Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 18 AUGUST 2016 at 4.00pm

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Chief Inspector Lou Cordiner	–	Local Policing Directorate
Frances Craven	–	Strategic Director, Children's Services, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Dr Peter Miller	–	Chief Executive, Leicestershire Partnership NHS Trust.
Superintendent Mark Newcombe	–	Adviser to the Police and Crime Commissioner, Office of the Police and Crime Commissioner.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Sarah Prema	–	Director Strategy and Implementation, Leicester City Clinical Commissioning Group.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.

Ruth Tennant	–	Director of Public Health, Leicester City Council.
Mark Wightman	–	Director of Marketing and Communications, University Hospitals of Leicester NHS Trust

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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16. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

John Adler, Chief Executive, University Hospital of Leicester NHS Trust.
Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner.
Andy Keeling, Chief Operating Officer, Leicester City Council.
Chief Superintendent Andy Lee, Head of Local Policing Directorate, Leicestershire Police.
Sue Lock, Managing Director, Leicester City Clinical Commissioning Group.
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group.
Trish Thompson, Locality Director Central NHS England – Midlands & East – (Central England).
Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

17. DECLARATIONS OF INTEREST

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

18. APPOINTMENTS TO THE BOARD

The Board noted that the Council had made the following appointments 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 had 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 reflecting these changes were received by the Board.

19. MINUTES OF THE PREVIOUS MEETING

AGREED:

> That the Minutes of the previous Board meeting held on 6 June be confirmed as a correct record.

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

NHS England presented 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 (CHD) Implementation Programme and Regional Director of Specialised Commissioning (London), NHS England and Dr Geraldine Linehan, Regional Clinical Director, Midlands and East for Specialist Commissioning, NHS England, attended the meeting to present the report.

The Board also received 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. Copies 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 had also been submitted for information.

The Chair welcomed the representatives of NHS England to the meeting, together with Mr E White CC, Chair of Leicestershire County Council's Health and Wellbeing Board and Councillor V Dempster, Chair of the Leicester City Council's Health and Wellbeing Scrutiny Commission.

The Chair invited members of the public to indicate if they would like to contribute to the discussion on this item and four members of the public asked to speak to the meeting.

Mr Huxter, NHS England, thanked the Chair for the opportunity to present the report and to set out the proposals for change and the basis upon which they had been made. He was also keen, as the Senior Responsible Officer for congenital heart disease work across the country; to listen to the Board's and the public's questions and concerns and have the opportunity to address them.

He also introduced Dr Linehan Clinical Director for specialist commissioning for the Midlands and East region. Dr Linehan stated that she was a GP by training, not a specialist in Congenital Heart Disease (CHD); but did have an overall remit for quality of services in the region.

In presenting the report, Mr Huxter stated he wished to set out the context of the proposals and their rationale and then outline the next steps in the debate and consideration of the proposals. During the presentation of the report he made the following comments:-

a) NHS England had not made any final decision yet on Glenfield or any other providers of CHD.

b) The proposals were based upon assessments of whether trusts currently met the standards or were likely to do so in the time frame set out in NHS England's standards.

c) NHS England were meeting University Hospitals of Leicester NHS Trust (UHL) on 16 September 2016 to discuss in detail their assessment and the trust's response.

d) There would be formal public consultation on the proposals later this year, and NHS England would want to come back to the area to talk to the Joint Health Overview Scrutiny Committee once the consultation was launched.

e) Much of the debate about CHD services was focused on the standards, their development and how they fitted in with the overall approach NHS

England were taking. After discussions with stakeholders over a wide range of areas, a new CHD review had been established in July 2013. The aims of the review were fundamental to what NHS England were trying to achieve and these were:-

- Secure the best outcomes for all patients. This was not just about the lowest rates of mortality but also about reduced disability and improved opportunity for survivors to lead better lives.
- Tackling variation. To ensure services across the country consistently meet national standards and were able to offer resilient care 24/7; so the care required was available at all times when needed day and night.
- Improve patient experience. To provide information to patients and families and consideration of access and support for families when they are away from home.

