University Hospitals of Leicester **NHS**
NHS Trust

## Trust Board Paper M

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| **To:** | **Trust Board** |
| **From:** | **Kevin Harris, Medical Director / Mark Wightman, Director of Marketing and Communications** |
| **Date:** | **27 June 2013** |
| **CQC regulation:** | **All applicable** |
| **Title:** | Initial Response to the publication of the Independent Reconfiguration Panel's report into Children's Heart Surgery. |

**Author/Responsible Director: Mark Wightman Director of Marketing and Communications, (DM&C)**

**Purpose of the Report:**
To brief the Board following the publication of the Independent Reconfiguration Panel's, (IRP) report and recommendations to the Secretary of State for Health, (SoS) re: 'Safe and Sustainable', the Paediatric Cardiac Surgery Review.

**The Report is provided to the Board for:**

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| Decision | | Discussion | X |
| Assurance | | Endorsement | X |

**Summary / Key Points:**
On July 4th 2012 the Joint Committee of Primary Care Trusts, (JCPCT) recommended that 7 clinical networks would be established across England, each with a lead surgical centre to cater for children with congenital heart defects. The East Midlands Congenital Heart Centre based at the Glenfield hospital, along with the Royal Brompton and the Leeds General Infirmary were not part of the recommendation.

On the 27th of July the Lincolnshire Health Overview and Scrutiny Committee referred this decision to the SoS.

On the 7th of September the Leicester, Leicestershire and Rutland HOSC also referred the matter.

The SoS then commissioned a full review of the Safe and Sustainable process and proposals. The Terms of Reference for that review were later amended to include a subsequent referral by the York's and Humber Joint HOSC.

The IRP's report, made public on June 12th concluded that "the JCPCT's decision to implement Option B was based on a flawed analysis of incomplete proposals and their health impact, leaving too many questions about sustainability unanswered and to be dealt with as implementation risks."

As a consequence the SoS in a statement to the House on 12th June said the "proposals cannot go ahead" and the review is "suspended".

The responsibility for future proposals now rests with NHS England. They have been tasked by the SoS with producing a methodology by the end of July with the intention to announce a new way forward in the autumn, “with plans for implementation within 12 months.”

The Trust’s Medical Director and Director of Marketing and Communications will attend a meeting on 21st June with NHS England and will update the Board on the outcomes of this meeting on 27th June.

**Recommendations:**

1. The Board are invited to note the contents of this paper and receive a verbal briefing following the meeting between Trust representatives and NHS England.
2. That following the meeting with NHS England (21 June 2013) and clarity on the implications of the IRP’s report, we will meet stakeholders to agree next steps.
3. The Trust Board continues to receive regular updates on the progress of this work

**Previously considered at another corporate UHL Committee?**
No

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| **Board Assurance Framework:** | **Performance KPIs year to date:** |

**Resource Implications (eg Financial, HR):**
**To be assessed**

**Assurance Implications:**

**Patient and Public Involvement (PPI) Implications:**
Essential as part of the next steps (see recommendation 2 above)

**Stakeholder Engagement Implications:**
A/A

**Equality Impact:** To be assessed as part of the work on travel / access

**Information exempt from Disclosure:**

**Requirement for further review?**
Ongoing

**Introduction:**
The board are fully conversant with the twists and turns that the Safe and Sustainable review process has taken to date. The publication of the IRP's report and the statement by the Secretary of State, the RH Jeremy Hunt MP marks the end of another chapter but not the end of the story.

For those colleagues who may want a reminder of the story so far, the IRP's report helpfully includes an overview of the process to date, (page 19), which can be found here.
http://www.irpanel.org.uk/view.asp?id=0

**The IRP's recommendations:**
As far as we can gather the IRP's recommendations will be followed in full by NHS England. The totality of the recommendations can be found in **Appendix 1** to this report.

It was heartening to see that of the 15 points we raised with the IRP during our evidence giving sessions, 14 of those points were taken on board. This has confirmed the view that the IRP genuinely listened to the concerns of our clinicians and stakeholders. **Appendix 2** shows the cross matching of our clinical case with the IRP's findings.

