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Supplementary Information

Item 7 refers

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (YORKSHIRE & THE HUMBER)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Tuesday, 24th July, 2012 at 10.30 am

MEMBERSHIP

Councillors

S Ali -
J Bromby -
D Brown -
J Clark -
P Elliott -
C Funnell -
M Gibbons -
R Goldthorpe -
B Hall -
J Illingworth (Chair) - Kirkstall;
T Revill -
B Rhodes -
M Rooney -
L Smaje -
J Worton -

Please note: Certain or all items on this agenda may be recorded.

Agenda compiled by:
Stuart Robinson
Governance Services
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LEEDS LS1 1UR
Tel: 24 74360

Principal Scrutiny Advisor:
Steven Courtney
Tel: 24 74707

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A G E N D A

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The Leeds Teaching Hospitals NHS
NHS Trust

Holding Statement from the Trust Board to JHOSC regarding the Safe and Sustainable review of Children's Heart Surgery Services, Tuesday 17th July 2012

The decision made by the Joint Committee of Primary Care Trusts (JCPCT) on Wednesday 4th July, to commission children's heart surgery from Newcastle rather than Leeds was deeply disappointing. This decision will affect our patients, now and in the future, their parents and our staff more than anyone else and they have already displayed their dismay at the process and the perplexing decision the Committee reached far more eloquently than we would be able to.

Like them, the Chairman of the Board of Leeds Teaching Hospital Trust has expressed our unease with this decision and the illogical nature of the outcome of the meeting 4th July. It also seems to fly in the face of patient choice and the very clear views of over 600,000 people in this region.

We are grateful that the whole community has come together to support our unit in such overwhelming numbers. It is clearly a very much loved service which we are proud to provide. We are following with interest the work of the Joint Health Overview and Scrutiny Committee for Yorkshire and the Humber (JOSC), the deliberations of the Children's Heart Surgery Fund and the region's Members of Parliament as they explore what they can do to challenge the outcome of the review, taking account of the expressed wishes of the patients.

In addition to the work described above the Board of Leeds Teaching Hospital Trust is now considering its options. We meet again at a Board meeting on 26th July 2012. We will advise the JHOSC immediately of any further action we propose to take. We will support others in following due process. In the meantime we will continue to provide safe and effective care for those patients referred to us. Unless or until we advise you otherwise our approach is to continue to provide high quality services as usual at this very popular and much loved unit.

The Leeds Teaching Hospitals NHS
NHS Trust

Ref: SH/SB
Date: 2012

From: Stacey Hunter
Divisional General Manager
Divisional Headquarters
1st Floor Old Nurses Home
Leeds General Infirmary
LEEDS LS1 3EX

Tel: 0113 39 22874

Dear

I am writing to update you on where things stand after the deeply disappointing decision on the outcome of the Safe and Sustainable review of children's heart surgery taken by the Joint Committee of Primary Care Trusts at their meeting in London on Wednesday 4 July.

The decision the Committee reached that day has already received widespread condemnation in this region, and I know that many families have been contacting staff at Leeds General Infirmary to express their shock and disbelief and to ask what happens next.

The most important thing to say, in terms of the care and support needed by your child, is that it remains "business as usual" for the team here in Leeds, including our children's cardiac surgeons. Any changes required as a consequence of this decision will need careful planning. The stated intention is for those changes to be in place by 2014 - so you will see that in the meantime we need to continue to do what we have always done to provide safe and effective care for our patients. We will be continuing to provide exactly the same levels of care as normal, so please attend appointments as usual and contact us through the network we have in place.

Clearly this decision has been a huge blow to staff on the unit and to our hospital as a whole, and it is not one we believe should go unchallenged. We are actively considering if there is a legitimate basis on which to challenge this decision. The Trust Chairman, Mike Collier, has already said publicly that the decision flies in the face of logic and needs looking at again.

Separately a huge amount of work is going on involving our partners and supporters right across Yorkshire, Northern Lincolnshire and North Derbyshire, all of whom are telling us they are determined to speak out against this decision.

MPs and Peers from all political parties have already started asking questions in Parliament and will be concentrating on persuading the Secretary of State for Health to review the conclusion reached by the Safe & Sustainable Team.

Councillors across the region have also been extremely interested in this outcome and are particularly concerned about how little weight has been given to issues such as population density and geography in this region. They have also said the decision goes against the clearly stated wishes of parents in Yorkshire and the surrounding area plus the 600,000 people who signed a petition in support of keeping our service in Leeds.

Councils have a statutory duty to scrutinise the National Health Service and can refer any decisions they disagree with back to the Secretary of State, particularly if they feel proper process has not been followed. There are strong indications this will happen in this case.

In addition, our dedicated charity, the Children's Heart Surgery Fund, which has done so much to raise the profile of the threat to Leeds during this national consultation, are taking legal advice about the possibility of a Judicial Review challenging the lawfulness of the process.

I know that many of you are already extremely involved in the campaign and have spoken to your MPs, councillors and the media to voice your concerns. We are incredibly grateful for your support which is especially powerful when you have real experience of the realities of coping with a child with a heart condition and all the worry that entails.

I hope this letter gives you some reassurance both about continuity of service and the potential options available to challenge this decision. We will continue to keep you informed as the situation develops.

In the meantime, if you have any specific concerns or questions about the impact on your child's condition, please contact the clinical nurse specialist you normally deal with, who will be happy to help.

Yours

Stacey Hunter

Stacey Hunter
Divisional General Manager
Women's, Children's, Head, Neck and Dental Division

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Safe and Sustainable
Paediatric Congenital Cardiac Services

NHS
Specialised Services

Cllr John Illingworth
Chair, Scrutiny Board
(Health and Wellbeing and Adult Social Care)
3rd Floor (East)
Civic Hall
Leeds LS1 1UR

2nd Floor Southside
105 Victoria Street
London
SW1E 6QT

Tel: 020 7932 3951

18 July 2012

Dear Cllr Illingworth

Please find below the response from the Joint Committee of Primary Care Trusts (JCPCT) to the consultation submission by the Yorkshire and Humber Joint Health Overview and Scrutiny Committee (JHOSC).

The response below represents the summary of the JCPCT's deliberations at its meeting in public on 4 July. I am conscious that the JHOSC has previously expressed concern that our response has not been submitted to you earlier, and I have explained that it would not have been appropriate do so before the JCPCT met on 4 July to formally consider the evidence submitted during consultation and to agree a final decision.

The option agreed by the JCPCT for implementation presents a rare opportunity to improve the quality of care for all children in England and Wales, including the children of Yorkshire and the Humber. The case for change has strong clinical support and I am heartened that on 6 July a number of Royal Colleges of medicine and professional associations welcomed the JCPCT's decision as one that would improve outcomes for the children of this country.

It is fully acknowledged by the JCPCT, and fully understandable that this is an emotional time for many parents and the NHS staff in the centres that will not provide surgery for children with congenital heart disease. The decision taken by the JCPCT was a difficult one. It is remarkable that it took as long as 12 years since the tragic events in Bristol.

The JHOSC has raised an issue of transparency of the review process. We have strived to be transparent throughout this process. All of the evidence on which we have relied has been published; the process that we have followed has been set out in considerable detail;

public events and workshops have been held across the country; and we have commissioned additional work from independent experts to test our own assumptions.

We also sought independent advice on how best to consult with various stakeholders; for example we sought advice from the Centre for Public Scrutiny before consultation started on how to best engage and consult with scrutiny committees. We also listened to advice given to us during consultation, for example, we extended the period of consultation to over seven months for HOSCs in response to representations put to us by Yorkshire and Humber JHOSC.

The process of consultation and for the development of options has already been scrutinised in depth by two courts and by the Independent Reconfiguration Panel. The final judgment was clear – the JCPCT had conducted a consultation that was proper, lawful and fair. It will be important for the NHS to continue this engagement with the NHS staff, patients and their families during implementation, to monitor the impacts of the reconfiguration and seek solutions together to any issues that may emerge.

There is a strong support for the review's principles, although not everyone who supports change is equally enthusiastic to see it happen locally. This is the right decision to ensure services are safe and sustainable for the future.

I look forward to meeting you and your colleagues on 24 July.

Yours sincerely

Sir Neil McKay C.B.

Chair of the Joint Committee of PCTs

1. **Recommendation 1:**

In order to meet the needs and growing demand of the 5.5 million people living in the Yorkshire and Humber region, the surgical congenital cardiac unit currently provided by Leeds Teaching Hospital NHS Trust must be retained and included in any future configuration of paediatric congenital cardiac surgical centres.

1.1 This recommendation touches upon issues of convenience and travel. But 'quality' has been paramount to this review. We were told during consultation that quality was considered to be the most important consideration by patients, parents and clinicians. Ipsos Mori reported that the JCPCT received many submissions that 'quality' should be the JCPCT's main consideration. Many respondents expressed support for Professor Kennedy's recommendation that

> *"mediocrity must not be our benchmark for the future*[1]"

1.2 The importance of high-quality care is also evident in respondents' views on one of the key principles underpinning the proposals that "all children in England and Wales who need heart surgery must receive the very highest standards of NHS care". Ipsos Mori reported that *"Almost all respondents answering the question agreed with the principle – 98% of personal respondents and 99% of organisations*[2]".

1.3 The analysis of the consultation responses concluded that:

> *"the quality of care provided was the most frequently mentioned issue for respondents discussing either specific hospitals or the options more generally. In fact, quality of care featured heavily throughout the consultation responses, at each of the questions posed in the response form and in the letters and emails that were submitted. There was a strong belief amongst many that quality should be the deciding factor in service planning*[3]".

1.4 The views submitted during consultation reflect those of stakeholders with whom we engaged in 2010 around the proposed criteria for the evaluation of potential options (including clinicians working in the Yorkshire and Humber cardiac

[1] Safe and Sustainable, *Review of children's congenital cardiac services in England – Report of the independent expert panel chaired by Professor Sir Ian Kennedy*, 2010

[2] Ipsos Mori, *Safe and Sustainable Review of Children's Congenital Heart Services in England – Report of the public consultation*, 2011, p. 23

[3] Ipsos Mori, *Safe and Sustainable Review of Children's Congenital Heart Services in England – Report of the public consultation*, 2011, p. 7

network and parents from Yorkshire and Humber who attended the engagement event in Leeds in 2010). The various groups agreed that 'quality' should be the most important consideration and that 'travel times' should be the least important consideration.

1.5 The clinical case for fewer surgical units is compelling and has garnered strong support from professional associations and national charities even though it is recognised that reconfiguration would result in longer travelling times for some children requiring surgery or interventional cardiology services.

1.6 The JCPCT has considered the issues put forward in Yorkshire and Humber, where respondents gave significant emphasis to issues around travel and population density.

1.7 The analysis set out in the Decision-Making Business Case has considered the impact of longer elective journey times for surgery. Under the current configuration of services 35% of families are over an hour away from their closest surgical centre; this would rise to 47% in option B. The evidence available to the JCPCT suggests that this equates to 92 more families in or around Yorkshire and Humber who would experience an increased journey time of over 1 hour in option B compared to option G, the next highest scored option[4].

1.8 The JCPCT therefore concluded that the significant quality potential offered by option B outweighs the relatively limited impact to elective travel times.

1.9 However, the impact to family life of increased travel times is clearly important to those individuals affected, particularly to those families whose children have multiple surgical procedures. The consultation process has highlighted particular concerns from parents in Yorkshire and Humber. The implementation plan will consider the extent to which potential mitigations suggested by respondents are achievable.

1.10 The JCPCT has sought to minimise inconvenience to families by proposals to develop non-interventional care locally so that children only have to travel to a surgical unit for a very small number of times over the course of their childhood. The

[4] See appendix R of the Decision Making Business Case for detail.

JCPCT has proposed that this will be achieved through the development of Children's Cardiology Centres and District Children's Cardiology Services.

1.11 The JCPCT's model of care therefore envisages that under option B children, including those in Yorkshire and Humber will have greater access to Children's Specialist Cardiac Nurses and Paediatricians with Expertise in Cardiology working across the local networks.

