London Borough of Hammersmith & Fulham

# Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

## Minutes

**Wednesday 4 February 2015**

**PRESENT**

**Committee members:** Councillors Hannah Barlow, Andrew Brown, Joe Carlebach, Elaine Chumnery (Vice-Chair) and Rory Vaughan (Chair)

**Co-opted members:** Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

**Other Councillors:** Vivienne Lukey (Cabinet Member for Health & Adult Social Care), Sue Fennimore (Cabinet Member for Social Inclusion) and Sharon Holder (Lead Member for Health)

**Care Quality Commission:** Professor Edward Baker (Deputy Chief Inspector of Hospitals), Dr Sanjay Krishnamoorthy (Clinical Fellow to Professor Baker) and Owen Davies (Senior Parliamentary and Stakeholder Engagement Officer)

**Imperial College Healthcare NHS Trust:** Dr Tracy Batten (Chief Executive), Professor Chris Harrison (Medical Director) and Professor Janice Sigsworth (Director of Nursing)

**Hammersmith & Fulham Clinical Commissioning Group:** Clare Parker (Chief Officer), Dr Tim Spicer (Chair) and Dr Susan McGoldrick (Vice-chair)

**Officers:** Liz Bruce (Executive Director of Adult Social Care & Health) and Sue Perrin (Committee Co-ordinator)

**50. MINUTES OF THE PREVIOUS MEETING**

The minutes of the meeting held on 20 January 2015 were approved as an accurate record and signed by the Chair.

## 51. APOLOGIES FOR ABSENCE

Apologies were received from Debbie Domb.

## 52. DECLARATION OF INTEREST

Councillor Carlebach declared an interest in that he is a trustee of Arthritis Research UK, the second biggest landholder on the Charing Cross site and a non-executive director of the Royal National Orthopaedic Hospital, Stanmore.

## 53. NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

The terms of reference for the North West London Joint Health Overview & Scrutiny Committee (JHOSC) were received.

**RESOLVED THAT:**

1. The Committee endorsed its decision made at the meeting on 22 July 2014 to appoint Councillor Vaughan as the voting member and Councillor Holder as the alternate member of the North West London JHOSC

2. The terms of reference were endorsed, subject to the inclusion of Councillor Holder's name in a final version.

## 54. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CQC REPORT AND ACTION PLAN

Professor Baker and Dr Krishnamoorthy presented an overview of the Care Quality Commission (CQC) inspection of Imperial College Healthcare NHS Trust (ICHT), which had taken place in September 2014.

The CQC's new approach focused on five key questions: Is the service safe, effective, caring, responsive and well-led? Eight core services had been identified for NHS acute trusts: A&E, Medical care (including frail elderly), Surgical care (including theatres), Critical care, Maternity and family planning, Children and young people, End of Life care and Outpatients (selected).

Each service was rated on each of the five key questions and overall. There was a four point scale: Outstanding, Good, Requires Improvement and Inadequate.

The overall trust rating for ICHT was Requires Improvement. The key questions in respect of Effective and Caring had been rated as Good.

The presentation provided the individual ratings for the four hospitals (St Mary's (SMH), Charing Cross (CXH), Hammersmith (HH) and Queen Charlotte and Chelsea, by key question and overall.

SMH urgent and emergency services had been rated as Requires Improvement with the key question 'well-led' being rated as Inadequate. There were issues in respect of leadership and cleanliness and infection control in the A&E department.

Outpatients and diagnostic imaging had been rated as Inadequate across the three sites.

Professor Baker commented on the rating of the five key questions:

- 'Safe' had been rated as Requires Improvement, and immediate steps had been taken to improve cleanliness.
- Clinical outcomes were generally very good, and 'effective' had been rated as Good.
- There was high quality compassionate care, and 'caring' had been rated as Good.
- 'Responsiveness' had been rated as Requires Improvement, with outpatients being the most challenging area, and specifically appointment delays and cancellations.
- 'Well led' had been rated as Requires Improvement. The CQC considered that ICHT had a history of unstable leadership and was impressed with the change in leadership, although this had not yet been embedded.

