LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: **THURSDAY, 18 AUGUST 2016**

Time: **4:00 pm**

Location:

MEETING ROOM G.01, GROUND FLOOR, CITY HALL, 115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey

For Monitoring Officer

NOTE:

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http://www.leicester.public-i.tv/core/portal/webcasts

MEMBERS OF THE BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor, Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor, Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor, Public Health

Councillor Sarah Russell, Assistant City Mayor, Children, Young People and Schools

City Council Officers:

Frances Craven, Strategic Director Children's Services

Steven Forbes, Strategic Director of Adult Social Care

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Trish Thompson, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Steve Robinson-Day, Collaboration Manager, Leicestershire Fire and Rescue Service

Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

STANDING INVITEES: (Not Board Members)

Kaye Burnett, Chair, Better Care Together Programme
Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust

Information for members of the public

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. APPOINTMENTS TO THE BOARD

Appendix A Page 1

The Monitoring Officer to report that the Council appointed the following Members to the Board at its meeting on 14 July 2016:-

Councillors

Councillor Piara Clair Singh – Assistant City Mayor, Culture Leisure and Sport.

NHS Representatives

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Healthwatch / Other Representatives

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Steve Robinson-Day, Collaboration Manager, Leicestershire Fire and Rescue Service

A representative of the city's sports community – to be appointed

A representative of the private sector/business/employers – to be appointed

In addition the Chair has also issued a standing invitation to the following to attend meetings as non-voting members of the Board.

Kaye Burnett, Chair, Better Care Together Programme

Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust
A representative of the Primary Care Sector – to be appointed.

The Local Policing Unit has also informed the Monitoring Officer that their representative on the Board is now Chief Superintendent Andy Lee, Head of Local Policing Directorate, following Chief Superintendent Sally Healy's retirement. Supt Kerry McLernon has also been nominated to attend the Board in Chief Superintendent Lee's absence.

The revised Terms of Reference for the Board to reflect these changes are attached for information.

4. MINUTES OF THE PREVIOUS MEETING

Appendix B
Page 7

The Minutes of the previous meeting of the Board held on 6 June 2016 are attached and the Board is asked to confirm them as a correct record.

5. NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES AT UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Appendix C
Page 17

NHS England to present a report on their proposals for the future provision of congenital heart disease services with particular reference to University Hospitals of Leicester NHS Trust.

Will Huxter, Senior Responsible Officer for the Congenital Heart Disease Review and Regional Director of Specialised Commissioning (London) and Christine Richardson from the local specialised commissioning team will attend the meeting to present the report.

Supporting Documents

A copy of the Deputy City Mayor's letter to the Secretary of State on 13 July 2016 requesting the decision to be reviewed and reversed is attached at **Appendix C1** (**Page 33)**

A copy of the decisions already taken by Leicester City Council and Leicestershire County Council on Children's Heart Surgery at Glenfield Hospital following NHS England's announcement are also attached at **Appendix C2** (**Page 35)**.

6. PRIMARY CARE STRATEGY

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Page 39

Leicester City Clinical Commissioning Group to give a presentation on the challenges faced by primary care in the city and the plans being developed for a Primary Care Strategy to address these. The strategy will be finalised once the local Sustainability and Transformation Plan is completed in September 2016, which is including work around general practice. In addition it will be informed by the Primary Care Summit which is being held on 9 September 2016.

Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group, will attend the meeting to present the item.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

8. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Monday 10th October 2016 – 3.00pm
Thursday 15th December 2016 – 5.00pm
Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

9. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Health and Wellbeing Board

Terms of Reference

(As amended at the Leicester City Council meeting on 14 July 2016)

Introduction

In line with the Health and Social Care Act 2012, the Health & Wellbeing Board is established as a Committee of Leicester City Council.

The Health & Wellbeing Board operated in shadow form since August 2011. In April 2013, the Board became a formally constituted Committee of the Council with statutory functions.

1 Aim

To achieve better health, wellbeing and social care outcomes for Leicester City's population and a better quality of care for patients and other people using health and social services.

2 Objectives

2.1 To provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and in work to reduce health inequalities.

2.2 To lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.

2.3 To maximise opportunities for joint working and integration of services using existing opportunities and processes and prevent duplication or omission.

2.4 To provide a key forum for public accountability of NHS, public health, social care for adults and children and other commissioned services that the Health &Wellbeing Board agrees are directly related to health and wellbeing.

3 Responsibilities

3.1 Working jointly, to identify current and future health and wellbeing needs across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required. Preparing the JSNA is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.2 Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities.

3.3 Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and supported by all stakeholders. This will set out strategic objectives, ambitions for achievement and how we will be jointly held to account for delivery. Preparing the JHWS is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.4 Save in relation to agreeing the JSNA, JHWS and any other function delegated to it from time to time, the Board will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties

3.5 Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the Joint Strategic Needs Assessment and demonstrate strategic alignment between the JHWS and each organisation's commissioning plans.

3.6 Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JHWS has been implemented in their commissioning decisions.

3.7 To monitor, evaluate and annually report on the Leicester City Clinical Commissioning Group performance as part of the Clinical Commissioning Groups annual assessment by the national Commissioning Board.

3.8 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.9 Ensure that the work of the Board is aligned with policy developments both locally and nationally.

3.10 Provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of Leicester City Clinical Commissioning Group to ensure that the Board is publically accountable for delivery.

3.11 Oversee progress against the Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes

3.12 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the relevant Scrutiny Commissions of Leicester City Council. Decisions taken and work progressed by the Health & Wellbeing Board will be subject to scrutiny by relevant Scrutiny Commissions of Leicester City Council.

3.13 The Board will need to be satisfied that all commissioning plans demonstrate compliance with the Equality Act 2010, improving health and social care

services for groups within the population with protected characteristics and reducing health inequalities.

3.14 The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes.

4 Membership

Members:

Up to five Elected Members of Leicester City Council (5)

- The Executive Lead Member for Health & Wellbeing (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)

Up to six representatives of the NHS (6)

- The Co -Chair of the Leicester City Clinical Commissioning Group (1)
- A further GP representative of the Leicester City Clinical Commissioning Group (1)
- The Managing Director of the Leicester City Clinical Commissioning Group (1)
- The Locality Director Central NHS England – Midlands and East (1)
- The Chief Executive of University Hospitals NHS Trust (1)
- The Chief Executive of Leicestershire Partnership NHS Trust (1)

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Adult Social Care (Leicester City Council) (1)
- The Strategic Director Children (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- The Chief Operating Officer of Leicester City Council (1)

Up to eight further representatives including Healthwatch Leicester/Other Representatives (8)

- One representative of the Local Healthwatch organisation for Leicester City (1)
- Leicester City Local Policing Directorate, Leicestershire Police (1)
- The Leicester Leicestershire and Rutland Police and Crime Commissioner (1)
- Chief Fire and Rescue Officer, Leicestershire Fire & Rescue Service (1)
- Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board (2)
- A representative of the city's sports community (1)
- A representative of the private sector/business/employers (1)

5 Quorum & Chair

5.1 For a meeting to take place there must be at least six members of the Board present and at least one representative from each of the membership sections:

- Leicester City Council (Elected member)
- Leicester City Clinical Commissioning Group or NHS England
- One senior officer member from Leicester City Council
- Local Healthwatch/Other Representatives

5.2 Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

5.3 Where any member of the Board proposes to send a substitute to a meeting, that substitute's name shall be properly nominated by the relevant 'parent' person/body, and submitted to the Chair in advance of the meeting. The substitute shall abide by the Code of Conduct.

5.4 The City Council has nominated the Executive Lead for Health & Wellbeing to Chair the Board. Where the Executive Lead for Health & Wellbeing is unable to chair the meeting, then one of the other Elected Members shall chair (noting that at least one Elected Member must be present in order for the meeting to be declared quorate)

6 Voting

6.1 Officer members of Leicester City Council and any representatives of bodies asked to attend meetings of the Board as 'Standing Invitees' by the Board shall not have a vote. All other members will have an equal vote.

6.2 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is require decisions will be reached through a majority vote of voting members; where the outcome of a vote is impasse the chair will have the casting vote.

7 Code of conduct and member responsibilities

All voting members are required to comply with Leicester City Council's Code of Conduct, including submitting a Register of Interests.

In addition all members of the Board will commit to the following roles, responsibilities and expectations:

7.1 Commit to attending the majority of meetings

7.2 Uphold and support Board decisions and be prepared to follow though actions and decisions obtaining the necessary financial approval from their organisation for the Board proposals and declaring any conflict of interest

7.3 Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties. Champion the work of the Board in their wider networks and in community engagement activities.

7.4 To participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery

7.5 To ensure that are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the Board to be effectively disseminated.

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

8.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the working subgroups of the Health & Wellbeing Board.

8.3 Meetings will be held six times a year and the Board will meet in public and comply with the Access to Information procedures as outlined in Part 4b of the Council's Constitution.

8.4 The first meeting of the Health and Wellbeing Board was on 11 April 2013.

Version 9.3
As amended at Council on 14 July 2016

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 6 JUNE 2016 at 10.00am

Present:

Karen Chouhan	–	Chair, Healthwatch Leicester.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Wendy Hoult	–	BCF Implementation Manager, NHS England – Midlands and East (Central Midlands).
Andy Keeling	–	Chief Operating Officer, Leicester City Council.
Superintendent Mark Newcombe	–	Local Policing Directorate, Leicestershire Police.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City Council.
Professor Martin Tobin	–	Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

* * * * * * * *

1. APOLOGIES FOR ABSENCE

Councillors Rory Palmer (Chair due to unforeseen circumstances), Adam Clarke and Abdul Osman (Leicester City Council), Francis Craven (Strategic Director Children's Services), Professor Azhar Farooqi (Vice Chair Leicester City Clinical Commissioning Group), Chief Supt Sally Healy (Head of Local

Policing Directorate, Leicestershire Police), Sue Lock (Managing Director Leicester City Clinical Commissioning Group), Dr Avi Prasad (Leicester City Clinical Commissioning Group) and Trish Thompson (Locality Director, Central NHS England).

2. APPOINTMENT OF CHAIR

RESOLVED:

That the Director of Public Health be appointed Chair for the meeting due to Councillor Palmer's unforeseen absence.

3. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

4. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from members of the public.

Ms Jean Burnage asked a number of questions relating to Better Care Together. The Chair suggested that these be taken as part of the presentation on the Better Care Together later on the agenda.

Mr Martin Trainer asked why the University Hospitals of Leicester NHS Trust was not represented on the Board.

In response the Chair stated that Councillor Palmer had recently written to Board members with a view to reviewing the Board's membership and that changes would be announced in due course.

Wendy Hoult (BCF Implementation Manager, NHS England Central Midlands) stated that other Health and Wellbeing Boards within her area of responsibility had representatives of major health service providers on their Boards.

5. MEMBERSHIP OF THE BOARD

The Board noted its membership for 2016/17 as approved by the Council on 19 May 2016as follows:-

<u>City Councillors</u>
Councillor Rory Palmer - Deputy City Mayor – Chair
Councillor Adam Clarke – Assistant City Mayor – Energy and Sustainability
Councillor Abdul Osman – Assistant City Mayor - Public Health
Councillor Sarah Russell – Assistant City Mayor – Children, Young People and Schools

<u>NHS Representatives</u>

Professor Azhar Farooqi – Co-Chair of the Leicester City Clinical

Commissioning Group
Sue Lock, Managing Director - Leicester City Clinical Commissioning Group
Trish Thompson - Director of Operations and Delivery, Leicestershire and Lincolnshire NHS England
Dr Avi Prasad - Co-Chair of the Leicester City Clinical Commissioning Group

City Council Officers

Andy Keeling - Chief Operating Officer
Frances Craven - Strategic Director – Children's Services
Stephen Forbes - Strategic Director - Adult Social Care.
Ruth Tennant - Director of Public Health

Local Healthwatch and Other Representatives

Karen Chouhan - Chair, Healthwatch Leicester
Chief Supt Sally Healy - Head of Local Policing Directorate
Professor Martin Tobin - Professor of Genetic Epidemiology and Public Health

6. TERMS OF REFERENCE

The Board noted its Terms of Reference that were approved by the Council on 19 May 2016.

7. MINUTES OF THE PREVIOUS MEETING

AGREED:

The Minutes of the previous meeting of the Board held on 2 February 2016 be confirmed as a correct record.

8. ADJOURNMENT OF MEETING

At 10.30am it was agreed to adjourn the meeting for 15 minutes as the Programme Director Better Care Together had been delayed at an earlier meeting.

At 10.45am the meeting resumed with all those who had been present when the meeting adjourned. The Programme Director Better Care Together was also present.

9. BETTER CARE TOGETHER

The Programme Director Better Care Together (BCT) presented a report that provided an update on the progress of the BCT health and social care change programme for Leicestershire, Leicester and Rutland. Members also received a presentation that gave an overview of the programme.

During the presentation it was noted that:-

a) The BCT programme was run through a series of work-streams considering a specific area for improvement in quality of care and sustainability.

b) BCT was in its third year of planning and had now become part of the process to produce a Sustainability and Transformation Plan (STP) announced earlier this year. The BCT provided a platform for producing the STP which other parts of the country did not have as their BCT programmes were not as advanced.

c) Work-streams were currently being reconfigured.

d) There was a Partnership Development session later in the week and representatives from the city were encouraged to attend.

e) There had already been changes to some services which did not require public consultation but those involving the overall changes to UHL and the future of the General hospital site, maternity services and the changes to community hospital services would require public consultation before any changes could be made.

f) The consultation process for BCT had been delayed by the introduction of the STP process. No consultation could take place until the financial elements of the STP had been approved by NHS England later in the autumn.

In response to the questions asked by a member of the public earlier it was noted that:-

a) Although the stroke unit was moving to the Evington Centre, this building was still on the General Hospital site.

b) The savings targets identified in the pre- business case were indicative targets to indicate the funding gap that would exist in five years' time if no service improvements were made. Treating patients in the acute sector was the most expensive way of treating patients and BCT was looking to provide different ways of coping with the extra demands being made on services within the future financial envelope.

c) The Mental Health Team were working to improve the availability of mental health services to patients before they reach a crisis point. This involved supporting patients arriving at UHL with early access to mental health services, rehabilitation centres were providing patients with new skills to enable them to integrate back into society more easily. Work was also under way to review out of county placements to see if treatment could be provided nearer to home.

Members of the Board received the following responses to their questions:-

a) Prevention and promoting wellbeing were important threads of BCT and

as it moved forward federations and the voluntary sector would have an important part to play in shaping services to enable a reduction in patients being admitted to the acute sector.

b) The Police were keen to be involved in shaping mental health services as they had regularly had early engagement in dealing with people involving mental health and safeguarding issues.

c) The Patient Participation and Assurance Group had recently changed its terms of reference and the new Chair was now in place and looking at how BCT could have effective engagement with the public.

d) Over 500 different engagement events had taken place and the feedback received had been reflected in service proposals. Whilst there had been satisfactory patient participation in the engagement events ways of further strengthening this involvement was being considered.

e) Initial evidence from providing increased community services for patients did not currently show a reduction in acute admissions and BCT was looking to see if different practices in other areas of the country were producing better results.

Members observed that there had been a growing demand on acute services for some time and that more needed to be done to understand the reason for this increase in order to reduce it. It was noted that this was a national trend and that although current initiatives were currently stemming the tide a radical rethink of how the health system coped with future demands was required.

It was reported that there was evidence that health trusts in Dorset, London and South Warwickshire had seen reductions in demand.

RESOLVED:

That the Programme Director Better Care Together be thanked for the presentation and the progress to date be noted.

10. SUSTAINABILITY AND TRANSFORMATION PLAN

Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group presented a report that provided information on the development of the Sustainability and Transformation Plan (STP) for Leicester, Leicestershire and Rutland. Members also received a presentation on the Sustainability and Transformation Plan Checkpoint Submission.

It was noted that the STP was a place based plan to accelerate the implementation of the Five Year Forward View required in the NHS Planning Guidance 2016/17 – 2020/21. The STP covered all areas of CCG and NHS England commissioned services including specialised services and primary medical care. The plan also covered the better integration with local authority services.

The Better Care Together programme would form an integral part of the STP and Leicester, Leicestershire and Rutland were ahead of many areas of the country in developing the BCT programme.

In developing the STP each area has to show how they are going to ensure sustainability in the following areas:-

- Health and Wellbeing
- Improving care and quality
- Ensuring financial sustainability

The feedback from NHS England on the initial submission in April had been positive and further work was ongoing to develop where LLR can go further on the three areas listed above. A detailed submission has to be submitted to NHS England by 30 June 2016 and this will be based upon both the BCT Programme and the STP emerging priorities.

The emerging priorities for the STP were:-

- BCT Phase 1 service reconfiguration.
- Public sector efficiency.
- Prevention.
- Urgent and emergency care.
- Mental Health.
- Integrated place based community teams.
- Primary medical care.
- Digital technology.
- Public sector estate.
- Health and care workforce.
- LLR place based system approach.

These priorities would be developed by the 6 STP work-streams of:-

- Improving health outcomes and independence.
- Delivering care in the right place.
- Making better use of resources.
- Integrated place based teams.
- Resilience in primary care.
- System leadership.

It was expected the STP would not be finally approved until late autumn. As part of this process the pre-consultation business case for the BCT was being refreshed. As a consequence, public consultation on BCT could not start until this business case had been approved.

Following questions from members the Director Strategy and Implementation commented that:-

a) There was patient participation involvement through the BCT

Programme and the Chair of the Patient Participation Group would be in attendance at the meeting on BCT referred to earlier in the meeting.

b) There was a transformation fund available for 2017/18 to reconfigure services; but access to this was dependent upon producing satisfactory plans.

c) BCT and STP provided an opportunity to work with community and voluntary sector groups to contribute to health service provision especially within the prevention strategy.

In response to the Chair's question on how the Board can add value to this work, it was noted that the demand on the acute sector from city residents was higher than other areas of LLR and the Board's should be involved in assisting to stem the demand and ensuring the plans for public consultation were robust. The Chair commented that the Board were looking at 'prevention' as a topic and recognised that the response to this issue in the city was different to that in the county and that it needed to involve a multi-agency approach.

Healthwatch indicated that they would welcome being involved in discussions with the community and voluntary sector groups.

The Local Policing representative referred to the 'Braunstone Blues' initiative with Blaby District Council to deliver a healthier, safer and more secure community. In addition to offering advice on safety and security issues the multi-agency team also offer help with loneliness, anxiety, depression and dealing with antisocial behaviour. The scheme could be rolled out elsewhere. It was recognised that the commissioning system did not operate that allowed mutual risks to be shared by multi-agency initiatives.

RESOLVED:

1) That the development of the Sustainability and Transformation Plan for Leicester, Leicestershire and Rutland be noted.

2) That the Board's involvement in the developing issues for STP be considered further at a development session.

11. BETTER CARE FUND

Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group presented a report on the Leicester City Better Care Fund (BCF) 2016/17.

It was noted that:-

a) The BCF approval process required each area to submit a 2 part plan; a planning templated detailing activity, finance and a metrics plan and a narrative plan providing a detailed description of plans for 2016/17.

b) Both parts the plan were jointly produced by the CCG and Council and approved by the Joint Integrated Commissioning Board and the Chair of the Board prior to submission.

c) The plans were submitted through the Regional Assurance and Support process and the review panel indicated that the submission highlighted the ongoing commitment to the BCF programme and the narrative descriptors gave confidence that plans were in place to deliver against the BCF outcomes in 2016/17.

d) There would be ongoing monitoring through the Joint Integrated Commissioning Board and further reports would be submitted to this Board.

e) The delivery model was based upon 3 key priority areas of:-

- Prevention, early detection and improvement of health related quality of life.
- Reducing the time spent in hospital avoidably.
- Enabling independence following hospital care.

These were now an integral part of the BCT work-stream.

The Central NHS England representative commended the plan and the work the city had done on the BCF and observed that the review and revision of the plan had been very effective.

It was noted that the number of non-elective admissions among the younger population was growing and that it may be beneficial to increase investment in a prevention-focused life-style hub for people over 40 years old to meet those challenges.

RESOLVED:

That the two components of the Leicester City better Care Fund Plan 2016/17 be approved.

12. PREVENTION

It was noted that the Deputy City Mayor had intended to lead on this item and the Board agreed to defer it to a future meeting.

13. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

Monday 1st August – 2.00pm
Monday 10th October – 3.00pm
Thursday 15th December – 5.00pm
Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board were scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

14. ANY OTHER URGENT BUSINESS

There were no items to be considered.

15. CLOSE OF MEETING

The Chair declared the meeting closed at 11.42am.

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD

18 August 2016

Title of the report:	NHS England's proposals for congenital heart disease services at University Hospitals of Leicester NHS Trust
Author:	Will Huxter, NHS England SRO for the Congenital Heart Disease Review, and Regional Director of Specialised Commissioning (London)
Presenter:	Will Huxter

Purpose of report

This paper provides a briefing for the Health and Wellbeing Board on NHS England's proposals for the future provision of congenital heart disease services, with particular reference to University Hospitals of Leicester NHS Trust.

Background

In July 2015, the NHS England Board agreed new standards and service specifications for congenital heart disease (CHD) services, with the expectation that in future all providers would meet the standards, leading to improvements in service quality, patient experience and outcomes. NHS England is the direct commissioner of CHD services, as prescribed specialised services.

The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:

> ***Specialist Surgical Centres (level 1)***: These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology. (Leicester is currently a level 1 centre.)
>
> ***Specialist Cardiology Centres (level 2)***: These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.
>
> ***Local Cardiology Centres (level 3)***: Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.

The Board agreed a go-live date of April 2016 for implementation of the new standards, embedded in contracts with providers, with a standard specific timetable

to achieve full compliance.

The Board agreed proposals for commissioning the service and endorsed initial work with providers to develop proposals for ways of working to ensure the standards would be met.

Work with providers commenced in April 2015, culminating in submission of proposals in October 2015. Seven submissions were received, some from networks based on a single surgical centre, others from new multi-centre networks. Leicester submitted a joint proposal with Birmingham.

The proposals were comprehensively assessed by a commissioner led panel, with clinician and patient/public representation. The panel advised that certain standards were considered particularly important determinants of service quality and safety:

- All surgeons should be part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and that each surgeon must undertake at least 125 operations per year. From April 2021 the aim is a minimum 1:4 rota.
- Surgery must be delivered from sites with the required service interdependencies.

The assessment was discussed at NHS England's Executive Group Meeting (EGM) in December 2015. EGM accepted the panel's assessment that, taken together, the provider proposals did not provide a national solution; and giving more time would not yield a different outcome; and that developing a national solution would require significant support and direction by NHS England. EGM agreed that action should be taken to ensure that the April 16 standards were met as soon as possible, with immediate action to ensure that appropriate short term mitigations are put in place in the meantime to provide assurance of safety. This approach was endorsed by the Specialised Services Commissioning Committee (SSCC) at its meeting in February 2016.

The assessment process

A process to assess compliance with selected standards was launched in January 2016. It focused on 24 paediatric standards (and the matching adult standards) most closely and directly linked to measurable outcomes (including the surgical and interdependency standards previously highlighted by SSCC) and to effective systems for monitoring and improving quality and safety.

Providers of CHD services, including Leicester, were asked to evidence their compliance with the 2016 standards. While the focus was on the 2016 standards, NHS England also took account of the ability of providers to reach the 2021 standards.

Where standards were not met providers were asked to provide plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one than gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective on 1 April 2016.

The process was based on NHS England's standard approach when introducing a new service specification for any specialised service.

Our initial assessment showed that additional information would be needed in order to complete the process. This was requested from all the hospitals involved in March 2016 to make sure that every hospital had the opportunity to supply all the relevant information before we completed our assessment. We gave initial feedback on the findings of the first round at a meeting with clinicians on 18 March, and explained why further detail was being requested. These additional returns were assessed in April 2016.

Each set of returns was initially evaluated at a regional level by the NHS England specialised commissioning team, followed by a national panel to ensure a consistency of approach. The national panel brought together NHS England staff from both national and regional teams with representatives from the Women and Children's Programme of Care Board and the Congenital Heart Services Clinical Reference Group to provide wide ranging and senior clinical advice and patient and public perspectives.

The panels were asked to concentrate on this assessment of compliance rather than trying to answer the question 'what should NHS England do?' The driver for this work has been to ensure delivery of the standards.

Outcome of the assessment process

All the providers were assessed against the standards, and rated on a scale from Green (meeting all the requirements as of April 2016) through to Red (current arrangements are a risk). Leicester was assessed as Amber/Red (does not meet all the April 2016 requirements and is unlikely to be able to do so).

Leicester was assessed as meeting 8 of the 14 requirements tested, and unlikely to be able to meet all the April 2016 requirements. Specifically:

a) Surgical activity

University Hospitals of Leicester reported a caseload of 331 procedures for 2015-16, an increase of 55 procedures compared with 2014-15. This is insufficient for three surgeons to meet the current minimum activity requirement of 125 cases per surgeon per year. The full standards (effective from 2021) require a team of four surgeons rather than three, and that there was felt to be no realistic prospect of Leicester increasing activity during this period to a level that would allow these requirements to be met.

b) Interventional cardiology rota

The Trust did not demonstrate that they have implemented a 1 in 3 interventional cardiologist rota.

c) Access to specialist services

The Trust does not have access to 24/7 bedside paediatric gastroenterology or paediatric nephrology.

The Trust does not have vascular and interventional radiology services on site.

The national panel report is available on the NHS England website https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/.
The individual assessment report for Leicester is attached as appendix 1 to this report.

Proposals for change

In line with these assessments, NHS England has set out decisions that it is minded to take in relation to congenital heart disease services, subject to the outcome of public consultation. No decisions have been taken at this time.

The proposal in relation to Leicester is:

- to cease commissioning level 1 (surgical) services from the Trust
- to discuss the potential continuation of level 2 CHD services in Leicester.

If these proposals are approved following public consultation, the closest alternative centre for most patients who currently undergo CHD surgery at Leicester would in future be Birmingham. The majority of care for all patients is non-surgical, and could continue to be provided at Leicester as a level 2 centre.

Engagement and public consultation

NHS England has committed to public consultation on its proposals for change in relation to Leicester and other congenital heart disease providers. This will be for a period of 12 weeks, and will be led nationally with regional support.

Prior to the launch of public consultation, NHS England will undertake engagement with the Trust, local authorities, patient groups and other stakeholders.

Pre-consultation engagement will include an assessment of the potential impact on other services within the Trust in the event that the proposals are approved.

Timescale

Subject to advice from Overview and Scrutiny Committees and others during our pre-consultation engagement, NHS England's high level timetable is as follows:

- Pre-consultation engagement: this has now started. Attendance at this meeting of the Health & Wellbeing Board is part of the pre-consultation engagement
- Public consultation: up to 12 weeks, starting in the autumn (date to be confirmed following pre-consultation engagement)
- Written six months' notification to providers of potential decommissioning of their services from April 2017, subject to the outcome of public consultation: 30 September 2016
- Review of the outcome of consultation: January /February 2017
- Final decisions: March/April2017
- Implementation of the final decisions: April 2017 onwards (with an appropriate transition plan for patients and staff).

Recommendations

NOTE the briefing provided.

Hospital Trust: University Hospitals of Leicester NHS Trust

RAG RATING: Amber/Red

University Hospitals of Leicester does not meet all the April 2016 requirements 2016 standards (meeting 8 of the 14 requirements tested), and is unlikely to be able to do so.

Meeting the requirements

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
1. Ensuring that paediatric cardiac / ACHD care is given by appropriate practitioners in appropriate settings.	1.1 All paediatric cardiac and adult CHD surgery, planned therapeutic interventions and diagnostic catheter procedures to take place within a Specialist Surgical Centre (exceptions for interventional and diagnostic catheters in adults noted below).	A9(L1) Paediatric; B8(L1) Paediatric; B12(L1) Paediatric; A9(L1) Adult; B8(L1) Adult; B12(L1) Adult	N	Y – acceptable plan provided	N

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	1.2 All rare, complex and innovative procedures and all cases where the best treatment plan is unclear will be discussed at the network MDT.	B2(L1) Paediatric; B2(L1) Adult	Y	N	N
	1.3 All children and young people must be seen and cared for in an age-appropriate environment , taking into account the particular needs of adolescents and those of children and young people with any learning or physical disability.	C2(L1) Paediatric	Y	N	N

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake sufficient practice to maintain their skills	2.1 Congenital cardiac surgeons must be the primary operator in a minimum of 125 congenital heart operations per year (in adults and/or paediatrics), averaged over a three-year period.	B10(L1)Paediatric; B10(L1) Adult	N	Y	Y
	2.2 Cardiologists performing therapeutic catheterisation in children/young people and in adults with congenital heart disease must be the primary operator in a minimum of 50 such procedures per year (a minimum of 100 such procedures for the Lead Interventional Cardiologist) averaged over a three-year	B17(L1)Paediatric; B17(L1) Adult	N	Y – acceptable plan provided	N

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	period.				
3. Ensuring that there is 24/7 care and advice	3.1 Surgical rotas should be no more than 1 in 3.	B1(L1)Paediatric; B9(L1) Paediatric; B1(L1)Adult; B9(L1) Adult;	Y	N	N
	3.2 Interventional cardiologist rotas should be no more than 1 in 3.	B1(L1)Paediatric; B15(L1)Paediatric; B1(L1)Adult;	N	Y – acceptable plan provided	N
	3.3 Cardiologist rotas should be no more than 1 in 4.	B14(L1) Paediatric;	Y	N	N
	3.4 A consultant ward round occurs daily.	B1(L1)Paediatric; B1(L1)Adult;	Y	N	N
	3.5 Patients and their families can access support and advice at any time	B1(L1)Paediatric;	Y	N	N
	3.6 Medical staff throughout the network can access expert medical advice on the care of children with heart disease and adults with congenital heart disease at any	A10(L1) Paediatric; B14(L1) Paediatric; A10(L1) Adult;	Y	N	N

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	time.				
4. Ensuring that there is effective and timely care for co-morbidities	4.1 Specialist Surgical Centres must have key specialties or facilities located on the same hospital site. Consultants from the following services must be able to provide emergency bedside care (call to bedside within 30 minutes).	A21(L1)Paediatric; D1(L1) Paediatric; D2(L1) Paediatric; D3(L1) Paediatric; D4(L1) Paediatric; D5(L1)Paediatric; D6(L1) Paediatric; D7(L1) Paediatric; D8(L1) Paediatric; A21(L1)Adult; D1(L1) Adult; D2(L1) Adult; D3(L1) Adult; D4(L1) Adult; D5(L1) Adult; D6(L1) Adult; D7(L1) Adult;	N	Y	Y
	4.2 Key specialties must function as part of the multidisciplinary team.	A21(L1)Paediatric; D1(L1) Paediatric; D2(L1) Paediatric; D3(L1) Paediatric; D4(L1) Paediatric; D5(L1)Paediatric; D6(L1) Paediatric; D7(L1) Paediatric; D8(L1) Paediatric; A21(L1)Adult; D1(L1) Adult; D2(L1) Adult; D3(L1) Adult; D4(L1) Adult;	N	TBC – see below	TBC – see below

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
		D5(L1) Adult; D6(L1) Adult; D7(L1) Adult;			
5. Assuring quality and safety through audit.	5.1 Specialist Surgical Centres must participate in national audit programmes, use current risk adjustment tools where available and report and learn from adverse incidents.	A21(L1)Paediatric; F4(L1) Paediatric; F7(L1) Paediatric; F9(L1) Paediatric; A21(L1)Adult; F4(L1) Adult; F7(L1) Adult; F9(L1) Adult;	Y	N	N

Development plan and mitigation requirements

2.1 University Hospitals of Leicester reported a caseload of 331 procedures for 2015-16, an increase of 55 procedures compared with 2014-15. This is insufficient for three surgeons to meet the activity requirement. They currently have three surgeons who were not projected to achieve the required 125 operations in 2015/16 (122, 95, 43[1] projected procedures).

University Hospitals of Leicester is predicting that growth will continue as a result of:

- continuing to develop relationships with level 3 hospitals such as Kettering General Hospital, Peterborough City Hospital and Northampton General Hospital;
- delivering new outreach clinics; and
- expanding their estate, specifically expanding their outpatient department, moving and increasing accommodation for parents and carers, increasing office space for staff and increasing the paediatric cardiology bed provision to provide a short-stay area, cardiac high dependency beds and a separate facility for adolescents (this work is scheduled for completion in August 2016).

University Hospitals of Leicester also described the mitigation it currently has in place including:

- seeking support and advice in complex or unusual cases, particularly from colleagues at Birmingham Children's Hospital; and
- following MDT discussion they have been supported by one of the senior surgeons at Birmingham Children's Hospital on four occasions in the last year.

The panel was concerned about whether these plans were realistic as it is not possible to know if the recent growth will continue. University Hospitals of Leicester must develop a more detailed plan to ensure that all surgeons meet the required numbers during 16/17.

University Hospitals of Leicester must demonstrate that where its plan is based on changes in patient flows this includes agreements with the referring hospitals and the hospitals currently providing a service to that hospital. University

[1] Surgeon started operating in November 2015. A previous surgeon had also performed 61 procedures in 15/16 prior to stopping operating in October 2015.

Hospitals of Leicester must also monitor surgeon activity during 2016/17 and inform regional commissioners if at any point they consider it likely that one or more of their surgeons will not meet the requirement.

While the predicted growth may in time ensure that the 2016 requirement for a team of three surgeons can be supported, NHS England activity projections suggest that University Hospitals of Leicester will not achieve sufficient activity levels to meet the 2021 requirement for a team of four surgeons.

2.2 University Hospitals of Leicester reported that they had performed 257 procedures in 2014-15; however, NICOR reported overall activity of 239 procedures (once all procedures which did not qualify had been removed). University Hospitals of Leicester therefore has sufficient activity to meet the requirements to have a lead interventionist who performs a minimum of 100 procedures and all interventionists to perform a minimum of 50 procedures for their proposed three interventionists.

University Hospitals of Leicester plan to reduce the number of interventional cardiologists from seven to three with a fourth cardiologist focussing on EP and implants. The panel considered this an acceptable plan.

University Hospitals of Leicester also report an average of 32 procedures each year performed by other staff and trainees for 2013/16. This would appear to be in breach of standard A2(L1) which requires that all congenital cardiac care including investigation, cardiology and surgery, is carried out only by congenital cardiac specialists and standard B12(L1) which requires that all paediatric congenital cardiology must be carried out by specialist paediatric cardiologists (and the equivalent adult standard). The plan described above should address this issue.

University Hospitals of Leicester must take steps to manage interventional workload to ensure that all interventional is undertaken only by congenital cardiac specialists, that all interventional cardiologists meet the required numbers during 16/17 and to monitor interventional activity and inform regional commissioners if at any point they consider it likely that one or more of their interventionists will not meet the requirement.

3.2 University Hospitals of Leicester has not demonstrated that they have implemented a 1 in 3 interventional cardiologist rota. They must provide further evidence to demonstrate that this standard is met or develop plans to meet the

requirement. NHS England's regional commissioning team will review and agree the plans and monitor implementation of the plan.

University Hospitals of Leicester must also develop plans to meet the 1 in 4 rota requirement from April 2017

4.1 University Hospitals of Leicester does not have access to 24/7 bedside paediatric gastroenterology.

The panel was concerned about whether the proposed mitigations (24/7 support from general paediatrics and paediatric surgery based at Leicester Royal Infirmary to provide first line care for gastroenterological emergencies with next day advice from a paediatric gastroenterologist) were acceptable. It noted that a business case has been developed for the recruitment of three gastroenterologists which would enable an out of hours rota to be established.

4.1 University Hospitals of Leicester does not have access to 24/7 bedside paediatric nephrology.

The panel was concerned about whether the proposed mitigations (24/7 on-site support from PICU nurses and intensivists with 24/7 telephone advice from an on-call paediatric nephrologist) were acceptable. It noted that the East Midlands, East of England and South Yorkshire are currently trying to recruit a network consultant paediatric nephrologist who will be predominantly based in Leicester.

4.1 University Hospitals of Leicester does not have vascular and interventional radiology services on site as required by Standard D7(L1)Adult.

The service is provided by Leicester Royal Infirmary with a site to site journey time under 30 minutes but evidence was not provided to demonstrate that this service is available 24/7 or of a commitment to 30 minute call to bedside care) were acceptable. The panel noted that this service is due to be moved to Glenfield Hospital in early 2017.

University Hospitals of Leicester must provide further evidence to demonstrate that this standard is met or that effective mitigations are in place. NHS England's regional commissioning team will review and agree the plans and monitor implementation of the plan.

4.2 University Hospitals of Leicester did not demonstrate the attendance of all required specialties at MDT meetings or explain clearly how the relevant specialties are involved in decision making. They will need either to provide further evidence demonstrating how this is achieved, or if this does not exist,

develop and submit plans to meet the requirement to NHS England's regional commissioning team. This should include taking steps to improve record keeping for MDT meetings.

Other requirements

1.1 Nottingham University Hospital is proposing a Level 2 centre and has reached an in principle agreement with University Hospitals of Leicester that it will provide oversight will be given by University Hospitals of Leicester. A decision regarding Nottingham's continuation as a Level 2 centre is required prior to any decisions being made regarding the University Hospitals of Leicester proposals regarding its role in providing supervision. If this arrangement proceeds, University Hospitals of Leicester will need to provide additional information on their arrangements for overseeing ASD closures at Nottingham University Hospitals following their meeting which was held during April 2016. Regional commissioners would then determine whether any further plans or mitigations were required.

5.1 University Hospitals of Leicester working with Birmingham Children's and University Hospital Birmingham will also continue to develop their wider pan-midlands network in line with commissioner requirements due to be confirmed during 16/17.

Appendix C1

Please ask for: Councillor Rory Palmer
Tel: 0116 4540002
Our ref: 2016/JULY/JH/RP/MH
Date: 13 July 2016

Leicester City Council

Rt. Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

Will Huxter
Regional Director of Specialised Commissioning
NHS England
Mezzanine Floor
Southside
105 Victoria Street
London
SW1E 6QT

Dear Secretary of State and Mr Huxter

I am writing on behalf of Leicester City Council in the strongest possible terms to ask that the recent announcement by NHS England to end the commissioning of children's heart surgery at Glenfield Hospital in Leicester is reviewed and reversed.

The East Midlands Congenital Heart Unit at Glenfield is securing excellent clinical outcomes which compare extremely well with the best performing centres nationally and it is very likely data to be published later this year will show that clinical outcomes at Glenfield are amongst the best in the country. CQC have also acknowledged the strength of these clinical outcomes in a recent inspection:

'We noted the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital.'

UHL are on track to meet the standard number of surgery cases each year and have invested in staff and facilities to support this. I also concur with the literature review carried out for NHS England which John Adler, Chief Executive of University Hospitals of Leicester cites in his representations to NHS England, that the 125 cases per surgeon per year should not be seen as some 'magic number' nor should it be understood to be as scientifically credible as some would suggest.

The wider and knock-on implications of children's heart surgery stopping at Glenfield should not be underestimated. The potential implications include losing more than half of the paediatric intensive care beds available in Leicester (important not just for Leicester but for the wider region); possible reductions and risk to other children's medicine services including general surgery; ear, nose and throat services; foetal and respiratory services; children's cancer services and neonatal units. Young patients from across the East Midlands and beyond need these services.

OFFICE OF THE DEPUTY CITY MAYOR
Rory Palmer

3rd Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ
TELEPHONE: (0116) 4540002 deputymayor@leicester.gov.uk www.leicester.gov.uk

The decision to cease children's heart surgery at Glenfield would also mean the pioneering and vital ECMO service would also become unviable. Taken together, the impacts of this decision can only be described as catastrophic for children's medicine in Leicester and our wider region. That is not hyperbole. I have enclosed the letter from John Adler, CEO of UHL to NHS England which sets out what this will mean for the trust.

On behalf of Leicester City I want to be clear that we agree with every word of John Adler's assessment of this situation and its potentially disastrous implications.

I also want to make clear that Leicester City Council is exploring all possible avenues to challenge this decision and to seek its reversal and will be doing all we can to support UHL, patients, families and campaigners to secure the future of the vital East Midlands Congenital Heart Unit at Glenfield.

At the very least we expect this decision to be subject to full public consultation.

Yours sincerely

COUNCILLOR RORY PALMER
DEPUTY CITY MAYOR AND CHAIR, LEICESTER HEALTH & WELLBEING BOARD

CC:
John Adler, CEO UHL
Sir Peter Soulsby, City Mayor
Councillor Vi Dempster, Chair Health Scrutiny Committee Leicester City Council
Sarah Wollaston MP, Chair of the House of Commons Health Select Committee
Jon Ashworth MP (Leicester South)
Liz Kendall MP (Leicester West)
Rt. Hon Keith Vaz MP (Leicester East)
Councillor Nick Rushton, Leader Leicestershire County Council
Councillor Terry King, Leader Rutland County Council
Edward Argar MP (Charnwood)
Andrew Bridgen MP (Leicestershire North West)
Alberto Costa MP (South Leicestershire)
Rt. Hon Sir Alan Duncan MP (Rutland and Melton)
Rt. Hon Sir Edward Garnier MP (Harborough)
Rt. Hon Nicky Morgan MP (Loughborough)
David Tredinnick (Bosworth)
Councillor Martin Hill, Chairman East Midlands Councils
All members Leicester Health & Wellbeing Board

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HEALTH AND WELLBEING BOARD
18 AUGUST 2016

Extracts of decisions taken by Leicester City Council and Leicestershire County Council on Children's Heart Surgery at Glenfield Hospital

Leicester City Council passed the following motion at the Council Meeting held on 14 June 2016:-

"This Council strongly supports the work of the Children's Cardiac Services specialist centre of national excellence based at Glenfield Hospital, Leicester and expect the services to be retained, consolidated and further developed to the benefit of the City, County and the Region. That the Health and Wellbeing Board collaborates with other authorities and interested organisations to make representations to NHS England and the Government to oppose the decision to cut these specialist services which are vital to hundreds of children.

This Council resolves to refer this matter to the Health Scrutiny Commission of Leicester City Council and to request that a meeting of the Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee meets to consider this matter and proceeds to make a formal referral to the Secretary of State for Health as per the powers set out in The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013."

Leicestershire County Council's Cabinet considered a report at its meeting on 18 July and the published minute is set out below.

The link to the papers/minutes of the meeting is:-
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=4604&Ver=4

465. Urgent item - Children's Heart Surgery at Glenfield Hospital.

Minutes:

The Cabinet considered an urgent joint report of the Chief Executive and Director of Public Health concerning NHS England's intention to cease the commissioning of children's heart surgery at Glenfield Hospital. The report was urgent because the announcement was made by NHS England after the agenda for the meeting had been published and a response needed to be made at the earliest opportunity. A copy of the report, marked '13', is filed with these minutes.

It was noted that since the report was circulated the NHS had published a rationale for its decision and further communication from the NHS was expected.

Mr. White CC said that NHS England's decision was simply wrong. Glenfield had excellent services and, he believed, would be able to demonstrate some of the best clinical outcomes in the country. He paid tribute to local MPs and Cllr. Palmer (Deputy Mayor of Leicester City Council) who had also voiced concerns. Mr. White said the County Council clearly wished the highest quality services to be provided and evidence showed that Glenfield Hospital was doing this. He reminded members that the County Council could refer such issues to the Secretary of State and noted that the Health Overview and Scrutiny Committee would consider the matter at its next meeting.

Mr. Ould CC, as the Cabinet lead member for children and young people, added his full support for the recommendations as amended.

RESOLVED:

(a) That the intention of NHS England to cease the commissioning of children's heart surgery at Glenfield Hospital, which will have serious local and regional implications and to do so ahead of NHS England's previously published timetable to address standards by 2021 is deplored;

(b) That the failings of the communications used by NHS England to inform families, staff and stakeholders of its intention that children's heart surgery will no longer take place at Glenfield are to be regretted;

(c) That the Cabinet does not believe there is evidence to substantiate NHS England's claim that to cease commissioning is "in the best interests of patients with congenital heart disease and their families";

(d) That the rebuttal letter sent by the Chief Executive of the University Hospitals of Leicester NHS Trust to NHS England is supported totally;

(e) That full support is offered to the NHS Trust in fighting NHS England on this matter, if necessary through the courts, and in establishing robust local opposition to NHS England's proposal which, if implemented, would see the end of a world class service;

(f) That the resolution of the Cabinet be conveyed to local MPs and that their already stated concern at the proposal from NHS England be welcomed;

(g) That the Health Overview and Scrutiny Committee be requested to consider a report on the implications of the announcement on both the Glenfield Hospital and the wider NHS at its meeting on 14th September 2016.

REASONS FOR DECISION:

To note the announcement made by NHS England, which will have implications on the wider health and care economy of Leicester, Leicestershire and Rutland, as well as the East Midlands as a whole.

The Health Overview and Scrutiny Committee has the responsibility for scrutinising the exercise by health bodies of functions which affect the County and is also able to make reports and recommendations to relevant NHS bodies.

The Director of Public Health has a responsibility to advise the County Council on matters relating to health and he is in agreement with the position taken by UHL.

LEICESTER CITY HEALTH AND WELLBEING BOARD

18 AUGUST 2016

Title of the report:	Leicester City Clinical Commissioning Group – Primary Care Strategy
Author:	Sarah Prema, Director Strategy and Implementation
Presenter:	Sarah Prema, Director Strategy and Implementation

Purpose of report:

Leicester City Clinical Commissioning Group is in the process of developing its Primary Care Strategy. The strategy will be finalised once the local Sustainability and Transformation Plan is completed in September 2016, which is including work around general practice. In addition it will be informed by the Health Summit which is being held in September 2016.

The attached presentation identifies the challenges faced by primary care in the city and the plans to address these.

Actions required by the Health and Wellbeing Board members:

NOTE draft Primary Care Strategy for Leicester City Clinical Commissioning Group.

NHS
Leicester City
Clinical Commissioning Group

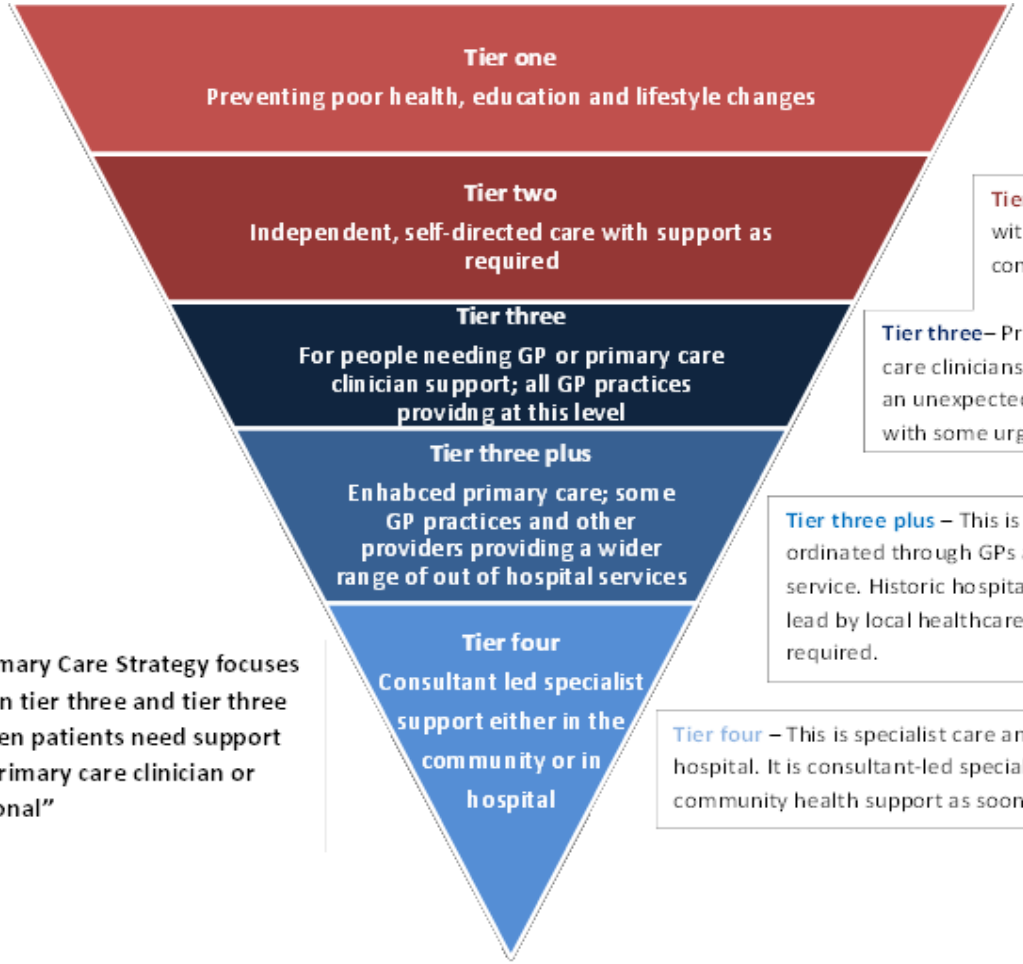
Appendix D1

4.1

Leicester Health and Wellbeing Board
Leicester City CCG Primary Care Strategy
12th July 2016

Professor Azhar Farooqi – Chair
Sarah Prema – Director Strategy and Implementation

Tiers of care – where does our primary care strategy focus?



Tier two – people manage most health needs independently with support such as websites, self- help groups and other community professionals (e.g. Pharmacists).

Tier three– Primary Care support, where input from GPs or primary care clinicians is required either to support long term condition(s) or an unexpected health concern. This is mostly planned appointments with some urgent and unexpected interventions from time to time

Tier three plus – This is real transformation, with patient centred care co-ordinated through GPs at the heart of a seamless integrated health service. Historic hospital services will be provided in local communities lead by local healthcare teams who can success specialist advice as required.

Tier four – This is specialist care and advice, either in community-based setting or in hospital. It is consultant-led specialist care that aims to return the patient back to their community health support as soon as possible.

"Our Primary Care Strategy focuses mainly on tier three and tier three plus, when patients need support from a primary care clinician or professional"

Background to primary care in Leicester City

- 59 practices – 6 single handed and 53 with GP partners or alternative providers
- As of April 2016 - 391,859 patients were registered with city GPs (resident population is 336,188)
- Majority of practice contracts are GMS but there are a large number of APMS contracts which are time limited
- Average list size 6531 which is slightly lower than the national average of 7225 (Jan 15)
- There are 14 training practices
- Leicester City primary care providers do not perform well in the national patient experience survey
- To date CQC outcomes have been good with more practices being rated as good than the England and Midlands and East average
- There is variation in outcomes across city practices

HNN	Total list size for HNN	Average Population per Practice	GP per 1000 registered patients	Total GP (WTE)	Average List Size per WTE GP
Central	128,157	6,745	0.39	49.61	2,583
North West	108,245	6,765	0.38	40.89	2,647
South	90,005	6,429	0.45	40.45	2,225
North East	65,453	4,675	0.44	28.66	2,284
Total	391,859			159.61	2,455

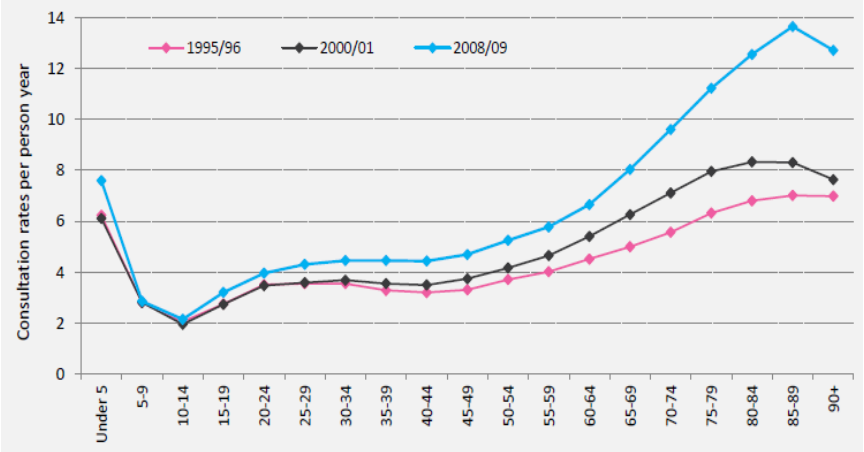
Contract Type	No of practices holding contract
General Medical Services (GMS)	46
Personal Medical Services (PMS)	1
Alternative Provider Medical Services (APMS)	13

Challenges facing primary care in Leicester City (1)

Demand on primary care

- The average number of consultations per patient in primary care shows an 11% increase over 13 year period
- There is an increase in most age bands but particularly those over 60 years of age
- More people are living longer with long term and often multiple complex conditions
- Increasing patient expectations

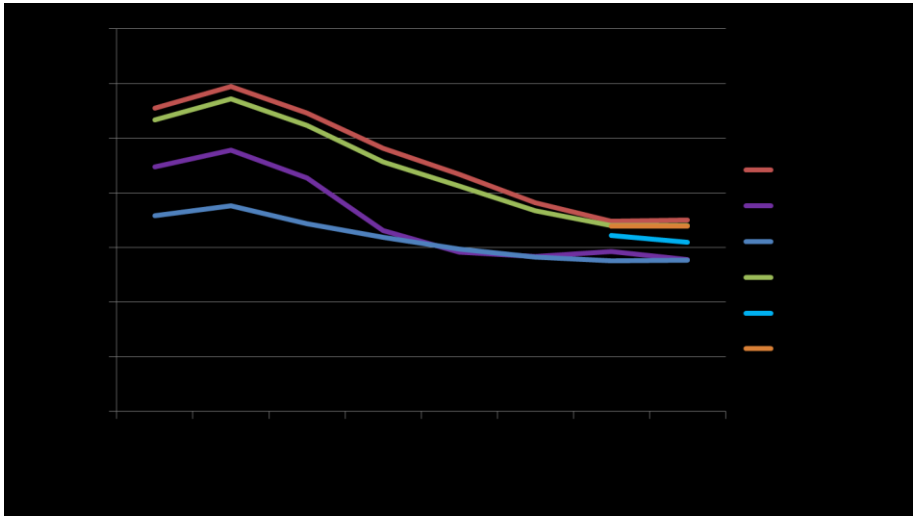
Figure 26: Trends in general practice consultation rates by age band and survey year



Source: HSCIC (2009)

Relative investment in primary care

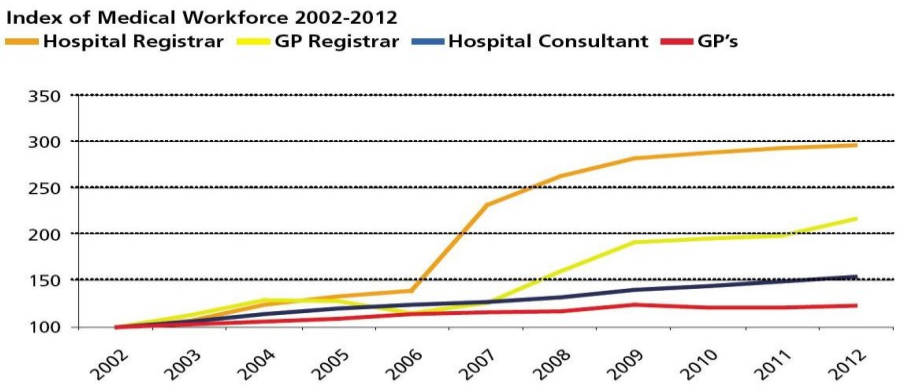
- Despite increasing demand on primary medical care the proportion of the NHS budget spent on primary medical care as a percentage of the whole budget has reduced since 2004.
- Primary care provides 90% of NHS contacts with 9% of the budget
- National and local programmes to equalise funding in practices is impacting on some practices in the city



Challenges facing primary care in Leicester City (2)

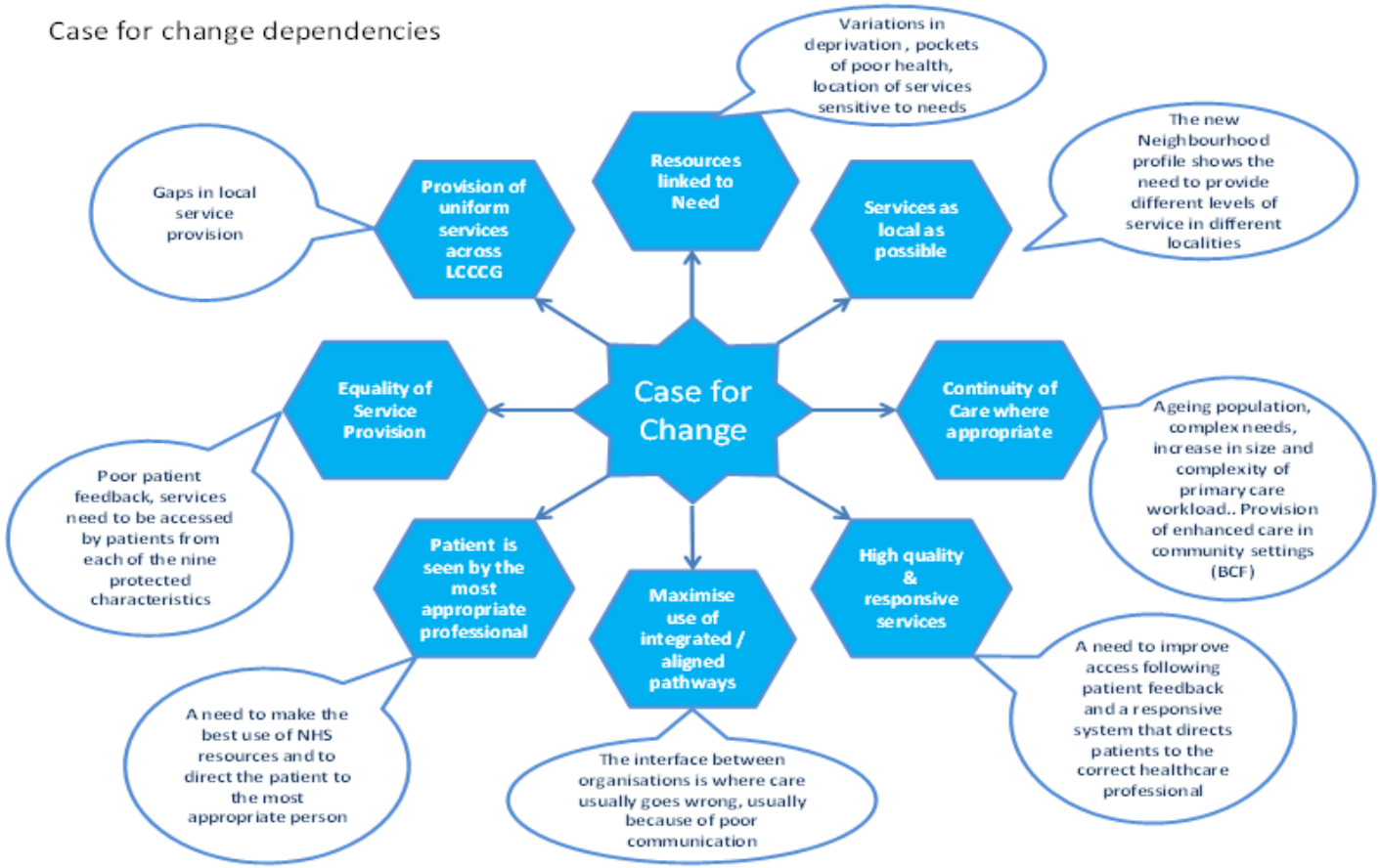
Workforce

- Royal College of General Practioners report that the number of unfilled GP posts has quadrupled in the last three years
- Between 2006 and 2013 GP numbers grew by 4% while the number of consultants in hospital and community grew by 27% nationally
- Applicants to GP training have dropped by 15%
- The Nuffield Trust reports that a third of GPs under 50 are considering leaving the profession in the next 5 years due to workload pressures
- There is an increasing trend towards part time posts with 12% of general practice trainees now working this way
- Only 66% of GPs are now working in partnerships compared to 79% in 2006
- Health Education England figures from 2014 suggest that one in ten slots for new GP trainees remain vacant



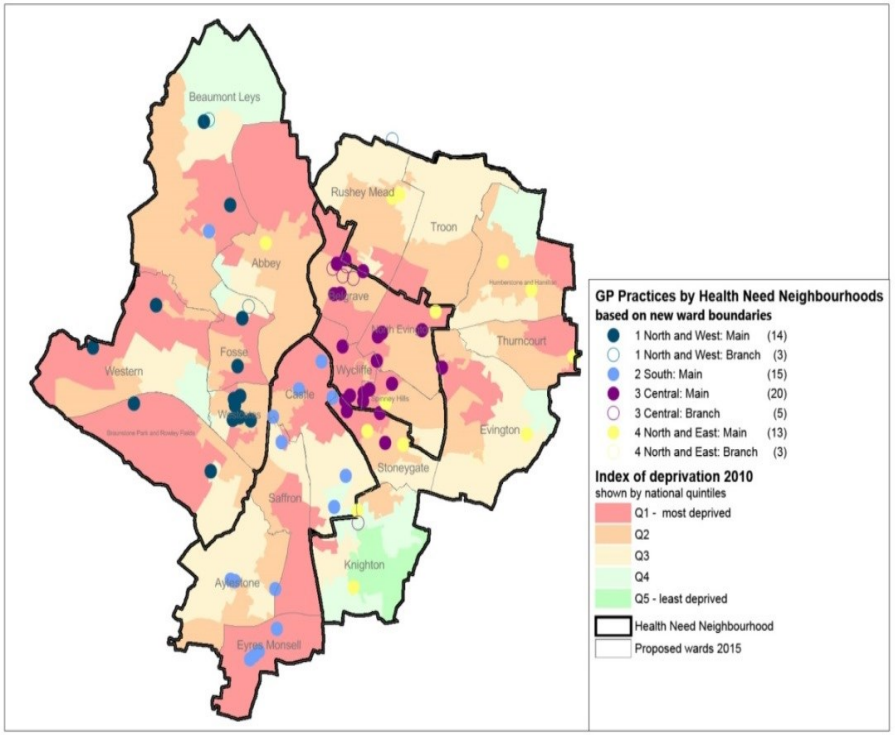
Vacancies by roles at July 2015	LCCCG	WLCCG	ELRCCG
Partner GP	3 (14%)	4 (14%)	1 (9%)
Salaried GP	8 (36%)	6 (20%)	2 (18%)
Long-term locum GP	2 (9%)	4 (14%)	0
Practice Nurse	4 (18%)	3 (10%)	0
Nurse Practitioner	1 (5%)	1 (3%)	0
Nurse Prescriber	1 (5%)	0	0
Health Care Assistants	0	1 (3%)	2 (18%)
Phlebotomist	2 (9%)	2 (7%)	0
Medical Secretary	0	1 (3%)	0
Support staff	0	8 (28%)	1 (9%)

Our case for change – how are going to make improvements?