1.12 In summary, we did not agree that the determining factor for the designation of children's congenital cardiac surgical services should be population levels or population density. It was taken into consideration with all of the other evidence in the round, but the most important consideration was that of 'quality' and the ability of the centres to meet the *Safe and Sustainable* standards in the future. This approach has the support of the professional associations and the majority of respondents to consultation.

2. Recommendation 2:

Based on the matters outlined in this report we recommend the following 8-centre configuration model:

- **Leeds General Infirmary**
- **Alder Hey Children's Hospital, Liverpool**
- **Birmingham children's Hospital**
- **Bristol Royal Hospital for Children**
- **Freeman Hospital, Newcastle**
- **Southampton General Hospital**
- **2 centres in London**

2.1 For the purpose of consultation we had proposed that 8-site options would not be viable. However, the strengths of the option suggested by the JHOSC were considered by the JCPCT. In fact, in response to submissions put to us during consultation we tested all of the assumptions that we had previously relied upon for the purpose of identifying potential configuration options, which resulted in six new

options for consideration (including three new options that included Leeds Teaching Hospital and three 8-site options).

2.2 We concluded that the option proposed by the JHOSC is unviable. The reasons are set out in the Decision-Making Business Case on pages 78, 84-85 and in Appendix Y on pages 189-193. In summary, we concluded that the relatively small caseload in the North of England would not support the retention of three surgical units in the North given the requirement for each centre to perform at least 400 paediatric cardiac surgical procedures each year.

3. Recommendation 3

Given the significant benefits to the patient and their families of genuinely co-locating relevant services, we believe genuine co-location should receive greater recognition and weighting when determining future service provision.

3.1 The *Safe and Sustainable* standards are based on the definition of co-location in the *Framework of Critical Interdependencies, ('the Framework'*), drafted by a team of clinical experts and supported by the relevant Royal Colleges and professional associations. The Specialist Surgical Centres have to be co-located with four specialised children's services defined by the Framework:

- ENT (airways)
- Paediatric surgery
- Paediatric critical care
- Paediatric anaesthesia

3.2 Leeds Teaching Hospital NHS Trust has all of these services co-located on the same site with paediatric cardiac surgery. Newcastle upon Tyne Hospitals NHS Foundation Trust has three of these services co-located at the Freeman Hospital with paediatric cardiac surgery; paediatric surgeons (non-cardiac) are based at the Great North Children's Hospital, less than ten minutes from the Freeman Hospital, and are transported to the Freeman Hospital when needed by the cardiac team.

3.3 During consultation, a number of respondents including the British Congenital Cardiac Association disagreed with the JCPCT's approach to the requirement for the co-location of services. We have set this evidence out in

some detail on pages 39 to 42 of the Decision-Making Business Case. The JCPCT's reading of the *Framework* was that the document did not stipulate an absolute requirement for the co-location of services on the same site. That the *Framework* demands a subjective approach in interpretation was acknowledged during consultation by Professor Edward Baker, the chair of the working group that developed the *Framework*.

3.4 The co-location of core paediatric services was an important consideration for the JCPCT. During the assessment process, surgical units were allowed to demonstrate the extent to which they met the 'gold standard' of co-location of all services on one site. This was then reflected in the score awarded by the Professor Kennedy's panel. In this regard, Leeds Teaching Hospital received a high score by Kennedy panel.

3.5 We listened carefully to the many voices from Yorkshire and the Humber who suggested that the review had given insufficient weighting to the issue of 'co-location'. We asked Professor Kennedy's panel to consider the evidence put to us during consultation and to re-consider its advice in this regard. The panel advised us that it was content that its application of the definition of 'co-location' was correct and it re-iterated that the Freeman Hospital / Great North Children's Hospital meet the requirements for the co-location of services. Before we accepted this advice on 4 July Dr Sheila Shribman CBE, National Clinical Director for Children, Young People and Maternity (and Department of Health sponsor of the *Framework*) confirmed with the JCPCT that she was content with this approach.

3.6 We also tested our own process by re-calculating the Kennedy panel scores for each centre by giving greater weighting to the requirement for co-location (see Appendix V of the Decision-Making Business Case). This test assumed that the requirement for co-location of services should be the most heavily weighted criterion. As Leeds Teaching Hospital received a high score against this criterion by the Kennedy panel, we were interested to see what impact this would have on the overall weighted scores awarded by the panel. In the event, there was only limited movement in the scores and Leeds Teaching Hospital remained at a lower score to the Freeman Hospital. This is because the less optimal elements of the service in Leeds, as reported by the Kennedy panel, were sufficiently significant that even a greater emphasis to the requirement of

co-location did not place Leeds Teaching Hospital higher than the Freeman Hospital.

3.7 The importance of a bond between a mother and a new born child, as described in your submission by Dr Sara Matley is recognised in the future model of care. The standards specify that services within the congenital heart network would plan and deliver services in close collaboration with each other and with the parents (see standards B3, B8, B9, and B10).

4. Recommendation 4:

Given the element of the review is to ensure more care is delivered closer to home, population density should be a key consideration in the configuration of future provision.

4.1 As I have set out earlier, the quality of services was the most important consideration for the JCPCT rather than population levels (or population density) or convenience and travel. Our analysis of population growth is set out in Appendix Y of the Decision-Making Business Case; over the next 15 years the growth in the number of children with congenital heart disease will be relatively small in terms of absolute numbers, including those from South Asian communities.

4.2 However, we have acknowledged that travel times are an issue for individual families and have proposed ways of reducing unnecessary long journeys for non-interventional care. Most children have surgery only once and the follow up appointments represent the majority of their care. At present, these usually take place in surgical centres, which means that patients and their families travel unnecessarily to the centres which are often far from where they live. This is disruptive on family life.

4.3 The JCPCT's decision means that this unnecessary travel should no longer be the case due to our decision to expand and develop specialist paediatric cardiac care locally. This includes the decision to expand the numbers of Consultant Paediatricians with Expertise in Cardiology and Children's Specialist Cardiac Nurses.

4.4 We have also tested in some detail the potential impacts to vulnerable groups and we have investigated how the NHS would discharge its

responsibilities under the public sector equality duty in regard to the implementation of our decision. The summary findings of the Health Impact Assessment are set out in detail on pages 79-84 of the Decision-Making Business Case and the full Health Impact Assessment report has been published on our website. As you know, the process for developing the Health Impact Assessment was extensive involving eleven public workshops across the country (including four in your region: in Bradford and Kirklees and two in Leeds).

4.5 Overall, the HIA concludes that the differences between the options are "fairly marginal". In terms of the impacts on vulnerable groups, it reports that:

> *"vulnerable groups are expected to benefit disproportionately from the positive impacts of improved health outcomes and care delivered closer to home".*

5. Recommendation 5:

Adult cardiac services and the overall number of congenital cardiac surgical procedures carried out should be considered within the scope of this review and used to help determine the future configuration of surgical centres. As a minimum there should be a moratorium on any decision to designate children's cardiac surgical centres until the review of the adult congenital cardiac services is completed and the two can be considered together.

5.1 The Decision Making Business Case addresses the relationship between *Safe and Sustainable* and the separate review of adult congenital cardiac services on pages 45 – 47 and 48 - 51.

5.2 In summary, the JCPCT does not have the legal authority to incorporate adult services within its remit. The powers of decision making delegated to the JCPCT by the Board of each PCT in England are confined to services for children with congenital heart disease.

5.3 The JCPCT was advised on 4 July that it could delay a decision on the review of paediatric congenital services until a decision could be made jointly with the separate review of adult congenital services. This would have meant a delay until 2014. In view of the calls upon the JCPCT to *"urgently"* conclude *Safe and Sustainable* in the interests of children, including from the British Congenital Cardiac Association, the JCPCT concluded that this would not be appropriate.

5.4 Neither did we agree that the threshold of ’400 surgical procedures’ in each centre should be measured with reference to both paediatric and adult congenital surgical procedures. The need for each surgical centre to perform at least 400 paediatric surgical procedures (and ideally a minimum of 500 paediatric surgical procedures) has been the bedrock of the *Safe and Sustainable* review in the interests of securing a sustainable service and good quality outcomes, and we did not agree that this standard should be relaxed. There was very strong support for this position amongst respondents to consultation.

The JHOSC has also raised a number of additional issues in its response. These issues have been previously addressed in correspondence between the JHOSC and the *Safe and Sustainable* secretariat and the JCPCT, and also via the Secretary of State for Health’s response to the referral by Yorkshire and Humber JHOSC.

6. **The views of people from Yorkshire and the Humber**

6.1 I would be disappointed if the view prevailed that the views of respondents in Yorkshire and Humber had been ignored by the JCPCT. They were most certainly considered, and they influenced our process and our deliberations. The Decision Making Business Case outlines in considerable detail how these responses were taken into account and how they have shaped the final decision. The Decision Making Business Case has dealt explicitly with comments and suggestions made by the JHOSC and it specifically refers to the significant support for the retention of surgery at Leeds Teaching Hospital.

6.2 However, it is necessary to bear in mind that as invaluable as these views have been, the JCPCT has consistently advised the respondents that the consultation is not a vote. The Court of Appeal said of the *Safe and Sustainable* consultation that:

> *“True consultation is not a matter of simply “counting heads”: it is not a matter of how many people object to proposals but how soundly based their objections are”*

6.3 The views of the people of Yorkshire and the Humber have influenced the process and the outcome of the JCPCT’s deliberations in a number of ways:

a. For the purpose of consultation we offered one option that proposed the retention of surgery at Leeds Teaching Hospital NHS Trust. In response to the view put to us during consultation we re-tested our assumptions in this regard and identified three new options that proposed the retention of surgery in Leeds. These options were considered in detail by us. Option G, which proposed the retention of surgery in Leeds, was scored highly by the JCPCT against the agreed criteria for the evaluation of options.

b. In view of the relative strength of Option G, the Decision Making Business Case provides a detailed analysis of the potential merits of Option G compared to Option B (section 12).

c. In direct response to views submitted by people in Yorkshire and Humber around the JCPCT's application of the co-location requirements, we re-tested the significance that we had attached to the issue of co-location and we asked Professor Kennedy's panel to consider the consultation submissions and advise us on the extent to which those submissions changed the panel's advice.

d. We also considered very carefully the potential impact to emergency retrieval times in response to concerns put to us from respondents in Yorkshire and Humber (pages 89 – 92) and we carefully considered evidence from a number of expert sources. We agreed to accept the professional advice that the proposals "*do not present increased risk to the child provided the options comply with the maximum journey time thresholds as set out in the Paediatric Intensive Care Society standards for the care of critically ill children*". We specifically considered evidence submitted by *Embrace*, the dedicated paediatric retrieval team based in Barnsley, and we were reassured by *Embrace*'s assessment of its continued ability to undertake emergency safe and timely retrievals of cardiac children in Yorkshire and Humber were paediatric cardiac surgery to cease at Leeds Teaching Hospitals NHS Trust.

e. In response to concerns put to us about assumed patient flows in the North we commissioned an independent third party, (PWC) to test these assumptions. This involved interviews with NHS staff, parents and the public in your region in:

Bradford
Doncaster
Huddersfield
Hull
Halifax
Leeds
Sheffield
Wakefield

f. A key issue for JCPCT members was to consider the extent to which the Newcastle network envisaged by option B can be considered viable in view of some respondents in Yorkshire and Humber expressing alternative preferences for centres in Liverpool, Birmingham and London. The Decision-Making Business Case acknowledges that the viability of the Newcastle centre in option B partly depends upon patient flows from Yorkshire and the Humber, including from the Doncaster, Sheffield, Hull, Wakefield and Leeds postcodes. The Decision-Making Business Case sets out the advice that we received from PwC and how this was applied to our deliberations. The document also sets out how we tested the impact of the exercise of patient choice to the viability of the Newcastle centre (and we concluded that the Newcastle centre would remain viable even if a significant number of people in Yorkshire and Humber exercised their right to be seen at other centres in Liverpool, Birmingham or London).

