

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

6 September 2017

Meeting held at Committee Room 5 - Civic Centre,
High Street, Uxbridge UB8 1UW



HILLINGDON
LONDON

	<p>Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Brian Crowe, Phoday Jarjussey and Michael White</p> <p>Also Present: Claire McDonald, Communications and Engagement Adviser, NHS England Hazel Fisher, Head of Delivery for NWL, Specialised Commissioning London, NHS England (London)</p> <p>LBH Officers Present: Dr Steve Hajioff (Director of Public Health) and Nikki O'Halloran (Democratic Services Manager)</p> <p>Press and Public: 2</p>
15.	<p>EXCLUSION OF PRESS AND PUBLIC (<i>Agenda Item 3</i>)</p> <p>RESOLVED: That all items of business be considered in public.</p>
16.	<p>MINUTES OF THE PREVIOUS MEETING - 11 JULY 2017 (<i>Agenda Item 4</i>)</p> <p>RESOLVED: That the minutes of the meeting held on 11 July 2017 be agreed as a correct record.</p>
17.	<p>PROPOSALS TO IMPLEMENT STANDARDS FOR CHD SERVICES FOR CHILDREN AND ADULTS IN ENGLAND (<i>Agenda Item 5</i>)</p> <p>The Chairman welcomed those present to the meeting. He noted that the Committee had already heard from representatives from the Royal Brompton and Harefield NHS Foundation Trust and were now looking to gain an understanding of NHS England's position in relation to the proposals regarding congenital heart disease services in England. Members had previously expressed concerns about the impact of the proposals on, and perception of, residents in Hillingdon. As this issue was close to residents' hearts, it would be important to ensure that expectations were managed.</p> <p>Ms Claire McDonald, Communications and Engagement Adviser at NHS England (NHSE), advised that the congenital heart disease services being reviewed were those that cared for people who were born with the disease. Over the last 16-18 years, there had been a range of national and local service delivery changes with the most recent proposals being a standards-based solution rather than numbers-based solution. As a result of significant and lengthy consultation, 200 standards had been agreed in 2015 for each of the three levels of care (1: surgical and interventional; 2: ongoing care and minor interventional; 3: ongoing care closer to home) in children's and adults services. Since then, NHSE had assessed each of the centres and worked with providers to</p>

determine how they were going to be able to meet all of the standards. Once the majority of patients had undergone surgery in a Level 1 centre (hub), they would then receive ongoing regular monitoring from a more local Level 3 hospital (spoke). Receiving this care closer to home enabled patients to live a more regular life.

Ms McDonald advised Members that the standards had not been developed on a cost basis and that parents and children had been encouraged to identify those elements that made their stay in hospital more comfortable (for example, the availability of onsite accommodation for parents, wifi, etc). NHSE had worked with providers to identify where capital investment would be needed and these providers had assured NHSE that this investment to meet the standards had already been provided for within their budgets so there would be no need for additional funding. It was thought that providers had already anticipated the increasing demand / projected growth and had put plans in place to address this. Great Ormond Street Hospital (GOSH) had advised that it would bring forward its expansion plans and Evelina had stated that it would be able to accommodate the growth. Members found it difficult to accept that the implementation of the proposals would not need additional funding from NHSE.

Congenital heart disease covered a huge range of conditions of varying severity. Members were advised that, to ensure that skills were maintained, the standards included positive volume outcomes where each surgeon needed to complete at least 125 surgeries per year and work in a team of four surgeons. This would ensure that each surgeon was performing a number of the same operation on the same type of congenital heart issue each year. It was thought that there were about 38 surgeons in the country (who shared their expertise) and about 5,000 surgeries performed each year. Members were advised that the more surgeries undertaken by each surgeon, the better the patient outcomes. The collocation of services standard would ensure that patients with comorbidities had specialist staff on hand at the same site to deal with those conditions.

