APPENDIX C7

UNIVERSITY HOSPITALS OF LEICESTER REPORT ON OUTCOME OF SAFE AND SUSTAINABLE CHILDREN'S CONGENITAL HEART SERVICES REVIEW – NEXT STEPS

Dear Councillors,

As you are aware, we have, since the announcement by the Joint Committee of Primary Care Trusts, (JCPCT) on July 4th regarding the future configuration of children's heart services, sought both clinical and legal opinion on the merits of challenging the decision to transfer surgery from Leicester to Birmingham Children's Hospital.

The clinical and legal case will be presented at the Trust's next board meeting on the 30th of August. Before the meeting and before the papers for that meeting are made publically available we wanted to give you, our supporters a heads up.

Based on the clinical case, we think that there are sufficient doubts surrounding the decision to justify a review by the Independent Reconfiguration Panel. Based on the advice from our barrister we do not think that there is any realistic chance of there being a successful legal challenge.

Hence we will be pressing the clinical case. The key elements of which are set out below:

Predicted demand and capacity at Birmingham Childrens' Hospital:
The original national projections for demand for paediatric heart surgery used by the JCPCT suggested that demand was flat. The latest information shows that demand is increasing. This increase is before the 143 cases a year which are expected to shift from Northern Ireland to the mainland as a result of the Kennedy review into children's heart surgery in Belfast. (Published 1/8/12). There are also question marks against some of the suggested patient flows. The combined impact of these elements is a level of demand far in excess of that set out in the JCPCT report and thus beyond any capacity planned at BCH.
Birmingham is creating an extra 11 Intensive Care Unit beds, taking their capacity to 33. These extra beds were announced in March 2010 in response to the Healthcare Commission's concerns regarding the then high numbers of cancelled operations due to ICU capacity, i.e. no new ICU capacity is planned to accommodate the work transferring from Leicester.

ECMO and increased mortality:
ECMO practitioners in the UK and overseas have voiced their concerns over the transfer of the service to Birmingham. The ECMO expert who advised the panel has stated publicly that his views were overlooked. Our argument is not about whether ECMO can be transferred; of course it can in principle, we simply wish to set out that we expect that the clinical outcomes will suffer for a number of years as a result of the transfer. The mortality rate for ECMO in Leicester is 20%. The national mortality rate (i.e. that of the other nationally commissioned centres) is 50% higher. That gap

will close over time as each centre ascends the learning curve but the point is *that Leicester's low mortality will not transfer with the service.* To give an indication of real impact of this; if over the last 10 years Leicester's ECMO mortality had been at the national average, 62 more children would have died.

Paediatric intensive care capacity in the Midlands:
Capacity is already tight across the region. In 2010, 86 children came to Leicester from the West Midlands. The transfer of services to Birmingham will mean the closure of the Glenfield PICU. The Glenfield and Leicester Royal PICU are run by one team in two locations. The review team concluded that the closure of the Glenfield PICU would have' limited risk' on the Trust's other PICU, that is not the case. We expect that when demand exceeds supply, general PICU patients from Leicester will have to travel elsewhere; the nearest is Nottingham, which is often full and that the leaves BCH / Sheffield / Leeds. Also, given that Nottingham does not offer a retrieval service, the closure of Glenfield PICU would mean the end of the paediatric retrieval service for the East Midlands.

In summary our concerns are therefore that: Birmingham Childrens Hospital will not have the capacity to handle the expected demand; that ECMO mortality will increase during the transition which means lives will be lost not saved and that general paediatric intensive care capacity in the Midlands and especially the East Midlands will be insufficient to deal with demand.

In advance of the Board Meeting we will be talking to the Chair of the JCPCT and the Chief Executive of the Midlands Strategic Health Authority, Sir Neil McKay, and as such we will update the Board and our stakeholders on the next steps, (including the merits of a referral to the Secretary of State and the IRP) on the 30th.

In the meantime, thank you for your continued support and we will be back to you after the 30th

Yours sincerely,

Mark Wightman
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