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

DATE: **TUESDAY, 27 JUNE 2017**
TIME: **5:30 pm**
PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Cutkelvin (Chair of the Committee)
Councillor Cassidy
Councillor Chaplin
Councillor Corrall
Councillor Dempster
Councillor Fonseca
Councillor Sangster

Leicestershire County Council

Mr L Breckon CC (Vice-Chair of the Committee)
Mrs H Fryer CC
Mrs A J Hack CC
Dr S Hill CC
Mr T Parton CC
Mrs L Richardson CC
Mrs D Taylor CC

Rutland County Council

Councillor Dr L Stephenson
Councillor Miss G Waller

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

G. J. Carey

Officer contacts:
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Tel: 0116 454 6356, e-mail: Graham.Carey@leicester.gov.uk
Kalvaran Sandhu (Scrutiny Support Manager):
Tel: 0116 454 6344, e-mail: Kalvaran.Sandhul@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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- ✓ 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.

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PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 18)**

The minutes of the meeting held on 14 March 2017 are attached and the Committee is asked to confirm them as a correct record.

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, petitions, or statements of case in accordance with the Council's procedures

6. CHAIR'S INTRODUCTION

The Chair to welcome new members of the Joint Committee and to recap on the Committee's previous consideration of NHS England's proposals for Congenital Heart Disease Services.

Background Information

NHS England launched a national consultation on its proposals for the future commissioning of Congenital Heart Disease services on 9 February 2017. This consultation period was originally intended to end on Monday 5 June, but was subsequently extended to close on Monday 17 July 2017 as a result of the recent Parliamentary Election.

This Joint Committee is the appropriate body to be consulted by NHS England on the proposals in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The regulation provides that where the appropriate person (NHS England) has any proposals for a substantial development or variation of a health service in an area they must consult the local authority. Where the consultation affects more than one local authority in an area, the local authorities are required to appoint a Joint Committee to comment upon the proposal and to require a member or employee of the responsible person to attend its meeting and respond to questions in connection with the consultation.

The Regulation does not prevent constituent Councils of the Joint Committee considering the issues separately; but it is the responsibility of the Joint Committee to formally respond to the consultation process.

The Regulations also provide that a Council may refer a proposal to the Secretary of State where:-

- it not satisfied that the consultation has been adequate in relation to content or time;

- it is not satisfied with the reasons given for the change in services; or

- it is not satisfied that that the proposal would be in the interests of the health service in its area.

This referral must be made by the full Council unless the Council has delegated the function to a Committee of the Council. Currently, only the City Council had delegated the powers to refer the NHS proposals to the Secretary of State. Leicestershire County Council and Rutland County Council would need to approve any referral at their respective Council meetings.

Supporting Information

The Joint Committee first met on 29 September 2016 and received the

following supporting documents:-

- NHS England's proposals published on 8 July 2016.
- Extracts of decisions taken by Leicester City Council and Leicestershire County Council's Cabinet in response to NHS England's proposals.
- A report from NHS England and a submission from the University Hospitals of Leicester NHS Trust (UHL) submitted to the City Council's Health and Wellbeing Board at their meeting on 18 August 2016, together with the Minutes of the Meeting.
- A report of NHS England and their Assessment of UHL submitted to the Board and updated to reflect the subsequent meeting held with UHL on 16 September 2016 and the revised high level timetable for the consultation and decision making process.
- A letter to the City Council's Deputy City Mayor from NHS England in response to questions asked at the Health and Wellbeing Board.
- Evidence base for new standards & specifications in relation to the 125 cases per surgeon that was requested by the Health and Wellbeing Board.

The second meeting on 14 March 2017 received the following documents:-

- The "Proposals to Implement Standards for Congenital Heart Disease Services for Children and Adults in England - Consultation Document"
- Minutes of the Meeting of the Joint Committee held on 29 September 2016 when the Joint Committee considered the proposals in the pre-consultation engagement stage.
- A letter from Will Huxter responding to issues raised by the Joint Committee on 29 September 2017.
- Proposals to implement standards for Congenital Heart Disease Services for Children and Adults in England - Consultation Summary.
- Congenital Heart Disease Equality and Health Inequalities Analysis – Draft for consultation.
- Congenital Heart Disease Provider Impact Assessment: National Panel Report.
- NHS England Congenital Heart Disease Provider Impact Assessment.
- Congenital Heart Disease Consultation – Events List.

The agenda, reports and minutes of the Joint Committee's meetings referred to above can be found at the following link:-

http://www.cabinet.leicester.gov.uk/ieListMeetings.aspx?CId=420&Year=0

7. UHL'S VIEW ON NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES

Appendix B (Pages 19 - 28)

Representatives from UHL will attend the meeting to present their current view on the proposals. A copy of presentation is attached.

8. REPRESENTATIONS FROM THE PATIENTS, PATIENTS' GROUPS AND OTHER STAKEHOLDERS

Appendix C (Pages 29 - 30)

To hear views from public, patients groups and other stakeholders on NHS England's proposals for Congenital Heart Disease Services.

Leicester University were invited to attend the meeting. Professor Philip Baker, Pro-Vice Chancellor and Head of College Medicine, Biological Sciences and Psychology is, however, unable to attend but has submitted a representation on behalf of the University. A copy of the letter is attached.