Members were assured that the congenital heart disease services being reviewed were not performed at Harefield Hospital so the impact on that centre was likely to be minimal and the expertise there would be retained. With regard to resources, it was suggested that the financial impact mentioned in the consultation document would be largely offset by the savings made through a reduction in overhead costs. It was thought that the £7m annual 'stranded costs' mentioned in the report related to those costs at Royal Brompton relating to the congenital heart disease service that would not be able to be transferred or scaled back. As such, Royal Brompton would need to look at its longer term financial planning.

It was noted that adult cardiology and respiratory services would continue at Harefield Hospital. The expectation was that there would be strong relationships between the centres providing all three levels of care. To this end, there would be a Level 3 provision included in network meetings.

The consultation document proposed the withdrawal of children's congenital heart disease services from Central Manchester, Leicester and Royal Brompton. The consultation ran from February 2017 to 17 July 2017 and prompted around 7,500 responses. NHSE was currently reviewing these responses and looking at the suggested impact and alternative methodology put forward by some of the providers.

An article had appeared in the HSJ on 18 July 2017 about Royal Brompton investigating the relocation of its congenital heart disease services to St Thomas' Hospital to achieve world class standards. Although NHSE would now need to assess this proposal from Royal Brompton, it was anticipated that this development would

meet the collocation standard.

Ms Hazel Fisher, Head of Delivery for North West London, Specialised Commissioning at NHSE, advised that NHSE had received no concerns from Royal Brompton about the wider sustainability of the Trust. Any joint arrangements with Guy's and St Thomas' would need to go through three stages: training and staff rotation across the sites to build a cohesive unit; children's services were already provided from the Evelina so services were collocated; adult services would move over and research capacity could be built. Although it was not mentioned in any detail in the consultation document, ideally, children would receive surgery in a hospital specifically for children rather than adults. The new proposal from Royal Brompton would go some way to meeting some of the standards.

Members were advised that it was hoped that the consultation responses and the new alternative proposals suggested by providers (including the proposal from Royal Brompton) would be considered by NHSE Board on 28 September 2017. If this was not possible (as there was a significant amount of work involved in getting this information processed ready to be presented), it was thought that an additional Board meeting would be scheduled as soon after this date as was practicable. It would be important to progress any agreed changes as soon as possible to relieve the uncertainty currently experienced by staff and patients. However, NHSE would need to look at the feasibility of the alternative proposals (likely to be in December 2017) which would be followed by a significant amount of investigation.

Ms Fisher advised that, if children's congenital heart disease services were withdrawn from Royal Brompton, GOSH and Guy's and St Thomas' had indicated that they had planned additional capacity that would be able to absorb the additional activity that the change would create.

It was noted that the number of surgeries undertaken each year was increasing and survival rates were also increasing which meant that children were living much longer lives than previously experienced. Furthermore, congenital heart disease was more prevalent in the Asian community who tended to live in concentrated areas, of which West London was one. Ms Fisher advised that these national and local growth rates and geographical locations had been taken into account as well as the number of surgeons required.

With regard to monitoring centres' adherence to the standards, a dashboard was being developed to focus on a number of key standards to enable NHSE to monitor issues such as patient experience. Three patient representatives had been involved in the development of this dashboard. If the dashboard highlighted any failings, NHSE would be able to take swift action to address the issues.

Ms McDonald stated that patient outcomes in the UK were very good. National Institute for Cardiovascular Outcomes Research (NICOR) collected clinical information from UK hospitals into secure registries established by the cardiovascular specialist societies. This helped to improve quality of care by checking that the care received by heart disease patients met good practice standards. This was done by conducting clinical audit and by comparing patient outcomes, such as readmission rates.

It was noted that there had previously been significant changes to the provision of services in Oxford. The adjustment process during this period of change had been refined and could now act as a blueprint for future significant service changes. Ms McDonald advised that an unplanned collapse of services would have more of an impact than a planned change and, as such, implementation plans would need to be

worked through with staff to maximise success.

Ms McDonald noted that the paediatric intensive care unit (PICU) at Royal Brompton would be at risk (reduced demand) if congenital heart disease services were no longer provided from the site as only patients with respiratory problems would be supported there. Members were advised that a PICU / ECMO review was currently underway and was being expedited to align with the congenital heart disease review to ensure that all requirements were met. NHSE was mindful of the impact of one service on another as well as the need to move swiftly but thoroughly to avoid any possible judicial reviews.

