

# Public Document Pack



## Rutland County Council

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Ladies and Gentlemen,

A meeting of the **HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland LE15 6HP on **Tuesday, 28th March, 2017** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs  
**Chief Executive**

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### **A G E N D A**

#### **1) APOLOGIES**

#### **2) RECORD OF MEETING**

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 31 January 2017 (previously circulated)

#### **3) DECLARATIONS OF INTEREST**

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

#### **4) PETITIONS, DEPUTATIONS AND QUESTIONS**

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 93.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received. Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

**5) LOCAL SAFEGUARDING CHILDREN'S BOARD AND SAFEGUARDING ADULTS BOARD: BUSINESS PLANS**

To receive Report No. 71/2017 from Paul Burnett, Chair of the Leicestershire and Rutland Safeguarding Children and Adults Boards  
(Pages 5 - 8)

**6) PROPOSALS TO IMPLEMENT CONGENITAL HEART DISEASE SERVICES FOR CHILDREN AND ADULTS IN ENGLAND**

To receive Report No. 60/2017 from Will Huxter, Regional Director of Specialised Commissioning & Dr Geraldine Linehan, Regional Clinical Director - NHS England  
(Pages 9 - 70)

**7) TRANSFORMATION PLAN FOR MENTAL HEALTH AND WELLBEING FOR CHILDREN AND YOUNG PEOPLE**

To receive Report No. 61/2017 from Chris West, Director of Nursing and Quality and Tim O'Neill Director for People and Deputy CEO for Rutland County Council  
(Pages 71 - 92)

**8) SPORT ENGLAND LOCAL DELIVERY PILOT BID**

To receive Report No. 69/2017 from Mike Sandys, Director for Public Health for Leicestershire and Rutland  
(Pages 93 - 98)

**9) PHARMACEUTICAL NEEDS ASSESSMENT**

To receive Report No. 70/2017 from Mike Sandys, Director for Public Health for Leicestershire and Rutland  
(Pages 99 - 110)

**10) SUSTAINABILITY AND TRANSFORMATION PLAN: UPDATE**

To receive a verbal update from Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group

**11) ANY URGENT BUSINESS**

**12) DATE OF NEXT MEETING**

The proposed date for the next meeting of the Rutland Health and Wellbeing

Board is Tuesday, 27 June 2017 at 2.00 p.m. in the Council Chamber, Catmose but this date has yet to be confirmed.

**Proposed Agenda Items:**

1. Director of Public Health: Annual Report  
Report from Mike Sandys, Director of Public Health for Leicestershire & Rutland
2. Health Protection Board: Annual Report  
Report from Vivienne Robbins, Consultant in Public Health.  
Annual report to provide assurance from the LLR Health Protection Board that it is meeting its statutory functions
3. General Practice Five Year Forward View  
Report from Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group

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**DISTRIBUTION**

**MEMBERS OF THE HEALTH AND WELLBEING BOARD:**

1.	Cllr Richard Clifton	Rutland County Council (Chair)
2.	Dr Andy Ker	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
3.	Fiona Taylor	Spire Homes
4.	Gavin Drummond	Leicestershire Constabulary
5.	Helen Briggs	Rutland County Council
6.	Jane Clayton Jones	Community & Voluntary Sector Rep
7.	Jennifer Fenelon	Healthwatch Rutland
8.	Mike Sandys	Rutland County Council - Public Health
9.	Rachel Dewar	Leicestershire Partnership NHS Trust
10.	Dr Tim O'Neill	Rutland County Council
11.	Tim Sacks	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
12.	Roz Lindridge	NHS England Local Area Team

**OTHER MEMBERS FOR INFORMATION**

13.	Cllr Alastair Mann	Rutland County Council
14.	Emma Jane Perkins	Rutland County Council
15.	Mark Andrews	Rutland County Council
16.	Sandra Taylor	Rutland County Council
17.	Wendy Hoult	NHS England Local Area Team
18.	Harpreet Kaur	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

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**Report No. 71/2017**

## Report to Rutland Health and Wellbeing Board

<b>Subject:</b>	<b>Leicestershire &amp; Rutland Safeguarding Adults Board (LRSAB) and Local Safeguarding Children Board (LRLSCB) Business Plans 2017/18</b>
<b>Meeting Date:</b>	<b>28 March 2017</b>
<b>Report Author:</b>	<b>Paul Burnett</b>
<b>Presented by:</b>	<b>James Fox</b>
<b>Paper for:</b>	<b>Note / Discussion</b>

### **Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:**

The purpose of this report is to set out the draft proposed Business Plan priorities for the Leicestershire and Rutland Local Safeguarding Children Board (LRLSCB) and the Leicestershire and Rutland Safeguarding Adult Board LRSAB for 2017/18 for noting and comment by the Health and Well-being Board.

Safeguarding is everyone's responsibility. Health and care needs can be linked to safeguarding risk for adults and children and health and care practitioners can have opportunities to identify and respond to safeguarding risk not available to workers in other agencies.

Connectivity between the LRSAB and the Better Care Together (BCT) Programme was established during 2014/15 when the Board was a consultee during the process of formulating the BCT Five Year Strategic Plan 2014-19. At that stage it was agreed that safeguarding would be a cross-cutting theme across the BCT Programme and we secured agreement to ensuring that the BCT Programme would incorporate, promote, measure and evaluate safeguarding outcomes within its improvement plans.

The Business Plan Priorities for 2017/18 incorporate areas within priority health work-streams, including emotional health and well-being and mental health. The priorities include a specific reference to assurance regarding the safeguarding implications and impacts of the Better Care Together and Sustainability and Transformation Plan programmes.

The LRLSCB and the LRSAB are partnerships that are required by regulation. The LRLSCB is required as a result of the Children Act 2004 and expectations of the Board are set out in Working Together 2015. The LRSAB is required as a result of the Care Act 2014.

It is a requirement of Working Together 2015 and the Care Act 2014 that the Annual Reports of the LRLSCB and LRSAB be presented to the Chairman of the Health and Well-Being Board. In Leicestershire and Rutland we have, in addition, a protocol between both safeguarding boards and the Health and Wellbeing Board that requires the presentation of the draft business plans of the safeguarding boards with an expectation that the Health and Wellbeing Board will consider any implications of these plans for the health and well-being strategies of both counties.

The Annual Reports for 2015-16 for the LRLSCB and LRSAB, which included some analysis of need for future priorities, were presented to the Health and Wellbeing Board on 15th September 2016.

### **Business Plan Priorities**

The Boards have continued to follow the approach to business planning that we adopted last year, focusing on areas that we have identified as specific priorities for development and improvement.

The Board is considering making a differentiation between Development priorities and Assurance priorities. Assurance priorities are solely identified as priorities for seeking assurance regarding safeguarding practice, risk or impact, rather than carrying out any specific development work. Development priorities are ones that require specific development work led by the Board, these may also include some element of assurance.

Effectiveness of safeguarding in areas not covered by the business plan or assurance priorities will be continue to be monitored through the core element of our performance and quality assurance framework.

The specific priorities that have arisen for the LRSAB are:

<b>Development Priority</b>	<b>Summary</b>
1. Prevention	Assurance regarding safeguarding elements of local prevention strategies
2. Making Safeguarding Personal (MSP)	Continuing development of MSP across partners
3. Thresholds	Identifying and addressing gaps re: over and under-reporting
4. Self-Neglect	Establishing and embedding a robust process for practitioners

The specific priorities that have arisen for the LRLSCB are:

<b>Development Priority</b>	<b>Summary</b>
1. CSE, Trafficking & Missing (Missing and online safety)	Developing assurance regarding missing children process and intervention and developing online safety responses.
2. Children with Disabilities	Assessing organisational responses and safeguarding risk understanding with regard to these children and their families.
3. Signs of Safety	Further embedding this across the partnership, particularly schools.

The priorities that have arisen for the part of the Business Plan shared between the LRSAB and the LRLSCB can be seen over the page:

<b>Development Priority</b>	<b>Summary</b>
1. The 'Toxic Trio'	Assessing and developing approaches to safeguarding adults and children where domestic abuse, substance misuse and mental health issues are present.
2. Participation and Engagement	Establishing visible effective participation by children and vulnerable adults at Board level.
3. Emotional Health & Wellbeing	Develop understanding of emotional health and well-being across the partnership and gain assurance regarding BCT and STP that work is addressing safeguarding issues, particularly re: mental health
4. Multi-Agency risk management / Supervision	Develop a multi-agency supervision approach for risk management in safeguarding adults and children.

Against each of these priorities the Board is in the process of identifying key outcomes for improvement and the actions that will need to be taken over the next year to achieve these improved outcomes.

The Priority on Emotional Health and Well-being currently references the Better Care Together Plan and Sustainable Transformation Plan.

The following are the identified assurance priorities arising from current priorities and the considerations from the development day. Seeking assurance on these would be built into the work of the Safeguarding Effectiveness Group (SEG) and the LSCB and SAB Multi-Agency Audit Groups as appropriate.

	<b>Assurance Priorities</b>
<b>LSCB</b>	<ol style="list-style-type: none"> <li>1. Early Help (step up and step down)</li> <li>2. Sports and other independent settings</li> <li>3. Thresholds</li> <li>4. Supervision</li> <li>5. Initial Health Assessments for Looked After Children (IHAs)</li> <li>6. Young People's Mental Health</li> </ol>
<b>SAB</b>	<ol style="list-style-type: none"> <li>1. Thresholds</li> <li>2. MCA DoLS</li> <li>3. Harm Caused by paid staff/ professionals</li> </ol>
<b>Joint</b>	<ol style="list-style-type: none"> <li>1. Domestic Abuse</li> </ol>

Young people have identified Hate Crime to be considered in the Business Plan, this will be considered further by the Board.

Feedback from this Board and other forums will support the development of the action plans for these priorities. The final Business Plan will be signed off at the meeting of the LRSAB and LRLSCB on 31 March 2017.

#### **Financial implications:**

There are no resource implications arising from the recommendation in this report. Both the LRLSCB and LRSAB operate with a budget to which partner agencies contribute under an agreed formula that reflects their size, operating budgets and legal safeguarding responsibilities.

The total budget within which the Boards operate in 2017/18 will be £346,090. The LRLSCB has a budget of £241,692 and the LRSAB a budget of £104,478, added to

which the Boards receive £40,500 from the community safety partnerships to support the undertaking of Domestic Homicide Reviews

**Recommendations:**

That the board:

1. Comments on the proposed Business Plan priorities 2017/18 for the LRLSCB and LRSAB, particularly in relation to the most appropriate route for assurance regarding the safeguarding implications and impacts of the Better Care Together and Sustainability and Transformation Plan programmes.

**Strategic Lead:**

**Risk assessment:**

<b>Time</b>	L	Previously the draft Business Plans have been presented in full to the Health and Well-being Board, however the business planning process has been delayed this year in order to incorporate the outcome of the Ofsted inspections. At this time the detail of the plans is still in development, and therefore this report just incorporates the Business Plan priorities.
<b>Viability</b>	L	Partner agencies have committed capacity both financial and human to the delivery of actions within the developing plans.
<b>Finance</b>	L	The budgets of the board are detailed under Financial Implications. Agency contributions for 2017/18 are agreed, with some reductions compared to the previous year. The Business Plan will be delivered within these resources.
<b>Profile</b>	L	The LRLSCB was rated as 'Good' by Ofsted in February 2017. Peer reviews of SABs are being trialled, as there is no regulatory framework in place to judge their performance at this time. The legislation regarding Local Safeguarding Children Boards is currently being reviewed nationally.
<b>Equality &amp; Diversity</b>	L	Safeguarding children, young people and adults concerns individuals who are likely to be disadvantaged in a number of ways. Specific impacts on or views of different groups is also considered in the work of the LRLSCB and LRSAB Safeguarding Effectiveness Group (SEG) in assessing performance and effectiveness with regard to safeguarding.

**Timeline:**

<b>Task</b>	<b>Target Date</b>	<b>Responsibility</b>
The final Business Plan will be signed off at the meeting of the LRSAB and LRLSCB	31 March 2017	Paul Burnett



Report No. 60/2017

## Report to Rutland Health and Wellbeing Board

<b>Subject:</b>	<b>Proposals to Implement Standards for Congenital Heart Disease for Children and Adults in England – Consultation Document</b>
<b>Meeting Date:</b>	<b>28 March 2017</b>
<b>Report Author:</b>	<b>NHS England</b>
<b>Presented by:</b>	<b>Will Huxter, Regional Director of Specialised Commissioning &amp; Dr Geraldine Linehan, Regional Clinical Director - NHS England</b>
<b>Paper for:</b>	<b>Discussion</b>

**Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:**

NHS England is consulting on its proposals to implement national standards for congenital heart disease services for children and adults. This document sets out the background and context for our proposals; explains the proposals in more detail, including their potential impact, if implemented; and how you can get involved in consultation.

Consultation runs from 9 February to 5 June 2017

**Financial implications:**

**Recommendations:**

That the board:

1. Comments upon and notes the Proposals to Implement Standards for Congenital Heart Disease for Children and Adults in England – Consultation Document from NHS England

**Comments from the board:**

**Strategic Lead:**

**Risk assessment:**

<b>Time</b>	L/M/H	
<b>Viability</b>	L/M/H	
<b>Finance</b>	L/M/H	
<b>Profile</b>	L/M/H	
<b>Equality &amp; Diversity</b>	L/M/H	

**Timeline:**

<b>Task</b>	<b>Target Date</b>	<b>Responsibility</b>

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# **Proposals to implement standards for congenital heart disease services for children and adults in England - Consultation Document**



**NHS England INFORMATION READER BOX****Directorate**

Medical	<b>Commissioning Operations</b>	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

**Publications Gateway Reference:****06374**

<b>Document Purpose</b>	Consultations
<b>Document Name</b>	Proposals to implement standards for congenital heart disease for children and adults in England - Consultation Document
<b>Author</b>	NHS England
<b>Publication Date</b>	09 February 2017
<b>Target Audience</b>	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs, Medical Directors, Directors of Nursing, NHS England Regional Directors, NHS England Directors of Commissioning Operations, NHS Trust CEs, Public; Patients; Families; Carers; Patient Group representatives; charities
<b>Additional Circulation List</b>	All NHS England Employees, Directors of HR, Directors of Finance, Communications Leads
<b>Description</b>	NHS England is consulting on its proposals to implement national standards for congenital heart disease services for children and adults. This document sets out the background and context for our proposals; explains the proposals in more detail, including their potential impact, if implemented; and how you can get involved in consultation.
<b>Cross Reference</b>	N/A
<b>Superseded Docs (if applicable)</b>	N/A
<b>Action Required</b>	N/A
<b>Timing / Deadlines (if applicable)</b>	<b>Consultation runs from 9 February to 5 June 2017</b>
<b>Contact Details for further information</b>	Michael Wilson Programme Director Congenital Heart Disease Programme NHS England Skipton House 80 London Road SE1 6LH  <a href="http://www.engage.england.nhs.uk">www.engage.england.nhs.uk</a>

**Document Status**

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# **Proposals to implement standards for congenital heart disease for children and adults in England**

## **Consultation Document**

First published: 9 February 2017

Prepared by: Specialised Commissioning, NHS England

Classification: OFFICIAL

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## Foreword

In July 2016, NHS England published a set of proposals regarding the future commissioning of congenital heart disease (CHD) services for children and adults. They describe the actions which we, as commissioners, propose to take in order to ensure a consistent standard of care for CHD patients across the country, for now and for the future.

We propose to do this by implementing national service standards at every hospital that provides CHD services. The effect of our proposals, if implemented, will be that some hospitals will carry out more CHD surgery and catheter procedures, while others, which do not meet the relevant standards, will stop doing this work.

The standards describe services of the highest possible quality. They were developed by patients, and their families and carers, by surgeons and other specialist doctors and nurses, and were formally agreed by the NHS England Board in 2015. We acknowledged then that implementation of them would be a challenge for some hospitals. We also recognised that it might subsequently prove necessary to make tough choices when considering how to put them into practice.

The guiding principle for our work has always been 'patients come first'. That principle remains at the forefront of our thinking today. It was patients, and their families/carers and representatives, as well as clinicians in the field, who told us – consistently – that the standards were only worth something if they were actually acted upon and met.

Now is the time for decisive action. We have an opportunity to future-proof CHD services, by ensuring that the standards are met. This will enable services to better cope with an increasing number of complex cases and make best use of advances in technology. We must not squander this opportunity. Equally, however, we must ensure that our commissioning decisions are informed by the views of patients and their families and carers, by clinicians and other hospital staff, and by other stakeholders.

We know that if our proposals are implemented, they will have an impact, not just on patients, but on this small number of hospitals, and some of the other services which they deliver, as well as on the staff working in them. We know that some of you are concerned about potentially longer journey times; having to travel greater distances for surgery; the availability of support and accommodation while away from home, and what might happen if there is an emergency. Thankfully, true emergencies in congenital heart disease are incredibly rare, but we recognise your concerns, and have tried to address them later in this document.

This is why we want to hear from you, during this public consultation, so that we can better understand how any changes might affect you and how we might support patients, hospitals and staff, during any future change. Before reading the rest of this consultation document, there are some important points which you might want to consider:



- No decisions about the future commissioning of CHD services have been taken. The proposals published in July were just that – proposals. If you can think of alternative ways in which the standards can be met, then we want to hear from you;
- This is not about saving money. You will already know that money is tight in the NHS, and the NHS has to live within its means. While implementing most of the standards will cost little, or nothing, we expect the overall amount of money spent on CHD care to increase in the future, driven by the growing number of patients living with this condition;
- These proposals are not about closing CHD units. We do not have a fixed number of hospitals providing CHD services in mind. This is about ensuring that every hospital providing a CHD service meets the standards. We have no view about the final number of hospitals which are able to do that;
- This is not about a short-term fix. We are focusing on the long-term resilience and sustainability of CHD services for generations to come.

Finally, we would like to acknowledge the significant time and effort which patients, parents, families, carers, and NHS staff have put into the various pieces of work which have been carried out during the past 16 years, all aimed at improving congenital heart disease services in England. We have all been at this a long time, and we recognise the cloud of uncertainty which hangs over these services as a result.

We need to put an end to this uncertainty, for everybody's sake. So, as you read this document, we hope that you will keep the future long-term stability of these important services in mind, and help us to reach a clear, and long-term, resolution, in the best interests of patients.



Will Huxter  
Senior Responsible Officer for  
CHD Commissioning and  
Implementation Programme &  
Regional Director for  
Specialised Commissioning



Professor Huon Gray  
National Clinical Director for Heart  
Disease, NHS England & Consultant  
Cardiologist, University Hospital of  
Southampton

## Background and context

“Sixteen years is a long time to wait. We have lost key consultant staff to posts abroad during that time, as they were not convinced that we were ever going to grasp this nettle. This is our last opportunity to make change happen. If we don’t grasp this opportunity now, we have to accept that ‘adequate’ is good enough”.

