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

Meeting to be held in Rooms 6 and 7, The Civic Hall, Leeds on Tuesday, 29th March, 2011 at 10.30 am

(Pre-meeting for all Committee Members at 10.00 a.m.)

MEMBERSHIP

Councillors

S Ali	-	Rotherham Council;
T Barker	-	North Lincolnshire Council;
E Byrom	-	Bradford Council;
J Clark	-	North Yorkshire County Council;
M Dobson (Chair)	-	Leeds City Council;
P Elliott	-	North East Lincolnshire Council
S Fraser	-	City of York Council
R Goldthorpe	-	Calderdale Council
B Hall	-	East Riding of Yorkshire Council
J Hancock	-	Barnsley Council
J Hewitt	-	Hull City Council
C Mills	-	Doncaster Council
B Rhodes	-	Wakefield Council
I Saunders	-	Sheffield Council
L Smaje	-	Kirklees Council

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

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Steven Courtney
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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

Item				Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal/prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES OF MEETING HELD ON 14 MARCH 2011** To confirm as a correct record, the minutes of the meeting held on 14 March 2011. **Minutes to follow**	
7			**RECONFIGURATION OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND - INITIAL RESPONSE FROM LEEDS TEACHING HOSPITALS NHS TRUST** To receive and consider the attached report of the Head of Scrutiny and Member Development	1 - 24
8			**RECONFIGURATION OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND - ADDITIONAL INFORMATION** To receive and consider the attached report of the Head of Scrutiny and Member Development	25 - 48

9			**RECONFIGURATION OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND - JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE: NEXT STEPS** To receive and consider the attached report of the Head of Scrutiny and Member Development	49 - 50
10			**DATE AND TIME OF NEXT MEETING** To be confirmed	

Agenda Item 7

Originator:	Steven Courtney
Tel:	247 4707

Report of the Head of Scrutiny and Member Development

Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

Date: 29 March 2011

Subject: Reconfiguration of Children's Congenital Heart Services in England – initial response from Leeds Teaching Hospitals NHS Trust

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to introduce and present details provided by Leeds Teaching Hospitals NHS Trust (LTHT) as an initial response to the Reconfiguration of Children's Congenital Heart Services in England options for consultation, published in early March 2011.

2.0 Background

2.1 As previously reported, in 2008 the NHS Medical Director requested a review of Children's Congenital Heart Services in England. The aim of the review was to develop and bring forward recommendations for a *Safe and Sustainable* national service that has:

- Better results in surgical centres with fewer deaths and complications following surgery
- Better, more accessible assessment services and follow up treatment delivered within regional and local networks
- Reduced waiting times and fewer cancelled operations
- Improved communication between parents/ guardians and all of the services in the network that see their child
- Better training for surgeons and their teams to ensure the service is sustainable for the future
- A trained workforce of experts in the care and treatment of children and young people with congenital heart disease
- Surgical centres at the forefront of modern working practices and new technologies that are leaders in research and development
- A network of specialist centres collaborating in research and clinical development, encouraging the sharing of knowledge across the network

2.2 On behalf of the ten Specialised Commissioning Groups in England, and their constituent local Primary Care Trusts, the *Safe and Sustainable* review team (at NHS Specialised Services) has managed the review process. This has involved:

- Engaging with partners across the country to understand what works well at the moment and what needs to be changed
- Developing standards – in partnership with the public, NHS staff and their associations – that surgical centres must meet in the future
- Developing a network model of care to help strengthen local cardiology services
- An independent expert panel assessment of each of the current surgical centres against the standards
- The consideration of a number of potential configuration options against other criteria including access, travel times and population.

2.3 At the Joint Committee of Primary Care Trusts (JCPCT) meeting held on 16 February 2011, the following recommendations and options for consultation were presented an agreed:

- Development of Congenital Heart Networks across England that would comprise all of the NHS services that provide care to children with Congenital Heart Disease and their families, from antenatal screening through to the transition to adult services.
- Implementation of new clinical standards that must be met by all NHS hospitals designated to provide heart surgery for children
- Implementation of new systems for the analysis and reporting of mortality and morbidity data relating to treatments for children with Congenital Heart Disease.
- A reduction in the number of NHS hospitals in England that provide heart surgery for children from the current 11 hospitals to 6 or 7 hospitals in the belief that only larger surgical centres can achieve true quality and excellence.
- The options for the number and location of hospitals that provide children's heart surgical services in the future are:

  Option A: Seven surgical centres at:
  - Freeman Hospital, Newcastle
  - Alder Hey Children's Hospital, Liverpool
  - Glenfield Hospital, Leicester
  - Birmingham Children's Hospital
  - Bristol Royal Hospital for Children
  - 2 centres in London[1]

  Option B: Seven surgical centres at:
  - Freeman Hospital, Newcastle
  - Alder Hey Children's Hospital, Liverpool
  - Birmingham Children's Hospital
  - Bristol Royal Hospital for Children
  - Southampton General Hospital
  - 2 centres in London[1]

[1] *The preferred two London centres in the four options are Evelina Children's Hospital and Great Ormond Street Hospital for Children*

Option C: Six surgical centres at:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London[1]

Option D: Six surgical centres at:

- Leeds General Infirmary
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London[1]

2.4 A period of public consultation has commenced and will run until 1 July 2011.

2.5 At the first meeting of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), members received a briefing around the proposals from representatives of the regional Specialised Commissioning Group (SCG) and agreed to invite representatives from LTHT to provide an initial response to the proposed reconfiguration of Children's Congenital Heart Services in England.

3.0 Initial response from Leeds Teaching Hospitals NHS Trust (LTHT)

3.1 Senior representatives from LTHT will be in attendance at the meeting, however by way of introduction, a brief summary of the Trust's initial response is appended to this report.

4.0 Recommendations

4.1 Members of the Joint HOSC (Yorkshire and the Humber) are asked to consider the details presented in this report and discussed at the meeting as part of its ongoing consideration of the options for consultation, and:

(a) Identify any specific matters that should be highlighted in the joint committee's final report and/ or consultation response

(b) Identify any specific matters/ issues that warrant further scrutiny.

5.0 Background Documents

- Children's Heart Surgery: The need for Change – April 2010
- A New Vision for Children's Congenital Heart Services in England: Consultation Document – March 2011

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The Leeds Teaching Hospitals NHS
NHS Trust

SAFE & SUSTAINABLE: REVIEW OF CHILDREN'S HEART SURGERY - IMPACT ON PATIENTS AND SERVICES YORKSHIRE AND THE HUMBER

The recent launch of a four-month public consultation on the Safe and Sustainable review of children's heart surgery units across England has a potentially very significant impact on patients across the Yorkshire and the Humber region.

Retaining the Leeds service is in only one of the four options being put forward for consultation, and is the least favoured option based on the complex scoring methodology adopted by the review team. There is therefore a very real prospect that the unit could be closed, with children having to travel outside this region for their surgery.

We believe there is a very strong case that Leeds should remain open and expand, and we are determined to take every opportunity of making that case throughout the consultation to as many different groups as possible. We are writing to seek your support in helping us argue that case, based on the serious implications this has for children from your district who need cardiac surgery.

Our view is that the scoring used to determine the options does not sufficiently reflect the important advantages Leeds has in terms of access, the size of the regional population, the services we provide on a single children's hospital site (alongside adult cardiac services) and the strength of the clinical network that has been established for paediatric congenital heart disease.

Sir Ian Kennedy's review team has already confirmed that there are no concerns about patient safety at any of the centres that remain within the scope of the review, so the decision ought to be made on the basis of sustainability of services. You will be aware of the strength of the geographical case for Leeds based on the large regional population we serve, so we believe there is a convincing argument to be made for retaining and expanding the Leeds service.

Already a strong public campaign has started, led by one our charities, the Children's Heart Surgery Fund, who have members and families they support from all the district hospitals in our region, and many of them are already speaking to their local media calling for the Leeds service to be retained. The charity has also been busy lobbying regional MPs, a number of whom have already been extremely supportive of keeping this service in Yorkshire.

Given that the outcome of this review is a significant issue for the entire Yorkshire and Humber region, we are keen to raise awareness that this is a regional issue and not one which only affects Leeds.

Whilst the review was primarily relating to safe and sustainable paediatric cardiac surgery, we are concerned that the impact on other services which are included in the scope of the review may have been missed, or not fully understood. This relates primarily to paediatric cardiology intervention and, as a consequence, the effective diagnosis of "blue babies".

LTHT
March 2011

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The Leeds Teaching Hospitals NHS
NHS Trust

Safe and Sustainable Children's Cardiac Services

Impact on children's services in Yorkshire and the Humber

The Leeds Teaching Hospitals NHS
NHS Trust

Where are we now?

