London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Wednesday 8 January 2014

PRESENT

Committee members: Councillors Lucy Ivimy (Chairman), Joe Carlebach, Stephen Cowan, Oliver Craig, Peter Graham (until 8.20pm), Rory Vaughan and Daryl Brown

Co-opted members: Patrick McVeigh (HAFAD) and Bryan Naylor (Age UK)

Other Councillors: Councillor Marcus Ginn

RBKC Councillors: Christopher Buckmaster, Robert Freeman, Pat Healy and Bridget Hoier

Westminster Councillors: Dr Sheila D'Souza, David Harvey, and Jan Prendergast

Imperial College Healthcare NHS Trust:
Professor Nick Cheshire, Chief Executive, Bill Shields, Chief Executive, Steve McManus, Chief Operating Officer and Dr Chris Harrison, Medical Director

Officers: Sue Perrin (Committee Co-ordinator)

34. WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

35. MINUTES

The minutes of the meeting held on 13 November 2013 were deferred to the next meeting.

36. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Andrew Brown, Peter Tobias and Andrew Johnson and Councillor Peter Graham for leaving early.

37. DECLARATIONS OF INTEREST

Councillor Joe Carlebach declared a personal interest in that he is a trustee of Arthritis Research UK and Chairman of Wormwood Scrubs Charitable Committee, which owns the Hammersmith Hospital car park.

38. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CONSULTATION ON ITS FOUNDATION TRUST APPLICATION

This item and item 6, 'Imperial College Healthcare NHS Trust (the Trust) Business Plan' were taken together.

Professor Nick Cheshire introduced the presentation of the NHS foundation trust application, emphasising that the changes were evolutionary dating back to the 1990s and that the application was part of the ongoing work to provide 21st century care on three sites.

Mr Bill Shields outlined key facts in respect of the Trust and the five hospitals: Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St. Mary's and Western Eye, and the reasons for becoming a foundation trust. The proposed governance arrangements included: membership open to all people over the age of 16, provided that they met the criteria; a Council of Governors and a Board of Directors.

Mr Shields outlined the Trust's vision for the future and strategic objectives, which were consistent with Shaping a Healthier Future proposals and the advantages of becoming a foundation trust.

Professor Cheshire presented the Trust's clinical strategy, operating from three main sites: Hammersmith Hospital (Specialist); St. Mary's Hospital (Major Acute) and Charing Cross (Local and Elective). All sites would provide local services in addition to their particular unique function.

Professor Cheshire outlined the outcomes against six core dimensions of clinical quality and specifically:

- Standardised mortality rate of 70, compared with an England Average of 100, which is amongst the lowest in the country and particularly strong in comparison with North West London hospitals; and

- The NHS Safety Thermometer indication that 96% of patients received 'harm free care'.

The patient experience indicator, however, showed a mixed picture, with improvement needed and significant underperformance in cancer care.

In respect of Operational Performance, the Trust had achieved seven out of eight standards in the third quarter. The Cancer Waiting Times Standard had

not been achieved. Operational Performance to December 2013 (when published) would show that the eight standards had been achieved.

In respect of financial performance, a surplus of £15 million was predicted.

Professor Cheshire presented:

- the Medicine Division 'Dashboard', which demonstrated the detailed work to analyse performance
- The Quality Assessment of the six dimensions of quality
- The Clinical Services categorised as locally provided service, specialist provided service, general emergency and specialist emergency and the percentage of the Trust's clinical income

The specialist emergency service was an unique area, but the locally provided services generated some 50% of the Trust's income.

Professor Cheshire emphasised that unselected emergency care could not be provided on three sites. St. Mary's would continue to provide specialist emergency services and would remain a Major Trauma Centre. Hammersmith and Charing Cross would provide local emergency services. The three sites would be inter-dependent, with 24/7 access to A&E consultants. Attendance figures for A&E and the Urgent Care Centres (UCCs) showed that, when all three UCCs were open, 50% of attendances were at the UCCs.

The services on the Charing Cross site had yet to be determined, and were dependent on a number of factors including Commissioner intentions, the University estate, Hammersmith & Fulham Council desires and the future of the Central Middlesex site.

Council Ivimy commented on the consultation document that it did not convey the coherent delivery of healthcare across the different sectors but presented the Trust as a single unit. Professor Cheshire responded that this was not the intention. The clinical strategy was an ongoing development of 21st century healthcare. It was not a response to SaHF, although it was based on the service reconfiguration across North West London.

Members commented on the governance structure and queried whether governors would be representative of the local community and involved with the work of the hospital. Members were clearly unhappy that patient governors would be drawn from Greater London, rather than from West London and asked for assurance that the local community would be properly represented on the Board of Governors. Mr Sheilds responded that origin of patients was approximately equal between North West London and the remainder of the country.