**Professor Huon Gray**

**Consultant Cardiologist, University Hospital Southampton NHS Foundation Trust, and National Clinical Director for Heart Disease, NHS England**

1. Congenital heart disease (CHD) refers to a heart condition or defect that develops in the womb, before a baby is born. There are many different forms of CHD, some more minor than others. Some people with CHD do not require any form of surgery or interventional procedure in the treatment of their condition; others require surgery before, or immediately after, birth. Thanks to advances in early diagnosis and medical advances, most babies born with CHD grow up to be adults, living full and active lives. CHD is common. It is estimated that between 5 and 9 in every 1000 babies born in the UK is born with CHD – this is around 5,500 to 6,300 babies each year. These figures will continue to increase if birth rates continue to rise, which leads to an increase in the number of operations and interventional procedures carried out on CHD patients each year.
2. Many congenital heart disease services work together in networks, so that neighbouring hospitals have good systems for referring patients, and for passing information back and forth. Networks help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible.
3. Services are based around a three-tiered model of care with specialist surgical centres (Level 1) managing the most highly complex diagnostics and care, including all surgery and interventional cardiology. At the next level are specialist cardiology centres (Level 2), which provide the same level of specialist medical care as Level 1, but do not provide surgery or interventional cardiology (except for one, specific minor procedure – atrial septal defect (ASD) closures, more commonly known as ‘hole in the heart’ – at selected hospitals treating adults. These Level 2 hospitals focus on diagnosis, plus ongoing care and management of CHD. At Level 3 will be local cardiology services, which are services in local hospitals run by general paediatricians/cardiologists with a special interest in CHD. They will provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from Level 1 and 2 hospitals. These services are commissioned by local Clinical Commissioning Groups (CCGs), and not by

NHS England. We are working with CCG commissioners to address the need for a more integrated approach to care across the three tiers.

4. Anybody who is familiar with the history of these services will know that publication of NHS England's proposals in the summer of 2016 represented the latest milestone in a very long journey, stretching back 16 years, to the publication of the report of a public inquiry into concerns about the care of children receiving complex cardiac surgery at Bristol Royal Infirmary. This was followed by the Safe and Sustainable review, launched by the Department of Health, in 2008. This review set out recommendations for a CHD service based on networks; with clinical standards for all hospitals designated to provide heart surgery for children, and a reduction in the number of NHS hospitals in England providing that heart surgery. Ultimately, these recommendations were not implemented, following intervention with the Secretary of State.
5. We know, from talking to stakeholders, that the failure to implement the recommendations of previous reviews has created uncertainty for patients and staff, and concerns raised during these, and other enquiries, have remained. However, despite the fact that previous reviews have not resulted in a coordinated programme of change, progress has been made. Outcomes for CHD surgery and interventional procedures across England are good, and compare well with other countries. We also know, from talking to patients and their families and carers in particular, that the quality of CHD care delivered in hospitals is very good. We have heard many, many positive stories about individual patient experiences, and recognise that each of those personal testimonies carries real weight, and shapes how people feel about the NHS service which has cared for, or saved the life of, their loved ones.
6. When NHS England took on responsibility for the commissioning of CHD services in 2013, we were aware of the impact that previous reviews had had, as described above, and were told by patients, families, doctors and nurses alike, that the best way to deal with these issues was through the development of service standards, setting out how a good CHD service should be set up, organised and run.
7. We worked with the different groups of stakeholders for more than two years, as part of the New Congenital Heart Disease Review, to create a set of quality and service standards that covered the entire patient pathway, from diagnosis, through treatment, and on into care at home and end of life care, to make sure that every child, young person and adult with CHD, in every part of the country, would receive the same high standard of treatment.
8. Surgeons told us how many operations should be done by each surgeon every year in order to maintain the surgeons' skills. Similarly, specialist doctors and nurses told us what medical care should be available by the bedside of a patient in a critical condition. Patient representatives led the work in developing the standards covering communication, facilities and bereavement. Additionally, for the first time ever, the transition from children's

services to adult services was included in the standards, to ensure that care is truly joined up.

9. The standards have never been considered as an end in themselves. They were developed in the full expectation that their implementation at every hospital in the country providing CHD services would be the means by which our work would be delivered, i.e:
  - securing best possible outcomes for all patients – not just reducing the number of deaths, but reducing disability caused by disease, and improving people’s quality of life;
  - tackling variation, so that services are consistent in meeting standards, each of them offering 24/7 care, seven days a week, as part of a nationally resilient service;
  - improving patient experience, including provision of better information for patients, plus more consideration of access and support for families when they are away from home.
  
10. This review has been underpinned by principles of openness and transparency, and a need to engage as widely as possible, bringing patients, families, carers, patient representatives, and clinicians together, in the joint pursuit of an effective and equitable solution, in the interests of patients now, and in the future. Consensus across all groups was achieved on the content of the standards, and it became clear that NHS England, as the sole national commissioner of CHD services had a unique opportunity to drive service improvement, and reduce variation in access and quality, by implementing a set of nationally-agreed standards, governing a truly national service.

## The case for change

11. The standards describe how to deliver CHD services of the very highest quality. We believe that implementation of these standards is the only way to ensure that patients are able to access care delivered to the same high standards, regardless of where they are treated. There is currently some variation as to where individual hospitals lie in meeting the standards, so care may vary, depending on where in England you access services.
  
12. We know, from talking to patients and their families/carers, that some people consider the care that they and their loved ones have experienced at a hospital to be the best there is. We do not wish to detract from that very personal experience, but it is not the same for everyone, and that simply is not fair.
  
13. Once all hospitals are meeting the standards, we can ensure that patients with CHD will be receiving the same levels of high quality care. For patients, and their families and carers, this means:
  - higher levels of support from specialist nurses and psychologists;

- improved communication and information, so that newly diagnosed patients have a better understanding of their condition; the care provided; treatment options; and how to take part in decisions about their own care;
- better managed transition from children's to adult services;
- improved palliative and end of life care, with specific standards focused on support for bereaved families and carers.

The above were all aspects of care which patients and patient groups told us were important, and are examples of the highest possible quality care, which we think should be available to all CHD patients, regardless of which hospital they attend.

14. For clinicians, and their teams, the broader benefits of meeting the standards will include:

- hospitals caring for people with CHD have the right staffing and skills mix, with no fewer than minimum staffing and activity levels, which support the maintenance of skills and expertise;
- improved resilience and mutual support provided by a networked model of care;
- enhanced opportunities for developing sub-specialisation;
- enhanced training and mentorship; sharing learning and skills; quality assurance and audit;
- elimination of isolated and occasional practice – this is when small volumes of surgery and interventional cardiology are undertaken in hospitals that do not offer specialist expertise in this field.

15. What we have described here are tangible benefits, things that will really make a difference to the care of patients with CHD, and to the teams caring for them. We believe that every patient receiving care for CHD should expect these highest possible standards of care, regardless of where they receive their treatment.

“From my perspective there are three main clinical advantages for having high-volume congenital cardiac surgical centres. Firstly, as an individual surgeon the more I do the better I become. There's lots of evidence for this in other surgical specialties, in particular showing that high volume centres reduce the number of post-operative complications and improving long-term quality of life. This also works for the whole team providing the care: the more the team does, the better they become, and this gives a huge opportunity for people to learn from each other in a large multidisciplinary setting.

And finally, higher surgical volumes enable specialisation in areas such as neonatal, congenital and device treatments. Importantly, these are all important for the next generation of surgeons coming up through the system - they will be less experienced when they become consultants than in the past - and they will need to fit into a large team to nurture them into becoming the surgeons of the future.”

**Mr Martin Kostolony - Head of Clinical Service - Cardiothoracic Surgery,  
Great Ormond Street Hospital for Children NHS Foundation Trust**

16. Apart from the benefits achieved by meeting the standards themselves, there are some specific additional benefits associated with implementation of the standards:

### 1.1 Ending uncertainty

17. The long history of repeated reviews of CHD services has created uncertainty within the specialty, damaging relationships between hospitals; harming recruitment and retention of specialist staff; and reducing the resilience of services. Continued uncertainty affects recruitment and retention of congenital heart disease surgeons, a group in short supply and subject to international demand.
18. The 2014 report on CHD services at Leeds Teaching Hospitals NHS Trust<sup>1</sup> recommended that NHS England should act to dispel the “almost morbid sense of spectatorship and foreboding that hangs over these services”. Clear resolution is now needed to bring the stability the service needs to move forward.

<sup>1</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/.../leeds-review.pdf>

## 1.2 Ending occasional practice

We have been calling for standards for adult congenital heart disease for many years and it is excellent that this has finally been achieved. Never before have the services for adults been designated and therefore occasional practice has happened. The introduction of these standards has already mainly eliminated that occasional practice and I am confident it will be a thing of the past, providing a much safer level of care and that is what these standards are all about.

**Michael Cumper, Vice President, Somerville Foundation**

19. Occasional and isolated practice (small volumes of surgery and interventional cardiology undertaken in hospitals without sufficient specialist expertise) has been a big concern, particularly for charities representing adults with CHD.
20. We asked every non-specialist hospital, where the data showed CHD procedures had taken place, to either cease occasional practice or take steps to meet the requirements of the standards, including minimum volume requirements. Most of these hospitals confirmed that the apparent occasional practice was due to coding errors. In other cases the practice had already stopped or steps were being taken to move this activity to an appropriate specialist Level 1 or Level 2 hospital. Some hospitals confirmed that they wished to be considered as specialist medical centres (Level 2), so we assessed them against the relevant standards
21. Occasional practice has largely been addressed through this process. Where the issue has not yet been resolved, it will be followed up by NHS England's regional teams.



### 1.3 Resilient, sustainable services

“We know that many people are very nervous about how the standards are moved forward, we must acknowledge those fears and support patients and families affected by any change but if we do not start to implement the new standards soon we will start to see a deterioration in the service.

We know that there are a growing number of children with highly complex conditions travelling through care. It is really important to make sure that there is a really strong service for them from the beginning of their lives, through their childhood and into adult services. They deserve nothing less.

**Suzie Hutchinson, Chief Executive and Service Lead, Little Hearts Matter**

22. Larger hospitals with bigger teams, more effectively networked with other hospitals, will be more resilient, providing an assurance of full 24-hour, seven- day care and a greater ability to cope with challenging events, for example the loss of a surgeon. We know, from talking to clinicians, that they feel best able to carry out their work when they are part of a team. Surgeons need the support of fellow surgeons, to provide cover for annual leave, and to step in when colleagues fall sick. They also need the support of an expert team around them. It is this kind of set-up that builds resilience in a service, and ensures that patients get access to the best possible care when they need it. The only way we can build this resilience is if we implement the standards.
23. The standards are – rightly – challenging, and it was acknowledged by the NHS England Board, when they were adopted, that it would be difficult for all hospitals to meet them, unless changes were made to the way in which those hospitals work. This is why the timeline for meeting some of the standards differs, as it was recognised that meeting some standards would take longer than others. For instance, the co-location of children’s CHD services with other children’s services might require physical changes to a hospital’s structure or layout.
24. Our proposals are described in detail on page 15. If they are implemented, in future, CHD services will only be provided by hospitals which already meet the standards required, or are likely to meet the standards within required timeframes as a result of the improvement plans they are putting in place.



“We fully support these standards. NHS England must ensure that the standards are applied for the benefit of patients, by ensuring that expertise is concentrated where it is most appropriate. The proposals put forward by NHS England in July 2016 should improve patient outcomes and help address variations in care currently provided”.

**Royal College of Surgeons and the Society for Cardiothoracic Surgery (SCTS)**

## Proposals for consultation

25. At the heart of our proposals is our aim that every patient should be confident that their care is being delivered by a hospital that is able to meet the required standards. In order to achieve this, we propose that in future, NHS England will only commission CHD services from hospitals that are able to meet the standards within the required timeframes.
26. Three specific standards are relevant to our proposals:
- Surgeon working requirements – the number of surgeons at each hospital, and the number of operations they each perform.
    - o The standards require that, for 2016, surgeons work in teams with a minimum of three surgeons, and in teams of at least four surgeons by April 2021. CHD surgeons are each required to carry out no fewer than 125 congenital heart operations a year (the equivalent of about three operations a week), averaged over a three-year period;
  - Service interdependencies, or co-location – the other services CHD patients depend upon, and which need to be on the same hospital site.
    - o The standards require that specialist children’s cardiac services are only delivered in settings where a wider range of other specialist children’s services are also present on the same hospital site. The standards require that certain paediatric specialties are within a 30-minute call to bedside range for April 2016, and co-located on the same site as children’s CHD services by 2019.
  - Interventional cardiology
    - o The standards require that for 2016, interventional cardiologists work in a team of at least three, and by April 2017 in teams of at least four, with the lead interventional cardiologist carrying out a minimum of 100 procedures a year, and all interventional cardiologists doing a minimum of 50 procedures a year.

27. The proposals on which we are consulting are, therefore:

**Level 1 (surgical)**

Proposal:

Surgery and interventional cardiology for adults would cease at **Central Manchester University Hospitals NHS Foundation Trust**. Central Manchester does not currently undertake surgery for children.

28. The standards require surgeons to be working in teams of three by April 2016, and in teams of four by April 2021. They also require each surgeon to be carrying out a minimum of 125 operations a year. Central Manchester University Hospitals NHS Foundation Trust has only one congenital heart surgeon, carrying out fewer than 125 congenital heart operations a year.

29. Interventional cardiology for adults at Central Manchester University Hospitals NHS Foundation Trust is already performed primarily by interventional cardiologists from Alder Hey Children's Hospital NHS Foundation Trust who travel to Manchester to see patients. Under our proposals, adult patients requiring surgery or interventional cardiology, who currently receive this level of care at Central Manchester University Hospitals NHS Foundation Trust, would be most likely to go to Liverpool Heart and Chest Hospital NHS Foundation Trust for surgery and/or interventional cardiology. All other care, with the exception of surgery and interventional cardiology, would continue to be provided in Manchester.

Proposal:

Surgery and interventional cardiology for children and adults would cease at **Royal Brompton and Harefield NHS Foundation Trust**.

30. The Royal Brompton and Harefield NHS Foundation Trust currently provides surgery and interventional cardiology for children and adults from the Royal Brompton Hospital. The agreed standards require a number of other specified services for children to be co-located by April 2019 on the same hospital site as surgical and interventional cardiology for children are provided from. The Royal Brompton Hospital does not have all of those required paediatric specialties on site, and does not have firm plans to do so. (These services are currently provided to the Royal Brompton's patients by Chelsea and Westminster NHS Foundation Trust). The Royal Brompton is therefore not able to meet that standard.

31. We are continuing to explore two avenues by which the Royal Brompton could continue to provide some, or all, Level 1 services by meeting all of the required standards:
- The hospital trust is exploring ways in which the paediatric co-location standards could be met by the required deadline of April 2019;
  - NHS England has raised with the Royal Brompton Hospital the potential for it to continue to provide Level 1 adult CHD services, including surgery. This would involve the hospital partnering with another Level 1 CHD hospital in London, that meets the required standards and that cares for children and young people. To date, the Royal Brompton Hospital has indicated that it does not support this approach, but it has not said that it would refuse to treat adults alone.
32. If a solution cannot be found then, under our proposals, children and adults who would currently be most likely to undergo CHD surgery and/or interventional cardiology at Royal Brompton and Harefield NHS Foundation Trust would still be able to receive their care in London, but would be most likely to go to Great Ormond Street Hospital for Children NHS Foundation Trust, Bart's Health NHS Trust or Guy's and St Thomas' NHS Foundation Trust if they required surgery and/or interventional procedures.

Proposal:

Surgery and interventional cardiology for children and adults would cease at **University Hospitals of Leicester NHS Trust**.

33. University Hospitals of Leicester NHS Trust performed 326 surgical procedures in 2015/16 which does not meet the minimum number of cases required by the standards. The hospital trust states that it is very close to meeting the requirement for an overall caseload of 375 operations for 2016/17, and has a growth plan in place to reach an overall caseload of 500 operations by 2021. NHS England does not consider these projections to be sound, and needs to see a more robust plan to support delivery of 375 cases now, and 500 cases by 2021. As of mid-January 2017, this plan has not been provided to us by the hospital trust.
34. The CHD service in Leicester lacks the capacity to deliver a full range of services as a fully independent centre, receiving clinical support for complex cases from surgical and cardiology colleagues in Birmingham. It has also transferred cases to Great Ormond Street Hospital for Children NHS Foundation Trust, and to Newcastle Hospitals NHS Foundation Trust. At this point in time, it is difficult to see how the hospital trust will be able to build up its resilience to ensure sustainable services for the future.

35. Similarly, University Hospitals of Leicester NHS Trust is at the margins of having enough interventional cardiology activity for its proposed team of three interventionists to meet the requirements of a lead interventionist carrying out a minimum of 100 procedures a year, and all interventionists doing a minimum of 50 procedures a year. While the hospital meets the April 2016 requirements, we need to see a credible plan which supports the development of a team of four interventionists by April 2017, and the associated activity that goes with that team.
36. Glenfield Hospital, which is part of University Hospitals of Leicester NHS Trust, and which is where the CHD service is located, has access to 24/7 paediatric gastroenterology and paediatric surgery, but does not have either of these services on site. The hospital originally proposed to achieve co-location of relevant paediatric specialties with its paediatric CHD service by 2019, through plans to build a new children's hospital, bringing all children's specialist services together on one site. However, the Trust has since developed an alternative plan that would involve moving paediatric cardiac services to the Leicester Royal Infirmary by 2019. We consider that the Trust's proposal to move paediatric cardiac Level 1 services to the Infirmary site would allow it to achieve full compliance with the co-location requirements, although the Trust would need to ensure that this move is achieved by the required deadline.
37. If we do not receive assurance that the hospital trust will meet the required standards then, under our proposals, children and adults who would currently be most likely to receive surgery and/or interventional cardiology at University Hospitals of Leicester would be likely to choose to receive their care at either Birmingham Children's Hospital NHS Foundation Trust or University Hospitals Birmingham NHS Foundation Trust. Some current Leicester patients would be likely to choose to receive care from Leeds Teaching Hospitals NHS Trust, if this was closer for them than Birmingham.
38. If our proposals are implemented, University Hospitals of Leicester NHS Trust could continue to offer Level 2 specialist medical services to children and adults, and we continue to discuss this option with the hospital trust. If the hospital carried on offering Level 2 CHD services, then the vast majority of patient care would continue to be offered in Leicester, and patients would only be required to travel elsewhere if they required surgery and/or interventional catheters. We continue to discuss this option with University Hospitals of Leicester NHS Trust.
39. It is important to note that change, such as that proposed above, has already taken place in CHD services without any adverse effects on patients. In 2010, Oxford stopped providing CHD surgery following the deaths of a number of babies. The hospital trust was carrying out more than 100 cases a year up until that time. Surgery was moved to Southampton. Surgeons employed at Oxford moved elsewhere, and there was no impact on other members of staff, who were all redeployed elsewhere within the hospital trust. Oxford is now part of a formal children's network, which means that patients can choose either Southampton or a hospital in London for surgery and/or

interventional catheters, but can have all of the rest of their CHD care in Oxford. One of the knock-on effects of the change was that children requiring specialist surgery are now transferred to Southampton, whilst general children's surgery at Oxford has increased, now that it has more capacity.

40. New patients accept referral to Southampton for surgery/interventional catheters as the norm, and, while some patients would prefer that Oxford were still offering Level 1 CHD surgery, the hospital trust Board made it clear that it would not be appropriate for the hospital to continue to provide CHD surgery. We do not use the Oxford illustration in any way to detract from the concerns that you might have about our proposals, but it does demonstrate that change such as this can take place with minimal impact, if well managed.

Surgery and interventional cardiology for adults and children would continue at **Newcastle upon Tyne Hospitals NHS Foundation Trust**.