The standards can be found on the NHS England website at the following link:-

https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/

f) The standards were lengthy but they did demonstrate they were not just focused in the clinical aspects of care; but also about support and services for families. The standards were central to the review and described what constituted an excellent CHD service, and had been used to assess Leicester and other provider centres across the country.

g) The standards had been developed with the CHD service and experts in CHD, patients, professional bodies and charities. They had received strong consensus before going to public consultation. The standards were formally agreed by the NHS England Board in July 2015. There had been strong representations from patient groups supporting the standards but also supporting NHS England, as the commissioner of services, to ensure the standards were met.

There were three levels of service set out in the paper –

- Specialist Surgical Centres (Level 1)
- Specialist Cardiology Centres (Level 2) - which NHS England was proposing for Leicester in the future
- Local Cardiology Centres (Level 3)

h) NHS England considered two areas of the standards were particularly important determinants of service, quality and safety. These were:-

– Surgery All surgeons should be at least part of a team of 4 surgeons, with on call commitments no worse than 1 in 3 from April 2016. Each surgeon must undertake a minimum of 125 operations per year and, from April 2021, a minimum on call commitment of a 1 in 4 rota. This was to ensure that there were

surgeons with the right level of expertise and experience across a range of operations which CHD may require. Also making sure that the system had resilience to have staff to cover 24 hrs.

- Surgery from sites having service interdependencies. This was not a technical abstract issue, but was fundamental to having expertise available when patients were very unwell and all services were on the same site 24/7 to be at the bedside when required.

i) NHS England were convinced that the standards would make a real difference in ensuring that services were safe, of high quality and were available 24/7 by teams of professionals working closely together in an integrated way.

j) The numbers of operations were not just important for the surgeon but also for the wider clinical team, theatre nursing and other clinical staff, to provide much greater resilience and stability within providers to attract and retain surgical and other clinical staff.

k) The assessment process had taken some time. The assessment had been based upon on evidence submitted by UHL. NHS England considered that the UHL had not meet minimum 125 operations per surgeon and a total of 375 cases spread across 3 surgeons and did not meet the full range of other services required to be provided on the same site.

l) After considering the evidence from UHL and all other providers, NHS England were proposing to cease commissioning specialist services (surgery and interventional cardiology) from UHL but were looking to continue to provide level 2 specialist cardiology services in Leicester. It was stressed that there were no proposals to close Leicester as a provider of CHD services, apart from surgery and intervention cardiology. Patients would continue to access services locally in Leicester. NHS England wished all patients across the country to have access to excellent CHD services, and the proposal, if implemented, would transfer some patients currently receiving treatment from Leicester to Birmingham. There were already close links between the two centres and some complex cases were already referred to Birmingham. Most of the care patients received was not surgical and that non-surgical care would continue to be provided at Leicester. NHS England accepted that some patients would have to travel further for surgery and intervention cardiology but considered that people already chose to travel for excellent care; and the greater part of treatment provided for CHD was not emergency surgery but elective planned work.

m) During the pre-consultation engagement on the proposals, NHS England wanted to talk and listen to concerns and questions from Health and Wellbeing Boards and other stakeholders. NHS England would also be talking to UHL about the proposals and their implications for other

paediatric services within the trust if these proposals were taken forward.

n) Both ECMO, which is a large and important service within Leicester, and paediatric intensive care services (PICU) were being looked at as part of national reviews being carried out by NHS England to ensure that they took a joined up approach to specialised paediatric services.

o) The high level timetable was set out in the report; with a final decision after consultation being taken in spring 2017. It was emphasised that nothing would change overnight. NHS England would consult on the proposals and, if agreed, would implement them carefully in a measured way. The primary concern was for patients to have access to best possible services.

