Update on the New Congenital Heart Review Process

Author: Alison Poole Sponsor: Mark Wightman **Trust Board paper E**

Executive Summary

Context

This paper provides the Trust Board with an update on the Congenital Heart Disease (CHD) Review, the key actions for immediate attention, and associated risks.

Questions

1. **What has happened in the EMCHC campaign since the last Trust Board update**
   - *1.1.* The Self-Assessment response and Impact Assessment response were submitted to NHS England on 7th November. Copies can be found in Appendix 1 and 2
   - *1.2.* The start of the public consultation has been delayed until the New Year
   - *1.3.* The Paediatric Critical Care and Specialised Surgery for Children: Expert Stakeholder Panel will convene on the 1st December. Details of the panel membership can be found in Appendix 3
   - *1.4.* A new letter has been received from NHS England on the 16th November which provides some clarity to questions previously asked, but requests more clarity on a number of other points. The Trust will prepare a response to be sent by the end of November and include the response and NHSE letter in the next Board update.
   - *1.5.* A stakeholder meeting was held on the 10th November, another is due on the 15th December
   - *1.6.* Cllr Rory Palmer, Deputy City Mayor visited the unit on the 24th November.
   - *1.7.* Key network meetings were updated on the current progress of the campaign.
   - *1.8.* EMCHC hosted the 2016 British Congenital Cardiac Association (BCCA) Annual Conference at the East Midlands Conference Centre, Nottingham

2. **What is the plan over the next month?**
   - *2.1.* Interviews are being held for the substantive consultant post on the 2nd December
   - *2.2.* Preparation for the public consultation with stakeholders, network specialist groups, OSC committees and through media and social media

3. **What are the risks to the campaign?**
   - *3.1.* The revised self-assessment submission is still subject to review by the assessing panel; the outcome of which will determine the next steps in the process.

Conclusion

4.1 The Trust Board are requested to :

4.2 Note the content of the paper and

4.3 Provide comments and guidance of any areas deemed appropriate

For Reference

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
2940	There is a risk that paediatric cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care and other specialist paediatric services	15	0	Women's and Children

If NO, why not? E.g. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken

4. Results of any **Equality Impact Assessment**, relating to this matter:
5. Scheduled date for the **next paper** on this topic: 5 January 2017 Trust Board
6. Executive Summaries should not exceed **1 page**. [My paper does not comply]
7. Papers should not exceed **7 pages.** [My paper does comply]

Update Paper on New Congenital Heart Disease Review

Prepared by Alison Poole Date: 24th November 2016

1. Context:

1.1. This paper provides the Trust Board with an update on the Congenital Heart Disease (CHD) Review, the key actions for immediate attention, and associated risks.

2. Questions: What has happened in the EMCHC campaign since the last Trust Board?

2.1. **Self-Assessment response–** a formal response was sent to NHS England on the 7th November2016. (Appendix 1) In the self-assessment we provided evidence of compliance of all the time related standards, either immediately or through mitigated plans. This includes a growth plan that is modelled using the growth of the past two years extrapolated to include population growth and a phased increase of referrals from network hospitals. The projected growth shows that we will meet the 500 caseload requirement by 2021. Acceptance of this plan by NHS England will be dependent upon their acceptance of the network development assumptions and our growth plan. We have requested that the deliberations and decisions made in this meeting should be recorded and published along with the outcome.

2.2. **Impact Assessment response** – a formal response to this document was sent to the NHS England on the 7th November 2016 (Appendix 2). The impact assessment required detailed information of the estimated impact on services, associated services, financials, workforce and equality and diversity. We provided top level information stating the need for clarity regarding what level 2 services would be required, and the output from the independent reviews on PICU, ECMO, transport and surgery before more detail could be provided. The impact assessment was shared with EMCHC staff with reassurance that it was 'business as usual' as far as the Trust was concerned.

2.3. **Delay to the start of the Public Consultation** – On 23rd November NHSE announced that the launch of the public consultation would be delayed until the New Year. The rationale for the delay is to give those Trusts who are currently look like they will be unable to meet the standards in full, within the required timescales, more time to refine and develop their plans for service delivery. The full blog can be found on https://www.england.nhs.uk/2016/11/will-huxter-18/

2.4. **Paediatric Critical Care and Specialised Surgery for Children: Expert Stakeholder Panel –** Dr Jonathan Fielden announced via his blog https://www.england.nhs.uk/2016/10/jonathan-fielden/ that the first meeting of this group will be held on the 1st of December, chaired by Dr Jonathan Fielden. The panel membership has also been announced (see Appendix 3) The EMCHC task group will review the membership at the task group meeting on the 25th November and agree if it is appropriate to suggest that Ms Gail Faulkner be considered to join the panel to ensure the requirements of the ECMO service are fully understood. Dr Mark Davidson Consultant paediatric Intensivist RHS Glasgow is on the panel and may be deemed to be an appropriate ECMO representation.

2.5. **Latest letter from NHSE received 16th November 2016 –** a letter was received in response to the Trust letter dated 13th October. The letter responded to the points raised, and requires further clarification on the level of support received by EMCHC from other level 1 CHD centres. NHS England have suggested that a meeting should be held to discuss this and the Trust will be asking for further clarification of the objective, attendees and agenda of this proposed meeting before agreeing a date.

The letter also refers to standard 2.1 and applies a retrospective interpretation of the requirement;

Standard 2.1 requires a team of at least 3 cardiac surgeons, each of whom must have been the primary operator in a minimum of 125 congenital heart operations per annum as at April 2016, averaged over the previous 3 years (and therefore averaged over that period a minimum of 375 cases per year for the team of surgeons as a whole is required).

The Trust disputes the interpretation of the standard in this way; not least because it is both illogical an inequitable to enforce a standard retrospectively. Moreover, we do not think this was the intention of the standards committee when this standard was originally discussed. The Trust will be once again suggest that the standard is interpreted from the time of approval (April 2016) and the three years average should therefore be calculated from then. If this is applied then EMCHC will comply with this requirement. The Trust will respond to this latest letter by the end of November and share both the NHSE letter and our response in the next Trust Board update.

2.6. **Stakeholder meeting** – a meeting of key stakeholders was held on the 10th November, at which the Trust provided an update on the current status of the campaign. We heard updates from the different stakeholder groups. We continue to receive excellent support from the Leicester Mercury Patients' Panel, the regional Overview and Scrutiny Committees who are facilitating opportunities for NHS England to meet and discuss their proposals at Council committee meetings, the Save Glenfield Childrens Hearts Campaign who not only are pivotal in driving the petition signatures, but also arranged the very successful demonstration in Leicester town centre on the 29th October , the amazing support from our different Faith groups who have arranged information and petitions to be circulated throughout the region , and of course our incredibly supportive charities HeartLink and Keep the Beat who are working tirelessly to ensure the service and the campaign is supported in every way possible. As always we are incredibly grateful to all of these stakeholders and look forward to their continued support. Another stakeholder meeting will be held on the 15th December to help prepare for the public consultation.

