Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Held: TUESDAY, 4 SEPTEMBER 2012 at 10.00am

P R E S E N T :

Councillor Cooke (Chair of the Committee)
Mrs R Camamile CC (Vice Chair)

Leicester City Council
Councillor Alfonso
Councillor Gugnani
Councillor Naylor
Councillor Sangster
Councillor Singh
Councillor Westley

Leicestershire County Council
Mr A D Bailey CC
Mr R M Wilson CC
Dr R K A Feltham CC
Mr S J Hampson CC

Rutland County Council
Councillor Stpehenson

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr G Jones CC and Mr P A Roffey CC (Leicestershire County Council) and Councillor Parsons (Rutland County Council).

2. DECLARATIONS OF INTEREST

Councillor Alfonso declared an interest in the general business of the meeting, in so far as she had been involved in raising signatures for the petition against the Secretary of State's decision.

Councillor Cooke declared an interest in the general business of the meeting, in so far as his wife was a patient at the Glenfield Hospital.

Councillor Naylor declared an interest in the general business of the meeting, in so far as he had signed the petition and had helped collect signatures for the petition against the Secretary of State's decision and he was a Shadow Governor of the Leicester Partnership NHS.

Councillor Westley declared an interest in the general business of the meeting, in so far as his sister worked in the cardiology unit at Glenfield Hospital and he had been involved in raising signatures for the petition against the Secretary of State's decision.

In accordance with Leicester City Council's new Code of Conduct the interests declared by its Members were not Disclosable Pecuniary Interests but were Other Disclosable Interests and for the Scrutiny Committee Members these were not considered so significant that they were likely to prejudice Members judgement of the public interest. Members were, therefore, not required to withdraw from the meeting as a consequence.

3. DRAFT PURPOSE AND SCOPE OF THE REVIEW

A Draft Purpose and Scope of the Committee's review of the Joint Committee for Primary Care Trusts decision on 4 July 2012 to move health services from Leicester to Birmingham was submitted for approval.

RESOLVED:-

That the draft Purpose and Scope of the Committee's review of the Joint Committee for Primary Care Trusts decision on 4 July 2012 be approved.

4. LETTER TO THE SECRETARY OF STATE

A copy of the letter sent to the Secretary of State indicating that the Joint Health Scrutiny Committee was considering referring the decision of the Joint Committee of Primary Care Trusts (JCPCT) back to Secretary of State once it has heard further evidence and completed the current review was submitted for Members information.

RESOLVED:

that the letter to the Secretary of State be noted.

5. PAEDIATRIC CONGENITAL CORONARY CARE AND ECMO UNITS GLENFIELD HOSPITAL

Members were asked to scrutinise the Joint Committee for Primary Care Trust's decision of 4 July 2012 to move the Paediatric Congenital Coronary Care Unit and the ECMO Unit to Birmingham Children's Hospital.

It was noted that the Decision Making Business Case, Safe and Sustainable, Review of Children's Congenital Heart Services in England: July 2012 could be found at: http://www.specialisedservices.nhs.uk/document/safe-sustainable-review-children-s-congenital-cardiac-surgery-decision-making-business-case. This link also provided access to a number of ancillary documents.

A copy of the Decision Making Business Case had previously been sent to all the Members of the Committee.

It was noted that the City Council's Health and Community Involvement Scrutiny Commission had already heard evidence from the Leicester LINks and the University Hospitals of Leicester at its meeting on 26 July 2012.

RESOLVED:

that the Minutes of the Meeting of Leicester City Council's Health and Community Involvement Scrutiny Commission held on 26 July 2012, together with the supporting reports and background papers that were submitted at that meeting, be received as evidence as part of the scrutiny process.

The supporting reports and background papers were:-

1) Appendix D of the Overview and Scrutiny of Health Guidance issued by the Department of Health.

2) The decision of the Leicester City Council Meeting held on 28 June 2012.

3) The decision of the Leicestershire County Council's Cabinet Meeting held on 23 July 2012.