The CQC was impressed with ICHT's response to the report and the immediate action to address the issues and develop long term plans.

Professor Baker responded to Councillor Carlebach that the Western Eye Hospital provided specialist services and had not been inspected on this occasion.

Professor Baker responded to Mr Naylor that some services had not been rated in the Effective category because of a lack of evidence on which to report.

Mr McVeigh noted that at the November inspection, ICHT, despite making significant improvements since the main inspection in November, had still been rated as Requires Improvement for the Safe category.

Professor Baker confirmed that the new inspections of hospitals were significantly more rigorous. 60% of hospitals had been rated as Requires Improvement. The inspections presented evidence which gave staff more insight into how to improve services.

Councillor Chumnery queried the potential impact of the inspection, if it had been undertaken before the closure of HH A&E. Professor Baker responded

that the inspections did not relate to any proposals to reconfigure services and were not intended to inform any other decisions.

Dr Batten, Professor Sigsworth and Professor Harrison presented the top line findings overall of the CQC inspection and ICHT's response and key action points. Whilst the report clearly set out ICHT's challenges, it also recognised the positive impact of work over the past year and highlighted the good care that was being provided.

Councillor Brown queried whether ICHT had been disappointed with the results and whether they had been brought about by ICHT concentrating on ground breaking work at the expense of the basic aspects of healthcare. Professor Harrison responded that the Good rating achieved in the Caring category illustrated how doctors and nurses put effort into a caring service for local people, in addition to providing a specialist service for a much wider area.

Councillor Brown queried whether ICHT being spread over a number of sites was a contributory factor and how could the committee be re-assured that the leadership would continue to bring about improvements.

Dr Batten responded that ICHT was a complex organisation, spread over five sites, with some 10,000 staff. ICHT provided an extensive range of services and there were in the region of one million patients a year. The CQC inspection was the first time that there had been a comprehensive review of the quality of services delivered. The report was extremely constructive, and the feedback had been shared in an open forum with all staff. Although the overall rating was disappointing, there was optimism amongst staff. The changes to the executive team would ensure clear lines of accountability and robust clinical governance and would be embedded, going forward. Further to the merger of two trusts in 2007, there was still not consistency of policy and practices across the sites.

Mr Naylor queried the involvement of other organisations and patient groups in providing information and correcting the issues. Dr Baker responded that as part of the preparation for the visit, information had been sought from a wide range of groups. The visit would have been planned to target issues raised.

A list of groups consulted to be provided.

**Action: Care Quality Commission**

Professor Sigsworth stated that ICHT received quite a lot of help from independent groups, for example in the mini mock inspections of cancer services at CXH and frail elderly services at HH. There had been patient led inspections of cleanliness. ICHT involved both staff and non-employees. Going forward, ICHT would invite much more input from patient and public bodies and peer scrutiny, as part of mock inspections to ensure that the action plan was implemented. ICHT liaised with GP commissioners and Healthwatch, but there would only be small numbers from each borough.

Mr Naylor queried if this input had been shown in the action plan. Professor Sigsworth responded that the outcomes of the Quality Summit had been quite detailed to show that ICHT had taken seriously the feedback from stakeholders.

Councillor Vaughan queried how ICHT took into account the range of opinion from other organisations and patients in continuing to monitor and develop services; and how ICHT planned to embed this into the process going forward and capture in its culture. Professor Sigsworth responded that ICHT would adopt a similar approach to the CQC in a series of its own inspections, looking at areas in a more systematic way. Data from patients, Healthwatch, PALS and complaints would be cross referenced. ICHT would work with its internal audit to develop a framework to deliver the CQC's standards.

Councillor Vaughan queried the role of the Trust Board. Members were informed that the Board's Quality Committee monitored in depth how the Action Plan was being implemented across the organisation. A patient attended every Board meeting to talk about their experiences of care. This item was at the beginning of the agenda so that it fed into the remainder of the Board, and specifically performance and monitoring targets.