41. While we are clear that all hospitals providing CHD services must meet the national CHD standards, we have had to propose a time-limited exception, or derogation, in the case of one particular hospital. Newcastle upon Tyne Hospitals NHS Foundation Trust does not meet the 2016 activity requirement and is unlikely to be able to meet the 2021 activity requirement. It also does not meet the 2019 paediatric co-location requirements or currently have a realistic plan to do so by April 2019. The CHD service for both children and adults is located at the Freeman Hospital, which is primarily an adult acute hospital. Relevant children's specialties – paediatric surgery, nephrology and gastroenterology – are located at the Great North Children's Hospital, which is part of the same hospital trust, but is not located on the same site. While the hospital trust meets the co-location requirement for 2016, i.e. bedside access within 30 minutes, it is unlikely to meet the full co-location requirement for 2019 for children's CHD surgery to be on the same site as other children's specialist services.
42. Newcastle upon Tyne Hospitals NHS Foundation Trust has a unique, strategic position in the NHS in England in delivering care for CHD patients with advanced heart failure, including heart transplantation and bridge to transplant. Advanced heart failure amongst people with CHD is increasing as a result of increased life expectancy, and treatment for people with this condition is dependent on CHD surgeons. Adult CHD patients with end stage heart failure have limited access to heart transplantation, and the unit in Newcastle is recognised as delivering more care to this group than other transplant centres nationally. This service is intimately connected to the CHD service and can only be delivered at a hospital providing Level 1 surgical services. No other provider currently has this capability so, while in principle it would be possible to commission these services from an alternative provider, the learning curve would be long and initially outcomes would not be as good.

43. In addition, the hospital trust is one of only two providing paediatric heart transplantation for the UK (the other is Great Ormond Street Hospital for Children NHS Foundation Trust in London).
44. While Newcastle does not meet these required standards now and is unlikely to be able to do so within the required timeframe, its role as one of only two national providers of critical heart transplantation and bridge to transplant services means that we need to consider retaining services at Newcastle despite the fact that it does not meet all the standards at present and is unlikely to do so within the required timeframes. The surgeons who perform CHD operations are the same surgeons carrying out heart transplants. If CHD surgery were moved elsewhere, the transplantation service could not be replaced in the short term without a negative effect on patients. For this reason, we are proposing to retain CHD services at Newcastle upon Tyne Hospitals NHS Foundation Trust.
45. This does not mean that change at Newcastle upon Tyne Hospitals NHS Foundation Trust will not happen in the longer-term. The hospital trust is required to meet the standards in the same way as all of the other Level 1 surgical centres. Timeframes for doing this may differ, but we will be working closely with the hospital trust to ensure that patients receiving CHD care at Newcastle upon Tyne Hospitals NHS Foundation Trust are not compromised in any way.
46. If our proposals were implemented, this would mean that, in future, Level 1 CHD surgical services would be provided by the following hospitals:
- **Alder Hey Children’s Hospital NHS Foundation Trust** (children’s services) and **Liverpool Heart and Chest Hospital NHS Foundation Trust** (adult service)
  - **Birmingham Children’s Hospital NHS Foundation Trust** (children’s services) and **University Hospitals Birmingham NHS Foundation Trust** (adult service)
  - **Great Ormond Street Hospital for Children NHS Foundation Trust** (children’s services) and **Barts Health NHS Trust** (adult service)
  - **Guy’s and St Thomas’ NHS Foundation Trust** (children’s and adult services)
  - **Leeds Teaching Hospitals NHS Trust** (children’s and adult services)
  - **Newcastle upon Tyne Hospitals NHS Foundation Trust** (children’s and adult services)
  - **University Hospitals Bristol NHS Foundation Trust** (children’s and adult services)
  - **University Hospital Southampton NHS Foundation Trust** (children’s and adult services)
47. Changes are also proposed to the provision of Level 2 specialist medical CHD care. In most cases, these proposals involve very small numbers of patients who might be impacted by that change. Whilst those changes are not the subject of this formal public consultation, we are very keen to talk to patients, their families/carers, and staff at affected hospitals, to better



understand the impact of any proposed change, and to hear their views about how we might limit that impact. We will be offering opportunities for stakeholders to talk to us about our proposals in relation to Level 2 services during this consultation period, so that we can discuss how we might support them to adjust to any changes in their care. You can find out about events in your area by visiting our [Consultation Hub](#)

48. If implemented, following our engagement with stakeholders, our proposals would result in the following changes at those hospitals that completed Level 2 self-assessments:

**Level 2 (specialist medical services)**

Proposals:

Specialist medical care and interventional cardiology should cease at **Blackpool Teaching Hospitals NHS Foundation Trust**

Specialist medical care and interventional cardiology should cease at **Imperial College Healthcare NHS Trust**

Specialist medical care and interventional cardiology should cease at **Nottingham University Hospitals NHS Trust**

Specialist medical care and interventional cardiology should cease at **Papworth Hospital NHS Foundation Trust**

Specialist medical care and interventional cardiology should cease at **University Hospital of South Manchester NHS Foundation Trust**

49. We are continuing to work with Papworth Hospital to consider whether it may be possible for the hospital trust to meet the required standards within the timeframes. At mid-January, there was a significant shortfall in terms of meeting the standards and a robust plan to address this had not been developed. Progress is being made, however. If the hospital trust can demonstrate that it is meeting the standards, or has a robust plan to do so, then we will review our proposal that Level 2 CHD services should cease to be provided at Papworth.

50. If our proposals for the hospitals listed above are implemented, this would mean that, in future, Level 2 CHD services would be provided by the following hospitals:

- **Brighton and Sussex University Hospitals NHS Trust** (adult service)
- **Central Manchester University Hospitals NHS Foundation Trust** (children's services)

- **Norfolk & Norwich University Hospitals NHS Foundation Trust** (adult service)
- **Oxford University Hospitals NHS Foundation Trust** (children's and adult services)

51. We continue to explore the potential for the provision of Level 2 specialist medical services at Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust.

## How our proposals were developed

### 1.4 Meeting the standards

52. The standards were agreed by NHS England's Board in July 2015, following a 12-week period of [public consultation](#). Once agreed, we started to look at how we might put the standards into practice. Patients and their families/carers, and patient representatives, told us early on that, while it was a good thing to have standards, they only really mattered if we ensured that they were met. Otherwise, they were a waste of time. That message is really important and has influenced our thinking throughout this process.

53. Initially we looked at whether the hospitals themselves, by working more closely together, could find new ways of working that would mean that the standards could be met across the country. However, this did not provide us with a solution that would give us a truly national CHD service.

54. It was decided, therefore, to look at each hospital individually, and ask them to complete a self-assessment to assess their compliance against a specific number of the standards. In deciding on which standards to focus on at this stage, we took advice from senior CHD clinicians, and from NHS England's Quality Surveillance Team, which has particular expertise in peer review. Collectively, the advice was to focus on those standards considered to be most closely and directly linked to measureable outcomes, and to effective systems for monitoring and improving quality and safety. This exercise was launched in January 2016, focusing on 14 specific requirements which covered 24 of the standards relating to children's care, as well as the corresponding adult standards.

55. The standards came into force on 1 April 2016. Each standard has an associated timeline for implementation, some of which are immediate, from April 2016, and some of which are longer. The timelines were set by NHS England's Congenital Heart Services Clinical Reference Group (CRG), which is made up of clinicians, patient representatives, commissioners and other experts, who felt that some of the changes required to meet the standards, such as the co-location of children's CHD services alongside other specialist children's services, could not be made overnight. They were also agreed by the NHS England Board in July 2015.



56. We asked each hospital whether it was able to meet the April 2016 standards. Where hospitals indicated that they could not meet that initial timescale, we set out development requirements to see them achieved by the end of the financial year (end of March 2017). These development requirements are being closely monitored via NHS contracts. We did not set out development requirements for Central Manchester University Hospitals NHS Foundation Trust, even though the hospital's assessment indicated that it was unable to meet the standards now, or in the future, as there was mutual recognition that the hospital would not be able to meet the requirements within the stated timeframe and would instead work with us to achieve any necessary changes in service delivery.

57. We considered two aspects of the standards to be of particular importance in terms of not just service quality, but for ensuring the resilience and safety of CHD services both for now, and for the future:

- Surgeon working requirements – the number of surgeons at each hospital, and the number of operations they each perform.

The standards require that, for 2016, surgeons work in teams with a minimum of three surgeons, and in teams of at least four surgeons by April 2021. CHD surgeons are each required to carry out no fewer than 125 congenital heart operations a year (the equivalent of about three operations a week); and

- Service interdependencies, or co-location – the other services CHD patients depend upon, and which need to be on the same hospital site. The standards require that specialist children's cardiac services are only delivered in settings where a wider range of other specialist children's services are also present on the same hospital site. The standards require that certain paediatric specialties are within a 30-minute call to bedside range for April 2016, and co-located on the same site as children's CHD services by 2019.

“125 really is a minimum number. It equates to three operations a week, per surgeon. Practice makes perfect, and 125 operations a year is considered the minimum to ensure that a newly appointed consultant surgeon acquires the skills they need across the differing surgical techniques. Some of the operations we do only come up once or twice a year, so ideally you would be doing at least four operations per surgeon each week, as that would result in 170-200 operations a year.

A surgeon doing too many, or too few, operations is not good. Either way can result in a poor performance when it matters, either through fatigue or a loss of skills. Individuals will, of course, vary in capability, but we must set a minimum standard in order to ensure that a surgeon has an acceptable level of skill refined and maintained through regular practice. Centres need to oversee the distribution of the work fairly, taking account of any specialist skills, to ensure that all surgeons have the opportunity to work at optimum levels.”

**Professor David Anderson, Consultant Heart Surgeon and Professor of Children’s Heart Surgery, Guy’s and St Thomas’ NHS Foundation Trust, and President of the British Congenital Cardiac Association (BCCA)**

58. Each set of returns from the hospitals was initially evaluated at a regional level by NHS England’s specialised commissioners, and then by a national panel, comprising patient representatives, clinicians, and commissioners, to ensure consistency of approach. The role of the regional and national panels was to assess each hospital’s ability to meet the standards, based on the evidence submitted by that hospital. A [report](#) of the panel’s work, and its assessments, was published by NHS England in July 2016.
59. In summary, the national panel found that as of May 2016, none of the hospitals providing CHD services met all of the standards tested. This was not unexpected, as the standards were aimed at ensuring that all services were brought up to the level of the best of existing practice. They were intended to be stretching, but realistic, and were focused on driving improvement.
60. The panel found that, with respect to Level 1 surgical services:
- Two hospitals – Birmingham Children’s Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust – were very close to meeting all of the requirements, with robust and credible plans to meet the rest within the required timescale, i.e. end of March 2017. They were rated green/amber;

- Seven hospitals<sup>2</sup> were likely to meet all of the requirements within the required timescale with development of their plans. They were rated amber;
- Three hospitals were unable to meet the requirements now, and were unlikely to be able to do so within the required timeframe. They were University Hospitals of Leicester NHS Trust, Newcastle Hospitals NHS Foundation Trust, and the Royal Brompton and Harefield NHS Foundation Trust. They were rated amber/red;
- One hospital – Central Manchester University Hospitals NHS Foundation Trust – was not able to meet the requirements now, and was unlikely to be able to do so within the required timeframe. Manchester has fewer than 100 operations annually undertaken by a single surgeon, with interventional cardiology provided on a sessional basis. Appropriate 24/7 surgical or interventional cover is not provided. The national panel considered these arrangements to be a risk, and rated the centre red.<sup>3</sup>

61. As the national commissioner of congenital heart disease services, it was the responsibility of NHS England to consider the information provided to it by the national panel, and for deciding what action, if any, should be taken on the basis of that information.

62. The Specialised Services Commissioning Committee met at the end of June 2016, and considered the information provided to members by the national panel. The committee recognised that NHS England needed to take action to ensure that CHD patients, wherever they live in the country, have access to the same safe, stable, high quality services.

63. It was proposed that in future, NHS England would only commission CHD services from hospitals that are able to meet the full set of standards within the required timeframes (with the time-limited exception of Newcastle upon Tyne Hospitals NHS Foundation Trust, for the reasons set out in paragraphs 41- 45), and decided that, subject to appropriate public involvement and/or public consultation, a change in service provision would be appropriate. On the basis of the information received, NHS England then published its proposals on 8 July 2016.

## Potential impact of implementing our proposals

64. We know, from talking to patients and their families, and carers; to clinicians and other hospital staff, and to other stakeholders, in the run-up to this consultation, that there are concerns about our proposals, and how implementation of them might affect them personally, or their jobs, or services, and the hospitals as a whole. We acknowledge that these are real

<sup>2</sup> Alder Hey, Leeds, University Hospitals Birmingham, Barts, Guy's & St Thomas', Bristol, and Southampton

<sup>3</sup> Individual assessment reports for each of the CHD provider hospitals were published in September 2016 and can be found at <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/applying/>

concerns and we have listened carefully to all those who have spoken, or written to us during the pre-consultation period. We have tried to answer some very challenging questions as openly and honestly as we could.

65. To better understand these issues, we have undertaken a detailed impact assessment, looking at how, if our proposals are implemented, they might be delivered in practice, and to identify the consequences for patients, providers, commissioners and others.
66. All hospitals providing Level 1 and Level 2 CHD services were asked to review their services in light of NHS England's proposals. Their responses were considered first by NHS England's regional teams, and then a national panel was drawn together to review those submissions. The findings of that panel's review are summarised at Appendix B. A full impact assessment has been published alongside this document.

## Pre-consultation engagement and involvement

67. Once the proposals were published, in July 2016, we entered a pre-consultation phase, which ran from July, right up until the start of formal consultation in February 2017.
68. The over-riding objective for NHS England during this period was to engage with hospitals providing CHD services – in particular, with those potentially affected by our proposals – to explore what the key issues were for them, in preventing them from meeting the standards, either for delivery in 2016, or the longer-term. Our aim throughout has been to maintain an open dialogue with the providers, so that we could work together to try and find alternative solutions to meeting the standards.

### 1.5 Engagement activity

69. Since July 2016, our regional and national teams have met regularly with managers and clinical teams at those hospitals currently providing CHD services and, in particular, with those whose current service will be affected if our proposals were to be implemented. As well as these more regular meetings, we also visited nine hospital trusts to talk specifically about our proposals, meeting with clinicians and managers, and touring the CHD facilities, including paediatric critical care and transplant units. Between July 2016 and January 2017 we visited:

- Royal Brompton and Harefield NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Barts Health NHS Trust
- Newcastle Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust

70. In addition to talking to the hospital clinicians and managers, we have also taken the opportunity – whenever possible – to meet with staff on the CHD units, as well as with patients, families, carers and patient representatives. We met with patients, carers and patient representatives in Leicester and Newcastle-upon-Tyne, and attended a meeting of the North West Adult Congenital Heart Disease Forum in Liverpool. We will be meeting with patients and their families/carers and representatives in London during the consultation period.
71. We have also met with MPs, particularly those whose constituencies include one of the CHD units potentially most affected by our proposals, and have provided a written briefing about our proposals to all local authorities across England, and attended Overview and Scrutiny Committees and Health and Wellbeing Boards where invited.
72. We have responded to a significant volume of correspondence relating to our proposals for CHD services during this period, assessing and re-assessing information provided by the hospitals; answering Parliamentary correspondence and Freedom of Information requests, as well as more general correspondence from stakeholders associated with the hospitals who wrote to us expressing concerns and/or asking for more information about our proposals.
73. The discussions during the pre-consultation period were dominated by the theme of how an individual hospital might achieve compliance with the standards, as well as the level of impact which our proposals – if implemented - might have on a hospital, as well as on its staff and, most importantly, its patients and their families.

## Consultation

### 1.6 Why are we consulting?

74. We know, from talking to patients, carers, patient representatives, hospital staff, and other stakeholders, that our proposals have caused some concern in certain areas of the country. We have tried, during the pre-consultation period, to address those concerns as best we can. However, we know that many of you remain concerned about what the future might look like in terms of your care, or that of your loved ones, or where you carry out your work.
75. Consultation is not a vote on whether or not our proposals should be implemented. Instead, it provides an opportunity for us to listen to people's views about our proposals, so that we can take them into account before any commissioning decisions are made. We have set out in this document some of the areas where we think our proposals could impact, or which people have told us could be impacted e.g. travel times for patients, and other hospital services. There may be other areas that we have not thought of, or alternative ways of meeting the standards which have not yet been explored. We need to hear about those now.

76. Consultation is open to everyone, not just those who have direct experience of CHD services.
77. The consultation is being run in accordance with [Cabinet Office guidance](#)
78. While our focus is on services for patients who are resident in England, we recognise that there are children and adults living in Wales, Scotland, and Northern Ireland, who use CHD services in England. We have agreed with our colleagues in the devolved nations that they will help support our consultation in making people aware of the consultation and how they can respond to it.
79. It is important that as many people as possible, with an interest in CHD services in England, have opportunity to contribute their views about the future of these important services.

## 1.7 How can I make my views known?

### 1.7.1 How to get involved

80. During consultation, there will be a number of opportunities for you to have your say about the future commissioning arrangements for CHD services.
81. Information about the different ways in which you can have your say is available at the NHS England [Consultation Hub](#). Consultation materials are also available here. We will be running a number of face-to-face events during the consultation period, which will enable us to tell you more about our proposals and provide you with an opportunity to ask us questions. We will also support charities, patient groups, clinicians, and provider hospitals to run their own events, and can provide materials to support this activity if required. To find out where, and when, your nearest event is taking place, and how to register to attend, please visit the [Consultation Hub](#)
82. Hard copies of the consultation document and response form can be made available. If you require a hard copy, please email us at [england.congenitalheart@nhs.net](mailto:england.congenitalheart@nhs.net)
83. We will also be holding a number of webinars throughout the consultation period, which will enable you to learn more about our proposals, and ask us questions, without having to travel. Details about all of the forthcoming webinars, and how to join them, are available at the [Consultation Hub](#).

## 1.7.2 How to let us know your views

This is an opportunity to set the standards for the next generation. It has clearly taken a long time, and a lot of discussion, to get to where we are now.

There is a real opportunity to have standards that have been nationally agreed; that have been agreed by clinicians; by providers; by patient groups; and set up services that will benefit children and adults with congenital heart defects over the coming generations.

**Jon Arnold**  
**Chief Executive, Tiny Tickers**

84. Consultation will run from Thursday 9 February 2017 to Monday 5 June 2017.

85. The full list of consultation questions can be found at Appendix A. For your response to be included in the analysis of this consultation, you need to ensure that we receive your response no later than 23.59 on Monday 5 June.

86. The online response form is located at our [Consultation Hub](#). Alternatively, you can send your response (whether on a response form, or as a letter) to:

Beverley Smyth  
 Specialised Commissioning, NHS England  
 4N08| Quarry House| Quarry Hill | Leeds | LS2 7UE

When you are replying, please let us know whether you are replying as an individual or whether your views represent those of an organisation. If you are replying on behalf of an organisation, please make it clear who the organisation represents and, where appropriate, how the views of the members were collated.

## 1.8 What happens next?

87. We have asked an independent company - Participate - to collate all of the responses we receive to the consultation and to produce an analysis of what respondents have said. The analysis will be published in due course and will include information about the number, type and other characteristics of the responses, giving us a good picture of the views expressed.

88. In coming to a decision, NHS England will consider the responses to the consultation and will adjust its proposals if we consider it appropriate to do so. We will take into account and balance all the main factors, including affordability, impact on other services, access and patient choice. Our

recommendations will then be considered by the relevant committees before a final decision is taken by the NHS England Board.



## Appendix A: Consultation Questions

It is important, before answering the questions in our consultation survey, for you to ensure that you have read all of the information provided about each of the individual CHD provider hospitals potentially affected by our proposals, so that you understand the potential impact of our proposals on those hospitals, and the way in which service delivery might change, should our proposals be implemented.