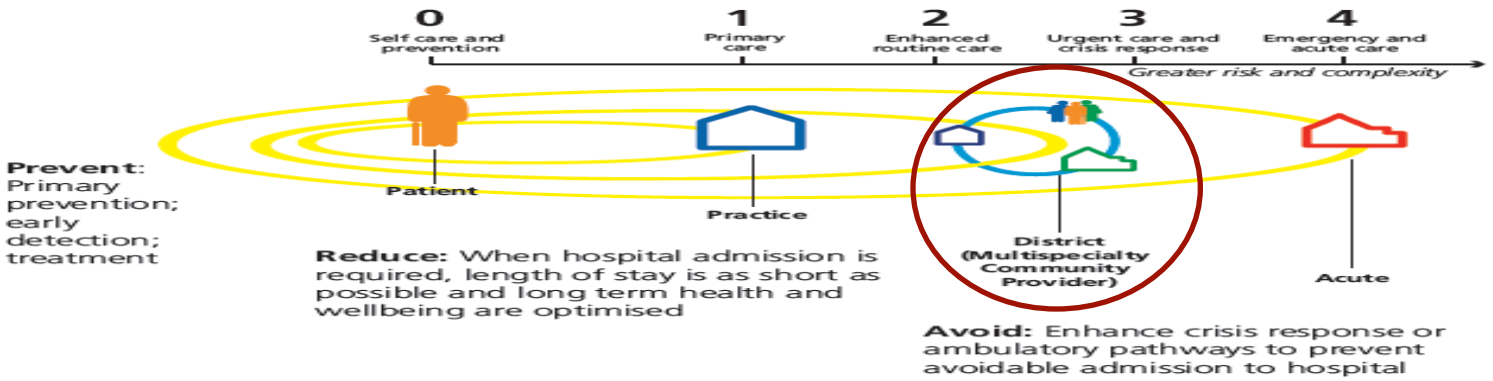
Services as local as possible - Health Needs Neighbourhoods

- In order to enable a locality delivery of primary and community care the city has been divided into four Health Need Neighbourhoods.
- These areas will enable local delivery of services based on the need of the local population – these could include:
  - Extended Hours provision
  - Urgent Care Services including diagnostics
  - Community nursing and therapy services
  - Social services, voluntary services
  - Self-care and patient education
- Particular focus on prevention and mobilising community "assets"
- They will form the basis of the development of integrated teams to support those patients with the most complex needs
- The CCG is also developing "HUBs" to support delivery of services there are likely to be two in the city (one across two areas) – this is where patients will have access to wider services



Developing integrated teams

- Research has shown that the interface between organisations is where care for patients often goes wrong. Boundaries make it harder to provide joined up care that is preventative, high quality and efficient. Across Leicester, Leicestershire and Rutland we are working towards the development of integrated teams to break down these barriers and to support the care settings described in the following diagram:



- Integrated teams could include general practice, community services such as nursing, hospital doctors, social services and the voluntary sector co-ordinating care for patients in a defined geographical area – for the city this will be either at city or HNN level depending on the service. There are a number integrated forms being tested across the country – for example Multi-Speciality Providers

Improving access to services

Uniform services

- All practices are required to deliver services set out in their medical services core contract. Other community or enhanced services contracts are discretionary. To ensure that all patients have access to these services we will:
  - Consider how these can be delivered on behalf of practices by either other practices or Federations
  - Consider what options there are to develop these into a single contract
  - Identify what services could be delivered from HNN Hubs
  - Common core offer across LLR for general practice to support all practices and encouraging joint working

Continuity of care

- Patients want continuity of care and with the ever increasing complex patients being looked after in primary care it is key. To support this we are going to:
  - Ensure all patients over 75 have a named GP
  - Implement a Planned Integrated Care programme for complex patients and a Care Home Service
  - Develop integrated teams to support patients aligned to the HNNs

Most appropriate professional

- Changing technology and skills now means that it is not always necessary for patients for see a GP. Therefore it is vital that we develop the workforce to respond to this and to encourage patients to look after their own health and wellbeing. We will:
  - Pilot the use of different skill mix such as clinical pharmacists in primary care
  - Develop training opportunities that upskill the workforce to enable new models of delivery e.g. GPwSI's
  - With our partners provide patient education that supports behavioural change to lower settings of care, e.g. Lifestyle Hub
  - Develop a self-care and social prescribing offer

Access

- Provide extended hours to primary care through our Extended Hours Hubs
- Explore the option of providing additional hub based capacity during core hours
- Pilot a digital GP service where patients can get telephone appointments

Workforce

Working across Leicester, Leicestershire and Rutland we are undertaking the following actions to improve the recruitment and retention of staff in primary care:

- Positively market general practice as a place to work
- Identify and implement approaches to support local recruitment within general practice
- Develop the wider primary care workforce including new roles for example clinical pharmacists to support capacity in general practice
- Work to develop a broad range of multi-professional training opportunities in general practice including student nurses and undergraduate training opportunities
- Develop and implement local training hubs – Community Education Provider Network, to promote multi-professional learning and development aiding recruitment and retention
- Enable a more portfolio approach to working in general practice – for example enabling a GP to do some sessions in practice, some in a research role or clinical lead role

In Leicester City we also:

- Have a GP “golden hello” recruitment scheme to attract out of area GPs to the city
- Encouraging more practices to become training practices

Premises

- There are currently 72 practice premises in Leicester City, 60 main and 12 branch sites.
- Premises Audits identify that the condition of the estate is variable with many practices operating out of converted houses and others in purpose build health centres.
- The CCG supported practices to apply to the NHS England Estates and Technology Fund based on the following priorities for investment. In 2016 the CCG was able to put forward five developments to the fund.
- We will work with NHS Property Services to improve the premises owned by them.

Priorities for investment
Enabling increase in patient list sizes to be managed
Supporting the development of Health Need Neighbourhoods
Providing additional clinical space to deliver primary care services out of hospital; services to reduce unplanned admissions to hospital; and improving seven day access
Increasing the capacity for undergraduate and postgraduate training
Improving the premises to enable a wider workforce to be employed within primary care
Developments that bring a number of practices together in one building
Improved utilisation of NHS owned and LIFT properties
Reduce the inequity of quality across the estate (not legislation compliance and general maintance issues)

IM&T

IM&T is an important enabler to changing models of care and to support the modern delivery of services and care to patients. The main objectives for the CCG to deliver these are:

- Optimise the use of existing systems to reduce the administrative burden and maximise care for patients
- Integrate systems across the health economy so that information can be shared
- Use IM&T to enable patients to have more accessibility to digital health care to help book appointments, view records and test results
- Encourage the use of electronic referrals systems to reduce administration burden on practices
- Have a single Care Plan that all professionals use and can access
- Explore the use of technology to support the care and independence of patients through our work on Long Term Conditions and Frail Older People

Supporting Federations

What are Federations?

Federations are groups of practices that are working together as a provider. The CCG thinks that Federations can:

- Support practices to become more sustainable
- Enable back office functions to be combined and practices to become more productive
- Support the uniform delivery of services – so all patients have access to all services
- Have the potential to share staff across member practices to support the workforce issues faced by some practices
- Have the potential to deliver wider services

In Leicester City there are currently three newly formed Federations, with a commitment to move to one city federation, and the CCG is supporting their development with non recurrent funding and management time.

Resources

- Working with NHS England to implement the General Practice Forward View which increases funding into primary medical care over the next five years and also offers a number of new areas of support including:
  - Workforce
  - Releasing time to care
  - Premises developments
  - Care redesign
- Consider options for bringing together non core services into one contract to improve patient outcome, reduce administrative burden and provide more sustainability for practices
- Reinvest resources from national and local funding reviews back into primary medical care to increase the minimum pound per patient, improve quality and provide a sustainability fund
- Commission services that support primary care such as Clinical Response Service and Extended Hours Hubs

General Practice Forward View – National Investment

- Investing £2.4 billion by 2020/21 into general practices services
- Investment will rise from £9.6b in 2015/16 to over £12b by 2020/21
- Capital investment of £900 m over five years
- £0.5b to support struggling practices, further develop the workforce, tackle workload and stimulate care redesign over the next five years
- New funding formula to better reflect practice workload including deprivation and rurality

What will be different?

Patient
1. Patients taking proactive choice and control of their care, managing LTCs and daily life independently 2. Better satisfaction on ease of access 3. High quality integrated services delivered as close to home as possible which is individual and meets patients needs and provides continuity of care Focus on wellness, not illness
People
1. Skilled and flexible workforce working seamlessly for patients across acute, primary, community and social care 2. Use of different professionals as part of the wider primary care team reflecting the need of the population 3. Improvement in recruitment and retentions of primary care staff
Process
1. Reduced variation across practices 2. Access to other services for GPs – e.g. diagnostics, secondary care and social care 3. Interoperability of records between systems and full sharing of care records
Premises
1. Fit for purpose and safe premises 2. Provision of Health Need Neighbourhood Hubs
Payments
1. Funding that follows where the care is delivered for patients that supports the move to proactive care that is closer to home 2. More sustainability in primary care
New models of care
1. Primary care effectively working within Health Need Neighbourhoods in integrated teams with partners to improve the populations health