London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Wednesday 20 February 2013

PRESENT

Committee members: Councillors Lucy Ivimy (Chairman), Joe Carlebach, Stephen Cowan, Oliver Craig, Peter Graham, Steve Hamilton and Rory Vaughan

Co-opted members: Maria Brenton (HAFAD)

Other Councillors: Marcus Ginn and Andrew Johnson

Central London Community Healthcare Trust: James Reilly (Chief Executive)

Imperial College Healthcare NHS Trust: Brendan Farmer (Director of Strategy), Steve McManus (Chief Operating Officer) and Dr Katie Urch (Trust Clinical Lead for Cancer)

NHS North West London: Daniel Elkeles (Director of Strategy) and Dr Mark Spencer (Medical Director)

Officers: Mike England (Director of Housing Options, Skills and Economic Development) and Sue Perrin (Committee Co-ordinator)

42. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 22 January 2013 be approved and signed as an accurate record of the proceedings.

43. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Iain Coleman and Peter Tobias.

44. DECLARATIONS OF INTEREST

Councillor Joe Carlebach declared a personal interest in respect of item 6 'Shaping a Healthier Future', in that he is a trustee of Arthritis Research UK, which owns property on the Charing Cross site.

45. CENTRAL LONDON COMMUNITY HEALTHCARE

The Committee received the Central London Community Healthcare consultation document, 'Get Involved: Have Your Say On Our Foundation Trust Plans'.

The discussion in respect of the Pembridge Palliative Care Unit was deferred.

46. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: WAITING LIST MANAGEMENT

This item was taken after item 6, at approximately 10.10pm.

Mr Steve McManus, Chief Operating Officer, stated that the Trust had reviewed the organisational structure for cancer, and further to his appointment in September 2012 as the executive director responsible for operational performance, a Lead Cancer Team reporting directly to him had been established.

Mr McManus and Dr Katie Urch, Trust Lead Cancer Clinician provided an oral progress report on four key areas.

Recommendations made via the external reviews in relation to the Trust management of waiting lists

All recommendations made via the external reviews undertaken over the previous 12 months in relation to the Trust management of waiting lists had been endorsed by the Trust Board, and a full action plan was being implemented. Specific actions included:

- The enhancement of clinical leadership.
- The establishment of similar cancer pathways throughout the Trust.
- IT improvements across the Trust.

Performance

The Trust had delivered, as at the end of December 2012, six out of the eight national standards and had measures in place to achieve the eight standards by the end of the financial year.

Further Clinical Audit

Dr Urch updated the committee on the outcomes from her case notes review of the 126 patients referred under the 31 and 62 day pathways for cancer care who had breached their treatment target date between January-August 2012. The review found that no patients had come to clinical harm or changed treatment pathways as a consequence of the treatment delays.

The review indicated that:

- 70% had delays of under 100 days,
- 26 patients had delays of between 100 and 150 days: the majority were on the prostate pathway, for which active surveillance should have been coded as acute treatment; and
- 7 patients had delays of over 150 days: these were either administrative errors (pathways not closed) or re-referrals linked to the original treated referral.

Seven patients had subsequently died from causes not associated with the delays in treatment.

The Trust had put in place monitoring actions in respect of: all patients on the two week wait pathway; urology and lower gastrointestinal pathways; and inter-trust referrals received after the breach date. The clinical audit would be ongoing and all breach patients would be reviewed.

Dr Spencer stated that he had been a member of the Clinical Review Team and was Chair of the Ealing Clinical Commissioning Group. GPs had been advised by NHS North West London to consider referral to other hospitals, but this recommendation was currently being reconsidered.

Councillor Carlebach considered that whilst the clinical review had been reasonably robust, there were still some concerns, and lack of independence in the governance review. Mr McManus responded that there had been a number of external reviews, including the NHS Intensive Support Team reports on patients pathways.