Review process, governance and transparency

7. Governance

7.1 The 2003 Direction from the Secretary of State requires scrutiny committees to convene a joint HOSC when two or more HOSCs consider proposals affecting a population larger than a single HOSC to be 'substantial'. However, despite this statutory requirement, a single, national JHOSC was not formed. Instead, the JCPCT was obliged to consult with hundreds of HOSCs across the country.

7.2 I have explained before that the invitations to the meetings of the Yorkshire and Humber JHOSC on 2 September 2011 and 19 September 2011 were issued to me with 6 working days notice. Regrettably, I was unable to attend at such short notice. I explored the availability of other JCPCT members to attend; however, this was not possible due to the short notice. A meeting on 22 September was attended by Ailsa Claire, the JCPCT member at the time, and Andy Buck, the designated member of the JCPCT, as well as Cathy Edwards, the Yorkshire and the Humber SCG Director.

7.3 The JCPCT comprises the 10 Specialised Commissioning Groups in England. The Directors of the 10 Specialised Commissioning Groups agreed in 2010 that for the purpose the consultation, in the absence of a national JHOSC, the local SCGs would lead on engagement with HOSCs as it would be impractical for the JCPCT members, including the Chairman, to attend all OSC meetings across the country. You will be aware that the Yorkshire and the Humber SCG representatives have consistently attended the JHOSC meeting and their attendance is acknowledged in the JHOSC's response.

8. Our approach to consultation

8.1 I am of course pleased that the Independent Reconfiguration Panel advised the Secretary of State for Health that our approach to consultation was reasonable and proper. This was a huge public consultation which presented obvious challenges. But we strived to reach the largest possible audience. We publicised the review through a number of channels with the aim of reaching the widest possible audience. The main message encouraged people to take part as "your views count".

8.2 The Decision Making Business Case summarises our approach, which I set out below for convenience:

- The consultation was publicised by advertisements in a number of Black and Minority Ethnic newspapers. The consultation was also publicised on the *Safe and Sustainable* website and of those of third parties within the NHS and the voluntary sector. A seven-minute video that explained the background to the review, including real-life stories, and which encouraged people to take part was professionally produced and was placed on the *Safe and Sustainable* website.

- Communications briefings were issued to local authorities, MPs, Health Overview and Scrutiny Committees, LINks and London Assembly members. Copies of the consultation document, together with response forms that were developed with input from Ipsos Mori were available from the *Safe and Sustainable* website, and were posted in large bundles to NHS Trusts, national and local parent groups, professional associations and SCGs. Respondents were also told that other forms of submission such as letters and emails were acceptable. Respondents were told in the consultation document that it could be translated into other languages upon request. Requests for different languages were acted upon as soon as they were received. In the event documents and response forms were translated into the following languages with 6 weeks of the consultation remaining: Arabic, Urdu, Farsi, Gujarati, Punjabi, Cantonese, Polish, Somali, Hindi and Bengali. Ipsos Mori reported that 20% of respondents to consultation were from Black and Minority Ethnic backgrounds, which is higher than the total percentage of BAME people in England.

- A facility for consultees to "text" responses by mobile phone was introduced by Ipsos Mori. This was aimed primarily at children and young people. Over 2000 people attended 16 consultation events in England and Wales:

  - Birmingham – 4 April 2011
  - Cardiff – 5 April 2011
  - Newcastle – 7 April 2011
  - Oxford – 4 May 2011
  - London – 7 May 2011, 11am–1pm
  - London – 7 May 2011, 2pm–4pm
  - Warrington – 9 May 2011
  - Leeds – 10 May 2011, 3pm–5pm
  - Leeds – 10 May 2011, 6pm–8pm
  - Gatwick – 19 May 2011
  - Cambridge – 23 May 2011
  - Southampton – 24 May 2011, 3pm–5pm
  - Southampton – 24 May 2011, 6pm–8pm
  - Taunton – 7 June 2011

- Leicester – 16 June 2011, 3pm–5pm
- Leicester – 16 June 2011, 6pm–8pm

- Clinicians from the *Safe and Sustainable* Steering Group were present at the events to answer questions put by the audience. Professor Sir Roger Boyle CBE, former National Director of Heart Disease and Stroke, was present at most events to give the background to the review and to explain the 'need for change'.

- The events were facilitated by an experienced, independent facilitator. In some locations an additional event was held on the same day in response to demand. A free crèche facility was available to facilitate access for parents. Interpreters were made available.

- Birmingham – 9 March 2011
- London – 19 March 2011
- York – 14 May 2011

- In an attempt to obtain even more qualitative information Ipsos Mori was asked to run focus groups targeted at specific groups: The aim was to conduct qualitative research to explore the issues raised throughout the consultation in depth. Parents of children with congenital heart disease and young people who currently use children's congenital heart services were asked about their views on the proposals. They were identified by the centres hospitals and parent groups.

- Ipsos MORI also conducted qualitative research with the general public from Black and Minority Ethnic groups, focusing on parents from a South Asian origin given the available research evidence that suggests that there is a higher relative incidence of congenital heart disease for some conditions amongst South Asian populations. Participants in the BAME groups were of Bangladeshi or Pakistani origin and from a range of socio-economic backgrounds.

- Focus groups with parents of children with congenital heart disease

- London – 17 May 2011
- Leeds – 31 May 2011
- Leicester – 1 June 2011
- Newcastle – 7 June 2011
- Oxford – 8 June 2011
- Southampton – 14 June
- Taunton – 15 June 2011
- Manchester – 21 June 2011
- London – 21 June 2011
- Birmingham – 22 June 2011
- Cardiff family interviews – 29th June 2011

- Focus groups with children with congenital heart disease

- Leicester – 1 June 2011
- Southampton – 14 June 2011

- Focus groups with people from BAME groups

- Oxford – 8 June 2011
- Southampton – 14 June 2011
- Manchester – 21 June 2011
- London–- 22 June 2011
- London – 22 June 2011
- Birmingham – 22 June 2011
- Leicester – 28 June 2011
- Leeds – 28 June 2011
- Cardiff – 29 June 2011
- Newcastle – 29 June 2011
- Cambridge – 30 June 2011

- In addition interviews were offered either on the phone or in the home with people who could not attend the groups.

9. The impact on children, family and friends

9.1 The impact on family life was an important consideration for the JCPCT and the JCPCT members were very conscious of how emotive and difficult it is for the families of children with congenital heart disease.

9.2 The JCPCT members understood that very long journey time impacts will be experienced by a small number of patients and their families, and that for these families this would be felt as significant. At the same time, the JCPCT recognised that these impacts are not specific to the patients of the Yorkshire and Humber. When the impacts on families were explored, for example by the independent expert third party, they have concluded that the differences between the options are marginal. Therefore, its does not appear that patients from a particular region would be disproportionately disadvantaged.

9.3 The well-being of children and their families was an important part of the JCPCT's deliberations. A substantive impact assessment was undertaken by an independent third party, Mott MacDonald, to explore these impacts. The research was considerable in scope and length – it took place between October 2010 and June 2012, including targeted workshops with affected families in England and Wales, as well as interviews with those who are considered to be most vulnerable. The findings were considered by the JCPCT on 4 July and can be found at appendices X1 and X2.

9.4 The JCPCT recognised there would be potential negative and positive impacts on patients and their families. It has also recognised that these negative impacts can be significantly mitigated or completely removed, and the positive ones should be enhanced. The Decision-Making Business Case sets out many measures that can help patients and their families who will be, to differing degrees, affected by the changes. Some of these measures are included on pages 77 and 217. Many measures were also suggested in the independent Health Impact Assessment and by PCTs as part of their compliance with the Equality Act 2010. The JCPCT have discussed these issues at their meeting in depth and committed to monitor the impacts and efficiency of the measures designed to deal with them during implementation.

9.5 The new model of care will address many concerns that patients had about the impacts. The agreed quality standards already include many measures that will help patients and their families.

9.6 Clinical and support facilities would be designed around the need of children and their families. Communication with families and children will be improved through provision of Children's Specialist Nurses and a Clinical Psychologist during decision-making processes to explain the diagnosis/treatment to help ease stress and provide a good family experience.

9.7 More care will be brought closer to patients' homes. At present, many patients from Yorkshire and the Humber have to travel to Leeds for these appointments, with consequences to the families' well-being. Instead, Consultant Paediatricians with Expertise in Cardiology will be based at most large hospitals. Children will be able to have echocardiograms in their local hospitals. Babies and children with suspected congenital heart disease may be referred to their local hospital for diagnosis and treatment.

9.8 The new congenital heart networks will result in better "joined up" care across the various NHS services that see children with congenital heart disease. Children will only need to travel for surgery and interventional care, which for most of them takes place once in their lifetimes. It is only this element of their care that will take place in the seven Specialist Surgical Centres.

9.9 However, these centres will also provide the non-interventional care for children who live nearby or wish to receive this care there. All this means that the non-interventional services will be significantly extended - they will be provided in more hospitals than in present.

9.10 Finally, as accommodation was a concern often raised by respondents in your area, it is important to bear in mind that the standards also include the provision of accommodation. The standards F1-F15 address specifically the family experience.

10. Nationally Commissioned Services

10.1 In your report you set out a number of concerns about the JCPCT's approach to the future location of the three nationally commissioned services (paediatric cardiothoracic transplantation, extra-corporeal membrane oxygenation

(ECMO) service for children with severe respiratory failure and complex tracheal surgery).

10.2 I want to emphasise that all centres were treated equally in this process. All centres were given the same information and asked to submit their applications by the same deadline.

10.3 Our approach to this issue was tested during consultation with a number of expert respondents and a detailed analysis is provided on pages 94 - 101 of the Decision-Making Business Case. For example, we sought advice on the possible re-location of paediatric cardiothoracic transplant service with the Cardiothoracic Transplant Advisory Group who advised us that Leeds Teaching Hospital could not be considered a viable provider of paediatric transplant services in the absence of an adult cardiothoracic transplant service in the same city (the nearest adult cardiothoracic transplant service to Leeds is in Manchester). Similarly the Advisory Group for National Specialised Services (comprising Royal Colleges of medicine and professional associations) advised us on the significant risks of moving paediatric cardiothoracic transplant services from the Freeman Hospital given its excellent outcomes and particular expertise in this field (including in the insertion of ventricular assist devices as a 'bridge' to transplantation).

10.4 However, that is not to say that this issue determined the JCPCT's decision. It did not. The strength of Option B – compared to Option G - was apparent based on a consideration of all of the evidence. Even if Leeds Teaching Hospital had been found to be a viable provider of transplant and ECMO services – and if the 'score' for each option had been adjusted accordingly - Option B would remain higher scored than option G based on a consideration of all of the evidence against all of the agreed criteria for the evaluation of options.

11. Yorkhill Hospital, Glasgow

11.1 A number of respondents from Yorkshire and Humber proposed that the paediatric congenital cardiac service in Glasgow be included in the scope of the *Safe and Sustainable* review. The service at Yorkhill Hospital is subject to the devolved administration in Scotland and, as such, the JCPCT has no authority over this service.

Decisions of the Meeting of Council held on Tuesday 10 July 2012

These decisions are published for information in advance of the publication of the Minutes

DECISIONS:

1. **PETITIONS**

Ingleby Place, Bradford

As the petitioners were not present in accordance with the Constitution's Rules of Procedure, paragraph 11.5 of Part 3A, the petition was not received.

Khidmat Centres

Resolved –

That the petition be referred to the Executive for consideration.

Holden Park, Oakworth

Resolved –

That the petition be referred to the Keighley Area Committee for consideration.

Neville Grange Resource Centre

That the petition be referred to the Executive for consideration.

Royal Mail Collection Offices

That the petition be referred to the Corporate Overview and Scrutiny Committee for consideration.

ACTION: ***City Solicitor***

2. **MEMBERSHIP OF COMMITTEES**

Resolved –

(1) That Councillor Ikram replace Councillor Malcolm Slater on the Corporate Governance and Audit Committee and Councillor Malcolm Slater be an alternate.

(2) That Councillor Warburton replace Councillor Robinson on the Bradford South Area Committee.