2.7. Visit from Cllr Rory Palmer to EMCHC – Cllr Palmer visited the EMCHC unit on Thursday 24th November. His key objective was to meet staff and hear how they are managing to maintain excellent care with the continued uncertainty surrounding the service. He visited the new ward 30, Outpatients and PICU and assured all staff of the Council's continued support for the campaign.

2.8. Updates provided at network meetings – updates on the current status of the campaign were provided at the CNN and LNC meetings

2.9. EMCHC host the 2016 British Congenital Cardiac Association (BCCA) Annual Conference at the East Midlands Conference Centre, Nottingham. Led by Dr Suhair Shebani, Consultant Paediatric Cardiologist, the conference delivered state of the art updates on the diagnosis

and management of Congenital Heart Disease through lectures, debates, special interest sessions and networking opportunities. EMCHC showcased our own expertise including advances in 3D imaging, virtual heart reconstruction and 3D printing. Other members of our team, including Dr Aidan Bolger, Dr Frances Bu'Lock, Elizabeth Aryeetey and Mr Antonio Corno helped host the event. Dr Saran Durairaj, our newest Consultant Paediatric Cardiologist and Dr Simone Speggiorin, our unit's lead surgeon, also presented their seminal work on the applications of 3D printing (actual and virtual) in CHD surgery.

3. Activity planned over the next month;

3.1. Interviews for the substantive consultant surgeon post are being held on December 2nd.

3.2. Network meetings for specialised services will be attended and updates on the campaign will be provided. It is essential we keep our wider stakeholders up to date on progress and rally support.

3.3. Attendance and information will be provided to the Overview and Scrutiny Committees across the East Midlands network. Briefing and attendance of EMCHC staff will be offered for all forthcoming meetings. The team will support and attend the Lincolnshire OSC meeting, chaired by Cllr Christine Talbot on the 21st December which his being attended by Mr Will Huxter from NHSE

3.4. Preparation of evidence and appropriate questions in advance of the consultation which will be tailored once the full consultation questions are made public

3.5. The formal opening of the new extension to Ward 30 at Glenfield Hospital is planned for the 2nd December. It will be opened by Ms Liz Kendall MP and Ms Nicky Morgan MP.

3.6. The petition is growing well with 40,639 online signatures and approximately 42,000 off line. Ms Liz Kendall has agreed to rally the East Midlands MPs to help present the combined petition and try and generate another parliamentary debate .

3.7. Information and stakeholder contact lists will be prepared in advance of the consultation

4. The key issues and risks associated with this;

4.1. The revised self-assessment submission is still subject to review by the assessing panel, the outcome of which will determine the next steps in the process

5. Conclusion The Trust Board are asked to;

5.1. Note the content of the paper

Provide comments and guidance of any areas deemed appropriate

University Hospitals of Leicester NHS
NHS Trust

East Midlands
Congenital Heart Centre

Paediatric Cardiac and Adult Congenital Heart Disease Compliance Assessment

University Hospitals of Leicester NHS Trust

7th November 2016

University Hospitals of Leicester NHS Trust welcomes the opportunity of providing an updated self-assessment in respect to the standards as outlined in the letter from NHS England dated the 13th October 2016.

For completeness we have responded to all of the standards listed in the letter irrespective of whether these were deemed compliant in the last assessment or not.

Requirement 1.1 – Standard A9 (L1)

Specialist Children's Surgical Centres will adhere to their Congenital Heart Network's clinical protocols and pathways to care that will:
a) Requires all paediatric cardiac surgery, planned therapeutic interventions and diagnostic catheter procedures to take place within a Specialist Children's Surgical Centre;

b) Allow neonates with patent ductus arteriosus (PDA) to receive surgical ligation in the referring neonatal intensive care unit (level 3)1 provided that the visiting surgical team is dispatched from a designated Specialist Children's Surgical Centre and is suitably equipped in terms of staff and equipment (this is the sole exception to the requirement that heart surgery must be performed in a designated Specialist Children's Surgical Centre). It will be for each Congenital Heart Network to determine whether this arrangement is optimal (rather than transferring the neonate to the Specialist Children's Surgical Centre) according to local circumstances, including a consideration of clinical governance and local transport issues;

c) Ensure that emergency balloon atrial septostomy and temporary pacing, if undertaken outside of a Specialist Children's Surgical Centre, can be safely conducted if clinically indicated. Networks will develop clear guidelines that govern this process;

d) Ensure that patients requiring electrophysiology must be treated in dedicated paediatric services, with paediatric cardiac surgical support not adult services; and
e) Enable access to hybrid procedures (those involving both surgeons and interventional cardiologists) in an appropriate facility either in the Specialist Children's Surgical Centre or in another Specialist Children's Surgical Centre, if the need arises.

Timeframe: Within 3 years

We can confirm that East Midlands Congenital Heart Centre (EMCHC) adheres to the Congenital Heart Network (CHN) clinical protocols and pathways of care.

Part (a).This standard is met completely**.**

Part b) The East Midlands has 3 (Level 3) neonatal units, one at the Leicester Royal Infirmary (LRI) as part of the University Hospitals of Leicester NHS Trust (UHL), and (one unit, over split sites at Nottingham University Hospitals (NUH). The University Hospitals Coventry and Warwickshire (UHCW) also has a Level 3 neonatal unit, which occasionally refers neonates to UHL for PDA ligation when Birmingham Children's Hospital cannot accommodate them.

Currently, when referred to UHL, surgical PDA ligation in premature neonatal patients is performed at the Glenfield Hospital (GH). There is a network-wide agreed protocol in place with specific documentation and transport arrangements. In general, patients are transferred on the day of surgery from their Network NICU to GH PICU by the regional neonatal transport service. This team remain on the unit whilst the baby is in theatre, and pick up the postoperative care in conjunction with the anaesthetic and surgical teams as well as the PICU staff. After surgery, the patient is observed for few hours and then transferred (the same day) by the NNU team to an appropriately staffed NICU which is usually their nearest level 3 centre until they are ready to return to their more local NICU. (*Please see Appendix 1)*

This protocol is constantly under review with our network partners and if their preferred model should change we have the capability to accommodate this.

c. The vast majority of Emergency Balloon Atrial Septostomies and Temporary Pacing are conducted at EMCHC and we do not envisage this changing. Some Septostomies are currently performed on the NICU at Leicester Royal infirmary by the same team that would undertake it at Glenfield i.e. 1 or more Consultant Paediatric Cardiologists and a scanning SpR, on the same basis as at Glenfield. There is no level 2 centre in the East Midlands Network therefore no standard network arrangement is in place. We do not routinely provide outreach Septostomy due to the large geographical network area; (one has been undertaken in the last 10 years only, in Derby.)Temporary External Cardiac Pacing has been undertaken on an occasional and individually supported basis at the LRI Level 3 neonatal unit (publication submitted). Emergency Transvenous pacing on older children in our network centres would only be provided in cases of extreme emergency by the local adult cardiologists (again only twice in 10 years has this been required.)

d. Fully compliant as a)

e. Fully Compliant as a)

Requirement 2.1 – Standard B10 (L1))

Congenital cardiac surgeons must work in teams of at least four surgeons, each of whom must be the primary operator in a minimum of 125 congenital heart operations per year (in adults and/or paediatrics), averaged over a three-year period. Only auditable cases may be counted, as defined

by submission to the National Institute for Cardiovascular Outcomes (NICOR). VAD surgery and cardiac transplant surgery may also be counted.