In response to queries in respect of orthopaedic referrals and general and orthopaedic waiting times, Mr McManus stated that the mechanisms for tracking and monitoring patients had been greatly enhanced. Since November 2012, the Trust had delivered against the national 18 week referral to treatment waiting time target for admitted/non-admitted patients and patients on incomplete pathways. Orthopaedic waiting times were improving and patients were no longer being referred to private hospitals.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the Committee extended the meeting by a further 5 minutes.

In response to a query in respect of IT, Mr McManus responded that a trust wide system was being implemented. However, the Trust's validation of patient records had found that in the past patients could be registered several times, for example through the use of slightly different names.

Dr Urch responded that every individual cancer patient was tracked and whereabouts on the pathway known. There was a unified system, but there remained improvements to be made in respect of urology and colorectal services.

In response to a query in respect of communication with GPs, Dr Spencer stated that there remained work to be done in respect of timely communication.

RESOLVED THAT:

1. The Committee welcomed the improvement in the cancer waiting list position.

2. The Committee noted how serious concerns in respect of cancer and other services and the administration system had been addressed.

3. The Committee remained concerned that further improvements had to be in place to have full confidence in the Trust.

47. SHAPING A HEALTHIER FUTURE

This item was taken first.

Mr Daniel Elkeles and Dr Mark Spencer presented the decision of the North West London Joint Committee of Primary Care Trusts (JCPCT) on the future of NHS services in North West London, and specifically the plans for Charing Cross Hospital, made on 19 February 2013.

The JCPCT had approved 'Option A', whereby there would be a future configuration of hospitals with five major hospitals (Chelsea & Westminster, Hillingdon, Northwick Park, St. Mary's and West Middlesex) and four local/specialist hospitals (Charing Cross, Central Middlesex, Ealing and Hammersmith). Option A had designated Hammersmith Hospital as a local and specialist hospital with an obstetric-led maternity unit and Charing Cross as a local hospital.

In response to consultation feedback, an additional recommendation had been proposed and approved by the JCPCT. The recommendation proposed an enhanced range of services on the Charing Cross site. The CCG's vision was to 'Deliver a Specialised Health and Social Care Hospital at Charing Cross, where primary care, community services, specialist services and social care would all be provided from a single site and where multi-disciplinary networks would convene to effectively manage patients' needs.'

The proposed service offering would now include:

- Primary, secondary and social care hub for the local population;
- Diagnostics service, comprising X-ray, Ultrasound, CT and MRI scanning, endoscopy and ECG;
- An ambulatory cancer care centre, including oncology for which Charing Cross is renowned, radiotherapy and chemotherapy and Maggie's Cancer Care Centre: the original proposal was for all cancer services to move to St. Mary's;
- Renal service centre, including delivery of dialysis;

- Step up/down beds: up to 60 beds for short admissions or rehabilitation;
- Ante/post natal care; and
- Retention of Imperial College teaching facilities.

Mr Elkeles outlined the benefits, which included:

- Improved quality and continuity for patients through care that is delivered: to the right clinical standards; in excellent facilities; and with good patient services;
- Integrated and proactive care for those most at risk of getting ill;
- 'One stop shop';
- Support for those with long term conditions; and
- Alignment with new bases for social workers and community nursing.

There would be up to £88 million investment required for the new build local hospital. 13% of the existing floor space would remain. Currently, 490,000 people per annum used Charing Cross; it was forecast that 385,000 (79%) would use the new healthcare facility. Charing Cross provided services for the whole of North West London and it was estimated that services for Hammersmith & Fulham residents cost £255,000 per annum. It was forecast that the future cost would be £220,000 (86%).

Dr Spencer explained that the rationalisation of Accident & Emergency (A&E) services had been based on the premise that concentration of care on fewer sites would improve care. Better outcomes had been demonstrated with the rationalisation of major trauma, stoke and vascular surgery. By concentrating services on five sites, it would be possible to provide 24 hour access to senior consultants and diagnostic facilities.

Councillor Carlebach considered that the NHS had not set out its targets. Dr Spencer responded by referring to mortality rates in North West London, which were worse at weekends than during the week. The rationalisation of services had already saved a minimum of 130 lives a year, and some 800 more lives could be saved by improving the worst performance to the level of the best performance. The impact of better community care would be measured against a matrix of a wide range of factors.

