NHS England

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Mr Kalvaran Sandhu (Scrutiny Manager)
Joint Health Scrutiny Committee (Leicestershire, Leicester, Rutland)

Dear Mr Sandhu

RE: Congenital Heart Services Review (Glenfield Hospital)

I refer to the minutes of the meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee meeting on 29 September 2016 and to your email to me dated 6 February 2017, which attached those minutes.

You will be aware that we are planning to launch our formal consultation on the level 1 proposals shortly. We will be publishing in the consultation document and supporting materials the detail of our current thinking on the issues raised in the minutes. I am also looking forward to discussing these proposals with the Joint Committee in March. In the meantime, let me provide you with the following preliminary responses.

125 operations
The Standards were approved by NHS England's board in July 2015, following extensive consideration and full public consultation, and their contents are not now up for debate. The number of operations required per surgeon was agreed following NHS England's engagement with all the surgeons on our clinical reference panel on this issue and analysis of validated data provided by NICOR. The surgeons who participated in our standards review have been unanimous in their belief that individual case numbers are the single most important statistic to apply in terms of 'numbers', and there is very little argument against 125 being a helpful and achievable minimum standard. The number of operations performed is measured per surgeon to ensure that each surgeon maintains their expertise by frequently practising and refreshing their skills.

Patient flow
University Hospitals Leicester (UHL) submitted a surgical growth plan which they consider would result in them achieving the minimum level of activity required to ensure four surgeons are able to perform a minimum of 125 procedures per year by 2021. The projected increase in activity depends on population growth, technical advances, and changes to patient flows (which UHL state would be helped if NHS England supported the flow to the Trust of all patients for whom it is the closest centre). NHS England has previously stated that it does not intend to mandate patient flows because it does not consider it appropriate to override clinical judgement and patient choice. This remains our view.

UHL's performance
It is essential that all patients receive the same standards of care, wherever they are in the country. Therefore all providers of CHD services must meet the standards set following work 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. Patients, and their families/carers and representatives, as well as clinicians in the field, have told us – consistently – that the standards were only worth something if they were actually acted upon and met.

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 and would bring an end to variation in service based

on location.

IRP/Safe and Sustainable review
We have borne the IRP carefully in mind throughout the CHD review process. See for example our published report setting out how the new congenital heart disease review has sought to learn lessons from the Safe and Sustainable review and specifically the recommendations raised by the IRP[1]. We continue to do so.

Travel times
We are aware of and have taken on board patient concerns regarding travel times where it is proposed that services are decommissioned. If our proposals are implemented, UHL 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. Our modelling suggests that the impact on average journey times for patients is relatively modest: an increase in the average journey time of 14 minutes for children who use Leicester and 32 minutes for adults. Thankfully, true emergencies in congenital heart disease are incredibly rare.

Some patients would still, of course, have longer journeys. However 90% of patients who would currently use University Hospitals of Leicester would 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).

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.

UHL's neonatal service
Last October we wrote to each of the Trusts as part of our impact assessment process, seeking information in relation to the impact of our proposals on a range of factors, including on CHD services, other interdependent services and the Trust as a whole. UHL was therefore provided with an opportunity to raise the impact on neonatal services and information supplied by the Trusts has been included in our Impact Assessment report. We have also taken the information provided by the Trusts into account in developing our consultation document.

Inaccuracies in UHL assessment
We have amended our view on paediatric co-location in the light of the information provided by UHL, and this will be reflected in our consultation document.

ECMO/PICU knock-on effect
NHS England is carrying out a Paediatric Critical Care & Specialised Surgery for Children Service Review, which will consider paediatric intensive care provision, paediatric transport and paediatric ECMO. UHL 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 UHL 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 UHL 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

[1] https://www.england.nhs.uk/wp-content/uploads/2014/11/5-chd-34-nchdr-lessons-learnt.pdf

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PICU at the Infirmary would be unaffected by the implementation of the proposals. The hospital trust does not share this assessment.

Timetable

We know, from talking to stakeholders, that the failure to implement recommendations from previous reviews has created uncertainty for patients and staff. At the same time, we are committed to following due process throughout the review, ensuring that sufficient time and consideration is given to each stage of the process and to make sure relevant stakeholders are able to participate and contribute effectively. The consultation period is in line with standard practice and provides a sufficient amount of time for patients, their families and carers, clinicians, organisations and other stakeholders to provide their opinions and any extra information or evidence as they wish.

I am happy to correct the suggestion that the outcomes of the review are pre-determined; no decision has been taken and any decision will be taken only following appropriate engagement and consultation.

Yours sincerely

Will Huxter

Regional Director of Specialised Commissioning (London Region)

SRO, CHD Programme