Leicester
City Council

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

Held: THURSDAY, 29 SEPTEMBER 2016 at 2.00pm

P R E S E N T:

Councillor V Dempster – Chair of the Committee
Mrs J A Dickinson CC - Vice Chair of the Committee for the Meeting

Leicester City Council

Councillor T Cassidy
Councillor V Cleaver
Councillor L Chaplin
Councillor L Fonseca
Councillor M Unsworth

Leicestershire County Council

Mrs R Camamile CC
Mr J Kaufman CC
Dr R K A Feltham CC
Mr T J Pendleton CC
Mr S Sheahan CC

Rutland County Council

Councillor G Conde
Councillor G Waller

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr S Hill CC (Vice Chair of the Committee) and Mrs B Newton CC.

Leicestershire County Council had nominated Mrs J A Dickinson CC as Vice Chair for the meeting and Mr S Sheahan CC was attending as a substitute for Mrs B Newton CC

2. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business

on the agenda.

Councillor Cassidy declared an Other Disclosable Interest as a trustee of Carlton Hayes Mental Health Trust.

Dr R K A Feltham CC declared an Other Disclosable Interest as a hospital manager at Northampton General Hospital.

In accordance with the Council's Code of Conduct the interests were not considered so significant that it was likely to prejudice either Councillor Cassidy's or Dr Feltham's judgement of the public interest. Councillor Cassidy and Dr Feltham were not therefore required to withdraw from the meeting during consideration and discussion relating to NHS England's proposals for the future provision of congenital heart disease services.

3. TERMS OF REFERENCE AND MEMBERSHIP OF THE JOINT HEALTH SCRUTINY COMMITTEE

Members noted the Terms of Reference and Working Arrangements of the Joint Health Scrutiny Committee which had been previously circulated with the agenda.

In response to a Member's question 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 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.

It was also noted that this 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.

4. PETITIONS

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

5. 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.

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

The Chair commented that this would be the first of a series of meetings to consider NHS England's proposals for the future provision of congenital heart disease services (CHD) with particular reference to University Hospitals of Leicester NHS Trust. It was not intended to cover every aspect of the proposals during the meeting; particularly as the process was currently in the pre-consultation engagement stage. There would be further opportunities at a later date to discuss the issues once the formal consultation process had started.

Members had received the following information prior to the meeting:-

a) Extracts of decisions taken by Leicester City Council and Leicestershire County Council following the publication of NHS England's proposals on 8 July 2016.

b) Rutland County Council's Health and Wellbeing Board considered the issue at its meeting on 27 September 2016.

c) Minutes of the City Council's Health and Wellbeing Board meeting held on 18th August which received a report from NHS England and a submission from the University Hospitals of Leicester NHS Trust (UHL). The minutes were supported by the following documents:-

   i) A report of NHS England and their Assessment of UHL submitted to the Board which had been updated to reflect the subsequent meeting held with UHL on 16 September 2016. It also included a revised high level timetable for the consultation and decision making process.

   ii) A letter to the City Council's Deputy City Mayor from NHS England in response to questions asked at the Health and Wellbeing Board.

iii) NHS England's evidence base for new standards & specifications in relation to the 125 cases per surgeon that had been requested by the Health and Wellbeing Board.

NHS England had been invited to attend the meeting and had originally indicated that they were available to attend, however, a national oversight meeting for all of specialised commissioning had subsequently been arranged for the same day as the Joint Committee. Consequently, NHS England staff involved in the review were now unable to attend or send a representative as they were all required to attend the national oversight meeting. They had, however, submitted a revised report and had stated they would welcome the opportunity to attend a future meeting of the Committee.

Councillor Conde reported that the leader and portfolio holder for health at Rutland County Council had both issued strong statements in support of retaining current CHD services at Glenfield Hospital.

In response to a question relating to the outcomes envisaged for the Joint Committee meeting, the Chair stated that she hoped the Joint Committee would be able to support a strong message to NHS England that, having considered the information supplied to them and also taking into account the views of UHL and the public, the proposals should be abandoned now to avoid wasting any further public funds. If that was not possible and the consultation process went ahead, then the Joint Committee should agree to meet again; with NHS England representatives present to explain their proposals.