Councillor Ivimy commented that stroke care also had an important role in reducing the degree of disability after a stroke. Dr Spencer responded that there was a demonstrable benefit in more people returning home and to work.

In response to a question in respect of staff capacity, Dr Spencer stated that to provide 24/7 consultant delivered care, there would be an increase in the number of doctors, nurses and health workers, with significantly greater capacity at major sites.

Dr Spencer responded to a question that patients using social care services were not included in the figure of 86% of patient numbers at Charing Cross using the new facility. It was estimated that there would be at least an additional 10%. There would be further detailed work.

Mr Elkeles referred to the slide 'alternative proposal site plans'. The buildings shown on the right would all remain, with the exception of the gym. Maggie's Cancer Care Unit was shown on the far left (block 7); its future location was under consideration. Imperial College teaching facilities would move into the main building. The main building might have four/six floors but this had not been reflected in the artist's impression.

Dr Spencer responded to a question that services lost would now include: Accident & Emergency, emergency admissions/surgery, in patient specialist services, intensive care and the hyper acute stroke unit. Currently, only 10% of the specialist beds were used by Hammersmith & Fulham residents. A large investment would be made at Chelsea and Westminster Hospital to meet the additional demand. There would be 90 additional beds and a new Accident & Emergency department, at a cost of £27million. Charing Cross would continue to provide planned surgery.

In response to requests for a comparison of patient numbers on the basis of current services, the committee was informed that this was not possible as the 2017/18 model of care would provide healthcare in a completely different way. Dr Spencer was confident that 86% of current activity could be achieved, but it would be a dramatically different service. Further details would be provided in the outline business case.

Dr Spencer responded to a question that out of hours GP services would be provided at the Urgent Care Centre, for those who did not need a home visit.

Councillor Vaughan considered that there had been a deliberate strategy to downgrade Charing Cross so that it could no longer function as a major acute hospital. Councillor Ivimy stated that the committee had, over a period of years, repeatedly requested Imperial's site strategy, but this had not been forthcoming.

In response to a query as to why Charing Cross could not remain as an acute site, the committee was informed that Chelsea and Westminster and Charing Cross hospitals were geographically close, and Chelsea and Westminster was the preferred option. It provided a full range of services including gynaecology and paediatrics.

Mr Elkeles responded to comments that '13% of the existing ground space' was misleading as, in addition to healthcare, this site would include health care research areas and laboratories not used by patients. The JCPCT had approved the recommendation of the Hammersmith & Fulham CCG for an enhanced range of services and there would be a minimum of 13% of floor space used for direct patient care, as opposed to 3% in the original Option A.

Councillor Cowan referred to the 'Tim Rideout report, on the original proposals which the Council had commissioned and queried whether Mr Rideout had been asked to provide an objective assessment of the revised proposals. Councillor Ginn responded that the Council had referred to the report in assessing the proposals and that Mr Rideout had supported the case

for change. The hospital reconfiguration would be supported by a range of out of hospital services, which the Council believed was in line with the Rideout report. The Council would not incur an additional cost for information, which it had already received.

Councillor Cowan referred to the impact on a hospital of the loss of its Accident & Emergency Department and suggested that the new type of hospital was a super GP centre/clinic. He did not believe the NHS and considered that the Council had radically changed its position. Mr Elkeles responded that many existing GP surgeries were terraced houses and that approximately £1 million each would bring them up to standard, whereas £88 million was being spent on Charing Cross to bring it to the cutting edge of service delivery.

Councillor Ginn responded that a new type of specialist hospital would be created, with significant cancer and out-patient services. The Council had judged that Charing Cross could not be retained in its current format, and had worked with the NHS to retain as many services as possible and to protect the hospital for future generations. Should the committee decide to refer the proposals to the Secretary of State, there was a risk that it would be recommended that the NHS should revert to Option A.

Councillor Cowan queried why the Council had deemed this to be a risk and with whom it had spoken. Councillor Ginn responded that there had been two parts to the Council's campaign: the public campaign and behind the scenes lobbying. Meetings had been held with Jeff Zitron, Anne Rainsberry, Daniel Elkeles and Mark Spencer. Letters had been sent to Ministers, as they had refused to meet with the Council.