In summing up Mr Huxter reiterated that most CHD care would still be provided at Leicester; the proposals solely moved surgery and interventional cardiology to Birmingham and the greater part of CHD work was not emergency but elective surgery. NHS England believed passionately that implementing these standards would deliver better outcomes for children's and adult's CHD services. They were conscious that there had been a long period of uncertainty in CHD dating back to Bristol in 2001, but believed these proposals, if taken forward, would end that uncertainty and ensure there were resilient services available to Leicester, the East Midlands and the area beyond for the future.

The Chair invited, Mark Wightman, Director of Communications, University Hospital of Leicester NHS Trust (UHL) to respond to NHS England's report. Mr Wightman stated that:-

a) He was representing UHL Trust Board and the 300 staff working in the in East Midlands Congenital Heart Centre unit. He introduced two staff present in the public gallery to answer clinical questions if necessary. Dr Frances Bu'Lock – Consultant Paediatric Cardiologist and Elizabeth Aryeetey, Lead Nurse for the East Midlands Congenital Heart Centre

b) The East Midland Congenital Heart Centre at Glenfield had made excellent progress over recent years. It had expanded bed numbers and staff, improved outcomes, invested in staffing, created a new adolescent unit and briefed architects to create new single site children's hospital which would meet the NHS England's co-location standard. This had been done against a backdrop of uncertainty following the Secretary of State's statement on the flawed decision to stop surgery in Glenfield 4 years ago.

c) UHL disagreed that to cease commissioning children's heart surgery in the East Midlands was "in the best interest of patients with CHD and their families." UHL failed to see how leaving the East Midlands as the only region without a specialist centre was equitable.

d) UHL already provided one of the best performing surgical centres in

England. They were confident that when latest NICOR data was published in October, Glenfield's clinical outcomes for patients would be amongst the best in the country. Despite seeing more children than ever, there had been no deaths within 30 days of surgery for 15 months. The same day cancellation rates and un-planned re-operation rates within 30 days were significantly better than the national average. The patient and families satisfaction rates were currently 99%. This was supported by the CQC's initial feedback of their recent inspection in observing "the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital" UHL felt this should alert NHS England that to implement their decision would be a grave mistake.

e) UHL were on target to meet surgical numbers. They had carried out 280 surgical cases in 2014/15 and had increased this to 332 in 2015/16. They expected to meet 375 cases per year with 3 surgeons within the next 3 years. This had been achieved by 31% increase in beds, including the adolescent unit and a short stay bay after approx. £1 m investment

f) UHL felt that the standards they had been consulted upon changed after the clinical engagement exercise from a commitment to achieve 3 surgeons and 375 operations from the introduction of the standards in April 2016 to a retrospective 3 surgeons and 375 operations by APRIL 2016. NHS England had effectively shortened the timescale for delivery by 3 years and must have known that it would exclude Leicester and yet had still stated, in a report to the NHS England National Board, that a major reconfiguration of specialist services with the associated risk and upheaval could probably be avoided.

g) UHL quoted NHS England's own words that the magical 125 cases per surgeon was "arbitrary". The School for Health and Related Research in Sheffield, 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."

h) UHL considered that the NHS England were proposing to close a top quality service despite clinicians working in the service being confident to achieve the required number of procedures; and this was compounded by NHS England applying the standards retrospectively. The decision was also based upon an arbitrary number of cases for which the NHS England's own reviewer had said there was no scientific evidence. UHL therefore encouraged NHS England to look again at UHL's outcomes, zero mortality rates and actual results.

i) EMCHC (East Midland Congenital Heart Centre) supported 12 PICU (Peadiatric Intensive Care Unit Service) beds which would be lost if NHS England ceased to commission CHD surgery at Glenfield. Losing the