(3) That Councillor Wainwright replace Councillor Malik and Councillor Poulsen replace Councillor Martin Smith on the Children's Services Overview and Scrutiny Committee and be appointed Deputy Chair.

(4) That Councillor Martin Smith replace Councillor Hawkesworth on the Corporate Overview and Scrutiny Committee.

(5) That on the Environment and Waste Management Overview and Scrutiny Committee Councillor Robinson be appointed to the vacancy on the Committee; Councillor Azam replace Councillor Ferriby and Councillor Ferriby replace Councillor Robinson as an alternate.

(6) That on the Health Overview and Scrutiny Committee Councillor Ikram replace Councillor Wainwright; Councillor Swallow replace Councillor Akthar; and Councillor Akthar replace Councillor Robinson as an alternate.

(7) That on the Social Care Overview and Scrutiny Committee Councillor Azam replace Councillor Jabar; Councillor Swallow be deleted from the membership and Councillor Robinson be deleted as an alternate.

(8) That Councillor Hawkesworth replace Councillor Shaw on the Regulatory and Appeals Committee.

(9) That the appointment of the following non-voting co-opted representatives to the Children's Services Overview and Scrutiny Committee for the 2012/13 Municipal Year be confirmed:

Health Representative: Kathy O'Connell
Teachers' Secondary Schools Representative – Stuart Davies
Teachers' Primary Schools Representative – Stephen Pickles
Teachers' Special School Representative – Irene Docherty
Voluntary Sector Representatives: Janet Jewitt and Freda Dyson.

(10) That the appointment of the following non-voting co-opted representatives to the Corporate Overview and Scrutiny Committee for the 2012/13 Municipal Year be confirmed:

Fiona Stephens - Airedale, Bradford and Leeds NHS
Julie Lintern - Keighley & Ilkley Voluntary and Community Action (KIVCA)

(11) That the appointment of the following non-voting co-opted representatives to the Environment and Waste Management Overview and Scrutiny Committee for the 2012/13 Municipal Year be confirmed:

Emma Hill – Bradford Environmental Action Trust
Julia Pearson – Bradford Environmental Action Trust
Jacqui Toothill – Environment Agency

(12) That the appointment of the following non-voting co-opted representatives to the Health Overview and Scrutiny Committee for the 2012/13 Municipal Year be confirmed:

Julie Lintern - Keighley & Ilkley Voluntary and Community Action (KIVCA)
Mike Young – Retired (former Statutory Mental Health Services Manager)

(13) That the appointment of the following non-voting co-opted representatives to the Social Care Overview and Scrutiny Committee for the 2012/13 Municipal Year be confirmed:

Shaun Morris Armitage – Strategic Disability Partnership
Tim Pickles – Strategic Disability Partnership
Isobel Scarborough – Bradford & District Older People's Alliance.

ACTION: City Solicitor

3. **RECOMMENDATIONS FROM COMMITTEES – CORPORATE GOVERNANCE AND AUDIT COMMITTEE – ANNUAL REVIEW OF FINANCIAL REGULATIONS**

Resolved –

(1) That the proposed amendments to the Constitution listed at Appendix 1 attached to Corporate Governance and Audit Committee Document "A" be adopted and implemented, subject to the addition of "for the purposes of paragraph 17.3.2" to paragraph 1.3.

(2) That the City Solicitor ensures the agreed amendments are implemented.

(3) That the City Solicitor be granted delegated authority to make consequential amendments to the Constitution as a result of the recommendations approved by Full Council.

ACTION: City Solicitor

4. **RECOMMENDATIONS FROM COMMITTEES – CORPORATE GOVERNANCE AND AUDIT COMMITTEE – ESTABLISHMENT OF A NEW STANDARDS REGIME**

Resolved –

(1) A Chair of Standards Committee be appointed from the elected members on the Committee and Councillor Ruding replace Councillor Thirkill on the Standards Committee and be appointed Chair.

(2) The Parish Council Liaison Committee be asked to nominate 2 Parish Councillors to be co-opted non-voting members of the Standards Committee.

(3) One of the existing Independent Members of the Standards Committee be appointed as the Independent Person.

(4) The Independent Person be appointed as a co-opted non-voting member of the Standards Committee.

(5) The new Code of Conduct as set out in Appendix A to this report be adopted.

(6) The Procedure for considering complaints alleging failure to comply with the Code of Conduct as set out in Appendix B to the report be adopted subject to the addition of "and/or their representative" to paragraph 24 b.

(7) The City Solicitor be given delegated authority in consultation with the Leader of Council to make such amendments to the Constitution as are necessary to implement the decisions of Council.

ACTION: City Solicitor

5. **CHILDREN'S CARDIAC SURGERY**

Resolved –

This Council condemns the decision of the Joint Committee of Primary Care Trusts to cease performing children's heart surgery at Leeds General Infirmary.

The Council notes that:

1) The decision means that there will no longer be specialist surgery anywhere within the Yorkshire and Humber Region and children and families from Bradford will face increased journey times to alternative provision which may put lives at risk .

2) 13.7 million people live within a two hour drive time of Leeds.

3) The birth rate in Yorkshire and Humber over the last 5 years and projected forward to 2015 is double the national average. Bradford's birth rate is the highest in the region.

4) Bradford has one of the highest rates of infant mortality in the country.

This Council further notes:

5) That there is a great deal of concern surrounding the decision-making process

6) That there is now to be a review of services to Adults with Congenital Heart Disease will take place during the Summer/Autumn 2013 and that in Leeds surgeons treat both children and adults on the same site providing continuity of care.

This Council believes:

7) The decision is short-sighted, flawed and will have a hugely negative impact on

families and children in the Bradford District and throughout the Yorkshire and Humber region who will face severe logistical difficulties and disruption at a time of massive worry about the health of their child and is not in their best interests.

8) The decision to cease the provision for children in isolation without considering the impact on the provision of services for people with Congenital Heart Disease is not in the best interests of people from across the region.

This Council resolves to:

9) Request that the Joint Health Overview and Scrutiny Committee for Yorkshire and the Humber considers if the decision of 4th July has been taken in the best interests of the health service users across the region.

10) That the Health Overview and Scrutiny Committee is requested to provide whatever support is required to the regional Committee to ensure that the best case possible is provided to support the retention of children's heart surgery in Leeds.

11) The Council writes to Andrew Lansley MP, the Secretary of State for Health, on a cross Party basis, urging him to review the decision and urging him to visit West Yorkshire to meet with families, Heart Unit staff and political representatives with a view to ensuring that children's heart surgery continues to be provided in Leeds and to our Members of Parliament informing them of our decision and requesting their support.

ACTION: Chief Executive/City Solicitor

6. **LOCAL DEVELOPMENT FRAMEWORK**

Resolved -

The Local Development Framework is critical to meeting the future needs of the Bradford District. The LDF needs to be based on the most accurate and valid data available. This Council, therefore, instructs the Chief Executive to obtain external confirmation as to the accuracy and applicability of data used to inform the LDF both demographic and economic and that the report should be taken to the Executive at the appropriate stage of the LDF process.

ACTION: Strategic Director Regeneration and Culture

7. **LDF AND STANDING ORDERS**

Resolved –

This Council notes:

1) Its widespread public consultation on the LDF Core Strategy which has resulted in numerous representations from members of the public and organisations such as Parish, Town and Community Councils, Civic Societies and campaign groups.

2) Under the Government's National Planning Policy Framework any delays to the Council adopting an up to date plan will increase the threat of development on

currently protected land including green field and green belt sites.

3) That organisations such as Parish, Town and Community Councils, Civic Societies and campaign groups will have the opportunity to make further representations to the Publication Draft Core Strategy before submission to Government and consideration by a Planning Inspector.

4) The Regeneration and Economy scrutiny committee already have put the scrutiny of the core strategy in their work programme at the behest of the portfolio holder

Council asks that:

1. The City Solicitor in consultation with the Strategic Director, Regeneration and the Portfolio Holder for Change , Housing, Planning and Transport draws up proposals for a process to enable a wider consideration of amendments to the LDF Core Strategy by members within the current timescales for adoption of the plan.

2. Group Leaders liaise to agree a process for discussion, debate and decision by Council.

ACTION: City Solicitor/Strategic Director Regeneration and Culture

8. NOMINATION OF THE LORD MAYOR BY POLITICAL GROUPS

Resolved-

Bradford Council resolves to instruct the City Solicitor to amend the present protocol on the rotation of nomination of Councillors to be Lord Mayor which presently only recognises the Labour, Conservative and Liberal Democrat groups.

The new protocol must recognise all Political Groups on Bradford Council. Nominations for Lord Mayor should be in proportion to the number of Councillors in each group.

ACTION: City Solicitor

9. YOUTH UNEMPLOYMENT

Resolved-

This Council notes:

1) The high levels of unemployment, and in particular, youth unemployment, in the Bradford district.

2) The adverse impact of redundancies being felt across the District by the people of Bradford as a result of economic circumstances beyond their control, and beyond the control of this Council.

3) That potential redundancies at Thomas Cook, may contribute to rising unemployment in the city.

4) The scale and speed of the Coalition Government's spending cuts which have forced the Council to reduce spending by £72 million over this year and last year with the prospect of further significant cuts to come.

5) That, massive despite spending cuts, compulsory redundancies have accounted for only 4.6% of the overall reduction in the Council's staff head count to date.

The Council further notes:

1) The £7.7 million Employment Investment Programme 'Get Bradford Working', the largest investment in employment and skills by any council in the country.

2) The creation of jobs which will be available to our most disadvantaged residents at a time when they most need intervention, support and leadership from their Council.

3) The dialogue established by the Council with Thomas Cook and the initiative by MPs George Galloway and Gerry Sutcliffe to seek a meeting with the chief executive of Thomas Cook to try to persuade him to review the decision to shut Thomas Cook's office in Bradford.

4) The recently announced City Deal which will promote employment, economic growth and infrastructure and deliver an apprenticeships hub in Bradford.

The Council therefore resolves to:

1) **Continue the dialogue with Thomas Cook with a view to exploring all possible avenues of support for those affected, including alternative sources of employment with other companies in the District.**

2) **To continue the detailed planning taking place with partners to implement "Get Bradford Working" so as to have maximum impact for the people of Bradford.**

3) **Confirm that its priority with regards to individual members of staff is to look to avoid compulsory redundancies and only consider them as a last resort.**

4) **Work with its City Region partners to maximise the benefit to Bradford District in terms of jobs, skills and infrastructure, of the City Deal.**

5) Work with the District's MPs in continuing to lobby Government for a fairer funding deal for Bradford, secure ongoing investment in support of the local economy and protect local jobs.

ACTION: Strategic Director Regeneration and Culture

10. **NEW FAMILY MIGRANT RULES**

Resolved-

This council notes:

That the Government introduced new family migrant rules on 9th July 2012.

These rules introduce new minimum gross income requirements of £18,600 for people wishing to sponsor a non EU spouse or partner to enter and settle in the UK.

The income requirement will be higher for those wanting to bring a child under the age of18 with a partner, rising to £22,440 for one child and an additional £2,400 for each further child.

Previously the income requirement was in line with UK income support levels therefore approximately £6,000 for a couple and £8,500 for a couple with a dependant child.

While it is a positive thing for migrants to be able to speak, read and write in English, the new rules impose punitive language knowledge conditions and the probationary period of entry will be extended from two years to five years

The Council believes that:

These rules could potentially apply to half the working population of the UK and will affect thousands of people within the Bradford District.

These rules will have a disproportionate impact on particular social and ethnic groups including those on low incomes, women, children, people with disabilities and ethnic minorities.

These rules discriminate between EU nationals and non EU nationals and between British nationals and EU nationals.

These rules adversely affect the human rights of British citizens to marry whom they wish and to enjoy family life with their spouses and children.

The Council resolves:

1) **To make urgent representations to the government urging them to withdraw these proposals.**

2) **To write to the District's MPs requesting their cooperation with the Council, its partners and local communities in developing a system of recording, monitoring and reviewing the impact on families in the District and to compile a dossier of case studies and evidence to bring to the attention of national government.**

3) **To work with its partners to ensure that people arriving in Bradford District as migrants are provided with appropriate support and assistance.**

ACTION: ***Chief Executive***

11. **BRADFORD BULLS**

Resolved-

This Council notes the fact that Bradford Bulls are in administration.