4) A report from the University Hospitals of Leicester NHS Trust to the Public Trust Board on 26 July 2012 giving an update on the Trust's review of the Secretary of State's decision in relation to securing legal advice and a clinical review of the decisions.

5) A copy of an e-mail from Leicester LINks to all East Midlands MPs together with a briefing note on the outcome of the Safe and Sustainable Review.

6) A paper submitted by Dr Nichani, Consultant Paediatric Intensivist University Hospitals of Leicester (UHL) outlining grounds for challenging the decision made on 4 July 2012 by the Joint Committee for Primary Care Trusts (JCPCT).

6. UNIVERSITY HOSPITALS OF LEICESTER (UHL)

Mr Jim Birrell, Interim Chief Executive and Mr Aidan Bolger, Head of Service for Cardiology, attended the meeting to present evidence on the outcome of the UHL review of the JCPCT's decision in relation to securing legal advice and a clinical review of the recommendations. A report that was submitted to the UHL Trust Board Meeting on 30 August had previously been circulated to Members.

Mr Birrell in presenting his evidence to the Committee made the following comments:-

- That, having considered Counsel's advice, the Board had concluded that challenging the decision of the JCPCT on legal issues was not likely to achieve a beneficial outcome and this route would not be pursued.
- The Board had considered that it had a convincing case to question the JCPCT's decision on clinical grounds based around quality, capacity and risk issues.
- Representatives of UHL had met with Sir Neil Makay last week and had presented their case to him. He had taken the case away to assess it and had subsequently written to the Secretary of State to suggest that the evidence now submitted should be looked at in detail.
- The Board believed that the only route to question the JCPCT's decision was through a formal referral by the Committee.
- The UHL supported the Safe and Sustainable process and felt it was a good model to secure the safest and best quality services and recognised the philosophy of concentrating the best skills in a smaller number of units to achieve this.
- The UHL had also put forward a further option to create a modified midlands unit based on two sites at Birmingham and Glenfield to be subject to single audit, reporting and research processes.

Mr Bolger stated that :-

- The capacity for the proposed midlands' network did not take account of the fact that demands for the services exceeded the capacity at the Birmingham Children's Hospital. The risks of the JCPCT's proposal had been underestimated and there were local, regional and national implications of closing the Paediatric Intensive Care Unit.
- The Safe and Sustainable Committee had commissioned work to predict demand up to 2025 for Paediatric Cardiac Surgery. The only data available to them was surgical data for 2006/07. At that

time there were 4,750 operations and a flat growth of operations were predicted. Data now available up to 2010 indicated a rapid increase in the number of operations to 5,452, an increase of 700 operations per year. This data was not available to the JCPCT at the time it made its decision but UHL felt that it would be negligent to ignore this now. Reference was made to the data on pages 8 and 9 of the UHL report (Appendix C7).

- If the data in the graph on page 9 of Appendix C7 was extrapolated, it showed a marked increase in the predicted number of operations nationally in the future.
- This had implications for the proposed midlands network as the predicted population growth for Age 0-4 years for the period 2010-2015 was 10% for the East Midlands and 9% for the West Midlands compared to national growth rate of 5%. The figures for 2010-2025 showed an increase of 11% for the East Midlands and 8% for the West Midlands. These increases above the national average were not considered as part of the JCPCT's consideration when it decided to move the services from Glenfield to Birmingham.
- The midlands network covered 14 post code areas and the data on page 18 of Appendix C7 showed that the current demand was 611 operations per year, rising to 651 operations in 2015 and 719 operations in 2025.
- In addition to the figures above, there would also be further demands from patients transferring in from other areas. Initial feedback from the Sheffield area indicated that most potential patients would prefer transferring to Birmingham rather than Newcastle, thus putting extra pressure on the services provided at Birmingham. It was predicted that the 611 operations per year would be nearer 900-1000 operations per year and this had not been accounted for in the Safe and Sustainable modelling process.
- It was considered that it was not possible to sustain 1,000 operations per year; given that it required 7 nurses per day to maintain 1 Intensive Care bed and 13 nurses per day to support 1 ECMO bed. It was felt that this was too much for one single centre to cope with, especially as this level of service would be unprecedented in the UK and it was questioned whether a unit operating on this scale could be found within Europe. There were also concerns that a unit trying to provide services for 1,000 operations per year would become prone to unavoidable inefficiencies.
- The Glenfield survival rates for ECMO treatment were far superior to the national and international figures currently available.
- The JCPCT were not aware of the ECMO data and unless the new unit at Birmingham provided the same quality of service as Glenfield then the mortality rate would increase and, based upon past data, this could translate into an additional 50 children per year dying.
- The JCPCT's decision had a major impact on the Paediatric

