Assessment – University Hospitals of Leicester NHS Trust

1. Overview

Whilst the proposals will undoubtedly impact on the hospital trust's finances and reputation, the level of risk is reduced by the wide range of specialised and non-specialised services which will continue to be offered by University Hospitals Leicester.

University Hospitals of Leicester considers the proposal to stop commissioning Level 1 services from it to be likely to have a significant impact on its finances, reputation and ability to provide other services. It considers that further work is required to understand what the impact of providing Level 2 services would be.

The panel considers that the risks associated with commissioning these services from other centres are less than those associated with continuing to commission them from University Hospitals of Leicester.

2. Impact on CHD services

2.1 The activity that would need to be transferred to different providers

Were University Hospitals of Leicester to no longer be commissioned as a Level 1 CHD hospital, it would cease performing any surgical or catheter procedures on people with CHD. This activity would need to be transferred to other centres with the majority of the paediatric activity transferring to Birmingham Children's Hospital and the majority of the adult activity transferring to University Hospitals Birmingham. The table below describes the potential additional patients received by different hospitals were University Hospitals of Leicester to no longer perform CHD surgery.

Receiving Trust	Patients/year From UHL		
	Adult	Paediatric	Total
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST		8	8
BARTS HEALTH NHS FOUNDATION TRUST	1		1
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST		174	174
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST		4	4
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		4	4
LEEDS TEACHING HOSPITALS NHS TRUST	10	37	47
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION		1	1

Receiving Trust	Patients/year From UHL		
	Adult	Paediatric	Total
TRUST			
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	49		49
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST		2	2
Total	60	230	290

The most recent activity as reported by the National Congenital Heart Disease Audit is displayed in the tables below. The 15/16 activity is as yet unvalidated.

Surgical procedures

Year	Paediatric	Adult	Total
2013/14	241	57	298
2014/15	239	47	286
2015/16	277	49	326

Catheter Procedures

Year	Paediatric	Adult	Total
2013/14	147	110	257
2014/15	220	117	337
2015/16	209	129	338

Outpatient activity

In addition to the inpatient activity associated with these patients University Hospitals of Leicester also stated that it provides the following outpatient activity each year¹⁸:

Paediatric Appointments	Adult Appointments	Paediatric Network Clinics	Adult Network Clinics
8642	1904	254	68

2.2 The potential for Level 2 CHD services to be offered if Level 1 CHD services ceased to be offered.

Level 2 centres represent a significant part of the model of care described by the standards for CHD services. They are able to provide the vast majority of the ongoing CHD care required by patients with the exception of any care requiring surgical intervention and the majority of that which requires catheter intervention. Although these have not been designated as Level 2 hospitals prior to the standards being agreed, Oxford University Hospitals and the University Hospital of Wales (Cardiff) have been operating successfully providing Level 2 services in partnership with University Hospital Southampton and University Hospitals Bristol respectively.

¹⁸ Due to the way outpatient appointments are coded it is not possible for NHS England to externally validate this figure.

University Hospitals of Leicester considers the concept of Level 2 centres to be unproven. The hospital trust has stated that it would require clarity over the viability and success of a Level 2 model, particularly in the ability of a Level 2 hospital to attract and retain the number and quality of staff required prior to considering this.

The panel considered that if Level 1 services ceased it would be possible for Level 2 services to be provided at University Hospitals of Leicester, working in partnership with the Birmingham hospitals. A high proportion of outpatient activity would then be able to remain at University Hospitals of Leicester, with the exception of one pre-operative and one post-operative visit to the Level 1 hospital. Outpatient appointments relating to surgical or interventional activity account for up to 15% of outpatient appointments p.a.¹⁹ It also may be able to retain its adult ASD and PFO catheter closures of which it performed 58 procedures last year. It would retain some inpatient activity where this was required for patients not undergoing surgical or interventional activity.

This would enable patients in the East Midlands to continue receiving the majority of their care in the same place as now, in Leicester. It would also increase the likelihood of University Hospitals of Leicester being able to retain the CHD staff required to support services. Interdependent services would retain more of the activity they provided to people with CHD under this model as the majority of their care would remain at University Hospitals of Leicester.

Whilst this would lessen the financial impact of the proposals on University Hospitals of Leicester, the vast majority of its CHD income (82%) relates to inpatient activity linked to a surgical or interventional procedure and therefore the hospital trust has suggested only about £3.3m of its commissioned income would be retained if it provided Level 2 services.

3. Impact on other interdependent services if L1 CHD services cease.

University Hospitals of Leicester considers the loss of Level 1 CHD services as likely to have a significant impact on a range of other services within the hospital trust. The two services it believes will be most impacted are their PICU and ECMO provision.

3.1 PICU

University Hospitals of Leicester has two paediatric intensive care units, one at the Leicester Royal Infirmary and one at Glenfield Hospital. If University Hospitals of Leicester continues to provide Level 1 paediatric cardiac surgery we understand that it plans to move this service from Glenfield to the Infirmary, so the future of the PICU at Glenfield is uncertain whether or not NHS England's proposals are agreed.

CHD activity accounts for the majority of PICU activity at the Glenfield hospital. It is likely that the PICU at Glenfield would be unviable if it was to stop providing Level 1 CHD services. University Hospitals of Leicester also has a PICU at Leicester Royal Infirmary.

¹⁹ This is based on two appointments for each surgical/interventional procedure in 2015/16 divided by the total number of outpatient appointments rounded up to the nearest 5% ($664 \times 2 / 10546 = 12.59\%$)

The hospital trust expressed concerns that the loss of CHD activity would negatively impact its ability to retain or recruit qualified PICU consultants and nurses for their PICU at Leicester Royal Infirmary. It considers that this could be sufficient to threaten the continued operation of the PICU at the Infirmary.

The panel noted that most trusts with PICUs do not provide CHD services and that the activity within the Leicester Royal Infirmary PICU was largely unrelated to CHD activity.

3.2 ECMO

Respiratory ECMO for children is currently provided by five centres in England: Alder Hey; Birmingham Children's Hospital; Great Ormond Street; University Hospitals of Leicester; and Newcastle upon Tyne Hospitals. There is also a paediatric respiratory ECMO centre at the Royal Hospital for Children in Glasgow. On average in the past five years respiratory ECMO has been used in just under 80 children each year in England, though the number of cases has been falling and this year is expected to be fewer than 70. Of the English centres, only University Hospitals of Leicester is currently commissioned to retrieve patients on 'mobile' ECMO which results in University Hospitals of Leicester providing around half of all respiratory ECMO for children. The Glasgow centre also provides mobile ECMO.

Because of the reliance of paediatric ECMO services on a paediatric cardiac surgeon we would expect that if our proposals were to be implemented, University Hospitals of Leicester would no longer be able to provide cardiac, respiratory and mobile ECMO for children. Taken together this would affect around 55 children a year.

We would expect University Hospitals of Leicester to be able to continue to provide respiratory ECMO for adults because this does not require the support of congenital heart surgeons. There are other providers of adult respiratory ECMO where the support is provided by adult cardiac surgery services (not congenital cardiac).

The optimal national model for provision of children's ECMO in the future will be considered as part of NHS England's review of paediatric critical care services. The maintenance of good outcomes will be a key consideration. The review is expected to consider the appropriate number of providers of children's ECMO, the case for minimum activity levels and the appropriate number of mobile ECMO providers.

NHS England will take steps to minimise any negative impact arising if the proposals are implemented by:

- ensuring that we commission appropriate levels of children's respiratory ECMO and mobile ECMO from an appropriate number of providers;
- working with Birmingham Children's Hospital (and University Hospitals Birmingham which provides the adult part of the CHD service) to undertake the necessary planning and preparation to manage any increase in ECMO activity if the proposals are agreed;
- establishing formal geographically-based networks for children's respiratory ECMO, like those for adult respiratory ECMO. This approach will minimise long transfers, balancing the activity between the centres, thus maintaining expertise in children's respiratory ECMO at the commissioned centres. Initially

networks will be introduced around Alder Hey and Birmingham Children's Hospital;

- training for staff at centres that have to date provided lower volumes of children's respiratory ECMO;
- peer review / audit of referrals and patients accepted for treatment, to ensure best practice is followed; and
- continued reporting of outcomes to the Extra Corporeal Life Support Organization (ELSO). NHS England would also continue to coordinate national audit days to which all centres that deliver ECMO – whether cardiac or respiratory – are already invited to present their data.

University Hospitals of Leicester received just over £4m for their paediatric ECMO provision in 2015/16 which they would no longer receive under these proposals.

3.3 Other services

University Hospitals of Leicester also identified a number of services as potentially impacted by these proposals. These are listed below. The scale and nature of any impact on these services was not described by the hospital trust in any detail and has not been corroborated.

The panel considers that much of the activity which related to the interdependent services identified by University Hospitals of Leicester may be able to remain in the Trust if it remained a Level 2 CHD centre. Providing Level 2 services would increase the likelihood of University Hospitals of Leicester retaining the staff required to support these services. In addition through providing the majority of the CHD services required by patients it would reduce the risk of patients accessing these other interdependent services at a different hospital.

Whilst there may be a reduction in University Hospitals of Leicester's activity in some of the services it identified the panel considered that these reductions are likely to be a small proportion of the overall activity within these services.

The services identified by University Hospitals of Leicester are listed below.

List of other services University Hospitals of Leicester identified as potentially impacted by the proposals

Paediatric

- Fetal cardiology – This will depend in part on whether they continue as a Level 2 centre or not.
- Long term ventilation and specialist paediatric surgery – This is dependent on PICU and with the continuation of PICU at the Leicester Royal Infirmary should be able to continue.
- Fetal medicine – Significant amount of this is supportive of cardiac programme and therefore may move to the Level 1 hospital.
- Research and training activities relating to CHD.
- Specialist neonatal surgery for those with concomitant cardiac problems will need to be delivered in a Level 1 hospital

- Technical physiology – University Hospitals of Leicester is concerned about its ability to attract and retain highly skilled staff.
- In house delivery of complex babies – Planned to be in Level 1 hospitals.
- Paediatric orthopaedic/ ENT/ General surgery on cardiac patients - Spinal patients and general surgical problems, dental cases etc. will all require cardiac anaesthetic input.

Adult

- High risk obstetric cardiology service – There is a concern that they will lose their regional service including outpatient care, high risk deliveries in cardiac patients and inpatient antenatal care.
- MRI cardiac specialists – They state that they will be unable to undertake MRI under general anaesthesia.
- Outpatients – University Hospitals of Leicester envisages a reduction in volume and therefore a concern over the retention of specialist sonographers
- Non cardiac surgical procedures on congenital cardiac patients (Gynae, Orthopaedic, Dental) – University Hospitals of Leicester envisages a reduction in volume, dependent on regional agreements with the level 1 hospital.

4. Impact on the Trust including financial, business and reputational considerations

The regional panel considered a number of risks associated with these proposals in relation to University Hospitals of Leicester.

Financial impact – University Hospitals of Leicester’s overall income for 2015/16 was £866m and the value of its contract for specialised services is approximated at £234m. While the panel accepted that the proposed changes would have a financial effect, NHS England’s estimate is £14m rather than the £19-20m estimate provided by University Hospitals of Leicester. Part of the reason for this difference is a difference in view on the impact of the proposals on PICU. University Hospitals of Leicester’s estimate expects that the hospital trust would no longer be able to provide PICU services. The panel considered that there was no reason why PICU services could not continue at the Infirmary site even if the Glenfield PICU needed to close. The table below shows the estimated financial impact using both data submitted by the trust and analysis by NHS England

	Trust Submitted	SLAM data	SUS data
CHD Services		5,831,555	10,608,805 ²⁰
PICU		4,073,042 ²¹	
Paediatric ECMO		4,083,645	
Total income lost	19,536,337²²	13,988,242	

²⁰ Based on spells relating to people with CHD at national tariff

²¹ Includes all PICU activity at the Glenfield Hospital

²² £17,963,572 commissioned by NHS England

	Trust Submitted	SLAM data	SUS data
Income retained if Level 2 centre	4,149,307 ²³		
Total income lost if Level 2 centre	15,387,030		

The loss of revenue to the Trust would therefore represent between 1.62% and 2.26% of the Trust's total income²⁴ and between 6% and 8% of its total specialised services income.²⁵

The loss envisaged by the Trust may be offset to some extent if it is agreed that University Hospitals of Leicester should provide Level 2 specialist medical CHD services.

Reputational impact

The panel accepts that the loss of Level 1 CHD services would have a reputational impact on University Hospitals of Leicester. Being one of only ten centres to offer these services enhances University Hospitals of Leicester's reputation as a hospital providing high quality specialist services and impacts on its ability to recruit and retain staff and increases its ability to be involved in specialist research.

University Hospitals of Leicester's reputation would also be impacted if it no longer to provides respiratory ECMO services. As one of only five centres in England providing these services for children, the only provider of mobile ECMO services for children in England, and also the largest provider University Hospitals of Leicester has both a national and international reputation as a paediatric respiratory ECMO centre. The panel considered that adult ECMO would still be able to be provided at University Hospitals of Leicester and this would reduce the reputational impact.

The panel noted that the reputational impact of these proposals must be considered in the light of University Hospitals of Leicester's overall provision of specialised services. The volume of respiratory ECMO cases is low and in total University Hospitals of Leicester's activity relating to CHD services and paediatric respiratory ECMO only account for between 6% and 8% of their overall specialised activity. As such the panel is confident that University Hospitals of Leicester would continue to be a highly valued hospital within the NHS offering a wide range of specialised services.

