London Borough of Hammersmith & Fulham

# Housing, Health And Adult Social Care Select Committee

## Minutes

**Monday 24 September 2012**

**PRESENT**

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

**Other Councillors:** Marcus Ginn and Andrew Johnson

**Officers:** Kathleen Corbett (Director, Finance and Resources, Housing and Regeneration Department) and Sue Perrin (Committee Co-ordinator)

**Imperial College Healthcare NHS Trust:** Steve McManus (Chief Operating Officer) and Justin Vale (Clinical Programme Director for Surgery and Cancer)

**Chelsea and Westminster NHS Foundation Trust:** Sir Christopher Edwards (Chairman) and David Radbourne (Chief Operating Officer)

**NHS North West London:** Daniel Elkeles (Director of Strategy), David Mallett (SRO SaHF Programme Delivery) and Dr Mark Spencer (Medical Director)

**15. MINUTES AND ACTIONS**

**RESOLVED THAT:**

The minutes of the meeting held on 17 July 2012 be approved and signed as an accurate record of the proceedings.

**16. APOLOGIES FOR ABSENCE**

Apologies were received from Councillors Oliver Craig, Peter Tobias and Iain Coleman and Ms Maria Brenton.

**17. DECLARATIONS OF INTEREST**

Councillor Carlebach declared a significant interest in respect of 'Imperial College Healthcare NHS Trust: Management of Waiting Lists', as he is a trustee of Arthritis Research UK. He considered that this did not give rise to a perception of a conflict of interests and, in the circumstances, it would be reasonable to participate in the discussion and vote thereon.

## 18. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: MANAGEMENT OF WAITING LISTS

Steve McManus, Chief Operating Officer, and Justin Vale, Clinical Programme Director for Surgery and Cancer updated the committee on progress in respect of the management of waiting lists at Imperial College Healthcare NHS Trust (ICHT) and apologised on behalf of ICHT for the distress and concerns generated for patients and their families through the lack of reliable information.

Mr McManus stated that in January 2012, ICHT had instigated a six month break in reporting on the 18 week referral to treatment time and waiting times for cancer and diagnostic tests and procedures, following a review of the administration of waiting lists by the NHS Intensive Support Team (IST) and ICHT's own staff. The review had identified significant anomalies, including patients recorded as waiting who had already been treated and duplicate entries for individual patients. Robust systems for recording patient information and improved staff training had been put in place and there had been radical changes in the management structure, including the appointment of Mr McManus as Chief Operating Officer. Reporting against national targets had re-commenced in July/August.

Mr McManus assured the Committee of his personal commitment to continuing improvements in patient safety and quality of care.

A full review of the clinical implications of the waiting list position had been carried out by a Clinical Review Group to determine any possible effect on patient care. The Group had been chaired by a clinician independent of the Trust, who is a medical director and a GP. The group's membership comprised another GP, the trust's commissioners, a non-executive director and senior Trust clinicians, an external Acting NHS Chief Executive, senior Trust management representatives, an external NHS Trust Director of Nursing and the Director of NHS IST, thereby combining external scrutiny with internal expertise about ICHT's patients, systems and processes. The Group had looked at admitted, non-admitted, diagnostic and cancer patient pathways, and had reviewed data relating to the potential impact on patient care, and had found no evidence of clinical harm as a result of these failures.

In addition, there had been an External Governance Review, to report to the Trust Board on issues relating to decision making, governance and reporting processes.

Mr Vale addressed the cancer element of the review. The in-depth validation of cancer pathways with referrals predominantly for suspected breast cancer

and symptomatic breast disease dating back over the last few years had been in three parts: administration validation; clinical validation; and primary care validation. The information demonstrated that there were no concerns relating to an extended wait which could have contributed to a patient's death. The issues identified as part of the validation process had been addressed by ICHT and a robust patient tracking system put in place.

Mr Vale stated that the results of the second national cancer survey published in mid-August had shown that ICHT had performed poorly in comparison with other trusts. This position was not acceptable. The scores had been reported as percentages relating to the number of patients responding with a positive response of their experience from the GP experience to experience as an inpatient, day case patient and outpatient.