In addition, ICHT was really listening to staff about what it was like on the ground. Board members and senior managers were going out around the trust, and were able to demonstrate what they had seen and found.

Councillor Barlow queried whether ICHT had put in place measures to ensure that it met the CQC's requirements and whether it knew what it would have to achieve for the next CQC inspection. Professor Sigsworth responded that the Mid Staffordshire Inquiry and the Francis Report had impacted on the level of rigour adopted by the CQC. There had been a big change very quickly and ICHT had to redouble its efforts in a number of areas and services. Whilst there were not national quality requirements, the CQC had been clear in what it expected and it was clear what ICHT needed to do.

Professor Baker stated that the CQC had not identified new standards. It identified standards which a hospital needed to apply consistently and reliably. A hospital needed to be realistic about where it was and what it needed to do to improve. Requires Improvement did not mean that it was a failing hospital, but that it needed to deliver the identified changes.

Mrs Bruce queried the top line findings overall in respect of not meeting the target for sending out appointment letters to patients within ten working days of receiving the GP referral; and shortfalls in how the needs of people with dementia and learning disabilities were considered.

Professor Sigsworth responded that, in respect of people with dementia and learning disabilities, the issue related to inconsistencies in staff responses, rather than interaction with patients. More work was required on environmental issues, particularly A&E which could be unsettling for these patients.

Dr Batten responded that the Action Plan addressed the problems associated with the administration of appointments which were leading to unnecessary delays and indicated the work across each of the sites. There were a number of different ways in which patients could access Outpatients; phase 2 would establish a single point of access. There had been some quick wins, for example standardisation of the appointments letter and sending out letters in a more timely manner. A new patient administration system had been implemented in April 2014; technical support to Outpatients was being expanded to improve the check-in and booking function locally and achieve consistency every time on each site.

Councillor Lukey requested that she and Mrs Bruce be sent the work with the joint forum on improving the pathways for people with learning disabilities and dementia. Councillor Lukey stated that the Council would like to support this work. Professor Sigsworth responded that there was still an opportunity to refine and strengthen the action plan.

**Action: Imperial College Healthcare NHS Trust**

Councillor Fennimore requested more information in respect of available languages. Professor Sigsworth responded that ICHT provided interpreters. However, this could be difficult to co-ordinate and the service was often provided by telephone.

**Action: Imperial College Healthcare NHS Trust**

Councillor Chumnery queried the action point in respect of registrars not always available out of hours on the ICU at CXH and cover being provided by junior doctors, none of whom had the required skills on that particular evening. Professor Harrison responded that ICHT had addressed the issue as part of the review of critical care service to ensure that skills were available across the site, but this had not been in place at the time of the CQC inspection.

Councillor Chumnery queried the issues with the storage of medicines at the correct temperature in refrigerators. Professor Sigsworth responded that a twice monthly audit of some 200 refrigerators was now undertaken.

Councillor Holder suggested that negative feedback should have been included in the presentation, in addition to the positive feedback.

Councillor Fennimore queried how much of the report had been a surprise. Dr Batten responded that her presentation to the CQC before the inspection, had highlighted the areas which had a body of work in train, but this had not been embedded across the organisation. The report was therefore not entirely a surprise. ICHT would work towards all areas being rated Good and ultimately Outstanding across all domains of quality.

Mr Naylor queried the priorities and their outcome and timescale for older people, who often presented in Outpatients with a number of chronic

conditions. Dr Batten responded that the Action Plan included: the reduction of clinical cancellations at short notice to an absolute minimum; the reduction of patients who did not attend; support to doctors to arrive at clinics on time; review of bookings and timeslots; and improvements in correspondence with patients and GPs. ICHT would provide a joined up, less fragmented service.

Mr Naylor noted that transport was a common issue for older people.