It was noted that if the PICU at Royal Brompton were to close, there was already sufficient capacity in the GOSH PICU to meet the demand. The national PICU review was likely to identify the optimal number of beds needed to ensure that the capacity was available to meet demand.

Concern was expressed that the review of congenital heart disease services had been ongoing in one form or another for a long time which had exacerbated uncertainty amongst patients and staff. Ms McDonald stated that NHSE had spent a lot of time rebuilding relationships and that it had been the community that had identified the need for standards to be in place.

Recruitment and retention had been an ongoing challenge in the NHS for some time and it was recognised that there was currently a degree of anxiety at Royal Brompton. It was noted that there was an opportunity with the alternative proposition to meet the collocation standard and that this proposition identified the need to rotate and build a single body of staff. Although surgeons would often move from one area in the country to another, this was not the case with nursing staff. Most of the nurses at Royal Brompton lived in London and it would be important that the support of staff be a key component in any changes implemented.

Although there was no empirical evidence available to suggest that collocation had better outcomes for children, the Royal Society of Paediatrics and Child Health had asserted that children did better as a whole if they were in a child specific environment. This meant that different teams worked together regularly in a child centred environment and therefore patients did not need to visit multiple centres for multiple conditions. The Clinical Advisory Panel had also emphasised the need for collocation despite there not currently being any empirical evidence to support better patient outcomes.

Members noted that Newcastle had been given special dispensation with regard to not meeting the standards and that this would raise the issue of fairness. Ms McDonald noted that Newcastle was currently in the process of developing plans for collocation. The centre dealt with advanced heart failure and provided the one of two paediatric heart transplant services in the country. However, there were no clear timescales for when the centre was expected to meet the standards. Members queried whether this leniency had been borne of geographical requirements but were advised that it was difficult to move a transplant service to another centre. It was anticipated that Newcastle would meet the collocation and volume standards but the logistics of how this would be achieved had not yet been established. It was suggested that a mobile transplant team might be the way forward.

It was noted that NHSE's proposals should not result in a worse situation. Ms McDonald advised that the provision of a service in only one location was not advisable. As such, the decommissioning of a service that was only available in one centre could not be undertaken until the service had been established elsewhere.

With regard to the hub and spoke model, it was noted that travel and accommodation could be an issue for some patients and their families. As such, the provision of multiple services in a particular centre (that was possibly a long way from the patient's home) with ongoing care located in a spoke that was closer to the patients home was seen as a good thing.

Members were advised that the transition from children's services to adult services mentioned in the consultation document referred to ensuring that the handover from one centre to another and the communication between them was seamless. This would be particularly important where a patient had moved from one city to another. It was noted that St Bartholomew's and GOSH had advised NHSE of their transition arrangements which were already in place.

RESOLVED: That the discussion be noted.

18. **WORK PROGRAMME 2017/2018** (*Agenda Item 6*)

Consideration was given to the Committee's Work Programme. Members were advised that the Community Sentencing Working Group would be meeting on 21 September 2017 and that there were still challenges in getting a representative from the Community Rehabilitation Company to attend a meeting.

The GP Pressures Working Group witness sessions had taken place in 2015/2016. Although the final report had been drafted, there had since been significant changes within the health sector. As such, the Chairman had requested that two additional witness sessions be organised to refresh the information that had already been received and to enable Members to speak to a representative from the Royal College of GPs.

At its meeting on 14 September 2017, the Committee would be hearing from the Borough Commander in relation to the MOPAC & MPS Public Access and Engagement Strategy consultation and would also consider a report on LAC offending. The Cabinet Member for Community Commerce and Regeneration would be responding to the consultation on behalf of the Council and any comments made by Members would be forwarded to him. It was noted that the Council's Chief Executive had expressed an interest in this matter and would be attending the meeting to watch proceedings from the public gallery.

RESOLVED: That the Work Programme be noted.

The meeting, which commenced at 6.00 pm, closed at 7.47 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.