A number of initiatives undertaken within the Cancer Patient Experience Work Programme following the first national survey in 2010, had not produced the required impact. ICHT recognised that an urgent and radical review of the experience of cancer patients was required and had agreed actions to be undertaken during the following three months. Actions included: a survey of other patients with questions which would help to identify the issues: the implementation of the MacMillan Values Based Standard; and visits to other hospitals.

A member queried the number of patients whose treatment had been delayed and by how long, and asked for re-assurance that the problems had been resolved and there would be not be a recurrence. Mr McManus responded that there were 243 patients on the 31 and 62 day pathways for cancer services across the organisation, and the clinical review would be completed within the next two weeks. Mr Vale added that it was likely that these patients had been seen and had a diagnostic test and possibly a diagnosis, but the pathway record was incomplete. It was not believed that these patients were at a higher risk than those previously validated.

Mr Vale informed that, on average, 10/12% of patients referred with suspected cancer were diagnosed with cancer and it was likely that those patients with more worrying symptoms would have presented again. ICHT was now delivering the national standard for the two week wait cancer pathway.

ICHT currently had a number of non-integrated systems. An integrated cancer management system, which had been approved as robust by the IST, was being rolled out with comprehensive training. The services of the IST had been retained and the cancer management team re-organised, with stronger reporting lines.

Mr McManus confirmed that both the Waiting List Clinical Review Report and the External Governance Review would be published in full and would be considered by the Trust Board at its meeting on 26 September. The External Governance Review originally scheduled for July 2012, had been delayed because of the number of witnesses who had to be interviewed.

**ACTION:**

The Waiting List Clinical Review Report and the External Governance Review to be circulated to the Committee.

**Action: Committee Co-ordinator**

Members commented on the inadequate response in respect of the independence of the person leading the External Governance Review. The response from the ICHT Chairman had addressed the competence of Terry Hanafin of Terry Hanafin & Associates Ltd to carry out this independent review in a professional, comprehensive and objective manner, but not the connection with an existing member of the Trust Board.

A member queried the use of the private sector to remedy referrals which had gone astray. Mr McManus responded that consistent improvements had been made and ICHT was achieving 88% of patients on an 'admitted' pathway being treated within 18 weeks, against a national target of 90%. ICHT was achieving the national standard of 95% of patients on a 'non-admitted pathway' being treated within 18 weeks. There had been a backlog of up to 3,500 patients. ICHT was working with other NHS hospitals with capacity and where clinically appropriate. A number of orthopaedic patients (287 patients) had been treated by a private provider (BMI).

Members queried the cause of the mis-management of waiting lists and performance data. Mr Vale responded that data had not been entered in a timely manner and there had been performance management issues, and specifically a lack of local ownership.

Councillor Cowan suggested that responsibility for the failure should be at senior management level. Members asked for a guarantee that the problem had been dealt with fully and measures had been put in place to ensure that there would not be a recurrence. Mr McManus responded that it would be inappropriate for him to comment on guarantees after such a short time in post, but he could offer assurance that: improvements had been made in the recording systems; and the management structure had been strengthened to centralise scrutiny of waiting lists and support staff and to meet national performance standards. Mr McManus guaranteed that scrutiny of waiting lists would remain a high priority for him, and that he would be spending time at each site in all areas to understand if there were any remaining problems.

The IST would be asked to address any specific problems and there had been a level of re-assurance from external reviews by for example, the Care Quality Commission and the achievement of NHSLA Risk Management Level 3, the highest level, which comprised assessment against 50 standards related to governance and risk processes.

A member highlighted the need for ICHT to improve its corporate reputation. Mr McManus acknowledged this and stated that ICHT was working with patients and stakeholders to rebuild its poor reputation.

**RESOLVED THAT:**

The committee remains concerned at the management of patient data and the management system.

The committee lacks confidence in the strategic governance review generally and, in particular, in ICHT's plans for Charing Cross Hospital.

The committee remains concerned at the weakness of ICHT's communication with stakeholders.

The committee recommended that ICHT procured an objective and independent strategic governance review, and shared the terms of reference with the committee.

