Specialised Commissioning
London Region
Skipton House
80 London Road
London SE1 6LH

0113 807 0909
will.huxter@nhs.net

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John Adler
Chief Executive
University Hospitals of Leicester NHS Trust
Leicester Royal Infirmary
Leicester LE1 5WW

Dear John

Congenital Heart Disease Review

Thank you to you and your team for the time and effort you all put into our visit to Glenfield on 16 September. The information you presented, the tour to see the facilities and to meet staff, and the opportunity to discuss NHS England's proposals with the stakeholder group were all helpful as part of our pre-consultation engagement. Please pass my thanks on to everyone we met. It was good to meet you after our extensive correspondence on this topic.

The slides which the team presented contained a great deal of useful information. However, we were left with some questions on which we need further detail. Can you send me a copy of the full slide set (and the underlying data where possible), so that we can review and come back to you for points of clarification as required?

Ahead of receiving the slide set, I am writing both to confirm key points that we covered, and to request some further detail in support of what you presented.

Firstly, I wanted to emphasise again the fundamental aim of NHS England in taking forward the Congenital Heart Disease review. Following the decision of the NHS England Board in July 2015 to approve the standards for CHD services, we are working to ensure their implementation across the country, so that current and future patients can have consistent access to high quality and resilient services.

As you know, the proposal put forward by NHS England, which we are discussing during pre-consultation engagement ahead of formal consultation, is to decommission University Hospital Leicester (UHL) as a level 1 CHD centre, and for the future to commission UHL as a specialist cardiology medical level 2 centre. There is no proposal for closure of UHL as a provider of CHD services, and I would welcome your support in making that explicit in your communications with staff, patients and other stakeholders.

As we discussed on 16 September, there are three fundamental areas where our assessment of the Trust, based on the information the Trust has provided to us, where the standards are not met:

- **The number of surgical cases p.a.** (against the interim requirement of a minimum of 375 cases pa and 3 surgeons, and the full standard of a minimum of 500 cases pa and 4 consultant surgeons). Standards B8 and B9 (paediatric) clearly require consultant congenital heart surgeons, by definition meaning those on the specialist register.

- **Overall co-location of paediatric services** to meet the interdependencies requirement.

- **Specific sub-specialty co-location requirements** (paediatric gastroenterology and paediatric surgery).

There are also some other standards where our assessment of the Trust being in compliance is dependent on successful delivery of the submitted mitigation plans, as NHS England does not support the delivery of services under ongoing derogation. For example, the Trust needs to confirm to us that it remains on track to deliver the required minimum of 200 interventional cardiology procedures in 2016/17. The service will be subject to a time-limited derogation from 1 April 2017, pending the outcome of the consultation.

We agreed at our meeting that it was important for us to have a common understanding of the facts in relation to both the Trust's compliance with the standards, and the implications for other services (including ECMO and PICU) if the proposal to decommission UHL as a level 1 CHD provider goes ahead.

I will deal in turn with each of the three specific areas of the standards in turn.

On surgery, we were disappointed by the Trust's presentation, and the argument that the only way in which the Trust could meet the minimum caseload of 500 cases was by commissioner changes to referral pathways. You did not describe the anticipated impact of these changes on activity at other centres, nor did you give any detail on the specific changes in referral pattern from secondary providers that would be required.

As you know, some patients currently attend UHL when this is not the closest level 1 centre to where they live. The principle of patient choice, to attend any provider which meets national standards, is important, and there would need to be a very strong rationale for any change to this principle.

The Trust has reported a significant increase in its surgical activity in 2015/16 compared to 2014/15. We are keen to understand what has contributed to this increase. To that end, please let us know the number of adult and paediatric CHD cases awaiting surgery at 31 March 2014, 31 March 2015 and 31 March 2016. The Trust presentation cited a change in referral pathway at Kettering General Hospital as contributing to the increased activity at UHL. How many cases did this amount to in 2015/16?

We were also surprised that your presentation made no reference to surgical support which you receive from Birmingham, although Simone Speggiorin helpfully provided some information on this during the session. Reference was made to a number of cases being referred to Birmingham because of their complexity, and to support provided by David Barron on site at Glenfield. To give us a full picture of the caseload, please send me details of the number of cases referred to Birmingham in the three years to 31 March 2016, and to date in 2016/17. Please also confirm on how many occasions since 1 April 2013 a surgeon from Birmingham has attended Glenfield to assist with an operation.

We also discussed your surgical workforce, with two locums (one of them not on the specialist register) and one substantive consultant surgeon, in the context of NHS England's concern that we wish to commission services which are resilient in the longer term. The Trust view at our meeting was that only having one substantive consultant surgeon was a result of uncertainty caused by the national CHD review. Our understanding however is that there has been a long-standing issue with the surgical workforce at UHL. So that we have a shared understanding on this, please send me details of the CHD surgical workforce at the Trust since 2012/13.

On overall co-location, the Trust presented a timetable for the interim work to deliver the standards. This was very positive information, which to my knowledge has not previously been shared with us. For the avoidance of doubt, please send us the following further details:

- Confirmation that the capital costs of this work are within your discretionary capital, and that this funding has been allocated accordingly.

- Confirmation of which paediatric services will be co-located where as a result of these capital works between now and 1 April 2019.

- Confirmation whether the proposal is to move only the paediatric element of CHD or both paediatric and adult. If the latter, please provide confirmation that this will not disrupt the equally important adult co-location requirements set out in the standards.

- Confirmation that delivery of these changes is on target against this timetable.

- Confirmation that the FBC for the new children's hospital is not dependent on the retention of level 1 CHD services at UHL.

On sub-specialisation, our requirement is for availability on site of specific services, including paediatric gastroenterology. The Trust's stated plan for delivery of this aspect of the standards is to employ a consultant paediatric gastroenterologist. The standard requires 24/7 30 minute call to bedside care (as well as co-location) which would not be deliverable by a single consultant. Please confirm progress against this commitment by the Trust, and how the Trust will deliver the required standard in full.

We also discussed at some length the issue of potential knock-on effects for other services from the NHS England proposals in relation to CHD services. This was quantified in summary on one of the Trust's slides, but to ensure that we have a shared understanding of the detail of this please set out in activity, income and workforce terms your assessment of the impact of level 1 CHD services being decommissioned for PICU, ECMO (quantified separately for adult and paediatric, and for respiratory and cardiac ECMO), fetal medicine, paediatric surgery and trauma. Our current view is that, should our proposals continue through the consultation process, the scenarios you are promoting to the public are not outcomes we believe will occur and create unwarranted concern to the public.

I appreciate that this letter sets out a list of further detail which we require. However, given the focus that the Trust has on this issue, and your public communications about your assessment of the impact for the Trust of our proposals, I am confident that you will have this information readily to hand. Please therefore send me the information requested by 3 October.

Best wishes

Yours sincerely

Will Huxter

Regional Director of Specialised Commissioning (London Region)

SRO, Congenital Heart Disease review

cc

Dr Jonathan Fielden, Director of Specialised Commissioning, NHS England

Catherine O'Connell, Regional Director of Specialised Commissioning, Midlands & East, NHS England

Jo Stringer. Senior Communications Manager, Specialised Commissioning, NHS England