Timeframe: Teams of at least three immediate, teams of at least four within 5 years
125 operations: immediate

Consultant numbers

East Midlands Congenital Heart Service (EMCHC) currently has three full time Consultant Congenital Cardiac Surgeons, therefore meeting the standard for 2016.

All our Congenital Cardiac Surgeons have completed specialist training programmes in Congenital Cardiac Surgery. Two are on the General Medical Council Specialist Register with accreditation in Cardiac Surgery and the third is accredited as a specialist in paediatric cardiac surgery in his native country.

A substantive consultant role is advertised and by the end of November 2016 we expect to have reviewed the applications and secured a substantive consultant appointment.

Our third consultant is employed as a Locum Consultant by virtue of UK immigration and employment law; having been employed as a substantive Consultant Congenital Cardiac surgeon abroad with significant experience. He previously worked in a similar role at Great Ormond Street from whence he came with a very favourable reference. He is now preparing his application to the GMC for inclusion on the specialist register; after which he can be considered for a substantive role. This is normal practice in NHS Trusts employing specialists from overseas and any perceived risk regarding the sustainability of this appointment has been mitigated by the Trust providing a long term Locum contract to cover the period until his registration process is complete.

Caseload

We confirm that EMCHC **is** on track to meet the 375 surgical activity standard averaged over the next three years as the standard stipulates

University Hospitals of Leicester Five Year Plan – 'Delivering Caring at its Best', outlines the Trust's overall vision and strategy to become more specialised and clinically and financially sustainable, delivering specialist services from two, rather than three, big hospitals in five years' time. The development and growth of the EMCHC is fully in line with this.

The Trust's strategic objectives describe the things we must do, concentrates on creating a single integrated local health and social care system and developing and formalising partnerships with a range of providers for tertiary and secondary services.

UHL Trust is working with other providers of tertiary services to look at how we work better together to lead on the planning and provision of specialised services across a wide geography.

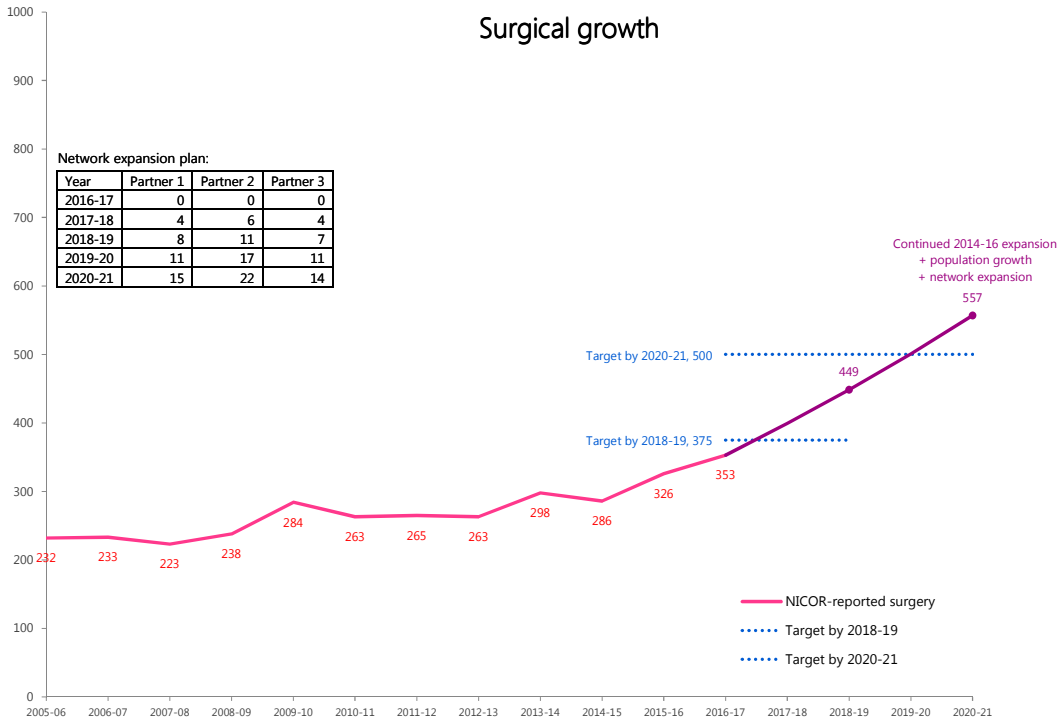
The UHL Children's Hospital Partnership Strategy forms part of the Trust wider strategy and includes the provision of Congenital Heart Disease services for the population of East Midlands. However,

despite the fact that the East Midlands network area already generates over 500 cases of CHD surgery per annum, EMCHC surgical activity currently falls below this figure. Our strategy is intended to remedy this; by enhancing choice for the vast majority of patients in the East Midlands, offering them the opportunity of receiving high quality care closer to home. In our proposal, we do not envisage any required change to doctor-patient/provider relationship for existing patients. We gave detailed clarification of how this would work in our Network submission in October 2015 (Appendix 2). Our proposal is principally aimed at new and transitioning (to ACHD services) patients and we are willing to support this proposal through the provision of network clinics in the relevant hospitals by our own specialist consultants.

Based on this strategy, and since our last self-assessment, we have successfully established a complete lifetime referral pathway with Kettering General Hospital. We have also had positive discussions with two other network hospitals to establish lifetime referral pathways. These new partnerships are being established despite the uncertainty surrounding the new review into Congenital Cardiac Heart Surgery and in some cases the implementation of new pathways may be contingent on referring centres knowing that they will have access to EMCHC going forward (something with which NHS England could assist – see below). These changes will contribute to our growth plan towards the 500 cases from 2021 averaged over 3 years. We are currently continuing to encourage similar changes for other geographically appropriate units, on the principal basis that this will secure the best services for ALL East Midlands patients in the longer term (the greater good for the greatest number), without compromising the ability of other regional centres to achieve the standards.

However, as this is early in our new referral relationships and understanding of the exact impact is not fully understood, should we not quite achieve this; we believe the variance will be insignificant, and will not impact quality or safety, which is a position in line with the relevant standard.