9. NEXT STEPS IN RESPONSE TO THE CONSULTATION PROCESS

The Joint Committee is asked to consider the next steps it wishes to take in response to the consultation process.

10. ANY OTHER URGENT BUSINESS

APPENDIX A

Leicester
City Council

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

Held: TUESDAY, 14 MARCH 2017 at 2.00 pm

P R E S E N T :

Councillor V Dempster – Chair of the Committee
Dr S Hill CC – Vice Chair of the Committee

Leicester City Council

Councillor Cassidy
Councillor Chaplin
Councillor Cleaver
Councillor Fonseca
Councillor Unsworth

Leicestershire County Council

Mrs R Camamile CC
Mrs J A Dickinson CC
Dr R K A Feltham CC
Mr J Kaufman CC
Mrs B Newton CC
Mr T J Pendleton CC

Rutland County Council

Councillor Miss G Waller

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21. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and asked those present to introduce themselves.

22. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Karen Chouhan	Chair, Healthwatch Leicester
Councillor Conde	Rutland County Council

Councillor D Sangster Leicester City Council

23. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business on the agenda. No such declarations were made.

24. MINUTES OF PREVIOUS MEETING

AGREED:

That the minutes of the meeting held on 14 December 2016 be confirmed as a correct record.

25. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

26. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, petitions, or statements of case had been received in accordance with the Council's procedures.

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

The Joint Committee received NHS England's proposals for the future provision of Congenital Heart Disease Services with particular reference to University Hospitals of Leicester NHS Trust.

NHS England had launched a national consultation on its proposals for the future commissioning of Congenital Heart Disease services on 9 February 2017. This consultation would run until Monday 5 June, closing at 23.59. Extra time has been added to the usual 12 week consultation period to allow those involved in local government elections to have a full opportunity to contribute to the consultation.

It was noted that the Joint Committee was the appropriate body to be consulted by NHS England on the proposals in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The regulation provided that where the appropriate person (NHS England) had any proposals for a substantial development or variation of a health service in an area they must consult the local authority. Where the consultation affects more than one local authority in an area, the local authorities were required to appoint a Joint Committee to comment upon the proposal and to require a member or employee of the responsible person to attend its meeting and respond to questions in connection with the consultation.

The Regulation did not prevent constituent Councils of the Joint Committee considering the issues separately; but it was the responsibility of the Joint Committee to formally respond to the consultation process.

The Regulations also provided that a Council may refer a proposal to the Secretary of State where:-

- it not satisfied that the consultation has been adequate in relation to content or time;

- it is not satisfied with the reasons given for the change in services; or

- it is not satisfied that that the proposal would be in the interests of the health service in its area.

This referral must be made by the full Council, unless the Council has delegated the function to a Committee of the Council. Currently, only the City Council had delegated the powers to refer the NHS proposals to the Secretary of State. Leicestershire County Council and Rutland County Council would need to approve any referral at their respective Council meetings.

The following information was supplied to the Joint Committee prior to the meeting to assist it comment upon the proposals in the Consultation Document.

a) The “Proposals to Implement Standards for Congenital Heart Disease Services for Children and Adults in England - Consultation Document”.

b) Minutes of the Meeting of the Joint Committee held on 29 September 2016 when the Joint Committee considered the proposals in the pre-consultation engagement stage.

c) Letter from Will Huxter responding to issues raised by the Joint Committee on 29 September 2017.

d) Proposals to implement standards for Congenital Heart Disease Services for Children and Adults in England - Consultation Summary.

e) Congenital Heart Disease Equality and Health Inequalities Analysis – Draft for consultation.

f) Congenital Heart Disease Provider Impact Assessment: National Panel Report.

g) NHS England Congenital Heart Disease Provider Impact Assessment.

h) Congenital Heart Disease Consultation – Events List.

Mr Huxter was invited to make an introductory statement and he welcomed the

opportunity to discuss the proposals and the consultation process as set out in the documents that had been circulated to the Joint Committee members prior to the meeting.

During his introduction Mr Huxter emphasised that:-

a) No decision had been made in relation to any of the providers in the proposals in the national consultation document.

b) This was a national consultation process and there were no predetermined views on how many providers of service there should be or on any proposed closure of services in the consultation document but it was important to make sure that the national standards for service were implemented.

c) The ambition and the role for NHS England was to ensure that all patients across the country had consistent access to high quality services and he felt progress had been made since the original proposals were put forward.

d) In relation to UHL NHS Trust, NHS England had held discussions on arrangements for co-location of services and the substantive recruitment to surgical posts which had now been resolved. The only outstanding issue related to the number of surgical operations carried by each surgeon to get to the figures of 375 operations per year.

e) NHS England were not responsible for choosing where patients came from or to mandate where patients came from to have surgery at a particular specialist centre. It was for the parents/patients to decide where they wished to receive treatment.

28. UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST'S (UHL) VIEW ON NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES

The Joint Committee had received a report from UHL presenting their initial view of NHS England's proposals.

The Chair welcomed John Adler, Chief Executive, UHL Trust and Claire Westrope, Consultant Paediatric Intensive, UHL Trust, who were attending the meeting to outline UHL's views on the proposals and to answer Members' questions.