### Meeting the standards

1. In what capacity are you responding to the consultation?

- Current CHD patient
- Parent, family member or carer of a current CHD patient
- Member of the public
- CHD patient representative organisation
- Voluntary organisation / charity
- Clinician
- NHS provider organisation
- NHS commissioner
- Industry
- Other public body
- Other

If other – please specify:

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2. In which region are you based?

- Not applicable/regional/national organisation
- England - North East
- England - North West
- England - Yorkshire and The Humber
- England - East Midlands
- England - West Midlands
- England - East of England
- England - London
- England - South East
- England - South West
- Scotland
- Wales
- Northern Ireland

3. NHS England proposes that in future Congenital Heart Disease services will only be commissioned from hospitals that are able to meet the full set of standards within set timeframes. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

4. Please explain your response to question 3.

Three hospital trusts have been assessed as not able to fully meet the standards within set timeframes. NHS England therefore proposes that surgical (level 1) services are no longer commissioned from:

- **Central Manchester University Hospitals NHS Foundation Trust** (adult service)
- **Royal Brompton & Harefield NHS Foundation Trust** (services for adults and children); and
- **University Hospitals of Leicester NHS Trust** (services for adults and children).

5. Can you think of any viable actions that could be taken to support one or more of the trusts to meet the standards within the set timeframes?

**Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust**

If Central Manchester and Leicester no longer provide surgical (level 1) services, NHS England will seek to commission specialist medical services (level 2) from them, as long as the hospitals meet the standards for a level 2 service. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

### **Royal Brompton and Harefield NHS Foundation Trust**

6. The Royal Brompton could meet the standards for providing surgical (level 1) services for adults by working in partnership with another hospital that provides surgical (level 1) services for children. As an alternative to decommissioning the adult services, NHS England would like to support this way of working.

To what extent do you support or oppose the proposal that the Royal Brompton provide an adult only (level 1) service?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

### **Newcastle upon Tyne Hospitals NHS Foundation Trust**

7. NHS England is proposing to continue to commission surgical (Level 1) services from Newcastle upon Tyne Hospitals NHS Foundation Trust, whilst working with them to deliver the standards within a different timeframe. To what extent do you support or oppose this proposal?

- Strongly support
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose

### **Travel**

We know that some patients will have to travel further for the most specialised care including surgery if the proposals to cease to commission surgical ( level 1) services from Central Manchester University Hospitals NHS Foundation Trust (adult service); Royal Brompton & Harefield NHS Foundation Trust (services for adults and children); and University Hospitals of Leicester NHS Trust (services for adults and children) are implemented.

8. Do you think our assessment of the impact of our proposals on patient travel is accurate?
- Yes
  - No

9. What more might be done to avoid, reduce or compensate for longer journeys where these occur?

**Equalities and health inequalities**

We want to make sure we understand how different people will be affected by our proposals so that CHD services are appropriate and accessible to all and meet different people's needs.

In our report, we have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

- Yes
- No

10. Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

**Other impacts**

We want to make sure that the proposed changes, if they are implemented, happen as smoothly as possible for patients and their families/carers so it is important that we understand other impacts of our proposals.

11. Do you think our description of the other known impacts is accurate?

Yes

No

12. Please describe any other impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

**Any other comments**

13. Do you have any other comments about the proposals?

**About you**

14. Which age group are you in?

- Under 18
- 19 – 29
- 30 – 39
- 40-49
- 50 – 59
- 60-69
- 70-79
- 80+
- Prefer not to say

15. Please indicate your gender

- Male
- Female
- Intersex
- Trans
- Non-binary
- Prefer not to say

16. Do you consider yourself to have a disability?

- Yes
- No
- Prefer not to say

17. Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.

**White**

- Welsh/English/Scottish/  
Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White  
background

**Asian or Asian British**

- Indian
- Pakistani
- Bangladeshi
- Any other Asian  
background

**Other ethnic group**

- Chinese
- Any other ethnic group

**Mixed**

- White and Black  
Caribbean
- White and Black African
- White and Asian
- Any other mixed  
background

**Black or Black British**

- Black - Caribbean
- Black - African
- Any other Black  
background



18. Please indicate your religion or belief

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> No religion | <input type="checkbox"/> Muslim             |
| <input type="checkbox"/> Buddhist    | <input type="checkbox"/> Sikh               |
| <input type="checkbox"/> Christian   | <input type="checkbox"/> Atheist            |
| <input type="checkbox"/> Hindu       | <input type="checkbox"/> Any other religion |
| <input type="checkbox"/> Jewish      | <input type="checkbox"/> Rather not say     |

19. Please indicate the option which best describes your sexual orientation

- Heterosexual
- Gay
- Lesbian
- Bisexual
- Prefer not to say

## Appendix B: Summary of Impact Assessment

89. The following section summarises key points from the provider impact assessment, and from the equalities and health inequalities impact assessment. It also summarises the likely financial impact on NHS England if our proposals are implemented. Documents setting out this detail in full have been published alongside this consultation document.

### 1.9 Impact on patients

90. A particular concern for some patients and their families is that they may face longer journeys to access Level 1 CHD services which will be inconvenient, and, they fear, carry a level of risk.

91. Our clinical advisers on NHS England's Congenital Heart Services Clinical Reference Group and Clinical Advisory Panel tell us that true emergencies are very rare. Thanks to advances in antenatal diagnosis, most congenital heart defects are detected while a baby is still in the womb, which enables the mother to give birth either at, or close to, an appropriate hospital providing CHD surgery to children. Even in those cases where CHD is not detected antenatally, and problems are spotted during or after delivery, surgery will often be planned over a period of a few days. If infants need to be moved from one hospital to another for emergency care, then ambulance services, local hospitals and specialist retrieval teams are well able to ensure that patients are stabilised before and during transfer so that the risks of long journeys are negligible.

92. We understand that patients feel safer having a hospital providing CHD surgery close by, but, given the relatively small number of congenital heart disease surgeons in England, this could never be the case for all patients. By implementing the standards, we are able to ensure that patients will receive their surgery in the best possible environment to achieve a good outcome. This is a delicate balance, but we believe that it outweighs the risk of additional journey time, given that emergencies in CHD patients are so rare.

93. Under the proposed model of care different journeys would only be required when patients need to undergo surgery or an interventional or other catheter procedure, and for some admissions. The CRG has advised that the distance travelled for surgery is less important than the distances travelled regularly for ongoing care.

94. Over the course of a lifetime, a person with CHD receives most of their care in an outpatient setting. This should not be affected by the proposed changes since outpatient care can be provided at hospitals providing Level 2 services, those offering Level 3 services, and in outreach clinics. In fact most patient care, apart from admission for a procedure, the pre-admission clinic, and a single follow-up outpatient visit, can be undertaken by Level 2 hospitals.

95. Where patients require more complex diagnostic tests, for most inpatient admissions and for surgery and almost all interventional cardiology procedures, patients and their families/carers will need to travel to a Level 1

hospital. In general we expect that patients would travel to their next nearest Level 1 hospital. For some patients this would mean a similar journey, for others, a longer journey than they would have at present.

96. Our modelling suggests that the impact on average journey times for patients is relatively modest:

- An increase in the average journey time of 11 minutes for adults who use Central Manchester.
- An increase in the average journey time of 14 minutes for children who use Leicester and 32 minutes for adults.
- Average journey times would stay much the same for patients who use the Royal Brompton, as most patients would be likely to continue to receive their care from one of the two other Level 1 hospitals in London.

97. Some patients would of course have longer journeys. However 90% of patients who would currently use University Hospitals of Leicester will still have a journey time of less than 1 hour and 45 minutes to their nearest surgical hospital and this is similar to the national picture and shorter than in some other parts of the country (for example the South West peninsula). Similarly, 90% of patients who would currently use Central Manchester University Hospitals would have a journey time of 64 minutes or less to their nearest surgical hospital, and, of the patients who would currently use the Royal Brompton Hospital, 90% will have a journey time of 85 minutes or less to their nearest surgical hospital.

98. We do, however, recognise that it is difficult for families to support patients in hospital at some distance from home. This is a problem faced by many families already, not just in CHD services, but in many other specialist services, which tend to be provided in a smaller number of hospitals across the country. Because of this, and based on the advice of patients and families, a number of standards were developed to make life easier in this situation - providing better information about where to eat and sleep; better facilities to prepare meals; provision of Wi-Fi; ensuring parking is easily accessible and parking charges affordable; and providing overnight accommodation for parents and carers.

99. Our equalities impact assessment showed that three groups of patients would potentially be more affected by the proposed changes:

- children and young people with CHD because most surgical and interventional procedures (around 7 in 10) occur in children and young people;
- people with CHD and learning disability (LD) because there is a higher likelihood of learning disability amongst people with CHD and people with learning disabilities and especially people with autistic spectrum disorder cope best when things are familiar, so changing settings and changing staff is more of an issue; and

- people of Asian ethnicity with CHD because people who are of Asian ethnicity have a higher incidence of CHD, and may be more likely to have more severe forms of the disease.

100. We will make available materials in different formats to assist people who are part of these groups to participate in the consultation, and will be talking directly to these groups during consultation so that we can better understand the potential impacts of our proposals and any steps we could take to minimise these.

### 1.10 Impact on CHD services

101. We have modelled the way in which patient flows may change if the proposals are implemented. The modelling assumes that a patient will go to their next nearest surgical hospital. There are clearly limitations to this approach which mean that the results should be treated as a guide rather than an exact representation of what will happen:

<b>Hospital</b>	<b>Additional Operations</b>	<b>% increase</b>
<b>Birmingham - Children's Hospital</b>	<b>180</b>	<b>36%</b>
<b>University Hospitals Birmingham</b>	<b>45</b>	<b>45%</b>
<b>Liverpool Heart and Chest</b>	<b>90</b>	<b>N/A<sup>4</sup></b>
<b>Leeds - General Infirmary</b>	<b>50</b>	<b>10%</b>
<b>Guy's and St Thomas'</b>	<b>200</b>	<b>40%</b>
<b>Great Ormond Street</b>	<b>220</b>	<b>31%</b>
<b>Barts</b>	<b>85</b>	<b>110%</b>
<b>Southampton</b>	<b>20</b>	<b>5%</b>

102. Under this modelling, there would be little or no change to activity at Newcastle, Alder Hey or Bristol.

103. NHS England is working with the hospitals listed above to ensure that they would be ready and able to manage any increase in activity if the proposals are implemented. In each case we have received an assurance that if the changes go ahead, the hospital would increase its capacity – facilities, equipment, staffing – as necessary to be able to take the extra patients without any fall in service quality or rise in waiting times.

104. The aim of our proposals is to ensure that every provider that we commission to deliver CHD services meets the agreed standards. The standards were set to reflect the best evidence, expert advice and the

<sup>4</sup> Liverpool Heart and Chest Hospital does not currently undertake CHD surgery.

experience of patients and families about what makes for the best services. We believe that making the changes we have proposed will ensure that no matter where they live, patients and their families will receive excellent care.

105. Services will also be more resilient and sustainable for the future. Under present arrangements services in some hospitals receive significant levels of support from other hospitals. Without this support, at best, these hospitals would not be able to offer their patients a full range of CHD services.
106. Bigger hospitals are generally more resilient. The provision of consistent care at all times of day and night throughout the year is more assured. Bigger teams are better able to cope when one of their number is unavailable or leaves. They are also better able to support the full range of surgical procedures and the development of very specialised practice.

## 1.11 Impact on other services

### 1.11.1 Impact on other services: Paediatric Intensive Care

107. Our assessment shows that if our proposals are implemented there will be an impact on paediatric intensive care (PIC) at University Hospitals of Leicester NHS Trust and the Royal Brompton and Harefield NHS Foundation Trust. The proposals affect only adult services at Central Manchester University Hospitals NHS Foundation Trust.

#### 1.11.1.1 University Hospitals of Leicester: Paediatric Intensive Care

108. University Hospitals of Leicester has two paediatric intensive care units (PICUs), one at the Leicester Royal Infirmary and one at Glenfield Hospital (which supports CHD services). While we cannot pre-empt the decisions that NHS England will make on CHD services, or the findings and recommendations of its [Paediatric Critical Care & Specialised Surgery for Children Service Review](#), at this point we expect that Leicester would still provide PICU care for the East Midlands if our proposals are implemented, even if it no longer provides Level 1 cardiac surgery for children. This would be through a single PICU at the Royal Infirmary. We understand that, even if our proposals are not implemented and Leicester continues to provide Level 1 children's cardiac surgery, it plans to move this service from Glenfield to the Infirmary, which would be likely to lead to the closure at the Glenfield anyway (and a corresponding increase in capacity of PICU at the Infirmary). Accordingly, the future of the PICU at Glenfield is uncertain, whether or not NHS England's proposals on CHD are implemented, whereas the provision of the PICU at the Infirmary would be unaffected by the implementation of the proposals. The hospital trust does not share this assessment.

#### 1.11.1.2 Royal Brompton: Paediatric Intensive Care

109. The Royal Brompton's PICU is largely dependent on the hospital's CHD service for children, because CHD accounts for 86% of the admissions. The hospital trust considers that its PICU would no longer be viable if the proposals are implemented, because paediatric cardiac patients are a large

proportion of its work and it would not have enough other patients to stay open. The national panel accepted that this was an accurate assessment. If the PICU at the Royal Brompton were to close, this would be expected to have an effect on their paediatric respiratory services, the only other clinical service for children offered by the Trust (see below).

### ***1.11.1.3 Paediatric Intensive Care: wider implications***

110. In order to ensure that there is still sufficient PICU capacity for CHD patients, NHS England will work with the other hospitals where increased paediatric cardiac surgery would be expected if our proposals are implemented (Birmingham Children's Hospital, Great Ormond Street, Leeds General Infirmary, St Thomas' - Evelina Hospital) to undertake the necessary planning and preparation to manage any increase in PICU capacity that would be needed for CHD patients.
111. If our proposals are implemented, there may also be an effect on the wider regional and national PIC system. NHS England has accelerated its Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric intensive care provision and paediatric transport. The critical care review aims to bring forward initial work looking at where paediatric critical care capacity is likely to be needed in future, with the first outputs coming through early in 2017. When the Board takes its decisions on the CHD proposals, it will therefore be able to take into account the impact on PIC for CHD patients in the wider regional and national context. The Paediatric Critical Care & Specialised Surgery for Children Service Review will then be able to pick up and deal with any wider implications for changes in PIC consequent upon the proposed CHD changes, as it considers the required capacity and distribution of PICU across the country as a whole.

### **1.11.2 Impact on other services: Extracorporeal Membrane Oxygenation (ECMO)**

112. Extracorporeal Membrane Oxygenation (ECMO) is a technique that provides cardiac and/or respiratory support for very sick patients. When we use ECMO to support the lungs, supporting individuals with severe, potentially reversible respiratory failure, it is called 'respiratory ECMO'. When it is used to support the heart, it is called 'cardiac ECMO'.

#### ***1.11.2.1 Leicester: ECMO***

113. Leicester provides cardiac and respiratory ECMO for children and is at present the only provider commissioned to offer mobile ECMO (which allows children to be transferred between hospitals on ECMO). It also provides cardiac and respiratory ECMO for adults. If our proposals were to be implemented, Leicester would no longer be able to provide cardiac or respiratory ECMO for children or mobile ECMO for children. Taken together this would affect around 55 children a year. It would no longer provide cardiac ECMO for adults with CHD. We would expect that Leicester could continue to provide adult respiratory ECMO, in a similar way to other hospitals

where services are supported by adult cardiac surgery services (not congenital cardiac).

#### **1.11.2.2 Royal Brompton: ECMO**

114. The Royal Brompton provides cardiac ECMO for children and cardiac and respiratory ECMO for adults. If our proposals were to be implemented, Royal Brompton would no longer be able to provide cardiac ECMO for children. This would affect around 15 children a year. It would no longer provide cardiac ECMO for adults with CHD. Adult respiratory ECMO provision at the Royal Brompton is the subject of a separate current procurement being undertaken by NHS England.

#### **1.11.2.3 Central Manchester: ECMO**

115. Central Manchester provides cardiac ECMO for adults with CHD. If our proposals were to be implemented, Central Manchester would no longer be able to provide cardiac ECMO for adults with CHD.

#### **1.11.2.4 ECMO: wider implications**

116. NHS England will work with the other hospitals, where increased paediatric cardiac surgery would be expected, if our proposals are implemented, (Birmingham Children's Hospital, Great Ormond Street, Leeds General Infirmary, and St Thomas' - Evelina Hospital) to undertake the necessary planning and preparation to manage any increase in paediatric cardiac ECMO capacity that would be needed for CHD patients.

117. If our proposals are implemented, there may also be a wider regional and national effect on ECMO services. NHS England has accelerated its Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric ECMO. When the NHS England Board makes its decision about the CHD proposals, it should, therefore, have greater clarity about the impact on ECMO for CHD patients in the wider regional and national context. The Paediatric Critical Care & Specialised Surgery for Children Service Review will then be able to pick up and address any wider implications for changes in children's ECMO services, as a consequence of the proposed CHD changes, as it considers the required capacity and distribution of children's ECMO across the country as a whole. We will re-commission appropriate levels of children's respiratory ECMO and mobile ECMO from an appropriate number of providers in the light of the recommendations of that review.

### **1.11.3 Impact on other services: Specialist paediatric respiratory services**

118. As outlined above, the Royal Brompton considers it likely that its PICU would no longer be viable if our proposals are implemented, because paediatric cardiac patients are a large proportion of its work and it might not have enough other patients to stay open. The national panel accepted that this was an accurate assessment. The hospital trust considers that this would have a serious detrimental effect on children's respiratory services which also use the PICU.



119. The national panel considered that there would be an impact on paediatric respiratory services, if paediatric cardiac services and PICU were no longer provided by the Royal Brompton. NHS England's work focusses on congenital heart disease and has not examined paediatric respiratory services. The membership of the panel reflects that focus. Given this, it would not have been appropriate for the panel to undertake detailed assessment of this impact.

120. If a decision is taken that results in closure of the PICU at the Royal Brompton Hospital, NHS England will work with the hospital trust to understand and manage the impact on paediatric respiratory services. This could require a local service change process with further public engagement, potentially including full public consultation. There are alternative providers of specialist paediatric respiratory services in London.

## 1.12 Workforce Impact

### 1.12.1 Provider organisations where level 1 services would be provided under the proposals: workforce impact

121. The panel considered that hospitals that would gain more patients if the proposals were to be implemented were well placed to be able to expand their capacity to be able to provide that care. The recruitment of the necessary workforce for this increased activity was seen as potentially challenging for a number of these hospitals. Specifically, the recruitment of the PICU nurses necessary for the additional beds which would be required. The hospitals gaining significant activity believed that although challenging they had a good record of recruiting staff and would be able to recruit the necessary staff as long as they were given sufficient time prior to these proposals being implemented.

### 1.12.2 Provider organisations where level 1 services would no longer be provided under the proposals: workforce impact

122. Under our proposals some hospitals would no longer provide level 1 CHD services. In some cases this is likely to also affect the future of other linked services. For the staff delivering these services the potential implications include:

- employees being redeployed into other roles;
- the transfer of the contracts of employment of employees from one organisation to another;
- changes to the volume of work carried out by employees (either through increases or decreases in patient activity within the Trust they work for);
- employees working within the service being made redundant; and
- changes to the future workforce requirements to deliver the CHD standards and service specifications across the commissioned centres.