(Page 17 par 59 of the final standards report published July 2015 (https://www.england.nhs.uk/wp-content/uploads/2015/07/Item-4-CHD-Report.pdf) *NHS England must reserve the right not to commission services from a provider that is so significantly at variance from the standards as to cause safety/quality concerns. Such a decision would only be taken following a risk assessment of the costs and benefits of both closure and non-closure)*



The above graph shows our actual surgical activity to 2015/16 and our projected activity for the period up to 2021. As recognised in the report of the New Cardiac Review 2015 , and accepted by the Board of NHS England, the drivers for the projected increase are: population growth , technical advances, and in our case changes in our network to allow patients choice to attend EMCHC and facilitate nearest centre attendance (as per the modelling produced by NHS England for the Impact Assessment exercise) There is clearly uncertainty around these projections as recognised by NHS England, but it is clear from the graph that any uncertainty does not lead to significant variance from the standards, nor would warrant any safety or quality concerns.

Recruitment of a fourth surgeon will be planned to coincide with our caseload growth which will be delivered by our network development plan. It is essential that the recruitment is phased to ensure that each surgeon still is able to meet the minimum 125 caseload requirement. This is in line with the intentions of the New Cardiac Review report. Further details of timescales can be found with our growth model above.

EMCHC has excellent Clinical, Quality, and Personal outcomes as illustrated by our latest Quality Report (Appendix 3) and the level of public outrage already demonstrated across the country by the threat of decommissioning our Level 1 Services.

On 27th October 2016 NICOR validated EMCHC 2015-16 data submissions and gave us an overall data quality indicator (DQI) of 97%. This is an improvement of 3.5% on our previous DQI, an impressive achievement which is made all the more remarkable because NICOR expected all participating hospitals to experience a slight drop in the first 1-2 years due to an expanded dataset (increased by 30% more data items). This achievement was made possible by the commitment of the

EMCHC team to complete transparency, to providing the highest quality of information and to establishing data quality processes to review and confirm data sent to the national audit.

We will continue to work with our other network colleagues to sustain the high quality, family friendly service offered at EMCHC. We are sure that the confidence in and levels of support for EMCHC demonstrated recently will continue to grow, and enable referral pathways currently driving patients outside the region, to be changed. These conversations however will take time to develop fully, but based on current success we feel these are possible, and will ensure we meet the 500 cases per annum by 2021

We were encouraged that you agreed with us that all centres achieving the standards should be commissioned and welcome your support in ensuring that we do this. It would seem extraordinary that despite our continued success in this strategy, (especially in the short timescale since the last self-assessment) if this increase in patient choice by a small change in referral pathways were to be viewed as more difficult to achieve than the prospect of allocating >1000 episodes of inpatient care per annum from EMCHC (against patient choice), to other units out of region as now proposed.

Public support from NHSE for this initiative will provide the remaining referring units with additional confidence that their patients will have the longevity of care from EMCHC that is assumed from the other Level 1 centres in the UK. As such we request you acknowledge the progress we have made in this initiative and formally support it. This is in line with the standards ratified by the NHS England Board and published in July 2015 (p11 paragraph 26) which make reference to referral and the need for (our emphasis) '**Networks supporting clinicians to meet the activity standards for procedures.** Under these arrangements clinicians will need to undertake minimum levels of surgical/interventional activity to maintain their skills. **Networks will need to establish systems to ensure that referrals to and between centres are managed in such a way as to ensure that each clinician is able to achieve their numbers,** that each patient receives care from a clinician with the appropriate skills and that the flow of patients appropriately matches the capacity of each institution.'

Requirement 3.1 – Standard B9 (L1)

Consultant congenital surgery cover must be provided by consultant congenital surgeons providing 24/7 emergency cover. Rotas must be no more frequent than 1 in 4. Each Specialist Children's Surgical Centre must develop out-of-hours arrangements that take into account the requirement for surgeons only to undertake procedures for which they have the appropriate competence. The rota will deliver care for both children and adults. If this means that the surgeon is on-call for two hospitals, they must be able to reach the patient bedside at either hospital within 30 minutes of receiving the call.

Timeframe: Rota: 1 in 3 immediate, 1 in 4 within 5 years. Other requirements: immediate

We are compliant to the standards and copies of our 1:3 Consultant Congenital Surgical rotas can be found in Appendix 4

As described above , our growth and development plan will deliver the required 500 cases necessary to sustain a 4th Congenital Cardiac Surgeon by 2021, and the recruitment timetable will be in line with the requirement for all surgeons to achieve the minimum 125 case load .

Once appointed a 1:4 rota will be established and a draft is attached in Appendix 4

Requirement 3.2 – Standard B15 (L1)

Consultant interventional cardiology cover must be provided by consultant interventional paediatric cardiologists providing 24/7 emergency cover. Rotas must be no more frequent than 1 in 4. This could include interventional cardiologists based at a Specialist Children's Surgical Centre or a Specialist Children's Cardiology Centre. Each Specialist Children's Surgical Centre must develop out-of-hours arrangements that take into account the requirement for interventionists only to undertake procedures for which they have the appropriate competence. The rota will deliver care for both children and adults. If this means that the interventionist is on-call for two hospitals, they must be able to reach the patient bedside at either hospital within 30 minutes of receiving the call.

Timeframe: Within 1 year

We are compliant with this standard.

We have previously submitted the 1 in 3 rota for this; a change in personnel means that this will remain as presented but will have a different number 3 operator from December 2016.

We can confirm the salary for recruitment of a fourth interventional cardiologist is already in place in our 3 year business plan, identified for recruitment in 2017.

Requirement 3.4 – Standard B1 (L1)

Each Specialist Children's Surgical Centre must provide appropriately trained and experienced medical and nursing staff sufficient to provide a full 24/7 emergency service within compliant rotas, including 24/7 paediatric surgery and interventional cardiology cover. A consultant ward round will occur daily. Each Specialist Children's Surgical Centre must provide a 24/7 emergency telephone advice service for patients and their family with urgent concerns about deteriorating health.

Timeframe: Within 6 months

We are compliant with this standard.

The paediatric cardiology service operates a "Consultant of the Week" (COW) system, where a named consultant is responsible for covering all in-house cardiology issues and providing network-wide advice. The COW does not carry out any elective activity during their hot week and works to the COW job plan during this period which includes daily ward rounds. At the weekend, the on-call

consultant job plan includes undertaking daily ward rounds in person There are multi-disciplinary business rounds seven days a week, which include consultants and senior team members in cardiology, cardiac surgery and intensive care.

The COW job plan and the paediatric cardiology on call rota reflecting day, night and weekend cover are included in Appendix 4

Requirement 4.1 – Standards D6(L1); D7(L1); D8(L1)

The following specialties or facilities must be located on the same hospital site as Specialist Children's Surgical Centres. They must function as part of the multidisciplinary team. Consultants from the following services must be able to provide emergency bedside care (call to bedside within 30 minutes).

Timeframe: 30 minute call to bedside: Immediate Co-location: within 3 years

D6 (L1) Paediatric Surgery

D7 (L1) Paediatric Nephrology/Renal Replacement Therapy.

D8 (L1) Paediatric Gastroenterology.

We are compliant with this standard

Thank you for the clarification in respect of the gastroenterology standard.

