Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 January 2017**
Subject:	**Congenital Heart Disease Services**

Summary:

On 21 December 2016, the Committee considered an item on Congenital Heart Disease Services. Two representatives from NHS England attended to provide information to the Committee. The two representatives were requested to attend this meeting to provide additional information and points of clarification. However, they are not available to attend. Any information received will be circulated to the Committee.

In the meantime some points of clarification have been provided by University Hospitals of Leicester NHS Trust, and the letter from the Trust's Chief Executive is enclosed. Representatives from the Trust are to attend the meeting.

The Committee is requested if it wishes to make any submission to NHS England in advance of the public consultation.

Actions Required:

(1) To consider any information received from the NHS England representatives, in relation to the questions raised by the Health Scrutiny Committee on 21 December 2016.

(2) To consider the information submitted by University Hospitals of Leicester NHS Trust – Letter from Chief Executive, John Adler, 1 January 2017 (Appendix A).

(3) To determine whether to make any submission to NHS England at this stage, in advance of the formal consultation phase.

1. Background

NHS England View

On 21 December 2016, Will Huxter, the Regional Director of Specialised Commissioning, NHS England (London Region), and Dr Geraldine Linehan, Regional Clinical Director of Specialised Commissioning, NHS England (Midlands and East Region) attended the Committee to provide information to the Committee on NHS England's reasoning for indicating that the East Midlands Congenital Heart Centre (EMCHC) would not meet the required standards for congenital heart disease surgery, with a view to decommissioning these services from the EMCHC.

Will Huxter and Dr Geraldine Linehan were requested to attend this meeting to provide additional information and further points of clarification. They have declined attendance owing to other commitments, but have indicated that they will provide written information on the information requested.

University Hospitals of Leicester NHS Trust View

In the meantime, the Chief Executive of University Hospitals of Leicester NHS Trust, John Adler, has written to the Chairman of the Committee, Councillor Mrs Christine Talbot. His letter, dated 1 January 2017, is attached at Appendix A to this report. Point 1(c) of the letter refers to treating information on the recruitment of staff confidentially, but it should be noted that University Hospitals of Leicester has now indicated that all the information in the letter can be published.

Timing of the Formal Consultation

The Chairman has written to NHS England to seek that they indicate the dates of the formal public consultation. Any responses received will be reported to the Committee.

2. Conclusion

The Committee is requested to consider any information received from the NHS England representatives, in relation to the questions raised by the Health Scrutiny Committee on 21 December 2016; and the information submitted by University Hospitals of Leicester NHS Trust (Appendix A).

The Committee is also invited to determine whether to make any submission to NHS England at this stage, in advance of the formal consultation phase.

3. Consultation

A formal public consultation is expected "early in 2017" and clarification has been sought from NHs England on when this consultation will take place. In the meantime, the Committee may wish to make a submission to NHs England in advance of the formal public consultation.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Letter from John Adler, Chief Executive of University Hospitals of Leicester NHs Trust to Councillor Mrs Christine Talbot, Chairman of the Health Scrutiny Committee for Lincolnshire - 1 January 2017

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

University Hospitals of Leicester NHS
NHS Trust

Leicester Royal Infirmary
Leicester LE1 5WW
Tel: 0300 303 1573

Cllr Christine Talbot
Lincolnshire Health and Scrutiny Committee

BY EMAIL

1st January 2017

Dear Cllr Talbot

Firstly, thank you for inviting us to attend the Lincolnshire Health and Scrutiny Committee meeting on the 21st December

On the **7th November** UHL sent a revised self- assessment of our ability to meet the standards to NHS England. Since our previous assessment, we are delighted to have made significant progress and feel confident that we now demonstrate compliance with all the standards, or can provide a robust plan showing how we will comply within the designated timeframes. Although our plans are not completely without risk, we are clear that the risks entailed in decommissioning our service are much greater.

I am therefore disappointed that on the **21st December** at your meeting, NHS England were still raising points against our compliance to the standards which we feel are very well covered in UHL's various responses, and that NHS England appear to have a very different interpretation to us on a number of other key points. As we were not able to respond in the meeting, and as requested, I have addressed each of the points raised with a summary of the point highlighted and provided more detail below.

Point 1

a) **375 cases this year -**This is not a requirement of the new cardiac review standards – the actual standard states 375 cases are required, averaged over three years from April 2016. East Midlands Congenial Heart Centre will achieve this standard in the required timescales

In our recent letter from NHS England dated 14th November 2016 they state that, *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).*

It is from this interpretation of the standard that NHS England is challenging our ability to meet the standard. We dispute the interpretation and implementation of the standard in this way; not least because it is both illogical and inequitable to enforce a standard retrospectively. Moreover, we believe this is the first occasion in which the word 'previous' has been included. Standard B9 (L1) and B10 (L1) both provide an "Implementation Timetable" of immediate for 3 surgeons and within 5 years for 4 surgeons.

This retrospective counting was not at any stage agreed by either the standards committee or indeed the wider sign off group. This standard is correctly interpreted as running prospectively from the time of implementation (1st April 2016) and the three years average should therefore be calculated forward from then.

When we look at the previous documentation, it is perfectly clear that up until now NHS England has always approached this on the basis that the three years were to run prospectively from April 2016 and this new interpretation is a change in tactics.

If we apply the interpretation of the standard in the way in which it was intended to be interpreted, then we are on track to achieve an average of 375 cases per annum over the three years averaged from April 2016. Our actual case load this year is likely to fall slightly short of the 375 number, but we have demonstrated through our growth analysis that we will be able to increase our numbers in 2017/18 and 2019/20 to ensure the three year average is met.

b) **500 cases by 2020 -** We provided a growth plan to NHSE on the 7th November that clearly shows that East Midlands Congenital Heart Centre will achieve the required 500 cases by 2020

We included in the submission, detailed in Appendix 1, a growth plan that clearly demonstrates us reaching 500 cases by 2020. This is based on our growth from the previous two years, population growth estimates taken from Office of National Statistics and a very cautious application of the additional referrals we believe we can generate from the on-going referral discussions with our network partners. Our network development plan is based on hospitals that we believe do not currently offer East Midlands Congenital Heart Centre as an option to their patients, despite it being the Level 1 centre closest to home, now starting to offer us as an option. This will only affect new patients unless existing patients choose to transfer to us. We believe this will take time to develop; we will need to demonstrate to the referring clinicians that we are able to match the level of service their patients currently receive. It is because of this we have been cautious in our expectations in the first two years.

This is a robust plan, backed up by our clinical and Executive teams speaking regularly to the network hospitals, and based on a very positive degree of traction recently, despite the on-going uncertainty facing the unit .

NHS England has not provided any explanation as to why they do not feel our plans are achievable. We have however had significant conversations and have started developing new referral pathways with a number of the Network Hospitals that show our plan is realistic. It would be helpful if NHS England more actively supported our network development, as we have repeatedly requested. They have declined thus far to do this, for whatever reason.

A point also has to be made in respect to the validity of the 500 cases being used as a measure. We agree that at the hospital level, the number of operations performed may be a rough starting point for an assessment of the volume of work if one can assume that the hospitals do the same range of complexity operations. There is no difference or acknowledgement made for operations that take 30 minutes vs. those that take 10 hours. East Midlands Congenital Heart Centre does very few of the least complex operations that constitute a large proportion of the surgical throughput of some other units.

NHS England commissioned the University of Sheffield to review the world research on the subject and then misrepresented their findings, as the principal author has made clear publicly. The ScHARR study found no convincing evidence that centres doing 500 operations a year provide any advantage over medium sized centres like our own.

c) **Surgeons -** The standards do not require surgeons to be employed in a substantive role and other centres also have consultants on locum contracts. It is usual practice to offer locum contracts to allow overseas consultants time to register with the GMC specialist register (a pre-requisite for a substantive post). In addition, on 2nd December we made a new substantive consultant appointment as well as an additional appointment from these interviews to allow service development and succession planning. Despite the adverse 'climate' we had nine high quality applicants for this post; perhaps demonstrating a significant degree of professional solidarity with, and faith in, EMCHC?

East Midlands Congenital Heart Service currently has three full time Consultant Congenital Cardiac Surgeons, therefore meeting the standard for 2016. Nowhere in the standards does it state that it is inappropriate to have a locum surgeon.

All our Congenital Cardiac Surgeons have completed specialist training programmes in Congenital Cardiac Surgery. One of our consultants is employed as a Locum Consultant by virtue of UK immigration and employment law, having been employed as a substantive Consultant Congenital Cardiac surgeon abroad with significant experience. He previously

worked in a similar role at Great Ormond Street from whence he came with a very favourable reference. He is now preparing his application to the GMC for inclusion on the specialist register; after which he can be considered for a substantive role. This is normal practice in NHS Trusts employing specialists from overseas and any perceived risk regarding the sustainability of this appointment has been mitigated by the Trust providing a long term Locum contract to cover the period until his registration process is complete.

The need to employ Locum surgeons from abroad can be explained by the pressures on paediatric cardiac surgery training.

To give you an idea of the extent of the issues, there were this year 70 applicants for 14 training posts in cardiac surgery. In other words, the CTS training programme was oversubscribed by 500%. Yet when it came to sub-specialism in paediatric cardiac surgery there was only 1 applicant for 3 places. This may be connected with the intense level of scrutiny which has been applied to the specialty over many years.

The interviews on December 2nd identified two candidates that the panel felt were of the required professional calibre to be appointed. We have therefore established an additional substantive surgical post in conjunction with Leicester University. This role will focus on service development and succession planning, and ensure the current solidity and outcomes of the team are retained as a new surgeon is introduced. Details of the two roles and the surgeons will be announced once the appointment has been finalised. We would be grateful if you could keep this information confidential until we have made our formal announcements.

In a letter to Mr Huxter on the 20th December we announced the two surgical substantive appointments. Despite a similar request to keep the appointments confidential, Mr Huxter chose to announce them at the meeting on the 21st December. He then went on to raise concern that the engagement of the fourth surgeon would further compromise our ability to meet the 125 caseload per surgeon standard. In our letter of the 20th December we made clear that;

'We can assure you that the surgical activity will be managed appropriately to maintain the required activity levels for each consultant. The additional appointment will allow us to focus on service development, mentoring, and succession planning; whilst ensuring the current solidity and outcomes of the team are retained as a new surgeon is introduced to it. This appointment will also offer us flexibility as our surgical numbers increase as per the growth plan we have submitted.'

We were therefore baffled as to why he felt the need to raise this concern, despite the explicit assurances within the letter. I will be raising the issue of breach of confidentiality separately with Mr Huxter.

Point 2 -

a) Network and out of area referrals are purely patient choice. We have a network development plan that will increase not decrease choice for patients. Our growth plan assumes that patients nearest to us will be offered the choice of Leicester but does not assume every patient will choose EMCHC. NHS England's plans will substantially reduce local patient choice.

The fact is that a number of hospitals within our catchment area, which see East Midlands based patients with CHD, have well established referral patterns to Great Ormond Street Hospital.

It is evident that NHS England assumes that by protecting the current referral pathways for the 150 surgical cases per annum who do not receive their surgery at EMCHC, they are in some way protecting patient choice. The reality is that this will deprive the thousands of patients in our area who currently are treated at EMCHC and are delighted with the quality of their care, of the right to choose to be treated in the hospital of their choice, nearest their home. They feel passionately about this.

It was evident from the meeting that journey time and cost, especially for those constituents who live in rural areas and are on a low income, is a key concern to your councillors. Our growth plan increases the choice for those patients to receive the highest quality service closest to home.

b) **Dr Geraldine Linehan GP commented on numerous occasions that patients want to experience care from someone with the best clinical expertise.** This is of course correct, and our surgeons have over fifty years' combined experience in congenital cardiac surgery. It is however the outcome of that surgery that is of greater relevance; the surgical outcomes at Glenfield Hospital exceed expectations in respect to deaths within 30 days following cardiac surgery

Our surgical outcomes, as illustrated in our latest quality report, (Appendix 2 page 20), show that our survival rate as adjusted by the PRAiS software (Partial Risk Adjustment in Surgery) is greater than the model predicts. In fact there have been four fewer deaths than would otherwise be expected over the three year period from 01/08/13 – 29/07/16. It is also not just the surgical experience that counts for outcomes; the whole team is crucial. East Midlands Congenital Heart Centre has some of the most experienced Cardiologists and Intensivists in the country and of course among the most ECMO experience in the world. So to question our service's 'expertise' against all evidence is inappropriate.

Due to the significant advances in Congenital Heart Disease surgery, any patient offered the choice of surgery at EMCHC or elsewhere in the UK would not be able to differentiate on outcome data alone, but would be able to assess the impact of being treated closer to

home, on the pastoral support they would receive, and the cost of travelling to and from the surgical unit.

Point 3 -

Only UHL and Manchester do not meet the 375 standard – the NICOR data for 2015/16 on the Nicor website shows that last year Alder Hey did 348 surgical cases, Newcastle did 328, and EMCHC did 326

The 2015/16 NICOR data can be found at https://nicor4.nicor.org.uk/chd/an_paeds.nsf/WSummaryYears?openview&RestrictToCategory=2015&start=1&count=500 .

Point 4 -

NHS England has no plans to close EMCHC. There will continue to be specialist medical services for CHD at Glenfield. On November 7th 2016 UHL submitted an impact assessment, of what services would not be able to be provided if Level 1 commissioning was removed. (Appendix 3 – impact assessment) This includes all invasive interventions and surgery.

Without the outcome of the independent reviews into PICU, ECMO, Paediatric surgery and transport, we were not able to clearly define the knock on effects across the wider paediatric specialisms, but it is the definite opinion of the clinicians responsible for delivering specialised services across the East Midlands, that very limited services would be able to be offered at UHL without the expertise and support of Cardiac Surgery. There will be a significant impact on experienced workforce, recruitment, retention, training and education.

In the meeting, Mr Huxter stated that the outcomes from the independent reviews would be incorporated into the post consultation decision making. We would strongly contest this as being transparent and fair, and feel this information is crucial for inclusion in the public consultation process.

Point 5 – Transition - extra capacity would be required elsewhere and that Birmingham had submitted funded plans to achieve this. Transition would take time 1-2 years to complete. The current capital availability within the NHS is very limited and it was confirmed at the last Cardiac Clinical Reference Group meeting, that there is no planned independent verification of how the additional capacity is going to be funded or provided.

The transition plans are solely dependent upon the three surgeons currently working at East Midlands Congenital Heart Centre staying with the centre during the transition period. In this scenario this may or may not be what happens so there is a high risk of service instability.

There is a lot of detail in this letter and the attachments; I hope the summary points will help you and your fellow councillors get a clear sense of our response to the points made by NHS England and be reassured that the apparent concerns they expressed about the service are unfounded. I have to confess to a level of frustration that NHS England continue to promote lines of argument which we have rebutted on several occasions. This suggests, at best, the lack of a genuinely open mind on their part.

Kind regards

Yours Sincerely

John Adler

Chief Executive