HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 2 July 2019

Present:

Councillor Mary Cooke (Chairman)
Councillor Robert Mcilveen (Vice-Chairman)
Councillors Gareth Allatt, Ian Dunn, Robert Evans, David Jefferys and Keith Onslow

Roger Chant

Also Present:

Councillor Diane Smith, Portfolio Holder for Adult Care and Health

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Judi Ellis and Lynn Sellwood.

2 DECLARATIONS OF INTEREST

Councillor Robert Evans declared that he was a Governor on the Council of Governors at King's, and Councillor David Jefferys declared that he was an elected Lay Governor on the Council of Governors at King's.

3 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

No questions had been received.

4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 3RD APRIL 2019

RESOLVED that the minutes of the meeting held on 3rd April 2019 be agreed.

5 UPDATE FROM KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST: CQC INSPECTION

Dr Clive Kay, Chief Executive – King's College Hospital NHS Foundation Trust ("Chief Executive"), Bernie Bluhm, Chief Operating Officer – King's

College Hospital NHS Foundation Trust ("Chief Operating Officer") and Dr Angela Bhan, Managing Director – Bromley Clinical Commissioning Group (CCG) provided an update in relation to the outcome of the CQC Inspection Report of the King's College Hospital NHS Foundation Trust.

At the invitation of the Chairman, Councillor David Jefferys provided a brief overview of the Committee's role in the scrutiny of health services.

The Chief Executive informed Members that he had been in post for three months, and the Chief Operating Officer for four months. As the Acting Executive Managing Director – Princess Royal University Hospital and South Sites was currently on sick leave, the Chief Operating Officer had been covering this substantive role. It had been a tough few months, and a challenging start, but partners at the CCG had been very supportive and it was hoped that there would be further opportunities for development and collaborative work in the coming months. They had terrific staff at the Trust who were desperate to put patients first, and care for them in the appropriate manner. However, the Trust was in a dire financial position, having reported the largest deficit in NHS history, and there were some major operational issues.

The Chief Operating Officer informed Members that the target for the Emergency Care Standard was 95%. For the week ending 14th April 2019, the performance of the Princess Royal University Hospital (PRUH) stood at 76.46%, and the Trust at 73.96%. There had been a slight improvement on these figures during May, however the performance during March to June 2019 had seen deterioration from the figures for the same period in the previous year. It was noted that the Trust reported the combined figure, but the PRUH presented very different challenges to Denmark Hill and a bespoke plan would be developed to manage performance. The Chief Operating Officer gave assurance that in her role she would be providing support across the organisation. The 'Inadequate' rating of the Emergency Department (ED) had a clear impact on patients, partners and staff. This was being taken very seriously by the Trust and was a key priority on the work programme of clinicians and managers of all systems. The staff in the department had found it hard to read the analysis in the Inspection Report.

The Chief Operating Officer advised Members that the Urgent Care Centre (UCC) at the PRUH was run by an independent provider, Greenbrook Healthcare, and offered primary care walk-in services. In response to a question from a Member, the Chief Operating Officer confirmed that Greenbrook Healthcare employed the GP's and nurses in the UCC. It was noted that the staff morale issues mentioned in the CQC Inspection Report were not related to the UCC, they were specific to the ED. The UCC was co-located with the ED, which meant that lesser, acute services were divided and this allowed the ED to focus on serious emergencies. The UCC was performing well, and contributed to the overall performance of the Trust. This was a national choice, and it was important to note that without the contribution of the UCC, the Emergency Care Standard figure would be significantly less than 76.46%. In response to a question from a Member, the

Chief Operating Officer said that the stand alone Emergency Care Standard figure for the ED would be approximately 65%. Members asked if future performance figures presented to the Health Scrutiny Sub-Committee could be broken down into 'UCC' and 'ED'. The Chief Executive and Chief Operating Officer confirmed that this would be possible.

The Chairman queried the plans that had been put in place to improve arrangements in the ED and admission arrangements onto wards, and how these would help to reduce lengthy waits for patients. The Chief Operating Officer advised that this was an issue with flow. Drawing parallels with hotel reservations, the Chief Operating Officer explained that new patients were effectively "checking in" before other patients had "checked out". As a result of this, there was a need for greater capacity to get patients in and out, whilst avoiding overcrowding in the ED. A Member questioned how the operational side of this would be managed for patients to be referred to specialists. The Chief Operating Officer said that the Clinical Director had previously worked as an Acute Physician and in the Medical Assessment Unit. However, it would not be as smooth for surgical admissions. The movement to assessment worked quite well at the PRUH, but the next steps would be to stop delays, reduce waiting times for results and referrals to other specialities, which would help aid a quicker flow.