Currently immediate gastroenterology advice is available 24/7 from the gastroenterology team Emergency bedside care is provided within 30 minutes by general paediatric and neonatal consultant teams, supported by paediatric intensive care consultant. For surgical gastroenterological emergencies, bedside care is provided in 30 minutes by our paediatric surgical consultants.

We attach the relevant rotas, protocols in Appendix 5. As such we confirm that we meet standard D8 (L1).

For reference, we quote 2013/14 NHS England Service Specifications for Paediatric Gastroenterology: gastroenterology, hepatology and nutrition (E03/S/c) (page 6 Para 1)

'The components of a Paediatric Gastroenterology, Hepatology and Nutrition Service are; sufficient consultant numbers to provide consultant continuity with cross- cover and access to expert opinion by telephone 24 hours/day'

https://www.england.nhs.uk/wp-content/uploads/2013/06/e03-paedi-med-gastro-hepa-nut.pdf

By 2019 all paediatric specialist services will be co-located including paediatric cardiac services. This will ensure the co-location of the paediatric EMCHC service with other paediatric services at the Leicester Royal Infirmary site. The project, which will also see the expansion of space for the required increase in cardiac activity, will ensure compliance with the NHS England requirement 4.1

and co-location standards D6(L1), D7(L1), and D8(L1) within the given deadline (April 2019). The project will not require external capital funding, as it will be funded using a combination of the Trust's Capital Resource Limit and charitable donations. It will be designed as part of (but is not dependent upon) the wider Children's Hospital Project, to ensure the integration of paediatric services to create a defined Children's Hospital in Leicester. For the avoidance of doubt, we confirm the Trust's commitment and ability to achieve co-location by April 2019. Further details of the project can be supplied on request.

As acknowledged in your letter of the 31st October 2016 we are compliant to standard D7 (L1).

Finally, in addition to the standards listed in your letter 13th October 2016, we would like to formally register again, our response to the Adult standard D7 (L1) to enable a formal acceptance of our compliance and approved mitigation plan

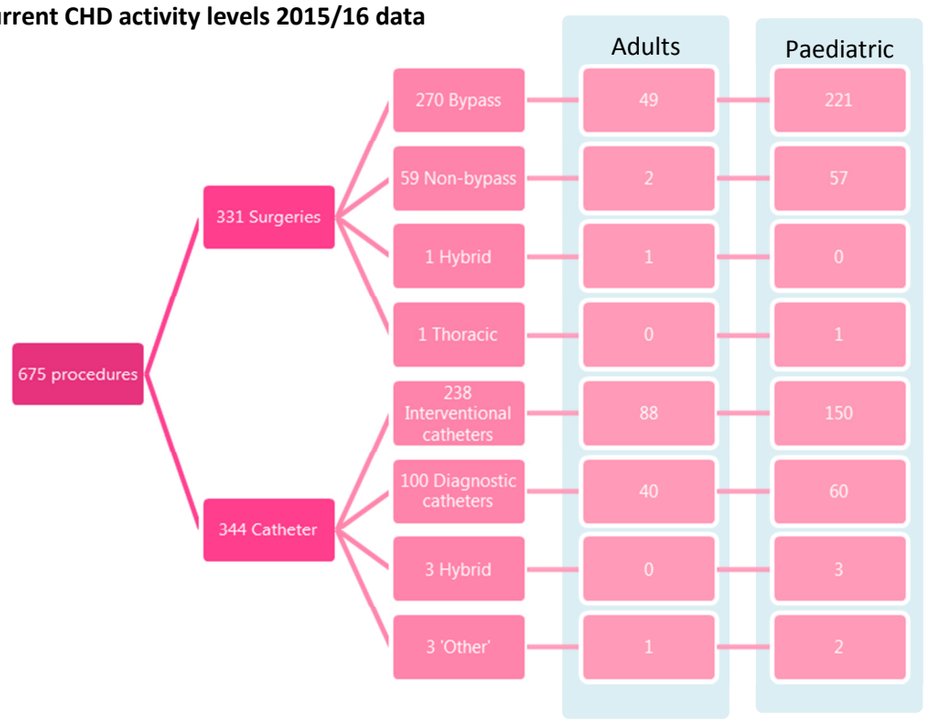
D7 (L1) (Adult) – co location of Vascular services including surgery and interventional radiology

ACHD services are not currently co located on same site as Adult Vascular services, but this is mitigated by same the arrangements as for the established acquired adult cardiac surgical and interventional catheterisation programme. We can confirm that, as described and physically demonstrated and inspected during your pre-consultation site visit, the entire UHL vascular surgery and interventional radiology programme will be relocating to the GH site in May 2017 and we will then be fully compliant with this standard.

CHD Impact Assessment University Hospitals of Leicester NHS Trust
7th November 2016

1. CHD activity levels

1.1 Current CHD activity levels 2015/16 data



1.2 Inpatient activity paediatrics

In 2015/16 our dedicated children's cardiac ward had a total of 2938 bed days, which equates to 1044 individual patient ward episodes

1.3 Adult inpatient activity

Adult inpatient activity is more difficult to extract from overall adult service activity, as such, detailed analysis of exact adult activity takes time to produce. We therefore require an extension to the timeframe for response.

1.4 Outpatient activity

EMCHC currently provide, In House**;** 1904 ACHD cardiology and surgical appointments per annum and 8642 paediatric cardiology and surgical appointments per annum

In addition we provide 322 Network clinic sessions per annum (254 paediatric and 68 ACHD). This equates to approximately 4000 additional clinic appointments per annum

1.5 Projected CHD activity levels if our proposals were to be implemented and basis for those projections.

Based on meeting the necessary standards for delivery of CHD services, it is our estimation that the following services would cease to be delivered at UHL.

Paediatric Congenital Heart Disease services	Rationale
Congenital Heart Disease Surgery	Decommissioned
All catheterisation i.e. Diagnostic Interventional Electrophysiological Diagnostic/ablation Pacing	Decommissioned
All GA required procedures on cardiac patients MRI Dental Spinal Gynae Gen surgical	All of these procedures would require a consultant paediatric cardiac anaesthetist. We would not have access to this speciality without the provision of cardiac surgery at UHL
PICU – Glenfield	Without cardiac surgery paediatric cardiac critical care beds would not be commissioned nor would we be able to retain the calibre of staff to provide this level of care
Ward 30 Glenfield	Some bed provision would need to be offered within the Children's Hospital but all of the beds at GH would be lost
All immediately pre/post-operative outpatient appointments	Our assumption is that these would be provided by the Level 1 centre and operating surgeons
Emergency lifesaving cardiac procedures Septostomy Pericardiocentisis	These procedures are performed by cardiac surgeons or interventional cardiologists , and as such would be performed at the Level 1 centre
PDA Ligation service	The standards require this to be provided by a Level 1 centre
Trans oesophageal echo cardiology	Needs a cardiac anaesthetist
Training status and revenue for cardiology training above Sp4	Training standards and curricula could not be met outside a Level 1 surgical centre and as such our ability to train would be lost
Paediatric ECMO Mobile ECMO	This service is dependent upon the availability of congenital cardiac surgeons , assessment of the degree of impact will be provided by the independent review process
Adult Congenital Heart Disease Services	**Rationale**
Adult congenital heart disease surgery	De commissioned
All catheterisation except simple diagnostic procedures and ASD/PFO closure in low risk patients i.e. Interventional Electrophysiological Diagnostic/ablation Pacing	De commissioned
ASD/PFO closure in low risk patients	Decommissioned or dependent upon agreement

	from a Level 1 centre
Complex cardio electro physiology and pacing	Decommissioned
Training status for cardiology training above Sp4	Unable to train ACHD as this requires surgical/ interventional inpatient cover

1.6 For Trusts where we have proposed that level 1 services would no longer be provided, what would be the CHD activity levels if level 2 CHD services continued to be provided?