A member of the public queried whether ICHT was building a relationship with the London Ambulance Service (LAS) and working to reduce spikes and the pressure on the LAS. Dr Batten responded that ICHT was particularly focused on 'off- loading', the time from which the ambulance arrived at the front door and ICHT received the patient and became the carer. In general, good times were achieved, enabling the LAS to get back on to the road quickly. ICHT aimed to smooth its demand and daily meetings were held across the sector. The data would be shared with the PAC.

**Action: Imperial College Healthcare NHS Trust**

A member of the public commented on the death rate figures across the country, published earlier that day, and queried the impact of the Stroke Unit moving out of CXH. Professor Harrison responded that ICHT morbidity rates were amongst the best in the country. In addition, Public Health had a role in supporting people to live healthier lives, and ICHT had a role to play in working with GPs, Public Health and Public Health England.

Dr Batten stated that it had always been intended to co-locate the Stroke Unit with the Major Trauma Unit at SMH, and there was a strategy for its relocation.

Councillor Vaughan queried whether IT in the Outpatients Department was actually working, and if there were plans to improve or replace. Dr Batten responded that a Cerner Patient Administration System (PAS) had been implemented in all Outpatients Department across ICHT in April 2014. Data quality was being monitored closely and was being tracked at Executive and Trust Board meetings. All data had been brought back to the levels recorded prior to go live of the Cerner PAS. The next step would be the roll out of clinical documentation, which was currently being piloted, together with electronic prescribing, at which point there would be greater benefits and efficiencies from the system. The implementation of the Cerner modules for theatre management and for the emergency department was on track to go live in early March.

Dr Batten responded to Councillor Brown that ICHT was working towards sending letters by e-mail. This opportunity would become available with one of the PAS modules. ICHT was also looking at good practice in other organisations. There were still some legacy systems in some Outpatient areas.

Councillor Vaughan asked for confirmation that the cleanliness issues identified by the CQC had been addressed. Professor Sigsworth responded

that the CQC's finding that cleanliness in SMH A&E had not been acceptable, related to the A&E cubicles not being cleaned in the way which they needed to be. The clinical schedule had been reviewed and processes improved to ensure equipment was always cleaned thoroughly and maintained to the required standards. Each cubicle now had an A4 checklist for completion with every patient coming in and going out. ICHT had worked through the cleaning pathway and clarified responsibilities and talked though in detail with staff.

Professor Baker responded to Councillor Carlebach that the CQC had inspected all services provided by ICHT, even if a joint venture but not services run by other providers. The Urgent Care Centres at CXH and HH were commissioned by H&F CCG, but run by ICHT and a local out of hours provider.

Councillor Vaughan queried whether the Action Plan to reduce nursing vacancy rates was adequate to provide cover by various grades. Professor Sigsworth responded that staffing levels were a nationally mandated process, with reports being submitted to the Quality Committee and Trust Board twice a year. ICHT was confident that the level was adequate. Currently levels were benchmarked across London. However, there could be an influx of trained nursing staff leaving the trust. Ideally, cover would be provided through ICHT's bank staff. Increasingly, less nurses were being employed through agencies. At the time of the CQC visit, there had been a high vacancy rate and a request for bank staff had not been filled.

The Action Plan included a focus on attracting student nurses into junior grade jobs and recruitment of experienced nurses. ICHT had a pool of nurse educators and specialist nurses who could be called upon to cover vacancies.

Professor Sigsworth stated that no beds had been closed as a consequence of the vacancies and confirmed that, should ICHT consider that staffing levels were not adequate, beds would be closed.

Professor Sigsworth stated that ICHT was confident that the Action Plan would achieve the CCG vacancy rate target of 5%.

Councillor Vaughan thanked the CQC and ICHT for attending and summarised the key points:

1. T
   he committee shared ICHT's disappointment with the outcome of the CQC inspection.
2. T
   here were some basic areas of cleanliness upon which ICHT needed to improve.
3. I
   CHT needed to build the feedback from patients, peers and other organisations. into its review of systems and decision making process.
4. T
   he CQC was impressed with the current leadership, and the committee hoped that the CQC would continue to reach the same judgement in a year's time.