Intensive Care Unit (PICU) provision. There was already a national shortage in this area and in 2010 Glenfield had taken 87 patients from the West Midlands. This would mean that the gap in under provision would get bigger if Birmingham were required to take up the extra capacity in the future.

- 40% of PICU cases at Glenfield were related to ECMO and cardiac services compared to 29% at Southampton and whilst the loss of the PICU at Southampton had been recognised by the JCPCT the same principles had not been applied to Glenfield in the review.
- If the PICU closed at Glenfield, it would leave the East Midlands short of PICU beds, since the only other unit would be at Nottingham; and they were stretched to capacity already.

Members of the Committee raised a number of questions in relation to comments made by Mr Birrell and Mr Bolger and in response they stated that:-

- It was considered that the JCPCT had not been negligent in making their decision, they had been faced with making a difficult decision and had made that decision on the data available to them at the time in the interests of securing the safest and sustainable services in the future. The data now available presented a challenge to the basic premise of the decision.
- The UHL were assured by Sir Neil McKay that the additional data presented to him would be looked at in detail and, although he had indicated that the JCPCT had concluded its representations to the Secretary of State, things could be reconfigured differently if the Independent Reconfiguration Panel made recommendations to the Secretary of State.
- The population data now provided strong evidence that the capacity for the future has been underestimated. This had been brought to the attention of Sir Neil and it will now be considered.
- The cost of implementation was one factor in the decision making process for selecting the current preferred options. It was felt that driving force behind the exercise was not primarily to save money; as it was likely that the future service provisions would cost more than currently. The main driver and focus had been on providing high quality expertise and services at fewer centres.
- The UHL did not consider that they had ruled out a legal challenge too lightly or too early. They were satisfied that, based upon the advice they had received, a challenge on legal grounds would only have resulted in the same decision being reached. The clinical case provided a stronger method of challenge.
- Generally, the increase in the number of operations required would match the growth in population rates as 1 in 200 babies were born with a congenital heart defect. In addition, advances in techniques and technology meant that it was now possible to provide a more comprehensive level of service. The success rate for children surviving after the first operation was higher than ever before and 25% of children receiving surgery required further

operations. This all added to further pressures in increasing the number of operations required in the future.