Glenfield PICU beds would also result in the viability of the Leicester Royal Infirmary PICU beds being compromised, as the paediatric intensivists worked across both units. These specialists were attracted to Leicester by the diverse caseload that working across the two sites offered and this would be lost if more than half the PICU beds disappeared at Glenfield. Glenfield provided 30 % of the PICU capacity across Birmingham, Leicester and Nottingham. The National PIC Directors meeting in July had unanimously expressed the view that the NHS England's proposals made proper evaluation and response impossible and presented a significant destabilising pressure on PIC services; which may be further destabilised through the PIC national review at a time when there was a national crisis in PICU capacity.

j) There would be a domino effect if Glenfield PICU capacity was lost and LRI's PICU capacity was compromised; as it would have a knock effect on other specialist paediatric services which required intensive care to function safely. This included children's general surgery, ear nose and throat surgery, metabolic surgery, fetal and respiratory medicine (children who received long term ventilated care) children's cancer and neonatal units. In addition, neighbouring hospitals supported by specialist teams in Leicester would not be able to look for support for their more complex patient care from their nearest specialist trust, UHL. This would affect Burton, Coventry, Kettering, Northampton and Peterborough hospitals. Therefore closing Glenfield CHD surgery would ultimately undermine other specialist services across the wider East Midlands.

k) The ECMO facility at Glenfield was the largest paediatric respiratory ECMO unit in the country and provided 50% of the national capacity. Leicester had pioneered ECMO and the unit was used in the swine flu pandemic in 2010. The Glenfield ECMO unit was the only service to provide a national transport service by stabilising patients before moving them to a specialist centre. The proposals to cease CHD surgery at Glenfield would also result in the loss of the ECMO unit as staff also worked in ECMO and the service would lose decades of staff experience, knowledge and innovation. The standards stressed the importance of numbers, and UHL questioned why this had not been applied to ECMO as well.

l) UHL felt that if NHS England wanted to support centres they should broker conversations that meant patients are treated in their nearest hospitals and not support the existing system where patients in Northampton are referred to Southampton for no real evident reason. If commissioning took place to the nearest centre, then Glenfield achieving 375-500 cases per year would be simple. Patient choice was not the reason for these apparent perverse patient flows. It was considered that any parent faced with dealing with a very sick child would send them to wherever their referring doctor suggested. They felt this was effectively a clinician choice and not patient choice that was being applied. If patient choice was important to NHS England, UHL questioned why they

were removing that choice from 300 patients a year that considered Leicester as their local centre.

m) Given all the above views, UHL had been incensed when NHS England had said they would work with Bristol and other centres to achieve the standards in full on the same day they indicated that UHL's CHD service would be closed. Bristol's Children's Heart Unit had triggered an investigation in 1990's when 35 children had died through poor clinical practice and more children suffered poorer outcomes than expected. A further review was carried out in 2014 related to concerns of mortality rates and the second review report for Bristol was published the same day as Glenfield were informed that their unit was identified for closure.

n) UHL failed to understand why NHS England was responding to a centre with quality concerns elsewhere when indicating to close a service with no concerns.

o) Many things had changed since the original review of the Bristol unit. There were now 5 fewer centres and mortality data for each centre was published annually, which was better than peer centres in other developed health economies. The mortality rates had halved in the last 10 years for this type of surgery.

p) UHL considered their position to be uncomfortable and unwelcomed. It seemed that NHS England were offering a new solution to old problem that no longer existed. UHL wanted to continue to do the best for their patients and families. UHL stressed that they were not being parochial in their views but they could not, in all consciousness, let a well performing service be destroyed.

Mr Ernie White CC – thanked the Chair for the invitation to take part in the Board's consideration of this issue. He stated that everyone was determined to fight UHL's case in partnership with the city council and other local stakeholders. He considered UHL's presentation completely demolished NHS England's position. The County Council's Health & Wellbeing Board had met in July which resulted in the County Council's Cabinet passing a strong and robust resolution in support of UHL. He felt it would be helpful if the joint health scrutiny committee could meet soon; as scrutiny had the power to refer decisions to the Secretary of State for Health. He considered that the position taken by NHS England was unconvincing and that they were offering an old solution to problem that had gone away. He felt they had got it wrong and hoped that, by a combined effort of everyone, a change of mind could be achieved.