5. The committee requested that an update on the Outpatients PAS be brought back to a future meeting.
6. The committee requested that ICHT provided assurance to a future meeting that the progress in respect of cleanliness had been sustained.

## 55. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY DEPARTMENT WAITING TIMES

Dr Batten stated that whilst there had been some improvement in A&E performance, ICHT was still not achieving the national target of 95% of patients waiting four hours or less. An Action Plan was in place to systematically improve key areas in order to achieve and sustain the 95%, focusing on: the management of patients within the A&E department; the admission process; working closely with partners to streamline the discharge process so that patients could be discharged home or to supported care in the community as soon as they were ready; moving forward the discharge time for inpatients to before the peak in A&E attendances; and delayed transfers.

Councillor Holder queried if there was any reason why SMH rates improved and CXH worsened at the time of the CQC visit. Dr Batten responded that the two departments were run separately, and the reasons for changes in performance would be different underlying causes.

Further measures to increase capacity were being put in place. At SMH, extra space was being created for more serious emergency cases by moving the UCC treatment rooms out of the middle of A&E to a new unit nearby. In addition, there were more senior staff and clinicians working until later times. Additional capacity at CXH would be in place by late February.

Councillor Chumnery queried how ICHT intended to manage seasonal trends with the current low level of resources. Dr Batten responded that the recruitment process for further additional consultants had already commenced. An action plan was in place to sustain performance. Until recently, ICHT has consistently achieved good performance of 94%. In the last few months, there had been greater volatility of attendances and acuteness. The low spikes at CXH corresponded with the virus outbreak, at which time beds had been closed.

Councillor Barlow queried why some domains has been rated Good when targets had been missed. ICHT was unable to respond in respect of the CQC rating system.

Councillor Lukey queried whether ICHT had conveyed the problems to people in higher levels of the NHS. Dr Batten responded that ICHT felt extremely well supported by the NHS Trust Development Authority, the CCGs and NHSE.

ICHT was working with the CCGs to provide more appropriate care in more appropriate settings.

Councillor Vaughan concluded the discussion, stating that the committee welcomed the re-assurance that ICHT was working to achieve and sustain the 95% target. It would be helpful for the committee to be provided with the statistics on a monthly basis.

**Action: Imperial College Healthcare NHS Trust**

## 56. SHAPING A HEALTHIER FUTURE

Dr Tim Spicer updated on the current position in respect of Shaping a Healthier Future (SaHF). There was an integrated site strategy for the different ICHT sites. SMH had been designated a major hospital and major trauma centre. HH had been designated as a specialist hospital with an emergency heart attack centre and a 24/7 UCC. CXH was a local hospital, designed to meet the needs of the local population to remain independent. Services provided at CXH included; support for carers; a range of outpatient services; a one-stop shop to reflect the fact that many patients had multiple conditions; and specialist rapid access clinics for frail and elderly people. CXH was part of an integrated approach to healthcare.

There were GP hubs in the north and south of the borough, comprising 31 practices, all working from a single IT platform.

It was expected that the Keogh Review would transform Urgent and Emergency Care in the NHS.

Workforce was an issue throughout North West London and the whole of London. A key role was the development of training to enable staff to work within hospitals and the community.

An Implementation Business Case (ImBC) collated all the outline business cases (OBC) across North West London (including eight CCGs and nine acute trusts). The ImBC would be submitted to NHSE in mid-March. The process would involve the NHS, Department of Health and the Treasury. It was believed that completion would be from 2016/2017 until 2020/2021.

Councillor Vaughan queried the details in respect of CXH, and emergency facilities in particular. Ms Parker confirmed that these details would have been included in ICHT's business case, but this was still a draft and confidential. Dr Spicer added that the CCG would ask NHS London/NHE when the details could be revealed.