5. Impact on staff

University Hospitals of Leicester considers that these proposals would have a wide ranging impact on its workforce. It considers that its entire workforce would be affected should this proposal be implemented. University Hospitals of Leicester specifically identified a range of staff including administrative and clerical staff, estates and ancillary, medical and dental and nursing and midwifery who work solely for East Midlands Congenital Cardiac Service. This totals over 150 WTEs.

²³ £3,289,050 commissioned by NHS England

²⁴ This is based on the total income identified regardless of whether it is commissioned or not.

²⁵ This is calculated as the range using all the revenue identified using SLAM data and the total of NHS England commissioned revenue divided by their total income for specialised services.

In addition to the staff directly impacted, University Hospitals of Leicester also identified other roles such as those working in theatres, imaging, outpatient care, catheter labs and intensive care which would be impacted.

University Hospitals of Leicester states that informal reaction from their highly skilled staff is that many of them would prefer to take up posts elsewhere in the Trust if possible. The members of the panel considered that their experiences of service change was that the majority of staff do not transfer to the alternative providers of these services from the centres which are decommissioned. Whilst the CHD surgeons would look to move to a Level 1 CHD hospital rather than find another role within University Hospitals of Leicester, the panel considered it is reasonable to expect that many staff currently providing Level 1 services at University Hospitals of Leicester would seek to take up alternative roles within the hospital trust rather than moving to another hospital. This would become more likely if University Hospitals of Leicester provided Level 2 services as more CHD roles would be retained within the Trust.

6. Risks and mitigation of any potentially negative impacts

Risk	Mitigation
<p>The loss of Level 1 CHD activity affects a significant number of staff currently working in this service. UHL estimate this to be over 150 WTE staff. In addition they believe this will impact a much wider (as yet unquantified) number of employees. This creates a risk of disruption to staff and potentially redundancies.</p>	<p>UHL to work closely with staff impacted by the change to ensure that staff are given the appropriate support. Ensure appropriate policies and processes are in place to support workforce affected by change. Ensure that sufficient lead time is given to enable workforce planning.</p>
<p>As a result of no longer providing Level 1 CHD services the Trust will lose the income it receives for the associated procedures and care through tariff. This is likely to be between £14 and £20m. This creates a financial risk to the Trust.</p>	<p>Seek to minimise the financial impact through ensuring appropriate costs are saved as a result of not providing Level 1 services and ensuring the maximum revenue is maintained through the provision of Level 2 services.</p>
<p>Losing Level 1 CHD services has an impact on the reputation of the Trust. This creates a reputational risk which may impact on UHL's ability to recruit staff</p>	<p>NHS England to develop contingency plans to reduce the impact if this was to occur. UHL to monitor vacancy rates and inform NHS England should there be any indication that services are under threat due to staff vacancies.</p>

NHS England Congenital Heart Disease Provider Impact Assessment



**NHS England
Congenital Heart Disease
Provider Impact Assessment**

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1 Introduction

1. In July 2015, NHS England Board agreed the proposed CHD standards and service specifications relating to three levels of CHD service provision that had been collaboratively developed with and agreed by all stakeholders. A 'go-live' date for commissioning of the standards and the service specification was agreed for April 2016.
2. Starting in April 2015 NHS England supported an initial provider-led process to consider how they might work together in order to meet the standards. On 9 October 2015 submissions from networks were received by NHS England and assessed. Overall it was considered that this work had not produced an acceptable solution, in the best interests of patients, and nor was it likely to do so even if the providers were given more time. NHS England concluded that developing a nationally coherent delivery model would require it to provide significant support and direction¹.
3. Between January and April 2016 existing providers of CHD services were assessed against key selected standards by a national commissioner led panel with clinician and patient/public representation. The panel's role was to assess each hospital's ability to meet the selected standards, based on the evidence submitted by the Trust. The panel was not responsible for deciding what action to take as a result of that assessment. That responsibility sits with NHS England as the single national commissioner of CHD services.
4. This assessment² demonstrated that some providers met most of the standards and were likely to be able to meet the remainder by April 2017, and that others should be able to meet the requirements with further development of their plans. NHS England has since been working with those providers as they progress towards full compliance. Other hospitals were not meeting or likely to meet all of the relevant standards within the required timescales. Some presented a clinical and governance risk. Since then, we have been working with them to look for ways to bring them into full compliance. This has not (so far) been possible. The panel's assessment was considered by NHS England's Specialised Services Commissioning Committee (SSCC), at the end of June 2016. SSCC recognised that the status quo could not continue and that NHS England needed to ensure that patients, wherever they lived in the country, had access to safe, stable, high quality services. SSCC also recognised that achieving this within the current arrangement of services would be problematic.

¹ The full report of this work is available here: <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/quick-links/>

² The full report of this assessment is available here: <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/>

5. SSCC determined that, subject to appropriate public involvement and/or consultation, a change in service provision was appropriate. As a result it was proposed that in future NHS England would only commission CHD services from hospitals that are able to meet the standards within the required timeframes.
6. As a result proposals for service change were announced on 8 July 2016. Subject to public consultation, if implemented, our proposals would mean that in future CHD level 1 (surgical) services in England would be provided by the following hospitals:
 - **Alder Hey Children’s Hospital NHS Foundation Trust** (children’s services) and **Liverpool Heart and Chest Hospital NHS Foundation Trust** (adult service)
 - **Birmingham Children’s Hospital NHS Foundation Trust** (children’s services) and **University Hospitals Birmingham NHS Foundation Trust** (adult service)
 - **Great Ormond Street Hospital for Children NHS Foundation Trust** (children’s services) and **Barts Health NHS Trust** (adult service)
 - **Guy’s and St Thomas’ NHS Foundation Trust** (children’s and adult services)
 - **Leeds Teaching Hospitals NHS Trust** (children’s and adult services)
 - **Newcastle Hospitals NHS Foundation Trust** (children’s and adult services)
 - **University Hospitals Bristol NHS Foundation Trust** (children’s and adult services)
 - **University Hospital Southampton NHS Foundation Trust** (children’s and adult services)
7. If implemented, our proposals would result in the following changes at hospitals that currently provide level 1 (surgical) CHD services:
 - Surgery and interventional cardiology for adults should cease at **Central Manchester University Hospitals NHS Foundation Trust (CMFT)**. CMFT does not undertake surgery in children.
 - Surgery and interventional cardiology for children and adults should cease at **Royal Brompton & Harefield NHS Foundation Trust**.
 - Surgery and interventional cardiology for children and adults should cease at **University Hospitals of Leicester NHS Trust**.
8. Changes are also proposed to the provision of level 2 specialist medical CHD care. While not the subject of the forthcoming consultation they will be

described in our consultation materials and stakeholders invited to provide us with their views. We will also be conducting specific further engagement with patients and others who would be affected by implementation of the proposals

9. If implemented, our proposals would mean that in future level 2 (specialist medical) CHD services in England would be provided by the following hospitals:
 - **Brighton and Sussex University Hospitals NHS Trust** (adult service)
 - **Central Manchester University Hospitals NHS Foundation Trust** (children's services)
 - **Norfolk & Norwich University Hospitals NHS Foundation Trust** (adult service)
 - **Oxford University Hospitals NHS Foundation Trust** (children's and adult services)
10. NHS England is exploring the potential for the provision of level 2 medical services at hospitals where level 1 care would cease. We are interested in the degree of support for this approach and will test this as part of the consultation. This possibility relates to:
 - **Central Manchester University Hospitals NHS Foundation Trust** (adult service)
 - **Royal Brompton & Harefield NHS Foundation Trust** (adult service)
 - **University Hospitals of Leicester NHS Trust** (children's and adult services)
11. NHS England has also raised with the Royal Brompton the potential for it to continue to provide level 1 adult CHD services, including surgery, by partnering with another level 1 CHD centre in London that is able to provide care for children and young people with CHD that meets the required standards. . To date, the Royal Brompton Hospital has indicated that it does not support this approach, but it has not said that they would refuse to treat adults alone. NHS England believes that it has sufficient merits to be explored further. The Royal Brompton is also exploring with partners ways in which it could achieve compliance with the standard for paediatric co-location, but to date no plan and timetable for this to be achieved have been shared with NHS England.
12. If implemented, our proposals would result in the following changes at hospitals that currently provide level 2 specialist medical CHD care (subject to further local engagement as appropriate).
 - Specialist medical care and interventional cardiology would cease at **Blackpool Teaching Hospitals NHS Foundation Trust**
 - Specialist medical care and interventional cardiology would cease at **Imperial College Healthcare NHS Trust**

- Specialist medical care and interventional cardiology would cease at **Nottingham University Hospitals NHS Trust**
 - Specialist medical care and interventional cardiology would cease at **Papworth Hospital NHS Foundation Trust**
 - Specialist medical care and interventional cardiology would cease at **University Hospital of South Manchester NHS Foundation Trust**
13. NHS England is continuing discussions with Papworth Hospital NHS Foundation Trust about its plans to meet the requirements to continue to provide specialist medical care and interventional cardiology. If the Trust can demonstrate that it now either meets the standards or has a robust plan to do so, NHS England will review its proposal that L2 CHD services should cease to be provided.

2 Part One: The impact assessment

14. NHS England has undertaken a detailed impact assessment considering the impact on patients and their families, on CHD services and other clinical services, on provider organisations including financial implications. This paper reports NHS England's assessment of the impact on providers of CHD services as at January 2017.
15. All level 1 and level 2 CHD providers were asked to review their services in light of NHS England's proposals.
16. The data received was considered first by specialised commissioning teams from the relevant NHS England region during the period 10-15 November 2016. This allowed for a review of both sets of data and for consideration of any wider regional implications.
17. The impacts were then considered by a national panel drawn together to review the submissions, to moderate the regional assessments and to take a national overview. The national panel met on 18 November 2016. A separate report from the panel has been published alongside this NHS England report.
18. The panel's role was to assess the likely impact of NHS England's proposals on each hospital and its services. The panel was not responsible for deciding what action to take as a result of that assessment. That responsibility sits with NHS England as the single national commissioner of CHD services.
19. Since the panel completed its assessment, NHS England has continued to maintain a dialogue with the affected hospitals as a result of which new or revised information has been provided and further analyses undertaken.
20. This report takes account of the panel's assessment and recommendations as well as NHS England's subsequent work. It reports NHS England's pre-

consultation assessment of the impact of its proposals on provider organisations. It should be read in conjunction with the national panel report.

2.1 The impact at centres which, under the proposals, would not continue to be commissioned as Level 1 CHD centres

2.1.1 Royal Brompton

21. Under the proposals the Royal Brompton would no longer perform surgical or interventional cardiology on people with CHD. The panel considered that the scale of this change was especially significant to the Royal Brompton's provision of paediatric services but the impact on the organisation and on patients could be reduced if it provided adult only level 1 services.

2.1.1.1 Impact on other services: Paediatric Intensive Care and Extracorporeal Membrane Oxygenation (ECMO)

22. The Royal Brompton's PICU is largely dependent on their paediatric CHD service, because CHD accounts for 86% of the admissions. The Trust considers that its PICU would no longer be viable if the proposals are implemented, because paediatric cardiac patients are a large proportion of its work and it would not have enough other patients to stay open. The national panel accepted that this was an accurate assessment. If the PICU at the Royal Brompton were to close, this would be expected to have an effect on their paediatric respiratory services, the only other clinical service for children offered by the Trust. NHS England accepts the panel's view.

23. The Royal Brompton provides cardiac ECMO for children and cardiac and respiratory ECMO for adults. If our proposals were to be implemented, Royal Brompton would no longer be able to provide cardiac ECMO for children. This would affect around 15 children a year. It would no longer provide cardiac ECMO for adults with CHD. Adult respiratory ECMO provision at the Royal Brompton is the subject of a separate current procurement being undertaken by NHS England.

24. There are close links between paediatric cardiac services and PIC and children's ECMO services. As a result, our proposals will have an impact on both. The effects, both on paediatric cardiac patients, and any wider impact on PIC and ECMO services nationally, can be managed, as described below, and should not preclude NHS England proceeding to consult on its proposals.

2.1.1.2 Impact on other services: Specialist paediatric respiratory services

25. The particular circumstances at the Royal Brompton where paediatric cardiac and paediatric respiratory are the only children's services offered mean that our

proposals will have an impact on their paediatric respiratory service because of the effect on their PICU.

26. The national panel considered that there would be an impact on paediatric respiratory services, if paediatric cardiac services and PICU were no longer provided by the Royal Brompton. NHS England's work focusses on congenital heart disease and has not examined paediatric respiratory services. The membership of the panel reflected that focus. Given this, it would not have been appropriate for the panel to undertake detailed assessment of this impact.
27. If a decision is taken that results in PICU closure at the Royal Brompton, NHS England will work with the Trust to manage the impact on paediatric respiratory services. This could require a local service change process with further public engagement, potentially including full public consultation. There are alternative providers of specialist paediatric respiratory services in London. This should not preclude NHS England proceeding to consult on its proposals.