Councillor Vi Dempster, Chair of the City Council's Health and Wellbeing Scrutiny Commission, supported Mr White's comments and felt that UHL's statement was a convincing demolition of the argument for ceasing to close the CDH unit at Glenfield. She indicated that she would have discussions with officers to see how members of the public could be best involved in the process of the joint scrutiny health committee.

Karen Chouhan, Chair of Leicester Healthwatch expressed the support of patient groups all over Leicester Leicestershire and Rutland for UHL and the CHD centre. The Leicester Mercury Patient's Panel and other patient groups would fight hard to support UHL and to reverse the decision. Healthwatch would like to see the decision reversed now. They also wished to make sure that the consultation proposed was framed in such a way that it empathised with the patient and not NHS England; as consultations had a habit of being framed in such a way to get the answers wanted by those issuing the consultation. They would like to know that there was independent expertise in framing the questions and patients were involved in that process. They would also like assurances that there would be independent scrutiny of that consultation and no decision would be taken without that. Full reasons of any decision taken in the future should also be made available.

The Chair commented that the Board had a role to understand and analyse the submission made to them. The Board needed to fully understand the 'magic' number of cases; particularly in relation to the validity that some people were placing upon it. This also included understanding the detail of why these were so important and what and where the evidence was to support this case.

In response to the Chair's question on how many current centres across the country met the current April 2016 standards at the moment; Mr Huxter confirmed that none of the centres had met the standards at the time of the assessment by NHS England.

The Chair commented that the basis of the proposals seemed to be a judgement about the trajectory of centres to meet those standards. It was important, therefore, that further clarity was required around the difference in amber/green and amber/red markers that had been used to make that judgement. He felt the clarity about the dividing lines and judgements made were critical in understanding the recommendations because UHL had indicated a strong, credible and ambitious vison for a single site children's hospital with all interdependencies NHS England had outlined and UHL's surgical numbers were on track. Given all the clinical and surgical inter-dependencies involved, he asked what analysis had been carried out or commissioned by NHS England of the implications for wider children's medical services if the proposals to cease commissioning in these centres were progressed. NHS England could not look at CHD surgery in isolation, and they needed to be mindful of whole breadth of children's medicine services in different parts of the country. The Board would require assurances from NHS England's analysis of how children's medicine services would look in Leicester, Leicestershire and Rutland and the wider East Midlands should the proposals be implemented.

In response to the Chair's comments, Mr Huxter and Dr Linehan stated that:-

a) Leicester's assessment had been included in the report. The centres in the amber/ green category all had plans to achieve the standards being delivered in this calendar year. This was different to those providers in

the amber/red category. Further details of these could be shared with Board.

b) The national review around PICU and ECMO services, in advance of going to public consultation, was to understand the potential impact of these proposals on other children's services and other broader services

c) The standards had taken two years to develop in consultation with large number of experts, patients, parents and different organisations and had been the subject of a huge amount of debate. There was a need to remember that CHD was pretty rare and within it there were rarer conditions which were managed within a centre. It was important, therefore, that the NHS had experts with the breadth of surgical experience to operate and look after those cases.

d) NHS England's efforts were designed to do the right thing for patients and the objective of the standards was to improve care and deliver excellent care; taking it to an extra level. In order to have a safe and sustainable service it was necessary for surgeons to undertake a good volume of operations.

e) It was acknowledged that the number of operations per year was arbitrary in the sense that they had been arrived at as a judgement after lengthy discussions. NHS England offered to provide the evidence in support of the standards; including the number of cases per surgeon and total caseload per centre.