The committee requested a written response in respect of patient referrals which had gone astray, to include on an individual basis (if possible): the reason why the referral had gone astray; the nature of the delay; and where the patient was being treated; and, for cancer patients, the type of cancer by tumour site.

**Action: Imperial College Healthcare NHS Trust**

## 19. SHAPING A HEALTHIER FUTURE: NHS PUBLIC CONSULTATION

Members queried whether ICHT supported NHS North West London's (NWL) preferred option, 'Option A'. Mr McManus responded that ICHT was broadly supportive of the proposals and the Trust Board would consider a draft response to the consultation at the meeting on 26 September. A draft response had been collated from feedback obtained through workshops with staff and debate by the Academic Health Science Centre (AHSC). The final response would be submitted by the AHSC.

Members considered that ICHT should submit its own response to the consultation, not in partnership with Imperial College.

Whilst ICHT acknowledged that should Charing Cross be downgraded to a local hospital, a significant part of the site would become available, the use of this land had not been debated. The committee was concerned at the vagueness of ICHT about the future of Charing Cross. Mr McManus did not believe that ICHT had indicated a preference for where services would be located on the three sites.

Sir Christopher Edwards, Chairman and David Radbourne, Chief Operating Officer, Chelsea and Westminster NHS Foundation Trust outlined some of the background to the proposals, including: demographic change; issues with the quality of the NHS estate; financial challenges; and a national shortage of

Consultants in Emergency Services. The College of Emergency Medicine recommended that Accident & Emergency (A&E) departments were staffed by consultants for 16 hours a day.

A member noted that Chelsea and Westminster was a constrained site and queried how the trust would manage the additional patients through A&E, as a direct impact of the loss of A&Es at other hospitals. Sir Christopher responded that the trust would require a maximum of 80 additional beds and would be able to expand and improve the current A&E. The paediatric A&E already provided a high quality environment. It was possible to expand the hospital building sideways, by moving non-clinical activity out of the hospital and into adjacent property.

Mr Radbourne added that should Charing Cross Hospital A&E become a stand alone Urgent Care Centre (UCC), it was likely that there would be a change in the profile of patients attending the hospital and corresponding changes in the workforce profile, with more cover being provided by GPs. Both models (co-located with A&E and stand alone UCC) had been shown to work.

Sir Christopher stated that Chelsea & Westminster had demonstrated that it could manage well and had generated a recurrent financial surplus, which, as an NHS foundation trust, it was able to invest in new facilities. Downgrading to a 'local hospital' would not be viable, as a stand alone UCC would impact on paediatrics, maternity, emergency surgery and anaesthetics.

Members were concerned that the active campaign and money spent by Chelsea and Westminster was effectively a campaign to close Charing Cross. Sir Christopher responded that this was not the case. The campaign, which had been mounted by the independent Board of Governors which held the Trust Board to account, compared Chelsea and Westminster with Imperial, not with Charing Cross. Sir Christopher considered that it was important for ICHT to become financially viable and to achieve foundation trust status. ICHT had the problem of three hospital sites, which meant that services were duplicated/triplicated across the trust.

Councillor Vaughan queried the timing of the decision in respect of the emergency service proposals before realisation of the Out Of Hospital strategy benefits. Sir Christopher responded that resolution of the problem of emergency medicine had to begin immediately. It was not in the best interests of patients for the decision to be deferred.

Councillor Carlebach commented on the importance of public education in respect of the difference between an A&E and an UCC.

The Chairman thanked Sir Christopher and Mr Radbourne for attending the meeting.

The Chairman asked ICHT to update the Committee on the proposals. Daniel Elkeles stated that he had provided a detailed response to the Rideout Report and that he considered that the NHS case for change had been endorsed by

the Council. Mr Elkeles noted that the Council considered the pre-consultation engagement of key stakeholders and the methodology used to identify and chose between the various reconfiguration options open to challenge, and that the scale of change proposed, and in particular the significant and potentially adverse impact on the people of Hammersmith & Fulham had not been adequately explained or addressed.