The Council applauds the efforts of supporters to save the club and resolves to continue to do all that it can to support those efforts and ensure that the club survives and continues to play in the Super League.

ACTION: Chief Executive/Strategic Director Environment and Sport

12. **DEFENDING THE WELFARE STATE**

Resolved-

This Council believes:

1) **That the Government is under a moral obligation to guarantee a Welfare State that acts as an essential safety net designed to assist people suffering from periods of hardship or for people who are unable to assist themselves.**

2) **That employment that pays a living wage represents the best route out of poverty and that those who can work have an obligation to actively seek work.**

We note that:

1) **As a result of the double dip recession, many people in the Bradford District are facing the hardship that the welfare state is designed to help alleviate. National economic policies and the scale and speed of public spending cuts are inhibiting economic recovery and making paid employment opportunities more difficult to secure.**

2) **Changes to Working Tax Credits and in-work benefits act as a disincentive to work and some families find themselves better off on benefits. Because over 50% of children in poverty live in households where at least one adult is working these changes undermine progress being made to address child poverty in the Bradford District.**

3) **Many people in receipt of benefits are in low paid employment, over 90% of new Housing Benefits claimants are in work. Those out of work will face a 10% cut after a year under Government reforms.**

4) **Almost half of workless households include someone with a disability.**

5) **Implementation of the Government's Welfare Reform programme will place increased pressure on people on low incomes and already stretched public services.**

6) **Tax avoidance costs the UK economy £25 billion a year.**

The Council agrees that we need a programme of job creation, house building, measures to ensure people are paid a real living wage and have access to decent, affordable housing.

We therefore welcome the Council initiatives that are addressing these issues and supporting people on low incomes including:

- **The £7.7 million "Get Bradford Working" Employment and Skills Programme.**
- **Helping to secure the Leeds City Region City Deal which will promote enterprise and employment.**
- **£34 million package of support for City Centre regeneration.**
- **Building the District's first Council housing for 30 years and a multi-million pound affordable housing investment programme to include 423 new units over the next two years.**
- **Mortgage Rescue Scheme and support for people at risk of losing their homes; Equity Loans Scheme replacing the loss of Government grant.**
- **Establishing the Child Poverty Board and implementing its programme of work.**
- **Paying the lowest paid Council workers a £250 increase**
- **Investment in Advice Services to compensate for cuts to Government grants and support for the growth of Credit Unions.**

The Council resolves to:

1) **Continue to play its part in getting people into work and promoting economic growth.**

2) **Fulfil its obligations to help support those residents experiencing hardship.**

3) **Call on the Government to reverse its changes to Working Tax Credits in order to help make work pay, reverse its tax breaks for the wealthiest tax payers and to take urgent measures to address the issue of tax avoidance.**

4) **Work closely with its partners to help mitigate the worst effects of implementation of the Government's Welfare Reform Programme.**

5) **Explore the implications of the Council becoming a Living Wage employer.**

ACTION: ***Chief Executive/Strategic Director Regeneration and Culture/Strategic Director Business Support/Director of Finance***

13. **LIVING WAGE**

Resolved-

This Council notes that:

1) In adopting a Living Wage policy an employer makes a commitment to guaranteeing its employees a minimum level of income.

2) The Living Wage reflects the minimum pay rate required for a worker to provide the essentials of life for themselves and their families. In defining a Minimum Income Standard the Joseph Rowntree Foundation concluded that it is the level of income needed to provide an acceptable standard of living in Britain to ensure good

health, adequate child development and social inclusion.

3) That the Living Wage outside of London is set annually by an independent body and is currently £7.20 per hour.

4) That the evidence from the introduction of a London Living Wage indicates that it produces significant benefits for employers adopting the policy including:

- **Increased productivity, motivation and loyalty..**
- **Reduced absenteeism**
- **Better quality services - over 80% of employers have reported an improvement in the quality of work of their staff**
- **Improved recruitment and retention**
- **More rapid adoption of changes to working practices.**

5) That the Living Wage Foundation estimates that the London Living Wage has lifted over 10,000 families have been lifted out of poverty.

The Council believes that:

1) The Living Wage could bring significant benefits to the District's employers and employees.

2) Paid employment offers the best route out of poverty for people of working age so the Living Wage could play a key role in reducing poverty in particular child poverty.

3) That paying a Living Wage to Council staff and the staff of its contractors could encourage other local employers to do the same.

4) That the Living Wage could provide a stimulus to the local economy.

The Council therefore requests the Corporate Overview and Scrutiny Committee, in consultation with staff, trade unions, business organisations and the Child Poverty Board to undertake an in depth investigation over the next twelve months into the implications for the District of the Council adopting a Living Wage policy and to report the findings of that investigation back to Full Council.

ACTION: ***Chief Executive/Strategic Director Regeneration and Culture/Strategic Director Business Support/Director of Finance/City Solicitor***

14. INDEPENDENT REMUNERATION PANEL RECOMMENDATIONS

Resolved-

We have taken notice of the recommendations of the Independent Remuneration Panel and we thank them for their involvement and their expertise which has informed this process.

The following recommendations are put to Council for immediate effect as an amendment to those made by the IRP.

Changes

1. **The Leader, Deputy Leader and Chief Whip of a Political Group will only be paid if that Group holds 15% or more of the membership of Council.**

2. **Chairs of Scrutiny, Corporate Governance and Audit, Planning, Licensing and Regulatory and Appeals be reduced to 35% of the Leader's SRA**

3. **The SRA for the Deputy chair of Licensing be removed.**

4. **The Chair of Standards Committee will receive 10% of the Leader's SRA**

5. **Members of the Fostering Panel shall receive 8% of the Leader's SRA**

6. **Members of the Adoption Panel shall receive 8% of the Leader's SRA**

7. **Members of Planning Panels shall receive 8% of the Leader's SRA**

8. **The SRA for the Chair of the West Yorkshire Pension Fund be removed.**

9. **Opposition Shadow Executive members shall receive 12.5% of the Leader's SRA**

10. **The Chair of Employee Appeals Panel shall receive 20% of the Leader's SRA**

11. **The Deputy Chair of Employee Appeals Panel shall receive 15% of the Leader's SRA**

12. **The SRA for other Members of the Employee Appeals Panel be removed.**

13. **The Chair of Hackney Carriage and Private Hire Panel shall receive 20% of the Leader's SRA**

14. **The Chair of Social Services Appeals Panel shall receive 15% of the Leader's SRA**

15. **The Chair of Corporate Parenting Panel shall receive 15% of the Leader's SRA**

Councillors should note that the Constitution states that there should be only one SRA per member.

ACTION: City Solicitor

15. **DATE AND TIME OF FUTURE MEETING**

Resolved-

That the date of the meeting of Council previously agreed as Tuesday 26 February 2013 be changed to Thursday 28 February 2013 at 1600.

ACTION: City Solicitor

FROM: Suzan Hemingway
City Solicitor
City of Bradford Metropolitan District Council

Committee Secretariat Contact: Adrian Tumber – 01274 432435
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E.Mail michael.rooney@sheffield.gov.uk

Ref. MR/ES180712
Date: 18 July 2012

Mick Rooney
Healthier Communities & Adult Social Care Scrutiny Board Chair
Town Hall
Sheffield, S1 2HH

Dear Councillor Illingworth.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee today discussed the decision made on July 4th by the Joint Committee of Primary Care Trusts that the Leeds Teaching Hospitals NHS Trust should cease carrying out Paediatric Cardiac Surgery.

Having considered the detailed work carried out over the past year by the Yorkshire and Humber Joint Overview and Scrutiny Committee, and having listened to the concerns of Sheffield people, the Committee is of the view that the decision to close the Leeds Unit is not in the best interest of children, young people and families of Sheffield.

The Committee therefore offers its support should the Joint Yorkshire and Humber Overview and Scrutiny Committee decide to use its formal powers of referral to refer this issue to the Secretary of State for Health.

In an event of a referral to the Secretary of State, Sheffield's Healthier Communities and Adult Social Care Scrutiny Committee will write to the Secretary of State, urging him to refer the issue to the Independent Reconfiguration Panel for detailed consideration. We will also be asking Sheffield MPs to support this action.

On behalf of Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee I'd like to thank you for leading the regional scrutiny process, and look forward to working with you further on this over the coming months.

Yours sincerely

Cllr MG Rooney

Cllr Mick Rooney
Chair, Healthier Communities and Adult Social Care Scrutiny Committee.

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REVIEW OF CHILDREN'S CONGENITAL CARDIAC SERVICES AT ROYAL HOSPITAL FOR SICK CHILDREN (YORKHILL), GLASGOW

REPORT OF THE INDEPENDENT EXPERT PANEL CHAIRED BY PROFESSOR SIR IAN KENNEDY

FEBRUARY 2012

Background and Context

In 2010 an expert group of children's heart doctors, lay representatives and NHS commissioners developed a set of quality standards against which paediatric congenital cardiac surgical units in England were assessed by an independent expert panel under the auspices of the *Safe and Sustainable* review. The standards had been endorsed by the relevant professional associations in the United Kingdom including the British Congenital Cardiac Association, the Society for Cardiothoracic Surgery of Great Britain and Ireland and the Royal College of Paediatrics and Child Health, as well as national heart charities such as the Children's Heart Federation. The standards are included as Appendix A to this report.

Although the service at the Royal Hospital for Sick Children at Yorkhill in Glasgow ('the Hospital') is not subject to the review of services in England, an expert panel was asked by the devolved administration in Scotland to assess the paediatric congenital cardiac surgical unit at the Hospital. The terms of reference required the panel to assess the service against compliance with the *Safe and Sustainable* standards. The process was in part objective, in so far as it drew together relevant data, and subjective in that it called for the judgment of experts as to the extent to which the facts put before them demonstrated compliance with the standards.

The unanimous judgments arrived at by the panel are set out in this document.

Purpose of this document

The panel sought to assess the Hospital's current compliance with the *Safe and Sustainable* standards, the Hospital's development plans to meet the standards where gaps in compliance were identified and the Hospital's development plans to meet the standards if activity were to increase to 400 surgical procedures per year or more.

In accordance with the terms of reference it was not the panel's role to assess how the Hospital compared to surgical centres in England. Rather, the panel assessed the extent to which the Hospital itself demonstrated compliance with the standards in so far as they relate to paediatric cardiac surgical services and paediatric interventional cardiology services.

Under each core requirement, a summary of the key areas where actions are required to comply with the standards is provided.

Assessment visit

The assessment visit took place on 3 November 2011.

The panel received and reviewed the Hospital's written submission, including documentary evidence provided by the Hospital, prior to the assessment visit taking place.

During the assessment visit the panel toured the facilities at the Hospital and received a presentation from the congenital cardiac service team.

The panel met a broad range of staff, including surgeons, cardiologists, intensivists, nurses and members of the management team. The panel also met patient and parent representatives.

There were opportunities for the assessment panel to question the staff and patient and parent representatives throughout the day and for evidence to be submitted to the panel.

The panel scored the Hospital against each of the core standards using the following scoring criteria:

Score	Definition
R	▪ **Inadequate**: No evidence to assure panel members
O	▪ **Poor**: Limited evidence supplied
A	▪ **Acceptable**: Evidence supplied is adequate, but some questions remain unanswered or incomplete
G	▪ **Good**: Evidence supplied is good, and the panel are assured that the centre has a good grasp of the issues
B	▪ **Excellent**: Evidence is exemplary

Assessment Panel

Professor Sir Ian Kennedy (Chair)

Professor Sir Ian Kennedy chaired the public inquiry into the care of children receiving heart surgery at the Bristol Royal Infirmary between 1984 and 1995. His landmark 'Kennedy Report' in 2001 highlighted fundamental flaws in the planning, delivery and management of paediatric cardiac surgical services, and it made a number of recommendations around safety, medical competency and public involvement relevant to the NHS as a whole. He was Chair of the Healthcare Commission from 2003 to 2009, after which he became Chair of the Kings Fund inquiry into the quality of general practice in England. In 2009 he became Chairman of the Independent Parliamentary Standards Authority.