The Chair invited Mr Adler invited to make an introductory statement during which he made the following comments:-

a) UHL still disagreed with the original intention to decommission congenital heart disease surgical services from the Trust and the reasons were set out in Appendix C previously circulated to the Joint Committee members.

b) The Trust's responses to the questions in the consultation paper had also been circulated to the Joint Committee.

c) The Trust had no difficulty with the motivation behind the review and agreed that there should be a good high quality service for children who were seriously ill with a congenital heart disease. The Trust felt, however, that the changes being proposed were misguided and appeared to be a solution looking for a problem. There were good Congenital Heart Disease outcomes in Britain when compared globally and the Glenfield Unit had good outcomes compared to the rest of country.

d) Mr Huxter's comments on the progress made by the Trust were welcomed and NHS England's participation in the public meeting had been appreciated.

e) It was pleasing that the issue of co-location and the concerns NHS England had on locums had been discussed and sorted out. All that remained unresolved with NHS England was the number of operations per surgeon. UHL were not in dispute with proposed standards per se but did disagree with the way in which they had been applied retrospectively by NHS England.

f) The other area of difference was how pro-active NHS England should be in assisting the Trust in getting to the required numbers. NHS England had declined to be pro-active in this and had consistently cited that they don't choose where patients are treated. This was essentially for the family and the child and the referring commission to decide. However, the organisation of these services was the responsibility of NHS England and, whilst NHS England may say that they do not choose where a patient will be treated, they ultimately do determine where a patient will not be able to be treated; and that was what the current proposals sought to do. UHL's preferred option was to work with NHS England and other network partners to make relatively small adjustments to UHL's effective catchment area to enable UHL to meet the required standards in relation to number of operations. This would allow UHL to continue to offer services to children which were currently highly regarded. In a recent CQC inspection they had been rated as outstanding, the highest rated service within the Trust. It would also avoid creating a large geographical gap across the country with no CHD surgical services. None of the other changes proposed by NHS England would result in an entire region not having CHS surgical services.

29. OTHER VIEWPOINTS ON NHS ENGLAND'S PROPOSALS

The Joint Committee noted that the East Midlands Councils' General Meeting considered a report on NHS England's proposals at its meeting on 15 February 2017. The report which summarised the activities of the health overview and

scrutiny committees in the region since July 2016 had been circulated to the Joint Committee prior to the meeting.

It was noted that the recommendations had been approved and it was also agreed that unless plans were already in place, that all health scrutiny committees across the East Midlands should be encouraged to actively consider NHS England's proposals relating to UHL Glenfield Hospital; and that the scope and detail of this work be shared to support co-ordination of scrutiny activity and wider lobbying.

30. MEMBERS QUESTIONS

Members discussed NHS England's proposals and UHL's initial response and made the following comments/statements and asked questions (these have been grouped into general themes for ease of reference). NHS England's response to the comments/statements and questions made during the meeting are shown below each themed area.

The Chair commented that other local authorities across the East Midlands were also extremely concerned about the proposals and were feeling upset and destabilised by these proposals. This issue was of concern across the whole of the region and not just to the Leicestershire, Leicester and Rutland area. A petition signed by people all across the region had also been sent to London.

ISSUES RELATING TO STANDARDS

a) There was concern about the process by which the standards were fixed and introduced which then resulted in losing a good service that was currently appreciated by everyone and the new system of standards would prevent it from being provided.

b) It was questioned whether all NHS Trusts currently providing Level 1 CHD services been given the same support by NHS England to reach the new standards and whether any NHS Trusts had been given more time to reach these standards than other NHS Trusts.

c) Members asked for the evidence base used by NHS England to determine that each surgeon should undertake 125 operations per year. Members referred to the quote from The School for Health and Related Research in Sheffield, which had stated that "whilst a relationship between volume and outcome exists this is unlikely to be a simple, independent and directly causal relationship, i.e that no cut-off relating to surgical volume and better outcomes was identified. There was never any indication of the number of minimum or maximum cases which should be done each year by an individual surgeon." As such, the figure of 125 was arbitrary and it was questioned why a surgeon carrying out 100 operations a year could not be as good as one carrying out 150 operations per year.

John Adler clarified that UHL did not dispute the numbers in the standards per se but did dispute how they were being applied. In relation to Newcastle, there appeared to be no evidence to suggest they would ever reach those numbers in the standards but NHS England were prepared to allow them to continue providing Level 1 services because they also undertook transplant services. UHL felt that, if it was safe for Newcastle to continue providing Level 1 services with numbers considerably smaller than Leicester, then why was it not safe for Glenfield to continue to provide Level 1 services which would also allow them to continue to support the national ECMO service, which they had pioneered and developed.