123. One of the key challenges both to current CHD services and to any future configuration is ensuring that there are sufficient staff with the necessary skills and experience to undertake this work across the country.
124. NHS England will work with provider organisations to ensure that staff are supported through any change process and redundancies are avoided wherever possible.
125. The national panel noted that experience at other hospitals where level 1 services have ceased – Edinburgh, Cardiff and Oxford – was that the majority of staff did not transfer to alternative providers of these services, but there were virtually no redundancies, with most staff being redeployed internally. It is reasonable to expect that many staff would seek to take up alternative roles within the relevant hospital trusts, rather than moving to another hospital. However, the panel noted that certain staff, such as CHD surgeons, would look to move to a Level 1 CHD hospital.

#### ***1.12.2.1 Impact on workforce at the Royal Brompton Hospital***

126. The Royal Brompton identified approximately 430 WTE staff that it considered would be affected by the proposals, including those working as part of their CHD service, paediatric respiratory, paediatric intensive care and other services which will be impacted to a lesser extent. The hospital trust has estimated the cost of redundancies to be approximately £13.5m.
127. The panel was not able to take a view on the likelihood of all these staff being significantly impacted by the proposed changes; however, it was acknowledged that there would be a significant impact on the Royal Brompton's workforce, if the proposals were to be implemented. The panel noted that this impact would be reduced, were the Royal Brompton to continue providing adult-only Level 1.
128. NHS England has reviewed the hospital trust's assessment of the potential level of redundancy. Given that we expect that most patients using the Royal Brompton would transfer to alternative hospitals within three miles of the Royal Brompton with the scope for redeployment that would result, NHS England has a materially different view of possible redundancy costs. Internal redeployment is also likely to make a significant contribution to avoiding redundancy. We estimate that the costs could however be up to £1 – 1.5m. This estimate is highly sensitive to the degree to which staff can be redeployed.

#### ***1.12.2.2 Impact on workforce at University Hospitals of Leicester***

129. University Hospitals of Leicester identified 153 WTE staff that would be directly affected by the proposals, including administrative and clerical staff, estates and ancillary, medical and dental and nursing and midwifery staff that work solely for East Midlands Congenital Cardiac Service. In addition to the staff directly affected, the hospital trust has also identified other roles, such as those working in theatres, imaging, outpatient care, catheter labs and intensive care that would be indirectly affected. University Hospitals of

Leicester considers it likely that many of its staff would prefer to take up posts elsewhere in the hospital trust if possible.

130. The panel was not able to take a view on the likelihood of all these staff being significantly impacted by the proposed changes; however, it was acknowledged that there would be a significant impact on the hospital trust's workforce, if the proposals were to be implemented. The panel noted that this impact would be reduced, were University Hospitals of Leicester to continue providing Level 2 specialist medical services.

131. NHS England considers it probable that most at risk staff will be redeployed and that therefore the costs of redundancy will be mitigated. We estimate that the costs could however be up to £1m. This estimate is highly sensitive to the degree to which staff can be redeployed.

### ***1.12.2.3 Impact on workforce at Central Manchester University Hospitals***

132. The hospital trust did not respond to the request to provide information on the potential impact of the proposals. The panel considered it likely that the impact on staff at Central Manchester University Hospitals would be considerably less than the other two hospitals as the scale of service reduction would be much smaller. Where staff are affected, close working between Central Manchester University Hospitals, Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital should enable Central Manchester to ensure that staff are appropriately supported and that clear plans are made to enable staff who wish to transfer to a Level 1 hospital to do so.

## **1.13 Financial Impact**

### **1.13.1 Provider organisations where level 1 services would be provided under the proposals: finance impact**

#### ***1.13.1.1 Confirmation that revenue costs of implementing standards should be covered by increasing income for increasing activity***

133. Trusts are paid for CHD services through tariff, which ensures that the money received is linked to patient activity. It is likely that there will be some economies of scale for providers linked with providing a higher volume of activity. As such the trusts which would gain activity under these proposals are confident of being able to fund this expansion through the income which would be associated with this extra activity.

134. The financial assessment undertaken in 2015 at the time the Board agreed the standards showed that additional income to hospital trusts resulting from growth in activity would be sufficient to fund the implementation of the standards. Growth predictions have been refreshed and continue to provide assurance that implementation of the standards will be affordable for providers.

### ***1.13.1.2 Assessment of capital requirements at hospitals that would take additional patients under the proposals and the sources of this capital***

135. NHS England asked hospitals providing CHD services whether there would be any capital implications if they were required to take additional patients if our proposals are implemented. NHS England has confirmed that no specific central funds will be made available.
136. Two hospital trusts indicated that they would need to source capital funds to accommodate additional activity: University Hospitals Birmingham (£4M) and Great Ormond Street (£6M). In both of these cases it is expected that the provider would be able to source the capital funding from existing allocations and/or charitable funds. This is being confirmed with NHS Improvement. No other provider indicated any requirement for capital funding, and the risk around capital funding requirement is minimal at this stage.

### **1.13.2 Provider organisations where level 1 services would no longer be provided under the proposals: finance impact**

137. NHS England has assessed for each of the hospitals where it is proposed that level 1 congenital cardiac surgery is no longer provided what proportion of their income comes from caring for patients with congenital heart disease.

#### ***1.13.2.1 Impact on finances at Leicester***

138. The overall contract value for specialised services at Leicester is approximately £234m. NHS England estimates that the financial effect of the proposed changes would be a reduction in income of around £14m (rather than the £19-20m estimate provided by the hospital trust). This is partly explained by a difference in view on the impact of the proposals on PICU. The hospital trust's estimate is based on an assumption that it would no longer be able to provide PICU services. The panel considered that there was no reason why PICU services could not continue at the Infirmary site even if the PICU currently located at the Glenfield site needed to close.
139. The loss of income to the hospital trust would, on the panel's assessment, represent between 1.6% and 2.2% of the hospital trust's total income, and between 6% and 8% of their total specialised services income. Some of this loss of income could be reduced if University Hospitals of Leicester continued to provide Level 2 specialist medical services. The loss of income to the hospital trust would also, to some extent, be offset by the reduction in the costs of providing the service.

#### ***1.13.2.2 Impact on finances at Central Manchester***

140. The overall contract value for specialised services at Central Manchester is approximately £348m. The hospital trust did not respond to the request to provide information on the potential impact of the proposals. NHS England estimates that the financial effect of the proposed changes would be

around £1m. The loss of income to the hospital trust would therefore represent approximately 0.3% of their total specialised services income.

141. Some of this loss of income could be reduced if Central Manchester University Hospitals continued to provide Level 2 adult CHD services. The loss of income to the hospital trust would also, to some extent, be offset by a reduction in costs.

### ***1.13.2.3 Impact on finances at the Royal Brompton:***

142. The overall contract value for specialised services at Royal Brompton is approximately £226m. NHS England estimates that the financial effect of the proposed changes would be around £35m excluding the impact on paediatric respiratory services. The hospital trust's estimate of a £47m loss in income when paediatric respiratory services are taken into account appears to be broadly in line with NHS England's own estimate. The hospital trust estimates that the loss resulting from these proposals would be approximately 13% of its total income and 21% of its total specialised services income, which represents a significant financial and business challenge. The scale of loss reflects the impact on PICU and the potential impact on paediatric respiratory services.
143. Some of this loss of income could be reduced if the Royal Brompton continued to provide adult-only Level 1 surgical services, in partnership with a Level 1 paediatric hospital. Whilst adult Level 2 services to be provided at RBH would lessen the financial impact of the proposals on the Royal Brompton to a limited degree the vast majority of its CHD income relates to inpatient activity linked to a surgical or interventional procedure and therefore the Royal Brompton have identified just over £3m income from CHD activity not relating to surgery or catheter interventions. However, this almost totally related to paediatric services and as such if the Royal Brompton were to only offer adult Level 2 services, it is unlikely this would provide significant income to the Trust
144. The loss of income to the hospital trust would, to some extent, be offset by a reduction in costs. Data supplied by the Royal Brompton indicates that its provision of CHD services results in an overall net loss, and therefore although the loss of income is significant it may be that in the long term no longer providing these services is in the best financial interest of the hospital trust. The Royal Brompton has, however, stated that owing to the stranded costs associated with this service they estimate an adverse impact of over £7m per year to its bottom line if these proposals are implemented. The financial impact of the changes could be reduced if the Royal Brompton provided Level 1 services for adults.
145. We note that the Royal Brompton is an active partner in the North West London Sustainability and Transformation Planning process and has identified a number of potential areas for partnership working which could potentially contribute to the mitigation of any financial losses if our proposals are implemented.

### 1.13.2.4 Finance impact: NHS England

146. The cost of the CHD service to NHS England has been estimated at £175m pa (based on 2013/14 figures). Activity is projected to increase whether or not the new standards are implemented. As a result, we forecast that – in today's prices - by 2025/26 expenditure on CHD services will be between £186m and £207m depending on the level of activity growth. We therefore expect that the challenge for us as commissioners will be in meeting the costs of activity growth rather than any costs arising from meeting the standards, or costs arising from the proposed changes. There are no current plans to reduce the CHD budget (per capita or overall).
147. As commissioners of CHD services we pay hospitals for the majority of these services using the national tariff (price) per unit of activity. Were we to change the number of centres where care is provided, this would therefore have no impact on our expenditure on patient care. NHS England finance experts have advised that it is logical to assume that an improvement to clinical outcomes and the clinical, operational and administrative efficiency and geographical/estates consolidation that would result from implementation of our proposals should lead to reduction in unit cost of this service for providers.

## Equalities and Health Inequalities

148. The CHD standards are intended to ensure that everyone with CHD gets the best possible care within available resources. Earlier analysis and engagement indicated that any proposed service change may differentially impact some Black and Ethnic Minority (BME) patients (those of Asian ethnicity), and those with a learning disability. In addition, services for CHD are of particular interest to children, and to the families and carers of children. We will be carrying out specific engagement activities with these groups during the consultation period.
149. We asked hospitals providing CHD services about any equalities or health inequalities as a consequence of our proposals being implemented. All responses submitted by the hospitals can be found in the Equalities and Health Inequalities Impact Assessment which has been published alongside this document.

## 1.14 Age

150. Our analysis shows that there has been an increase in demand for adult CHD care. More children now benefit from advances in treatment for CHD, and are therefore reaching adulthood. As more people survive with this condition, it is likely that the service will move from one that is centred on children, to one that is, in addition, treating a growing number of young people and adults. This has consequences for the way in which services are planned and delivered.

151. Most surgery and interventional cardiology for CHD happens early in life so our proposals, if implemented, will affect where care for children and young people will be delivered and will therefore impact children and young people. We will be talking directly to children and young people during the consultation period, and have also developed an Easy Read version of the consultation document to help younger children better understand our proposals.

### **1.15 Disability**

152. Children and adults with CHD are at an increased risk of developing further difficulties. Many children with CHD experience delays in their development, for instance, taking longer to walk or talk. Some children will have a learning disability. Around 50% of children with Down's Syndrome have a congenital heart defect and around 60% of those children will require treatment in hospital.
153. Change for people with learning disabilities or on the autistic spectrum is more difficult. Any service change for this population can be more difficult and needs to be managed well. This is not unique to the CHD proposed service change; however careful consideration should be given to the management of change for these patients. The particular concern has been around the practical elements of change like travelling to a new location, and patients being treated by clinical teams in a location that they are not familiar with. For example, people with learning disabilities who allow clinicians that they know to work with them are more likely than people without learning disabilities to refuse the same treatment in an unfamiliar surrounding by unfamiliar people.
154. During consultation we will make special arrangements to gather the views of people with learning disabilities and their families and carers. We have also produced an Easy Read version of this consultation document to help parents and carers explain the proposals to people with learning disabilities. As part of our consultation we are asking people about the impact implementation of the proposals would have on people with learning disabilities and their families and carers and also for advice on dealing with any concerns.

### **1.16 Gender reassignment**

155. We have not identified any specific evidence relating to gender reassignment (including transgender) and CHD. The standards and service specifications do not alter access or delivery of these services to people with this protected characteristic.



## 1.17 Marriage and civil partnership

156. We have not identified any specific evidence relating to marriage and civil partnership and CHD. (We do not think it appropriate or justified to assume that people who are married or in a civil partnership are more likely to be the parents or carers or in a family with a person with CHD). The standards and service specifications do not alter access or delivery of these services to people with this protected characteristic.

## 1.18 Pregnancy and maternity

157. Two distinct groups in this category may be affected by the proposed changes.

- Women with CHD who are pregnant
- Women who are pregnant carrying a baby with CHD

158. In both cases most maternity care is delivered through local maternity services at a hospital close to the woman's home. Arrangements will be made for the delivery of the baby that take account of the needs of both mother and child. This may be at the local obstetric unit or at an obstetric centre at or close to the specialist surgical centre. For some women, if the proposals are implemented it will mean that delivery will take place at an obstetric unit further from home

159. We believe that the proposed standards will have a positive impact on the experience and outcomes of women with CHD who are considering pregnancy, are pregnant or are receiving maternity care and on women who are pregnant carrying a baby with CHD. For the first time services will be nationally commissioned using common service specifications.

## 1.19 Race

160. Ethnicity is known to relate to the prevalence of certain diseases. The relationship between ethnicity and CHD is complex and may be confounded by cultural and religious factors. Research dating back to the 1980s<sup>5</sup> and 1990s<sup>6</sup> demonstrated higher prevalence among Asian communities in various UK cities including Manchester and Leeds, and in the West Midlands.

161. We looked at the recorded ethnicity of CHD patients at the three affected level 1 hospitals. All three trusts have a higher prevalence of South Asian patients than the average for the population and higher than the CHD patient group at other level 1 CHD hospitals:

<sup>5</sup> Gatrad AR, Reap AP, Watson GH Consanguinity and complex cardiac anomalies with situs ambiguous, *Arch. Dis Child* 1984; 59: 242-5

<sup>6</sup> Sadiq M, Stumper O, Wright JGC, de Giovanni JV, Billingham C, Silove ED Influence of ethnic origin on the pattern of congenital heart defects in the first year of life *Br Heart J* 1995; 73: 173-176

- CMFT has the highest prevalence of Asian population of the three providers that will be impacted by the service change at 15.9% compared to the average of 11.2% of all hospital trusts.
- UHL has a prevalence of 12.6% compared to the average of 11.2% of all hospital trusts.
- Royal Brompton has a prevalence of 12.1% compared to the average of 11.2% of all hospital trusts.

The data above shows that the changes will affect more people of Asian origin than the general population because of the higher incidence of CHD amongst people of Asian origin.

It is not straightforward to assess whether the proposed changes will affect people of Asian ethnicity differently from other groups. Implementation of the standards will ensure that everyone benefits from services provided to a consistent standard across the country. The consultation process will enable us to better understand the impact of the proposed changes by engaging with BME groups, and we will make special arrangements to gather the views of people of Asian ethnicity with CHD during the consultation period. We have produced a summary version of this consultation document in a number of Asian languages and the full document can be translated on request. We heard that religion and belief and culture could make it difficult for some people to engage with us in an open forum, and will therefore ensure that there are opportunities for people to engage with us on a one-to-one basis, via telephone interview, during the consultation period.

## **1.20 Religion or belief**

162. We do not have any evidence that shows a particular impact of the proposed changes on people of differing religions and beliefs. It is envisaged that hospitals that would be expected to provide care for more patients, under our proposals, will review ethnic, religious and cultural mix of patient information in light of the standards and feedback of the communications, engagement and the independent consultation report

## **1.21 Sex or gender**

163. We do not anticipate that the proposed changes will have a differential impact either by sex or gender of patient or carer.

## **1.22 Sexual orientation**

164. We do not anticipate that the proposed changes will have a differential impact depending on sexual orientation.

## **1.23 Asylum seekers and/or refugees**

165. We have not identified any specific evidence relating to asylum seekers and or refugees and CHD. Access to healthcare, understanding of the English health system and communication difficulties and cultural differences may be



relevant differences for asylum seekers and refugees but would not be specific to CHD services or the proposed changes.

### 1.24 Carers

166. We have heard how important it is for parents and carers to be supported, particularly when they are away from home. They told us about difficulties with finding their way around new hospitals, finding accommodation and eating balanced meals. They also told us about problems with car parking. These effects may be amplified if parents and carers have to travel to a new hospital. We also heard about the importance of having support for end of life for both children and adults. This means having identified support structures that encourage and enable open and honest communication with families and carers at that time. We have developed specific standards to address these issues.

Consultation will seek views from families and carers as well as from people with CHD. The consultation questions include open ended questions where families and carers will have the opportunity to share their experiences and concerns. This may include families and carers who would have compounded impacts of the proposed service changes.

### 1.25 Those living with mental health issues

167. In addition to medical problems, people living longer with CHD face psychological, sociological and behaviour challenges<sup>7</sup>. Since people with CHD are surviving longer into adulthood, the increasing population of adults with CHD also means there will be an increasing percentage of adult CHD patients that have mental health issues such as anxiety and depression.

168. We do not have any data to understand the percentage of people with mental health issues and CHD that would be impacted by the changes. However, we have heard during the 2016 preliminary stakeholder engagement that people with mental health issues may be differentially impacted by the proposed service changes. This will need further exploration during the consultation to understand the specific impact.

### 1.26 Other groups

169. We have not identified any specific evidence relating to the following groups and CHD:

- Alcohol and/or drug misusers
- Ex-service personnel/veterans
- Those who have experienced Female Genital Mutilation (FGM)
- Gypsies, Roma and travellers
- Homeless people and rough sleepers

<sup>7</sup> [Int J Cardiol.](#) 2013 Dec 5;170 (1):49-53. doi: 10.1016/j.ijcard.2013.10.003. Epub 2013 Oct 11.

- Sex workers
- Trans people or other members of the non-binary community

## Glossary

Adult Congenital Heart Disease	ACHD	This is also known as “grown-up congenital heart disease”, or “GUCH”.
Atrial Septal Defect	ASD	Most common type of ‘hole in the heart’
Bridge to heart transplant		The use of a ventricular assist device (VAD), or other form of circulatory assistance, to support the pumping action of a failing heart until a donor heart becomes available for transplantation. The technique is known as ‘bridge to transplant’.
Cardiologist		A doctor who specialises in investigating and treating diseases affecting the heart and some blood vessels.
Cardiothoracic:		Conditions affecting organs within the thorax, such as the heart, lungs and oesophagus.
Clinical Commissioning Groups	CCG	Groups of GP practices responsible for buying the majority of hospital and community-based health services for patients within their local communities
Clinical Reference Group	CRG	Groups of clinicians, patient representatives, commissioners and other experts, covering the full range of specialised clinical services, (such as cardiac), and providing clinical advice in support of NHS England’s direct commissioning function.
Clinician		Any health professional who is directly involved in the care and treatment of patients, for example, nurses, doctors, therapists, and midwives.
Co-location / service interdependencies		The other services required to provide optimum care of the whole patient, particularly when their conditions are complex or complications arise, and which need to be on the same hospital site.
Commissioning:		The process of buying health services, involving the assessment and understanding of a population’s health needs; the planning of services to meet those needs; securing services on a defined budget, and then monitoring of the services. Commissioning in the NHS in England is managed locally by CCGs, and nationally by NHS England.
Congenital Heart Disease	CHD	Refers to a range of birth defects that

		affect the normal workings of the heart.
Consultant		A senior doctor who is a specialist in a particular area of medicine
Diagnostics		Medical tests used to identify a medical condition or disease.
Extracorporeal Membrane Oxygenation	ECMO	A complex technique that provides cardiac and/or respiratory support for very sick patients
Gastroenterology		Area of medical specialism which deals with disorders of the abdomen, particularly the stomach and intestines.
Interventional cardiology		Various non-surgical procedures for treating cardiovascular disease, such as coronary angioplasty (inserting a tube with a balloon on the end to treat a narrowing or blockage in an coronary artery) or cardiac valve intervention.
Nephrology		Area of medical specialisation that deals with the physiology and diseases of the kidneys.
NHS England Board		The Board is the senior decision-making structure in NHS England and consists of a Chair and eight non-executive directors and four voting executive directors.
NHS England Clinical Advisory Panel	CAP	A group of experienced clinicians that is part of the CHD Review's governance structure.
Paediatric		A branch of medicine providing care for infants and children.
Paediatric Critical Care and Specialised Surgery for Children service review		NHS England national service review which will consider the provision of paediatric Intensive Care and paediatric transport in England
Paediatric Intensive Care	PIC	A highly specialist hospital ward that provides sick children with the highest level of medical care.
Referral		Sending a patient to a specialist, or between specialists, for expert care.
Service Standards		Sets out how NHS services should be set up, organised and run
Specialist		A clinician whose work is concentrated on a particular area of medicine.
Stakeholder		All individuals, parties or organisations with a particular interest in the organisation and delivery of particular clinical services, etc.
Sub-specialisation		Surgeons and cardiologists train generally in their specialty and, at the end of their training, will qualify as a

		consultant. Many will then sub-specialise in an area of particular expertise. These areas are known as sub-specialties.
Surgeon		A clinician who is qualified to practice surgery.
Time limited derogation		NHS England will put in place time limited exceptions (or derogations) allowing hospitals to continue providing essential quality services for their patients whilst working to meet more rigorous service specifications.
Whole time equivalent	WTE	A measure of staffing that takes account of both full time and part time workers.