The Chief Operating Officer informed Members that the cancer 62-Days performance was generally a positive story for the PRUH, which was due to the staff's level of tracking and diligence in relation to the waiting list. Performance as at March 2019 for the 62-Days from GP Referral stood at 86.1%, which was above the 85% target, and the 62-Days from Screening at 81.5%, compared to a target of 90%. The 62-Day figures were variable, and it was acknowledged that there was still some work to do. It was felt to be more of a challenge at Denmark Hill, and the Board would discuss how to better provide these services and the use of clinicians at the sites. The Chairman noted that feedback received from her constituents was that the cancer care at the PRUH was very well received.

The Chief Operating Officer advised the Committee that Diagnostics performance stood at 87.5% as at March 2019, compared to the 100% target. This was almost entirely due to endoscopy at the PRUH, where over a period of months a significant backlog had been created. A Member questioned if more could be done in Health Centres and GP Practices in relation to endoscopies. The Chief Operating Officer responded that a piece of work looking at capacity across London, and local sustainability and transformation partnership's (STP), was being undertaken. Alternative models for the service were needed, as the NHS could not keep up with the demand. There needed to be a system wide approach and a long-term, sustainable solution.

In relation to the PRUH's performance for referral to treatment, as at March 2019, 75.07% of patients were referred within 18 weeks, which was lower than the figure of 76.37% recorded for February 2019. However, as there were still a number of patients waiting over 52 weeks for referrals this was to be expected, and it would otherwise mean that patients were being seen "out

of order". Therefore the percentage of 18 week referrals would not fall whilst there were still patients waiting over 52 weeks.

Vacancy rates at the Trust were a fairly mixed picture with the PRUH's generally less challenging at 9.21%, compared to Denmark Hill at 11.36%, as at May 2019. There was generally a sense within the Trust of local people wanting to work for a local organisation, which was a positive picture. They were mindful of the staff survey results, and were looking at how to better engage with staff, listen more and respond to feedback.

The Chief Executive reported that the Trust's financial problems had been well documented, with an in-year deficit of £189m for 2018-19. It was noted that the reporting of this deficit was extremely damaging for the Trust, and had a knock-on effect with the recruitment and retention of staff. This year the Trust had agreed a control total deficit of £167.9m, a Financial Improvement Plan of £50m and a System Improvement Plan of £10m. Changes would be put in place around transformation, improvement and investment to become more innovative. Staff engagement would help to realise the solution to deliver better healthcare in a different financial climate – staff would be encouraged to own issues and solve them. There needed to be a change in culture, behaviours and how they worked within the system. The fundamental message was that the Trust needed to put things right, and do what they could to be efficient and productive, without affecting patient care. They needed to reduce the number of outpatient visits and reduce waiting times.

The Trust was starting to deliver what was stated in its plans. At month two (May 2019) the Trust was reporting a Year-to-Date deficit of £31.7m, which was £0.218m favourable to the plan overall. However it was noted that it was still very early in the financial year. In response to a question, the Chief Executive said that no other Trust had been able to deliver a balanced budget. The costs of delivering healthcare were greater than the tariff for each procedure, and they had to keep treating patients. The vast majority of Trusts had also been unable to deliver the 95% four hour ED target for many years. The Trust spent more money per month than it was earning, and they had to maintain a grip on this whilst ensuring that systems and processes were efficient and productive. A Member asked if a contribution to the Trust's financial problems was that they did not receive enough from the block contract with the CCG, and if a reasonable income stream could be for NHS hospitals to treat private patients. The Chief Executive responded that the block contract had been decided before he was in post, but that he supported the decision. The reality was that the Trust needed to make the best use of Bromley's money, spending it as wisely as they could, and for providers and commissioners to work together. In relation to treating private patients, in other parts of the country insurance companies had different prices agreed with different providers, and this may be the case in Bromley. This would need to be looked at internally and considered very carefully – how much income could be brought in would need to be countered against the bed availability for NHS and Urgent Care patients.