NHS England responded by indicating that if Newcastle could not meet the numbers in the future in the agreed time frame then it would be necessary to revisit the issue of commissioning those services. It was further emphasised that there was no implication in NHS England's proposals that any current service was unsafe; the proposals were intended to ensure there was resilience for the future. No time frame had yet been specified for Newcastle to meet the standards and the Joint Committee were entitled to comment upon that and put views forward in response to the consultation.

d) Members commented that they felt double standards were being applied to Newcastle compared to Glenfield. Members felt that if it was acceptable for Newcastle to be given more time to meet the standards, then Glenfield should have the same opportunity to meet them; particularly as the arbitrary figure of 125 operations per surgeon was not being applied equally to both centres and there was no scientific evidence to prove that 125 operations per surgeon was an absolute criteria for providing a resilient service in the future. Members saw no reason as to why UHL could not have the same opportunity to meet the standards as Newcastle and, if they did not meet them in the agreed time frame, then the situation could be reviewed at that time. It was felt that Glenfield should be taken out of the process for de-commissioning Level 1 services at the current time.

e) Concerns was expressed that the 'numbers' seemed very random and very convenient minimal figures. It was also questioned why the same criteria being applied to Newcastle in relation to the effect to people in the region if the centre was not there, couldn't be applied to Leicester. NHS England seemed to be flexible in the way some criteria were applied which gave rise to a lack of consistency.

f) The UHL's CHD unit was rated by CQC as 'Outstanding'; the only one in the country to have that category.

g) There were nearly 200 standards in the full list and not all centres met all the standards and it seemed arbitrary as to which of the standards had been weighted as being more important than others.

h) It was questioned why the standards had been implemented retrospectively for the previous 3 years and not from the date they were approved in July 2015.

NHS England Responses

i. The aim of the review was to ensure that all patients with rare conditions had access to a good service to the standards now being proposed. The current standards had been the subject of extensive consultation. There was no desire to close a centre, but the focus was to get the right standards for patients.

ii. NHS England had been consistent in the process with providers and in negotiations with surgical teams on delivering the new standards.

iii. NHS England had not been involved in initiating any changes of patient flows anywhere in the country.

iv. Newcastle Hospitals NHS Trust was the only current provider that had been given more time to reach the standards. The Trust was only 1 of 2 centres in the country providing paediatric heart transplant services. NHS England's view was that it was unsafe to remove this provision and only leave Great Ormond Street Hospital for Children NHS Foundation Trust as the only provider of the service. Newcastle was considered a special case because the surgeons that carried out operations in the CHD service also performed paediatric heart transplants. It was reiterated that because Newcastle was I of only 2 centres that carried out paediatric heart transplants, they were a special case; this did not apply to Glenfield.

v. Very often precise scientific studies were not available to provide evidence and, therefore, it was necessary to rely on the consensus of clinical experts working in the particular specialism. It was recognised that there was a wide range and number of operations that were carried out in relation to congenital heart disease disorders. The standard was felt to recognise the diversity of those requirements for surgery and this had pointed to the number of 125 operations per surgeon which had been agreed through consultation. This represented approximately 2 operations per week per surgeon and some surgeons were carrying out 300 operations a year.

vi. NHS England considered that there was strong consensus to say that the volume of work proposed led to a level of assurance about the diversity, range and robustness of services provided by the surgical team.

vii. The requirement for a team of 3 surgeons undertaking 125 operations per year was considered appropriate for providers in order to have resilience and support ward and theatre staff. It was important for providers to have a resilience of a range of procedures provided through

a wider support team of clinical psychologists and specialist nurses etc. It was accepted that the comments relating to the additional unspecified time being given to Newcastle was a valid challenge and NHS England needed to provide a response as part of the national consultation; particularly as it was not proposed to give Leicester or any other provider extra time to meet the standards. Newcastle was considered an exception because of the links to the transplant services and there needed to be a robust national heart transplant service.

viii. NHS England had always been clear on 125 operations being a minimum requirement, particularly as some providers were already undertaking more than 500 operations a year.

ix. 125 operations per year for each surgeon had been used for basis of discussions with the Trusts; both those that will no longer provide surgery and those who would be expected to do more surgery under these proposals.

x. NHS England reviewed numbers nationally from the data received from the NICOR (National Institute for Cardiovascular Outcomes Research) audit across all providers of CHD services. The figure of 125 operations per surgeon had been the result of clinical consensus and not managerial consensus.

xi. NHS England had looked at how centres could create additional physical capacity, particularly in relation to the London providers taking on additional work. It was acknowledged that the real challenge was around the workforce because, if a service was no longer provided in one place, then getting the skilled and experienced workforce at the receiving centre to deliver the extra capacity would be a challenge and was identified as a risk. However, as NHS England did not mandate where people were required to go for treatment, it was necessary for NHS England to have to make some assumptions on a planning basis about how the service would work so they had an overview of what happens in reality. They also had to ensure the process was managed so that patients were not disadvantaged by the changes if they are implemented.