**Report No. 61/2017**

## Report to Rutland Health and Wellbeing Board

<b>Subject:</b>	Transformation Plan for Mental Health and Wellbeing for Children and Young people - Refresh 2016/17
<b>Meeting Date:</b>	28 March 2017
<b>Report Author:</b>	Elaine Egan-Morriss
<b>Presented by:</b>	Chris West, Director of Nursing and Quality and Tim O'Neill Director for People and Deputy CEO for Rutland County Council
<b>Paper for:</b>	Note

### **Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:**

The purpose of this report is to present the refresh of the Mental Health and Wellbeing Transformational plan delivered through the Future in Mind – Children and Young People’s Mental Health and Wellbeing Transformation Programme.

The Transformation Plan for mental health and wellbeing services for children and young people (Oct 2016), sets out Leicester, Leicestershire and Rutland’s (LLR) multi-agency Transformational Plan to improve the mental health and wellbeing of children and young people (C&YP) up to the age of 25. It is a five year plan, based on the principles set out in The Department of Health’s Task Force Report (Feb 2016): Future in Mind: Promoting and improving our children and young people’s mental health and wellbeing.

The Transformational Plan identifies six core schemes of work which will contribute to the transformation programme.

- Improve Resilience
- Enhance Early Help
- Improve access to specialist Children Adult Mental Health Services (CAMHS)
- Enhance the Community Eating Disorder Service
- Develop a Children’s Crisis and Home Treatment Service
- Workforce development

The plan has been developed as part of the LLR Better Care Together Programme and is referenced in the LLR Sustainable Transformation Plan (STP). It is underpinned by partnership working across health organisations, local authority and public health, voluntary and community sector, schools and youth justice system.

### **Financial implications:**

In 2016 – 2017 the three CCGs for LLR have set aside a total of £2.055m for the transformation plan.

Business cases were developed for all work schemes across the Future In Mind programme. Each business case identified the budget and spend which were reviewed by the steering group and approved by the Collaborative Commissioning Board. The FIM steering group will monitor the performance and ensure value for money.

**Recommendations:**

The board is requested to note the content of the refreshed transformation plan and approve the document prior to publication on the CCG and LA websites.

**Comments from the board: (delete as necessary)**

**Strategic Lead:** Elaine Egan-Morriss

**Risk assessment:**

<b>Time</b>	L/M/H	
<b>Viability</b>	L/M/H	
<b>Finance</b>	L/M/H	
<b>Profile</b>	L/M/H	
<b>Equality &amp; Diversity</b>	L/M/H	

**Timeline:**

<b>Task</b>	<b>Target Date</b>	<b>Responsibility</b>



LEICESTER, LEICESTERSHIRE AND RUTLAND

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## BETTER CARE TOGETHER

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73 **Transformation Plan for Mental Health and Wellbeing for children and young people (Oct 2016)**

**2015 - 2020**

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## 1. Introduction - Transformation Plan for mental health and wellbeing for children and young people (Oct 2016)

The Transformational Plan produced in November 2015 sets out Leicester, Leicestershire and Rutland's (LLR) a multi-agency approach to improve mental health and wellbeing in children and young people (C&YP) up 25. This plan, is based on principles set out in The Department of Health's Task Force Report (Feb 2016): Future in Mind: Promoting and improving our children and young people's mental health and wellbeing.

The Transformational Plan (2015) identified six core schemes of work:

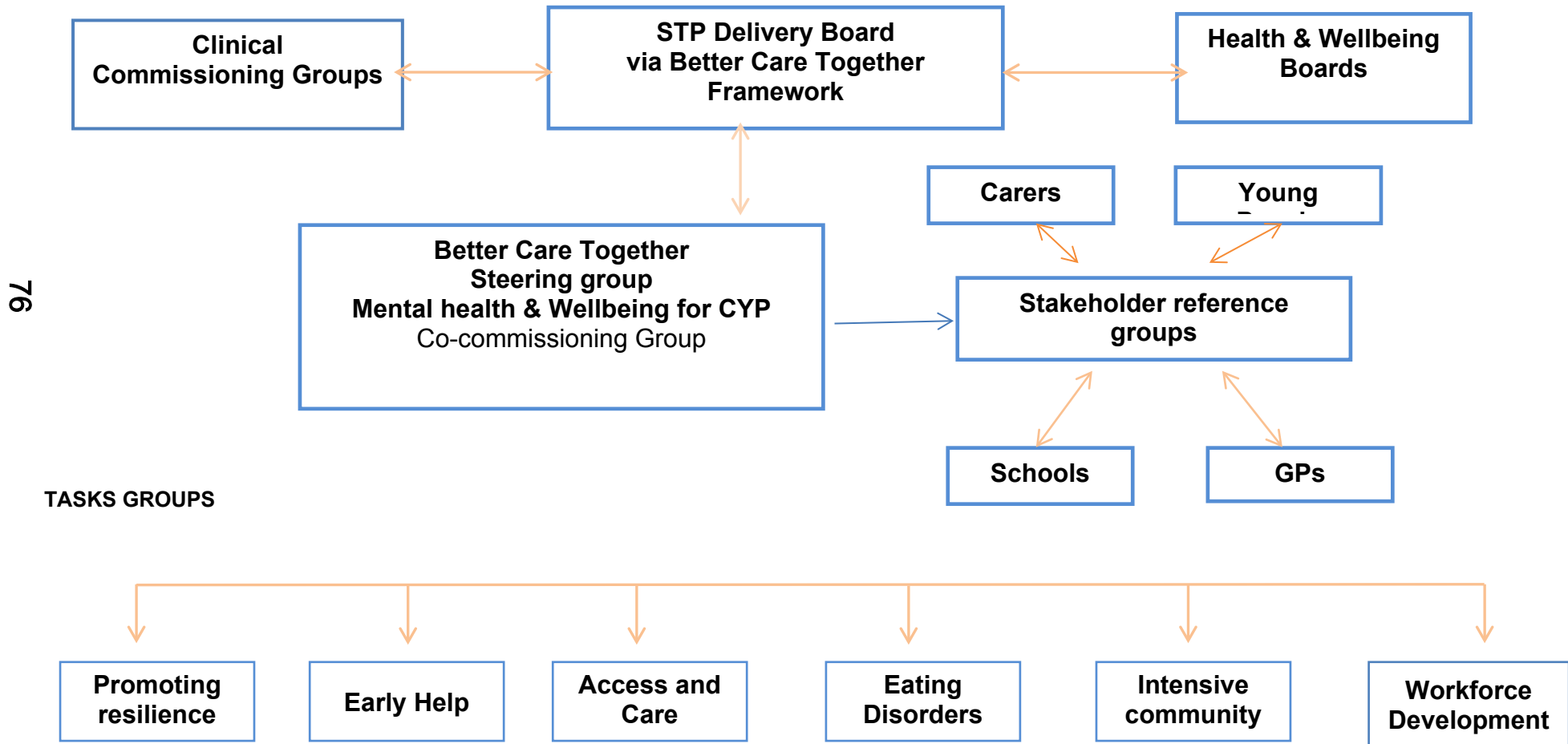
- Improve Resilience
- Enhance Early Help
- Improve access to specialist Children and Adolescent Mental Health Services (CAMHS)
- Enhance the Community Eating Disorder Service
- Develop a Children's Crisis and Home Treatment Service
- Workforce development

The plan was developed as part of the LLR Better Care Together Programme and is referenced in the LLR Sustainable Transformation Plan (STP). It is underpinned by partnership working across health organisations, local authority and public health, voluntary and community sector, schools and youth justice system. This plan has been shaped through extensive engagement with children, young people and their families. Children, young people and their carers have consistently told us that they are worried about bullying, peer and academic pressure and other issues and they would like to have more and easier access to support to help them.

This refresh of the Transformational Plan (2015) outlines the progress in each of the core scheme and demonstrates how the programme has been adapted to deliver the overarching ambition to improve children and young people's mental health and well-being.

## 2. How we control and manage the transformation (Governance)

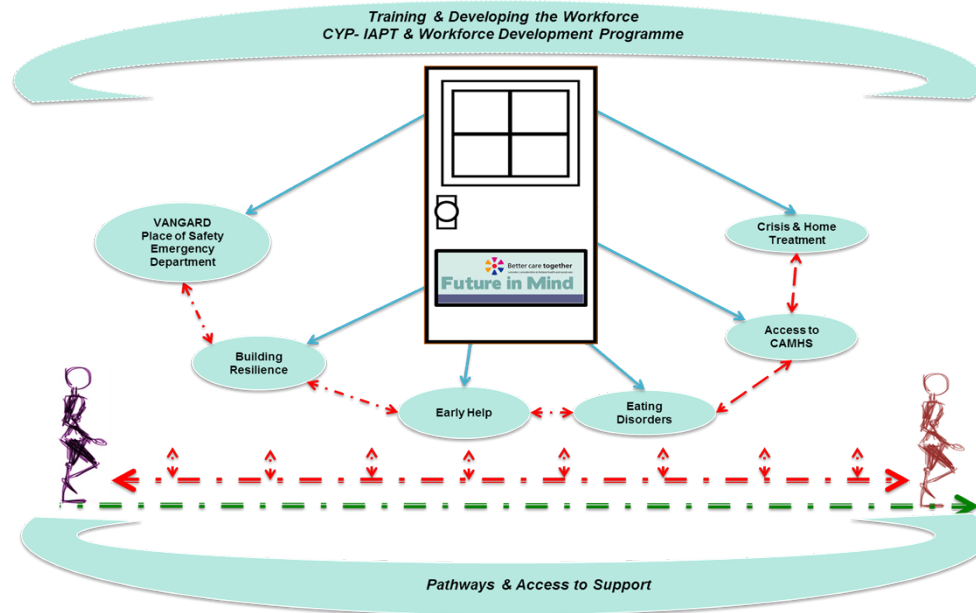
This programme of work is being delivered through Better Care Together (BCT) framework and reports to the STP Delivery Board (System Leadership Group). It is part of the Women and Children's work stream as shown in the diagram below;



A steering group<sup>1</sup> was established with representation from local authorities, voluntary sector, health watch, Office of Police Crime Commissioner (OPCC), health commissioners and providers. The steering group meets monthly it is responsible for the delivery, implementation and monitoring of plan, and delivery of services as agreed in business cases and service specifications. The group is accountable to each organisation's Boards / Governing Bodies and three Health and Wellbeing Boards for the area.

### 3. How we developed the Transformation Pathway

The transformation journey started with engagement events, held between January and March 2016. These enabled us to capture children and service user views. The voice of the child was used to inform pathway development (shown below) and the planned schemes of work



<sup>1</sup> Better Care Together Mental health and wellbeing of children and young people steering group 2015: terms of reference

## 4. Progress of each scheme of work

Each scheme of work aims to achieve set goals. Implementation and service delivery is overseen by six multi-agency working groups who each hold responsibility for achieving the goals of a scheme. The transformation pathway established through these workstreams will provide appropriate, timely, access to a range of services to meet the needs of children and young people (C&YP), their families and carers. We have developed a range of new referral routes to provide access to services. These include self-referral in to the early help service and on line counselling and enabled direct referral to CAMHS by schools, school nurses and the voluntary sector.

Through collaborative working and monitoring of the whole pathway we will ensure the ease of service, allowing C&YP to be discharged from one service and admitted into another without prolonged waits. We will work with adult mental health services to ensure the smooth transition of C&YP into adult services as necessary.

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### 4.1 Building Resilience - Promote good emotional health and resilience for all children, young people and their families

Young people said that they wanted to have the confidence to talk about emotional problems openly and without stigma. They want to be able to find information and support from their school, college or youth service, as well as from websites and social media.

Education services want to offer guidance to pupils, and provide pastoral support and understand when to ask for specialist assistance. Parents, young people and schools were all concerned about the impact of cyber-bullying.

The aim of the resilience scheme is to develop a range of ways for children, young people and carers to find information about mental health support including the use of social media and more traditional communication methods.

We have

- Developed and agreed a resilience service model for the future
- Commenced the procurement process to identify an appropriate service provider to be completed by end of December 2016. The resilience model will be fully operational from December 2017

The Resilience Service Model will build on initiatives already undertaken in some local schools and introduce resilience activity to others. It will support and engage schools and wider partners across LLR to strengthen mental health resilience throughout our schools. Actions will encourage staff and children to promote mental wellbeing and develop self and organisational resilience.

The provider will work with partners to focus on supporting, extending and consolidating existing work and identifying gaps or emerging areas of concern. The work will take into account mental health needs, emerging problems and target gaps in service provision

## **79 4.2 Early Help - Development and delivery of co-ordinated, accessible and non-stigmatising early and targeted support for those experiencing emotional distress and the first signs of mental disorders**

Young people and carers have said that they want access to help and support quickly and locally, without being stigmatised, they want a say in the kind of help they receive and be encouraged to become resilient and maintain their independence. They also want potentially serious problems to be recognised quickly, and to no longer be told that “they are not ill enough” to get any help.

Organisations such as health, education, youth justice and social care said they want to work together to understand the needs of a young person and decide together with the young person and/or parent what support to offer. We know that a range of public, private and community organisations can provide effective support. Providers and users want their services to be part of a commissioned pathway of support, meeting high quality standards and linked to more specialist services.

We have

- Developed a multi-agency “First Response” service model which will assess the level of distress and risk facing a child, young person or family in order to co-ordinate the right intervention and support.
- Agreed the use of approved risk assessment tools; the Merton Risk Assessment Tool and Signs of Safety.
- Started to build on and develop partnerships with local community groups such as the City of Sanctuary (refugees and asylum seekers) and the Lesbian, Gay, Bi-sexual and Transgender organisations in order to work with children and young people from hard to reach groups .
- Commenced the procurement process, the service will be operational from April 2017.

It is important that a prompt local access to ‘First Response’ occurs and that it benefits from the expertise and knowledge of practitioners from various agencies. The services will signpost the young person or family, escalate the case if required, or offer low intensity support and help. This will include offers such as counselling, group work and parental support. But it will also include direct access to specialist mental health services if required. Mental health professionals within co-located with other Early Help service staff will support a team around the professional model

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### **4.3 Access to CAMHS - Single gateway to specialist CAMHS services with clear access standards**

The specialist Child and Adolescent Mental Health Services (CAMHS) is experiencing approximately 9% more referrals each year and an increasing number are for urgent situations and complex cases. Young people say they value the quality of care and support they receive from the specialist CAMHS service; they appreciate the therapeutic relationship they can develop with their practitioners and the support offered to their family and carers.

It is recognised that accessing the service can be difficult and there is a perception that a young person will be told that they are “not ill enough” to receive CAMHS help.

We have



- Supported the CAMHS service to pilot a single access team during 2015/2016: The pilot; team received all referrals to the service and made direct contact with both the referrer and the young person and their carers (if appropriate) to understand the presenting issues, offering short term interventions or they were referred to specialist CAMHS services if required.
- Commissioned a full service from 2016/17 onwards.
  - It has locally agreed access waiting time standards and includes engagement with local authority social care access teams to share information (with consent) and to plan joint interventions.
  - It provides a range of evidence based NICE concordat therapies, such as Systemic Family Therapy, Cognitive Behavioural Therapy, Parenting Support and Interpersonal Psychotherapy.
- Enhanced access to CAMHS and the new model is now operational; it has addressed a backlog of referrals and is now meeting the national 13 week target.
- We have an agreed reporting schedule with providers. Providers are currently developing these reports.

#### 4.4 Eating Disorder - Specialist community services for children and young people with eating disorders

NICE clinical guidance recommends family interventions for those with anorexia and cognitive behavioural therapy for children and adolescents with bulimia.<sup>2</sup>

We have

- Invested in a specialist multi-disciplinary community based eating disorders service for children and young people up to the age of 18, for up to 100 new referrals per year. The service will serve a general population of 1 million children and young people.

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<sup>2</sup> Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders: National Institute for Clinical Excellence 2004

We are reviewing further opportunities to enhance the service and enable full compliance with current and future guidance in line with new NICE guidelines planned for publication in 2017.

#### 4.5 Crisis and Home Treatment - Co-ordinated support to prevent crisis and at time of crisis

The current co-ordinated service includes an all age crisis resolution and home treatment service (CRHTx), a designated “Place of Safety” and an all age liaison service. Children, young people and their families as well as some service providers identified a gap in the current crisis and home treatment service.

As a result, the all age Crisis Resolution and Home Treatment Service (CRHT) has been extended to children and young people as well as adults and will be a 24hour -7days a week service. The children’s service is aligned to the adult service and the local authority single point of access (referred to as the front door). Referral into the crisis service can be made by a range of organisations including: health services, GPs, early help, schools, police and voluntary sector through a dedicated phone line.

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We have

- We have developed an all age liaison service for children and young people as well as adults will support children and young people with acute mental health or behavioural problems arriving at the emergency department. The team will include a CAMHS consultant, CAMHS nurse, child psychologist, family social worker and specialist substance misuse worker. This is set out in the action plan for Leicester, Leicestershire and Rutland to deliver the Mental Health Crisis Care Concordat<sup>3</sup>.
- Agreed a phased implementation of the service, phase 1 became operational in September 2016, with 3 staff delivering telephone and face to face assessments for C&YP in crisis.


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<sup>3</sup> Crisis Care Concordat for Mental Health: Leicester, Leicestershire and Rutland action plan

## 4.6 Workforce

To support delivery of the transformation plan a multi-agency group has developed a service model to help improve both the capacity and capabilities of practitioners that work with children and young people with mental health issues.

To meet expected standards a specialist workforce with clinical skills and experience in Cognitive Behavioural Therapy, Systemic Family Therapy, and Psychodynamic Psychotherapy as core interventions is required. These need to be supported by knowledgeable and well trained professionals from the wider children's workforce. Therefore both targeted and universal practitioners will have training in generic child mental health and have access to support and advice.