Councillor Buckmaster commented on the focus in the consultation document on governance, rather than the vision for the future and development of the Trust, and specifically Charing Cross. Professor Cheshire responded that a key part of the ongoing strategy had been presented to members earlier. The strategy would be finalised and presented to the Trust Board at its March meeting.

In respect of Charing Cross, Professor Cheshire responded that the site presented opportunities to modernise the delivery of healthcare, through specialist out patient care supported by extensive diagnostic facilities. Hammersmith would continue to provide the non-emergency services which it currently provides. Services at Charing Cross, which would include local services and specialist local services, had to be determined.

Mr Shields added that the foundation trust process was one year, with a five year business plan to be provided to Monitor. Currently, the Trust was developing a ten year strategy.

Councillor Graham queried services to be provided at Emergency Centres. Professor Cheshire responded that national criteria would be issued and that until additional capacity was in place, there would be no changes to the Charing Cross A&E department.

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Mr McVeigh referred to the issue of delayed transfers and the problems of access to social care, which was not free at the point of delivery. Professor Cheshire responded that the 'Winter Challenge' included a daily update on delayed discharges. On the previous day, there had been 23 patients. These patients tended to have an underlying chronic illness.

Councillor Prendergast queried the rehabilitation facilities which the Trust required the Councils to provide. Professor Cheshire was unable to answer, but highlighted the rehabilitation facilities being provided on site currently for 20 patients (with a maximum capacity of 28 patients) who no longer needed surgical care but were not able to go home.

Councillor Freeman stated that the improvement in the Trust's finances had been achieved through cuts and that substantial funding would be required for the capital programme, and queried whether assurance could be given to Monitor that the financial position was sufficiently robust to achieve foundation trust status.

Mr Shields responded that the surplus had been achieved through reduced expenditure across the Trust and that the focus would continue to be on how to rationalise services and deliver better patient outcomes in a sustainable way. The current site was not sustainable and required significant capital expenditure. The development plans included another tower block, which would be funded by the sale of land and borrowing. Mr Shields acknowledged the significant challenge, but had confidence in the business case. The Trust had the benefits of scale and a number of income streams (NHS, private, teaching and research).

Councillor Ginn noted the tri-borough work with the Clinical Commissioning Groups (CCGs), and specifically the Better Care Fund, which would bring about greater investment in rehabilitation and the Council's willingness to share information.

Councillor Cowan queried: whether the Council of Governors would be genuinely influential; the demonstration of best practice in the clinical strategy; and the evidence of integrated care being provided with the local

authorities. Mr Shields responded that the basic structure of all NHS foundation trusts was determined by Monitor, the independent regulator of health services in England. The Trust would work with the membership, through the Council of Governors, and would be dependent on the Chairman and individual governors being committed to strengthen the Council and establish an effective body.

In respect of the strategy, the Trust had been advised by a consultancy, with global experience of Board processes. In addition, the strategy, which would be a living document, had been consulted upon within the Trust.

In respect of cross boundary working, those patients who needed to access different parts of the service would be a challenge for providers across the country, with joined up discharge being the biggest challenge in improving quality.

Councillor Carlebach queried why a strategy designed for 21st century care had not been more radical, with services being transferred to specialist trusts, such as the Royal Marsden. Professor Cheshire responded that there were ongoing discussions in respect of services across North West London. Strategic partnerships with the Royal Marsden and the Royal Brompton would be an ideal way forward. Some organisations might not be viable in ten years time, and therefore there would be a stratification of services, focusing on the good and established services. The foundation trust networks were part of 21st century care.

Councillor D'Souza noted the ongoing discussions between the Council and CCGs in respect of integrated health and social care and commented that the Trust's clinical strategy should be co-produced with the Councils and CCGs, rather that consulting at the Outline Business Case stage.

Members commented on the governance structure and the proposal to allocate only two seats to Local Authority representatives, in comparison with eight to other nominated partners. Councillor Harvey emphasised the importance of engagement with stakeholders. Professor Cheshire responded that the Trust had embarked upon a new era of more open communication, including re-instatement of regular meetings with the consultant body and regular staff updates. Staff were more instrumental in the clinical strategy and direction of travel.

Councillor Vaughan queried: the retention of the proceeds of land sales, should the Trust achieve foundation trust status; the University provision on the Charing Cross site; and the role of the Council of Governors, given that members could come from a broader area, in respect of the clinical strategy and issues of concentration of services on the St. Mary's site and local access.

Mr Shields responded that currently, should a business case be approved, it was likely that an NHS trust would retain the capital receipts, whilst there was no formal requirement for a foundation trust to go through the Treasury.