The Chairman said that there was a need to change the culture and behaviour of staff, as reflected in the comments of the CQC Inspection Report, and asked if the Trust's leadership believed they would be able to do this and how it would be addressed. The Chief Executive said that if he did not believe it was possible, he would not be there – categorically, they can and they would. Plans could be written, but they would not count for anything if staff did not own them and buy into them. A Member noted that the morale of the staff was low before the publication of the Report, and asked how it was planned to raise it. The Chief Executive said that the CQC issued the ratings and their processes had determined that the Trust required improvement. The Trust needed to boost staff and performance, however the publication of the Report had the dramatically opposite effect, and staff had been very upset. The Trust's response would not be to coach the staff on what they should say, but to create an environment in which staff wanted to come to work and tell everyone what a good job they were doing. The Chief Operating Officer said that they would support the staff in the ED to interpret and understand the marks and ratings from the CQC, and consider what could be done to improve them. This would help staff to feel they had the ability to make changes themselves.

The Chief Executive noted that there had been a significant amount of fluctuation in the King's leadership team over the past five years. It was notable that for organisations rated as 'Outstanding', there was a clear correlation between higher ratings and a long-standing senior leadership team. Fluctuations in the senior leadership team resulted in uncertainty. A senior leadership event had recently been held, which was the first that had taken place at King's in over two years. In addition there was an increased visibility of Executives on site through walk-rounds. Staff engagement was a priority for Executives this year, and they were already investing in improving morale.

The Chairman noted that there were some quick, but impactful changes that could be made at the PRUH, such as communication and the length of time patients waited in the ED for results, which could be addressed immediately. Complaints received from constituents often related to administration, and communication (for example using email to communicate rather than a letter). The Chief Executive agreed that there were some "quick wins" and changes must be made as to how they communicated patient's results. However, any changes made needed to be sustainable and not just "sticking plaster" solutions.

A Member said that the CQC Inspection Report's 'Inadequate' rating of the ED had highlighted issues that were not within the staff's control. These included 'staffing levels and skills mix were not sufficient to meet the needs of patients', 'the layout of the emergency department was not suitable for the number of admissions the service received' and 'there was not the leadership capacity and capability to deliver high-quality, sustainable care'. It was noted that the 'caring' element of the ED had been rated as 'Good' earlier in the year and the reasons for it now dropping to 'Requires Improvement' were queried. The Chief Operating Officer said that the CQC visit to the ED had taken place

on an exceptionally busy day – the busiest day of the year, up to that point. At times, two patients were nursed in cubicles designed for only one person, and the Chief Nurse had been supporting the team due to concerns of overcrowding. From previous experience at another hospital, a visit had taken place on a busy day, but they had been rated as 'Good' across all areas. This had been because staff were able to articulate how to keep patients safe, communicate and minimise risks. They had told a positive story in a single voice, which is what staff had been unable to do at the PRUH. It was not just about being busy, it was about how leaders and doctors on the day had described and evidenced that they were doing the right thing. They needed to get staff to look beneath the comments of the Report. In relation to the layout of the ED, the Chief Operating Officer said that building a bigger department was not the answer, it was about improving the flow of patients to more appropriate care centres. The Chief Executive noted that there was an importance attached to the four hour ED target, as it reflected the overall system and was indicative of how well a hospital was run.

Members highlighted that there were a number of reoccurring issues that came up throughout the CQC Inspection Report. These included training, patient's safety, lessons learned not being applied, the maintenance of equipment, and incomplete 'do not attempt cardio pulmonary resuscitation' documentation which needed urgent attention. The Chief Executive said that the Trust had an extensive Action Plan which was being overseen by the Board and the CQC. They needed to ensure that they were practicing in the right way all of the time, and this was what they would aspire to do. A Member noted that there were clear requirements for the checking of medication and equipment, and asked for reassurance that these were being followed. The Chief Operating Officer said that they were, and they were required to evidence this. If it was found not to be the case, conversations would take place with the owners of those services. The Chief Executive noted that there could sometimes be confusion between being busy and being disorganised. Staff should know what they should be doing, and how it was to be reported and monitored themselves, without the CQC telling them.