Councillor Cowan queried who had led the campaign and when the Council had changed its position. Councillor Ginn responded that he had led the campaign and had been supported by the Leader. The Council's change of position had evolved as it understood the case in favour of service reconfiguration and the reality of not being able to protect Charing Cross as it had been in the past and the need to push for new proposals. The NHS had been under no obligation to present new proposals.

Councillor Cowan queried when Councillor Ivimy had been informed of the Council's change of position. The Chairman responded that the North West London Joint Health Overview & Scrutiny Committee (JHOSC), of which she was the Chairman, had been considering the potential changes for a year and had been pressing the NHS for considerably better proposals. Two weeks previously, the NHS had briefed the JHOSC on the revised proposals.

Councillor Cowan considered that an emergency meeting of the Select Committee should have been called at this stage and queried when Councillor Ivimy had been aware of the Council changing its position. Councillor Cowan stated that Councillor Ivimy had informed the JCPCT that this committee was unlikely to refer the decision to the Secretary of State.

The Chairman responded that the meeting with the JHOSC on 7 February had been an oral briefing, with no copy and that it had not been known precisely what was on offer until the JCPCT meeting on 19 February. The proposals seemed to be a good deal for the residents of Hammersmith & Fulham and she would not be recommending that the decision was referred to the Secretary of State. The JCPCT had considered the evidence for the reorganisation of Accident & Emergency services and reached a sensible decision. It would not be in the interests of the residents of North West London to fight this decision.

The Council had accepted the hypothesis that there should be five major hospitals instead of nine in North West London. Whilst the Council would have liked to have retained Charing Cross as a major hospital, Imperial did not appear capable of running two major hospitals. In addition, Charing Cross had been paired with Chelsea & Westminster, which provided a wider range of acute services.

Councillor Ginn added that the Council had changed its position because there was a strong argument for the reconfiguration of services in North West London and regrettably could not protect Charing Cross as the hospital which it had been. The Council, had negotiated an enhanced hospital at Charing Cross, which was fit for purpose and, given the current realities, was best for residents. The NHS had been under no obligation to offer a second option.

Councillor Ginn considered that the opinion expressed by clinicians indicated that reconfiguration was inevitable. At the time of the Council's initial decision, there had not been the offer of a specialist hospital. Should there be a future proposal to move the Urgent Care Centre to White City, the Council would consult with residents. The Council had saved Charing Cross from virtual closure and there would be a £90 million cash investment.

Dr Spencer responded to a question that in patient beds run by geriatricians had been included in the step up/down beds and that more detail would be provided in the outline business case. Councillor Carlebach considered that the business case should: provide a compelling vision for the new service; address the confusion in respect of definitions of services; and clarify how services would work and how patients would access the multiplicity of patient pathways. He suggested that there should be a patient contract.

Mr Elkeles stated that the Urgent Care Centres would provide a comprehensive range of services. There would be a detailed specification, which would be consistent across London.

Councillor Carlebach queried how the proposals addressed health inequalities. Dr Spencer responded that inequalities would be addressed mostly through developments in primary care. The CCG's Joint Health & Wellbeing Strategy would include proposals to improve the health of residents of Hammersmith & Fulham, and local priorities would be endorsed through the Health & Wellbeing Board.

Dr Spencer responded to queries from Mr Andrew Slaughter in respect of patient activity at Charing Cross by providing indicative figures; exact numbers would be in the detail of the business case:

- 60 beds would be provided at Charing Cross by providing slightly less beds at other sites.

- Currently, there were 20,000 emergency admissions and 25,000 elective admissions per annum. 15,000 admissions were proposed for the future Charing Cross site.

- 69% of out patient services would remain at Charing Cross, increasing to 80% with the new ante and postal natal services. 100,000 attendances were by Hammersmith & Fulham residents.

- 70% of patients who currently attend Charing Cross would be treated in the Urgent Care Centre.