- Given the number of staff required to support and ECMO bed, it was questionable that sufficient staff could be recruited in sufficient numbers locally to replace the loss of the current staff at Glenfield and the increased pressures on the service in the future. The clear message from the staff survey at Glenfield was that it would be wrong to assume that staff in the ECMO unit at Glenfield would transfer to Birmingham.
- It had not been possible to undertake a feasibility study on the proposal to create one unit on two sites as dialogue only started last week. The proposal envisaged both sites scaling up to deal with the projected future demand that was now envisaged. A feasibility study could be concluded, however, in the timescale envisaged. It was felt that the option was a sensible approach as it did not compromise the integrity of the safe and sustainable exercise or its principles.
- If the suggested option was taken up, it was envisaged that the ECMO unit would be retained at Glenfield along with paediatric cardiac surgery.
- The National Specialist Commission Group provided the budget for the paediatric cardiac surgery at Glenfield which was in the region of £2.5m. The impact of losing the paediatric cardiac surgery was more significant and had a potentially bigger impact upon the services provided at the hospital than the impact of the transfer of the current budget to Birmingham.
- The JCPCT had not been convinced by the UHL arguments that there was instant access between the two sites in Leicester and Glenfield. As a result of that, the UHL had addressed the issues last October and transferred some Ear Nose and Throat (ENT) staff to Glenfield to provide a 24 hour service at Glenfield.
- There was a typographical error in the table on page 7 of Appendix C7 figure. The figure for the validated CCAD data for 'infant' for 2010 should be 1,770 and not 1,170 as printed.
- UHL were surprised that the Glenfield only received a score of 2 (Poor) for Innovation and Research Capacity. (Page 156 of the JCPCT's Decision Making Business Case) It was noted that the initial request for information had been a 'dry' process and whilst the documentation requested had been supplied, Glenfield appeared to have been underscored in some areas compared to other centres. Glenfield had been marked down for sustainability despite increasing the number of beds from 8 to 12. The generic process of information gathering had not been scoped to include the national service provision of ECMO.
- It was felt that the impact of transferring the ECMO unit had been underestimated by the JCPCT and it was encouraging that Sir Neil Mckay had expressed surprise at the evidence now provided in relation to the evidence given to the JCPCT and the fact that the advice of the ECMO world expert had been ignored. Furthermore, the JCPCT did not have the data relating to the

survival rate at Glenfield up to 2010 when they had made their decision.

The Committee thanked Mr Birrell and Mr Bolger for their contribution to the meeting.

7. UNIVERSITY OF LEICESTER

Sir Bob Burgess, Vice Chancellor, University of Leicester supported by Jo Wood, Assistant Registrar, University of Leicester attended the meeting to highlight and publicise the excellence of Leicester University and the research/training benefits and links with the Glenfield Heart Unit facilities.

The Vice Chancellor thanked the Committee for the opportunity to submit evidence and made the following comments:-

- The University had built up considerable achievements and expertise in research since 1974. This had led to a reputation and ethos which attracted high calibre people who wanted to work in a successful research environment.
- The work of the Cardiovascular Research Centre provided benefits to both the local and national provision of cardiovascular services.
- This had been further recognised when the Secretary for State had visited the Cardiovascular Biomedical Research Unit and had stated that the 'centre cemented Glenfield's reputation as a leading international heart hospital.'
- The University was judged as 'internationally excellent' in the rigorous 2008 Research Assessment Exercise. 95% of the submissions were judged to be of international standing and 55% of the submissions had been placed in the top two grades compared to 40% for Birmingham University.
- Considerable funds had been raised from external sources based upon the success of the research and the close working arrangements with Glenfield Unit. £13m had been raised in the last two years for the construction of the Cardiovascular Research Centre with approximately £6m being donated by local philanthropists.
- The University had recently secured £7m of investment through the van Geest Foundation and staff involved in the Cardiovascular Research Centre had independently secured £20m of funds in the last three years. The ability of the University to secure future investment and funding could be jeopardised if cardiovascular and ECMO services were lost at Glenfield as this would impact negatively on the current comprehensive cardiovascular service that had been built up over a long period of time. The ability to raise funds was dependent upon having a

comprehensive range of services available and often local philanthropists donated generously because they or a family member had been treated at the Glenfield Hospital. This local connection would be lost if services transferred.

- The current paediatric surgery and ECMO made a substantial contribution to published work on trials and other work by staff in the Lancet and the New England Journal of Medicine.
- Professor N Samani, Director Leicester NIHR Biomedical Research Unit in Cardiovascular Disease had originally trained at the University and had an international reputation. He had a support staff of 30 academics, 150 researchers as well as clerical, technical and manual staff. Any diminution of the services and opportunities currently available could have detrimental impacts upon these staff as well.
- Currently there are a number of Professors who were undertaking research of international recognition in the following fields:-
    - Genetic factors in heart disease;
    - Advances in controlling blood pressure;
    - Stents for coronary heart disease;
    - Strokes;
    - Diabetes prevention; and
    - Valve replacement surgery.
- The current reputation for research and the close working with the Glenfield Hospital attracted the appointment of high calibre consultants and many worked part time in research and part time in delivering clinical services in the hospital, which was to the mutual benefit of both institutions. Many consultants also held honorary positions at the University.

Following questions from members of the Committee, the Vice Chancellor commented that:

- Experts migrate from environments where they cannot pursue their research or where there is not a comprehensive range of services available. Transferring the paediatric congenital coronary care unit and the ECMO unit would make Leicester less attractive to experts.
- Research activity directly impacted upon clinical practice and skills. Skills developed in Leicester attracted national and international interest from specialists who visited the hospital to acquire those skills.
- It would be worth investigating whether monies raised locally were tied to local services.

The Vice Chancellor was thanked for his contribution to the meeting.

8. RESPONSES FROM EAST MIDLANDS HEALTH AND OVERVIEW SCRUTINY COMMITTEES

The responses received from other East Midlands Health Overview and

Scrutiny Committees were submitted to the Committee for information.

RESOLVED:

that the responses from other East Midlands Health Overview and Scrutiny Committees be noted.

9. EAST MIDLAND LINKS

A copy of a press release issued by the East Midlands Local Involvement Networks supporting the University Hospitals of Leicester's clinical case for review of the closure of the Glenfield Paediatric Cardiac Care Centre was circulated at the meeting.

RESOLVED:

that the press release be noted.

10. BUSINESS FOR THE NEXT MEETING

The Chair stated that a number of attempts had been made to arrange for the Committee to hear evidence from Sir Neil McKay and his Team from the Joint Committee for Primary Care Trusts (JCPCT). The original approach had been made on 27 July and on 1 August an invitation had been made for the team to present evidence at this meeting but the JCPCT Team had indicated they were unable to attend and they wished to send as strong a Team as possible to give evidence and explain their decision. A further offer was then made to arrange a meeting in October on dates suitable to them. An e-mail had been received earlier in the day stating that the only date they could attend a meeting was 29 October 2012, although the date was still provisional.

The Chair stated that he wished for the Scrutiny process to be as thorough as possible but felt that delaying the process until the end of October could compromise the Committee's position in making a referral to the Secretary of State.

The Chair further commented that it had been brought to his attention the previous day that Lincolnshire County Council's Health Scrutiny Committee had already referred the JCPCT's decision to the Secretary of State on 27 July 2012. The Secretary of State had responded to their referral letter on 8th August 2012 stating that he had referred the matter to the Independent Reconfiguration Panel (IRP) and had asked them to report back to him by 21 September. In view of this it was felt that it would be inappropriate to wait any longer before following up the letter sent to the Secretary of State on behalf of the Committee on 23 August (Appendix B).

The Chair therefore submitted a number of proposals which were circulated to the Committee. Following discussion of these proposals it was unanimously:

RESOLVED:

1) that the Committee considers that the evidence submitted at the meeting at Minute 5 above, together with the evidence

from the UHL and the University of Leicester, is sufficiently strong enough upon which to make a decision to make a referral to the Secretary of State;

2) that in view of the response of the Secretary of State to the referral made by Lincolnshire County Council indicating that the Independent Reconfiguration Panel (IRP) was undertaking an initial review with a view to reporting back by 21 September, the Committee needs to ensure that the additional evidence in its referral is taken into account by the IRP before it submits its views to the Secretary of State on 21 September;

3) that in view of the urgency, the Committee should respond to the Secretary of State by the end of the week and that the Chair and Vice Chair be given delegated authority to approve the response which will then be circulated to all members;

4) that given the attempts to invite the JCPCT to give evidence to this Committee today and their unavailability to attend until the end of October at the earliest, the Committee considers that it cannot wait to hear evidence from them before making a formal referral to the Secretary of State; and

5) that a copy of the referral be sent to the JCPCT who are understood to be meeting on 4th October for their information.

11. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

12. CLOSE OF MEETING

The Chair declared the meeting closed at 3.56pm.