The Chair invited Members for their initial views on the proposals and the following comments were made:-

a) It was disappointing that NHS England had not attended the meeting

b) The arbitrary figure of 125 operations per surgeon was not supported by tangible evidence.

c) Place based planning was a requirement for the development of Sustainability and Transformation Plans but place based planning did not appear to be applied in NHS England's proposals.

d) The rationale for sending patients in the region to London and Southampton was questioned not only in relation to the costs to the families involved, but also on the grounds that if NHS England did not support sending patients with the region to the nearest specialist centre then, by default, they were contributing to Glenfield Hospital not hitting the required targets.

e) UHL's neonatal services currently provided services to the East Midlands region and the unit's viability could be jeopardised by the current proposals.

f) The additional travelling time from Leicester to Birmingham in an emergency was considered to be totally unacceptable.

g) Patients already travelled from Boston to Leicester for care and this journey would be further exacerbated if services were then transferred to Birmingham.

h) A number of statements had been made by NHS England in relation to patient choice being the reason for cases of CHD being treated outside of the region and, if this was the case, Members felt they should be provided with the number of patients and locations involved.

i) Councils in the East Midlands and East Anglia regions should be contacted to see if they have any evidence that would be helpful in responding to the proposals.

j) Some scepticism was expressed at the timetable for the review process and whether this allowed for a realistic consideration of the responses to the consultation. The 12 weeks consultation period would start in December 2016 and end in March 2017. The review of the consultation outcomes would start in April/May 2017. Letters to NHS Trusts giving them 6 months' notice of NHS England's intention to cease commissioning services from them, subject to the consultation outcomes, would be issued on 30 September 2016 with the six months' notice expiring on 31 March 2017. The timetable was considered to be cynical and intimidating and suggested the outcomes were predetermined.

k) The current review appeared to present the same outcomes of the previous Safe and Sustainability Review in 2012, which was successfully challenged through a referral to the Secretary of State. This had resulted in the Independent Reconfiguration Panel recommending that the Safe and Sustainable Review be abandoned. Glenfield Hospital was still considered to be delivering excellent outcomes for patients and no concerns had been expressed in recent years about the Hospital's performance for CHD services. Members queried what evidence, if any, NHS England had found to suggest that CHD services were not safe and should not be carried out in Leicester.

l) Glenfield provided an excellent facility and was well placed to serve Lincolnshire, Derbyshire, Nottinghamshire and Northamptonshire. Removing CHD services from Glenfield would result in the East Midlands being the only region in the country without a Level 1 specialist centre.

m) Strong concerns were expressed that the announcement had already had a destabilising and unacceptable effect upon Glenfield's reputation and could affect more people deciding to choose treatment elsewhere in the country; further destabilising Glenfield's position during the pre-engagement and consultation periods.

n) MP's in the region and the extended region under the proposed parliamentary boundary reviews should be encouraged to support the continuation of Level 1 services at Glenfield.

The Chair invited Members of the public to comment on the proposals:-

a) Karen Chouhan, Chair of Leicester Healthwatch stated that NHS England had confirmed that the consultation process would be conducted on a national basis which did not favour Glenfield Hospital. Healthwatch in Leicester Leicestershire and Rutland were proposing to organise local consultations on the proposals.

b) Sally Ruane, Chair of the Leicester Mercury Patient's Panel felt that the Joint Committee should invite interested parties to submit formal written and oral evidence and to advertise future meetings more widely.

The Chair commented that it had not been intended to involve the public at this first meeting but future meetings would be widely publicised. She further stated that any referral to the Secretary of State would be supported by robust and detailed evidence.

AGREED:

1) That the comments made by Members be endorsed.

2) That a letter be sent on behalf of the Joint Committee to NHS England outlining the Joint Committee's initial concerns and asking for the proposals to be withdrawn.

3) A further meeting of the Joint Committee be arranged once the any formal consultation process begins on the proposals and that NHS England be required to be represented at the meeting under Regulation 27 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

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

Mark Wightman, Director of Communications, University Hospital of Leicester NHS Trust (UHL) attended the meeting to present UHL's initial view on proposals from NHS England. He introduced Aidan Bolger, Paediatric Cardiologist and Head of Service for East Midlands Childrens' Heart Centre (EMCHC) and Claire Westrope, Consultant in Paediatric Intensive Care and Clinical Lead for Paediatric Intensive Care Unit who could provide clinical responses if required.

UHL were grateful for the support of the Joint Committee and the opportunity to provide evidence to enable the Joint Committee to make a qualified and

evidence based decision. UHL had always maintained that if the EMCHC had given them cause for concern or was not providing its patients with excellent outcomes they would have a different viewpoint on the proposals, however, they felt that the proposed changes were not right for their patients.