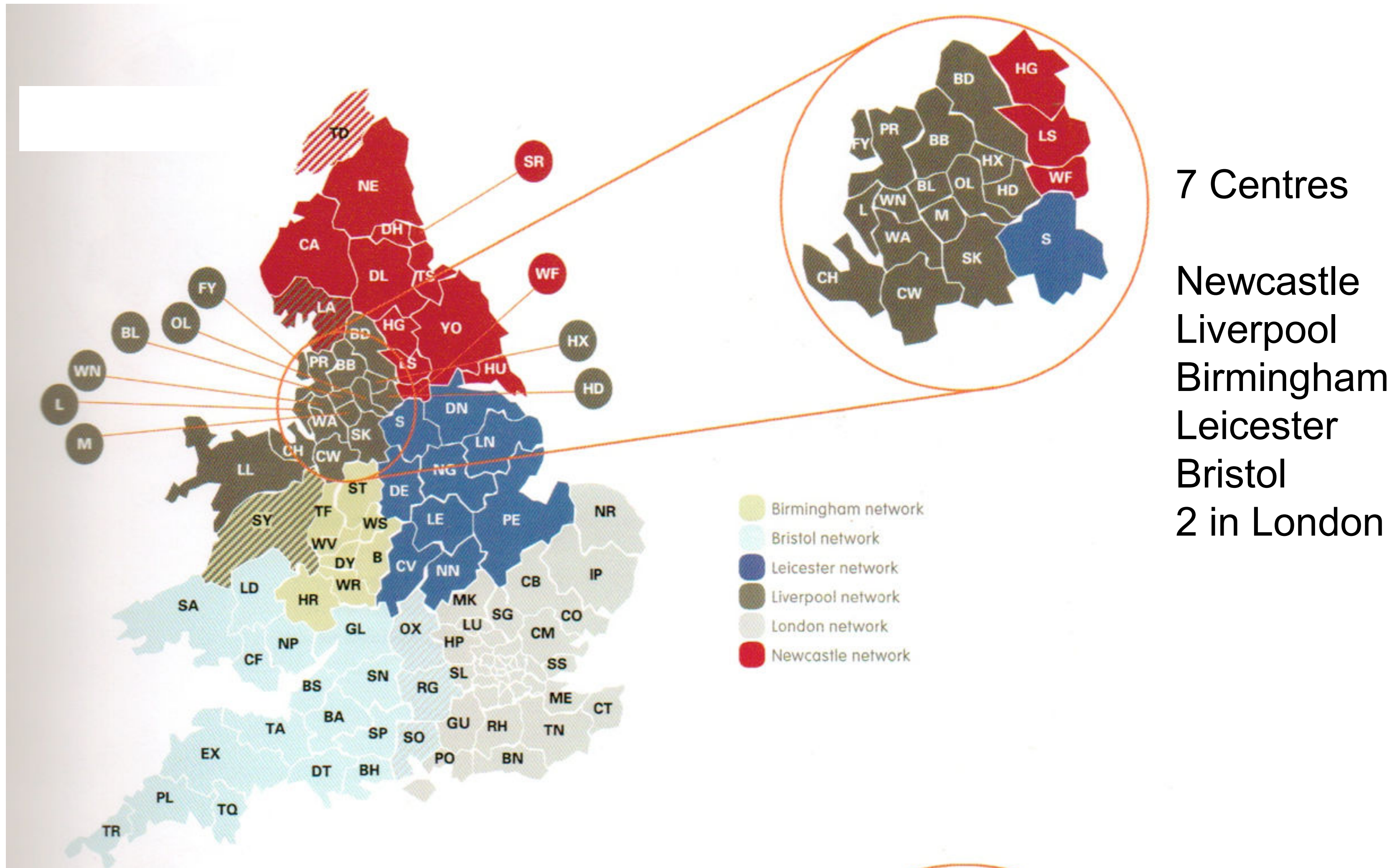
- At the end of an extensive review process, sponsored by the national specialist commissioners
- Finding that **all** UK centres are safe
- Potential options, narrowed down to 4 (with a preferred option), reducing 11 paediatric cardiac surgical options to 6/7

The process from here

- Joint committee of PCTs charged with making a final decision, considering:
  - option appraisal
  - health impacts (i.e. the impact on deprived and vulnerable communities)
  - information from the public consultation (runs from 4 months from 1/3/2011)

The Leeds Teaching Hospitals NHS
NHS Trust

The four options
Number 1*



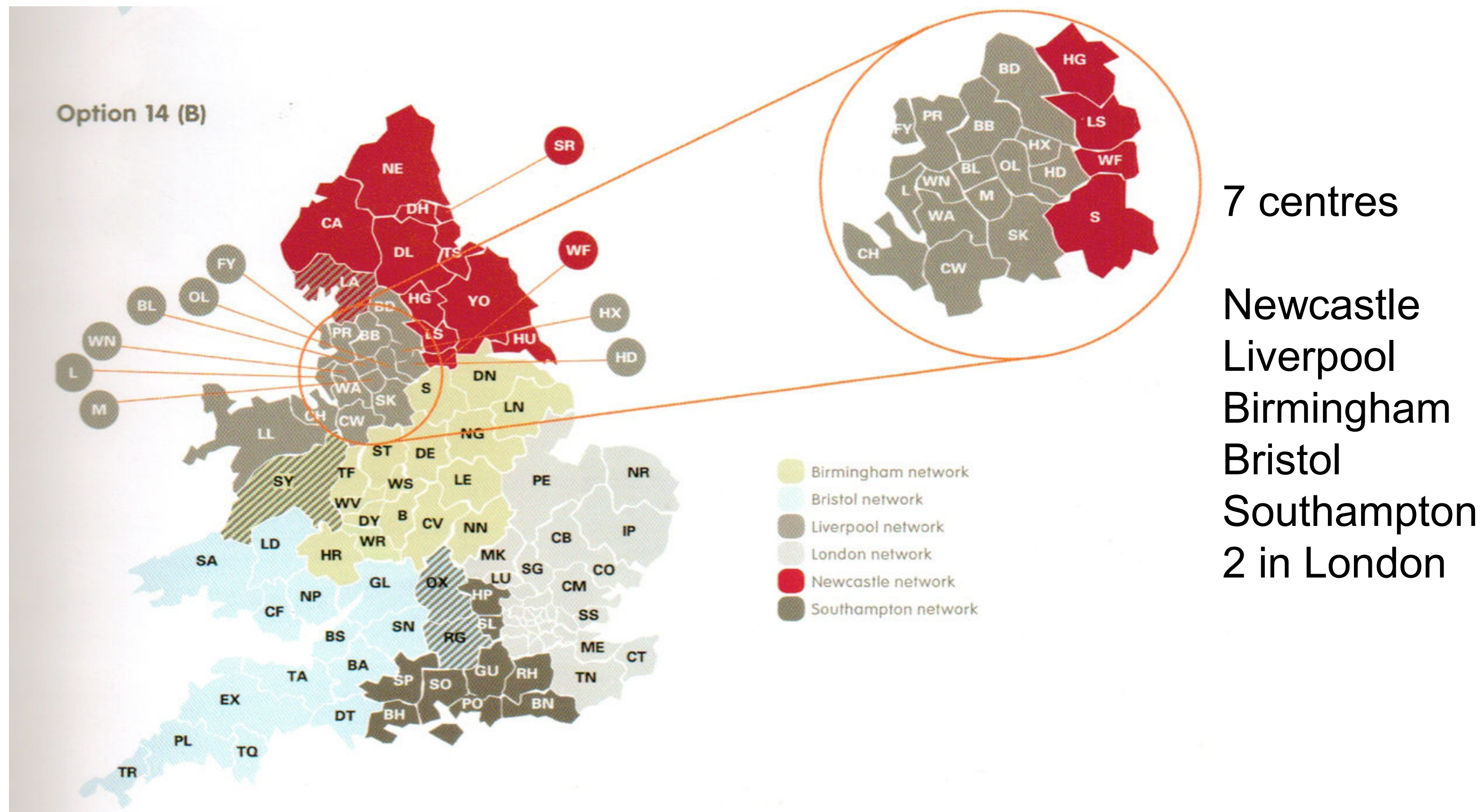
7 Centres

Newcastle
Liverpool
Birmingham
Leicester
Bristol
2 in London

* "Preferred option"

