RESPONSE TO POINTS IN JOHN ADLER'S LETTER TO WILL HUXTER OF 13 OCTOBER 2016

1. Thank you for sharing the slide deck used in the meeting and to which you referred during the discussions.

2. The section of the NHS England Board report which you cite (not paragraph 59 on page 17, but paragraph 132 on page 29) relates to circumstances under which NHS England would need to take urgent action on safety grounds to close a service. This would only take place under exceptional circumstances. As you know, there is no proposal from NHS England to close the unit at UHL; our proposal is to continue to commission CHD services from Leicester, as a level 2 centre. The section that is relevant to the commissioning decisions which NHS England proposes to take, subject to public consultation, is paragraphs 97 to 101, as follows:

97. The group has agreed to pursue a multi-centre network approach as the most likely to maximise achievement of the proposed standards. Initial network groupings have been explored, but the final groupings are not yet settled. The group has been asked to "strain every sinew" to get as close to meeting the standards as they can. There is a collective recognition that the standards cannot be completely met by all of the centres without changing the way they work. We have asked participants to consider how they could best set themselves up to be able to deliver the standards, or failing that to get as close as possible. Where providers believe that they cannot meet a standard, they have been asked to consider what mitigation they would put in place.

98. This will allow NHS England, as the commissioner responsible for CHD services, to make decisions about whether, with the appropriate mitigations, this produces an acceptable solution, in the best interests of patients. Our commissioning decisions will need to take into account and balance all the main factors, including affordability, impact on other services, access, and patient choice, and not treat the standards as though they exist in isolation. *[Emphasis added]*

99. We expect that the process will now begin to move from the present informal approach to a formal commissioning process. Within this we expect to seek formal submissions of the proposed service delivery models in October 2015, for NHS England to review and make a decision whether to continue with the current commissioning approach in November.

100. Key factors that we will consider in our evaluation of those proposals are expected to be:

- *Patient driven including choice*
- *Meeting the standards and specifications*
- *Network service model and service integration*
- *Capacity, activity, access*
- *Affordability*
- *Staff/workforce.*

101. If it becomes clear that the joint work is not progressing at sufficient pace, or if it is clear that it will not be able to deliver a desirable solution, then in the interests of patients, we would expect to move to a procurement-based solution. A number of alternative procurement approaches exist. It is possible that a differentiated solution may emerge if collaborative working is successful in some parts of the country but not in others.

3. Standard 2.1 requires a team of at least 3 cardiac surgeons, each of whom must have been the primary operator in a minimum of 125 congenital heart operations per annum as at April 2016, averaged over the previous 3 years (and therefore averaged over that period a minimum of 375 cases per year for the team of surgeons as a whole is required). Based on your own data, UHL's reported numbers are 292, 276 and 327 for 2013/14, 2014/15 and 2015/16, or an average of 298 per annum at April 2016, broken down by consultant as follows:

Surgeon	2013-14	2014-15	2015-16 (projected)	Average procedures per year
Current				
Simone Speggiorin	91	127	101 (122)	113
Antonio Corno	-	3	74 (95)	95
Branko Mimic [1]	-	-	27 (43)	103 [1a]
Previous				
Attilio Lotto [2]	81	86	61	-
Giles Peek [3]	101	54	-	-

1. Branko started operating in November 2015.
1a. Based on 43 procedures over 5 months – extrapolates to 103 procedures over 12 months
2. Attilio stopped operating in October 2015.
3. Giles stopped operating in December 2015

Where providers could not demonstrate that standards are met, they were asked to describe their plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one that gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective. As set out in in our assessment report, the NHS England panel remains concerned about whether UHL's plan to meet the numbers requirement by April 2017 are realistic.

4. Thank you for providing your waiting list information, which demonstrates that a reduction in waiting list numbers contributed to a net increase of 11 cases in your activity for 2015/16 (22% of your increase in activity above 2014/15).

5. We will set out for the public in our forthcoming consultation document our proposals in relation to level 1 services. Under these proposals, people served by Leicester at present would have access to level 1 services from Birmingham, Leeds, Great Ormond Street and other providers. As part of our decision-making at the end of consultation we will also take into account the early outputs from the national review of PICU, paediatric surgery, paediatric transport, and paediatric ECMO.