**The key recommendations:**
Aside from the fundamental point that the IRP did not endorse the JCPCT's proposal to adopt Option B, i.e. to create a network of 7 surgical centres (Bristol, Southampton, Great Ormond St, Evelina, Birmingham Children's, Alder Hey Children's and Freeman) they made a further 15 recommendations.

The clinical team are currently assessing those recommendations and their likely impact on the EMCHC case.

Our initial assessment is that there are six recommendations which are *particularly* material, (Note that the full text of the recommendations are in appendix 1, the descriptions below seek to capture their essence):

Recommendation 1: Children's and adult services should be considered together in the 'new way forward'.

Recommendation 2: There should at least 4 full time surgeons in each centre and appropriate numbers of other specialist staff.

Recommendation 3: Before considering options there should be detailed work on the 'whole pathway of care'. i.e. effective, sustainable, cardiology centres are as important as the consideration of where surgery takes place.

Recommendation 6: Further capacity analysis, including for paediatric intensive care units, should consider recent and predicted increases in activity, and patient flows.

Recommendation 10: More work on travel and accessibility required.

Recommendation 11: Decisions about location of Transplant (currently at Freeman in Newcastle) and ECMO services, (UHL) should be 'contingent' on the final proposals of the wider review. i.e. the *very* specialist tail should not wag the specialist dog.

Although not a specific recommendation the IRP also said, (Page 119, para' 5.4.2) in relation to the proposed minimum number of 400 operations per centre, that, "Whilst there is some evidence of a positive relationship between volume of procedure and outcome at lower numbers per centre… the proposed minimum of 400 procedures per centre, the evidence is that there is no significant positive relationship between increases in volume and expected outcomes."

**Conclusions:**

The decisions made by the JCPCT on July 4th 2012 to pursue 'Option B' *felt* wrong. The subsequent forensic work of the team to build an empirical clinical case to rebut the assumptions underpinning that decision has been successful. Their work and the support we have received from stakeholders, which amplified the clinical case and shone a light on the deep concerns of the public and parents, is recognised by the Board.

As regards next steps we would hope that the approach from now, led by NHS England will be *collaborative*. Specifically, that a genuinely Safe and Sustainable service will be created by engaging the currently practicing clinicians and the parents / children who rely on them.

**Next steps:**

The clinical team are working hard to understand the implications of the IRP recommendations. Meanwhile, the meeting between representatives of all the current surgical centres and NHS England will make the process from here clearer.

At some stage over the next few weeks we will invite local stakeholders to meet with us to share their thoughts and to set out what work we think we need to do together to secure the future of children's heart surgery for the East Midlands.

**Recommendations:**

1. The Trust Board continues to receive regular updates on the progress of this work
2. That following the meeting with NHS England (21 June 2013) and clarity on the implications of the IRP's report, we will meet stakeholders to agree next steps.

**Appendix 1: Extract from the IRP's report, 'Summary and Recommendations'**

"The Secretary of State for Health asked the IRP to advise whether it is of the opinion that the proposals for change under the *"Safe and Sustainable* Review of Children's Heart Services*"* will enable the provision of safe, sustainable and accessible services and if not why not. Overall, the Panel is of the opinion that the proposals for change, as presented, fall short of achieving this aim. The Panel's view is that people - children and adults - with congenital heart disease in England and Wales will benefit from services commissioned to national standards for the whole pathway of their care.

The Panel agree that congenital cardiac surgery and interventional cardiology should only be provided by specialist teams large enough to sustain a comprehensive range of interventions, round the clock care, training and research.

However, the Panel has concluded the JCPCT's decision to implement option B (DMBC – Recommendation 17) was based on flawed analysis of incomplete proposals and their health impact, leaving too many questions about sustainability unanswered and to be dealt with as implementation risks. *Safe and Sustainable IRP*

Throughout our review, people told us that being listened to was something they valued. The opportunity to change and improve services is widely recognised and, in taking forward our recommendations, those responsible must continue to listen to legitimate criticisms and respond openly.

We set out below recommendations to enable sustainable improvements for these services and learning for future national commissioning of health services.

1. The proposals for children's services are undermined by the lack of co-ordination with the review of adult services. The opportunity must be taken to address the criticism of separate reviews by bringing them together to ensure the best possible services for patients.