The Leeds Teaching Hospitals NHS Trust

The four options
Number 2

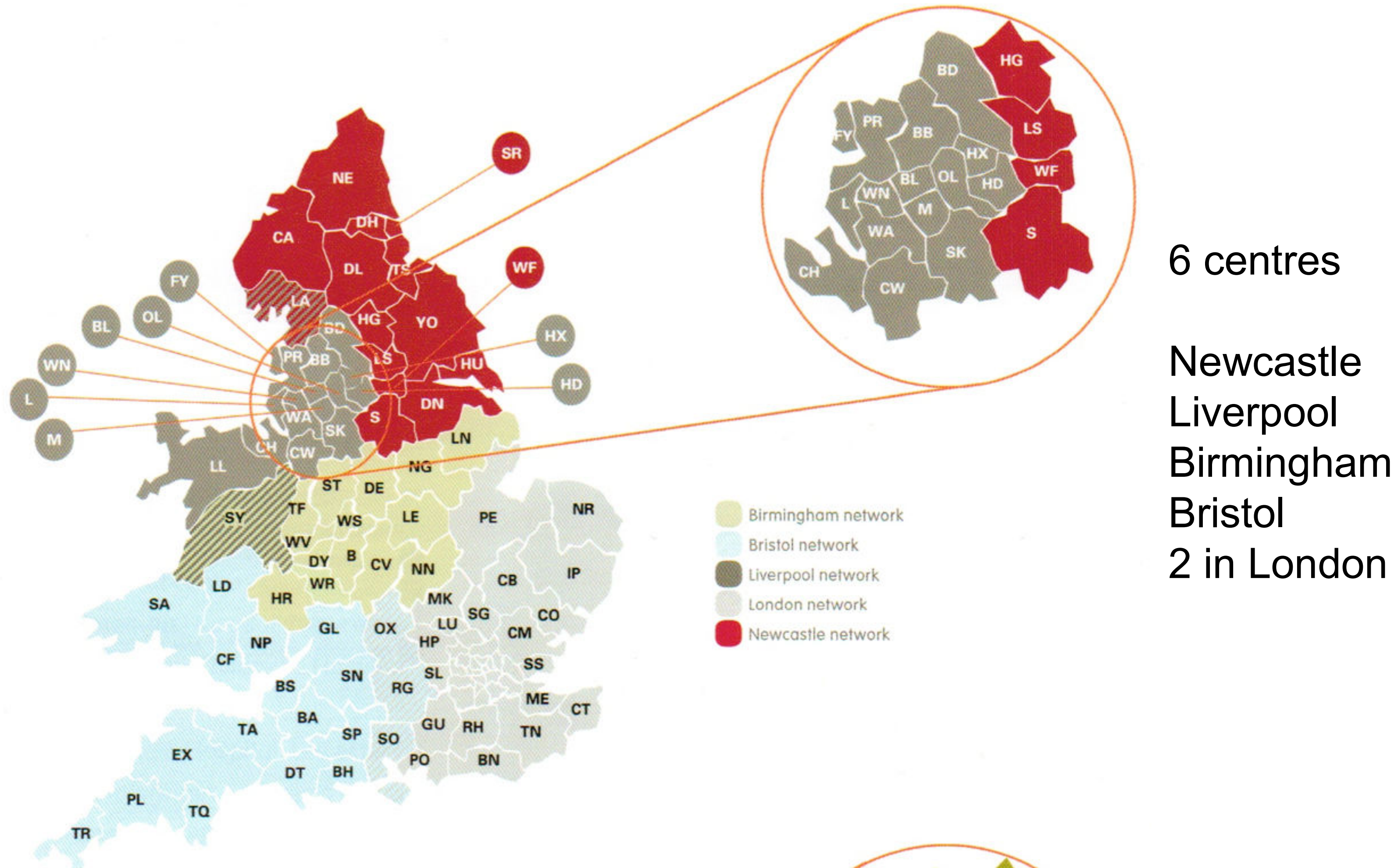


7 centres

Newcastle
Liverpool
Birmingham
Bristol
Southampton
2 in London

The Leeds Teaching Hospitals NHS
NHS Trust

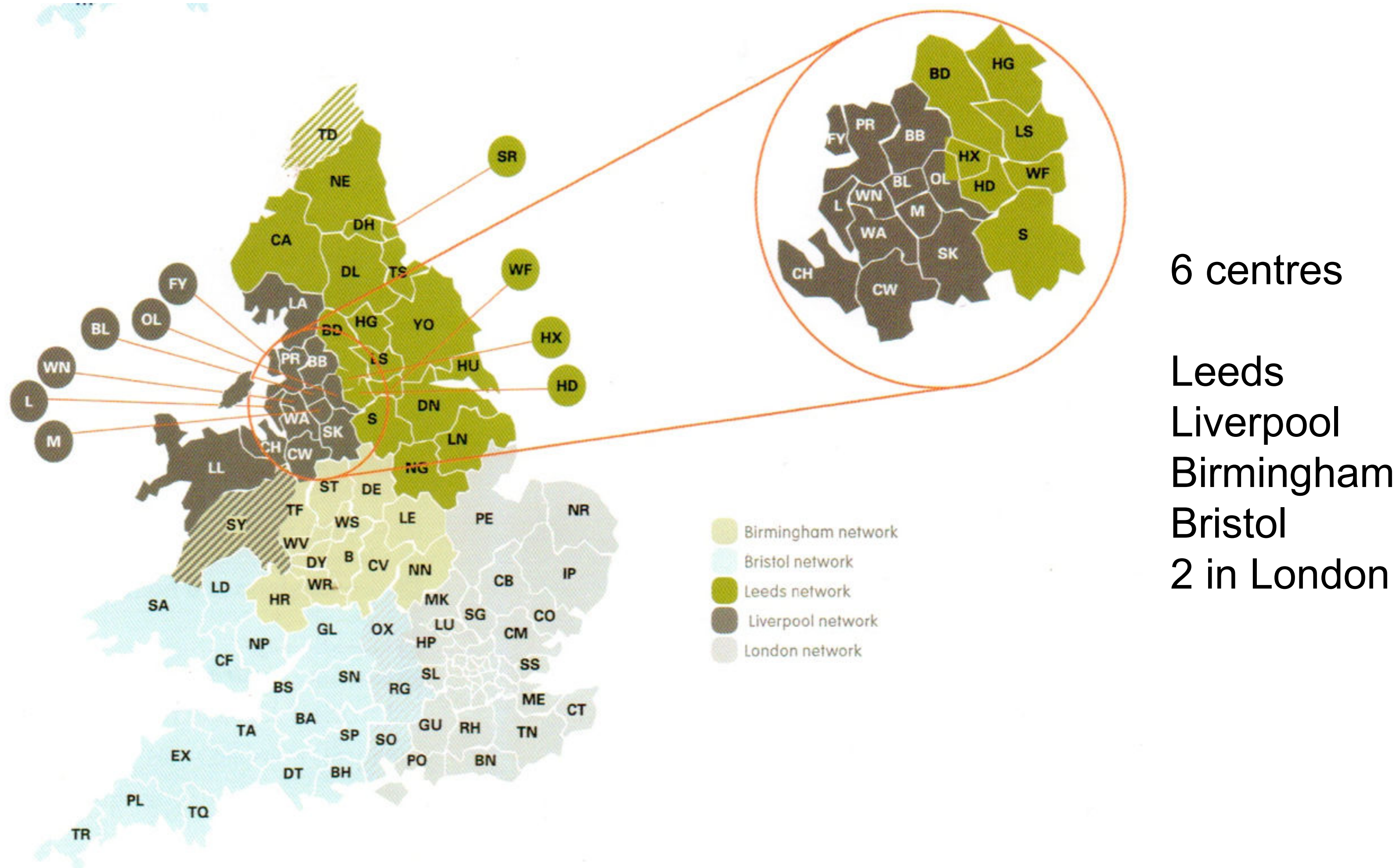
The four options
Number 3



6 centres

Newcastle
Liverpool
Birmingham
Bristol
2 in London

The four options
Number 4



6 centres

Leeds
Liverpool
Birmingham
Bristol
2 in London

The Leeds Teaching Hospitals NHS
NHS Trust

What is the regional response?

- Leeds only in 1 option (not the preferred one)