UHL's initial views on the proposals included the following:-

a) The proposal to conduct the consultation process on a national basis was of concern to UHL as the local perspective could become diluted since other areas of the country were unlikely to comment upon the proposals because they would not have any particular interest in the issues affecting the East Midlands. There was a concern that NHS England would use the national consultation to suggest that both the Glenfield and the Royal Brompton Hospitals should cease to provide Level 1 CHD services because there would be no overwhelming support in the national consultation to support them continuing.

b) The proposals also raised concerns relating to the knock on effect upon other services such as ECMO and paediatric intensive care services in the East Midlands. There was also concern that NHS England had subsequently announced they were fast tracking two national reviews on ECMO and Paediatric PICU provision to inform the review of CHD services. There was a strong view that these reviews should have undertaken before the CHD proposals were announced and not as an apparent afterthought.

c) UHL felt they had now reassured NHS England on the colocation of all services in one building and had explained the plans in place to move to 24/7 access to services. UHL were confident that they could give the necessary assurances to NHS England on this.

d) The remaining issue for UHL was the arbitrary figure of 125 operations per surgeon per year. The advisor to NHS England had never indicated a minimum or maximum number of operations and NHS England had determined the number of 125 operations per surgeon.

e) If all patients in the East Midlands area were treated at Glenfield, then the 500 operations per year could be achieved. There were currently 502 cases in the East Midlands but a number were treated out of the area. NHS England promoted 'patient choice' as being enshrined in the NHS constitution but, in reality, it was the referring clinician that was leading the 'patient choice' to go to other centres. It was felt that NHS England could provide stronger leadership in requiring centres in the East Midlands to refer patients to Glenfield in the first instance, unless there were compelling reasons for not doing so.

Following questions from Members the representatives from UHL stated:-

a) That 'patient choice' was effectively driven by longstanding established clinician networks based upon personal relationships. It was felt that

with the various reorganisations in the NHS over recent years these relationships should be reviewed to see if they were still appropriate and relevant.

b) Patients from Northamptonshire, Cambridgeshire and East Norfolk were referred elsewhere for treatment and when this was raised with NHS England their response had been that this was patient choice being exercised. UHL felt that patients were not being made aware of Glenfield as a specialist centre when being referred elsewhere.

c) The number of patients diagnosed with CHD before birth was increasing and this also determined where patients were treated. For example, patients in Peterborough had historically been referred to London for treatment and patient choice is not discussed in these clinics.

d) UHL would refer patients to other centres if it was felt that better services or treatment were available at that centre, or if the patient felt they had previously had a bad experience at Glenfield, or if being treated at Glenfield would result in a delay in them receiving treatment. UHL had raised the issue of other centres in the East Midlands referring patients elsewhere and had generally received unsupportive replies and an unwillingness to discuss the issue further.

e) UHL had raised the factual inaccuracies in NHS England's assessment of CHD services at Glenfield during their visit to Leicester on 16 September 2016 and these had been accepted by NHS England. UHL had subsequently written to NHS England requesting that their assessment should be amended in view of these inaccuracies. UHL felt that their initial assessment of meeting 8 out of the 14 core standards should rise to 10 or 11 out of the 14 core standards. The highest score in the original assessments of all centres had been 12 out of 14 and the lowest had been 6 out of 14. It appeared that colocation of services and performing 500 operations per year outweighed the other standards in NHS England's assessment process. UHL would be raising these inconsistencies within the assessments with NHS England.

f) UHL was currently on target to achieve the 125 operations per surgeon with 3 surgeons. If they moved to 4 surgeons now this would undermine their case to continue to provide Level 1 CHD services as they would not achieve this benchmark; unless more cases were referred to UHL from the East Midlands area instead of being referred elsewhere. In addition, recruitment had also been affected by NHS England's announcement of the proposals, which had cast a shadow of uncertainty over the future provision of CHD services at Glenfield and this would not encourage prospective applicants to want to work in the unit.

g) UHL had originally suggested a two site East Midlands' network centre solution, with treatment being shared between Leicester and Birmingham, in response to the previous safe and sustainability review proposals. This had been suggested again to NHS England in the

preliminary stages of this current review, but had not received any favourable support.

h) UHL had obstetricians working at Kettering Hospital and the arrangement worked well. The same offer had been made to Northampton Hospital and had been rebuffed.

i) UHL were working closely with both Liz Kendal MP and Nicky Morgan MP; who were both supporting UHL's position.

j) Pregnant women diagnosed with foetal heart conditions would not be treated by their GP's but by obstetricians in hospitals. The recognised pathways for treatment for these cases were Oxford and London.

Members asked for the following to be supplied to them:-

a) Evidence of why patients chose to receive treatment at other centres and why patients chose to have treatment at Glenfield.

b) A copy of UHL's plan to demonstrate that it will meet the standards in the required timescale.

c) A copy of UHL's response to NHS England following the visit to Leicester on 16 September 2016.

d) A copy of the upgraded assessment of Glenfield CHD services when this had been received from NHS England.

UHL's agreed to share the documents requested.

The Chair invited members of the public to make comments and observations:-

Eric Charlesworth, Leicester Mercury Patient's Panel made the following comments:-

- He thanked the Councils for arranging the meeting and for the opportunity for the public to make their views known.