**Action: H&F Clinical Commissioning Group**

Councillor Lukey stated that it was deeply frustrating that there had been no information since the Independent Review and endorsement by Jeremy Hunt.

There had subsequently been timetable slippage, the CQC report and ICHT not proceeding with foundation trust status application.

Councillor Lukey queried how public money would be sought for investment in the plans. Dr Spicer responded that CCGs could not raise capital and therefore the OBCs had to be handed over to an organisation which could raise capital. Ms Parker confirmed that implementation had slipped. The different OBCs had to be reconciled to ensure that no activity had been duplicated or missed.

Dr Batten responded that ICHT had to receive a CQC rating of Good or Outstanding to proceed with its foundation trust application, after which it would take approximately 12 months to achieve. Following approval of the ImBC, each trust would have to submit a final business case providing a detailed level of planning across the sites. This was likely to take 12 months to complete. There would then be a three/four year timescale for the capital programme.

Councillor Carlebach considered that as a draft had not been shared with the committee, the Medical Director and Chief Executive of NHS London should be formally contacted. Dr Spicer stated that substantial capital investment was required for North West London and therefore the support of NHS London was needed.
Councillor Brown queried the position in respect of the Central Middlesex Elective Surgery Centre. Ms Parker responded that ICHT would not be responsible for the PFI, responsibility would remain with the Trust. The Centre provided elective surgery for a number of trusts, providing better outcomes and safer facilities.

Councillor Brown requested clarification of the additional consultants and other staff in the A&E departments at CXH and HH.

**Action: Imperial College Healthcare NHS Trust**

***The Chair proposed and it was agreed by the committee that the guillotine be extended to 10.15pm.***

A member of the public queried the percentage of patients attending A&E compared with previous years. ICHT did not have this information.

The member of the public then commented on a recent press article in respect of telemedicine. Dr McGoldrick responded that three years previously the CCG had received funding to identify, in conjunction with ICHT, where telemedicine could be helpful. There had also been a number of national pilot sites. The evidence at that time indicated that telemedicine could be effective for patients living in more rural areas, but not so much for densely packed inner cities. There had been no consequent funding. The CCG had not seen a role for telemedicine at that point in time.

Dr Spicer responded to the member of the public's comments in respect of reductions in A&E demand by highlighting the whole systems work which was addressing the integration of acute and community care.

Mr Naylor emphasised that A&E needed back up beds and that the residents of the borough needed to be told what would be available at CXH. Dr Spicer agreed that there would always need to be beds, but the percentage and how arranged could change. There would be more consultants in A&E for more hours. There was evidence that consultant involvement earlier in the pathway resulted in improved decisions and reduced investigations, and patients being more likely to be discharged rather than admitted. Some beds were currently blocked by people who were medically fit.

Mr McVeigh commented on the difference between the A&E figures reported on by the CQC and those provided by ICHT. Professor Sigsworth responded that the CQC inspection had been in September and they had looked at figures retrospectively, and had used a range of qualitative indicators. The graphs provided by ICHT had a quantitative basis, representing a range of service standards on which fundamental clinical decisions were made.

Councillor Chumnery referred to information which had previously been provided in response to her concerns in respect of communication of the Shaping a Healthier Future changes. Of the 257 groups listed, only 11 groups were based in Hammersmith & Fulham and had received communication in the form of leaflets. In addition, face to face meetings had been very limited.

Councillor Chumnery noted that there was a lot more work to do in respect of communication and that better communication was required going forward.

**Action: H&F CCG to contact Councillor Chumnery to clarify communications.**

Councillor Vaughan concluded the discussion by emphasising the committee's frustration at the lack of a clear business case for CXH and decision making process.

Councillor Vaughan thanked H&F Clinical Commissioning Group and Imperial College Healthcare NHS Trust for attending the meeting.

## 57. WORK PROGRAMME

The work programme was received.

## 58. DATES OF FUTURE MEETINGS

9 March 2015
13 April 2015

Meeting started: 7.00 pm
Meeting ended: 10.15 am

Chairman .....

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