2. Patients should receive congenital heart surgery and interventional cardiology from teams with at least four full-time consultant congenital heart surgeons and appropriate numbers of other specialist staff to sustain a comprehensive range of interventions, round the clock care, training and research.

3. Before further considering options for change, the detailed work on the clinical model and associated service standards for the whole pathway of care must be completed to demonstrate the benefits for patients and how services will be delivered across each network

4. For the current service and any proposed options for change, the function, form, activities and location of specialist surgical centres, children's cardiology centres, district children's cardiology services, outreach clinics and retrieval services must be modelled and affordability retested.

5. NHS England should ensure that a clear programme of action is implemented to improve antenatal detection rates to the highest possible standard across England.

6. Further capacity analysis, including for paediatric intensive care units, should consider recent and predicted increases in activity, and patient flows.

7. NHS England must establish a systematic, transparent, authoritative and continuous stream of data and information about the performance of congenital heart services. These data and information should be available to the public and include performance on service standards, mortality and morbidity.

8. NHS England and the relevant professional associations should put in place the means to continuously review the pattern of activity and optimize outcomes for the more rare, innovative and complex procedures.

9. NHS England should reflect on the criticisms of the JCPCT's assessment of quality and learn the lessons to avoid similar situations in its future commissioning of specialist services.

10. More detailed and accurate models of how patients will use services under options for change are required to inform a robust assessment of accessibility and the health impact of options so that potential mitigation can be properly considered.

11. Decisions about the future of cardiothoracic transplant and respiratory ECMO should be contingent on the final proposals for congenital heart services.

12. NHS England should assure itself that any wider implications for other services of final proposals are fully assessed and considered within a strategic framework for the provision of specialised services.

13. NHS England should develop a strategic framework for commissioning that reflects both the complex interdependencies between specialised services provision and population needs.

14. NHS England must ensure that any process leading to the final decision on these services properly involves all stakeholders throughout in the necessary work, reflecting their priorities and feedback in designing a comprehensive model of care to be implemented and the consequent service changes required.

15. NHS England should use the lessons from this review and create with its partners a more resource and time effective process for achieving genuine involvement and engagement in its commissioning of specialist services.

The Panel's advice has been produced in the context of changing and peculiar circumstances. Since 1 April 2013, responsibility for commissioning congenital heart services rests with NHS England, which has inherited the original proposals, a judicial review, responsibility for the quality of current services and the potential consequences of the IRP's advice, subject to the Secretary of State's decision.

The Panel’s advice sets out what needs to be done to bring about the desired improvements in services in a way that addresses gaps and weaknesses in the original proposals. The Panel’s recommendations stand on their own irrespective of any future decision by NHS England regarding the judicial review proceedings. We note that the court’s judgment of 27 March 2013 appears congruent to our own advice and that a successful appeal on legal grounds will not, of itself, address the recommendations in this report.

The Panel’s advice addresses the weaknesses in the original proposals but it is not a mandate for either the status quo or going back over all the ground in the last five years. There is a case for change that commands wide understanding and support, and there are opportunities to create better services for patients. The challenge for NHS England is to determine how to move forward as quickly and effectively as possible.

Work to address gaps in the clinical model and associated service standards (Recommendation Three above) is underway and should be brought to a rapid conclusion. In parallel, there are different potential approaches to effect positive change that might be considered. These include whether to bring forward proposals for reconfiguration again or adopt a more standards-driven process that engages providers more directly in the managed evolution of services to be delivered. The critical factor to consider, in the Panel’s view, is that engagement of all interested parties is the key to achieving improvements for patients and families without unnecessary delay.”

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## Appendix 2 cross matching the UHL clinical case with the IRP's report