Our assessment of the activity resulting from the implementation of the proposals will be based on the assumptions above only. There is a need for a clearer understanding of the role and viability of level 2 units working across multiple surgical centres (if commissioned), and the outcomes of the independent reviews of ECMO, PICU, Transport and Surgery. Without this information we are unable to estimate a level 2 service appropriately. We are willing to provide detailed analysis when these issues have been clarified.

2. Capacity

2.1 Current CHD capacity

Paediatric

Wards - EMCHC has a dedicated congenital cardiac ward for children with 17 beds; there is provision for adolescents and sufficient capacity to accommodate the required growth in activity prior to co-location with Children's services at the LRI in 2018
Diagnostics / Cath lab– access to four Cath lab sessions per week and one EP session, plus emergency daytime and out of hour's access
Theatre - full time theatre with access to additional theatre capacity as workload dictates plus emergency out of hour's access
Critical care – PICU at GH is commissioned for 7 beds and has physical capacity for a further 5 beds. Frequently flexes to accommodate up to 10 patients at a time currently.
Outpatients - 5 outpatient rooms currently supporting 11 clinics a week in house, three fetal clinics a week in association with our maternity services, and (as above) 254 clinics per year in nine sites across our network.

Adult

Wards – Adult patients are accommodated on 'home wards' for ACHD (medical and surgical.) There is no operational limit to this capacity within current and predicted workload
Diagnostics / Cath lab– access to four Cath lab sessions per week and one for EP plus emergency out of hour's access -
Theatre – full time theatre with access to additional theatre capacity as workload dictates plus emergency out of hour's access
Outpatients - 5 outpatient rooms + 3 scan rooms; we currently run 3 clinics a week in-house and 68 clinics per year in six sites across our network.

Critical care – The Adult Intensive Care Unit on the Glenfield Site has capacity of 22 physical beds and accommodates L3 (ICU), L2 (HDU) and ECMO patients. This enables to team to flex the bed base to support the care requirements of the patients on a day to day basis

2.2 CHD capacity required if our proposals were to be implemented

Unable to assess at this stage without further clarification - Please see above

2.3 For Trusts where we have proposed that level 1 services would no longer be provided, what would be the CHD capacity required if level 2 CHD services continued to be provided?

Unable to assess at this stage without further clarification - Please see above

2.4 For Trusts where additional capacity would be required if our proposals were to be implemented, please describe your plans for developing that capacity and indicate when that capacity will be available? What are the rate limiting factors?

N/A

2.5 Do you have any comments on our predictions of changes to patient flows and the impact on their journey times, or on the assumptions underpinning the modelling?

We welcome the nearest centre approach to the modelling for our centre. Our assumption is that as this approach has been used by NHS England to model the impact of the proposals, there will be no challenge to the same approach being used to determine our projected growth model.

We note however, patient choice needs to be a factor in both scenarios, and without full understanding of exactly how the patient flow will be affected by the proposal, it is very difficult to assess the impact especially on patient travel times, and staff impact.

We are struggling to understand how it can be possible that when all of our catchment population live closer to UHL than the proposed next closest centre, that travel times to the new level 1 centre will increase by only 14 minutes as a median and fall by 90% of all paediatric patients.

Reliance on the median as a measure of overall burden is inappropriate. Greater consideration should be given to the families whose journey times are in the longest quartile and those families where frequent and repeated hospital visits are required.

We remind you that in our proposed nearest centre network model we have been able to demonstrate that travel times and distances fall considerably for the region's patients compared with current Level 1 providers.

Figure 1 Midlands Congenital Heart Network: travel times to UHL from proposed network hospitals by road and rail

	By road			Change vs travel to current Level 1 by road			Change vs travel to current Level 1 by train[3]
	Distance (miles)	Time[1] (mins)	Time[2] (mins)	Distance (miles)	Time[1] (mins)	Time[2] (mins)	Time (mins)
Peterborough City Hospital[4]	43	62	64	-42	-56	-59	+2 to -23
Queen Elizabeth Hospital, King's Lynn	80	112	115	-42	-30	-36	+32
Kettering General Hospital[5]*	40	43	46	-42 -84	-70 -82	-76 -81	-37 -163
Northampton General Hospital*	46	52	52	-22 -64	-39 -71	-50 -72	+3 to +32 -87 to -116
Bedford Hospital	68	76	76	+11	-7	-18	+3 to -28
Milton Keynes Hospital	58	65	65	+5	-15	-30	+59

[1] standard travel time given by Google Maps
[2] travel time given by Google Maps at 10.30h on 08.10.15 (i.e. accounting for known delays)
[3] to-from nearest mainline station to arrive at 10.30h (does not include travel time from station to hospital). The range reflects variance in train timetable around the 10.30h arrival time
[4] Peterborough City Hospital is currently a member of two networks (East Midlands and GOSH)
[5] Kettering General Hospital is currently a member of three networks (East Midlands, Oxford-Southampton and GOSH)
* the upper line refers to travel to GOSH, the lower line to travel to Southampton General Hospital (both hospitals have services supplied by the Oxford-Southampton network)

3. Impact on other interdependent services and facilities

3.1 What other services would be affected if our proposals were to be implemented?

We note that the reviews into PICU, ECMO, Transport and Surgery have not yet commenced. The output from these reviews is a crucial element in assessing the impact to other associated services should the proposal go ahead.

The impact on other associated services is not clearly articulated as it is dependent upon a clearer understanding of the role and viability of level 2 units (if commissioned), and the outcomes of the independent reviews of ECMO, PICU, Transport and Surgery. Without this information we are unable to estimate the impact on our wider services appropriately. We are willing to provide detailed analysis when these issues have been clarified.

As such we list below the services where there will be some degree of impact .We are not able to quantify this without further understanding of exactly how the proposals will be implemented, and the outcome of the associated reviews .