 We have:

- Recruited staff onto the CYP IAPT programme
- Commenced a training needs analysis, to be completed by Jan 2017.
- The training needs analysis findings will be shared across the partnership and will lead to the development of a mental health and wellbeing workforce training offer for the children and young people's workforce with a clear coordinated training offer.

## 5. How we will know the Transformation Plan is making a difference to children and young people's mental health and well-being?

The pathway and identified schemes of work will provide access to a range of services to meet the individual needs of the children and young people (C&YP) and we will know they are receiving the right service at the right time by:

- a reduction in A&E attendances, in-patient admissions, inpatient facilities, out of area placements and care and treatment reviews
- a reduction on the length of time from referral to access CAMHS
- C&YP who are able to recognise when they need help and are able to access it

- A reduction on the length of time from referral to treatment

## 6. Measuring the Impact of Change

Performance will be monitored through our contracting teams, assessing delivery of services in terms of activity as well as measurement against quality indicators and clinical outcomes as described in the service specifications. We want to be assured that the service being delivered is making a difference to C&YP and their families and that we are able to measure the impact of this change. This will be will be captured and presented in the emotional health and well-being dashboard to include;

1. Reduction in CYP attendance a A&E presenting with non-physical needs
2. Reduction in in-patient admissions to CAU or Paediatric ward of C&YP with a mental Health need.
3. Reduction in admissions / reduced length of stay to the CAMHs Ward.
4. Reduction in CYP Tier 4 placements OOA
5. East CCG Reduction on OOA placements complex care - shared funding (Speak to Noelle)
6. Reduction in patients referred back to GP following CAMHS assessment
7. Numbers accessing early help
8. Numbers accessing CAMHs
9. Numbers accessing CRHTx
10. Increasing number of schools accessing the resilience programme
11. Service user led, local annual, feedback and patient satisfaction survey.

LLR will be agreeing the details of the national CQUIN focusing on transition from Children to Adult services. This will be reported and monitored on a quarterly basis and will be linked to the Children and Young Peoples pathway.

## 7. Workforce: staffing levels and skill mix

The workforce relevant to this plan is comprised of staff working in a wide range of services across the system, including those supporting parents, those working in community groups, those in universal services (such as schools), those in targeted services and services for specific groups of children (such as the children’s centre programme or specialist voluntary organisations) and those working in specialist CAMHS.

One of the aims of the Future in Mind Programme is to increase the number of staff across the partnership by 1,700 by 2020 to meet the additional demand for services. The current local specialist CAMHS workforce has 80 whole-time equivalent clinical posts within this specialist service which is less than recommended by the Royal College of Psychiatrists

The chart shows the workforce data for the specialist CAMHS service including primary mental health, community CAMHS, specialist CAMHS teams as well as local hospital (tier 4) services.

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Role	Grade	WTE 15/16	WTE 16/17	Additional staff 2016/17		
Medical	Consultant	13	14.55			
	Specialty Doctor	1				
Nursing	Qualified	46	53.20	X3 CRHTx	X1 Liaison service	X6 Early help
	Unqualified	11	21.20			
OT	Qualified	8	23.13			
	Apprentice	1	1.00			
Psychology		22	25.44			
Therapy		7	7.13			
Overall Total		109	145.65			

Data tells us that the CAMHS has

- 24% of staff are from an ethnic minority background.
- 80% are female
- A staff age range from 21-65yrs ; with 20% aged over 50.

Further work to undertake a whole system analysis of the workforce available across services in LLR is required.

We need to be certain that the existing and new workforce is suitably skilled and confident, capable of delivering the new models of care that we are developing through the transformational programme. Therefore we are taking a whole systems approach to recruitment and retention and training and development of all staff delivering care across the C&YP pathway.

The CAMH service has established a workforce development plan which covers recruitment, leadership development, and training in specific therapeutic approaches such as cognitive behavioural therapy and interpersonal psychotherapy, this will be complemented by a programme of training and support for all practitioners across the system; it will be open to health, social care, public health, police, school staff and the voluntary and community sector.

The training programme will be provided through the Children & Young People's Improving Access to Psychological Therapies Programme (CYP-IAPT) as LLR is part of the East Midlands Collaborative aimed at supporting the delivery of the CYP IAPT programme.

There are 3 routes available for training

1. IAPT programme
2. Psychological wellbeing practitioners
3. Recruit to train

Recruitment to these courses is underway with staff from specialist services and partnership organisations

## 7. Finance

The three CCGs fund the specialist CAMH service to the value of £6.5 million in 2015/16. They also fund other children's services such as paediatric, disabled children's services and speech and language therapy which also work with many children and young people who will have associated neurodevelopmental or mental health conditions. Adult mental health services (which receive CCG funding of £80million per year) also support young people aged 16-25years.

Local Authority Children's and Early Help services are funded at around £25million per annum. This includes a range of specialist services (such as Educational Psychology, Disabled Children's Services) and generic child and family services.

NHS England (East Midlands) estimates an annual cost of £3.5 million per year on hospital and specialist services for children and young people from Leicester, Leicestershire and Rutland.

The Office for the Police and Crime Commissioner has committed £140,000 per annum to commission emotional support services for a child that is a victim of crime as a contribution to a partnership approach.

There is a commitment from the partners to this plan to deploy existing budgets alongside the Transformational Plan funding to jointly address the issues facing our local communities.

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## **7.2 Financial Allocations 2016/2017**

In 2016 - 2017 the three CCGs for Leicester, Leicestershire and Rutland have set aside a total of £2.055m for the transformational plan.

In August 2016 an additional £0.466m (non-recurrent) was awarded by NHSE to accelerate the implementation of the Liaison & CRHT service, plus an additional allocation of £0.519m has also been received for Eating Disorders. Further additional funds of £0.431m has now been awarded non-recurrently to support a reduction in waiting times.

There are also other funding streams from the CCGs, local authorities, public health and the Office for the Police and Crime Commissioner that will contribute to the overall transformation. We have a clear view that the Future in Mind funding is a catalyst for partner agencies to contribute to the overall transformational of mental health services for C&YP.

Priority	Funding (£m) 2015/16			Funding (£m) 2016/17		
	Total Funding	Funding Sources		Total Funding	Funding Sources	
		FIM	Other		Baseline	Other
<b>Eating Disorders</b>	0.440	0.440		0.519		0.519
<b>Programme Management</b>	0.100	0.100		0.100	0.100	
<b>Children's CRHTx</b>	0.966	0.500	0.250	0.966	0.500	0.466
<b>Improving Access to CAMHS</b>	0.100	0.100	0.288	0.196	0.196	
<b>Early Help</b>	0.460	0.460		0.460	0.460	
<b>Public Help and Engagement</b>	0.200	0.200		0.200	0.200	
<b>Workforce Development</b>	0.142	0.070		0.070	0.070	
<b>CAMHS Interventions</b>	0	0		0.529	0.529	
<b>Waiting Times</b>	0	0		0.431	0	0.431
<b>Total</b>	<b>2.408</b>	<b>1.870</b>	<b>0.538</b>	<b>3.471</b>	<b>2.055</b>	<b>1.416</b>



## 8. The Implementation Plan 2015-2017

The Implementation Plan for 2015-17 set out below is based on the aspirations set out in Future in Mind. It is the first stage of our journey to transform the mental health and wellbeing of children and young people by 2020.

Each objective aims to be SMART: to be clear, measurable, to a deadline and with a clear accountable officer. There are identified leads for each objective, although all will require strong partnership working.

Future in Mind - implementation plan				
REF	Action	Task Owner	16/17	status
68 Improve Access to Children and Young peoples services -	Sign off business case at CCB	MT/EEM	June	Green
	Write Service Specification and Contract variation		July	Green
	Identify and agree key performance and quality indicators	EEM	July	Green
	Present case at competition and procurement panel - for procurement regulations	MT/EEM	July	Green
	Agree Reporting Schedule	EEM/AM	Aug	Yellow
	Agree timeline for recruitment of staff and implementation of the new service model	EEM/AM	Sept	Green
	Commence recruitment	CM/CT	Oct	Green
	Commence population of dashboard	EEM	Nov	Yellow
	Complete phase 1 of service	EEM /AM	Jan 17	Yellow
	Full service delivery	EEM / AM	April 17	Green
Deliver an all age 24/7 Crisis & Home Treatment service	Release of accelerator money from NHS E	GW	July	Green
	Write Service Specification	EEM	Oct	Green
	Identify and agree key performance and quality indicators	EEM /AM	July	Green
	Agree Reporting Schedule	EEM	Aug	Green
	Agree timeline for recruitment of staff and implementation of the new service model	EEM /AM		Green
	Begin phase 1 of the implementation	EEM	Sept - March17	Yellow
Eating Disorders	Agree Implementation plan for delivery of full service over 3 years	AM	Dec17	Yellow
	Agree Monitoring of Service Spec	AE/EEM	June16	Green
	Agree Reporting Schedule	AE/EEM	Aug 16	Yellow

	Populate Dashboard - Key Performance and Quality Indicators	AE/EEM	Nov16	
	Undertake gap analysis	AE/EEM	July16	
	Membership of Regional Eating Disorder Group	AE/EEM	July 16	
	Agree actions to address gap	AE/EEM	Nov16	
	Develop RAP	AE/EEM	Dec16	
IAPT	Recruit 5 mth support officer	MT/EEM/H	Nov 16	
	Allocation of staff onto leadership programme	EEM	Jan16	
	Share CIAPT across partners	EEM	Oct 16	
	Agree request for placement onto training	EEM	Nov	
	Submit applications to NHSE	EEM	Nov	
	Monitor staff attendance	EEM	Nov	
	Manage backfill	EEM	Nov-March	
	Create whole system staffing number base line and projection plan to increase staffing	EEM	Feb16	
Early Help	Sign off business case at CCB	MT/EEM/BC	Aug	
	Present case at competition and procurement panel - for procurement regulations	MT/ EEM/BC	Nov 16	
	Commence procurement process	EEM /KG	Oct – Jan 17	
	Write Service Specification	EEM/BC	Oct 16	
	Identify and agree key performance and quality indicators	EEM/BC	Oct 16	
	Undertake marketing event	TR	Oct 16	
	Agree Reporting Schedule	BC/EEM	Aug 16	
	Agree timeline for recruitment of staff and implementation of the new service model	BC/EEM	Aug 16	
	Commence population of dashboard	BC/EEM	Jan16	
Resilience	Sign off business case at CCB	MMC/MT/EEM	Aug	
	Present case at competition and procurement panel - for procurement regulations	KG	Oct	
	Commence procurement process	KG / P	Oct	
	Commission implement a public health campaign on mental health and resilience for CYP	MMC/MT/EEM	Nov 15	
	Evaluate public Health Campaign	MMC/MT/EEM	Jan16	
	Write Service Specification	MMC/MT/EEM	Oct16	
	Identify and agree key performance and quality indicators	MMC/MT/EEM	Aug16	
	Present case at competition and procurement panel - for procurement regulations	MMC/MT/EEM	Nov 16	
	Agree Reporting Schedule	MMC/MT/EEM	Nov16	
	Agree timeline for recruitment of staff and implementation of the new service model	MMC/MT/EEM	Nov 16	
improving access to therapies	Commence population of dashboard	MMC/MT/EEM	Jan16	
	Review of current service	AM/CT	Sept16	
	Design service model	AM/CT	Oct16	
Early implementer of	Agree way forward	AM/CT	Nov16	
	Presentation from researchers and clinicians	Nott's /LPT	Oct16	

evidence based practice for assessment of ADHD	Agree way forward	Nott's /LPT	Nov16	
	Agree model	Nott's /LPT	Nov 16	
	Agree evaluation	Nott's /LPT	Dec16	
Developing the workforce	Recruit 5 month Lead	LM	Oct - March	
	Undertake training needs analysis	LM	Nov - Dec	
	Undertake marketing event	LM / VAL	Jan 17	
	Produce report	LM	Feb 17	

## 9. Appendix 1: Transformation plan for mental health and wellbeing services for children and young people (Oct 2015)

Please double click the icon below to open the 2015 plan.

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November 2015 CYP  
Mental Health Transfo

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Report No. 69/2017

**Report to Rutland Health and Wellbeing Board**

<b>Subject:</b>	<b>Sport England Local Delivery Pilot: Expression of Interest</b>
<b>Meeting Date:</b>	<b>28 March 2017</b>
<b>Report Author:</b>	<b>Elizabeth Orton</b>
<b>Presented by:</b>	<b>Mike Sandys</b>
<b>Paper for:</b>	<b>Discussion and to note</b>

<b>Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:</b>	
<p>The purpose of this report is to outline the emerging bid for Rutland to join in partnership with Leicestershire to be a Sport England Local Delivery Pilot site and to seek support from the Health and Wellbeing board for the bid.</p> <p>The bid, which is focused on getting more people walking more often, is consistent with the Government’s physical activity strategy (Sporting Future) and Sport England’s physical activity strategy (Towards an Active Nation), the Department for Transport’s Cycling and Walking strategy and Public Health England’s physical activity strategy Everybody Active Every Day).</p> <p>If successful, the Local Delivery Pilot bid will support the delivery of the Joint Health and Wellbeing Strategy by contributing to healthy life expectancy and reducing inequalities. It also contributes to the Adult Social Care Strategy and the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP) by providing a substantial investment in walking programmes contributing to the prevention and treatment of ill-health, development of volunteer capacity and community resilience.</p>	
<b>Financial implications:</b>	
<p>Award of the bid is not dependent on matched funding, though applicants are expected to demonstrate that physical activity is a strategic priority locally. In-kind commitment in terms of person time to develop the project further would be required, should the bid get through to the next stage.</p>	
<b>Recommendations:</b>	
<p>That the board:</p> <ol style="list-style-type: none"> <li>1. The Health and Wellbeing Board is asked to support the bid and initial expression of interest</li> </ol>	
<b>Comments from the board:</b>	
<b>Strategic Lead:</b>	

<b>Risk assessment:</b>		
<b>Time</b>	L/M/H	
<b>Viability</b>	L/M/H	
<b>Finance</b>	L/M/H	
<b>Profile</b>	L/M/H	
<b>Equality &amp; Diversity</b>	L/M/H	
<b>Timeline:</b>		
<b>Task</b>	<b>Target Date</b>	<b>Responsibility</b>

## **Sport England Local Delivery Pilot: Expression of Interest**

### **Background**

1. Sport England is inviting bids for 10 local areas to become Local Delivery Pilots to help test what works to get the most inactive people to be more active. Sport England investment will total £130million over 4 years in these 10 areas.
2. The Local Delivery Pilots will test new approaches to help get those most inactive people to be more active and to explore the barriers that exist to people being more physically active. Sport England wants the local offers to be based on a 'whole systems approach' and to focus on outcomes for people in their own communities (i.e. geographical communities) and communities of interest (e.g. people who share the same health conditions). Outcomes should align with the 5 government outcomes of physical wellbeing, mental wellbeing, individual development, social and community development and economic prosperity. Sport England wants the approaches to be transformational and to be grounded in behaviour change theory.

### **Proposals/Options**

3. Prior to the announcement of the Local Delivery Pilots, work had already begun to develop a whole-systems focus on walking in Rutland and Leicestershire as a way of helping inactive people become active and achieve co-benefits associated with this: walking for health and fitness to improve physical and mental wellbeing, walking as a form of sustainable travel and thus reducing traffic congestion and improving air quality and walking as a social activity, reducing isolation and building community cohesion.
4. With 18% of people in Rutland doing less than 30 minutes of activity per week, there is substantial scope to target this segment of the population, reduce the proportion of inactive people and, in doing so, improve the overall health and wellbeing of our population.
5. The bid will focus on getting more people walking. Walking has been shown to be the most achievable, accessible and affordable form of physical activity for inactive people to take up and has been shown to be the gateway to other, more varied forms of physical activity. Rutland and Leicestershire areas have a track record of training volunteers to become walk leaders and in developing community activators to motivate and mentor people in their own communities to walk more. There is an extensive network of green assets in our country parks and rights of way that are freely accessible for people to use.
6. This is not simply a walking programme. The bid will develop a comprehensive approach to all types of walking on a scale that has not been done before in the UK. The bid will promote innovation by developing a digital platform that will bring together information on all walking opportunities available locally (a 'walking.com'). The platform will record walking activity data populated by individuals (manually or automatically through e.g. wearable devices such as fitbits), groups (e.g. Ramblers, Age UK, Macmillan etc) and organisations (e.g. district leisure services) using open data institute standards. This is an innovative approach to using data to motivate

people to be more active and to monitor people's activity so that we can demonstrate the impact of the programme.

7. A multi-disciplinary collaboration to take the bid forward is led by Public Health including colleagues across Rutland County Council, Leicestershire County Council, District Councils, Leicester-Shire and Rutland Sport, the University of Loughborough (National Centre for Sports and Exercise Medicine, British Heart Foundation National Centre and NIHR Biomedical Research Centre), East Leicestershire and Rutland and West Leicestershire CCGs and Voluntary Action Leicester. This collaboration builds on a track record of working together to deliver on projects including 'Get Healthy Get Into Sport', Walking Away from Diabetes and the FaME falls prevention programme.
8. The bid will be seeking funding from Sport England in the region of £13-15m to support walking programme delivery, volunteer training, website/digital platform development and capital investments in walking infrastructure.
9. An outline of the project, described using a logic model, can be found at Appendix 1.

### **Consultation/Patient and Public Involvement**

10. There is substantial insight from residents from a range of walking and other programmes regarding barriers and facilitators to being more active and attitudes to walking for health, utility and leisure. This insight has been used to form the basis of the project idea.

### **Resource Implications**

11. The bid does not require matched funding. It would, though, require in-kind commitment in terms of person time to develop the project further, should the bid get through to the next stage.

### **Timetable for Decisions**

12. The expression of interest is due in by 5pm on the 31 March 2017. The decision on progress to stage 2 will be made by May 2017. Further details regarding dates are not yet available.

### **Conclusion**

13. A successful bid to Sport England would lead to improvements in population health, contributing to the Joint Health and Well Being Strategy and the STP. The bids aims are:
  - To make walking a more desirable, easier choice for health, leisure and daily transportation, creating opportunities to do this on a scale not seen before in the UK
  - To have a measurable population impact on inequalities in health, wellbeing and economic prosperity
  - To transform the way that people find out about walking opportunities and transform how they are motivated to walk more.