Dr Michael Godman

Dr Godman is a retired Consultant Paediatric Cardiologist. He worked in the Royal Hospital for Sick Children in Edinburgh until 1999, during which time he was also a Senior Lecturer in the Department of Child Life and Health, and the Medical Director for the hospital. He was nominated to the panel by the British Congenital Cardiac Association.

Dr Ian Jenkins

Dr Jenkins is a Consultant in Paediatric Intensive Care and Cardiac Anaesthesia at the Bristol Royal Children's Hospital. He is the Immediate Past President of the Paediatric Intensive Care Society and was also co-opted onto the Councils of the Association of Paediatric Anaesthetists of Great Britain and Ireland (2007-2011) and the Intensive Care Society (2010 -2011). He chaired the working party writing the new Standards for the Care of Critically Ill Children, published in 2010.

Dr David Mabin

Dr Mabin is a Consultant Paediatrician with expertise in paediatric cardiology at the Royal Devon & Exeter NHS Foundation Trust. He is the Convenor for Paediatric Cardiology at the Royal College of Paediatrics and Child Health. He also sits on the British Congenital Cardiac Association Council and is Clinical Sub-Dean at the Peninsula Medical School in Exeter.

Mr James Monro

Mr Monro was a Consultant Congenital Cardiac Surgeon in the NHS until 2004. He was President of the Society of Cardiothoracic Surgeons of Great Britain and Ireland from 2000-2002, President of the European Association for Cardiothoracic Surgery in 2003 and 2004 and a founding Chairman of the EACS Congenital Cardiac Surgical Committee. He was co-chairman of the committee which produced the "Report of the Paediatric and Congenital Cardiac Services Review Group" in 2003.

Julia Stallibrass MBE

For the last 20 years Julia Stallibrass has worked in the NHS in various public health and commissioning roles, most recently as Head of Specialised Services Commissioning in the National Specialised Commissioning Team. She has also worked for the Department of Health where she was the policy lead for commissioning specialised services. Whilst at the Department of Health she produced the Carter Report on the 'Review of Commissioning Arrangements for Specialised Services'. She retired in 2009 and in that year she received an MBE for services to the NHS.

Sharon Stower

Sharon is an Independent Nursing and Healthcare Consultant and founder and Managing Director of Sharon Stower Consultancy Ltd. Her current work involves undertaking service reviews in health care environments advising on health care issues and legal nurse expert work. She was a former Director of Nursing and Service Improvement at Doncaster and Bassetlaw Hospitals NHS Foundation Trust. Sharon was nominated to the panel by the Royal College of Nursing.

Maria Von Hildebrand

Maria von Hildebrand has been working in patient and public involvement since 1995. She is the founder of Constructive Dialogue for Clinical Accountability, a national charity set up in partnership with patients, the public and clinicians. The objective of her work has been to improve the information exchange between health care professionals and patients, to ensure there is knowledge transfer and shared responsibility for the process of informed consent resulting in improved quality and safety outcomes for public benefit.

Declarations of Interest

No conflicts of interest have been declared.

Dr Godman, Dr Jenkins, Dr Mabin and Mr Monro all know clinicians at the Hospital in a professional capacity.

Dr Godman worked as a Consultant Paediatric Cardiologist at Edinburgh Royal Hospital for Sick Children until his retirement in 1999.

1. SUMMARY OBSERVATIONS AND COMMENTS

Introduction

The panel had significant concerns about important aspects of the service in the surgical unit and in the broader congenital heart network. Of most concern was a lack of leadership and coherent team working. Also of concern was a sense that the provision of paediatric intensive care may be unsafe if critical staffing problems are not addressed.

Strategy and vision

The panel felt that whilst the Hospital had a vision that included proposals and development plans, these tended to be aspirational; it was not always clear how these plans would be implemented, and who would lead them.

This was typified with the Hospital's ambition to develop the research programme. Whilst the ambition was evident, this was not supported by a robust research strategy and there was insufficient staff capacity and resource to undertake an extensive research programme.

Leadership

The panel was left with an impression that the senior leadership team were not operating as a cohesive team and that there was a lack of clear strategic leadership.

This was evidenced in part by the fact that there was almost no Board-level presence during the assessment visit, and it was not clear how the paediatric cardiac surgery service was integrated with the Hospital Board's broader strategic objectives.

This view was reinforced by the panel's observation that there was a poor working relationship between members of the cardiology and surgical teams.

Commissioning arrangements

The commissioning arrangements for paediatric cardiac surgery and related services were fragmented and confusing.

This had made planning and investment a significant challenge for the Hospital.

Patient engagement

Parents and patients whom the panel met demonstrated strong support for the service and indicated excellent relationships with staff which had led to a high degree of trust between patients and staff; however patients and parents did not appear to be actively involved in decision-making.

The panel identified several opportunities for increasing patient and parent involvement, for example: identifying critical success factors and developing the 'transition to adult' service.

Network arrangements

The panel recognised the challenges of the large geographical area and the dispersed population in managing the network.

The Hospital had excellent telemedicine arrangements within the network; however other aspects of the network were under-developed.

In particular the panel felt that there was an emphasis on centrally provided care. This was exemplified by the lack of coherent protocols within the network and the fact that services such as those provided by liaison nurses and transition nurses were not available within the network.

Staffing and capacity

There were significant concerns over the staffing and capacity levels within the paediatric intensive care unit (PICU), which had been exacerbated by the recent departure of two PICU consultants. The panel was also of the view that Hypolplastic Left Heart Surgery had been introduced without sufficient consideration of the pressures that this would bring to PICU.

The panel was of the view that urgent remedial action is required in PICU to prevent care from becoming unsafe.

The panel's key findings and deliberations are described in detail under each of the core requirements.

	Compliance	Gaps in Compliance	Final Score
Aims, business strategy and strategic priorities	▪ The Hospital referred to a business plan; however this was not supported by a robust strategy or financial information.	▪ The mechanism for commissioning paediatric cardiac services and related services was unclear and confusing and had led to disjointed service provision. ▪ The panel felt that leadership within both the Hospital generally and in paediatric congenital cardiac surgical services was poor as there was no clear leadership structure; there appeared to be a lack of cohesion between the senior team members.	Poor
IT and estates strategy	▪ Implementation of telemedicine, both within the Hospital and the network was good, and there was an awareness of where there were current gaps in provision, and the reason these may exist, such as Paisley and Elgin. ▪ A good technician-led echocardiogram service was present throughout the hospital. ▪ The Hospital's estates strategy was predicated on the move to the Southern General site in 2015, and the plans for this transfer had been well developed with Hospital staff.	▪ The panel noted that whilst HeartSuite had been implemented elsewhere in the Hospital, it had not been implemented within the network. ▪ Whilst the Hospital's estates strategy was predicated on the transfer of services to the Southern General Site in 2015, it was not clear what the Hospital will do to develop and maintain the existing estate until then.	Good
Contribution to key objectives	▪ The Hospital provided a clear description of its key objectives; however it was not always evident how the Hospital Board would achieve these objectives.	▪ The panel felt that the Hospital Board had not displayed a good track record of how it had achieved its key objectives for paediatric cardiac services in the 12 year period since the merger of Glasgow and Edinburgh paediatric cardiac services.	Acceptable

		▪ The panel expressed concerns over the degree of leadership in achieving the Hospital's key objectives.	
Service delivery arrangements, including networks and major contracts	▪ The Hospital outlined clear, comprehensive service delivery arrangements; however the panel felt that there were some gaps in these.	▪ The service development plans appeared to be heavily focused on the medical workforce and made insufficient reference to other staffing groups, including nurses. ▪ There was limited explicit reference to cardiac surgery in the service delivery arrangements. ▪ Plans for the network appeared aspirational; it was not clear how these would be implemented.	Acceptable
Main stakeholder groups	▪ The Hospital identified a broad range of stakeholders; however these were largely 'inwards' facing and represented different staff groups within the Hospital.	▪ The Hospital did not identify patients and parents or DGHs within the network as key stakeholders.	Poor
Critical success factors for delivering plans and Main internal and external factors upon which successful delivery is dependent upon	▪ The Hospital identified a range of critical success factors, including sources of investment, as a major external factor. ▪ Succession planning was identified as a potential concern, and the Hospital indicated a strategy for addressing this.	▪ The Hospital indicated an awareness of concerns relating to PICU capacity, and it was unclear how these concerns would be addressed. ▪ There was insufficient engagement of patients and parents in identifying critical success factors; this was exemplified by the bi-annual survey, which suggested a low level of patient involvement in service planning. ▪ The panel felt that concentrating on the transfer to the new hospital in 2015 may have caused the Hospital to reduce their focus on considering critical success factors.	Acceptable

	Compliance	Gaps in Compliance	Final Score
Main constraints and risks	▪ The Hospital demonstrated an awareness of constraints and risks.	▪ Where the Hospital identified constraints and risks, they often did not identify possible remedial actions.	Acceptable
High level strategic and operational benefits	▪ The Hospital gave a sound description of the benefits that they would seek to extract from their plans; however it was not always clear how these would be achieved, or who would lead the delivery of these.	▪ The Hospital did not sufficiently describe any benefits within the network.	Acceptable
Opportunities for innovative working	▪ The development of the Advanced Nurse Practitioner role was deemed as innovative. ▪ The Hospital had been groundbreaking in its implementation of telemedicine within the network, however the telemedicine technology was not, in itself, innovative.	▪ Whilst the Hospital described several new working practices, these were often not innovative practices as they had already been implemented in other organisations in the UK. An example of this was the recent introduction of Hypoplastic Left Heart surgery by the Hospital.	Poor
Learning, development and growth	▪ The Hospital benefited from shared learning from other UK providers, and this was exemplified by the introduction of Hypoplastic Left Heart surgery to the Hospital through training from other UK centres. ▪ The Hospital had a strong learning culture. ▪ Advanced Nurse Practitioners had been provided with training opportunities in Liverpool ▪ Training for physiologists appeared strong.	▪ There was a limited description of the training opportunities for other non-medical staffing groups. It is crucial that training be made available for all workforce groups.	Good

2. STRENGTH OF NETWORK

Summary

In the Scottish network there is a single paediatric cardiac surgical unit (in Glasgow) that has a relationship with the main non-interventional cardiology service in Edinburgh and with a number of district general hospitals. The network in Scotland has unique challenges due to geography and population dispersal. The panel recognised these challenges but did not consider that the challenges preclude providing a well managed, coordinated and effective network.

In the panel's opinion the network was generally under-developed; there was poor evidence of clinical leadership across the network and limited evidence of the benefits that a network model of care could bring to the treatment and management of children in Scotland with congenital heart disease. The Hospital did not demonstrate an appropriate understanding of how networks could work or the benefits of a networked approach; rather the Hospital's approach was based on a model of 'command and control'.