The Chair sought an explanation in laymen's terms of how much better a surgeon was in undertaking 125 operations per year compared to one who did 120 operations.

In reply, Dr Linehan stated that specifically in relation to CHD being a rare condition, it was difficult to get enough cases of rare forms of CHD to provide data to prove the number operations that were needed before you had no problems; so there was an element of extrapolation involved. However, it was known in other areas, such as centralised stoke and vascular services, that better outcomes correlated to the number of interventions that were done in a centre. Whilst the number of operations to become expert was unknown, the concept of doing more operations to achieve more expertise was an established principle. The size of teams was also important in having sustainability and to have 'fresh' surgeons to undertake the operations.

Mr Huxter added that sustainability was not just about surgeons but the whole clinical team. Although the minimum standard was 125 operations per year, there were surgeons currently doing more than 200 operations per year. Whilst the 30 day mortality data shows no statistical difference between providers, NHS England believed surgical volumes to be a key assurer of quality and safety.

Councillor Osman felt it was unfortunate that NHS England had issued their

statement in July the day after the Brexit referendum. He reported on a recent meeting of East Midlands Councils which had overwhelmingly expressed support for retaining the services at Glenfield. He felt that having a helipad at Glenfield added to its ability to carry out the services. He also questioned whether the proposed changes to the service were about standards or financial savings.

Councillor Russell commented that if the clinical standards data showed no difference in mortality rates for different levels of operations, what data should the Board be looking at in its consideration of the issue?

The Chair then invited members of the public to address the Board meeting.

Eric Charlesworth, Leicester Mercury Patient's Panel stated that he had been involved with Bristol's inquiry, safe and sustainable, the IRP review and the process for the current standards. When the standards had been approved, there had been no mention of changing the rules afterwards. He also felt that some statements made by NHS England were causing damage in this, and other areas, as they implied that patients did not receive excellent service at the centres identified for closure. He urged NHS England to look again at the evidence and data provided by Glenfield and reconsider their proposals.

He also submitted the following question:-

"In line with Governments requirements for openness candour and patient involvement throughout all change processes and to ensure that you and we avoid the repeated serious flaws highlighted in the safe and sustainable review why have you not listen to what Lord Ribeiro said in his IRP when he made his recommendations which some of them you have not even bothered to take up it would appear. Would you please give the names of the patient and public involvement representatives; can you give me assurance that they have found out local data and have consulted with local people and, by local, I mean the east midlands, before they can contribute to whether the statement that you are making about the mindfulness to withdraw this commissioning has been made? And I would like to know why there has been no apparent recent involvement of PPI when all the previous agreements were that nothing would be done without it coming back for consultation before items were issued or alterations made?"

Heather Rawlings stated that family members had received CHD surgery in October and fully praised the CHD unit at Glenfield. She felt that she had heard an excellent case of why Glenfield should stay open and endorsed UHL's statement. She expressed reservations about the review and asked how much it would cost to close centres. She also felt that the implications for families had been underestimated. Many people were living in austerity, on '0' hour contracts or on benefits, and were facing financial difficulties every day. This impacted upon their ability to travel distances to receive treatment, look after other family children and to keep their employment. These factors also affected the health of individuals.

Ms Sally Ruane – Chair of Leicester Mercury Patient's Panel re-iterated that

NHS England had stated that the 125 figure for operations was not evidence based. She commented that standards were inputs which were designed to achieve the outputs desired for a service. Standards in themselves were not an end, but a means to an end; which were excellent outcomes. She stated that the meeting had heard that Glenfield patients get excellent care at the moment; so it appeared that NHS England wished to close an excellent service on the basis of a non-evidenced based standard. This raised the question of whether the standards were being set deliberately high that they were likely to result in closures somewhere across the country. She felt there was a danger that the public confidence in NHS England would be undermined by these judgements. It was of concern that an announcement had been made that was very destabilising of the service and would have huge knock on effects on other children's services in this area and affecting children across the region; and yet no impact assessment has been undertaken.