## **Officer to Contact**

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## **List of Appendices**

Appendix A - Logic Model

### **Relevant Impact Assessments**

#### Equality and Human Rights Implications

14. Will be considered as part of the bidding process

#### Crime and Disorder Implications

15. Not applicable

#### Environmental Implications

16. Not applicable

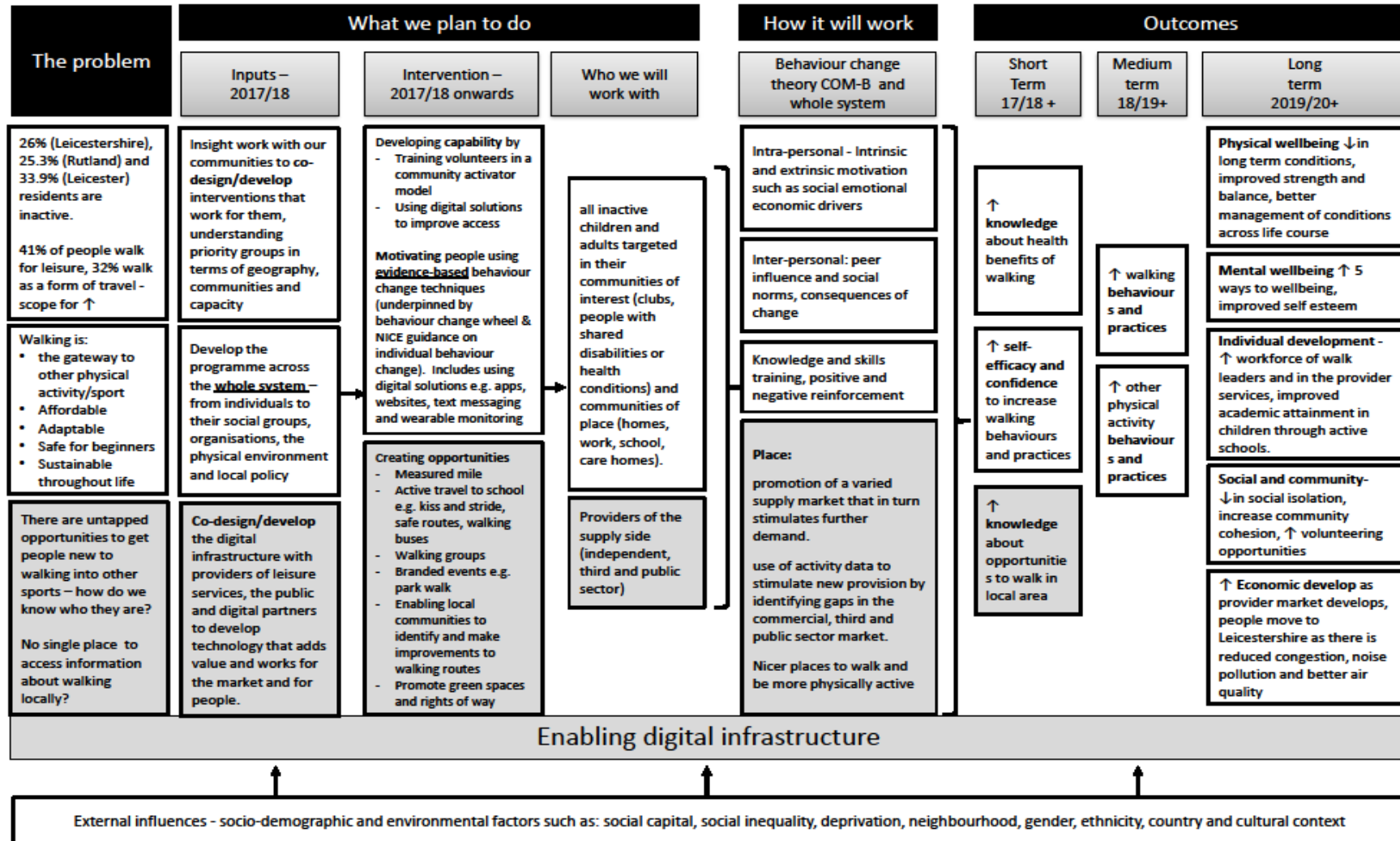
#### Partnership Working and associated issues

17. If successful, partnership working across NHS, Local Government, voluntary and community sector and other partners will be crucial in order to have a system-wide approach and outcomes as described above and to ensure the programme is sustainable after Sport England funding has ended.

#### Risk Assessment

18. Not applicable

Vision: to make walking a more desirable, easier choice for health, leisure and daily transportation, creating opportunities to do this on a scale not seen before in the UK using enabling digital infrastructure



## Report to Rutland Health and Wellbeing Board

<b>Subject:</b>	<b>Pharmaceutical Needs Assessment 2018</b>
<b>Meeting Date:</b>	<b>28<sup>th</sup> March 2017</b>
<b>Report Author:</b>	<b>Mike Sandys</b>
<b>Presented by:</b>	<b>Mike Sandys</b>
<b>Paper for:</b>	<b>Note &amp; Approval</b>

**Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:**

The Health and Well Being Board has a statutory responsibility to prepare and publish a Pharmaceutical Needs Assessment (PNA) every 3 years. The PNA is part of and informed by the JSNA. The process for undertaking and preparing the PNA is outlined in the paper and proposes undertaking this process jointly with Leicester and Leicestershire because many of the relationships required for the PNA are Leicester, Leicestershire and Rutland (LLR) wide.

**Financial implications:**

The purpose of a HNA is to ensure that the evidence base is effective and joined up to better support NHS England, CCGs and Local Authorities in their commissioning decisions and meeting the needs identified will be addressed through the commissioning cycle.

**Recommendations:**

The Health and Wellbeing Board is requested to:

1. Note this report
2. Approve the proposal to form an interagency LLR wide Working group and the draft terms of reference for the project team
3. Receive further reports on progress and the final PNA report for approval in March 2018

**Comments from the board:**

**Strategic Lead:** Mike Sandys

**Risk assessment:**

<b>Time</b>	L/M/H	A timetable and project plan is included
<b>Viability</b>	L/M/H	
<b>Finance</b>	L/M/H	
<b>Profile</b>	L/M/H	This will be subject to a statutory consultation process
<b>Equality &amp; Diversity</b>	L/M/H	The PNA will be subject to an Equality Impact Assessment

**Timeline:**

Task	Target Date	Responsibility

**RUTLAND HEALTH AND WELLBEING BOARD:**  
**REPORT OF THE DIRECTOR OF PUBLIC HEALTH**  
**PHARMACEUTICAL NEEDS ASSESSMENT 2018**

**Purpose of Report**

1. The purpose of this report is to highlight the responsibility of the Health and Well Being Board to publish a Pharmaceutical Needs Assessment (PNA), the timescale to do so, and the proposed governance structure to enable production of the PNA.

**Background**

2. The Health and Wellbeing Board has a statutory responsibility to prepare a Pharmaceutical Needs Assessment (PNA) for Rutland and publish it by March 2018.
3. The purpose of the PNA is to:
  - Identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future;
  - inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be;
  - inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy. The organisation that will make these decisions is NHS England.
4. The last PNA for Rutland was produced in 2015. The responsibility for producing the PNA rests with Health and Wellbeing Boards in the general reforms embodied in the Health and Social Care Act (2012). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at:  
<http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/>
5. The PNA is a statutory document that is used by NHS England to agree changes to the commissioning of local pharmaceutical services. As such, if NHS England receives a legal challenge to the services they commission based on the PNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the PNA is a robust document.

**Governance**

6. It is proposed that we establish a Leicestershire and Rutland project team to oversee the detailed production of the PNA documents for Leicestershire and Rutland. These documents will reflect local needs and priorities for Leicestershire and Rutland.

7. In addition, because many of the relationships required for the PNA are Leicester, Leicestershire and Rutland (LLR) wide – involving representation from NHS England, the Leicestershire Pharmaceutical Committee, Local Professional Network for Pharmacists and the Leicester, Leicestershire and Rutland Local Medical Committee - a PNA Reference Group will be established. This Reference Group will support PNA work across the three Health and Wellbeing Boards, identify any economies of scale that can be delivered through joint work and ensure that there is an effective process for consultation on the PNAs. However, there will be separate PNAs for Leicester, Leicestershire and Rutland and each will be signed off by the respective Health and Wellbeing Board.
8. Draft terms of reference and membership for the PNA Project Team are attached as Appendix A. The proposed membership for the Reference Group is shown in Appendix B. The terms of reference for this group are in development in consultation with Leicester City and Leicestershire and will be agreed at the first meeting.
9. It is proposed that the Integration Executive will approve the pre-consultation draft version of the Rutland PNA and provide assurance to the Health and Wellbeing Board that the final PNA is an accurate reflection of the pharmaceutical needs of the population and has been developed using robust processes. The PNA Project Team will report regularly to the Integration Executive and submit the pre-consultation draft PNA for approval in September 2017.
10. The principal resourcing for the development of the Rutland PNA is provided by the Leicestershire County Council Business Intelligence Service, with information and advice provided through the PNA Project Team by NHS England, the LPC, CCGs and others.

## **Consultation**

11. The PNA is subject to a 60 day statutory consultation period which will start at the end of September 2017. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following :-
  - the Local Pharmaceutical Committee
  - the Local Medical Committee
  - any persons on the pharmaceutical lists and any dispensing doctors list for its area
  - any LPS chemist in its area with whom NHS England has made arrangements for the provision of any local pharmaceutical services
  - Healthwatch, and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area;
  - any NHS trust or NHS foundation trust in its area
  - NHS England
  - any neighbouring HWB.
12. Health and Wellbeing Boards must consult the above at least once during the process of developing the PNA. Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

13. The draft PNA will be published on the Rutland County Council website and views invited more widely than that of only the statutory consultees.

### **Content and Timescales**

14. The regulations and guidance documents provide information on the PNA content. This has been reflected in the overview of proposed content of the PNA provided in Appendix C. We propose a similar approach to that taken in the 2015 PNA, but may seek more innovative ways to present and visualise the data which might also facilitate easier updating.
15. It should be noted that during the period leading up to the finalisation of the PNA 2018 the Government's decisions regarding "Community pharmacy in 2016/17 and beyond" will have started to be implemented. The impact of these changes will become apparent as 2017 progresses and there will need to be a thorough understanding of the new emergent system and an assessment of its implications for the PNA 2018.
16. Appendix C also provides the project timescales. The project plan is tight with respect to delivering a signed off PNA by the 31st March 2018. The PNA Project Team will monitor this and report any issues of concern to the Integration Executive.

### **Equality Impact Assessment**

17. The PNA will be subject to an EIA.

### **Recommendations**

18. The Health and Wellbeing Board is requested:
  - to note this report
  - to approve the delegation of the assurance role to the Integration Executive
  - approve the proposal to form a project team and an interagency LLR wide reference group and the draft terms of reference for the project team
  - to receive further reports on progress and the final PNA report for approval in March 2018.

### **Officers to Contact**

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## **APPENDIX A**

### **LEICESTERSHIRE COUNTY COUNCIL, RUTLAND COUNTY COUNCIL**

#### **PHARMACEUTICAL NEEDS ASSESSMENT PROJECT TEAM**

##### **TERMS OF REFERENCE**

###### **Purpose:**

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB) and each HWB will need to publish its own revised PNA for its area by 1<sup>st</sup> April 2018.

The purpose of this project team is to develop the PNA for Leicestershire and the PNA for Rutland.

The team will set the timetable for the development of the PNA, agree the format and content of the PNA and ensure that each PNA fulfils statutory duties around consultation for the PNA.

The team will be a task and finish group, meeting between March 2017 and March 2018.

###### **Key responsibilities:**

- To oversee the PNA process
- To ensure that the development of the PNA meets the statutory duties of the HWBs
- To ensure active engagement from all stakeholders
- To communicate to a wider audience how the PNA is being developed
- To ensure that the PNA addresses issues of provision and identifies need
- To map current provision of pharmaceutical services
- To identify any gaps in pharmaceutical provision
- To map any future provision

###### **Governance:**

- Leicestershire County Council – the Health and Wellbeing Board will task the Integration Executive with ensuring the PNA is conducted according to the legislation.
- Rutland County Council – the Health and Well Being Board will task the Integration Executive, with overall responsibility resting with the Health and Wellbeing Board.
- The project team will be chaired by the Public Health Director, Mike Sandys.

###### **PNA Project Team membership:**

###### **Local Authority PNA Leads**

- Mike Sandys, DPH Rutland County Council, Leicestershire County Council, Chair
- Caroline Boucher, Business Intelligence, Leicestershire County Council
- tbc, Rutland County Council

###### **Local Pharmaceutical Committee**

- Chief Officer and Secretary

### **Clinical Commissioning Groups**

- Medicines Management lead, East Leicestershire and Rutland CCG
- Medicines Management lead, West Leicestershire CCG
- Medicines Management lead, Leicester City CCG

### **HealthWatch**

- To be confirmed

### **Public Health Intelligence leads**

- Stephanie Webb/ Natalie Greasley, Leicestershire County Council
- Tbc, Rutland County Council

### **Local Medical Committee**

- GP representative to be confirmed

NB: Membership will be reviewed regularly and may be extended by agreement of the Project Team members

**Frequency of meetings:** five meetings to be arranged – March 2017, April 2017, June 2017, September 2017, December 2017.

Additional meetings may be required between March 2017 and June 2017 as this will be the main development phase of the PNA.

### **Support arrangements:**

The meetings will be minuted by Leicestershire County Council.

### **Confidentiality**

An undertaking of confidentiality will be signed by non-Local Authority employed group members. During the period of membership of the Project Team, members may have access to information designated by the Local Authorities or other members as being of a confidential nature and which must not be divulged, published or disclosed without prior written consent. Improper use of or disclosure of confidential information will be regarded as a serious disciplinary matter and will be referred back to the employing organisation. For the avoidance of doubt as to whether an agenda item is confidential all papers will be marked as confidential before circulation to the group members.

### **Declarations of Interest**

Where there is an item to be discussed, where a member could have a commercial or financial interest, the interest is to be declared and formally recorded in the minutes of the meeting.



## **APPENDIX B**

### **LEICESTER CITY COUNCIL, LEICESTERSHIRE COUNTY COUNCIL, RUTLAND COUNTY COUNCIL**

#### **PHARMACEUTICAL NEEDS ASSESSMENT REFERENCE GROUP**

##### **TERMS OF REFERENCE**

More detailed terms of reference will be developed at the first reference group meeting. The main purpose of the reference group will be to identify economies of scale by joint working across Leicester, Leicestershire and Rutland, to share good practice and to plan effective consultation.

##### **PNA Project Team membership:**

###### **Local Authority PNA Leads**

- Mike Sandys, Rutland County Council, Leicestershire County Council, Chair
- Caroline Boucher, Business Intelligence, Leicestershire County Council
- tbc, Rutland County Council

###### **NHS England**

- Pharmacy Contracts Manager, NHS England

###### **Local Pharmaceutical Committee**

- Chief Officer and Secretary

###### **Local Professional Network for Pharmacists**

- To be confirmed

###### **Clinical Commissioning Groups**

- Medicines Management lead, East Leicestershire and Rutland CCG
- Medicines Management lead, West Leicestershire CCG
- Medicines Management lead, Leicester City CCG

###### **HealthWatch**

- To be confirmed

###### **Public Health Intelligence leads**

- Leicester City Council
- Stephanie Webb/ Natalie Greasley, Leicestershire County Council
- Rutland County Council

###### **Local Medical Committee**

- GP representative to be confirmed

## APPENDIX C

### PHARMACUETICAL NEEDS ASSESSMENT – WORKING OUTLINE AND TIMESCALE

#### Purpose

1. To support local commissioners in deciding on the provision of NHS funded services through community pharmacies in Leicester. These services are part of the local healthcare provision and affect NHS and Local Authority budgets.
2. To support the NHS England-Leicestershire and Lincolnshire Area Team in the determination of market entry decisions.
3. To provide a robust governance framework should a market entry decision are contested or challenged legally by an applicant or by existing NHS contractors.
4. To provide a source of relevant reference to Leicester, Leicestershire and Rutland local authorities, clinical commissioning groups and NHS England for the commissioning of any future of local pharmaceutical services.

#### Publication Outline

The PNA will review and include:

- Existing pharmacy provision and services including dispensing, health care and lifestyle advice, medicines reviews and information and implementation of public health messages and services.
- Dispensing by GP surgeries.
- Services available in neighbouring Health and Wellbeing Board areas that could affect the need for services.
- Demographics of the relevant population shown as a whole and more specifically by locality with clear indication of needs specific to each area.
- Gaps in the provision of services, taking into account future requirements that could be met by providing more pharmacies or pharmacy services.
- Local area maps locating pharmacies and pharmaceutical services.

The PNA will not include:

- Prison pharmaceutical services;
- Hospital pharmacies.

**The published document will cover the following key areas of review (this list is a guide and will evolve alongside the development of report):**

1. Context for the Pharmaceutical Needs Assessment
2. Description of current services

## 2.1. Essential Services

- Dispensing
- Repeat Dispensing
- Disposal of Unwanted Medication
- Promotion of Healthy Lifestyles
- Sign Posting
- Support for Self Care
- Clinical Governance

## 2.2. Advanced Services – these are optional services that are commissioned nationally by NHS England through the core contract

- Medicine Use Review (MUR)
- New Medicines Services (NMS)
- Appliance use reviews (AUR)
- Stoma Appliance Customisation Service

## 2.3. Enhanced Services which are locally commissioned (list is an example)

- Out of Hours Services
- Supply of Palliative Care Drugs
- Minor Ailment Scheme
- Advice and Support to Care Homes
- Emergency Hormonal Contraception (EHC)
- Chlamydia Screening
- Stop Smoking Services
- Alcohol Brief Interventions
- NHS Health Checks
- Flu vaccinations
- Supervised Consumption
- Needle Exchange
- Healthy living pharmacies

## 2.4. Pharmacies facilities

- Wheelchair access
- Access to disabled car parking within 100m
- Private consultation rooms
- Customer toilets
- IT facilities
- Foreign languages spoken

## 2.5. Different types of pharmacy contract

- Internet/distance selling
- 100 hour dispensing
- Dispensing practices
- Dispensing appliance contractors
- One-Stop primary care centres
- Cross-border pharmacies affecting local population
- Hospital pharmacy discharge medication arrangements
- Prison pharmacy arrangements
- Rurality

3. Each local authority will produce an overarching health needs document as part of their JSNA process which will inform the PNA.

- 3.1. Local Health Needs
  - This will be the section that identifies the health needs that need to inform the commissioning of the pharmaceutical needs assessment – so the interpretation of the health needs document into the services that can be commissioned through community pharmacy
  - For example, mapping of teenage pregnancy hotspot wards to EHC provision.
  - Include a review of patients that are not within a 10 minute drive time or a 20 minute walk time of a pharmacy
  - Leicestershire and Rutland need to include a section on rurality and the changes to the areas designated as rural linked to the existing PNA
4. Changes to demography, services, etc. that will effect pharmaceutical needs
  - Demographic changes
  - Planning intentions and housing developments
  - Care homes and retirement villages
  - Issues such as the impact of the co-operative pharmacy plans
5. Key Strategic Priorities
  - Local Authority JHWS
  - NHS England Primary Care Strategy
  - Better Care Fund
  - Better Care Together 5 year strategy
  - CCG 5 year plans
6. Neighbouring and Regional Services
7. Engagement
8. Conclusions
9. Recommendations
10. Equality Impact Assessment
11. Table of Abbreviations/Glossary
12. Appendices

## Implementation

### Project Schedule – Under Development

#### Stage 1 – Project implementation (March 2017)

<b>Milestone</b>	<b>Complete</b>
Formally initiate project	31 <sup>st</sup> March
Establish Project Team	31 <sup>th</sup> March
Set up project templates	31 <sup>th</sup> March
Confirm recruitment of key project team members	31 <sup>st</sup> March

#### Stage 2 – Stakeholder Consultation & Initial Document Drafts (April – August 2017)

<b>Milestone</b>	<b>COMPLETE</b>
Draft PNA template (contents) agreed	May 2017
Draft risk register	May 2017
Develop engagement plan	June 2017
Equality Impact Assessment	
1 <sup>st</sup> draft PNA document	
Communications plan in place	

#### Stage 3 – Final Document Draft, Approval & Publication (August 2017 – March 2018)

2 <sup>nd</sup> draft PNA – Full Document	
Start 60 day consultation	
End of consultation period	
Revised draft PNA document	
Health and Wellbeing Board sign off (March 2018)	
PNA document published	31 <sup>st</sup> March 2018

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