Mr Shields stated that the capital requirements were likely to be greater then receipts and that the Trust would have to borrow a significant amount, possibly in the region of £150/£200 million.

Professor Cheshire stated that it was intended to re-provide a significant percentage of the University buildings on the Charing Cross site. Discussions were at a high level between the Trust, School and Faculty and a number of external agencies were also involved.

Professor Cheshire confirmed that the Council of Governors would contribute to the ongoing clinical strategy.

Professor Cheshire responded to Councillor Hoier that the Trust was moving towards seven day services. The availability of beds was an issue and this had been addressed through the Winter plan, which had expanded bed numbers by 71. Improved quality of care was being addressed through more consultant services set out in job plans. Access to all diagnostic facilities was required, but this would not be possible in smaller units.

Mr Naylor referred to older people for whom the total experience was not just the clinical element and the importance of waiting times and transport. Patients were people, not just a specialty and needed to be treated holistically. Mr Naylor referred to patients who did not attend appointments, as displayed in out patients departments, and suggested that in some cases this was because of the process which could involve attending a number of different clinics. Staff communication with patients was also an important issue.

A member of the public stated that a Royal College of GPs survey had identified a requirement for some 20,000 additional staff, including 10,000 GPs and that present numbers were inadequate to provide 24/7 care. Professor Cheshire responded that all three UCCs had been reorganised and were now open: St. Mary's 10am to 7pm; Hammersmith 8am to 10pm; and Charing Cross 24 hours.

In response to an issue raised by a member of the public in respect of a blood test, Professor Cheshire emphasised that blood tests would continue to be provided at all three sites.

Members of the public were concerned about services remaining at Charing Cross. Professor Cheshire provided re-assurance that out-patient and all diagnostic services would remain at Charing Cross. There were no plans in place to move services.

In response to concerns raised by a member of the public in respect of the Medical School at Charing Cross, Professor Cheshire responded that there was no intention to downgrade any of the three campuses of the Imperial Medical School. Re-provision of the School was currently at discussion level by the Dean, the Rector of the faculty and the Chairman of the Trust, not student level.

Professor Cheshire responded to members queries' that the Western Eye Hospital would move on to the St. Mary's site, as it needed to be co-located with a major A&E department, as it offered the only 24-hour emergency eye

service in West London. Professor Cheshire added that part of the current building had been closed for some time.

RECOMMENDED THAT:

The Trust reconsiders the proposed governance structure and reports back to the three boroughs.

RESOLVED THAT:

The draft business plan be noted.

39. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: BUSINESS PLAN UPDATE

This item was taken with item 5.

40. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CANCER SERVICES UPDATE

Mr Steve McManus presented the Cancer Services Update, outlining sustainable improvements:

• New pathways implemented in Lower GI, lung, breast and urology;

• Head and Neck and Upper GI pathways currently being reviewed and revised;

• Pathways broken down into 'timed sections' to ensure no un-necessary delays at any point in the pathways;

• Work in partnership with providers across the network to ensure more timely Inter-Trust Referrals;

• Additional capacity in place where required;

• Prospective reporting now in place highlighting all booked activity and flagging all treatments scheduled outside target to Operational Managers.

A series of events has been scheduled every 100 days to ensure key stakeholder engagement in cancer improvements and to maintain high momentum in implementing best practice. Members were invited to attend the next event on 14 February. Further information would be provided.

Action:

The Trust had delivered seven out of eight of the nationally defined cancer standards in the current quarter. The 62 day standard (first referral to treatment) had not been met. Performance to December would show that all standards had been delivered, and it was expected that the Trust would continue to deliver the eight standards.

Mr McManus outlined the clinical review process, instigated after the reporting break, whereby a comprehensive clinical audit was carried out for all patients that had waited longer than 100 days for treatment The audits undertaken to date had been completed by the Chief of Service for Cancer and in future would include external LCA representatives for additional assurance.

Mr McManus stated that there was no evidence of harm to the progress of the cancer caused to any patient as a consequence of pathway delays.

Mr McManus outlined the initiatives to improve patient experience and the improvement in multi-disciplinary team meetings.

Mr McManus responded to a member query that improvements had been made to the data system and the Trust was confident that there were no further misplaced referrals. Assurance was provided by regular internal audit and external scrutiny.

Councillor Carlebach queried the outstanding information in respect of flu vaccinations. Dr Harrison responded that he had provided the process and would provide the data as soon as it was available.

Action:

Imperial College Healthcare NHS Trust

RESOLVED THAT:

The update be noted.

41. DATES OF NEXT MEETINGS

21 January 2014

19 February 2014

2 April 2014

Meeting started: 7.00 pm
Meeting ended: 9.36 pm

Chairman .....

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