John Adler then referred to the difference between having the physical capacity to provide services and the ability to use it. UHL had been trying to expand its adult intensive care capacity, and, whilst they had the physical space to provide it, they had been unable to staff the unit safely because the people with intensive care skills, and nurses in particular, were in very short supply. He observed that phrases such as 'it will a very real challenge' effectively meant that it was likely to be a huge problem. Usually beds closures resulted from nurse shortages. There was currently a great shortage across the country of paediatric intensive care nurses and medical staff. He felt that if the proposals went ahead it would have a destabilisation effect on

an existing centre, such as Leicester, and the new receiving centre couldn't simply up their capacity immediately because the existing specialist staff would generally choose not to relocate; but would seek alternative employment in their local area. Given these circumstances, he queried why this risk was being taken when the problem did not exist in the first place.

xii. The calls for consistency on the proposals were understood and NHS England would welcome views on this in the response to the consultation.

xiii. Although the CQC rating of 'Outstanding' was acknowledged the CQC had not been inspecting to the same standards now being put forward in the proposals.

xiv. NHS England had described why the sub set of standards had been chosen and why NHS England felt these to be the most important based upon consultant advice in the Assessment Report and the documents supporting the consultation documents.

xv. By end of March 2017, most of the centres in the proposals recommended to continue with Level 1 Services would meet the new standards. When the original assessment of centres had been carried no centre had met the standards. Newcastle had been assessed and the proposals were suggesting a different approach for Newcastle to the other centres, for the reason previously stated. The proposals were out for consultation and comments and views on the proposals were welcomed.

xvi. Although UHL had indicated that they would undertake 350 operations in 2016/17 this would mean they would need to undertake considerably more operations in the following year in order to achieve the average of 375 surgical procedures over the 3 year period.

THE PROPOSALS IN GENERAL

a) It seemed inequitable that, if the proposals in the consultation document were implemented, the East Midlands Region would have no Level 1 service provision and the West Midlands would have 2 centres providing Level 1 services. It would also mean that the East Midlands would be the only Region in the Country without a centre providing Level 1 Services. This could result in the Region being downgraded in NHS Services in relation to other Regions.

b) Members referred to the Equality Impact Assessment and questioned the implications of the proposals for the protected groups and how individuals groups would be affected by the proposals if the services were removed from Glenfield.

c) Recent meetings of the East Midlands councils had shown that all

councils had concerns in relation to the proposals.

d) NHS England's view that patients chose where to go to receive treatment was challenged as it was known that patients in Northamptonshire did not have the choice, because Leicester was not offered as an option.

e) There was a feeling that the consultation process was flawed and could be open to legal challenge; particularly as not all the centres had been treated consistently. There was a view that Newcastle should be assessed in the same way as the 3 centres that were being proposed for closure.

f) There was a view that the proposals had created a public perception that Glenfield was not a good centre and this had a destabilising effect on the centre which had some of the best outcomes in the country.

g) Views were expressed that the outcomes of the consultation process were already pre-determined. It was difficult to understand why a centre that was already providing a safe service with good outcomes was being recommended for closure, particularly as it was understood that the review was not driven by making financial savings but by providing a safe service.

h) General comments were made in relation to the equity and fairness of the process and outcomes. The issues of potential judicial review were raised as Glenfield was being treated differently to other centres in the time allowed to meet the standards. It would be inequitable as everywhere else in country would have access to good local services, but the East Midlands would be the only region with no local service provision.

i) The NHS England's Equalities Impact Assessment showed that 3 groups of patients would be potentially more affected by the proposed changes (Children and Young People with CHD – People with CHD and Learning Difficulties – People of Asian origin) and NHS England were asked how they would mitigate the impacts of the proposals for these groups.

j) People with Asian ethnicity were identified as a specific disadvantaged group who had higher rates of CHD. It seemed inequitable, therefore, to remove the Level 1 Service from Glenfield when Leicester had a very high level of BME population.

k) There was a view that the CHD Review was again being proposed as a solution looking for a problem that no longer existed. The proposals did not appear to be about future resilience, enhancing patient options, or improving waiting times and travel times but about concentrating skills in some areas. The logic was understood to some extent but it assumed staff would transfer from centres that were proposed to be closed to

centres that were identified as increasing their capacity. Serious doubts were expressed that this would materialise and it would be better to allow the current system to have more time to develop the resilience being sought.

John Adler commented that there had been strong support at the public meeting from the public and patients that NHS England should be more proactive and be prepared to be to help Leicester to meet the standards and UHL would support this.

NHS England Responses

i. Although it was proposed to remove Level 1 services from UHL, NHS England were of the view that Level 2 Services could still be provided by UHL which would mean that the East Midlands would retain a specialist centre for non-surgical interventions. There was a difference in opinion between NHS England and UHL Trust on what Level 2 Services could offer. There was also more work needed by NHS England to define what Level 2 services could look like.

John Adler suggested it would be helpful to explain why UHL were in dispute with NHS England on the question of whether they could be a Level 2 Centre. Claire Westrope, Consultant Paediatric Intensivist and Clinical Lead, stated that one reason for this was that the model of a Level 2 care centre did not exist, so it was very difficult to determine if UHL could provide these services as there was nothing upon which to base an informed decision. Currently Oxford and Cardiff were working as Level 2 Centres but they did not do high level interventions because those centres did not have cardiac intensive care, anaesthetists or the necessary support expertise required. For example, it would not be possible to undertake a cardiac catheter procedure in a Level 2 centre because cardiac anaesthetists would be in a Level 1 centre. There was also disagreement about how a Level 2 centre would look without a Level 1 cardiac services also being in place. A specialist cardiac lead or cardiac intensivists would not be in Leicester if there was not a Level 1 centre and this part of the model had not been thought through in the proposals. It was also felt that there were too many other inconsistencies in that model to be able to say that a Level 2 service could be provided in Leicester.