Elaine Murray Stated that a petition had already received 26,000 signatures. The Unit was not failing in any shape or form and ECMO, in particular, received world-wide acclaim. She questioned what would happen if Birmingham could not cope with referrals from the East Midlands. The service belonged in Leicester and the East Midlands and felt that the efforts of Keep the Beat and HeartLink and all other research money that had gone into the Unit belonged to Leicestershire and the Unit should stay operational.

In response Mr Huxter stated that:-

a) There was no requirement to achieve savings in the review and no savings would be achieved. The review was driven by standards.

b) The information requested by Mr Charlesworth could be provided.

c) All parties involved had a responsibility to demonstrate transparency and openness.

d) Details of the public consultation and the PPI involvement could be made available.

e) The review was not about cost or privatisation of the NHS and the impact on families travelling to obtain intervention surgery was noted.

f) The Standards had not been set too high for achieving excellent care.

g) The public announcement was not timed to coincide with the Brexit referendum.

h) The views expressed at the meeting had been heard and he wanted to listen and to have a debate in Leicester about the proposals. He felt that the meeting had been useful to hear these views and NHS England genuinely believed that the proposals would improve services.

The Chair thanked everyone for their contributions and attendance at the

meeting and for NHS England setting out their proposals and for listening to the views expressed in the meeting.

AGREED:-

1) That the given the comments and statements made at the meeting, the Board supports UHL in its challenge to NHS England's proposal to cease commissioning Level 1 CHD services from UHL and that all partners and stakeholders be strongly encouraged to do so as well.

2) That NHS England's offer to provide details of the full assessment of all the other centres be accepted to allow the Board to understand the precise methodology used to assess those centres; including the categorisation within the NHS England's traffic light indicators.

3) That NHS England provide the Board with an analysis/impact assessment of how children's medicine services would look in Leicester, Leicestershire and Rutland and the wider East Midlands should the proposals be implemented; particularly in relation to ECMO, PICU and the other children's services mentioned in UHL's statement to the Board.

4) That NHS England provide further evidence, and details of the analysis and research, around the 125 cases per year for surgeons and that scrutiny be recommended to consider in detail this particular aspect of the review.

5) That the joint health scrutiny committee be encourage to meet as soon as possible, in order to exercise its powers in relation to health scrutiny and to provide a further arena for public discussion and accountability.

The Chair adjourned the meeting for 5 minutes at 5.12 pm to allow members of the public and others to leave the meeting if they wished to do so.

The meeting recommenced at 5.17pm.

21. PRIMARY CARE STRATEGY

Professor Farooqi, Co-Chair Leicester City Clinical Commissioning Group (CCG) and Sarah Prema, Director, Strategy and Implementation, (CCG) gave 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 would be finalised once the local Sustainability and Transformation Plan was completed in September 2016; which included work around general practice. In addition, it would be informed by the Primary Care Summit that had been organised for 9 September 2016.

During the presentation it was noted that:-

a) The number of single handed practices in the City had decreased from 26 to 6 in recent years as a result of some GPs retiring and others

merging with other practices.

b) There were 59 practices in city of which 14 were training practices. The average list size of a practice was 6,531. This was slightly lower than the national average of 7,225.

c) There were a large number of Alternative Provider Medical Services (APMS) contracts; 13 practices out of the total number of 59 practices in the City. This was in contrast to the county area where there were no APMS contracts. This was an indicator of the difficulty in ensuring services in the City.

d) More practices in Leicester were rated as good by the CQC compared to the England and Midlands and East averages.

e) The number of primary sector consultations had increased continually over the last 13 years. Applicants to GP training had dropped by 15% and in 2014 one in ten slots for new GP trainees remained vacant. The number of unfilled GP posts nationally had quadrupled in the last 3 years.

f) The average funding for a GP in the city was approximately 10% below the national average.