East Midlands Congenital Heart Centre

| We Said That: | The IRP: | Ref (paragraph in IRP report) |
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| **Future projections for population and activity in the 'S&S' review are flawed** | **Agreed!** 'Further capacity analysis, including for PICUs, should consider recent and predicted increases in activity, the latest population projections and patient flows.' | **4.13.2-7<br>5.5.25<br>Recommendation 6** |
| **The effects of closing ECMO in Leicester have not been fully considered** | **Said that:** 'everyone agreed that relocation of respiratory ECMO is not entirely risk free and, therefore, weighing those risks against the benefits of concentrating congenital heart services is a legitimate and necessary part of the decision.' **But also said that** 'the respiratory ECMO "tail" should not wag the CHD "dog"', **and recommended** 'Decisions about the future of … respiratory ECMO should be contingent on the final proposals for congenital heart services.' | **4.15.14-19<br>5.8.1-5** |
| **The effect on Children's intensive care in the Midlands has not been properly considered** | **Agreed!** 'Doubts were expressed about whether sufficient [PICU] capacity would exist to avoid disruption to the delivery of planned cardiac interventions. This view was overlaid with concerns about the impact of rising birth rates, particularly in the Midlands and London.' | **5.5.23 &<br>5.5.25<br>Recommendation 6** |
| **The required minimum surgical volume of 400 cases is not evidenced based, is arbitrary and is flawed.** | **Agreed!** 'For the current surgical centres in England and the proposed minimum of 400 procedures per centre, the evidence is that there is no significant positive relationship between increases in volume and expected outcomes.' | **5.4.2** |

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| | **But they also said:** ‘Patients should receive congenital heart surgery and interventional cardiology from teams with at least four full-time consultant congenital heart surgeons and appropriate numbers of other specialist staff to sustain a comprehensive range of interventions, round the clock care, training and research.’ | |
| **The process was flawed by undisclosed conflicts of interest** | **Said:** ‘the fact that this selection [*of the steering* group] excluded anyone with a link to three of the ten centres was always going to be an issue that would attract attention. This sense of unease was subsequently given greater focus when the selected option excluded the centres that had no link to the Steering Group members. Given the inevitability of the concerns, this issue should have received greater consideration in constructing the governance arrangements for the review…’ | **5.9.9** |
| **There was a flawed interpretation of the public consultation** | **Disagreed.** ‘The Panel were satisfied that the results of the consultation were reported accurately and these issues had been dealt with appropriately in the independent report on the consultation.’ | **5.9.7** |
| **There were flaws in the maths and logic of the ‘S&S’ business case** | **Agreed!** ‘The Panel found no logic or evidence to explain the relationship between the Kennedy scores and differences in scores for quality of services between options in the DMBC.’ | **5.6.16** |
| **We have concerns regarding the sense, methodology and conclusions of the scoring process** | **Agreed!** ‘NHS England should reflect on the criticisms of the JCPCT’s assessment of quality and learn the lessons to avoid similar situations in its future commissioning of specialist services.’ | **5.6.17<br>&<br>Recommendation 9** |
| **Insufficient weight was given to access and travel times in the proposals** | **Agreed!** ‘The Panel found that the assessment and scoring of the options on the access criterion was flawed … and systematically understated the impact and numbers of patients and families affected.’ | **5.7.4** |
| | **And they said: ‘**The Panel concludes that the JCPCT’s decision used a flawed and incomplete analysis of accessibility based on an inadequate health impact assessment. Consequently, the real impacts of the proposals and their potential mitigations were missed.’ | **5.7.12<br>&<br>Recommendation 10** |

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| **Many patients are being asked to travel to a centre that is not their nearest** | **Agreed!** ‘The Panel was concerned that the network areas as proposed require some children and their families to travel to the CCC and/or surgical centre that is not the nearest, and in some cases not the second nearest to where they live.’ | **5.7.9** |
| **Capacity issues at BCH have not been properly assessed** | **Qualified Agreement.** ‘There are risks that some centres, particularly Birmingham Children’s and Great Ormond Street hospitals, may see excessive demands placed upon them’ | **5.5.20**<br>**(& Rec$^{n}$ 6 & 5.5.25)** |
| **The implications of the proposals for a district cardiology centre have not been adequately thought through** | **Agreed!** ‘The Before further considering options for change, the detailed work on the clinical model and associated service standards for the whole pathway of care must be completed to demonstrate the benefits for patients and how services will be delivered across each network’ | **5.5.1-8** |
| **The implications for adult congenital heart disease have not been adequately thought through** | **Agreed!** ‘The proposals for children’s services are undermined by the lack of co-ordination with the review of adult services. The opportunity must be taken to address the criticism of separate reviews by bringing them together to ensure the best possible services for patients.’ | **5.3.5** |

Peter Barry
June 2013

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