ii. It was misleading to suggest that the West Midlands would have 2 Level 1 centres in Birmingham as 1 Trust provided Adult Services and 1 Trust provided Children's Services, but both Trusts provided these services at the same single centre.

iii. NHS England's proposals were not intended to down grade services but to make sure providers met the new service standards.

iv. It was recognised that UHL was a large NHS Trust that already delivered a number of other specialist services commissioned by NHS England to the standards required for those services and NHS England would wish to see these maintained in the future.

v. It was refuted that the proposals were being put forward with pre-determined outcomes or that NHS England were determined to close any Level 1 Centre. Professor Huon Gray, National Clinical Director for Heart Disease for NHS England had said at the local public meeting that NHS England would like to be in position that all providers, including Glenfield met the standards, but that was not the case. There was no pre-determination to close any centre but NHS England were determined to ensure that the new standards were met. Feedback on the proposals would be welcomed.

vi. It was expected that all providers would give patients and their families information about options of services that were currently commissioned.

vii. NHS England would be working with voluntary and community organisations in relation to the 3 groups identified in the Equality Impact Assessment. A recent blog had also been published that signposted children and young people to a website containing material on the review.

viii. NHS England had been charged with implementing the proposals to meet the standards and they needed to see how they could manage the impact of the proposals on individuals who were affected by them, and the consultation process should assist with this.

ix. There was a basic tenet of a relation between number of operations carried out and outcomes achieved. There was some evidence that the more operations that were carried out did lead to better outcomes for patients; particularly in relation to outcomes in strokes in London and aortic aneurism procedures. The general direction of travel underlined continual improvement and aimed to ensure expertise. There were already good outcomes for CHD services, monitored by 30 day post operation mortality rate, but the challenge was to improve these further for the future.

Claire Westrope commented that it was accepted that there was some evidence that higher volumes produced better outcomes in certain fields, but these did not stack up well in CHD services. However, one area where the evidence was fully accredited was in relation to ECMO. She observed that the reason Newcastle was protected was because of the expertise and relationship with heart transplant surgery, but there were not large numbers involved. It had been shown time and time again by UHL in relation to neo-natal respiratory ECMO that outcomes were better. However, because ECMO was being looked at separately to CHD, Glenfield was being disadvantaged as ECMO was

fundamental to Glenfield's CHD unit. If Leicester's CHD unit was closed, the impact on the national service would result in lower outcomes because the ECMO experience would be dispersed and spread out across all the cardiac centres and the expertise currently provided by Glenfield would be lost. This aspect had been lost in the consultation process for CHD Services. Newcastle had something special and were being treated as a special case and yet Glenfield had something equally special with ECMO and were not being seen as a special case.

x. The proposals for both Newcastle and Leicester were clearly set out in the proposals together with the reason for them. The views expressed in the meeting had been noted and would no doubt be reflected in the formal response to the consultation.

xi. It was accepted that Glenfield had pioneered work on ECMO but there have been changes over years and more providers now had ECMO in addition to Leicester. NHS England felt that it would be possible to commission extra ECMO capacity elsewhere in the country, in the event that the service would no longer be delivered by Leicester. It was considered to be more feasible to commission extra ECMO capacity at relatively short notice compared to what is considered to be a greater learning curve around paediatric heart transplants.

xii. NHS England had focused discussions on the area where the Trust and NHS England were in disagreement. The challenge clearly expressed at the public meeting was how long Leicester would be given to meet those standards.

<u>ISSUES RELATING TO TRAVEL</u>

a) The East Midlands was a rural area and many families did not have access to cars. The journey time from Lincoln to Birmingham using Public Transport was in excess of 2 hours. The proposals would place additional burdens on families by removing a service that already provided safe outcomes in the East Midlands.

b) NHS England's travel time analysis set out in Table 12 of their Congenital Heart Disease Equality and Health Inequalities analysis was questioned in terms of the times quoted and why there were differences for Adult and Children's traveling times.

c) The travel analysis failed to recognise the actual geography of an area and not historic travel movements. The proposals also contained a proposal to cease Level 2 services at Nottingham, so if Leicester could not provide Level 2 services either without providing Level 1 services as well, then there would no local access to Level 2 services in the East Midlands. There was no indication in NHS England's travel analysis of how much further all people in the region would have to travel for both Level 1 and 2 appointments. Unlike Newcastle, UHL had said they

could meet the standards within a specified time frame, so it was questioned why flexibility could not be exercised to give them the time to meet the standards.

d) The proposals would increase the distance for people to travel and this would increase the pressures on families at a worrying time. Travel to Birmingham Children's Hospital was often in excess of 2 hours. East to west travel across region was difficult and congestion around Birmingham Hospital would only add to length of travel time and, in addition, the M6 was often congested and subject to long delays

NHS England Responses

i. NHS England had undertaken and impact assessment relating to travel. It was known that a significant number of patients from Lincolnshire currently travelled to Leeds for treatment so it was wrong to assume that everyone in East Midlands went to Leicester for treatment.

ii. Strong views were raised in public meeting in relation to the travel and transport issues. NHS England had made a commitment at the meeting to provide more evidence of the modelling of the travel time differences. The current model reflected where people travel from at the moment and it was possible that if people travelled great distances it could give a distortion.

iii. The model currently looked at where people would go to the nearest Level 1 centre but it was recognised that patients may not choose to go there. There were other ways of modelling these could be looked at as well.

iv. NHS England had looked at where everyone currently lived who attended an existing centre. If they all went to their nearest alternative centre, the model identified what would be their change in travel time. It was possible that some people already travelled from long distances outside the local area to come to Leicester at the moment, so this could be why the model identified them as travelling less. The model was also based upon private transport not public transport. The data for the travel model had been from NHS Trusts currently providing Level 1 Services. NHS England would look to explain the apparent travel anomalies on their website. It was noted that the existing travel maps had a busier feel that might have been expected.

v. NHS England had noted Members' comments, many of which echoed the views put forward at the local public meeting.

vi. NHS England were still of the view that if Nottingham ceased to provide Level 2 Services these could still be provided in Leicester, but it was recognised that was still area of dispute with UHL. NHS England recognised that they needed to describe in more detail what a Level 2 centre would look like and use these in discussions with UHL.

vii. NHS England had not got any pre-conceived outcomes on the proposals and as such were keen to hear views express during the consultation process.

The Chair commented that there had been a useful discussion of the issues, it was clear what the concerns were and they were shared by shared by all. The issue of services continuing at Glenfield effectively came down to whether 125 operations per year per surgeon was the right level and what NHS England could do to assist UHL to get to that number. She felt that generally patients' do not have a 'choice' as they take doctors/consultants advice. UHL could easily achieve the numbers required if existing centres in the East Midlands, such as Northampton, told patients that good CHD services were available at Leicester and not refer them to Southampton.

The Chair stated that there would be a further meeting of the Committee to hear the views of patients, members of the public and stakeholders. NHS England were invited to attend the meeting to hear the views expressed as she felt that holding 1 public meeting for the East Midland's area was insufficient in relation to the potential effect upon the region. It would also be helpful to invite representatives of the groups that were identified in the NHS England's Equality Impact Assessment to hear how they felt the proposals could be mitigated for them and how the changes would be different for them.

31. NEXT STEPS IN RESPONSE TO THE CONSULTATION PROCESS

AGREED:-

1) That a further meeting be held to hear the views of patients, members of the public and stakeholders on the proposals in the consultation document, including representatives of protected characteristic groups that were identified in the NHS England's Equality Impact Assessment as being affected, to hear how they felt the impacts of the proposals could be mitigated for their particular group.

2) That NHS England be requested to be represented at the meeting.

32. ANY OTHER URGENT BUSINESS

There were no other items of Any Other Urgent Business.

33. CLOSE OF MEETING

The Chair declared the meeting closed at 3.45pm.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

University Hospitals of Leicester NHS Trust East Midlands Congenital Heart Centre update

Leicester , Leicestershire and Rutland Health Overview and Scrutiny Committee

APPENDIX B

2017 Hold on to our Hearts

East Midlands Congenital Heart Centre

Consultation timeline

- **9th February 2017** - NHS England launched the consultation
- **6th June 2017 -** original completion date to take into account the period of purdah for the local government elections
- **8th June 2017 -** General Election will require a further extension of the consultation period
- **9th June 2017** – public consultation meetings can resume
- **17th July 2017** – end to public consultation
- **30th November/ 14th December 2017** – NHS England Board meeting dates

NHS England consultation key points

	Criteria	Compliance
1.1	Surgery and catheter procedures to take place in a Specialist Surgical Centre	Compliant
1.2	Network MDT discussions for rare, complex and innovative procedures	Compliant
1.3	Age-appropriate care environments	Compliant
2.1	Surgeons to be primary operator in 125 procedures each year (3-year average), 4 surgeons by 2021	Plan not approved
2.2	Cardiologist to be primary operator for 50 procedures each year (lead cardiologist = 100) each year (3-year average)	Plan
3.1	Surgical rotas should be no more than 1 in 3	Compliant
3.2	Interventional cardiologist rotas should be no more than 1 in 3	Compliant
3.3	Cardiologist rotas should be no more than 1 in 4	Compliant
3.4	A consultant ward round occurs daily	Compliant
3.5	Patients and their families can access support and advice at any time	Compliant
3.6	Network medical staff can access expert CHD advice at any time	Compliant
4.1	Co-location of key specialities and facilities (call-to-bedside within 30 mins)	Plan
4.2	Key specialities to function as a multidisciplinary team	Compliant
5.1	Participate in national audits, use current risk adjustment models and learn from adverse incidents	Compliant

- Standard 2.1 is now the ONLY standard that NHS England consider we do not meet
- Our network relationships are crucial to meet the 500 case standard by 2021
- EMCHC growth plan will be sent to NHS England this week

EMCHC Growth Plan

- **Total East Midlands Demand** – current demand is 512 surgical cases- NHS England's own activity forecasts show East Midlands demand will be between 525 and 546 by 2020-21
- **Current activity** – EMCHC have increased caseload from 232 cases in 2005/6 to 345 cases in 2016/17 – and will meet the 375 average by 2018/19
- **Growth from increasing referrals from existing partners** – through dedicated PIC/NIC transport, improved facilities and increased capacity , outreach provision and improved prenatal detection rates