g) The city had been divided into 4 Health Need Neighbourhoods to enable a locality delivery of primary and community care. These would include extended hours provision, urgent care services (including diagnostics), community nursing and therapy services, social services, voluntary service, self-care and patient education. The focus of the Health Need Neighbourhoods would be on prevention and mobilising community "assets" as well as the development of integrated teams to support patients with the most complex needs.

h) The CCG were also developing a HUB within 2 Health Need Neighbourhoods to provide patients with access to wider services. The strategy also included a number of initiatives (outlined in the presentation) to improve access to the services.

i) There was raft of initiatives to improve the recruitment and retention of staff in primary care. These were listed in full in the presentation.

j) The 59 GP practices were delivered from 60 main premises and 12 branch sites. There were a number of practices operating from converted houses and the CCG supported practices to apply to the NHS England Estates and Technology Fund and 5 developments to the fund were made in 2016.

k) The CCG supported the development of Federations which supported practices to become more sustainable, combine back office functions, provide uniform delivery of services, share staff across practices and

provide the potential to deliver a wider range of services.

l) There was a need for some changes in patient expectations as not all services in the future may be provided by one practice and patients may be 'referred' to a HUB for specialist services such as diabetes etc. Also patients needed to understand that minor ailments such as sore throats, colds and flu and sprained ankles etc did not require appointments with GPs; as treatment could be safely provided by other qualified health professionals. This would reduce the burden on GPs time to concentrate on patients with more serious illnesses.

The strategy would continue to evolve and comments were welcomed.

The Chair commented that it would be helpful to have milestones for the initiatives. It was recognised that some solutions were easier than others to implement and some would be more popular than others. It was, therefore essential to develop these through engagement and discussion and the forthcoming Primary Care Summit would provide a good opportunity to begin this process. He also asked what the impact of having 1 federation and Health Needs Neighbourhoods would have on the financial viability of GP practices.

Members of the Board commented that:-

a) Primary care was critical to the success and sustainability of health services and there was a real challenge in the city to achieve this. A more ambitious strategy to achieve national averages of performance in the primary care services would be welcomed. Given the intention to transfer significant activity from UHL and LPT in the future to the primary care sector through BCT and STP, it would be essential to have a robust primary care sector in place to achieve this.

b) Integrated teams already made differences to the ways in which patients were presenting to the acute sectors and were transforming services for better patient experiences.

c) Continuity of care was the prime consideration of patients and this should be linked to BCT and STP

At 5.57pm the Chair was called away from the meeting on other Council business and Assistant City Mayor Piara Singh Clair took the Chair.

In response to the Chair's and Board Members' comments, Professor Farooqi stated that:-

a) The CCG recognised that the strategy needed to be ambitious and link in with the government's initiative to recruit an additional 5,000 GPs.

b) Retention of GPs was still challenging. A number GPs recruited from aboard eventually move to Canada, Australia and America after a period of training in the UK.

c) Providing a portfolio of experiences for GPs would lead to making careers more attractive.

d) There was a challenge in breaking the circle of heavier workloads for GPs which were exacerbated in some practices by a GP leaving and the practice being unable to recruit a replacement.

e) There was scope within the integrated teams for UHL and LPT staff to work part time in the community.

f) Continuity of care was fully recognised and the planning of long term or complex conditions would require stable teams to be in place.

g) There would be consultation with the public as it was essential for them to be involved in designing the services for the future.

h) Currently 30% of GPs were aged over 50 years old which could lead to 50 GPs being recruited in the next 5 year to maintain the status quo of current number of GPs.

AGREED:

That Professor Farooqi and Sara Prema be thanked for their presentation and the Boards comments be taken into account in developing the Primary Care Strategy.

22. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public present at the meeting.

23. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would 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 were scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

24. ANY OTHER URGENT BUSINESS

There were no items to be considered.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 6.05pm