- Clinicians believe this is contrary to reason and based upon a flawed process

What should have been important

1. Proximity to the population

Proximity to the population

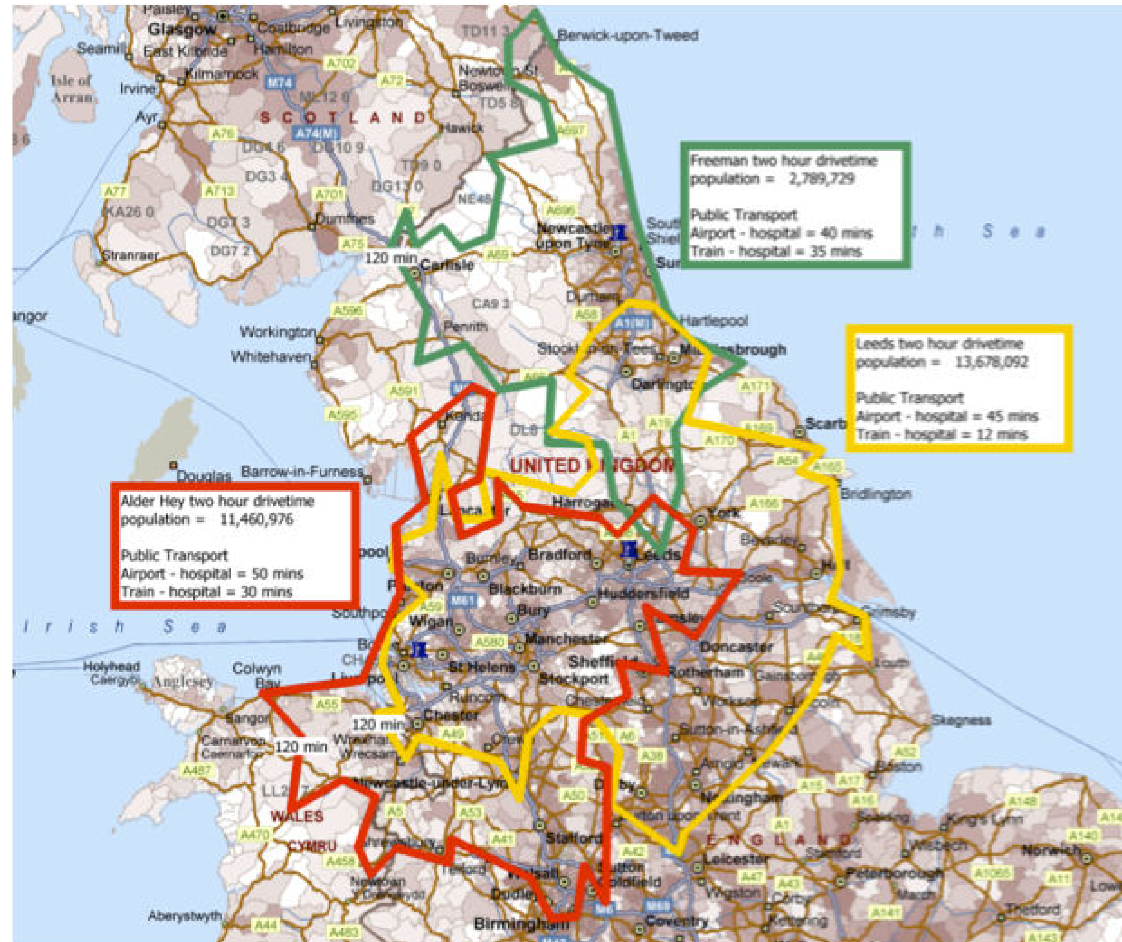
WITHIN 2 HOURS DRIVE:

LEEDS 13.7 MILLION

LIVERPOOL 11.5 MILLION

NEWCASTLE 2.8 MILLION

We believe regional health services should be located where people are



The Leeds Teaching Hospitals NHS
NHS Trust

Geography and population - an inequitable process?

- Liverpool and Birmingham appear in all options because of population density
- Southampton, is only in 1 option because of lack of geography and population density
- Options in the North-East appear to have systematically favored Newcastle over Leeds despite overwhelming population arguments

What should have been important

2 Co-location of services

- Sick children are best cared for in environments where they can access all necessary services
- Leeds in the only centre in the North of the UK to fulfill every paediatric and adult inter-dependency under one roof
- Newcastle, Liverpool and Leicester cannot provide this

Commissioning
Safe and Sustainable
Specialised
Paediatric Services

A Framework of Critical Inter-Dependencies

• Allergy • Blood and marrow transplantation • Burns • CAMHS • Cardiology • Cardiothoracic surgery • Cleft lip and palate • Clinical Haematology • Complex child & adolescent gynaecology • Cystic fibrosis • Dermatology • Endocrinology • ENT (Airway) • Ear nose and throat surgery • Gastroenterology • Haemophilia • Hepatology • HIV/AIDS treatment and care • Immunological disorder • Infectious disease • Major trauma • Malignant haematology • Medical genetics • Metabolic medicine • Morbid obesity • Neonatal intensive care • Neonatology • Nephrology • Neurology • Neurosurgery • Non-malignant haematology • Nutritional support • Oncology • Ophthalmology • Oral & maxillofacial surgery • Orthopaedics and spinal surgery • Paediatric critical care • Pathology • Plastic surgery • Renal replacement therapy • Respiratory medicine • Rheumatology • Specialised paediatric anaesthesia • Specialist paediatric surgery • Urology

DH Department of Health

The Leeds Teaching Hospitals
NHS Trust

Co-location of services – a critical issue

The view of the profession in response to the S&S recommendations: 18/2/2011

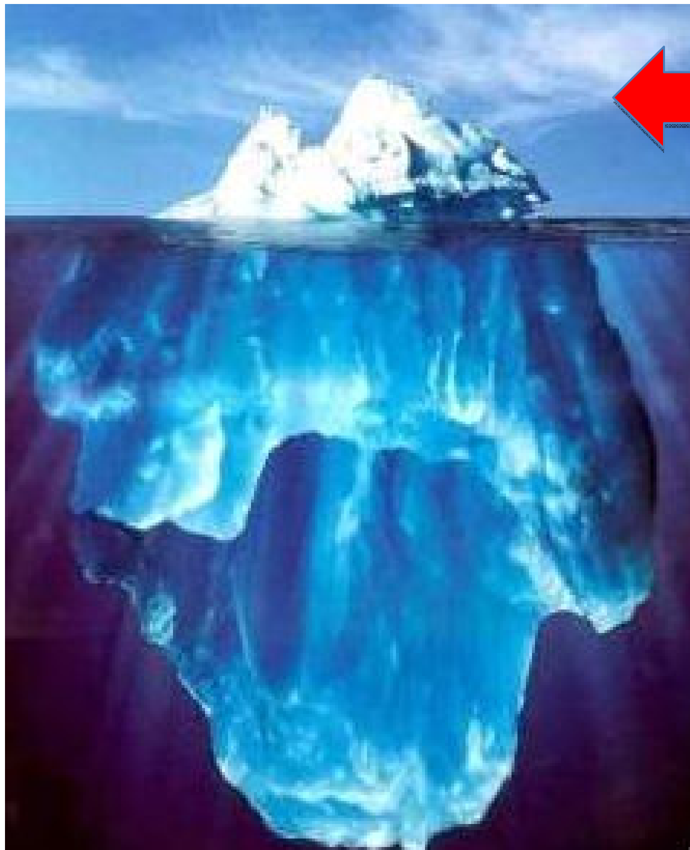
- The BCCA believes that quality of service is key and where possible, the location of units providing paediatric cardiac surgery should reflect the distribution of the population to minimise disruption and strain on families. It has become increasingly clear throughout this review that paediatric cardiac surgery cannot be considered in isolation and that numerous inter-dependencies between key clinical services (from fetus to adult) must be reflected in the final decision. The BCCA welcomes the recognition by the review that the linking of paediatric and adult cardiac services is integral to providing high quality care. It is important that the centres designated to provide paediatric cardiac surgery must be equipped to deal with all of the needs of increasingly complex patients. **For these services at each centre to remain sustainable in the long term, co-location of key clinical services on one site is essential**.

The Leeds Teaching Hospitals NHS
NHS Trust

The review - other concerns

- Inaccuracies and assumptions used to support the final option include:
  - an assumption Leeds has a maximum capacity of 600 operations – this is untrue and not information supplied by Leeds
  - inaccuracies documented in Sir Ian Kennedy’s report include Leeds not having transition nurse and having a separate PICU units - neither of these things are accurate.
- Leeds has pioneered clinical networks in this area and the majority of our regional work has now been adopted as national guidelines – this has not been reflected in the scoring as all centers received the same score.
- Start up costs for Leeds in the report published as £2 million – not clear where these figures have come from - these are not accurate and did not come from LTHT.

What does this mean for pediatric services in the Yorkshire and Humber?



Paediatric Cardiac Surgery

"The rest" – much wider impact than just paediatric cardiac . It is important to recognise and understand this

Includes (1)……..

- Loss of interventional cardiology
  - Some of the longest transfer times in the UK for time dependent babies will be for babies in the region to travel to Newcastle for this service
  - Babies who come to Leeds via a blue light ambulance to have a heart problem ruled in or out. This service will not be able to be provided in Leeds (approx 400 babies in 2010/11)
  - impact for Adult Congenital patients – same surgeons , so if Paediatric surgery moves then the Adult surgery could not be done in Leeds

Includes (2)........

- Significant reduction in children's intensive care capacity (closure of 8 beds , 50% of Leeds PICU capacity). This would have a significant impact for all parts of Yorkshire and the Humber and a high risk that children needing intensive care could not be accommodated in the region

- Impact for all other services that interact with this area – e.g. if there are no cardiac anesthetists or intensive care doctors then children with congenital heart disease who need elective surgery /intervention of almost any type may have to travel to a centre with these specialist staff.

Are the patients and services of this region really best served by moving them to support geographically isolated services?

It seems the main reason that Newcastle is in more options than Leeds is because of paediatric heart transplant service. However there is a very small numbers of such patients (less than 10 a year). It makes more sense to move the transplant service as it affects a much smaller number of children a year than moving a minimum of 1,000 patients a year from Yorkshire and the Humber to a different centre.

Patients matter

- LTHT and regional referrers do not believe this is the best or fairest way to treat patients
- Demography and geography are the obvious drivers
- Leeds is already acknowledged as safe
- We will make it sustainable by appointing a 4th surgeon

The Leeds Teaching Hospitals NHS
NHS Trust

Agenda Item 8

Originator:	Steven Courtney
Tel:	247 4707

Report of the Head of Scrutiny and Member Development

Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

Date: 29 March 2011

Subject: Reconfiguration of Children's Congenital Heart Services in England – additional information

Electoral Wards Affected:	Specific Implications For:
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to provide some additional information to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) to assist in its consideration of the proposed reconfiguration of Children's Congenital Heart Services in England and the associated options for consultation, published in early March 2011.

2.0 Background

2.1 The first meeting of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) took place on 14 March 2011. At that meeting, the joint committee received a briefing around the proposed reconfiguration of Children's Congenital Heart Services in England, from representatives of the regional Specialised Commissioning Group (SCG).

3.0 Additional Information

3.1 At that meeting, the joint committee subsequently identified a range of additional information that may assist in its consideration of issues associated with the proposed reconfiguration of Children's Congenital Heart Services in England. The following information is appended to this report:

- Projected/ estimated population flows under each of the 4 consultation options
- A series of frequently asked questions (FAQs) and the associated responses available from the Safe and Sustainable website

3.2 Further information identified at the meeting is currently been sort and will be provided as soon as practicable.

Letter from the Leader of Leeds City Council

3.3 A letter from the Leader of Leeds City Council has been received by the Chair of the joint committee and is attached for information. This may identify issues that the joint committee wish to explore further with the author, or third party organisations/ stakeholders.

4.0 Recommendations

4.1 Members of the Joint HOSC (Yorkshire and the Humber) are asked to consider the details presented in this report, as part of its ongoing consideration of the options for consultation, and:

(a) Identify any specific matters that should be highlighted in the joint committee's final report and/ or consultation response

(b) Identify any specific matters/ issues that warrant further scrutiny.

5.0 Background Documents

- A New Vision for Children's Congenital Heart Services in England: Consultation Document – March 2011

Population Flows to Surgical Centres

Postcode			Option A					
			London	Birmingham	Bristol	Newcastle	Liverpool	Leicester
AL	St Albans	18	18					
B	Birmingham	183		183				
BA	Bath	25			25			
BB	Blackburn	26					26	
BD	Bradford	32					32	
BH	Bournemouth	39			39			
BL	Bolton	20					20	
BN	Brighton	56	56					
BR	Bromley	22	22					
BS	Bristol	42			42			
CA	Carlisle	27				27		
CB	Cambridge	30	30					
CF	Cardiff	45			45			
CH	Chester	35					35	
CM	Chelmsford	48	48					
CO	Colchester	31	31					
CR	Croydon	29	29					
CT	Canterbury	35	35					
CV	Coventry	83						83
CW	Crewe	17					17	
DA	Dartford	31	31					
DE	Derby	33						33
DH	Durham	26				26		
DL	Darlington	31				31		
DN	Doncaster	43						43
DT	Dorchester	14			14			
DY	Dudley	42		42				
E	East London	65	65					
EC	East London Central	2	2					
EN	Enfield	25	25					
EX	Exeter	25			25			
FY	Blckpool	15					15	
GL	Gloucester	28			28			
GU	Guildford	53	53					
HA	Harrow	32	32					
HD	Huddersfield	15					15	
HG	Harrogate	8				8		
HP	Hemel Hempstead	21	21					
HR	Hereford	18		18				
HU	Hull	25				25		
HX	Halifax	9					9	
IG	Ilford	22	22					
IP	Ipswich	45	45					
KT	Kingston upon Thames	38	38					
L	Liverpool	46					46	
LA	Lancaster	18				11	8	
LD	Llandindod Wells	2			2			
LE	Leicester	43						43
LL	Llandudno	29					29	
LN	Lincoln	14						14
LS	Leeds	45				45		
LU	Luton	24	24					
M	Manchester	57					57	
ME	Medway	44	44					
MK	Milton keynes	22	22					
N	North London	58	58					
NE	Newcastle upon Tyne	97				97		
NG	Nottingham	52						52
NN	Northampton	30						30
NP	Newport	22			22			
NR	Norwich	54	54					
NW	Northwest London	36	36					
OL	Oldham	24					24	
OX	Oxford	26	13		14			
PE	Peterborough	40						40

PL	Plymouth	36			36			
PO	Portsmouth	60	60					
PR	Preston	28					28	
RG	Reading	34	23		11			
RH	Redhill	39	39					
RM	Romford	37	37					
S	Sheffield	77						77
SA	Swansea	33			33			
SE	Southeast London	67	67					
SG	Stevenage	30	30					
SK	Stockport	33					33	
SL	Slough	15	15					
SM	Sutton	16	16					
SN	Swindon	20			20			
SO	Southampton	48	42		6			
SP	Salisbury	16			16			
SR	Sunderland	22				22		
SS	Southend on Sea	37	37					
ST	Stoke	66		66				
SW	Southwest London	61	61					
SY	Shrewsbury	31		27			4	
TA	Taunton	15			15			
TD	Berwick on Tweed	2				2		
TF	Telford	21		21				
TN	Tunbridge Wells	49	49					
TQ	Torquay	13			13			
TR	Truro	14			14			
TS	Middlesborough	51				51		
TW	Twickenham	34	34					
UB	Uxbridge	25	25					
W	West London	35	35					
WA	Warrington	33					33	
WC	West Central London	2	2					
WD	Watford	19	19					
WF	Wakefield	30				30		
WN	Wigan	16					16	
WR	Worcester	31		31				
WS	Walsall	45		45				
WV	Wolverhampton	39		39				
YO	York	33				33		
		3598						
	PCBC after roundings		1442	472	420	406	445	414

Population Flows to Surgical Centres

Postcode			Option B					
			London	Birmingham	Bristol	Newcastle	Liverpool	Southampton
AL	St Albans	18	18					
B	Birmingham	183		183				
BA	Bath	25			25			
BB	Blackburn	26					26	
BD	Bradford	32					32	
BH	Bournemouth	39						39
BL	Bolton	20					20	
BN	Brighton	56						56
BR	Bromley	22	22					
BS	Bristol	42			42			
CA	Carlisle	27				27		
CB	Cambridge	30	30					
CF	Cardiff	45			45			
CH	Chester	35					35	
CM	Chelmsford	48	48					
CO	Colchester	31	31					
CR	Croydon	29	29					
CT	Canterbury	35	35					
CV	Coventry	83		83				
CW	Crewe	17					17	
DA	Dartford	31	31					
DE	Derby	33		33				
DH	Durham	26				26		
DL	Darlington	31				31		
DN	Doncaster	43				43		
DT	Dorchester	14			14			
DY	Dudley	42		42				
E	East London	65	65					
EC	East London Central	2	2					
EN	Enfield	25	25					
EX	Exeter	25			25			
FY	Blckpool	15					15	
GL	Gloucester	28			28			
GU	Guildford	53						53
HA	Harrow	32	32					
HD	Huddersfield	15					15	
HG	Harrogate	8				8		
HP	Hemel Hempstead	21						21
HR	Hereford	18		18				
HU	Hull	25				25		
HX	Halifax	9					9	
IG	Ilford	22	22					
IP	Ipswich	45	45					
KT	Kingston upon Thames	38	38					
L	Liverpool	46					46	
LA	Lancaster	18				11	8	
LD	Llandindod Wells	2			2			
LE	Leicester	43		43				
LL	Llandudno	29					29	
LN	Lincoln	14		14				
LS	Leeds	45				45		
LU	Luton	24	24					
M	Manchester	57					57	
ME	Medway	44	44					
MK	Milton keynes	22	22					
N	North London	58	58					
NE	Newcastle upon Tyne	97				97		

NG	Nottingham	52		52				
NN	Northampton	30		30				
NP	Newport	22			22			
NR	Norwich	54	54					
NW	Northwest London	36	36					
OL	Oldham	24					24	
OX	Oxford	26			14			13
PE	Peterborough	40	40					
PL	Plymouth	36			36			
PO	Portsmouth	60						60
PR	Preston	28					28	
RG	Reading	34			10			24
RH	Redhill	39						39
RM	Romford	37	37					
S	Sheffield	77				77		
SA	Swansea	33			33			
SE	Southeast London	67	67					
SG	Stevenage	30	30					
SK	Stockport	33					33	
SL	Slough	15						15
SM	Sutton	16	16					
SN	Swindon	20			20			
SO	Southampton	48						48
SP	Salisbury	16						16
SR	Sunderland	22				22		
SS	Southend on Sea	37	37					
ST	Stoke	66		66				
SW	Southwest London	61	61					
SY	Shrewsbury	31		27			4	
TA	Taunton	15			15			
TD	Berwick on Tweed	2				2		
TF	Telford	21		21				
TN	Tunbridge Wells	49	49					
TQ	Torquay	13			13			
TR	Truro	14			14			
TS	Middlesborough	51				51		
TW	Twickenham	34	34					
UB	Uxbridge	25	25					
W	West London	35	35					
WA	Warrington	33					33	
WC	West Central London	2	2					
WD	Watford	19	19					
WF	Wakefield	30				30		
WN	Wigan	16					16	
WR	Worcester	31		31				
WS	Walsall	45		45				
WV	Wolverhampton	39		39				
YO	York	33				33		
	Total	3598						
	PCBC after roundings		1160	725	360	526	445	382

Population Flows to Surgical Centres

Postcode			Option C				
			London	Birmingha	Bristol	Newcastle	Liverpool
AL	St Albans	18	18				
B	Birmingham	183		183			
BA	Bath	25			25		
BB	Blackburn	26					26
BD	Bradford	32					32
BH	Bournemouth	39			39		
BL	Bolton	20					20
BN	Brighton	56	56				
BR	Bromley	22	22				
BS	Bristol	42			42		
CA	Carlisle	27				27	
CB	Cambridge	30	30				
CF	Cardiff	45			45		
CH	Chester	35					35
CM	Chelmsford	48	48				
CO	Colchester	31	31				
CR	Croydon	29	29				
CT	Canterbury	35	35				
CV	Coventry	83		83			
CW	Crewe	17					17
DA	Dartford	31	31				
DE	Derby	33		33			
DH	Durham	26				26	
DL	Darlington	31				31	
DN	Doncaster	43				43	
DT	Dorchester	14			14		
DY	Dudley	42		42			
E	East London	65	65				
EC	East London (	2	2				
EN	Enfield	25	25				
EX	Exeter	25			25		
FY	Blckpool	15					15
GL	Gloucester	28			28		
GU	Guildford	53	53				
HA	Harrow	32	32				
HD	Huddersfield	15					15
HG	Harrogate	8				8	
HP	Hemel Hemps	21	21				
HR	Hereford	18		18			
HU	Hull	25				25	
HX	Halifax	9					9
IG	Ilford	22	22				
IP	Ipswich	45	45				
KT	Kingston upor	38	38				
L	Liverpool	46					46

LA	Lancaster	18				11	8
LD	Llandindod W	2			2		
LE	Leicester	43		43			
LL	Llandudno	29					29
LN	Lincoln	14		14			
LS	Leeds	45				45	
LU	Luton	24	24				
M	Manchester	57					57
ME	Medway	44	44				
MK	Milton keynes	22	22				
N	North London	58	58				
NE	Newcastle upo	97				97	
NG	Nottingham	52		52			
NN	Northampton	30		30			
NP	Newport	22			22		
NR	Norwich	54	54				
NW	Northwest Lon	36	36				
OL	Oldham	24					24
OX	Oxford	26	13		14		
PE	Peterborough	40	40				
PL	Plymouth	36			36		
PO	Portsmouth	60	60				
PR	Preston	28					28
RG	Reading	34	23		11		
RH	Redhill	39	39				
RM	Romford	37	37				
S	Sheffield	77				77	
SA	Swansea	33			33		
SE	Southeast Lon	67	67				
SG	Stevenage	30	30				
SK	Stockport	33					33
SL	Slough	15	15				
SM	Sutton	16	16				
SN	Swindon	20			20		
SO	Southampton	48	42		6		
SP	Salisbury	16			16		
SR	Sunderland	22				22	
SS	Southend on S	37	37				
ST	Stoke	66		66			
SW	Southwest Lo	61	61				
SY	Shrewsbury	31		27			4
TA	Taunton	15			15		
TD	Berwick on Tw	2				2	
TF	Telford	21		21			
TN	Tunbridge We	49	49				
TQ	Torquay	13			13		
TR	Truro	14			14		
TS	Middlesboroug	51				51	
TW	Twickenham	34	34				
UB	Uxbridge	25	25				

W	West London	35	35				
WA	Warrington	33					33
WC	West Central	2	2				
WD	Watford	19	19				
WF	Wakefield	30				30	
WN	Wigan	16					16
WR	Worcester	31		31			
WS	Walsall	45		45			
WV	Wolverhampto	39		39			
YO	York	33				33	
		3598					
	PCBC after roundings		1442	725	420	526	445

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Population Flows to Surgical Centres

Postcode			Option D				
			London	Birmingham	Bristol	Leeds	Liverpool
AL	St Albans	18	18				
B	Birmingham	183		183			
BA	Bath	25			25		
BB	Blackburn	26					26
BD	Bradford	32				32	
BH	Bournemouth	39			39		
BL	Bolton	20					20
BN	Brighton	56	56				
BR	Bromley	22	22				
BS	Bristol	42			42		
CA	Carlisle	27				27	
CB	Cambridge	30	30				
CF	Cardiff	45			45		
CH	Chester	35					35
CM	Chelmsford	48	48				
CO	Colchester	31	31				
CR	Croydon	29	29				
CT	Canterbury	35	35				
CV	Coventry	83		83			
CW	Crewe	17					17
DA	Dartford	31	31				
DE	Derby	33		33			
DH	Durham	26				26	
DL	Darlington	31				31	
DN	Doncaster	43				43	
DT	Dorchester	14			14		
DY	Dudley	42		42			
E	East London	65	65				
EC	East London Central	2	2				
EN	Enfield	25	25				
EX	Exeter	25			25		
FY	Blckpool	15					15
GL	Gloucester	28			28		
GU	Guildford	53	53				
HA	Harrow	32	32				
HD	Huddersfield	15				15	
HG	Harrogate	8				8	
HP	Hemel Hempstead	21	21				
HR	Hereford	18		18			
HU	Hull	25				25	
HX	Halifax	9				9	
IG	Ilford	22	22				
IP	Ipswich	45	45				
KT	Kingston upon Thames	38	38				
L	Liverpool	46					46
LA	Lancaster	18					18
LD	Llandindod Wells	2			2		
LE	Leicester	43		43			
LL	Llandudno	29					29
LN	Lincoln	14				14	
LS	Leeds	45				45	
LU	Luton	24	24				
M	Manchester	57					57
ME	Medway	44	44				
MK	Milton keynes	22	22				
N	North London	58	58				
NE	Newcastle upon Tyne	97				97	

NG	Nottingham	52				52	
NN	Northampton	30		30			
NP	Newport	22			22		
NR	Norwich	54	54				
NW	Northwest London	36	36				
OL	Oldham	24					24
OX	Oxford	26	13		14		
PE	Peterborough	40	40				
PL	Plymouth	36			36		
PO	Portsmouth	60	60				
PR	Preston	28					28
RG	Reading	34	23		11		
RH	Redhill	39	39				
RM	Romford	37	37				
S	Sheffield	77				77	
SA	Swansea	33			33		
SE	Southeast London	67	67				
SG	Stevenage	30	30				
SK	Stockport	33					33
SL	Slough	15	15				
SM	Sutton	16	16				
SN	Swindon	20			20		
SO	Southampton	48	42		6		
SP	Salisbury	16			16		
SR	Sunderland	22				22	
SS	Southend on Sea	37	37				
ST	Stoke	66		66			
SW	Southwest London	61	61				
SY	Shrewsbury	31		27			4
TA	Taunton	15			15		
TD	Berwick on Tweed	2				2	
TF	Telford	21		21			
TN	Tunbridge Wells	49	49				
TQ	Torquay	13			13		
TR	Truro	14			14		
TS	Middlesborough	51				51	
TW	Twickenham	34	34				
UB	Uxbridge	25	25				
W	West London	35	35				
WA	Warrington	33					33
WC	West Central London	2	2				
WD	Watford	19	19				
WF	Wakefield	30				30	
WN	Wigan	16					16
WR	Worcester	31		31			
WS	Walsall	45		45			
WV	Wolverhampton	39		39			
YO	York	33				33	
		3598					
	PCBC after roundings		1482	660	420	636	400

FAQs on the public consultation into the proposed changes to children's congenital heart services in England

The recommendations

Who agreed the recommendations for public consultation?

The recommendations for change were agreed by a joint committee of Primary Care Trusts (JCPCT) which comprises the Chair of each of the 10 Specialised Commissioning Groups in England (or the nominated PCT representative) and the Director of National Specialised Commissioning; it is chaired by the Chief Executive of the East of England Strategic Health Authority – Sir Neil McKay. The establishment of a JCPCT ensures that each region and each PCT in England is represented on the decision-making body.

Why just two centres in London?

The *Safe and Sustainable* consultation on the future of children's congenital heart services proposes that there should be two rather than three Specialist Surgical Centres in London. The forecast activity levels for London and its catchment area (currently around 1,250 paediatric procedures per year) mean that two centres would be well placed to meet the proposed ideal number of 500 procedures a year. This could only happen with three London centres if patients were diverted from neighbouring catchment areas into London. The JCPCT recommends that this would significantly, and unjustifiably, increase travel times and impact on access for patients outside of London, South East and East of England.

Based on the considerable evidence available members of the Joint Committee of Primary Care Trusts expressed a preference that children's heart surgery should be carried out at the Evelina Children's Hospital and Great Ormond Street Hospital. People taking part in the consultation will be free to say that they want three London

centres and to express a preference for the Royal Brompton Hospital as a Specialist Surgical Centre if they prefer only two centres.

Why just two centres in the north?

Northern England (defined as Newcastle, Liverpool and Leeds centres) needs 2 centres as there are not enough patients to ensure all 3 achieve the 400 procedure minimum. These 2 should either be Liverpool and Newcastle or Liverpool and Leeds as Newcastle and Leeds cannot achieve the 400 minimum each while maintaining strong networks and access times.

Why does Southampton only appear in one option when it was ranked so highly by Sir Ian Kennedy's assessment panel?

Although the Southampton centre scored highly in Sir Ian Kennedy's assessment it remains unclear whether the Southampton centre can generate enough referrals to meet the proposed minimum level of 400 child heart operations a year. This figure was developed and endorsed by the professional associations and is considered by the clinical experts to be one of the core standards for improving care in the future.

Why does the Bristol centre appear in all of the options?

Based on the assumption that patients will travel to their nearest centre and a consideration of existing clinical networks, the initial findings of the JCPCT's analysis suggest that the Bristol and Southampton centres are not both viable in the same configuration options. This is due to the fact there are too few patients in South Central England, South West England and South Wales to ensure both centres carry out the minimum 400 procedures, without making potentially unreasonable changes to catchment areas for the populations of London, South East England and the Midlands. Bristol has been included in all options because an ambulance would not be able to retrieve children from the South West Cornwall and South Wales in an emergency within the time-limits recommended by the Paediatric Intensive Care Society if the Bristol centre no longer carried out surgery as it is over three hours to Southampton or Birmingham.

So why does Option B include both Southampton and Bristol?

It is possible that since our analysis the Southampton centre may be able to demonstrate that it can perform 400 child heart operations each year due to a proposed collaboration with the John Radcliffe Hospital. During consultation we will test how patient flows in South Central England could change following the suspension of the service at the John Radcliffe Hospital in 2010 and what impact, if any, this would have on the numbers for the Bristol service. The validated activity data for the 2010/11 year will be available to us in June 2011. Separately, we will also test whether the postcodes that we have included in the Southampton network make option B viable.

Why doesn't the John Radcliffe Hospital in Oxford appear in any of the recommendations?

The JCPCT has recommended that the Oxford Centre should be discounted from all options on the basis that it is not viable to assume that this centre could meet the quality standards in the future and because retention of the centre would not improve access arrangements.

Can you explain briefly how you see services actually working if we have fewer centres offering surgery to children with congenital heart defects?

The JCPCT proposes that services would be provided through networks called congenital heart networks. These would be clinically led. These networks would be led by the specialist surgical centre which would be able to perform specialist interventional and surgical procedures. Although many children will need surgery the number of children needing surgery more than once in their life is low. Therefore, the new networks would bring cardiology care closer to home through district children's cardiology services. The role of paediatricians with expertise in cardiology and children's cardiology specialist nurses would be strengthened to ensure seamless and consistent local care.

When considering patient flows, might parents prefer to follow the surgeon they already know, regardless of what your patient flow analysis says?

This is an important point and, given the importance of patient choice, one of the factors that we are very keen to test out during the consultation period. We already have professional data on 'patient flows' – including forecasts - which have informed the recommended options. However, as part of the consultation process, we seek the views of patients, parents, staff and local commissioners to gather their views.

I have heard that the NHS in Wales is planning its own child heart surgery service in Cardiff. Does this mean that your assumptions about activity levels at Bristol are wrong?

The NHS in Wales has confirmed that it has no plans to develop a child heart surgery service. The centre in Cardiff stopped performing heart surgery for children in 1998 because it recognised that it was not performing a sufficient number of surgical procedures to be sustainable.

Is your process robust?

Details about the process we have used are set out in the Pre-Consultation Business Case. The *Safe and Sustainable* review has been led by clinicians and the chosen options were arrived at after an extremely thorough process. On 27 January 2011, just before the JCPCT agreed recommendations for consultation on 16 February, the process that we have followed to identify potential options was presented to the expert steering group which endorsed the process. We have set out a significant amount of information about the way in which the Joint Committee of Primary Care Trusts reached its recommendations. Safe and Sustainable has itself been subject to external scrutiny by both the National Clinical Advisory Team and the Office of Government Commerce Gateway programme and the review team has been commended for the robustness of the process.

The clinical evidence

What is the clinical evidence for concentrating centres/ having fewer centres?

A recommendation for the concentration of medical and nursing expertise in smaller centres of excellence providing children's congenital cardiac services was made as far back as 2001 in the report of the public inquiry into paediatric cardiac surgical services at the Bristol Royal Infirmary. Subsequent working groups and reports have endorsed the recommendation, including the Royal College of Surgeons in 2007 and then in 2010 by the expert group of clinicians that has advised the *Safe and Sustainable* review and the independent National Clinical Advisory Team. The evidence base for ensuring a critical mass of surgical procedures per surgical unit is drawn from other examples in surgery which show that the more frequently a surgeon is performing a particular procedure, the better the outcomes in both morbidity and mortality.

The *Safe and Sustainable* review team asked the Public Health Resource Unit to carry out an independent review of the available literature around the relationship between volume and outcome in paediatric cardiac surgery. Two particular studies from that review are worth highlighting. The first was published in 2008 and was significant in that it was based on a study of a large number of operations of more than 55,000 over a period of 17 years. This study concluded that large volume hospitals performed more complex operations and achieved superior results. A further study based on over 32,000 patients found that for more difficult surgical procedures smaller surgical units performed significantly worse.

What are the risks that come with smaller centres?

- <u>24 hours a day seven days a week</u>
  Smaller centres with two or three surgeons are unable to operate safe surgical rotas which guarantee care at all times of the day or night when a child needs it.
- <u>Cancellations</u>
  Some centres need to cancel planned surgery which can cause considerable distress and upheaval for families. Without enough surgeons at each centre

planned operations are more likely to be cancelled especially if an emergency arises.

- Attracting and retaining the best staff
  At smaller centres it is harder for surgical teams to see enough children with a variety of conditions to maintain their skills so that they can give children the very best care and attract other excellent staff.
- Isolation
  Staff working in small centres that do not work in collaboration with other centres risk being isolated from their peers in larger busier centres. This can mean smaller centres might not use the latest techniques for children's care.
- Suspensions in service
  Centres rely heavily on their staff. Sudden changes in staffing could destabilise a small centre meaning that surgery and cardiology services have to be suspended for a period of time.
- Strain on surgeons
  If a centre only has two surgeons it can place a significant strain on them especially when urgent care is required. Imagine the strain on surgeons who may have performed operations all day and then get called out at night. It is not sensible for a surgeon who is over-tired to carry out complex surgery.

What is the clinical evidence for four cardiac surgeons per centre?

The proposed *Safe and Sustainable* standards, endorsed by the relevant professional associations, recommend that children's congenital heart surgery units are staffed by a minimum of 4 consultant congenital cardiac surgeons. In 2003 the report of the Paediatric and Congenital Cardiac Services Review Group recommended a minimum of three surgeons in each surgical centre, based on professional consensus. However, in 2007 the Royal College of Surgeons of England recommended 'four or five surgeons' in each centre based on the need to concentrate expertise in the interests of quality.

The minimum of 4 surgeons per team can be supported by looking at the job plans and available sessions of the surgeons. At all times there should be a surgeon available to be in theatre; a surgeon on-call for emergencies; a surgeon available for outpatient clinics; and a surgeon available to undertake ward rounds. In addition,

given the average of 40 weeks at work per year (the remaining time being spent on annual leave, study leave or conducting research), there may only ever be 3 of the surgeons at work, available to cover all of the above positions at any one time.

Who is actually supporting this review?

Many organisations and individuals support the rationale for change. Professional associations, surgeons, cardiologists, paediatricians, nurses and other clinicians have urged the NHS for many years to centralise children's heart surgery in fewer, larger centres. Parent groups and the leading national heart charity also publicly support the fact that there needs to be change.

Examples of supporting organisations:

- British Heart Foundation
- Children's Heart Federation
- Little Hearts Matter
- British Congenital Cardiac Association
- Academy of Royal Colleges
- Royal College of Paediatrics and Child Health
- Royal College of Surgeons
- Royal College of Nursing
- Society for Cardiothoracic Surgery in Great Britain and Ireland
- Specialised Healthcare Alliance
- Paediatric Intensive Care Society

Taking part in the consultation

What are you actually consulting on?

We would like people's views on the following areas:

- Standards of care: higher standards of care provided consistently across the country
- Congenital heart networks: surgical centres lead a congenital heart network

- Better monitoring: improved system for analysis and reporting of mortality and morbidity data
- Surgical centres: for the number and location of hospitals that provide children's heart surgical services in the future

Haven't decisions already been made?

Absolutely not. We take the process of the review – and the consultation – very seriously. We would like to hear from anyone with a view on the future of congenital heart services, including the people most affected: parents, young people and NHS staff.

Will you be reimbursing travel expenses for the consultation events?

We have given careful consideration to requests for the NHS to reimburse travel expenses for those attending consultation events. We have checked with the ten Strategic Health Authorities which have advised *Safe and Sustainable* that it is not recognised policy to reimburse travel expenses for public consultation events. We have also considered the rules set out by the Department of Health in this area. The Department encourages the NHS to reimburse expenses for 'engagement' events but not for 'consultation' events. We have therefore reluctantly decided that travel expenses will not be reimbursed.

We have ensured that there are a number of different ways for people to participate in the consultation. It is important that young people with congenital heart disease, parents, staff and stakeholders can easily participate in the consultation. The consultation events are only one of the ways in which individuals can get involved. The consultation materials including the response form are available online and can be provided in hard copy on request. Hard copies of the consultation document and response form will also be available through parent groups, NHS Trusts and professional associations.

Requests for hard copies of the consultation document and the consultation response form can be emailed to nhsspecialisedservices@grayling.com or alternatively you can call 0207 025 7520.

Why did you reimburse travel for the engagement events last year?

The Department of Health makes a distinction between 'engagement' and 'consultation' events. The DH encourages the NHS to reimburse travel fares to engagement events because attendance in person is considered necessary for effective engagement to take place. This is why we offered reimbursements for attendees of the engagement events that took place in 2009 and 2010.

In view of the population size, why are you only holding one event in London?

We are holding three events for the catchment area served by the London centres. We are holding them in London, Cambridge and Gatwick to make it easier for people to attend.

Will petitions be counted if submitted in response to the consultation?

All views count but this is not a 'vote'. All reports, letters and petitions will feed in to the formal consultation process. However, the most effective way to have your say is by filling out the response form with the consultation document on the website at www.specialisedservices.nhs.uk

We encourage people to respond to the consultation by completing the consultation response form (www.ipsos-mori.com/safeandsustainable). The form includes a number of questions enabling you to set out your preferences. It also includes spaces for you to add your comments and suggestions.

We are aware of numerous petitions that people have signed to express their support for a particular surgical centre. Whilst we will be considering all forms of response, it is worth noting that petitions themselves will not carry any extra weight than a consultation response form. We encourage you to use the consultation

response form as this is the best way for your views to be analysed by Ipsos Mori, an independent third party. After the consultation period a detailed analysis of the response forms will be carried out and Ipsos Mori will deliver a report to help inform the JCPCT's final decision.

You are also invited to register to attend consultation events to put your questions to expert clinicians (www.eventsforce.net/safeandsustainable). Comments made at these events will be summarised in a report for the JCPCT to consider before it makes its final decision.

Who will make the final decision on these proposals after consultation?

Following full consideration of the views of the public during the consultation phase and taking into account tests done on the viability of each option during the same period the Joint Committee of Primary Care Trusts plans to meet in November 2011 to make a final decision on the best configuration of services.

Councillor Keith Wakefield
Leader of Leeds City Council
Civic Hall
Leeds LS1 1UR

Telephone: (0113) 247 4444
Fax: (0113) 247 4046
Email: keith.wakefield@leeds.gov.uk

Cllr Mark Dobson
Chair, Regional Health Scrutiny Board

Our ref: KW\SS137

3rd March 2011

Dear Cllr Dobson

Following the Joint Committee of Primary Care Trusts' endorsement of last month's recommendations of the NHS' Safe and Sustainable review, I am writing to express grave concern about the implications for children's cardiac surgery services in Leeds.

I would like my comments to be considered by the regional health scrutiny board as you review the proposed reconfiguration of children's cardiac surgery services.

My concern is borne out of the fact that Leeds features in only one of the four options recommended by the committee, despite the fact that the unit serves a regional population of almost 14 million. Leeds General Infirmary is ideally placed to deliver services, as it does now, to people living throughout Yorkshire, Humberside, Lincolnshire and the north Midlands.

The medical teams in Leeds are very highly regarded by families whose children have undergone cardiac surgery. This review could present an opportunity to build upon that reputation for excellence by expanding services in Leeds. Instead, in three of the four options under consideration, families in the north of England are facing a two tier system whereby children may have diagnostic tests in Leeds before being transferred to another centre. The consistency of treatment and medical staff that families have come to expect and value at the unit in Leeds would therefore be lost.

At present services in Leeds are structured in such a way as to enable access to a range of children's health services on one site, thus promoting the effective treatment of a range of interdependent conditions.

On first reading, it is unclear to what extent the co-location of services has been considered by the review team. My understanding is that children with cardiac conditions often present a range of complex conditions that may require access to and treatment by other specialist paediatric services. Therefore, it would seem sensible to consider

children's cardiac surgery services in this wider context. However, I feel this is not explicitly addressed in the consultation document.

The creation of the dedicated children's hospital on the Leeds General Infirmary site was part of a wider Clinical Services Reconfiguration, which involved capital costs in excess of £34m. The programme, which was developed and supported by key stakeholders, including NHS Leeds and NHS Yorkshire and the Humber, was approved by the Trust Board in March 2009. The new Children's Hospital opened about a year later. This constituted a significant investment in the future of services for children at the Leeds General Infirmary. To now remove specialist surgical services from Leeds appears to contradict the significant regional efforts to develop a truly holistic, one site service for children.

Leeds does currently experience periods where there are not enough pediatric intensive care beds available to meet demand. If children's cardiac surgery is removed from Leeds, the number of these local intensive care beds will also further decrease. This move will therefore impact on children across the region, not just those specifically in need of cardiac surgery.

This issue of transport is crucial in the consideration of the future of these services. Preventing specialists in Leeds from carrying out life saving surgery will inevitably result in critically ill children being transported greater distances over a longer period of time. The consequential need for families to travel those distances in order to support their child through treatment will inevitably place unnecessary additional strain on parents and carers.

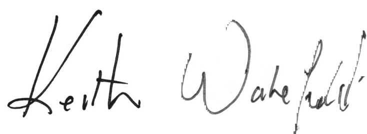
This distressing experience will not be limited to children with congenital heart conditions as the extra pressure on teams transporting sick children would also reduce their ability to respond quickly to requests to transfer other poorly children to specialist units such as paediatric intensive care.

Equally, an expectant mother, whose unborn child has a suspected congenital heart condition would be required to deliver her baby a long way from home, at a time when local and regional support networks would arguably be most important.

Aside of the impact these proposals will have on families, removing highly valued surgical expertise from this region will clearly also have an adverse impact on already challenging health inequalities.

When considering this reconfiguration of services I would urge all concerned to prioritise the needs of the many families across our region who could potentially benefit from an excellent local and regional service that has a proven track record of success.

Yours sincerely



Councillor Keith Wakefield
<u>Leader of Leeds City Council</u>

Agenda Item 9

Leeds
CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

Date: 29 March 2011

Subject: Reconfiguration of Children's Congenital Heart Services in England – Joint Health Overview and Scrutiny Committee: Next Steps

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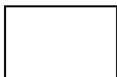
Electoral Wards Affected:	Specific Implications For:
	Equality and Diversity ☐
	Community Cohesion ☐
 Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to consider the next steps for the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to its consideration of the proposed options to reconfigure Children's Congenital Heart Services in England, and the implications for the Yorkshire and Humber region.

2.0 Background

2.1 At the first meeting of the joint committee (14 March 2011), members identified a range of additional information that may assist in its consideration of the proposed reconfiguration of Children's Congenital Heart Services in England (the proposals), and elsewhere on the agenda, the joint committee has been presented with some additional and further details.

3.0 Next steps and timescales

3.1 A more detailed timetable for the work of the joint committee is currently being prepared, and will be presented as soon as practicable. The following actions/ requests are also being taken forward:

- The Specialised Commissioning Group (Yorkshire and the Humber) - impact assessment: Details around the scope and timescales associated with the assessment. Alongside details of the expected audience and where this may be presented.
- Details of current patient numbers/ flows within the region – both in terms of postcodes and hospitals

- The regional Children's Congenital Heart Services Strategy identified at the meeting
- Appropriate contacts/ representatives for:
    - the current regional network;
    - Embrace (the regional transportation service)
    - Appropriate professional bodies, including surgeons, cardiologists and the Royal College of Nursing
- Details of any relationship between patient numbers and areas of deprivation i.e. whether or not there is an increased risk (and therefore need) for children born in more deprived communities?
- Input from Local Involvement Networks (LINks) from across the region.
- Request for appropriate attendance from the Safe and Sustainable team at future meeting of the joint committee.
- Request for the details of the consultation response form – currently only available online or through individual hard-copy requests.

4.0 Recommendations

4.1 Members of the Joint HOSC (Yorkshire and the Humber) are asked to note the content of this report and identify any additional actions and/or information not identified that may be required.

5.0 Background Documents

None