University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper F

TRUST BOARD – 27 November 2014

NHS England New Congenital Cardiac Services Review: UHL Response to Public Consultation

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DATE:	25 November 2014
PURPOSE:	NHS England has been carrying out a review of congenital heart services for children and adults. We are now at the end of a three month formal public consultation on the standards (closes midnight on the 8th December 2014) the UHL response to the New Congenital Cardiac Review needs to address two key issues. The Trust Board are asked to receive the report and endorse the response to the consultation
PREVIOUSLY CONSIDERED BY:	
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☐ For information ☐

NHS England New Congenital Cardiac Services Review: UHL Response to Public Consultation

Background

1. NHS England has been carrying out a review of congenital heart services for children and adults. This review covers the complete continuum of services from antenatal screening through to end of life care. The six key objectives of the review are:

    1. to develop standards to give improved outcomes, minimal variation and improved patient experience for people with Coronary Heart Disease (CHD)
    2. to analyse demand for specialist inpatient CHD care, now and in the future
    3. to make recommendations on function, form and capacity of services needed to meet that demand, taking account of accessibility and health impact
    4. to make recommendations on the commissioning and change management approach including an assessment of workforce and training needs
    5. to establish a system for the provision of information about the performance of CHD services to inform the commissioning of these services and patient choice
    6. to improve antenatal and neonatal detection rates.

2. We are now at the end of a three month formal public consultation on the standards (closes midnight on the 8th December 2014) and University Hospitals of Leicester (UHL) will want to make a formal response. We intend to respond in two ways. Firstly via the online portal that NHS England have established and secondly with a full detailed response with a covering letter from the Chief Executive.

3. It is important to note that this consultation on the standards only really addresses objective one as it focusses on a series of proposed service standards relating to numbers and types of staff, equipment and facilities as well the models of care locally (co-location of services) and regionally (networks). Information gained during this exercise will then influence approaches to meeting objectives 3 and 4.

4. Objective 2 has already been completed by NHS England and the work being undertaken by NHS England to meet objectives 5 and 6 is, on the whole, not relevant to this public consultation exercise, although as an organisation we are involved in shaping this work, as it will be essential in putting the new system of care into place.

5. The public consultation asks 11 questions of respondents. These are given in Appendix A.

The key issues

6. Literally hundreds of new standards have been drafted that cover all aspects of cardiac care for children and adults with congenital heart disease. They were drafted by a committee of clinicians, nurses, NHS England employees, patients and patient representatives. One of our senior paediatric cardiologists represented UHL on this group. The overwhelming majority of draft standards were unanimously agreed but from this work a number of "knotty issues" arose where there wasn't agreement amongst committee members or wider stakeholders. NHS England sought further opinion on these from other expert groups and took advice from their own Clinical Advisory Panel.

7. The draft standards that arose from this additional deliberation are:

    - the requirement that children's cardiac services should be co-located with all other children's services
    - each surgeon should undertake 125 operations per year
    - each centre should have four surgeons and therefore each centre should undertake 500 operations per year

8. We do not disagree with the co-location standard, in fact we welcome it. We do not disagree with the standard relating to the minimum case load per surgeon and this also has the endorsement of the professional societies. We believe that with time we can fulfil the requirement to employ four surgeons and undertake 500 operations per year but that until such time three surgeons, each undertaking the minimum case load, is both necessary and safe.

9. NHS England have published the following time line with respect to commissioning within the context of the New Review

Indicative milestones and timescales

Commissioning timeline: milestones	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17		Q4 18/19
Draft standards agreed	■									
Consultation Launch	■									
Consultation Completed		■								
Standards and specification signed off			■							
Baseline patient experience survey completed			■							
Design commissioning process	■	■	■							
Business case agreed				■						
Commissioning intentions issued					■					
Commissioning process					■	■	■			
Contracts awarded							■			
New standards come into effect								■		
Contract management begins								■		
All standards met										■

10. The key milestones are (i) the design of the commissioning process, (ii) the issuing of commissioning intentions and (iii) the meeting of all standards

UHL's current position with regard the key issues

11. UHL's current position:

    - it has three congenital cardiac surgeons not four
    - the service undertook 300 operations in the 2013-14 year this will need to rise to 500. Of note around 100 operations per year are undertaken outside the East Midlands on patients from the East Midlands. This relates to historical connections between John Radcliffe Hospital Oxford and Great Ormond Street Hospital London with Northampton General Hospital, Kettering General Hospital and Peterborough City Hospital
    - children's cardiac services are not currently co-located with all other children's services but we are starting to develop plans for a new children's hospital on the Leicester Royal Infirmary (LRI) site with a planned delivery in five years

12. We have clear plans for the development of co-located children's services on the LRI site and a project team is in place to start to develop the model of care. This will address the standard around co-location. We have also started to have conversations with Birmingham Children's Hospital about the possible development of a network of care across the Midlands, this is in an early stage of discussion.

13. We have also presented proposals to NHS England around ensuring that new service pathways encourage care as close to home as possible.

The UHL response

14. The UHL response focuses not on challenging the standards *per se* but on helping NHS England develop solutions to strategic objectives 3 and 4 that secure the future of congenital cardiac surgery and catheter intervention in the East Midlands at UHL. These recommendations would allow NHS England, through UHL, to find solutions that enable UHL to bridge the gap between what we do now and what we will be expected to do.