Paediatric associated services	Rationale
CICU at LRI	The ability to maintain a PICU/CICU at LRI is totally dependent on our ability to retain the appropriately qualified PICU consultants/ nurses. It is feared that without the specialised services offered through Congenital Cardiac surgery, and our lack of other specialised paediatric services at UHL we would struggle to retain or attract these staff. The outcome of the PICU review will clarify if our fears are genuine.
Fetal cardiology	Geography will dictate whether or not there is any benefit in maintaining a tertiary fetal cardiac service separately from that which will continue to be needed at the Level 3 centres now serving the East

	Midlands. Even if Tertiary fetal cardiology is still provided, activity will reduce by at least 1/3rd as prospective parents will need at least 1 visit to their surgical unit pre-delivery
Long term ventilation	Limited PICU capacity and expertise is likely to lead to these patients being treated elsewhere
Specialist paediatric surgery	This is dependent upon an appropriately trained and staffed PICU, the outcome of the PICU review will illustrate if this is possible at LRI post implementation
Training status for Paediatricians with cardiology expertise	This will diminish over time, as the acuity and specialisms within the PICU are reduced. UHL will not attract trainees
Training status for ITU nurses and technicians	As above
Fetal medicine	A substantial proportion of fetal medical activity is supportive of the cardiac programme; this would be significantly impacted.
Cardiac BRU	Our ability to perform significant Cardiac research will be significantly impacted by a loss of cardiac surgery and its associated patients
Specialist neonatal surgery	Many patients with complex neonatal surgical conditions have concomitant cardiac problems and therefore will need to be delivered in a Level 1 centre; this will have a detrimental impact on the ability to provide tertiary neonatal surgery
Technical physiology	Currently EMCHC has one of the most highly trained, qualified and independently function team of congenital cardiac physiologists in the UK, with an excellent track record for in house training, recruitment and retention. It is highly likely that these very skilled practitioners will be in high demand and will migrate their skills elsewhere. It will similarly be very difficult to attract new staff.
In house delivery of complex babies	These deliveries are likely to be planned in the Level 1 centre to ensure access to congenital cardiac surgery is immediately available should it be required
Paediatric orthopaedic/ ENT/ General surgery on cardiac patients	Spinal patients and general surgical problems, dental cases etc. will all require cardiac anaesthetic input and hence will need to travel elsewhere.
Adult associated services	**Rationale**
High risk obstetric cardiology service	Loss of regional service, outpatient care, high risk deliveries in cardiac patients and in-patient antenatal care. Prospect of expectant mothers travelling out of region for obstetric care.
MRI cardiac specialists	Unable to undertake MRI under general anaesthesia. Concern about retention of specialist cardiologists and radiologists.
Outpatients	Reduction in volume. Concern over retention of specialist sonographers

Non cardiac surgical procedures on congenital cardiac patients Gynae Orthopaedic Dental	Reduction in volume, dependent on regional agreements with level 1 centre.

3.2 What would be the nature of the impact for each of those services? Can this be quantified?

Not at this stage. Without the clarity needed from the implementation plan and from the associated reviews of PICU, ECMO, Surgery and Transport it is not possible to accurately assess this impact.

3.3 Would any interdependent services or facilities become non-viable if our proposals were to be implemented? Why?

As above, it is not possible to answer this question without the output from the associated reviews

4. Financial and business impact

Financial and Business Impact Summary to the EMCHC Impact Assessment (Nov'16)			
Q1. What income does the Trust currently derive from CHD activity? Please provide a breakdown of the income if appropriate			
C or NC?	**Income Category**	**Group**	**Total**
Commissioned	**Income - Nhs Patient Care**	LLR CCGs Acute Contract	£194,997
		NHSE Acute Contract	£17,963,572
		Non LLR Contracts	£208,973
Commissioned Total			**£18,367,543**
Non Commissioned	**Income - Education, Training & Research**	Madel	£299,878
		Nmet	£15,179
		Sift	£224,336
	Income - Nhs Patient Care	NCA	£62,519
	Income - Non-Nhs Patient Care	Private Patient	£21,858
	Income - Other	Other Operating Income	£545,025
Non Commissioned Total			**£1,168,794**
Grand Total			**£19,536,337**
Q2. What income would the Trust derive from CHD activity if our proposals were to be implemented? Please provide a breakdown of the income if appropriate			
Q3. For Trusts where we have proposed that level 1 services would no longer be provided, what income would be derived from CHD services if level 2 CHD services continued to be provided?			
C or NC?	**Income Category**	**Group**	**Total**
Commissioned	**Income - Nhs Patient Care**	LLR CCGs Acute Contract	£55,705
		NHSE Acute Contract	£3,289,050
		Non LLR Contracts	£73,530
Commissioned Total			**£3,418,285**
Non Commissioned	**Income - Education, Training & Research**	Madel	£218,942
		Nmet	£8,678
		Sift	£158,368
	Income - Nhs Patient Care	NCA	£5,378
	Income - Non-Nhs Patient Care	Private Patient	£14,499
	Income - Other	Other Operating Income	£325,157
Non Commissioned Total			**£731,022**
Grand Total			**£4,149,307**

The financial assessment assumes the services lost are those as illustrated above in point 3.

4.1 For Trusts where additional capacity would be required if our proposals were to be implemented, how would the necessary expansion of capacity be funded? Do you have agreed access to any required capital?

N/A

4.2 What would be the wider impact on the Trust's positioning in the local, regional and national healthcare market, its long term development plans and its overall viability if our proposals were to be implemented?

We are very concerned about the potential effect of losing a large and internationally renowned clinical service on the Trust's position and future development. Working with regional partners we have developed

a number of collaborative approaches to specialist services in the East Midlands, and these collaborations would be threatened by the loss of such a significant service from our Trust. As noted previously, without further clarification of the effect of the proposals and the other independent reviews on specialist care provided by the Trust it is not possible to quantify this concern in any detail. We would very much like to participate in further discussions to clarify these issues.

5. Workforce implications

5.1 What staff would be considered to be affected by change if our proposals were to be implemented? How would they be affected?

The table below shows the staff who work directly (and only) for East Midlands Congenital Cardiac Service. These staff therefore will all be affected by change if the proposals were to be implemented. Without confirmation of the exact patient flows and the transition plan associated with these, it is impossible to predict in detail how the staff would be affected.

We assume the transition of such large numbers of staff and affectively the whole service provision will be subject to TUPE arrangements, and will require co location with the service to its receiving Level 1 centre. We carried out a staff survey in September 2016 which illustrated however, that 85% of our nursing staff would not be prepared to move away from Leicester should the proposal be implemented. It is therefore not appropriate to assume that TUPE of the entire staff is possible.