2.1.1.3 Impact on finances

28. The overall contract value for specialised services at Royal Brompton is approximately £226m. NHS England estimates that the financial effect of the proposed changes would be around £35m excluding the impact on paediatric respiratory services. The Trust's estimate of a £47m loss in income when paediatric respiratory services are taken into account appears to be broadly in line with NHS England's own estimate. The Trust estimates that the loss resulting from these proposals would be approximately 13% of the Trust's total income and 21% of its total specialised services income, which represents a significant financial and business challenge. The scale of loss reflects the impact on PICU and the potential impact on paediatric respiratory services.
29. The loss of income to the Trust would, to some extent, be offset by a reduction in costs. The Trust stated that owing to the stranded costs associated with this service they estimate an adverse impact of over £7m per year to the Trust's bottom line if these proposals are implemented. Data supplied by the Royal Brompton indicates that its provision of CHD services results in an overall net loss, and therefore although the loss of income is significant it may be that, depending on the stranded costs, in the long term no longer providing these services is in the best financial interest of the Trust.
30. The financial impact of the changes could be reduced if the Royal Brompton provided level 1 adult services.
31. We note that Royal Brompton is an active partner in the North West London Sustainability and Transformation Planning process and has identified a number of potential areas for partnership working which could potentially contribute to the mitigation of any financial losses if our proposals are implemented.

32. While there would be an impact on the income of The Royal Brompton, this could be partially offset by other forms of service provision. This should not preclude NHS England proceeding to consult on its proposals.

2.1.1.4 Impact on workforce

33. In further correspondence with NHS England following the panel's assessment, The Royal Brompton identified approximately 430 WTE staff that it considered would be affected by the proposals, including those working as part of their CHD service, paediatric respiratory, paediatric intensive care and other services which will be impacted to a lesser extent. The Trust has estimated the cost of redundancies to be approximately £13.5m.
34. The panel was not able to take a view on the likelihood of all the staff identified by the Royal Brompton being significantly impacted by the proposed changes. However, it was acknowledged that there would be a significant impact on the Royal Brompton's workforce, if the proposals were to be implemented. The panel noted that this impact would be reduced, were the Royal Brompton to continue providing adult only level 1 services.
35. NHS England has reviewed the Trust's assessment of the potential level of redundancy. Given that we expect that most patients using the Royal Brompton would transfer to alternative providers within 3 miles of the Royal Brompton with the scope for redeployment that would result, NHS England has a materially different view of possible redundancy costs. Internal redeployment is also likely to make a significant contribution to avoiding redundancy. We estimate that the costs could however be up to £1 – 1.5m. This estimate is highly sensitive to the degree to which staff can be redeployed.

Estimate of Redundancy at RBH - Redeployment at 90%		
Service	WTE	Estimate of Redundancy Costs
Adult CHD	3.86	£149,865
Long Term Ventilation (LTV)	0.00	£0
Morphology Unit	0.00	£0
Paediatric CHD	15.62	£461,919
Paediatric Intensive Care	12.24	£345,346
Paediatric Respiratory	0.00	£0
Primary Dyskinesia Ciliary (PCD)	0.00	£0
Grand Total	31.71	£957,130

Estimate of Redundancy at RBH - Redeployment at 85%

Service	WTE	Estimate of Redundancy Costs
Adult CHD	5.79	£224,797
Long Term Ventilation (LTV)	0.00	£0
Morphology Unit	0.00	£0
Paediatric CHD	23.43	£692,879
Paediatric Intensive Care	18.35	£518,019
Paediatric Respiratory	0.00	£0
Primary Dyskinesia Ciliary (PCD)	0.00	£0
Grand Total	47.57	£1,435,694

36. Experience from previous CHD service changes shows that a number of staff, perhaps most, would prefer to be re-deployed within their current Trust, though in some cases staff may transfer in accordance with TUPE regulations
37. However, we do not expect that it will be viable for the Royal Brompton to continue to provide PICU if our proposals are implemented so there would be little or no opportunity for internal redeployment of PICU specialist staff.
38. There is no experience of such changes within London but it is reasonable to suppose that more staff would consider transferring with the patients because the distances involved are so small and the impact on staff would therefore be lower. Additional PICU staff especially nurses will be needed by those Trusts delivering more activity if our proposals are implemented and we would expect TUPE to apply.
39. Previous experience suggests there will be relatively few redundancies but with such large numbers of staff potentially affected by the changes, some redundancies cannot be ruled out. NHS England will encourage providers to minimise redundancies by supporting staff to transfer with the patients or by redeploying them internally. This should not preclude NHS England proceeding to consult on its proposals.

2.1.2 University Hospitals Leicester (UHL)

40. Under the proposals the UHL would no longer perform surgical or interventional cardiology on people with CHD. The panel considered that the scale of this change was not as significant as at the Royal Brompton due to the greater number of services which UHL provide. The panel also noted that the impact on the organisation and on patients could be reduced if it provided level 2 services.

2.1.2.1 Impact on other services: Paediatric Intensive Care and Extracorporeal Membrane Oxygenation (ECMO)

41. UHL has two paediatric intensive care units (PICUs), one at the Leicester Royal Infirmary and one at Glenfield (which supports CHD services).
42. The panel accepted that the proposals would make the PICU at the Glenfield Hospital unviable but did not accept that they would result in the cessation of PICU services at Leicester Royal Infirmary.
43. While we cannot pre-empt the decisions that NHS England will make on CHD services, or the findings and recommendations of its Paediatric Critical Care & Specialised Surgery for Children Service Review, at this point we expect Leicester would still provide PICU care for the East Midlands if our proposals are implemented, even if it no longer provides level 1 paediatric cardiac surgery. This would be through a single PICU at the Royal Infirmary.
44. If Leicester continues to provide level 1 paediatric cardiac surgery it plans to move this service from Glenfield to the Infirmary, so the future of the PICU at Glenfield is in question whether or not NHS England's proposals on CHD are agreed.
45. UHL provides cardiac and respiratory ECMO for children and is at the present the only provider commissioned to offer mobile ECMO (which allows children to be transferred between hospitals on ECMO). It also provides cardiac and respiratory ECMO for adults. If our proposals were to be implemented, Leicester would no longer be able to provide cardiac or respiratory ECMO for children or mobile ECMO for children. Taken together this would affect around 55 children a year. It would no longer provide cardiac ECMO for adults with CHD. We would expect that Leicester could continue to provide adult respiratory ECMO, in a similar way to other hospitals where services are supported by adult cardiac surgery services (not congenital cardiac).
46. There are close links between paediatric cardiac services and PIC and children's ECMO services. As a result our proposals will have an impact on both. The effects, both on paediatric cardiac patients, and on the wider national service, can be managed, as described below, and should not preclude NHS England proceeding to consult on its proposals.

2.1.2.2 Impact on finances

47. The overall contract value for specialised services at UHL is approximately £234m. NHS England estimates that the financial effect of the proposed changes would be a reduction of income around £14m (rather than the £19-20m estimate provided by the Trust). This is partly explained by a difference in view on the impact of the proposals on PICU. UHL's estimate is based on an assumption that it would no longer be able to provide PICU services. The panel

considered that there was no reason why PICU services could not continue at the Infirmary site even if the PICU currently located on the Glenfield site needed to close.

48. The loss of income to the Trust would therefore represent between 1.6% and 2.2% of the Trust's total income and between 6% and 8% of their total specialised services income.
49. The panel viewed the potential financial loss to UHL as less significant than that at the Royal Brompton due to the projected income which would be lost being smaller and the higher overall income of the Trust. Some of this loss of income could be reduced if UHL continued to provide Level 2 services. The loss of income to the Trust would also, to some extent, be offset by a reduction in costs.
50. While there would be an impact on the income of UHL, this could be partially offset by other forms of service provision. This should not preclude NHS England proceeding to consult on its proposals.

2.1.2.3 Impact on workforce

51. Leicester identified 153 WTE staff that would be directly affected by the proposals, including administrative and clerical staff, estates and ancillary, medical and dental and nursing and midwifery staff that work solely for East Midlands Congenital Cardiac Service. In addition to the staff directly affected, the Trust has also identified other roles, such as those working in theatres, imaging, outpatient care, catheter labs and intensive care that would be indirectly affected. Leicester considers it likely that many of its staff would prefer to take up posts elsewhere in the Trust if possible.
52. The panel was not able to take a view on the likelihood of all these staff being significantly impacted by the proposed changes; however, it was acknowledged that there would be a significant impact on the Leicester's workforce, if the proposals were to be implemented. The panel noted that this impact would be reduced, were Leicester to continue providing level 2 services.
53. NHS England considers it probable that most at risk staff will be redeployed and that therefore the costs of redundancy will be mitigated. We estimate that the costs could however be up to £1m. This estimate is highly sensitive to the degree to which staff can be redeployed.
54. Experience from previous CHD service changes shows that a number of staff, perhaps most, would prefer to be re-deployed within their current Trust, though in some cases staff may transfer in accordance with TUPE regulations
55. Previous experience suggests there will be relatively few redundancies but with such large numbers of staff potentially affected by the changes, some

redundancies cannot be ruled out. NHS England will encourage providers to minimise redundancies by supporting staff to transfer with the patients or by redeploying them internally. This should not preclude NHS England proceeding to consult on its proposals.

2.1.3 Central Manchester Foundation Trust (CMFT)

56. Under the proposals the CMFT would no longer perform surgical or interventional cardiology on adults with CHD. The panel considered that the scale of this change was considerably less than at the other Level 1 centres no longer being commissioned due to the significantly lower number of surgical or interventional procedures which are undertaken at CMFT. The panel also noted that this impact will be reduced if CMFT continue to provide level 2 services as part of the overall CHD service provision in the North West.

2.1.3.1 Impact on other services: Paediatric Intensive Care and Extracorporeal Membrane Oxygenation (ECMO)

57. The proposals would have no effect on PICU provision in Manchester as CMFT does not provide level 1 CHD services.
58. CMFT provides cardiac ECMO for adults with CHD. If our proposals were to be implemented, Central Manchester would no longer be able to provide cardiac ECMO for adults with CHD. It does not provide paediatric ECMO.
59. These proposals would have no significant impact on any other services within the Trust.

2.1.3.2 Impact on finances

60. The Trust did not respond to the request to provide information on the potential impact of the proposals.
61. The overall contract value for specialised services at Central Manchester is approximately £348m. NHS England estimates that the financial effect of the proposed changes would be around £1m.
62. The loss of income to the Trust would therefore represent approximately 0.1% of the Trust's total income and approximately 0.3% of their total specialised services income.
63. The panel viewed the potential financial loss to CMFT as much less significant due to the overall income they currently receive for level 1 CHD services being much lower than other centres which would lose activity as a result of these proposals. The panel considered that the financial impact of the changes will be offset by the establishment of a new model for the delivery of CHD services in the North West. The impact on CMFT as a Trust would be very limited, as it has only been undertaking a relatively low volume of CHD surgical activity.

64. The financial impact of this change is therefore not likely to have a significant impact on the Trust. Some of this loss of income could be reduced if Central Manchester continued to provide level 2 adult CHD services. The loss of income to the Trust would also, to some extent, be offset by a reduction in costs.
65. While there would be an impact on the income of Central Manchester, this could be partially offset by other forms of service provision. This should not preclude NHS England proceeding to consult on its proposals.

2.1.3.3 Impact on workforce

66. The Trust did not respond to the request to provide information on the potential impact of the proposals.
67. The panel considered it likely that the impact on staff at CMFT would be considerably less than the other two centres as the scale of service reduction would be much smaller. Where staff are affected, close working between CMFT, Alder Hey Children's Hospital and Liverpool Heart and Chest should enable CMFT to ensure that staff are appropriately supported and that clear plans are made to enable staff who wish to transfer to a Level 1 centre to do so.
68. Previous experience suggests there will be relatively few redundancies and because of the small scale of the services that are affected, the number of staff affected is expected to be commensurately small. NHS England will encourage providers to minimise redundancies by supporting staff to transfer with the patients or by redeploying them internally. This should not preclude NHS England proceeding to consult on its proposals.

2.1.4 Paediatric Intensive Care: wider implications

69. In order to ensure that there is still sufficient PICU capacity for CHD patients, NHS England will work with the other hospitals where increased paediatric cardiac surgery would be expected if our proposals are implemented (Birmingham Children's Hospital, Great Ormond Street, Leeds General Infirmary, St Thomas' - Evelina Hospital) to undertake the necessary planning and preparation to manage any increase in PICU capacity that would be needed for CHD patients.
70. If our proposals are implemented, there may also be an effect on the wider regional and national PIC system. NHS England has accelerated its review of Paediatric Critical Care & Specialised Surgery in Children, which will consider paediatric intensive care provision and paediatric transport. The critical care review aims to carry out initial work looking at where paediatric critical care capacity is likely to be needed in future, with the first outputs coming through early in 2017. When the Board takes its decisions on the CHD proposals, it should therefore have greater clarity around the impact on PIC for CHD patients

in the wider regional and national context. The Paediatric Critical Care & Specialised Surgery in Children Service Review will then be able to pick up and deal with any wider implications for changes in PIC consequent upon the proposed CHD changes, as it considers the required capacity and distribution of PICU across the country as a whole.

2.1.5 Paediatric ECMO: wider implications

71. NHS England will work with the other hospitals, where increased paediatric cardiac and adult congenital surgery would be expected, if our proposals are implemented, (Birmingham Children's Hospital, Great Ormond Street, Leeds General Infirmary and St Thomas' - Evelina Hospital) to undertake the necessary planning and preparation to manage any increase in paediatric cardiac ECMO capacity that would be needed for CHD patients.
72. If our proposals are implemented, there may also be a wider regional and national effect on ECMO services. NHS England has accelerated its Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric ECMO. When the Board takes its decisions on the CHD proposals, it should therefore have greater clarity around emerging thinking from the national review, which is likely to be ongoing at the time of the Board's decision. The Paediatric Critical Care & Specialised Surgery for Children Service Review will then be able to pick up and deal with any wider implications for changes in children's ECMO consequent upon the proposed CHD changes, as it considers the required capacity and distribution of children's ECMO across the country as a whole.