A member of the public commented that if there were 15,000 admissions per annum and 60 beds the average length of stay would be 1.5 days. Dr Spencer responded that this projection was realistic. Beds for more specialist services would be moved to other hospitals. Patients accessing the ambulatory specialist services at Charing Cross would not require a bed. In addition, the Out of Hospital proposals would result in 25% of people being looked after in their own homes. Length of stay decreased as hospitals became more efficient, and the number of beds reduced with medical advances. The step down beds would be used for short stays and convalescence.

Councillor Ginn responded to comments in respect of the Council leaflet, 'Charing Cross Saved' and the two page article in the Hammersmith & Fulham chronicle that Charing Cross would remain in existence, with a hospital on site for years to come. Buildings would be demolished, but then rebuilt.

A member of the public queried whether the proposals had been scrutinised with medical assistance. Councillor Ivimy responded that the JHOSC had heard a wide range of evidence and had reached the conclusion that the clinical case for the reconfiguration of Accident & Emergency services had been well made and well founded. Some of the concerns in respect of Option A had been addressed by the JCPCT at its meeting on the previous day. The timescale for the reconfiguration had been extended from three to five years, and assurance had been given that the bed reductions would not happen until the Out of Hospital service was in place and working. Dr Spencer added that the NHS had taken a range of external advice.

Councillor Cowan considered that the Council should not have accepted the deal offered and should have tried to negotiate a better deal, and that, without support from all GPs, the NHS had not met the Secretary of State's four tests.

Councillor Stephen Cowan moved, seconded by Councillor Rory Vaughan the motion in their names:

There should be a ballot of all individual GPs in Hammersmith & Fulham as a matter of emergency.

Dr Spencer stated that the CCGs were membership organisations and the members had not asked for a vote on the proposals, before it was put to the vote:

FOR	4	(Councillors Carlebach, Cowan, Craig and Vaughan)
AGAINST	3	(Councillors Graham, Hamilton and Ivimy)

The motion was declared **CARRIED**.

Councillor Stephen Cowan moved, seconded by Councillor Rory Vaughan the motion in their names:

There should be an independent medical assessment of the Option A variation proposal.

FOR	3	(Councillors Cowan, Ivimy and Vaughan)
AGAINST	4	(Councillors Carlebach, Craig, Graham and Hamilton)

The motion was declared **LOST**.

Councillor Stephen Cowan moved, seconded by Councillor Rory Vaughan the motion in their names:

The North West London service reconfiguration proposals should be referred to the Secretary of State.

FOR	2	(Councillors Cowan and Vaughan)
AGAINST	5	(Councillors Carlebach, Craig, Graham, Hamilton and Ivimy)

The motion was declared **LOST**.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the Committee extended the meeting by 30 minutes.

Councillor Stephen Cowan moved, seconded by Councillor Rory Vaughan the motion in their names:

There should be no further advertising of the Council's position before receipt of advice from GPs and independent analysis of the proposals.

FOR	2	(Councillors Cowan and Vaughan)

AGAINST 5 (Councillors Carlebach, Craig, Graham, Hamilton and Ivimy)

The motion was declared **LOST**.

RESOLVED THAT:

1. The Committee noted the enhanced plans for Charing Cross.

The Committee voted on the following two resolutions:

FOR: 5 (Councillors Carlebach, Craig, Graham, Hamilton and Ivimy)

AGAINST: 2 (Councillors Cowan and Vaughan)

RESOLVED THAT:

2. The Committee was satisfied that the enhanced proposals for Charing Cross would provide a good service and would not press for a referral to the Secretary of State.

3. The Committee noted that NHS North West London had listened to the consultation responses from residents and the Council, and provided a greatly enhanced proposal.

48. WELFARE REFORM UPDATE

This item was deferred to the next meeting.

49. WORK PROGRAMME AND FORWARD PLAN 2012-2013

The work programme was noted.

50. DATE OF NEXT MEETING

Tuesday 9 April 2013.

Meeting started: 7.00 pm
Meeting ended: 10.35 pm

Chairman .....

Contact officer: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk