# Update on the New Congenital Heart Review Process

Author: Alison Poole Sponsor: Mark Wightman **Trust Board paper F**

**Executive Summary**

**Context**

This paper provides the Trust Board with an update on the Congenital Heart Disease (CHD) Review, the key actions for immediate attention, and associated risks.

**Questions**

1. **What has happened in the EMCHC campaign since the last Trust Board update**
   - *1.1.* A second substantive consultant surgeon has been employed, and we have established an additional substantive surgical post at Professorial level in conjunction with the University of Leicester
   - *1.2.* We are in regular contact with the Regional Overview and Scrutiny Committees and have been invited to attend more in the New Year
   - *1.3.* NHS England attended an OSC meeting in Lincoln and have been asked to return in January to present responses to the questions raised. We too have been asked to respond to the points made against our compliance to the standards.
   - *1.4.* The dates of the public consultation have yet to be formally confirmed. Initial informal discussions are raising concern over the size of the planned events limiting the opportunity for stakeholders to consult appropriately
   - *1.5.* Formal letters have gone to Liz Kendal MP in response to the questions raised when NHS England presented to the cross party group of MPs, and to Mr Will Huxter, NHS England requesting a response to our self-assessment and informing him of our surgical appointments
   - *1.6.* Cllr Rory Palmer has offered substantial support to the campaign and is meeting with the campaign team in January to agree approach
   - *1.7.* Ward 30 was official opened on 2nd December by Liz Kendal MP and Nicky Morgan MP

2. **What is the planned over the next month?**
   - *2.1.* Attendance at OSC meetings in Lincolnshire on the 18th January 2017 (with Will Huxter present) and Derbyshire on the 23rd January 2017.
   - *2.2.* Invitations to those Trusts within the East Midlands Network not currently working with us to meet to discuss what a potential Network partnership may look like, and what is required for this to be successful from both Trusts.
   - *2.3.* Preparation of a short presentation on the potential impact of the NHS England proposals and attendance at the All Party Parliamentary Group for Heart Disease at Portcullis House on the 18th January 2017.

*2.4.* Presentation of the final tally of petitions to Liz Kendall in the Houses of Parliament once the online petition has closed.

*2.5.* 100 short Bio case studies of patients who have attended EMCHC ward 30, PICU and ECMO continue to be prepared. These will be shared by social media channels every day of the public consultation phase to raise awareness of the campaign.

3. **What are the risks to the campaign?**

*3.1.* The revised self-assessment submission is still subject to review by the assessing panel; the outcome of which will determine the next steps in the process. There does not appear to be any movement in opinion of NHS England despite numerous submissions from EMCHC indicating our compliance to the standards.

**Conclusion**

4 The Trust Board are requested to :

4.1 Note the content of the paper and

4.2 Provide comments and guidance of any areas deemed appropriate

For Reference

1. The following **objectives** were considered when preparing this report:

| | |
|---|---|
| Safe, high quality, patient centred healthcare | [Yes] |
| Effective, integrated emergency care | [Yes] |
| Consistently meeting national access standards | [Yes] |
| Integrated care in partnership with others | [Yes] |
| Enhanced delivery in research, innovation & ed' | [Yes] |
| A caring, professional, engaged workforce | [Yes] |
| Clinically sustainable services with excellent facilities | [Yes] |
| Financially sustainable NHS organisation | [Yes] |
| Enabled by excellent IM&T | [Not applicable] |

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

**If YES please give details of risk ID, risk title and current / target risk ratings.**

| Datix Risk ID | Operational Risk Title(s) – add new line for each operational risk | Current Rating | Target Rating | CMG |
|---|---|---|---|---|
| 2940 | There is a risk that paediatric cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care and other specialist paediatric services | 15 | 0 | Women's and Children |

**If NO, why not? E.g. Current Risk Rating is LOW**

b. Board Assurance Framework [Yes /No /Not applicable]

**If YES please give details of risk No., risk title and current / target risk ratings.**

| Principal Risk | Principal Risk Title | Current Rating | Target Rating |
|---|---|---|---|
| No. | There is a risk … | | |

3. Related **Patient and Public Involvement** actions taken, or to be taken
4. Results of any **Equality Impact Assessment**, relating to this matter:
5. Scheduled date for the **next paper** on this topic: December
6. Executive Summaries should not exceed **1 page**. [My paper does not comply]
7. Papers should not exceed **7 pages.** [My paper does comply]

# Update Paper on New Congenital Heart Disease Review

Prepared by Alison Poole Date: 23rd December 2016

## 1. Context:

1.1. This paper provides the Trust Board with an update on the Congenital Heart Disease (CHD) Review, the key actions for immediate attention, and associated risks.

## 2. Questions: What has happened in the EMCHC campaign since the last Trust Board?

2.1. **Surgical appointments –**The interviews held on the 2nd December identified two candidates that the panel felt were of the required professional calibre to be appointed. It should be noted that the service attracted nine highly qualified surgical applicants (despite the obviously difficult context). Due to the quality of the field, we were able to employ our second substantive consultant surgeon, and have established an additional substantive surgical post at Professorial level in conjunction with the University of Leicester. It is essential that the surgical activity is 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. Details of the two roles and the surgeons will be announced once the appointment process is finalised.

2.2. **Public Consultation- Leicester –** We have had informal discussions via the NHS England communications team in relation to proposed public consultation meetings. We have had no formal communication regarding the start date. Once details are formally announced we will respond accordingly if this hasn't been addressed. NHS England has also asked if we would provide representatives from the Trust to sit on the consultation panel, we have advised that we will confirm who will do this once the details of the event and panel have been published.

2.3. **Public Consultation wider Network** – NHS England have written to Nottingham University Hospital asking if they can join any pre planned stakeholder events to discuss the consultation. Public Consultation is the responsibility of NHS England, and events should focus on the consultation question and give stakeholders appropriate opportunity to raise concerns. This request has been referred to the Nottingham OSC for consideration, due to the unusual nature of the request. Dr Aidan Bolger in his role as Chair of the East Midlands Congenital Heart Network has written to NHS England requesting details of what formal consultation events they have planned across the Network

2.4. **Regional Meeting of the Overview and Scrutiny Committees** – On the 13th December we attended the Regional meeting of the Overview and Scrutiny Committees attended by the Chairs of each area. We were afforded significant time to present the campaign progress to date and debate the key issues. Invitations followed from Derby and Nottingham to attend their meetings.

2.5. **Lincolnshire Overview and Scrutiny meeting –** On the 21st December we attended the Lincolnshire OSC meeting which was attended by Mr Will Huxter and Dr Geraldine Linehan from NHS England. The OSC committee raised a large number of concerns and questions and requested information from Mr Huxter which will be forwarded on after the meeting. They have asked that Mr Huxter return to meet the committee on the 18th January 2017 so his responses can be discussed. We have been asked to respond to the points made by Mr Huxter and Dr Linehan for factual accuracy which will be sent before the Christmas break..

2.6. **Invitation to present to MPs –** we have received an invitation from Andrew Stuart MP Chair of the All Party Parliamentary Group for Heart Disease, to present at Portcullis House on the 18th January . The Royal Brompton Hospital and Manchester will also be represented. We have been asked to present a short presentation on the impact of the proposed CHD changes. Dr Aidan Bolger will attend with another Trust representative yet to be confirmed.

2.7. **Leicester Council support –** Cllr Rory Palmer continues to play an active role in our campaign and is meeting Tiffany Jones and Alison Poole on the 11th January to discuss how the council can support the consultation process. He has also confirmed;

- The Leicester Scrutiny process will be organised to sync with the formal consultation process. He has set aside a budget of £50,000 should it be needed as the council's contribution to potential legal challenge costs or commissioning of any specialised work to support consultation responses;
- The 'giant' image from our campaign continues to be projected onto the Ramada Encore in central Leicester

2.8. **Latest communication to NHSE** – on the 20th December we sent a letter to Mr Will Huxter NHS England asking for a formal response to our latest self-assessment. We highlighted that we had only been given three weeks to prepare our response which was sent on the 7th November, and we have not had any reply to date. We also requested that the unanswered questions from our letter dated 13th October should be addressed with some urgency. In this letter we announced the appointment of our two substantive surgical posts, assuring NHS England that caseloads will be managed accordingly in compliance to the standards. The letter can be found in Appendix 1

2.9. **Formal response to Liz Kendal MP -** Following the All Party meeting of MP's with NHS England on the 29th November, Liz Kendall MP asked us to respond to some key points raised by NHS England in respect to their interpretation of our ability to meet the standards. A formal response to each point with evidence was sent to Liz on the 5th December a copy can be found in Appendix 2. Based on our response Liz has requested that NHS England return in January to meet the MP's and explain the variance in interpretation.

2.10. **Stakeholder meetings –** a meeting was held on the 15th December and was well attended by all stakeholders. It was agreed that the meetings should be held monthly and dates have been circulated. Staff update meetings have now been established monthly in addition to the bi weekly update meetings to allow staff opportunities to raise questions and concerns, especially during the consultation process

2.11. **Network engagement –** The Task Group have agreed that it would be beneficial for the Trust to rally support from the existing Network Hospitals that currently use EMCHC services, and write to the CEO's, Paediatric and Adult clinicians in those Trusts within our network that currently do not refer CHD patients to EMCHC.

2.12. **Petition update –** The online petition has reached 43,742 signatures and the offline version has 66,000. The online petition closes on the 22nd January 2017

2.13. **Ward 30 official opening –** the ward was opened official on the 2nd December by Liz Kendall MP and Nicky Morgan MP. We were joined by over 50 patients, family stakeholders and staff and a plaque was unveiled.

## 3. Activity planned over the next month;

3.1. Attendance at OSC meetings in Lincolnshire on the 18th January (with Will Huxter present) and Derbyshire on the 23rd January. We have extended to offer of presenting to all OSC Chairs and will accommodate all requests.

3.2. Following the circulation of the three letters as described above to Network Trusts who currently work with us for their endorsement, the letters will be sent to Peterborough, Northampton and Chesterfield CEO's, and clinicians. We will offer to meet each Trust to discuss what a potential Network partnership may look like, and is required for this to be successful from both Trusts. Network meetings for specialised services will continue to be attended and updates on the campaign will be provided. It is essential we keep our wider stakeholders up to date on progress and rally support.

3.3. Preparation of a short presentation on the potential impact of the NHS England proposals and attendance at the All Party Parliamentary Group for Heart Disease at Portcullis House on the 18th January .

3.4. Preparation of evidence in advance of the consultation which will be tailored once the full consultation questions are made public

3.5. Presentation of the final tally of petitions to Liz Kendall in the Houses of Parliament once the online petition has closed. This will be done by the campaigners who have organised the petition, and once presented will also be taken to the Department of Health and presented there.

3.6. Information and stakeholder contact lists continue to be prepared in advance of the consultation

3.7. 100 short Bio case studies of patients who have attended EMCHC ward 30, PICU and ECMO continue to be prepared. These will be shared by social media channels every day of the public consultation phase to drive awareness of the consultation.

## 4. The key issues and risks associated with this;

**4.1.** The revised self-assessment submission is still subject to review by the assessing panel, the outcome of which will determine the next steps in the process.

## 5. Conclusion The Trust Board are asked to;

5.1. Note the content of the paper

5.2. Provide comments and guidance of any areas deemed appropriate

University Hospitals of Leicester NHS
NHS Trust

**Leicester Royal Infirmary**
Leicester LE1 5WW

Tel: 0300 303 1573

Liz Kendall MP
Houses of Parliament
Westminster
London
SW1A 0AA

5th December 2016

Dear Liz

Firstly, thank you for your continued support in relation to the East Midlands Congenital Heart Service campaign; it is very much appreciated. As you will have seen, we have made reference to the cross party meeting with NHS England in my weekly stakeholder update.

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 seriously disappointed that on the **29th November** NHS England are still raising points against us which we feel are adequately covered in this response. I attach the full response in Appendix 1 which is in the public domain, but for ease I will address each of your questions with a summary of the point highlighted and provide 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. EMCHC 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 are challenging our ability to meet the standard. We strongly 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 of the discussion the intention either of the standards committee or indeed the wider sign off group. This standard is correctly interpreted as running prospectively from the time of implementation (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 EMCHC 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 ONS and a very cautious application of the referrals we believe we can generate from the on-going referral discussions with our network hospitals. Our network development plan is based on hospitals that currently do not offer UHL as an option to their patients, despite it being the Level 1 centre closest to home, now starting to offer UHL 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 . In fact on Tuesday this week, of the 8 patients in our PICU

4 were referred from the network hospitals in question, a clear indication of their willingness to take us seriously.

NHS England has not provided any explanation as to why they do not feel our plans are achievable. We have howeverhad 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 better 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. EMCHC 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. This may be why NHS England decided to ignore the standard in the case of Newcastle, when it is not likely to surpass its present total of 328 cases because the population it serves is modest and not increasing, but does not explain why the choose not to ignore it for EMCHC despite its potential to grow.

c) **Surgeons -** The standards do not require surgeons to be employed in a substantive role and many 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; we will be making an additional appointment from these interviews to allow service development and succession planning. Despite the adverse 'climate' we had 9 high quality applicants for this post; perhaps demonstrating a significant degree of professional solidarity with EMCHC

East Midlands Congenital Heart Service (EMCHC) 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 damage and the difficulties under which we are all now labouring, 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. So intense is the level of scrutiny and so much has the profession struggled under the threats of closure that most British surgeons simply do not appear to want to work in this specialty. There is a steady trickle of those who have trained here who have left to go overseas. Often English centres have had to engage them on a locum basis yet we continue to see from Will Huxter's blog last month and your meeting that NHS England uses this as additional grounds on which to criticise us.

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 approved by the Royal College. We would be grateful if you could keep this information confidential until we have made our formal announcements.

**Point 2 –Network and out of area referrals.** 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 in a number of hospitals within our network that see patients with CHD have well established referral patterns to Great Ormond Street Hospital.

It is evident that NHS England project that by protecting the current referral pathways for the < 175 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.

**Point 3 – Reliance on advice from Birmingham -**This is a wholly unsubstantiated assertion. It is clinical best practice for clinicians to speak about cases. Without a full analysis of all the other centres against which to compare, it is not possible to make any judgement as to whether EMCHC is more or less reliant on this support than any other centre.

NHS England's continued focus on this alleged issue is entirely inappropriate, since it risks discouraging appropriate interaction between centres. As we stated in our previous response, NHS England's own standards A3 (L1), A4 (L1) for clinical best practice expect, and indeed require, clinicians to seek peer advice and support. Every Level 1 centre across the UK will send patients to other centres when capacity dictates or when it is clinically appropriate to do so. Indeed this is something most valued by parent and patient groups alike. High quality medical and surgical learning is an iterative and progressive process; to suggest that EMCHC does not learn from any / all advice given (not all of which is taken, and all of which contributes to our excellent outcomes) is at the very least tautological, if not frankly insulting. To state that seeking additional opinion / sense checking internal decision making currently, implies a risk of future difficulties, is bizarre.

**Point 4 – Co Location being dependent upon funding for the Children's Hospital.** In the self-assessment document sent to NHS England on the 7th November we clearly stated that the co-location of the EMCHC to the children's hospital at the LRI is **not** linked to the main children's hospital project. Capital for the move has been allocated from the Trust's discretionary spend and the project is entirely within our control.

By 2019 all paediatric specialist services will be co-located, including paediatric cardiac services. This will ensure the co-location of the paediatric EMCHC service with other paediatric services at the Leicester Royal Infirmary site. The project, which will also see the expansion of space for the required increase in cardiac activity, will ensure compliance with the NHS England requirement 4.1 and co-location standards D6(L1), D7(L1), and D8(L1) within the given deadline (April 2019). The project **will not require external capital funding**, as it will be funded using a combination of the Trust's Capital Resource Limit and charitable donations. It will be designed as part of (but is not dependent upon) the wider Children's Hospital Project, to ensure the integration of paediatric services to create a defined Children's Hospital in Leicester. For the avoidance of doubt, we confirm the Trust's commitment and ability to achieve co-location by April 2019.

**Point 5 - PICU in Leicester –** the loss of Cardiac surgery from Leicester will seriously impact PICU provision in the region at a time of considerable PICU capacity issues in the UK, with children being transferred very long distances. The lack of any paediatric specialist services at UHL will reduce our ability to attract or retain key staff.

NHS England has identified the University Hospitals of Leicester (UHL) as one of the five Tier 1 providers of acute Specialised Services in the Midlands and East Region. Our PICU is part of the network of centres serving a population of around 17 million. In common with all other specialised PICUs in England, patients with complex needs from quaternary services are essential to maintain the expertise of our staff and attract and retain the best clinicians. We therefore stand by our assessment that any significant change in the flows of children with complex heart problems away from UHL will seriously impact on the viability of our PICU and risks seriously destabilising the wider network. This is even more evident in a week when NHS England has asked the London Hospitals to cease elective paediatric surgery likely to require PICU input, due to winter bed pressures.

**Point 6 – Relocating ECMO across the country -**The quality of the ECMO service will be seriously undermined by spreading the service across the country. As demanded by the CHD standards, quality is improved with numbers; it allows staff to be developed and gain experience. They have not sought advice or input from the ECMO team at Glenfield- the second largest ECMO service in the world, and the only service that offers mobile ECMO.

Over the last few years we have continued to do approximately 50% of the country's ECMO at Glenfield. This represents a significant workload for a single centre and works at Leicester because of the years of experience and the flexibility that the adult service brings in terms of staffing and the ability to treat older kids. In addition we have performed nearly 100% of the countries mobile ECMO; a service that works again due to the unique situation at Glenfield and the very nature of having a permanent ECMO team. It would be unlikely that any centre could build up the necessary experience without having some detrimental effect on outcome.

There are indeed a number of designated additional centres for paediatric respiratory ECMO around the country. However, despite their being designated and favourably funded to do so, this is occurring to a minimal degree. So this again implies that capacity is an issue NOW; how much worse will this be if EMCHC is closed?

The other option would be to disseminate respiratory ECMO to all cardiac centres…again this in our opinion is not a sensible option as it would mean that no centre was doing more

than a handful of cases. For paediatric respiratory ECMO there are rarely more than 20 cases annually across the UK. Expertise would be lost and as the NHSE argument seems to be mainly that quality is gained from quantity, especially at low numbers, then this would be against their whole ethos.

With regard to the review it would be nice if NHSE would divulge the name of their expert in ECMO and exactly what the question he/she has been asked to answer. From your statement it would suggest that the question asked of him/her is “could it be moved” and not “should it be moved” or rather just a general review of the current service

There is a lot of detail in this letter and the attachment; I hope the summary points will help you and your colleagues 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 several lines of argument which we have rebutted on several occasions. This suggests, at best, the lack of a genuinely open mind on their part.

Thank you again for your support.

Kind regards

Yours Sincerely

John Adler

Chief Executive

University Hospitals of Leicester NHS
NHS Trust

**Leicester Royal Infirmary**
Leicester
LE1 5WW

Tel: 0300 303 1573
Fax: 0116 258 7565
Minicom: 0116 287 9852

**Direct Dial:** 0116 258 8940
**Email:** john.adler@uhl-tr.nhs.uk
mandy.johnson@uhl-tr.nhs.uk

Will Huxter
Director of Specialised Commissioning
London Region
Skipton House
80 London Road
London SE16LH

20th December 2016

Dear Will

As the festive break approaches, I am keen that our staff and stakeholders are as informed as possible on the current situation regarding the New Cardiac Review process.

We submitted an updated self- assessment of our compliance with the standards on 7th November, along with our initial impact assessment. Can you please provide me as requested with the minutes and outcome of the assessment panel's findings, assuming that the panel has in fact met? We were given three weeks to prepare our responses and I find it somewhat surprising that 6 weeks later we have heard nothing. I am sure you can understand that my team are very keen to have feedback on the progress we have made.

I also wrote to you on 5th December; this letter contained a number of questions that were still unanswered from our correspondence on the 13th October. Again, I would request that you now respond to those questions with some urgency please.

In your blogs and in fact whenever NHS England is asked to justify their concerns regarding our ability to meet the standards, you raise concerns regarding the sustainability of our service due to the fact we have 2 Locum consultants (despite the fact that the standards do not require our surgeons to be employed substantively and the use of Locum consultants is not uncommon in the Level 1 centres).

In the light of these expressed concerns, we are delighted to inform you that we held interviews on 2nd December and identified two candidates that the panel felt were of the required professional calibre to be appointed. I am sure that you will be as delighted as we are that our service attracted nine highly qualified surgical applicants (despite the obviously difficult context). Due to the quality of the field, we were able to employ our second substantive consultant surgeon, and have established an additional substantive surgical post at Professorial level in conjunction with the University of Leicester. I 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. Details of the two roles and the surgeons will be announced once the appointment process is finalised. We would be grateful if you could keep this information confidential until we have made our formal announcements.

We are also pleased to be able to let you know that the University of Leicester have continued to demonstrate their recognition of the EMCHC service by awarding an Honorary Associate Professorship to Dr Frances Bu'Lock.

May I take this opportunity to wish you and your colleagues a Happy Christmas and a prosperous New Year. I look forward to our continued dialogue in 2017.

Yours sincerely

John Adler
Chief Executive