EMCHC Growth plan

- **Intrinsic EMCHC growth** – Increased ACHD population re-operation rate , on- going ECMO Programme with new NICOR applicable cannulation's and a new overseas patients plan leads us to a projection of 471 surgical case load by 2020/21
- **Growth from new network partners** – we have had confirmation and desire to support our growth plan from Chesterfield, Peterborough and Northampton Hospitals and have begun discussions on how to implement the necessary referral pathways
- **Growth from outside our original network (numbers not included in plan as yet)** Milton Keynes and Bedford Hospitals fall within the NHS England travel time catchment and we will extend the offer of our services . South Warwickshire NHS Foundation Trust have established a new referral pathway with EMCHC

Anticipated position for 2020/21

Financial year	Growth based on 2014-16 activity	Continued 2014-16 growth + population increase + network expansion
2016-17	345	345
2017-18	375	381
2018-19	403	419
2019-20	435	459
2020-21	471	515
2021-22	509	546

We sent NHS England our Growth Plan on the 3rd May 2017

Key areas of concern in the consultation

Inconsistency of approach

- Despite not meeting the numbers or co location standards Newcastle is being given more time and support to achieve them due to their heart transplantation work
- NHS England are not affording the world class ECMO services at UHL the same derogation
- Growth plans/ impact statements to meet numbers from other Level 1 centres are not published and do not appear to be subject to the same scrutiny as ours

Key areas of concern

Lack of crucial information

- The PIC review which is covering ECMO , PICU , and specialist surgery is running alongside this review – although we have been assured that initial findings will be fed into the CHD consultation process – this will not be in time for the public to see before commenting
- This is in contrast to the IRP recommendations post Safe and Sustainable

Key areas of concern

Transition and implementation

- The detail behind the ability of the proposed centres to receive EMCHC caseload is scant and based on numbers that are 4 years out of date and do not match current caseload
- Specialist workforce recruitment is seriously under question and the impact on the wider profession is worrying
- Capacity – PICU capacity and waiting lists in other level 1 centres are under severe pressure currently – what the is risk of implementation?

Summary

- Geographical balance of CHD provision severely threatened by NHSE plans and specifically to the detriment of the East Midlands population
- The risk of implementation is yet to be fully quantified and appears to be significantly higher than the risk of EMCHC not meeting the standards within the timeframe
- EMCHC Growth plan is highly detailed, uses NHS England's own data and clearly demonstrates that the 500 caseload standard is achievable by 2021
- Even with our conservative growth estimates – the 500 caseload standard will be achieved by 2021/22

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15th June 2016

Dear Mr Sandhu

Re: NHS England proposals to downgrade the Congenital Heart Disease services at Leicester

Thank you for providing me with the opportunity to comment on the proposals to downgrade Congenital Heart Disease services in Leicester, on behalf of the University of Leicester.

Unequivocally, there are powerful arguments based on the clinical need of the local and regional populations, and based on the impact that any altered service would have on other aspects of the delivery of high calibre medical care. In addition to these clinical arguments, there are massive implications for the Academic Mission in the city – in terms of our research endeavour, training and reputation.

The University of Leicester's strategy, mission, objectives, and workflows, are all closely intertwined with those of the Trust. Our research mission has been particularly successful, as a consequence of an almost seamless progression from scientific discovery through to translation for patient benefit. A strong research mission ensures the very best clinical care, with highest calibre clinicians and access to cutting edge clinical trials. It is for this reason that clinical outcomes are improved around centres of academic excellence such as in Leicester.

Cardiovascular science is a particular strength in Leicester. Cardiovascular disease is one of 3 themes in the National Institute of Health Research Biomedical Research Centre that Leicester was recently awarded (an award made to the Trust-University partnership. In recent months Cardiovascular researchers have secured several major research programme and project funding awards from the British Heart Foundation, National Institute of Health Research, and the UK Research Councils. Our cardiovascular research endeavour is one of, if not the strongest such centres in the UK, and leads research across the world. On several objective measures, cardiovascular disease is the strongest area research activity within the University.

The arguments are just as strong from a teaching and education perspective. Medical students are typically inspired to enter individual specialties based on interactions with particular mentors. In Leicester we have some of the most prominent and successful clinical academics in the UK who are committed to ensuring that there is a continuous and continual pipeline of talented educators and researchers. In recent medical student feedback, the cardiovascular module was one of the most highly rated by our students.

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The presence of the cardiovascular disease service offers a unique opportunity to researchers and educators at the University of Leicester and we would unequivocally want to support this and see it remain in the city. There will be a range of lost opportunities if the service was to be lost. The University's commitment to this particular element of the cardiovascular service is emphasised by our recent funding and appointment of a Professor in Children's Heart Surgery.

Children's heart surgery is a jewel in Leicester's clinical crown and the University is delighted to be able to support the arguments to retain the service within Leicester.

If there is anything further I can do to augment these comments, please do not hesitate to contact me.

Very best wishes,

Yours sincerely,

Professor Philip Baker

cc. Aidan Bolger
Alison Poole