	Compliance Strength of Network	Gaps in Compliance	Final Score
Current achievement against the core standards A1, A2, A5, A7, A8, A13, A24, A25 and B3	▪ Telemedicine was present throughout the network, and the necessity of telemedicine, based on the challenging geographical circumstances, was recognised.	▪ The Hospital had an informal relationship with DGHs in the network, predicated on strong personal relationships. ▪ The Hospital failed to meet several of the standards, including: ▪ active leadership of the network; ▪ formal protocols agreed with the network; ▪ a nominated nurse leader; ▪ multi disciplinary working across the network.	Poor
Development plans/ risks to meeting standards A1, A2, A5, A7, A8, A13, A24, A25 and B3 (if not all ready achieving)	▪ The Hospital demonstrated clear proposals for the network which are currently awaiting approval.	▪ The panel felt that the £50,000 available for funding administrative support for the network was insufficient in developing the network, as dedicated clinical leadership is also necessary. ▪ The implementation plan for delivering the proposals for the network was unclear.	Poor
Impact on standards A1, A2, A5, A7, A8, A13, A24, A25 and B3 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased	▪ The panel felt that the proposals for the network were valid if activity increased to 400 procedures or more.	▪ It was unclear what the implications of extending the geography of the network would have on the network. For example, there may be a requirement to recruit additional staff if the network expands further, and this had not been recognised in the proposals for the network.	Poor

Core Standard	Actions to achieve compliance (Strength of Network)
A1	▪ Develop protocols for care, treatment, transition and referrals within the network. ▪ Monitor performance against protocols within the network. ▪ Undertake audits within the network.
A2	▪ Consult with DGHs in the network in designing models of care.
A5	▪ Appoint a dedicated lead nurse who works wholly within paediatric cardiac services.
A7	▪ Develop relationships with other Specialised Surgical Centres.
A8	▪ Develop a managed network for paediatric congenital heart services that includes formal protocols. ▪ Ensure DGHs within the network are signed up to these protocols.
A13	▪ Ensure all protocols are developed with DGHs within the network, with patients and with parents. ▪ Formally document all protocols.
A24	▪ Develop pathways of care that include referral, treatment and transition with DGHs in the network.
A25	▪ Include arrangements for multi disciplinary care in the network care pathways.
B3	▪ Include arrangements for foetal medicine services in the network care pathways.

3. STAFFING AND ACTIVITY

Summary

The standards stipulate a minimum of 4 full-time consultant congenital cardiac surgeons in a congenital cardiac surgical unit based largely on a need for a safe and sustainable surgical rota that can be delivered around the clock. In order to avoid occasional surgical practice the standards also stipulate that each surgeon should be performing a minimum of 100 paediatric congenital surgical procedures a year, and ideally a minimum of 125 such procedures a year. The Hospital failed to meet several of these standards giving rise to serious concerns amongst panel members about the sustainability of the service overall.

The Hospital had 3 surgeons, which impeded an ability to deliver a safe surgical rota around the clock as required by the standards. Work was not evenly distributed between the surgeons which led the panel to express concerns over sustainability. One surgeon performed around 140 paediatric surgical procedures per year, meeting the critical mass proposed by the standards, whereas the other two surgeons fell considerably short at around 70 paediatric surgical procedures each per year.

The Hospital had also identified the need to recruit a further two intensivist consultants to increase the numbers to 10 consultants. The panel noted with significant concern that there was an acknowledgment by Hospital staff that this may still leave the PICU stretched to a degree that maybe unsafe.

	Compliance Staffing and Activity	Gaps in Compliance	Final Score
Current achievement against the core standards C4, C5, C6, C7, C9, C11 and F2	▪ Theatres and wards were staffed to sufficient capacity subject to the 'gaps in compliance' observed by the panel.	▪ The Hospital failed to meet several of the standards including: ▪ 4 surgeons; ▪ minimum of 7 wte cardiac liaison nurses; ▪ a dedicated lead cardiac nurse. ▪ The Hospital had 3 surgeons; however work was not evenly distributed between these surgeons. One surgeon undertook approximately 140 procedures per year whilst the other two surgeons each undertook approximately 70 procedures per year. ▪ The panel also raised concerns regarding the number of intensivists and PICU nurses. ▪ The panel was told that there had been a relatively recent reduction in the number of cardiac liaison nurses, and the panel observed little evidence of plans to rectify this by increasing the number of nurses to meet the standards.	Inadequate
Development plans/ risks to meeting standards C4, C5, C6, C7, C9, C11 and F2 (if not all ready achieving)	▪ The Hospital had identified a need to recruit an additional (fifth) cardiologist and has a business case for the post.	▪ The Hospital had identified the need to recruit a further 2 intensivist consultants to increase the numbers to 10 consultants; however there was a recognition by Hospital staff – and endorsed by the panel - that this may still leave the PICU stretched. In any event there were concerns over an inability to recruit additional intensivist capacity. ▪ The Hospital had attempted to recruit an additional cardiologist, however this was unsuccessful. ▪ There was limited evidence of robust plans to increase the number of cardiac liaison nurses.	Poor

		▪ The panel felt that the Hospital held a view that the cardiac liaison nurses must be based in Glasgow, when they can in fact be based within a hospital in the network. In the panel's opinion this demonstrated a lack of understanding and appreciation of the benefits of a network approach, which ultimately was to the detriment of care for children and their families. ▪ The Hospital had not identified any plans to increase their PICU nursing workforce.	
Impact on standards C4, C5, C6, C7, C9, C11 and F2 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased	▪ The panel recognised that there were credible plans to increase the workforce, however there was no clear process for achieving these plans.	▪ There were concerns over recruitment for some posts. ▪ The Hospital had not indicated plans to increase all areas of the workforce where there were deficiencies, such as PICU nursing.	Poor

Core Standard	Actions to achieve compliance (Staffing and Activity)
C4	▪ *The panel was unable to make recommendations that would address the concerns around sustainability and the need to provide a safe surgical rota around the clock in the absence of four full time consultant congenital cardiac surgeons. It must be for Commissioners and Hospital management to identify the implications of non-compliance with the standards and how non-compliance with the standards may be addressed to ensure safety and sustainability.* ▪ Ensure that activity is appropriately distributed between the surgeons in so far as it can be achieved within the constraints of a relatively low surgical caseload. ▪ Ensure appropriate mentoring arrangements are in place when recruiting any additional surgeons.
C9	▪ Provide sufficient medical and nursing staff for continuous emergency cover around the clock. ▪ Consider whether current staffing levels in PICU are sufficient to provide a compliant rota and recruit as required.
C11	▪ Review establishment levels in PICU and recruit nursing and medical staff to ensure sufficient capacity in PICU. This has become even more important with the introduction of surgery for Hypoplastic Left Heart Syndrome.
F2	▪ Ensure each patient has a named specialised nurse. ▪ Recruit additional specialised nurses to ensure sufficient capacity. ▪ Increase the number of cardiac liaison nurses working across the network..

4. INTERDEPENDENT SERVICES

Summary

The panel noted that the standards for interdependent services were met, and that all critically interdependent services were co-located. The panel noted that maternity, neonatology and foetal medicine were co-located as stipulated and defined in the standards.

	Compliance Interdependent Services	Gaps in Compliance	Final Score
Current achievement against the core standards C12-21, C64 and C65	▪ All critically interdependent services were co-located.		Excellent
Development plans/ risks to meeting standards C12-21, C64 and C65 (if not all ready achieving)	▪ All critically interdependent services were co-located. ▪ Once services are transferred to the Southern General site, maternity and children's services will be co-located on one site.		Excellent
Impact on standards C12-21, C64 and C65 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased	▪ All critically interdependent services were co-located. ▪ Once services are transferred to the Southern General site, maternity and children's services will be co-located on one site.	▪ Whilst all critically interdependent services were currently co-located, the Hospital had not indicated to what extent capacity for interdependent services would need to be increased should activity increase to 400 procedures per year or more.	Good

Standards C64 and C65 were reviewed under Facilities and Capabilities, and not under Interdependent Services.

5. FACILITIES AND CAPACITY

Summary

The panel had strong concerns that current staffing levels in the paediatric intensive care unit may be unsafe and are certainly not sustainable. The panel noted that these concerns were also shared by key Hospital staff interviewed on the day. Although there was some evidence of plans to address this problem by increasing the workforce, the panel members considered that the plans described to them would still leave significant risks in the service even if implemented. The panel recommends that urgent remedial action be taken.

	Compliance Facilities and Capacity	Gaps in Compliance	Final Score
Current achievement against the core standards C64, C65 and F6	▪ There was currently good capacity for parents and families to stay at the hospital. This included a Ronald McDonald House. ▪ Current PICU provision indicated a larger proportion of beds per capita of population than the rest of the UK; however not all of these beds were staffed.	▪ The panel felt that nurse staffing levels in PICU may not currently be safe and were certainly not sustainable, and this had led to low resilience, in particular because there was not separate or bespoke staff for emergency retrievals. The introduction of Hypoplastic Left Heart surgery had further increased pressure on PICU capacity to a degree that is unsustainable and may become unsafe. ▪ The panel noted that the PICU would be stretched even with 10 consultants; at the time of the visit there were only 8; a 1 in 4 on call rota covering 22 beds was deemed insufficient. ▪ The Hospital had moved to a 'Hospital @ Night' model, which tended to lead to a more junior, less specialised skills mix on call. ▪ The Hospital did not provide quiet rooms in all relevant care areas, including out patients.	Poor
Development plans/ risks to meeting standards C64, C65 and F6 (if not all ready achieving)	▪ The Hospital had developed plans to increase their workforce, for instance there were plans to recruit a clinical psychologist. ▪ The Hospital had funding to recruit 2 more PICU consultants.	▪ There must be immediate action to fill the 2 consultant PICU vacancies; even then Hospital staff acknowledged that this would leave the PICU stretched to an unacceptable and unsustainable level. ▪ The panel had concerns that whilst plans to increase the workforce were in place, the Hospital had not demonstrated a commitment to apply funding.	Poor
Impact on standards C64, C65 and F6 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased	▪ The Hospital had indicated good relationships with Caledonian University, which would be beneficial in recruiting additional nurses.	▪ There were concerns that the Hospital may not be able to recruit additional staff.	Poor

Core Standard	Actions to achieve compliance (Facilities and Capacity)
C64	▪ Remedy staffing capacity in PICU as a matter of urgency. ▪ Recruit additional consultant and nursing cover as required.
F6	▪ Ensure the provision of quiet rooms in all relevant care areas, including out patients.

6. AGE APPROPRIATE CARE (TRANSITION TO ADULT SERVICES)

Summary

Although there is no requirement for children's congenital heart services to be co-located with adult congenital heart services, a seamless transition from child to adult services is essential. It is at the transition stage that adolescents are at risk of 'falling out' of the system and being 'lost to medical follow up'. Overall, the panel members were of the opinion that transition arrangements were poor.

	Compliance Age Appropriate Care	Gaps in Compliance	Final Score
Current achievement against the core standards D1- D8		▪ Although the panel was presented with a transition policy, there was little evidence of compliance with the standards. ▪ There was only one nurse-led clinic per month. ▪ There were no dedicated beds for adolescents, although cubicles were made available for adolescents where possible. ▪ There was insufficient staff for transition working in the network.	Poor
Development plans/ risks to meeting standards D1- D8 (if not all ready achieving)	▪ The Hospital was moving from a one-off clinic for transition to a period of transition from the age of 14 onwards. ▪ There were plans to recruit clinical psychologists, and the Hospital reported that funding had been identified.	▪ There were no plans to develop transition capacity within the network. ▪ The panel raised concerns that there was little active patient involvement or engagement in developing plans for transition and ensuring care was age appropriate.	Poor
Impact on standards D1- D8 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased		▪ The concerns over transition within the network remain valid if activity increased to 400 procedures or more. ▪ The need to develop plans for transition will remain valid if activity increases to 400 procedures or more.	Poor

Core Standard	Actions to achieve compliance (Age Appropriate Care)
D1	▪ Develop a comprehensive approach to transition, in partnership with adult congenital heart disease services, including, where appropriate, provision within the network.
D3	▪ Recruit a dedicated transition nurse.
D4	▪ Provide ongoing review of care management plans. ▪ Undertake audit to ensure compliance with the standard.
D6	▪ Recruit additional clinical psychologists to ensure psychological support is made available to all patients, parents and families.
D7	▪ Provide a dedicated area and facilities for adolescents. ▪ Ensure plans for transition exist within the network as well as the designated surgical centre in partnership with adult congenital heart disease services

7. INFORMATION AND CHOICE

Summary

Whilst patients and parents were provided with good quality, accessible information about the care they would be receiving in a range of formats there were some deficits under standards relating to information and choice. This was particularly notable in the allocation of specific staff groups, such as cardiac liaison nurses and clinical psychologists, as they were not always accessible to patients and parents at key points in the care pathway, particularly at the point of decision-making.