6. Our commissioning proposal is to commission level 2 medical services from Leicester. My letter of 26 October requesting information from the Trust to support our impact assessment, and your subsequent response, will help to address the question about the proportion of activity that would be delivered in a level 2 centre.

7. Workforce and training are very important to us, and we are committed to ensuring that there is a resilient specialist workforce, both trainees and consultant staff, to deliver the services which we commission.

8. We will consider PICU provision across the Midlands and East Region as part of our current national review.

9. An important element of the national CHD programme as a whole is developing the detail of network relationships, across level 3, level 2 and level 1 providers. UHL clinicians are part of this programme, and we would welcome an opportunity to bring together clinicians from UHL and the proposed level 1 centres to discuss the detail of how this would work for Leicester.

10. The national team is working very closely with the Midlands and East Regional specialised commissioning team, led by Catherine O'Connell, in relation to CHD. This includes my letter of 26 October requesting information from the Trust to support our impact assessment of the proposed changes.

11. Details of these reviews are now on the NHS England website, as highlighted in Jonathan Fielden's recent blog https://www.england.nhs.uk/2016/10/jonathan-fielden/

12. We are undertaking some further analysis of surgical and interventional cardiology activity across the country, which demonstrates the complexity of current referral and access arrangements – including both patients with Leicester postcodes being seen in other centres, and patients who live closer to other centres being seen at Leicester, as well as patients from Leicester being seen further afield. We will reflect on this pattern of access in our public consultation document. We will not use differences in Market Forces Factor as a determinant of access to services.

13. The NHS England CHD Review Programme Board considered the recommendations from the Verita report. The Clinical Advisory Panel was asked to consider whether the recommendation in relation to a service-wide discussion about referral policy should be added to the standards.

14. Noted.

15. As referenced under point 9 (above), we are working with clinicians from across all providers to develop our plans for networks of care.

16. As referenced under point 12 (above) we are undertaking some further analysis of surgical and interventional cardiology activity across the country, which demonstrates the complexity of current referral and access arrangements.

17. NHS England has been transparent in its approach to the assessment of all providers of CHD services, and the individual assessments of each centre are in the public domain on the NHS England website https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/

18. Noted.

19. Noted.

20. Thank you for this further information.

21. There is no negative connotation to my reference to the surgical support received from Birmingham. Thank you for the further information you have provided. Following our work with other providers across the country, it has become apparent that Birmingham is not the only provider to which Leicester makes referrals, and that patients have been transferred from Leicester for interventional cardiology as well as surgery. I also understand that, in the absence of paediatric EP at Leicester, all of this activity is provided elsewhere. To ensure that we have a fully rounded picture of the position at Leicester, and the range of clinical relationships which Leicester has with other centres, please provide the following additional information to complement the data you have already sent us in relation to surgical support from Birmingham (on site at Leicester and at BCH):

    - The volume of interventional cardiology cases referred to Birmingham since April 2013, and the detail of the procedures concerned

- The volume of surgical activity referred to any other UK CHD centre (other than Birmingham) since April 2013, with details of the centre referred to, and of the procedures concerned

- The volume of interventional cardiology activity referred to any other UK CHD centre (other than Birmingham) since April 2013, with details of the centre referred to, and of the procedures concerned

- The number of cases on which surgeons at Leicester have sought telephone advice from other UK CHD centres since April 2013, with details of the centre contacted, and of the procedures concerned

- The volume of paediatric EP undertaken for Leicester by Birmingham since April 2013

22. Thank you for the information you have provided in relation to ECMO. The current national review will address future provision.

23. Noted.

24. Noted.

25. Noted.

26. Thank you for the confirmation in relation to funding of the capital costs associated with the co-location of CHD services to the Children's Hospital at LRI. We had asked for confirmation of which services will be located on each site when; please send us the programme plan which makes this explicit for all the specific sub-specialty co-location requirements within the remit of the CHD review.

27. I have written separately to you (my letter of 31 October) to clarify the position in relation to specific sub-speciality co-location requirements, including paediatric gastroenterology.

28. I can confirm that you have provided confirmation of the co-location of vascular services with ACHD; the provision of the programme plan that delivers the required co-location, with the associated dates, will enable us to be assured on this point, and on the broader issue of co-location of all paediatric services by 2019. As referenced in point 27 above, I have written separately to you to confirm the requirements in relation to paediatric gastroenterology.

Will Huxter
11 November 2016