- He noted that NHS England had agreed to attend a meeting with Rutland County Council on 31 January 2017.

- He felt NHS England had failed to comply with a number of recommendations made by the Independent Reconfiguration Panel (following their review of the Safe and Sustainability Reviews proposals in 2012) in the current review.

- There was concern that the proposals could mean the loss of the ECMO unit and this provided a valuable health asset for both adults and children living in the East Midlands.

- Councillors should raise the implications of the NHS England's proposals in their own localities and wards at every opportunity.

Shirley Barnes – a parent of a child with congenital heart condition stated that if Glenfield lost its Level 1 services, there would not be a specialist centre on the eastern side of the country between Newcastle and London. The East Midlands would be the only region in the country without a specialist heart centre. Patients could only travel to Birmingham Children's Hospital if there were beds available, otherwise patients in the East Midlands would have to travel long distances to other centres for treatment such as Liverpool, Newcastle, Southampton or London. It was felt the additional travelling time to Birmingham would be dangerous in instances where emergency treatment was required, particularly as there were regular occurrences of traffic congestion on the M6 motorway to Birmingham.

Mrs Barnes was organising a petition at Glenfield Hospital to support the on-line petition at https://petition.parliament.uk/petitions/160455. The paper petition was being signed by the elderly and those that did not access to the internet. It was important to spread the awareness of the review as widely as possible as it affected every child in the country.

Members made the following suggestions:-

a) UHL should make all GP's in the East Midlands aware of the services offered by the EMCHC at Glenfield as it appeared that they were unware of its existence, especially in Northampton and Cambridgeshire.

b) The current petition had received 33,000 signatures and more publicity on the issue was needed to get this figure to over 100,000 so that it triggered a parliamentary debate.

c) Engagement should take place with all the MPs in the East Midlands area and for the new proposed parliamentary constituencies which went further south than at present.

d) UHL should continue to make approaches to Northampton Hospital on the issue of referrals.

e) The letter to NHS England agreed in the previous item should also be copied to the Secretary of State for Health.

The Chair thanked everyone for their participation in and effective discussion which had raised a number of points to be included in the letter to NHS England. It was important to put these views to NHS England now rather than wait for the formal consultation to start.

It was also important to use the period before the start of the consultation process to engage with other authorities and organisations and undertake further research of the issues, including the practicalities of patient choice.

As soon as the date of the formal consultation was known there would be a minimum of two further meetings. There would be a meeting with NHS England and one involving interested parties including parents, carer groups, young people, and representatives of the wider public to put forward their views.

AGREED:

1) That the Chair and Vice Chair prepare the letter to be sent to NHS England and circulate it to members of the Joint Committee for comment and approval before it is sent to NHS England and copied to the Secretary of State.

2) That UHL provide copies of the documents requested earlier in the meeting.

3) That further details be provided to the Committee as to why the two site East Midlands' network centre was rejected by NHS England.

8. OTHER VIEWPOINTS ON NHS ENGLAND'S PROPOSALS

Members received the following information and viewpoints on NHS England's proposals:-

a) NHS England's press announcement of its proposals dated 8 July 2016.

b) The report of NHS England's National Panel on Paediatric Cardiac and Adult Congenital Heart Disease Standards.

c) Questions and Answers from NHS England's website on the decision making process.

d) A copy of Will Huxter's blog on the Congenital Heart Disease Implementation Programme issued on 13 September 2016.

Note: Will Huxter is the NHS England Senior Responsible Officer for the Congenital Heart Disease Review and his blog can be found at the following link:-

https://www.england.nhs.uk/2016/09/will-huxter-15/

The blog would be used to keep everyone up-to-date with activities during the pre-consultation and consultation period on NHS England's proposals for meeting the national standards on CHD, and anyone can request to receive it by e-mailing england.congenitalheart@nhs.net

e) Leicester City's Health and Wellbeing Board had also requested the assessments of every other centre currently providing CHD Services. NHS England had subsequently published these on their website at the following link:-

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

Note: The link above also has details of the New CHD Review's report, including around two hundred new standards and service specifications which providers of CHD services should meet. These standards came into effect in April 2016.

9. TIMELINE FOR CONSULTATION AND TAKING THE REVIEW OF CONGENITAL HEART DISEASE SERVICES AT UHL NHS TRUST FORWARD

The Committee considered this item during discussion of previous agenda items.

10. BUSINESS FOR THE NEXT MEETING

The Committee considered the next steps in taking the review forward during discussion of previous agenda items.

11. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business to be discussed.

12. CLOSE OF MEETING

The Chair declared the meeting closed at 4.00pm