	Compliance Information and Choice	Gaps in Compliance	Final Score
Current achievement against the core standards E1- E14	▪ The consent process was undertaken in advance, using a two stage approach. ▪ Nurse support was available during the consent process. ▪ Information was made available in several different formats including books and pamphlets. ▪ Details of out of hour contacts were made available to all patients and families.	▪ Clinical psychologists were not available at the point of decision-making, as there was a week's wait to access an appointment. ▪ There is no evident culture of informing parents of how to obtain second opinions although there was evidence of referrals to England for complex cases. ▪ Whilst patients and families indicated a strong degree of approval for the care provided by the nurses and doctors, they did not appear to be actively involved in decision-making.	Acceptable
Development plans/ risks to meeting standards E1-E14 (if not all ready achieving)	▪ The Hospital demonstrated good compliance against several of the standards including E2, E3, E5, E6-10, and there were plans for achieving compliance with other standards, such as E4. These plans were at times weak and it was not always evident how achievable these would be, for instance there were concerns over funding for cardiac liaison nurses.	▪ The Hospital did not demonstrate an understanding of the role of some staff groups, such as cardiac liaison nurses.	Poor

	Compliance Information and Choice	Gaps in Compliance	Final Score
Impact on standards E1-E14 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased		▪ The concerns over the role and use of cardiac liaison nurses remain valid if activity increases to 400 procedures or more. ▪ The need to develop plans remains valid whether or not activity increases to 400 procedures or more.	Poor

Core Standard	Actions to achieve compliance (Information and Choice)
E1	▪ Enable and encourage patients and parents to actively take part in the decision-making process.
E4	▪ Recruit sufficient clinical psychologist capacity to ensure all patients, parents and families have access to clinical psychology support during the decision-making process.
E11	▪ Formalise in protocols, and routinely communicate to patients and parents, the option of a second opinion at another Specialised Surgical Centre.

8. ENSURING EXCELLENT CARE

Summary

The panel felt that the Hospital broadly met the standards relating to governance arrangements. Otherwise the panel felt that the plans relating to 'ensuring excellent care' were aspirational. Whilst the Hospital described an ambitious research programme, the panel felt that the capacity and capability to deliver it was not apparent.

	Compliance Ensuring Excellent Care	Gaps in Compliance	Final Score
Current achievement against the core standards G1, G4 and G12	▪ The Hospital demonstrated a good track record with regard to audit. ▪ The Hospital had clinical governance arrangements in place. ▪ The Hospital had a clear, multi disciplinary management structure in place. ▪ The Hospital used mentoring for junior staff.	▪ Whilst the Hospital indicated a strong appetite for research, this appeared aspirational as there was no research strategy, and staff had limited capacity available for undertaking research.	Poor
Development plans/ risks to meeting standards G1, G4 and G12 (if not all ready achieving)		▪ The Hospital demonstrated commendable aspirations with regard to research; however this was not encapsulated in a strategy.	Poor
Impact on standards G1, G4 and G12 if activity increases to 400 procedures per year and any additional development that would be necessary if activity increased		▪ The concerns over ensuring excellent care, particularly with regard to implementing the plans for research remain valid if activity increases to 400 procedures or more. ▪ The need to develop plans for ensuring excellent care will remain valid if activity increases to 400 procedures or more.	Poor

Core Standard	Actions to achieve compliance (Ensuring Excellent Care)
G12	▪ Develop a coherent research strategy, outlining all major research areas and indicating opportunities for working in partnership with other centres. ▪ Ensure sufficient capacity and resources exist to implement the research strategy, including dedicated time in work plans for clinicians to undertake research.

Additional Full Council Motions:

Leeds City Council – 11 July 2012

'That this Council notes with great concern the decision by the Joint Committee of Primary Care Trusts not to retain Leeds as a designated surgical centre for children's congenital cardiac surgery services.

The decision will leave 5.5 million people in Yorkshire and Humber, and the 14 million people living within a 2 hour drive of Leeds, severely and disproportionately disadvantaged. Council believes the decision fails to adequately acknowledge the gold standard provision Leeds offers to patients and families as a result of the co-location of services.

This Council confirms its support for a referral of the JCPCT's decision to the secretary of state, given the significant adverse impact the plan would have on the population of this region and our local health services.'

City of York Council – 12 July 2012

'Council unanimously supported a previous motion in April 2011, to lobby for the retention of the Children's Heart Unit at Leeds General Infirmary.

The Review of Children's Congenital Cardiac Services in England undertaken by the NHS Specialised Services Safe and Sustainable Programme continues to be fully supported by the Council as a member of the Joint Health Overview and Scrutiny Committee, Yorkshire and the Humber. We recognise that specialists centres providing 24/7 care are essential to ensure safe, high quality care in a highly specialised clinical area.

However, we are concerned at the way the Meetings held by the JCPCT have been conducted. They have not shared information, no papers were available at the final Meeting of the JCPCT held in London on Wednesday 4th July, this meeting while, held in public, did not make available any of the documentation being considered by them, and the agenda was only published on Friday 29th June at 17.40 hours.

CYC therefore request a Meeting with the Secretary of State for Health, Mr Andrew Lansley to share these concerns which do not comply with Department of Health Guidance on openness in the NHS, and for Mr Lansley to give answers to the many unanswered questions put to the JCPCT by the Yorkshire and Humber Overview and Scrutiny Committee.'

Doncaster Metropolitan Borough Council – 12 July 2012

'Agreed that this Council is dismayed by the decision of the NHS to close the children's heart surgery unit in Leeds and resolves to join the other Yorkshire local authorities in calling on the health secretary to reconsider the decision.'

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ASSESSMENT PANEL SCORES

criterion	sub criterion	Brief Description	Southampton		Newc
			consensus	weighted	
Leadership and Strategic Vision	1	Organisation's main aims etc	4	3	4
	2	IT and estates strategy	4	7	4
	3	How proposals contribute to key objectives	4	7	4
	4	Current service delivery arrangements	4	7	4
	5	Stakeholder groups and their contribution	4	7	4
	6	Critical success factors	4	7	4
	7	Internal and external factors	4	7	4
	8	Constraints and riskd	4	7	4
	9	Benefits	4	10	4
	10	Opportunities for innovative working	4	10	4
	11	How the Team learns,developes and grows	4	10	5
			44	**82**	**45**
Strength of Network	a	Current achievements against standards	4	10	3
	b	Development plans	4	10	4
	c	Meet the minimum of 400 procedures	4	27	3
			12	**48**	**10**
Staffing and Activity	a	Current achievements against standards	2	10	2
	b	Development plans	4	20	3
	c	Meet the minimum of 400 procedures	4	64	3
			10	**94**	**8**
Inter- dependent Services	a	Current achievements against standards	5	25	4
	b	Development plans	5	25	4
	c	Meet the minimum of 400 procedures	4	64	3
			14	**114**	**11**
	a	Current achievements against standards	5	13	4

Facilities and Capacity	b	Development plans	5	13	4
	c	Meet the minimum of 400 procedures	5	34	4
			15	**60**	**12**
Age Appropriate Care	a	Current achievements against standards	4	7	3
	b	Development plans	4	7	4
	c	Meet the minimum of 400 procedures	4	17	3
			12	**31**	**10**
Information and Choices	a	Current achievements against standards	4	7	3
	b	Development plans	4	7	3
	c	Meet the minimum of 400 procedures	5	21	3
			13	**35**	**9**
Ensuring Excellent Care	a	Current achievements against standards	5	9	4
	b	Development plans	4	7	4
	c	Meet the minimum of 400 procedures	5	34	4
			14	**50**	**12**
Deliver-ability & Achiev-ability	1		0	0	0
	2		0	0	0
	3		0	0	0
Original			**134**	**513**	**117**

:astle	Leicester		Bristol		Leeds		Liverpool	
					consensus	weighted		
3	4	3	3	3	3	3	3	3
7	3	5	4	7	3	5	2	3
7	4	7	4	7	3	5	3	5
7	4	7	4	7	4	7	4	7
7	4	7	3	5	4	7	3	5
7	3	5	4	7	3	5	4	7
7	4	7	4	7	4	7	4	7
7	3	5	4	7	3	5	4	7
10	4	10	4	10	3	8	3	8
10	4	10	3	8	2	5	3	8
13	4	10	4	10	4	10	4	10
85	**41**	**77**	**41**	**77**	**36**	**67**	**37**	**69**
8	3	8	3	8	4	10	3	8
10	3	8	3	8	4	10	3	8
20	4	27	3	20	3	20	3	20
38	**10**	**43**	**9**	**36**	**11**	**41**	**9**	**36**
10	2	10	2	10	2	10	2	10
15	3	15	4	20	3	15	3	15
48	3	48	4	64	3	48	3	48
73	**8**	**73**	**10**	**94**	**8**	**73**	**8**	**73**
20	2	10	4	20	5	25	5	25
20	2	10	4	20	5	25	5	25
48	2	32	4	64	4	64	4	64
88	**6**	**52**	**12**	**104**	**14**	**114**	**14**	**114**
10	3	8	4	10	3	8	4	10

10	3	8	4	10	3	8	4	10
27	4	27	4	27	3	20	4	27
48	**10**	**43**	**12**	**48**	**9**	**36**	**12**	**48**

5	3	5	3	5	4	7	3	5
7	4	7	3	5	4	7	4	7
13	4	17	3	13	3	13	4	17
25	**11**	**29**	**9**	**23**	**11**	**26**	**11**	**29**

5	4	7	4	7	4	7	4	7
5	4	7	4	7	4	7	4	7
13	3	13	4	17	3	13	4	17
23	**11**	**26**	**12**	**31**	**11**	**26**	**12**	**31**

7	3	5	4	7	3	5	3	5
7	4	7	4	7	3	5	3	5
27	4	27	4	27	3	20	3	20
41	**11**	**39**	**12**	**41**	**9**	**31**	**9**	**31**

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0	0	0		0	0	0		0
0	0	0		0	0	0		0

425	**108**	**402**	**117**	**449**	**109**	**401**	**112**	**420**

Birmingham		Oxford		Brompton		GOSH		Eve
5	4	2	2	4	3	4	3	5
4	7	2	3	4	7	4	7	4
5	9	2	3	4	7	4	7	5
4	7	2	3	4	7	3	5	4
4	7	3	5	4	7	4	7	4
4	7	2	3	4	7	4	7	5
4	7	2	3	4	7	4	7	5
4	7	2	3	3	5	4	7	5
4	10	2	5	4	10	4	10	5
4	10	3	8	4	10	4	10	4
5	13	2	5	4	10	5	13	5
47	**87**	**24**	**45**	**43**	**80**	**44**	**83**	**51**

3	8	3	8	3	8	3	8	3
4	10	2	5	3	8	3	8	4
4	27	2	14	3	20	3	20	4
11	**45**	**7**	**26**	**9**	**36**	**9**	**36**	**11**

2	10	1	5	4	20	4	20	2
4	20	1	5	4	20	3	15	4
4	64	1	16	4	64	3	48	4
10	**94**	**3**	**26**	**12**	**104**	**10**	**83**	**10**

5	25	3	15	4	20	5	25	5
5	25	2	10	4	20	5	25	5
5	80	2	32	4	64	5	80	5
15	**130**	**7**	**57**	**12**	**104**	**15**	**130**	**15**

4	10	2	5	2	5	4	10	5

4	10	2	5	4	10	4	10	5
4	27	2	14	4	27	4	27	5
12	**48**	**6**	**24**	**10**	**43**	**12**	**48**	**15**

4	7	3	5	4	7	3	5	4
4	7	3	5	4	7	4	7	4
4	17	2	9	4	17	4	17	4
12	**31**	**8**	**19**	**12**	**31**	**11**	**29**	**12**

4	7	3	5	4	7	3	5	5
4	7	3	5	4	7	4	7	5
4	17	2	9	4	17	4	17	5
12	**31**	**8**	**19**	**12**	**31**	**11**	**29**	**15**

4	7	2	3	3	5	4	7	4
4	7	2	3	4	7	4	7	4
4	27	2	14	4	27	4	27	5
12	**41**	**6**	**20**	**11**	**39**	**12**	**41**	**13**

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0	0		0	0	0		0	0
0	0		0	0	0		0	0

131	**495**	**69**	**237**	**121**	**464**	**124**	**464**	**142**

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