Staff Group	Payscale Description	Heads	Wte
Additional Clinical Services	Review Body Band 2	11	8.99
Additional Clinical Services Total		11	8.99
Administrative and Clerical	Apprentice	2	2.00
	Non Review Body Band 1	2	0.00
	Non Review Body Band 2	9	8.44
	Non Review Body Band 3	1	0.48
	Non Review Body Band 4	10	8.00
	Non Review Body Band 5	1	1.00
	Non Review Body Band 7	1	1.00
Administrative and Clerical Total		26	20.92
Estates and Ancillary	Non Review Body Band 1	3	2.09
Estates and Ancillary Total		3	2.09
Medical and Dental	Consultant (post 31 Oct)	17	15.80
	Consultant (pre 31 Oct) - 6yrs Snr	1	1.00
	Consultant (pre 31 Oct) - 7-8yrs Snr	2	2.00
	Locum Consultant	3	3.00
	Medical Ad Hoc	8	0.00
	Specialty Registrar	16	16.00
	Specialty Registrar Core training	1	1.00
Medical and Dental Total		48	38.80
Nursing and Midwifery Registered	Review Body Band 5	43	36.99
	Review Body Band 6	34	28.85
	Review Body Band 7	15	12.19
	Review Body Band 8 - Range A	3	2.92
	Review Body Band 8 - Range B	1	1.00
Nursing and Midwifery Registered Total		96	81.95
Grand Total		184	152.75

In addition to the EMCHC staff who definitely will be affected should the proposal be implemented there are a number of associated staff who depending on the anticipated knock on effects will also be affected

Manpower impact outside EMCHC	
Job role	**Adult/Paediatric**
Theatres	
Cardiac Team Leader	both
ODP's	both
Scrub nurses	both
HCA's	both
Perfusionists	both
Congenital Cardiac anaesthetist	Paediatric
Paediatric cardiac anaesthetists	Paediatric
Adult cardiac anaesthetists	Adult
Paediatric Fellow	Paediatric
Imaging	
Radiographers	Both
RDA's	Both
Administrative staff	Both
Modality team	Both
Mixed practice Radiologists	Both
Outpatients	
Clinical psychologists	both
Cardiac physiologists	both
Respiratory physiologist	both
Speech and Language therapists	both
Adult cardiac investigations team	Adult
Cath Lab	
Nurses	both
Radiographers	both
Cardiac technicians	both
HCA's	both
Cardiac anaesthetist (as above)	Paediatric
Intensive Care unit	
AICU nurses	Adult
Ward 32 ACHD nurses	Adult

5.2 For Trusts where we have proposed that level 1 service would no longer be provided, what staff would be considered to be affected by change if level 2 CHD services continued to be provided? How would they be affected?

The very concept of Level 2 centres is unproven as was recognised by the IRP in their review of the flawed 'Safe and Sustainable' proposals. We would seek clarity over the viability and success of a Level 2 model, particularly in the ability of a Level 2 centre to attract and retain the number and quality of staff required. There has been no testing of the concept of a level 2 centre working across a number of surgical centres. Informal reaction from our highly skilled staff is that many of them would take up posts elsewhere in the Trust if possible. We believe as above our entire workforce would be affected by change should this proposal be implemented.

5.3 Is a 'staff affected by change policy' in place? If so, please provide a copy.

Our growth strategy requires additional capacity and resource to be made available from supporting services, and our recruitment and retention strategy for CHD services at UHL assumes growth as per our shared model. We are not prepared to undermine these strategies by entering into any speculative discussions with our staff before a decision is made. We are actively encouraging business as usual, despite the considerable strain and uncertainties caused by the review process, and remarkably continue to attract high quality candidates who believe that EMCHC is a great place to work.

5.4 For Trusts where additional staffing would be required if our proposals were to be implemented, what strategy would the Trust adopt to ensure that it had the required staff in place, and when would it expect those staff to be in post?

There is a national shortage of all associated staff and recruitment for the additional posts in the receiving Level 1 units will be challenging. It is not appropriate to assume that requirements for additional staff will be met by those staff affected by the demise of EMCHC.

6. Equalities and health inequalities

6.1 Are there issues relating to equalities and/or health inequalities that your Trust has identified in the delivery of your current service? Please provide the relevant assessment and evidence.

The Trust has not had cause to carry out an equalities and/or health inequalities assessment of our current service. The last major review was commissioned by the JCPCT as part of the Safe and Sustainable process and will be available to NHS England as a legacy document.

6.2 If you have identified equalities and/or health inequalities issues, how are you addressing these? Is this approach effective?

Please see above

6.3 What effect, if any, would our proposals have on groups in your catchment population, sharing protected characteristics, if they were to be implemented? How could we mitigate those impacts?

We are not in a position to make this assessment in the absence of the completed impact reviews and a detailed definition of the proposed service model including patient flows. This important assessment will require a significant piece of work, including wide patient and carer engagement of those patient groups identified, which we will support NHS England in completing.

6.4 What effect, if any, would our proposals have on health inequalities in your catchment population, if they were to be implemented?

See previous response

6.5 For Trusts where we have proposed that level 1 services would no longer be provided, if level 2 CHD services continued to be provided what effect would this have on any impacts on equalities and/or health inequalities?

See previous response

Paediatric Critical Care and Specialised Surgery for Children: Expert Stakeholder Panel

The purpose of the expert stakeholder panel will be to contribute to a vision for sustainable, high quality and responsive paediatric critical care and specialised surgical services, that takes into account the linkages between these and other key services such as extracorporeal membrane oxygenation (ECMO) and paediatric transport for children requiring critical care.

NHS England will additionally be holding targeted stakeholder engagement events with particular groups with an interest in the review. Updates from the review will be made available via Dr Jonathan Fielden's blog at: https://www.england.nhs.uk/2016/10/jonathan-fielden/

The first meeting of the group will be held on 1st December 2016.

Panel membership

Chair: Dr Jonathan Fielden, Director of Specialised Commissioning and Deputy National Medical Director

Name	**Title and organisation**
Dr Liam Brennan	President, Academy of Medical Royal Colleges
Dr Jacqueline Cornish	National Clinical Director: Children and Young People & Transition, NHS England
Dr Mark Davidson	Consultant Paediatric Intensivist, Royal Hospital for Sick Children, Glasgow
Sir Mike Deegan	Chief Executive, Central Manchester University Hospitals NHS Foundation Trust
Professor Liz Draper	Principal Investigator, Paediatric Intensive Care Audit Network
Dr Peter Marc Fortune	President Elect, Paediatric Intensive Care Society
Mr Oliver Gee	Clinical Reference Group Chair: Specialised Surgery, NHS England
Dr Mike Linney	Wessex Regional Representative, Royal College of Paediatrics and Child Health
Fiona Lynch	Consultant Nurse, Evelina Children's Hospital, Guy's & St Thomas NHS Trust
Dr Gale Pearson	Clinical Reference Group Chair: Paediatric Critical Care, NHS England
Eithne Polke	Chair, Paediatric Intensive Care Society: Acute Transport Group
Louise Shepherd	Chair, Children's Hospital Alliance
Mr Richard Stewart	Chair, Children's Surgical Forum, Royal College of Surgeons

Miss Carin Van Doorn	Chair of Congenital Committee, Society for Cardiothoracic Surgery in Great Britain and Ireland
Dr Peter Wilson	Women and Children's National Programme of Care Co-Chair, NHS England
Professor Andrew Wolf	President, Association of Paediatric Anaesthetists of Great Britain and Ireland/Royal College of Anaesthetists

Note: Full membership is being finalised and the list will be updated accordingly.