2.1.6 Summary

73. There would be a significant impact at each of the Trusts where it was proposed that current level 1 services should cease, if our proposals are implemented. The scale of these is not considered such that it should prevent NHS England from proceeding to consult on its proposals.
74. The proposals can be implemented and that the risks identified can be reduced or mitigated through ongoing work with Trusts.
75. Whilst the financial impact of these proposals is likely to be material for the Royal Brompton and UHL they are not considered sufficient to threaten the viability of the Trusts or their ability to continue to provide a wide range of services.
76. Detailed planning of the changes and an appropriate implementation timetable will be important for effective management of the changes needed.

2.2 The impact at centres which, under the proposals, would continue to be commissioned as Level 1 CHD centres

2.2.1 Confirmation that revenue costs of implementing standards should be covered by increasing income for increasing activity

77. Trusts are paid for CHD services through tariff, which ensures that the money received is linked to patient activity.
78. It is likely that there will be some economies of scale for providers linked with providing a higher volume of activity. As such the trusts which would gain activity under these proposals are confident of being able to fund this expansion through the income which would be associated with this extra activity.
79. The financial assessment undertaken in 2015 at the time the Board agreed the standards showed that additional income to Trusts resulting from growth in activity would be sufficient to fund the implementation of the standards.
80. Growth predictions have been refreshed and continue to provide assurance that implementation of the standards will be affordable for providers.

2.2.2 Assessment of capital requirements at hospitals that would take additional patients under the proposals and the sources of this capital

81. NHS England asked providers whether there would be any capital implications if they were required to take additional patients if our proposals are implemented. NHS England has confirmed that no specific central funds will be made available.
82. Two providers indicated that they would need to source capital funds to accommodate additional activity: University Hospitals Birmingham (£4M) and Great Ormond Street (£6M). In both of these cases it is expected that the provider would be able to source the capital funding from existing allocations and/or charitable funds. This is being confirmed with NHS Improvement.
83. No other provider indicated any requirement for capital funding.
84. The risk around capital funding requirement is minimal.

2.2.3 Provider organisations where level 1 services would be provided under the proposals: workforce impact

85. The panel considered that centres that would gain more patients if the proposals were to be implemented were well placed to be able to expand their capacity to be able to provide that care. The recruitment of the necessary workforce for this increased activity was seen as potentially challenging for a number of these centres. Specifically, the recruitment of the PICU nurses necessary for the additional beds which would be required. The centres gaining significant activity believed that although challenging they had a good record of

recruiting staff and would be able to recruit the necessary staff as long as they were given sufficient time prior to these proposals being implemented.

2.2.4 The impact at centres which, under the proposals, would continue to be commissioned as Level 1 CHD centres

2.2.4.1 Alder Hey Children's Hospital

86. No significant increase in surgical activity is expected at Alder Hey as a result of the proposals. The direct impact on Alder Hey will therefore be minimal.
87. However, under the proposals Alder Hey will form a joint level 1 centre with Liverpool Heart and Chest Hospital (which does not currently offer a level 1 adult CHD service) with a single surgical team. NHS England accepts the panel's recommendations that Alder Hey would therefore need to act as the senior partner in the transition of Level 1 services from CMFT to Liverpool Heart and Chest in order to provide assurance for the continuation of the service at CMFT and support LHCH in the development of its service.

2.2.4.2 Barts Health

88. The proposals are likely to result in increased activity at Barts. While the number of patients involved is relatively small this still represents a doubling of activity for Barts. The panel considered this scale of increase to be a significant challenge for Barts, Other factors noted by the panel as contributing to the risk posed by this change were:
 - Barts only took on responsibility for delivering Level 1 CHD services for adults at the new Barts Heart Centre in 2015, following comprehensive reorganisation of cardiac services across North Central and North Central London between UCLH and Barts.
 - Barts is currently in financial special measures.
 - Barts had not clearly demonstrated that it had quantified the additional staff it would require.
89. As such the panel considered there to be a moderate risk associated with its ability to provide Level 1 CHD services for the increased number of patients envisaged under these proposals. The panel considered the most significant risk associated with Barts increasing its capacity to be in relation to the additional workforce they would require.
90. Barts is part of a joint level 1 centre with Great Ormond Street Hospital with a single surgical team. NHS England accepts the panel's recommendations that Great Ormond Street should act as the senior partner in the scaling up of Level 1 services at Barts in order to provide assurance of the development of its service.

91. NHS England recognises that it will have an important role to play in supporting implementation if the proposals are agreed. This is described in more detail in section 3.7 below.
92. We note that Barts Health NHS Trust is in Special Measures. Some adult CHD activity is expected to transfer to Barts Health from Royal Brompton if our proposals are implemented. The proposed expansion of CHD activity at Barts will bring a positive contribution to the Trust bottom line by increasing income by greater use of an existing facility.
93. There is available capacity in the PFI-financed Cardiac Centre on the St Bartholomew's site. Further development of cardiac services is in line with the Trust's strategic aims.

2.2.4.3 Birmingham Children's Hospital

94. The proposals are likely to result in significantly increased activity at Birmingham Children's Hospital. While the number of patients involved is relatively large this represents a more modest proportional increase in activity for Birmingham Children's of 36%.
95. Birmingham Children's Hospital is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided very good evidence of having understood the scale of what would be required and of plans to increase capacity.
96. Birmingham Children's Hospital identified that in order to provide the extra activity required by these proposals it would need additional PICU and ward beds. It has identified a number of options for providing this additional capacity and is currently in the process of appraising these options. It is confident it would have this additional capacity in place by early 2018 but notes the significant challenge there will be in recruiting the necessary PICU nurses for this expansion.
97. The panel did not consider there to be any significant risks associated with Birmingham Children's Hospital increasing their capacity to meet the activity required by the proposals but did note the challenges associated with the recruitment of staff, most notably PICU nurses, and the need for sufficient lead in time.

2.2.4.4 Great Ormond Street Hospital

98. The proposals are likely to result in significantly increased activity at Great Ormond Street Hospital. While the number of patients involved is relatively large this represents a more modest proportional increase in activity for Great Ormond Street of 31%.

99. Great Ormond Street Hospital is confident of its ability to increase capacity sufficiently to provide the extra activity required under these proposals. The panel considered that they had provided good evidence of having understood the scale of what would be required of them and of their plans to increase capacity.
100. Great Ormond Street identified that in order to provide the extra activity required by these proposals they would need additional PICU beds. It plans on providing this additional capacity through its new “Premier Inn Clinical Building” which will be completed in September 2017. If Great Ormond Street is required to provide extra capacity prior to this, it stated it would be able to utilise vacant capacity on its current PICU and NICU in the short term.
101. The panel did not consider there to be any significant risks associated with Great Ormond Street increasing their capacity to meet the activity required by the proposals, but did note the challenges associated with the recruitment of staff, most notably PICU nurses, and the need for sufficient lead in time.
102. Great Ormond Street is part of a joint level 1 centre with Barts. NHS England accepts the panel’s recommendations that Great Ormond Street would need to act as the senior partner in the scaling up of Level 1 services at Barts in order to provide assurance of the development of its service.

2.2.4.5 Guy’s and St Thomas’ Hospitals NHS Foundation Trust

103. The proposals are likely to result in significantly increased activity at Guy’s and St Thomas’. While the number of patients involved is relatively large this represents a more modest proportional increase in activity for Guy’s and St Thomas’ of 40%.
104. Guy’s and St Thomas’ is confident of its ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided good evidence of having understood the scale of what would be required of it and of their plans to increase capacity.
105. Guy’s and St Thomas’ identified a need for both additional ward and PICU capacity in order to provide the additional activity modelled under these procedures. It has not identified the number of additional PICU and ward beds required because it is confident that the extra capacity to be provided under its planned expansion scheme will be sufficient. This will provide up to eleven ward beds and up to ten PICU beds by December 2017.
106. The panel noted that as the surgical work undertaken by Guy’s and St Thomas’ on behalf of Northern Ireland moves to Dublin (currently expected to happen at the end of 2017) this would free up capacity.

107. The panel did not consider there to be any significant risks associated with Guy's and St Thomas' absorbing the activity required by NHS England's proposals. However, the panel did note that the most significant risk related to the workforce implications of the proposals on Guy's and St Thomas' and its ability to recruit the appropriate staff, most notably PICU nurses.

2.2.4.6 Leeds Teaching Hospitals

108. The proposals are likely to result in increased activity at Leeds Teaching Hospitals. The number of patients involved is relatively modest and represents a small proportional increase in activity for Leeds of 10%.

109. Leeds Teaching Hospitals is confident of their ability to increase its capacity sufficiently to provide the extra activity required under these proposals. The panel considered that it had provided good evidence of having understood the scale of what would be required of it and of their plans to increase capacity.

110. Whilst the panel had some concerns relating to its ability to increase capacity in their cardiac ward, PICU and theatre they did not consider that these posed a significant risk to their ability to provide services for these additional patients.

2.2.4.7 Liverpool Heart and Chest Hospital

111. Liverpool Heart and Chest Hospital (LHCH) currently provides level 2 CHD services. Liverpool Heart and Chest does not currently have a level 1 adult CHD service. Under the proposals LHCH would begin performing Level 1 services including surgery and interventional cardiology on adults for the first time³. This will mean a significant change in the cohort of patients and activity levels.

112. The panel considered the scale and nature of this change to be a significant challenge for LHCH and the most significant risk amongst hospitals gaining activity as a result of the proposals.

113. Liverpool Heart and Chest Hospital would be providing adult Level 1 CHD services for the first time having previously been a level 2 centre. As a result of this it will not simply be doing more of the activity it has already been undertaking (as is the case with other centres gaining activity) but rather starting to undertake a type of activity it has not previously done. This increases the risks.

114. In addition, the panel was concerned that Liverpool Heart and Chest Hospital had not clearly quantified the additional capacity and workforce it would require to provide this additional activity in its submission. Therefore it could not provide

³ Although Liverpool Heart and Chest has reported CHD surgical procedures to NICOR, most of the procedures concerned were either aortic surgery (patients referred to an aortic specialist surgeon including referrals from CHD surgeons) or cases that do not require a CHD surgeon (based on the definitions of adult CHD surgery established before NHS England's work in this area).

convincing assurances about how and when this would be provided. These risks were seen as more significant due to Liverpool Heart and Chest Hospital's current breaching of referral to treatment waiting times (RTT) specifically in relation to cardiac surgery.

115. Under the proposals LHCH will form a joint level 1 centre with Alder Hey. NHS England accepts the panel's recommendations that Alder Hey would therefore need to act as the senior partner in the transition of Level 1 services from CMFT to Liverpool Heart and Chest in order to provide assurance for the continuation of the service at CMFT and support LHCH in the development of its service.
116. Managing the risk of this change will require close working between CMFT, Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital to ensure that they have a clear understanding of the activity LHCH will be required to undertake and the systems, facilities, staffing and capacity needed to manage this activity.
117. NHS England recognises that it will have an important role to play in supporting implementation if the proposals are agreed. This is described in more detail in section 3.7 below.

2.2.4.8 Newcastle Hospitals

118. No significant increase in surgical activity is expected at Newcastle as a result of the proposals. The impact on Newcastle will therefore be minimal.
119. While noting that this meant that proposals posed a minimal risk at Newcastle, the panel considered that real risks did arise because Newcastle does not meet the 2016 activity requirement and is unlikely to be able to meet the 2021 activity requirement. It also does not meet the 2019 paediatric co-location requirements or have a realistic plan to do so by April 2019.
120. The panel considered that if Newcastle could not meet the standards, a clear plan would be needed either to move the advanced heart failure service, or deliver it under a different model. A phased, planned transition supported by the Newcastle team would be required if the service needed to move. This would minimise the risks.
121. The panel also considered that succession planning would be an issue for the service in Newcastle.
122. NHS England notes the panel's concerns. However Newcastle has a unique role in delivering care for CHD patients with advanced heart failure including heart transplant and bridge to transplant and that this could not be replaced in the short term without a negative effect on patients. On balance therefore our present view is that it is better to continue to commission level 1 CHD services from Newcastle.

123. This does not mean that change at Newcastle Hospitals NHS Foundation Trust will not happen in the longer-term. The hospital trust is required to meet the standards in the same way as all of the other Level 1 surgical centres. Timeframes for doing this may differ, but we will be working closely with the hospital to ensure that patients receiving CHD care at Newcastle Hospitals NHS Foundation Trust are not compromised in any way.
124. NHS England notes the panel's recommendation that these shortfalls could not be ignored and that if there was to be derogation, the issues needed to be resolved by the end of the period of derogation. If this proposal is implemented we will work with Newcastle to ensure progress is made towards meeting the standards and to ensure the service is sustainable and resilient. We will take expert advice on the best possible development plans; and mitigations in the circumstances and support their implementation. These arrangements will be time limited and subject to further review by 2021.
125. The panel recommended that NHS England would need to undertake specific work on the future of advanced heart failure services in England, to ensure their ongoing provision and resilience. If this were to result in the development of an alternative model for advanced heart failure services for CHD patients then a review of the long term future of Level 1 CHD services in Newcastle would also be enabled.
126. NHS England notes the panel's recommendation that there should be a review of the future of advanced heart failure services in England. If our proposals are agreed, this recommendation will be further considered.
127. NHS England recognises that it will have an important role to play in supporting implementation if the proposals are agreed. This is described in more detail in section 3.7 below.