A Member suggested that the CQC's findings that some staff 'displayed an apathy towards patients and visitors' and 'did not always provided emotional support to relatives' were signs of them being over stretched. The Chief Operating Officer said that some issues had been raised prior to the publication of the CQC Inspection Report, and work to address this was being led by Dr Shelley Dolan. They would need to do some tough things – they could not be positive and create changes without having some difficult conversations. This reflected the comments on the struggle of the leadership and lack of direction. They needed to stop seeing what was abnormal as "the norm", as this was unacceptable. It was stressed that they did not accept staff being busy as mitigation for not being caring, as this was a fundamental expectation of their roles. The comments made in the Report had been difficult to read, and individuals needed to understand why they were made. The Trust had put in place a heightened amount of daily Executive support and coaching of staff, and an Organisational Development Plan would focus on relationships and team working. The Chairman enquired if any differences

had been observed since the publication of the CQC Inspection Report. The Chief Operating Officer said that due to her time post, it was difficult for her to personally comment, but that the feedback from the Senior Nurse and Director of Operations at the PRUH was a sense of a shift, and nursing staff understanding what the CQC Inspection Report meant. The Chief Operating Officer had visited the ED herself, carrying out quiet observations and had seen some things that did not make sense. During her visits, the ED had not been overly busy, and she would like to see how the staff responded when it was overcrowded.

A Member noted the Chief Executive's reference to the Trust's Action Plan earlier in the meeting, and asked if a version could be provided to the Health Scrutiny Sub-Committee. The Chief Executive and Chief Operating Officer agreed that they would be happy to provide a copy of the Action Plan, and advised Members that it was very extensive. In response to a question, the Chief Operating Officer said that they were able to get on and do some of the actions, whilst others had complicated pathways. Actions could take anything from a week to twelve months, and it would be a "living" document with the Trust continuing to strive to do better. It provided a system-wide oversight and an extra layer of support, as well as questioning and scrutiny.

A Member said that their impression was that the creation of the Trust had not worked. Board agendas highlighted that the PRUH had received less attention. Reassurance was sought that a focus would remain on the PRUH as it was a very different hospital, and the staff felt they were "poor relations" to King's. The Chief Executive said that they could provide reassurance, but that they also had to deliver. They were committed to providing high quality care across the Trust, and at different sites. It was fair to say that at Denmark Hill it was perceived that staff were treated differently in specialist areas. They had to provide services of the highest quality at the PRUH and South Sites and Denmark Hill, and the proof would be seen in the results. The review of care across the spectrum would be included in future Board papers.

The Chairman asked if the Chief Executive and Chief Operating Officer personally believed that the CQC Inspection Report was a fair and balanced view of the Trust, on the day of the visit. The Chief Operating Officer said that although she had not been part of the organisation when the visit took place, as hard as it was, they could not challenge the rating of the ED as it was what the CQC had seen and been told by the team on that day. They had however been disappointed by the rating received for end of life care.

In response to a question from the Chairman, the Chief Operating Officer said that she was now on a fixed term contract in the post, and was 110% committed to the organisation. The Chief Executive said that his had been a substantive appointment, and that he was committed to building a strong Executive team and strong working relationships with partners.

The Chairman thanked Dr Clive Kay, Bernie Bluhm and Dr Angela Bhan for attending the meeting of the Health Scrutiny Sub-Committee and providing an

update on the outcome of the CQC Inspection Report of the King's College Hospital NHS Foundation Trust.

Following this item, Dr Clive Kay, Chief Executive – King's College Hospital NHS Foundation Trust and Bernie Bluhm, Chief Operating Officer – King's College Hospital NHS Foundation Trust, left the meeting.

6 MATTERS OUTSTANDING and WORK PROGRAMME 2019/20

Members considered the forward rolling work programme for the Health Scrutiny Sub-Committee.

Members requested that Dr Kay, Ms Bluhm and Sir Hugh Taylor be invited to attend a meeting of the Health Scrutiny Sub-Committee during the autumn, to provide an update on what actions had be taken in relation to the Trust's Improvement Plan, thus far and whether the "quick wins" that were referred to in the meeting had been achieved.

7 FUTURE MEETING DATES

5.30pm, Tuesday 8th October 2019
4.00pm, Tuesday 28th January 2020
4.00pm, Thursday 23rd April 2020

The Meeting ended at 6.02 pm

Chairman