Members raised concerns at the lack of clarity in respect of the implications for Charing Cross Hospital and for non-blue light travel. Councillor Cowan stated that the Council did not accept every aspect of the case for change and the broad principle of reducing the number of A&Es.

Councillor Graham queried the range of disposal values for the Charing Cross site and was incorrectly directed to a specific table in the pre-consultation business case, which showed the estimated disposal value per hectare for St. Mary's, Charing Cross, Ealing and Chelsea Westminster, but did not relate to any specific 'parcel' of land being sold within the site.

**Action:**

The range of disposal values for the Charing Cross site to be provided.

**Action: NHS NW London**

Mr Elkeles stated that the Chief Executive of ICHT had indicated the trust's support for Option A. Mr McManus stated that the decision would be taken at the Trust Board meeting on 26 September, and this was endorsed by Ms Rebekah Fitzgerald, Director of Communications.

Councillor Graham, on checking the Trust Board papers for 26 September, informed that the agenda indicated that there would be an oral report and the item had been allocated ten minutes. The committee was concerned at this discrepancy and the short time allocated to such an important issue.

Members considered the North West London Cluster Integrated Board Assurance Framework, version 7 September 2012, which had been tabled by Councillor Cowan and specifically the risk in respect of: the objective to deliver £1billion of financial savings by 2014/2015 to achieve financial balance.

Members queried the lack of mitigating actions in respect of the objective to support the implementation of new models of care and best practice to deliver improvements in clinical quality and patient experience across NWL, and the risk that the strategy was not accepted by patients, politicians and public. Mr Elkeles responded that the mitigating actions should have been completed before the report was taken to the Cluster Board and would be included in the report to the November meeting.

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

Members referred to the NHS 'Four Tests' required to be met by all reconfiguration proposals, and the engagement with CCGs being given as evidence of engagement with GPs. Mr Mallett stated that the JCPCT would be reconstituted to ensure that CCGs were part of the final decision making. However, it was not intended to poll individual GPs.

**RESOLVED THAT:**

1. The Committee noted the report, 'Shaping a Healthier Future – an independent review' (Tim Rideout).

2. The Committee deplored the way in which Charing Cross and Chelsea and Westminster had been set against each other in the 'Shaping a Healthier Future' proposals.

3. The Committee questioned the conclusion and analysis of the 'Shaping a Healthier Future' proposals.

4. The Committee did not believe that the effective closure of Charing Cross as a major hospital as a consequence of the closure of the Accident & Emergency Department was in the best interest of the borough.

5. The Committee called for more imaginative solutions.

6. The proposal should be referred to the Secretary of State.

7. The committee endorsed the Council's response to the Consultation 'Shaping a Healthier Future' and recommended that the response be sent as a joint response from the Council and the Housing Health & Adult Social Care Select Committee.

## 20. HOUSING AND REGENERATION DEPARTMENT KEY PERFORMANCE INDICATORS

Kathleen Corbett responded to questions that the homeless acceptances was a reflection of the on-going pressure on the service caused by the introduction of housing benefit caps that mitigating action was being taken, and every effort being made to move families out of B&B. Officers continued to: negotiate with landlords; utilise discretionary housing payments to assist applicants to remain in their existing accommodation; assist applicants to find their own alternative accommodation; and provide incentives to private sector landlords.

Ms Corbett suggested that Mike England would hold information in respect of individual cases and further action.

**RESOLVED**

That information be provided to the next meeting in respect of a longer term strategy for homeless acceptances in conjunction with the Housing Benefits update.

**Action: Mike England**

## 21. WORK PROGRAMME AND FORWARD PLAN 2012-2013

**RESOLVED:**

That the following additions to the work programme be noted:

- Out of Hospital Care and Homecare: January 2013
- Remodel of Adult Social Care Day Services, February 2013
- Transition from Children's to Adult Social Care, April 2013
- Safeguarding Annual Report, January/February 2013
- Personalisation/direct budgets: April 2013
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## 22. DATES OF NEXT MEETINGS

14 November 2012
22 January 2013
19 February 2013
09 April 2013

Meeting started: 7.05 pm
Meeting ended: 10.30 pm

Chairman .....

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