2.2.4.9 University Hospitals Birmingham

128. The proposals are likely to result in increased activity at University Hospitals Birmingham (UHB). The number of patients involved is relatively modest although this represents a 40% increase in activity for UHB.
129. University Hospitals Birmingham (UHB) is confident of their ability to increase their capacity sufficiently to provide the extra activity required under these proposals. The panel considered that UHB had provided good evidence of having understood the scale of what would be required of them and of their plans to increase capacity.
130. The panel did not consider that there was any significant risk associated with UHB absorbing this additional activity.

131. Due to the size of its overall adult cardiac service including ITU provision the level of activity it would absorb as a result of the proposed changes is not considered to be significant, and the panel was therefore confident that any transition of activity would be able to be undertaken in a timely manner.

2.2.4.10 University Hospitals Bristol

132. No significant increase in surgical activity is expected at Bristol as a result of the proposals. The impact on Bristol will therefore be minimal.

2.2.4.11 University Hospital Southampton

133. The modelling of patient flows which NHS England produced did not envisage significant activity flowing to Southampton as a result of these proposals.

134. The proposals are likely to result in increased activity at Southampton. The number of patients involved is relatively modest and represents a small proportional increase in activity for Southampton of 5%.

135. Southampton is confident of their ability to increase its capacity sufficiently to provide the extra activity required by the standards.

136. The panel did not consider that there was any significant risk associated with Southampton absorbing this additional activity.

137. The panel considered that it had provided good evidence of having understood the scale of what would be required and of its plans to increase capacity. Work is already underway to expand PICU.

2.2.5 Conclusion

138. The panel considered that centres that would gain more patients if the proposals were to be implemented were well placed to be able to expand their capacity to be able to provide that care.

139. All the centres which would gain additional activity under the proposals indicated that they were able to increase capacity in order to meet this increased demand.

140. Detailed planning of the changes and an appropriate implementation timetable were considered important for effective management of the changes needed.

141. The recruitment of the necessary workforce for this increased activity was seen as potentially challenging for a number of these centres. Specifically, the recruitment of the PICU nurses necessary for the additional beds which would be required. The centres gaining significant activity believed that although challenging they had a good record of recruiting staff and would be able to recruit the necessary staff as long as they were given sufficient time prior to these proposals being implemented.

142. All centres are confident of their ability to provide high quality CHD services to these additional patients and the risks which remain largely relate to ensuring that sufficient lead in time is given to any changes and that the detailed work of understanding the precise nature of any changes and thus the specific requirements on these centres has been undertaken prior to these proposals being implemented.
143. A higher level of support will be needed for the changes proposed at Liverpool Heart and Chest, Barts and for Newcastle as it works towards meeting the standards.
144. NHS England recognises that it will have an important role to play in supporting implementation if the proposals are agreed. This is described in more detail in section 3.7 below.

3 Response to National Panel recommendations

145. The national panel made a number of recommendations to NHS England. Most relate to the planning and preparation for change if a decision is taken to implement the proposals.

3.1 Workforce

146. NHS England recognises the importance of employing Trusts supporting current staff during a period of uncertainty.
147. Sufficient experienced staff within the service is vital key to good patient outcomes across the care pathway and therefore were these proposals to be implemented significant work would be required to ensure every effort was made to retain experienced staff, and ensure that every Level 1 centre maintained a highly skilled and experienced workforce.
148. NHS England would support TUPE and/or COSOP arrangements to enable staff affected by change to transfer their employment to other Level 1 centres requiring their skills.
149. A priority will be the development of a framework across organisations to ensure the best possible outcome for staff. The national panel advised that all units are resourceful and where there is a shortfall in the staff available they were confident they will continue to find ways to recruit the necessary staff, including international recruitment where necessary.

3.2 The resilience of surgical teams

150. NHS England accepts the panel's recommendation that if the proposals are implemented, each centre's implementation planning must ensure that appropriately robust surgical teams are in place with clear succession plans.

3.3 Managing patient flows

151. We have modelled the way in which patient flows may change if the proposals are implemented. The modelling assumes that a patient will go to their next nearest centre, calculated as car journey time. The results of this modelling are intended as a guide rather than an exact representation of what will happen.
152. During planning and preparation for implementation, NHS England recognises that further modelling may be required to explore different assumptions, for example if CHD referrals align with referrals for other specialised paediatric services.

3.4 Communication

153. NHS England will continue to offer open communication on its work on CHD services, seeking to support patients in understanding the proposals, the staged approach to meeting the standards and the timetable for implementation if the proposals are agreed.

3.5 PICU and ECMO

154. NHS England notes the panel's support for the national paediatric critical care and children's surgery review. This review will consider the overall requirement for PICU beds in future across the country and for all patient groups, the appropriate model of children's ECMO provision and the appropriate number of providers, the case for minimum activity levels and the appropriate number of mobile ECMO providers.

3.6 Advanced heart failure

155. NHS England acknowledges the panel's recommendation that NHS England should undertake specific work on the future of advanced heart failure services in England.
156. If our proposals are agreed, this recommendation will be further considered.

3.7 Support

157. NHS England accepts the panel's recommendation that, if our proposals are implemented, centres will need to collaborate to ensure close working between centres to support the safe transition of services. The changes proposed will take some time to implement.
158. NHS England remains committed to promoting collaborative working and will continue to work with providers to facilitate these conversations, including the development of network protocols.
159. In addition to this, once final decisions have been made, NHS England will make money available to pump prime the formation of networks, in line with the approach to other Operational Delivery Networks for specialised services.
160. If a decision to move services is made, work would begin to turn those 'agreements in principle' into firm plans. Clinicians at all the affected centres will be involved in developing plans for how the service would work in the future.
161. NHS England recognises that it will have an important role to play in supporting implementation if the proposals are agreed.
162. The current CHD Implementation and Commissioning Programme Board will oversee implementation. Membership of the group will be reviewed and refreshed to reflect the different nature of the implementation challenge. This would allow the inclusion of representatives from affected provider organisations if appropriate. The programme board reports to the national Specialised Commissioning Oversight Group (SCOG) which in turn reports to the Specialised Services Commissioning Committee, a sub-committee of the NHS England Board.
163. The work will continue to be supported by a national programme team with programme management, communications and engagement, information and analytical capabilities. The programme will continue to receive dedicated resources, as part of the national specialised commissioning programme budget.
164. The programme board will continue to identify and manage risks and escalate these to SCOG in line with organisational policy.
165. The programme board will oversee the implementation process to make sure that:
 - the process is carried out carefully and thoroughly;

- there is a strong link between the plans of those hospitals that would cease to provide level 1 services and those hospitals that would expand their provision;
 - that no change happens until there is enough capacity at the new hospital, including overnight accommodation and other facilities for families;
 - that staff and patient representatives from the hospitals concerned are included in the planning process;
 - there is frequent and clear communication so that everyone knows what to expect and how it will affect them; and
 - service quality and waiting times are closely monitored and managed.
166. NHS England's regional teams are represented on the programme board either by the Regional Director for Specialised Commissioning or the Regional Clinical Director for Specialised Commissioning.
167. Regional teams will continue to manage NHS England's relationships with the affected hospitals. This will include working closely with providers to support the development of:
- Locally appropriate care model including consideration of the role of level 2 care
 - Capacity planning and development
 - Transition planning
 - Implementation of 'staff affected by change' policies across affected organisations including action to minimise redundancies; there will be no reduction in the number of specialist staff required to deliver services
Workforce planning and development
 - Staff communication plans
 - Patient communication plans
 - Local media management
168. Patients and their families have told us that changes to where their care is provided and to the staff providing their care can be unsettling, so we will ask the hospitals involved to look carefully at how this process is managed if our proposals are implemented. We think the pattern set out in the standards for transition from children's to adult services may be helpful as this offers an opportunity to visit the new centre and meet the new staff in advance of the change happening. We will also ask them to maximise continuity in care so that as much as possible can remain familiar. If level 2 care continues to be provided at hospitals that no longer provide level 1 services many aspects of patient care will continue as before and patients would experience a high degree of continuity.

169. We will ask for special attention to be paid to people with learning disabilities and their families because we know that change can be particularly difficult for this group.
170. All providers of CHD care are contractually required to meet NHS England's service standards by the CHD service specifications (Paediatric Cardiac E05/S/a and Adult CHD E05/S/b). Where a provider did not meet one or more of the standards, but we considered that they would be able to in future, we have agreed with them an improvement plan with an agreed timetable, and this plan has been made binding through a contract variation. Delivery against these plans will be monitored by commissioners in regular performance management meetings. The NHS England CHD Programme Board will receive regular reports of delivery against plan in order to ensure that there is a national understanding of progress.

3.8 Level 2 services and the impact of the end of Commissioning through Evaluation for Patent Foramen Ovale (PFO)

171. Following the end of Commissioning through Evaluation for PFO closures we will monitor interventional activity at Brighton and Oxford to determine whether these centres are able to continue performing these procedures.
172. If these centres are not able to perform ASD catheter closures they may still choose to provide level 2 CHD services in the same way as Norfolk and Norwich Hospital.

4 Part Two: Further assessment against the standards

4.1 Introduction

173. NHS England's initial assessment of compliance against the specifications and standards focussed on the standards that came into effect in April 2016.
174. Where the panel considered that the evidence did not show that providers met the 2016 standards their assessment also took account whether providers were likely to be able to meet the elements of the interdependency/co-location requirements that come into effect in 2019 or the surgical standards that come into effect in 2021.
175. NHS England has always been clear that the implementation date specified by the standard does not indicate that NHS England will not consider whether the standard has been met until this time. On the contrary, NHS England will require hospitals either to show that they meet the required standards at the go-live date or that they have robust plans in place to do so, where necessary supported by appropriate mitigations to deal with the shortfall in the interim.⁴ In addition, our letters to providers at the start of the self-assessment process clearly stated that if a provider does not meet the specification and is unlikely to be able to do so, we would need to discuss future service provisions.
176. However, as we had not explicitly asked providers about their plans to comply with these future standards we wrote to the Royal Brompton and UHL and offered them the opportunity to submit additional information to the National Panel on their ability to meet these requirements.
177. Assessment of the additional information submitted by UHL and the Royal Brompton in respect of standards with a future implementation date was undertaken by the national panel at the same time as the Impact Assessment.

4.1.1 Paediatric interdependency requirements

178. The standards state that by 2019 the following specialties or facilities must be located on the same hospital site as Specialist Children's Surgical Centres. They must function as part of the multidisciplinary team. In addition, consultants from the following services must be able to provide emergency bedside care (call to bedside within 30 minutes).
- Paediatric Cardiology;
 - Paediatric Airway Team capable of complex airway management (composition of the team will vary between institutions);

⁴ <https://www.england.nhs.uk/wp-content/uploads/2015/07/Item-4-CHD-Report.pdf>

- Paediatric Intensive Care Unit (PICU);
- High Dependency beds;
- Specialised paediatric cardiac anaesthesia;
- Perioperative extracorporeal life support (Non-nationally designated extracorporeal membrane oxygenation (ECMO));
- Paediatric Surgery;
- Paediatric Nephrology/Renal Replacement Therapy;
- Paediatric Gastroenterology.

4.1.2 Surgeon minimum activity levels and surgical team size

179. The standards state that congenital cardiac surgeons must be the primary operator in a minimum of 125 congenital heart operations per year (in adults and/or paediatrics), averaged over a three-year period. Only auditable cases may be counted, as defined by submission to the National Institute for Cardiovascular Outcomes (NICOR). They must work in teams of three by April 2016 and teams of four by April 2021.

4.2 University Hospitals Leicester (UHL)

4.2.1 Paediatric interdependency requirements

180. UHL stated that all paediatric specialist services, including paediatric cardiac services, will be co-located at Leicester Royal Infirmary by 2019 and they will therefore be fully compliant with the co-location requirements. This plan no longer depends on the building of a new children's hospital.

181. The panel considered that UHL's proposal to move paediatric cardiac Level 1 services to the Infirmary site would allow it to achieve full compliance with the requirements. However, the panel considered that UHL needed to set out their plans in more detail to be fully reassuring that this move could and would be achieved by the required deadline.

182. UHL provided assurances that the project will not require external capital funding, as it will be funded using a combination of the Trust's Capital Resource Limit and charitable donations. It will be designed as part of (but is not dependent upon) the wider Children's Hospital Project, to ensure the integration of paediatric services to create a defined Children's Hospital in Leicester.

4.2.2 Surgeon minimum activity levels and surgical team size

183. UHL's surgical activity in 15/16 was 326 procedures. 16/17 activity data was not available to the panel.

184. UHL submitted a surgical growth plan which they consider would result in them achieving the minimum level of activity required to ensure four surgeons are each able to perform a minimum of 125 procedures per year by 2021.
185. The projected increase in activity depends on population growth, technical advances, and changes to patient flows. NHS England has repeatedly stated that it has no intention of mandating patient flows and as such the panel remained unconvinced that the changes to patient flow required to achieve the necessary growth are likely to occur.
186. UHL reported that they have successfully established a complete lifetime referral pathway with Kettering General Hospital and had positive discussions with two other network hospitals to establish lifetime referral pathways. UHL suggested additional surgical cases from these partners as demonstrated in the table below:

Table 4: UHL estimated additional future referrals

Year	Partner 1	Partner 2	Partner 3
2016/17	0	0	0
2017/18	4	6	4
2018/19	8	11	7
2019/20	11	17	11
2020/21	15	22	14

187. To date these arrangements have not been established and as such UHL do not expect to see any additional activity from these until 2017/18.
188. UHL did not provide any evidence of formal agreements having been established or any basis for its assertions over the amount of additional activity they would receive from these networks.
189. The changes to referral pathways described by UHL were not considered sufficient to bring about the level of growth required for them to meet the 2021 requirements. In order for these requirements to be met their activity would need to increase by 53% from 2015/16 levels in five years, when the previous five years have only resulted in a total growth of 24%.
190. Applying national predicted growth rates to UHL surgical activity, and factoring in the additional referrals cited above (though evidence for these has not been provided) NHS England has estimated that UHL's surgical activity in 2020/21 will be more than 20% below the minimum requirement of 500 operations and 4 surgeons. As a result, some if not all surgeons would be undertaking fewer than the minimum of 125 cases per surgeon per year.
191. UHL's growth estimate assumes growth will continue at the rate seen at UHL between 2014 and 2016 as well as technical advances and changes in its

network. The basis for these assumptions and their impact within UHL's modelling is not well explained

192. The panel considered it likely that UHL would reach activity levels sufficient to support a team of three surgeons each undertaking 125 operations per year but that it was not clear when this would happen. The Trust's own most recent estimate was that this would be achieved by 2017/18.
193. The panel considered that UHL had not provided sufficient evidence to provide confidence that it would achieve the minimum surgical activity requirements by 2021.

4.2.3 Summary

194. Following the Trust's latest submission the panel considered that:
- UHL had demonstrated that it could meet the April 2019 co-location requirement though more detailed plans were required to be fully reassuring;
 - UHL had not demonstrated that it met the April 2016 requirement of three surgeons each performing a minimum of 125 procedures per year;
 - While UHL had not provided sufficient information to know when the April 2016 requirement would be met, it was likely that this requirement would be met; and
 - UHL had not set out a convincing plan as to how they will meet the April 2021 requirements of four surgeons each performing a minimum of 125 procedures per year.
195. NHS England accepted this assessment.

4.3 Royal Brompton Hospital (RBH)

4.3.1 Paediatric interdependency requirements

196. RBH has previously demonstrated that it meets all of the co-location requirements with the exception of paediatric surgery and gastroenterology.
197. RBH did not provide any additional information or evidence as to how they plan to meet the 2019 requirements to co-locate their paediatric CHD service with other key specialties.
198. They stated that although they do not have paediatric surgery or paediatric gastroenterology co-located on site they provide these services through their partnership with Chelsea and Westminster who participate in MDTs and ward rounds and provide out of hours cover as required.

199. RBH stated that it did not consider that 2019 requirements should be a part of this assessment process or that decisions should be made on the basis of these.

4.3.2 Summary

200. Following the Trust's latest submission the panel considered that:

- RBH had not demonstrated that it could meet the April 2019 co-location requirement for paediatric gastroenterology or paediatric surgery

201. NHS England accepted this assessment.

5 Conclusion

202. The panel did not consider that any of the potential impacts or risks identified through this process was sufficient to require the proposals to be altered.

203. The panel was confident that those centres required to provide additional Level 1 services were these proposals to be implemented would be able to provide sufficient capacity for this.

204. The panel concluded that the additional evidence submitted did not alter their original assessment of the three trusts (CMFT – Red; UHL – Red/Amber; RBH – Red/Amber).

205. The panel considered that while the proposals would have a material impact on the trusts no longer providing Level 1 services, especially the Royal Brompton and Leicester, it did not consider it to be likely that these would be sufficient to threaten either their continued viability or their continued ability to provide a wide range of specialised services.

6 Next steps

206. This is a high level impact assessment intended to identify the risks associated with the proposals as they currently are and test the plausibility of the proposals, to inform NHS England's assurance processes prior to the launch of public consultation. Whilst there remain a number of unknowns relating to the implementation of these proposals as well as a number of risks which will require managing, there is nothing highlighted within this document which seems likely to make the proposals unviable.

207. No commissioning decisions have yet been made, as the public consultation is pending and therefore it is not appropriate to produce a detailed implementation plan at this stage. This will be produced once decisions have been taken by the

Board of NHS England, following the completion of public consultation. Throughout the consultation period and beyond we will continue to work with providers to understand the impact of the changes which are being proposed and refine the impact assessment we have completed to date.

Draft for consultation

Appendix B8

Congenital Heart Disease Consultation – Events List

Date and Time	Event Name
28 th February, 1.30 – 4pm	Norfolk & Norwich Patient, Public and Staff Event Room 10 Bob Champion Centre, Norfolk and Norwich University Hospital
1 st March, 5 – 7pm	NHS England CHD Webinar
2 nd March, 2 – 4pm	NHS England CHD Webinar for CCG's
2 nd March, 5 – 7pm	NHS England CHD Webinar for families and carers of those with CHD and Learning disabilities
2 nd March 10am	North East Health Scrutiny Committee
3 rd March 10.30am – 12.30pm	Oxford Patient, Public and Staff Event Cardio Thoracic Public Partnership Group
6 th March 10am	Derbyshire Health Scrutiny Committee
6 th March, 12 -2pm	Brighton & Sussex Patient, Public and Staff event
7 th March, 6 - 8pm	London Question Time event , Coin Street neighbourhood centre
9 th March, 6-8pm	Leicester Question Time event – Leicester tigers stadium
9 March	Leicester Staff Briefing
11 th March 10am – 12pm	Manchester Patient, Public and Staff event
14 th March 10.15am	Nottingham/Nottinghamshire Overview and Scrutiny committee
14 th March PM	Joint Leicester, Leicestershire and Rutland Overview and Scrutiny committee
15 th March PM	Cardiff Patient, Public and Staff event
15 th March 10am	Lincolnshire Overview and Scrutiny committee
17 th March	Birmingham Patient, Pubic and Staff Event

Congenital Heart Disease Consultation – Events List

18 th March	Little Hearts Matter Patient and Families Event This event is closed to members of Little Hearts Matter only
21 st March 5pm – 7pm	Leeds Patient Public and Staff event, Kaberry Theatre, Leeds general Infirmary
22 nd March, 5pm	Kensington & Chelsea Overview and Scrutiny committee
22 nd March	Bart’s Patient, Public and Staff event Bart’s Hospital
23 rd March, 4 – 7pm	Alder Hey Patient, Public and Staff event Institute in the Park (next to Alder Hey)
25 th March, 10am	Papworth Patient Event
27 th March 2- 4pm	Great Ormond Street Patient, Public and Staff Event
28 th March – 2pm	Rutland Health and Wellbeing Board
28 th March 5 – 7pm	Evelina/Guys Patient, Public and Staff event
31 st March	Southampton Patient, Public and Staff event
5 th May	Wrexham patient event
6 th May -	Brompton Patient and Families event
8 th May – 4 – 6pm	Lincolnshire Patient, Public and Staff event
8 th May – suggested 3.30 – 6pm	Blackpool Patient, Public and Staff event

Appendix C

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NHS ENGLAND REVIEW OF CONGENITAL HEART DISEASE SERVICES

REPORT TO THE JOINT LLR HEALTH SCRUTINY COMMITTEE

14th MARCH 2017

Introduction

NHS England is conducting a formal public consultation on its proposals to change the configuration of congenital heart disease (CHD) services across England. These proposals would see the de-commissioning (i.e. removal) of at least the surgical service from Leicester and most likely a further loss of services both related to CHD and more widely across the Leicester Children's Hospital.

University Hospitals of Leicester NHS Trust disagrees fundamentally with these proposals, for the following key reasons:

- The outcomes for children being delivered in Leicester are at least as good as those from the other UK centres and compare well globally
- The future sustainability of the service has been secured through the recent appointment of two key substantive clinicians
- We are very close to achieving the required minimum numbers of cases (375) per year and have a robust plan for further expansion to meet the longer term standard (500 cases)
- We have a robust, funded, plan to meet the requirement that all children's services are on one site, within the required timescale
- NHS England is no longer suggesting that we have material issues with any of the other standards
- The removal of the service in Leicester will leave the East Midlands as the only region in England without a Level 1 (surgical) centre and force children and their families to travel much further for care
- These wholly unnecessary changes also risk destabilising a number of other key services for children, including already stretched paediatric intensive care and the largest ECMO centre in the country.

Consultation response

To assist the Committee's deliberations, the attached document is structured in the same way as the consultation questionnaire. We have set out, for each question, our view of the facts and our response.

The UHL Chief Executive and senior clinical staff will be in attendance at the Committee meeting to answer any questions that members may have.

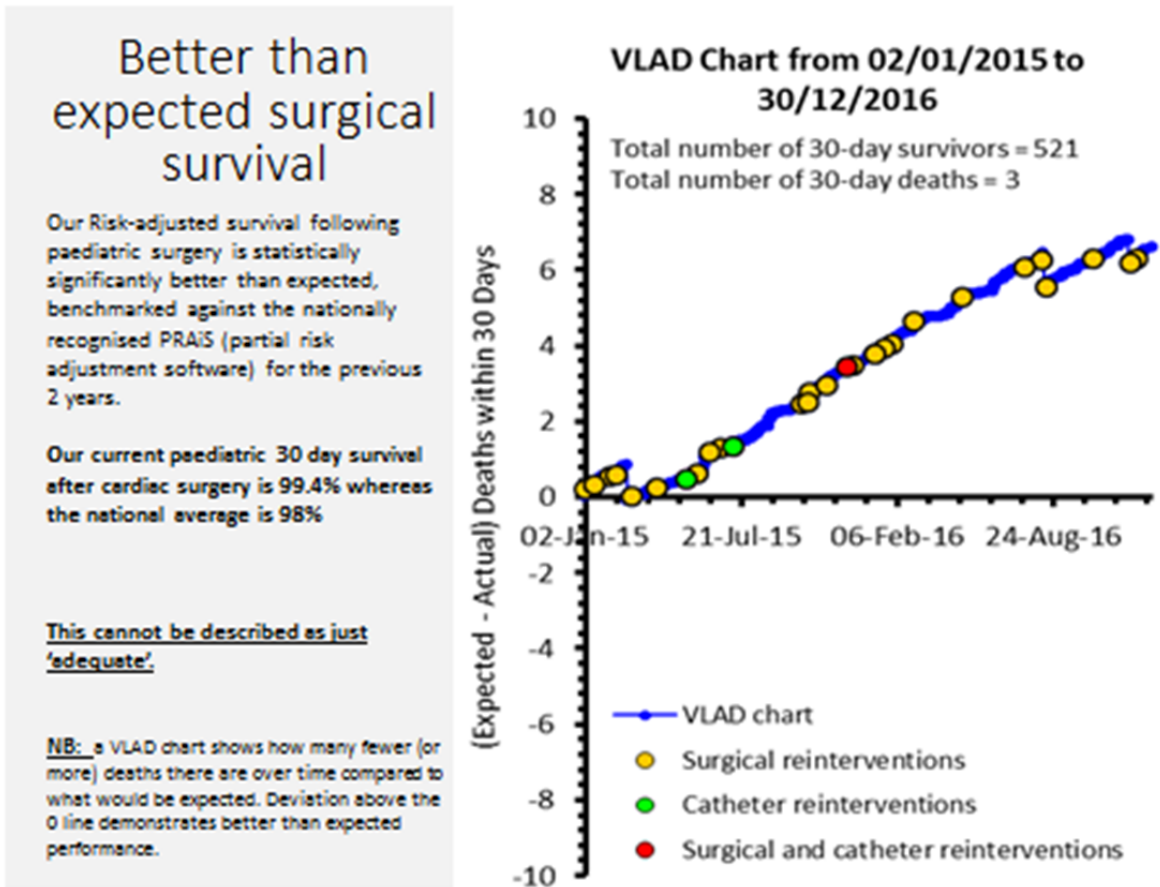
John Adler

Chief Executive

6th March 2017

Introduction

The University Hospitals of Leicester NHS Trust (UHL) welcomes the consultation into the proposals to implement standards for congenital heart disease (CHD) for children and adults in England. The East Midlands Congenital Heart Centre (EMCHC) currently based at Glenfield Hospital is a high quality Level 1 centre that provides congenital heart surgery, diagnostic and interventional catheter procedures and all related medical CHD services for the population of the East Midlands. We also provide the majority of extracorporeal membrane oxygenation (ECMO) services for the entire UK. Our latest CQC inspection rated EMCHC as good overall with Outstanding for effectiveness. Our latest results below show we are performing above expectations in many areas;



Consultation Questions

Question 3; NHS England proposes that in future Congenital Heart Disease services will only be commissioned from hospitals that are able to meet the full set of standards within set timeframes. To what extent do you support or oppose this proposal?

Question 4 Please explain your response to question 3.

NHS England is not doing what it says it is doing

- It is not possible to support or oppose this statement - as this is not what is being proposed
- In the consultation document, NHS England states that none of the centres currently meet all of the standards.
- Moreover, some of the centres who retain commissioning in this proposal currently meet fewer standards than UHL.
- They say that only centres that can meet the full set of standards within set timeframes will be commissioned but don't provide any evidence that other centres can do this better than EMCHC

Inconsistency

- NHS England clearly intends to retain commissioning of Newcastle despite the centre not meeting two of their key standards:
 - a) The ability to reach the required caseload by 2021 and
 - b) Co-location now or in the future.
- The geographic location of Newcastle makes it impossible for them to ever meet the 500 caseload standard without very major shifts in referrals to them from other areas much further away. NHS England has made it very clear that they (at least in theory) will not influence referral pathways and as such NHS England should not be supporting this assumption.
- If it is possible to derogate, and thereby accept that having less cases than required by the standard does not in itself add to patient risk for this centre, then it should also be possible to allow EMCHC additional time to meet the standards, should it be required.
- There is no evidence in the consultation document to demonstrate that NHS England's assessment of the growth plans proposed by other centres are any more or less robust than those proposed by EMCHC. NHS England's concerns regarding the UHL growth plan have not been discussed with the Trust other than simply dismissing our assertions.

NHS England then state that:

Three hospital trusts have been assessed as not able to fully meet the standards within set timeframes. NHS England therefore proposes that surgical (level 1) services are no longer commissioned from:

- **Central Manchester University Hospitals NHS Foundation Trust** (adult service)
- **Royal Brompton & Harefield NHS Foundation Trust** (services for adults and children); and
- **University Hospitals of Leicester NHS Trust** (services for adults and children).

UHL comments in relation to this are as follows:

Interpretation of the standards

The Trust supports the principles of the standards that were approved by NHS England in April 2016, and in fact had representation from EMCHC on the standards development group. This group debated the standards at length and accepted that their implementation would be challenging which is why realistic timescales were agreed to allow centres the best chance of achieving the standards. At no point was it agreed that the standards would be used to close centres.

NHS England states that we do not meet standard 2.1 and are unlikely to do so in the timescales expected. On the 14th November NHS England wrote to the Trust and stated that;

Standard 2.1 requires a team of at least 3 cardiac surgeons, each of whom must have been the primary operator in a minimum of 125 congenital heart operations per annum as at April 2016, averaged over the previous 3 years (and therefore averaged over that period a minimum of 375 cases per year for the team of surgeons as a whole is required).

The actual wording in the standards document states ‘ averaged over 3 years ’ not ‘ averaged over the **previous** 3 years ’

Our understanding of the view of the profession is that the timescales for the implementation would be measured from the date of approval of the standards by NHS England. At no time was it suggested, or accepted, that any of the standards would be applied retrospectively. If this was the case, requirement 2.1 would have immediately excluded a number of centres from ever being given the opportunity to meet the standards. The introduction of an immediate timeframe by NHS England (not the standards committee) therefore was widely interpreted as being measured from April 2016 onwards.

UHL is predicting that in 2016/17 we will have delivered 350 operations in year (93% of 375 targets). Our network growth plan indicates that by 2018/19 the average case load will be 375 operations per year (detail below)

If the standard is interpreted in the way in which we think it was intended UHL will meet the standard within the timeframe

Network growth plan - UHL currently has a close working relationship with many hospitals across the East Midlands. Over the last couple of years we have worked closely with even more of the East Midland's Hospitals to provide CHD clinics and services as close to home as possible. This has already increased the number of CHD patients who have been referred to EMCHC. Based on the success of this strategy and extending it to a wider area, we are able to predict continued growth which will enable us to meet the required standards in the necessary timeframes.

EMCHC growth plans to meet the key standards around case load have been submitted to NHS England on numerous occasions , we have not received any detail explanation as to why NHS England deems our plans not to be robust .

Our growth plan is specifically based on the following assumptions;

- Population growth as per Office of National Statistics (ONS)
- Continuing our growth over the last three years (which has come from robust network relationships, providing satellite clinics in local hospitals, and providing robust , high quality referral pathways and excellent outcomes)
- Higher than average number of procedures per head of population due to the pattern of disease and complexity seen in our regional patient groups
- Expanding our network to three additional hospitals within the East Midlands network that have not traditionally referred a significant number of patients to UHL; despite UHL being the closest centre geographically for these patients.

Discussions with these centres are underway and very positive; we have acknowledged that it will take time for the network clinicians to see that an equivalent service is on offer and to build relationships. We have therefore been very conservative in the first two years rising to a maximum requirement of only 51 patients in total in 2021 from these three centres.

The key point to note here is our growth plan clearly demonstrates our ability to meet the standard within the necessary timescale and INCREASES patient choice not reduces it. We are not asking NHS England to force patients to go where they do not want to – unlike the current NHS England proposals which will require MUCH larger numbers of patients to go out of East Midlands for their care with no choice.

Question 5; Can you think of any viable actions that could be taken to support one or more of the trusts to meet the standards within the set timeframes?

- Apply the standards fairly and as originally intended.- the timescale for 125 cases should be measured from April 2016 onwards, not applied retrospectively.
- Treat all centres equally ensuring their ability to meet the standards is not predicated on the demise of another centre
- Ensure that all patients across the entire East Midlands are offered the choice of attending EMCHC, as an option in addition to the current usual referral pathway from those centres not already usually referring to us. EMCHC's growth plan recognises this will require relationships to be developed further. This will take time.
- Support UHL in the development of these relationships, thus reducing the need for thousands of patients in the East Midlands to be denied care closest to home and the choice of being treated at Glenfield
- Work with UHL to fully understand their growth plan and help implement standard B5 L1 which encourages Network referral to sustain the viability of Level1 centres in a Network
- Remove the cloud of uncertainty from Glenfield, enabling them to continue to build the expertise of their team for the future and put your efforts into celebrating and supporting its success

Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust

If Central Manchester and Leicester no longer provide surgical (level 1) services, NHS England will seek to commission specialist medical services (level 2) from them, as long as the hospitals meet the standards for a level 2 service. To what extent do you support or oppose this proposal?

It is surprising that NHS England has chosen to group these 2 centres together when the situation for each is totally different. It is not possible to answer this question sensibly as the rationale for decommissioning either centre is very different. Asking for a combined response is unfair.

The impact of establishing a Level 2 centre in Manchester with a level 1 (surgical and catheter) centre retained in the North West region is far less than downgrading the service in Leicester and leaving the entire East Midlands region with no Level 1 centre, and where every patient will have to go out of the region for level 1 care

In the consultation document NHS England outlines how Oxford has successfully moved from a Level 1 centre to become a Level 2 centre. Oxford was only performing around 100 surgical cases per year at the time it closed. There were evident concerns about quality where no such concerns exist at EMCHC. This was therefore a significantly smaller process to relocate compared to that from a centre delivering 350 surgical cases a year, >400 catheter cases and all the associated other inpatient procedures for patients from a much wider geography.

UHL stands by its predictions on the impact on other services: fetal medicine, neonatal surgery, neonatal surgery and intensive care, paediatric intensive care and speciality paediatrics, and ECMO, both within UHL and across the wider East Midlands and UK. If these proposals go ahead we believe the only services realistically able to be offered in a Level 2 centre are outpatient clinics and some inpatient drug therapies. Since <1/4 of the East Midlands patients actually live in Leicester, Leicestershire and Rutland, it is not clear why they would be better coming to Leicester for these services rather than being seen in their local (level 3) centres, some of which are very big teaching hospitals in their own right.

Royal Brompton and Harefield NHS Foundation Trust

Question 6; The Royal Brompton could meet the standards for providing surgical (level 1) services for adults by working in partnership with another hospital that provides surgical (level 1) services for children. As an alternative to decommissioning the adult services, NHS England would like to support this way of working.

We believe that this would depend on whether the partnership enabled all surgeons (both adult and Paediatric) to meet the 125 requirement.

Newcastle upon Tyne Hospitals NHS Foundation Trust

Question 7 ; NHS England is proposing to continue to commission surgical (Level 1) services from Newcastle upon Tyne Hospitals NHS Foundation Trust, whilst working with them to deliver the standards within a different timeframe. To what extent do you support or oppose this proposal?

We would strongly oppose this ONLY BECAUSE it treats one centre differently from another. If the same approach was applied to all centres equally, then we would support this.

There is major Inconsistency of approach - the geographic location and historical growth information for Newcastle makes it impossible for them to meet the 500 caseload standard without significant shift in referrals to them from other centres.

Irrespective of the rationale for this derogation (exception making) based on the Transplant services offered by Newcastle, it means that NHS England **is** prepared to derogate against the standards. We would argue that the same flexibility should be shown (if necessary) to EMCHC in order to maintain local access for the population of the East Midlands. This cannot be unsafe as if it were then Newcastle would have to be closed.

Travel

We know that some patients will have to travel further for the most specialised care including surgery if the proposals to cease to commission surgical (level 1) services from Central Manchester University Hospitals NHS Foundation Trust (adult service); Royal Brompton & Harefield NHS Foundation Trust (services for adults and children); and University Hospitals of Leicester NHS Trust (services for adults and children) are implemented.

Question 8; Do you think our assessment of the impact of our proposals on patient travel is accurate?

Question 9; What more might be done to avoid, reduce or compensate for longer journeys where these occur?

This travel analysis is clearly wrong.

We have asked for the 'raw data' on which NHS England has based their calculations to enable us to analyse how the figures have been derived. As yet we have not been provided with this. But it is also clear that they have only used a (low) number of patients having surgery elsewhere rather than all the procedures and admissions and clinic appointments that would have to move (>800 pa).

Since the majority of our patients live on the opposite side of Leicester from Birmingham, and it regularly takes more than an hour from Leicester to central Birmingham, these figures don't make sense.

NHS England's analysis suggests that **children** who currently come to EMCHC for treatment will have an average journey time increase of 14 minutes, whilst **adults** from the same region currently travelling to EMCHC will have an increase of 32 minutes! How is this possible? This inconsistency also casts doubt on the accuracy of the remainder of their travel time calculations.

If we assume these travel times are by road, significant numbers of our patients rely on public transport and have no cars of their own. We therefore also challenge that the proposals will only add this very small amount of time onto these journeys.

Patients from the east coast of Lincolnshire who rely on public transport and have an appointment in the morning in Birmingham would need to leave the night before

We accept that parents will drive to the moon and back if it would benefit their child – that is not the point. The question is therefore whether the magnitude of the benefits suggested by these proposals outweighs the risks.

Equalities and health inequalities

We want to make sure we understand how different people will be affected by our proposals so that CHD services are appropriate and accessible to all and meet different people's needs. In our report, we have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

Question 10; Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

We would suggest a 'no' response to this:

Whilst NHSE have acknowledged some of the 'ethnic minority' issues for East Midlands patients, they appear able to ignore both urban and rural deprivation issues as this is not a statutory duty as it is not a 'protected group'. Despite this, there are very significant levels of both within the East Midlands which we believe have been ignored, not just for travel times but accessibility, family support and social care provision which EMCHC provides in great depth. Congenital Heart Disease is a life-long condition, and our patients have to visit hospital regularly throughout their lives; this is not a one off inconvenience. Whole families will be affected by the proposals.

UHL is the only Level 1 centre in the UK able to offer gender realignment surgery if requested to patients with CHD.

Other impacts;

We want to make sure that the proposed changes, if they are implemented, happen as smoothly as possible for patients and their families/carers so it is important that we understand other impacts of our proposals.

Question 11; Do you think our description of the other known impacts is accurate?

Question 12; Please describe any other impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

Transition Risk

There is a lack of consideration as to what will actually happen as soon as a surgeon or interventional cardiologist leaves during the 'transition period'. There is an assumption that this will be a gradual process but there is no evidence to support this and patients are likely to suddenly be left in a limbo situation with their cardiologists struggling to find them a bed in units with their own current capacity issues.

There is no formed description of how a level 2 centre can or will work across a number of surgical networks, patients in the East Midlands are likely to be referred to 4 other Level 1 centres if these proposals go ahead.

There is an assumption that the current outreach clinic provision will continue / be replicated in the new 'network' but there is no clear description of how this will be provided or indeed resourced. There is no financial incentive for the larger level 1 centres to provide this. The Independent Reconfiguration Panel, (IRP) themselves doubted the validity of the level 2 centre model and this has been ignored.

ECMO

No other centre provides mobile ECMO; all UK ECMO training is provided by EMCHC, and there has been little regard shown for the respiratory ECMO caseload. Caseload (numbers) features as the key 'safety standard' in the CHD review. In theory, all cardiac surgical centres have to be able to undertake ECMO as it may be required after cardiac surgery; in fact the majority of ECMO provided by EMCHC is provided for infants and children with catastrophic respiratory and cardiac failure not related to cardiac surgery. Most of these centres have little or indeed no expertise in this, which is why currently the EMCHC ECMO team travel the country (including to the current surgical centres) to place patients in this situation on ECMO and bring them back to Glenfield for optimal expert care.

NHS England has assumed that the current EMCHC ECMO work can easily and safely be dispersed across all the remaining surgical units and abolishes the mobile ECMO service. This therefore dilutes any residual expertise across the country whereas the proposal for cardiac surgery is to concentrate it! This is in direct contrast to NHS England's own quote from Mr Martin Kostolny highlighted on page 12 of the consultation document and again shows an inconsistency of approach which is not acceptable or fair.

In addition, no account has been taken of the impact of additional bed days and ICU stays for these patients either in one centre or many

Paediatric Intensive Care Unit, (PICU);

Since the Cardiac PICU at Glenfield is already planned to MOVE to the LRI in order to achieve compliance with the co-location standard, NHS England's dismissal of 'closure of the PICU at Glenfield' is both irrelevant and deliberately misleading. The unit at Glenfield is being moved to achieve co-location with the other UHL Children's Hospital services, as required by the CHD standards. It is not therefore being closed and to suggest otherwise is highly inappropriate. To be clear, the service provided by the PICU at Glenfield is only under threat as a direct result of NHS England's proposals.

