

Table 4.2: Increased volumes of paediatric cardiac procedures by hospital network

Option	Birmingham	Bristol	Leeds	Leicester	Liverpool	London	Newcastle	Oxford	Southampton
A	-72	144	-338	186	48	212	161	-21	-313
B	124	113	-338	-214	48	-82	288	-21	175
C	167	144	-338	-214	48	251	288	-21	-313
D	103	144	347	-214	-11	251	-271	-21	-313
E	167	144	-338	-214	48	251	288	-21	-313
F	103	144	347	-214	-11	251	-271	-21	-313
G	60	86	347	-214	-11	-82	-271	-21	175
H	-73	144	-338	186	48	212	161	-21	-313
I	-89	86	-338	186	48	-121	161	-21	175
J	80	-336	-338	186	49	22	161	-21	274
K	-73	144	282	282	-11	67	-271	-21	-313
L	-73	144	282	282	-11	67	-271	-21	-313

Availability of clinical infrastructure (paediatric beds, paediatric intensive care unit (PICU) beds, planned theatre sessions, etc.) at the newly designated specialist centres was questioned. In the short term insufficient infrastructure or staff capacity could, in the worst case scenarios, result in some planned procedures being cancelled, possibly at short notice. For patients and their families who have travelled some distance, and potentially, having taken time off work, this will exacerbate the emotional stress incurred.

Patient choice is another factor which needs to be considered in terms of capacity planning as it has the potential to disrupt planned flows; people may choose to travel to centres which are outside of their network which could induce capacity pressures. The exercise of patient choice may mean that some centres may find it difficult to reach the 400 optimum caseload whilst others, in locations which are easily accessible or which have a high profile or quality reputation, may witness more than the forecast demand and face future capacity constraints.