15. **Partnership and innovation:** NHS England should support new ways of working that facilitate individual surgeons and particular centres achieving activity targets. We suggest that the development of supra-regional networks and joint working with adjacent centres will allow this. Flexible management of facilities, capacity and skills in two campuses would allow patients across the larger region to have access to any therapy at any time. This type of collaboration would manage regional surgical and Paediatric Intensive Care Unit (PICU) demand as well as national Extra Corporeal Membrane Oxygenation (ECMO) demand. Waiting lists and emergency referrals would be balanced and allocated according to bed availability within the partnership whilst remaining sensitive to patient choice and ease of access. Activity surges in one centre could be balanced by a shift in elective activity to the other allowing both centres and all surgeons to meet the required activity standards. Training, education and research would benefit enormously from such an approach.

16. The natural partnership in the Midlands would be between UHL and the Birmingham Children's Hospital. The respective clinical and management teams have had several meetings on this theme and we would like to seek the support of NHS England to develop these ideas further as an official strategy in the commissioning phase of the New Review. Similar partnerships could be developed elsewhere as part of a national solution.

17. Within this context we could then move to developing managed clinical networks across the Midlands. This would give choice and service sustainability to a population mass of around 10 million people.

18. ***Timelines to co-location*** NHS England are aware that three current providers (UHL, Freeman Hospital Newcastle and Royal Brompton Hospital) do not have their cardiac services co-located with their other children's services. It is our view that the New Review risks pre-determining and prejudicing its outcome unless special provision is made to allow those organisations to move to a co-located model where they have declared their intention to do so. The timelines, governance and oversight for those NHS Trusts reconfiguring their services on this scale should be developed by NHS England in partnership with the Trusts involved. This work should be acknowledged in the commissioning strategy.

19. At the very minimum, NHS England must declare as soon as possible what the implications are for providers at each stage of the indicative commissioning milestones and timescales. This will allow UHL to better understand whether it needs to move to co-location of services by the issuing of commissioning intentions (Quarter 2 2015-16) or whether it would suffice to do this by Quarter 4 2018-19.

Achieving activity standards

20. When NHS England has implemented challenging standards for other services they have allowed a period of 'derogation' from the standards to allow services to reach stretching standards. We will want to recommend that derogation on activity standards should be permissible. Additionally we believe that it would be unhelpful to decommission a service that has increased its activity substantially and will achieve the activity for four surgeons, but may have fallen short of doing so by Quarter 4 2019. In respect of surgeon numbers the clear clinical opinion is that it is the number of cases done by individual surgeons which is most important. Therefore in a period of planned service growth the move from 3 surgeons to 4 with all the requisite supportive infrastructure should only happen once the activity is in place. Partnership with Birmingham Children's Hospital may help to mitigate this.

The commissioning model

21. NHS England are currently working on different commissioning models in order to find the one that will best achieve their objectives. They will be calling on all stakeholders to input to this project. UHL should propose a commissioning model that best suits the needs of the population it serves in the context of this national process. This should involve commissioning around managed network boundaries

as set out above. We propose that NHS England commissioners work with regional providers, such as UHL, in a co-commissioning model. In this way we can join up commissioning not just for paediatric cardiac services but also that for adult congenital heart disease, fetal medicine, paediatric surgery and other related specialist services. This will allow the creation of centres large enough to fulfil the cardiac activity standards but also establish life-time care pathways for patients in their own region and avoid the post-code lottery and disjointed journey that many currently have.

Conclusions

22. The UHL response to the New Congenital Cardiac Review needs to address two key issues. Firstly it should focus on solutions that allow it to bridge the surgical activity gap by championing network management and a new commissioning model. Secondly it should argue that new structures within this process need to be devised that allow sufficient time for this Trust and others to move their children's cardiac services to a co-located setting. It should be made clear that the failure of NHS England to do so will risk predetermining and prejudicing the outcome of the New Review.

Recommendation

23. Receive the report and endorse the response to the consultation

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Annex A: Consultation questions

STATEMENT

In order to help us analyse and consider all responses as quickly as possible, we are asking you to consider limiting the length of your responses. We are grateful for your understanding.

The aims of the new CHD review are to ensure:

- the best outcomes for all patients, not just lowest mortality but reduced disability and an improved opportunity for a better quality of life for survivors
- that variation is tackled so that services across the country consistently meet demanding performance standards and are able to offer resilient 24/7 care;
- excellent patient experience is delivered, which includes how information is provided to patients and their families and consideration of access and support for families when they have to be away from home

1. Will the draft standards and service specifications meet these aims?

   Strongly agree
   Agree
   Neither agree nor disagree
   Disagree
   Strongly disagree
   Don't know

   Please explain your answer

Model of care

2. What do you think of the model of care that we are proposing?

3. What do you think about our proposals for level 2 Specialist Cardiology Centres?

Networks (Section A)

4. What do you think of our proposals for the development of networks?

Staffing and skills (Section B)

5. What do you think of our proposals for staffing CHD services?

6. What do you think of our proposal that surgeons work in teams of at least four, each of whom undertakes at least 125 operations per year? Please explain your answer

7. What do you think about our proposed approach to sub-specialisation?

Interdependencies (Section D)

8. What do you think of the proposed standards for service interdependencies and co-location?

Introduction to the proposed service specifications (Part 3)

9. What do you think of the proposed service specifications.

Delivering the standards within existing resources (Part 4)

10. To ensure that we work within the available resources, difficult decisions may need to be made. What parts of our proposals matter most to you?

Making it happen (Part 5)

11. Do you have any comments on the range of approaches proposed to ensure that the standards are being met by every hospital providing CHD care?

Any other thoughts

12. Is there anything else that you want to tell us or to ask us to consider? If your comments relate to a particular standard or section please specify which you are referring to.