Our concerns about PICU capacity across the UK (as evidenced by this winter's bed crisis, closure to admission within London etc.), remain entirely valid and have not been addressed by this review.

Since the timescales for the national PICU, specialised surgery and ECMO review do not line up with the CHD process, it is totally inappropriate for NHS England to prejudge the impact on PICU services or to expect patients and families to be reassured by these proposals and comment accordingly.

We remain very concerned about the ability of a retained non-cardiac PICU at the LRI to retain and recruit appropriately expert staff in the mid to longer term. Most other PICUs that do not have cardiac surgery do have some other highly specialised surgical programmes such as major trauma or neurosurgery to provide a background level of high expertise activity to maintain activity and focus between the periods of seasonal high intensity respiratory problems that are what cause the capacity issues year on year.

Reputation and workforce;

NHS England has dismissed our concerns on this on the basis of the effect on the entire trust not the Children's Hospital component. They have also ignored the loss of expertise to CHILDRENS SPECIALITIES as a whole. Not just in PICU but across the entire Children's Hospital. EMCHC has an excellent reputation for training both in paediatric cardiology and ECMO; there is no evidence of any credible plan to re-provide this elsewhere.

FETAL and maternal medicine and cardiology;

NHS England accept that this will be severely impacted but make no comment as to whether or not this matters. Loss of these services will mean that women have to travel much further, repeatedly, during pregnancy if they or their baby has CHD. Not only is this an unnecessary strain of itself but it is clear that this may alter their decision making about continuation of pregnancy or not.

Cost - It may not be about saving money – it may end up costing more money. Those centres potentially receiving additional patients will need to find funding to provide the infrastructure to meet the capacity. There is very limited capital investment available in the NHS currently, which will provide uncertainty and delay to capital development plans. If transition is not as smooth as NHS England hope, there is a real danger that the physical facilities will not be available in time to cope with increases in patient numbers at the remaining centres. We would challenge the capital requirements estimated to accommodate the additional capacity from EMCHC.

Any other comments

Question 13; Do you have any other comments about the proposals?

'Adequate' – Prof Huon Gray fears that without action the service will be left to be 'adequate'. This is implying that EMCHC and RBH are in some way currently 'only adequate' or indeed 'less than adequate' which is not the case. Even if it refers to the CHD speciality as a whole rather than these centres in particular, since the events in Bristol in 1991 and the subsequent reviews, the CHD speciality has actually been transformed and in fact should be seen as a major success story for the NHS. It is already far from merely 'adequate' National Mortality rates have gone from 14% to 2%

- UHL mortality rates have gone from 13% - 0.6%
- The number of CHD centres has gone from 17 to 10
- Occasional practice has gone from 190 cases to 5 case
- All existing UK Paediatric cardiac surgical centres are LARGE by international standards and UK cardiac surgical mortality is amongst the lowest in the world.

Crucial information needed to inform the consultation - The review into ECMO services is a crucial aspect of this consultation and it is inappropriate that the results of that review are not part of this consultation process. This was a recommendation from the previous Independent Review Panel following the Safe and Sustainable review.

FOCUS on surgical number - Caseload has featured as the key standard in the CHD review. NHS England assumptions are that the current ECMO caseload for ECMO delivered by EMCHC can easily and safely be dispersed across the remaining cardiac surgical centres, all of whom in theory can undertake ECMO as it may be required after cardiac surgery.

It is a huge assumption that the ECMO currently provided by EMCHC (over 50% of the UK requirements) will be able to be delivered by the units spread across the country. They are proposing

to dilute ECMO practice whilst using further concentration of cardiac surgical practice as a rationale for service reconfiguration.

This is in direct contrast to NHS England's own quote from Mr Martin Kostolony highlighted on page 12 of the consultation document and again shows an inconsistency of approach which is not acceptable or fair.

Specialist knowledge - The assumption that there will be appropriately trained clinical and nursing staff available to deliver this specialist care across all of the units is severely challenged by the fact that the majority of ECMO provided by EMCHC is provided for children with catastrophic respiratory and cardiac failure not related to cardiac surgery and in which other Level 1 centres have little or indeed no expertise (This is currently evidenced by the fact the EMCHC ECMO team travel the country including to the current surgical centres to place patients in this situation on ECMO and bring them back to Glenfield for optimal expert care) Replicating this expertise will be as difficult as expecting all centres to deliver transplant surgery – the key rationale for the derogation being applied to Newcastle.

This is an initial response to the consultation document and questions. UHL will be responding in detail to NHS England before the end of the consultation period



General Meeting

15th February 2017

Congenital Heart Disease Services Impact on East Midlands Congenital Heart Disease Centre

Summary

This report updates the General Meeting of East Midlands Council on the latest position regarding the NHS England's proposals for Congenital Heart Disease (CHD) Services, which impact on the East Midlands Congenital Heart Centre (EMCHC), formerly known as Glenfield Hospital. In July 2016, NHS England stated that it was minded to decommission CHD surgery from EMCHC, without any commitment to full public consultation. The continuation of CHD surgery and interventional cardiology at the EMCHC would make it a 'Level 1' centre. In October 2016, NHS England conceded that public consultation would be required and the consultation would take place from mid-December 2016.

After delaying the start of the consultation period from mid-December 2016, NHS England has now stated that it has received clearance from the Department of Health to run consultation through the local government purdah period.

In the meantime, University Hospitals of Leicester NHS Trust (UHL), which manages the EMCHC, has been continuing to work to achieve the standards set by NHS England as part of the commissioning process.

Recommendation

Members of East Midlands Councils are invited to:

- Confirm the support of East Midlands Councils for the continuation of Level 1 Congenital Heart Disease Services at the East Midlands Congenital Heart Centre, in particular supporting the work undertaken by University Hospitals of Leicester NHS Trust to meet the required service standards.
- Consider NHS England's statement that it may consult from early February 2017 onwards, which will continue during the local government purdah period.

1.0 Announcement by NHS England – 8 July 2016

- 1.1 On 8 July 2016, NHS England issued an announcement, which included the following statement:

*"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."*

- 1.2 On 15 July 2016, NHS England published *Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: report of the National Panel*, which is available at the following link: -

<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/07/chd-national-panel-report.pdf>

- 1.3 In effect NHS England signalled in July 2016 that it would be decommissioning Level 1 Congenital Heart Disease (CHD) services from the East Midlands Congenital Heart Centre (EMCHC), formerly known as Glenfield Hospital, which is part of University Hospitals of Leicester NHS Trust (UHL). Level 1 centres will provide the most highly specialised diagnostics and care including surgery and most interventional cardiology. As part of the network arrangements, they would be supported by Level 2 centres (specialist care, but no surgery or interventional cardiology); and Level 1 centres (accredited services in local general hospitals – initial diagnosis and monitoring).

2. Developments Since July 2016 – Consultation

- 2.1 The immediate concern in July 2016 was that NHS England would not be holding public consultation. This issue was raised immediately by local authority health overview and scrutiny committees. In October 2016, NHS England confirmed via a local authority briefing paper that there would be full public consultation beginning in mid-December 2016. However, on 23 November 16 a blog posted on the NHS England website indicated consultation would now begin early in 2017.
- 2.2 On 21 December 2016, the Health Scrutiny Committee for Lincolnshire sought, but did not receive clarification on the consultation dates from the representatives of NHS England who attended the Committee's meeting. In a written statement from NHS England on 17 January 2017, the Committee was advised that 'clearance had been provided by the Department of Health [to NHS England] to run consultation during purdah'. The Health Scrutiny Committee for Lincolnshire authorised the Chairman to raise this matter by letter with the Secretary of State for Health, which was sent on 24 January 2017. NHS England has indicated to the Leicester, Leicestershire and

Rutland Joint Health Scrutiny Committee that consultation might begin in early February.

- 2.3 The activities of the health overview and scrutiny committees in the region since July 2016 are summarised in Appendix A.

3.0 Standards for Congenital Heart Disease Services

- 3.1 On 23 July 2015, following consultation during 2014, the NHS England Board approved the Standards and Specifications for Congenital Heart Disease. There are approximately two hundred standards. From these, three are highlighted as most challenging (and also contentious):

- A minimum of 125 surgical procedures per surgeon averaged over three years;
- four surgeons at each Level 1 Centre; and
- the co-location of children's CHD services with other paediatric services.

4.0 Re-Submission of Self-Assessment Submission of information by UHL.

- 4.1 The report *Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: report of the National Panel* was based on the data submitted in March and April 2016. UHL submitted a revised self-assessment in November 2017, which is available at the following website, on which UHL has published all the correspondence between itself and NHS England:

<http://www.eastmidlandscongenitalheart.nhs.uk/our-campaign/>

5.0 Recommendation

Members of East Midlands Councils are invited to:

- 5.1 Confirm the support of East Midlands Councils for the continuation of Level 1 Congenital Heart Disease Services at the East Midlands Congenital Heart Centre, in particular supporting the work undertaken by University Hospitals of Leicester NHS Trust to meet the required service standards.
- 5.2 Consider NHS England's statement that it may consult from early February 2017 onwards, which will continue during the local government purdah period.

Simon Evans
Health Scrutiny Officer
Lincolnshire County Council

**ACTIVITIES BY OTHER HEALTH OVERVIEW AND SCRUTINY COMMITTEES
IN THE EAST MIDLANDS**

Derbyshire Health Scrutiny Committee

The Derbyshire Health Scrutiny Committee met 23 January 2017 was attended by Alison Poole and Simon Robinson from the EMCHC (Glenfield). NHS England has been invited to attend the next meeting of the Committee on 6 March and both a national and regional officer will be attending.

Having received the presentation from EMCHC, Derbyshire Health Scrutiny Committee is keen to support the retention of services at Glenfield, especially as its closure would leave the East Midlands as the only region without such a facility. At this stage the Committee is keen to exhort NHS England to allow and assist EMCHC to take steps to reach the "500 procedures" target, including encouraging more referrals from local consultants to the EMCHC as opposed to centres located further afield.

This will be put to NHS England when they attend the meeting on 6 March, following which there is an intention for a formal response to the proposals to be submitted to NHS England by the Derbyshire Health Scrutiny Committee.

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

The Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee has had one meeting which considered the pre-consultation engagement proposals at the end of September, with UHL in attendance and they outlined their concerns against the proposals. The Committee recorded their concerns on the proposals and urged NHS England to reconsider its plans to close the Glenfield Hospital Congenital Heart Unit.

There were a number of concerns raised such as the timetabling of the process, the impact on neonatal services on the region, the lack of consideration of travel time to Birmingham or other units in the country, lack of concerns raised previously about the unit, the lack of recognition as to how successful the Glenfield Unit has been performing (underlined by the current CQC report), the destabilising effect of these proposals on the hospital, the fact that alternative proposals offered by UHL had not been considered, there would be no specialist centre on the eastern side of the country between Newcastle and London and that factual inaccuracies in their assessment of Glenfield had been accepted but not been taken into consideration.

The Joint Committee then agreed that they would reconvene a meeting when the consultation goes live, which we have been informed by NHS England is likely to be the first couple of weeks in February, with a meeting planned in March should the consultation go live. The views of NHS England, UHL and involving interested parties including parents, carer groups, young people, and representatives of the wider public would be able to put forward their view to the committee.

Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire considered NHS England's July 2016 announcement statement on 20 July 2016 and sought clarification from NHS England on what its intentions were in relation to consultation. The Committee cited the relevant regulations and the fact that any decision to decommissioning CHD surgery and interventional cardiology from the East Midlands Congenital Heart Centre would constitute a substantial variation and development of health care provision in Lincolnshire. The correspondence with NHS England did not immediately elicit a commitment for public consultation.

Representatives of NHS England attended the Health Scrutiny Committee for Lincolnshire on 21 December 2016. The original purpose of their attendance would have been to present the consultation document, which had been expected to be published in mid-December. The representatives attended as part of a pre-consultation engagement exercise. They were challenged on their intentions and the assumptions used to decommission CHD surgery and interventional cardiology. They were also advised of the local government purdah period, affecting county councils from the end of March 2017. NHS England could not give a commitment to the consultation dates, other than referring to a consultation exercise in early 2017. They were invited to attend the next meeting of the Committee on 18 January, but declined and are due to attend on 15 March 2017.

Nottingham and Nottinghamshire Joint Health Scrutiny Committee

The Nottingham and Nottinghamshire Joint Health Scrutiny Committee is leading on the scrutiny of changes to congenital heart disease services for the Nottingham and Nottinghamshire area. In September 2016 the Joint Committee was informed of the NHS England announcement about the future of congenital heart disease services and gave initial consideration to the information available at that time about the implications for Nottingham and Nottinghamshire residents arising from proposed changes to services provided at Nottingham University Hospitals NHS Trust and the East Midlands Congenital Heart Disease Centre in Leicester. The Committee wanted further information about both the proposals and the consultation process, which was not available at that time. Since then the Committee has kept up to date with information that has been published and local developments, including information provided by University Hospitals Leicester at an informal meeting of health scrutiny chairs from the East Midlands in December. Representatives of NHS England are scheduled to come to the Committee's meeting on 14 March 2017 as part of the consultation process.

