CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

24 January 2019

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Paul Singh (Con)

Cllr Obaida Ahmed
Tracey Cresswell (Healthwatch)
Sheila Gill (Healthwatch)
Cllr Milkinderpal Jaspal
Cllr Asha Mattu
Cllr Phil Page
Cllr Susan Roberts MBE
Dana Tooby (Healthwatch)
Cllr Martin Waite

Quorum for this meeting is three voting members.

Information for the Public

If you have any queries about this meeting, please contact the Democratic Services team:

Contact Martin Stevens
Tel/Email Tel: 01902 550947 or martin.stevens@wolverhampton.gov.uk
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Agenda

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
[To receive any apologies for absence].

2 **Declarations of Interest**

3 **Minutes of Meetings** (Pages 5 - 34)
To approve the minutes of the following Health Scrutiny Panel Meetings: -

Special Health Scrutiny Panel – 23 October 2018
Special Health Scrutiny Panel – 25 October 2018
Health Scrutiny Panel – 15 November 2018

4 **Matters Arising**
[To consider any matters arising from the minutes.]

5 **Cancer Treatment Services**
[To receive a report from the RWHT on Cancer Treatment Services].

[Report is marked: To Follow].

6 **Patient Advice and Liaison Service** (Pages 35 - 42)
[To receive a report from the RWHT on the Patient Advice and Liaison Service].

[Alison Dowling - Head of Patient Experience and Public Involvement to present report].

7 **RWHT Staff Recruitment and Retention** (Pages 43 - 52)
[To receive a report on Staff Recruitment and Retention at the RWHT].

[Alan Duffel – Director of Workforce - RWHT to present report].

8 **NHS Long-Term Plan** (Pages 53 - 56)
[To receive a briefing note on the recently published NHS Long-Term Plan].

[Ankush Mittal – Consultant in Public Health to present report].

9 **Brexit Preparations**
[To receive a verbal update from Health Partners and Public Health on the preparations for Brexit].

10 **Work Programme** (Pages 57 - 60)
[To receive the Scrutiny Work Programme].

11 **Future Meeting Dates**

Thursday, 21 March 2019 at 1:30pm
Thursday, 6 June 2019 at 1:30pm
Thursday, 12 September 2019 at 1:30pm
Thursday, 7 November 2019 at 1:30pm
Thursday, 16 January 2020 at 1:30pm
Thursday, 5 March 2020 at 1:30pm

Meetings take place in Committee Room 3 at the Civic Centre, St. Peter's Square, Wolverhampton.

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CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 23 October 2018

Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Tracey Cresswell
Sheila Gill
Cllr Jasbir Jaspal (Chair)
Cllr Asha Mattu
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Dana Tooby
Cllr Martin Waite

Councillors from Staffordshire in Attendance

Cllr Johnny McMahon (Healthy Staffordshire Select Committee Chairman)
Cllr Victoria Wilson (Healthy Staffordshire Select Committee)
Cllr Gwyneth Boyle (Lichfield District Council)
Cllr Carolyn Trowbridge (Healthy Staffordshire Select Committee)
Cllr Phil Hewitt (Healthy Staffordshire Select Committee)

In Attendance
Cllr Hazel Malcom (Portfolio Holder for Public Health & Wellbeing)
David Loughton (Chief Executive RWHT)
Dr Jonathan Odum (Medical Director RWHT)
Dr Helen Hibbs (Clinical Accountable Officer – CCG)
Sally Roberts (Chief Nurse and Director of Quality - CCG)

Employees
Martin Stevens (Scrutiny Officer)
John Denley (Director of Public Health)
Dr. Ankush Mittal (Consultant in Public Health)
Majel McGranahan (Public Health Registrar)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Cllr Milkinderpal Jaspal and Cllr Phil Page.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Learning from Deaths in Wolverhampton and Steps Forward**

The Chair welcomed members of the Staffordshire County Council, Healthy Staffordshire Scrutiny Committee to the meeting. She stated that she understood there had been a Summit held in Wolverhampton recently with the various health agencies on the 10 October 2018 concerning the subject of Mortality statistics.

The Consultant in Public Health presented a report titled, "Learning from Deaths in Wolverhampton and Steps Forward." He stated that there had been some constructive discussion on the subject of mortality with health partners. The Council had recently hosted a summit, led by Public Health, to discuss the subject of Hospital and City wide mortality data with representation from the Clinical Commissioning Group and the Royal Wolverhampton Health Trust. The purpose of the report was to provide a summary of the data relating to deaths in Wolverhampton at both a City wide level and Hospital level. The report also assessed the implications of the data and made recommendations on the best approach moving forward.

The Consultant in Public Health stated that hospital mortality statistics worked on a ratio. The ratio was, observed deaths divided by expected deaths. The most difficult part of the equation was the calculation of expected deaths. There were a few different statistics used to measure expected deaths to create the ratio, which all relied on some logical processes. They looked at what proportion of people admitted nationally die and then applied that proportion to the local numbers of people admitted in any given hospital, to predict the expected mortality rate in the hospital. If the ratio figure was close to one, it showed that the hospital was on the same level as the national average mortality rate. If the ratio figure was above or below one, then the hospital was having higher or lower deaths than the national hospital average. He added that there were a variety of different adjustments made, depending on the measure, used on various elements of the admitted population. As examples, he cited the age mix of the patients admitted to the hospital, their associated medical conditions and their mode of admission.

The Consultant in Public Health stated that the national average was for men to die around four years earlier than women. There were a variety of reasons for the difference with one of the main reasons being that men were at a higher risk of suffering from a cardiovascular disease.

The Consultant in Public Health commented that when reviewing hospital mortality data it was important to understand that some hospitals coded conditions differently. He cited the example of a cough being classed as a chest infection or pneumonia. The expected number of deaths could be significantly different depending on how the condition had been coded, with pneumonia carrying a higher risk of death than a standard chest infection. Due to the differences in coding practices, the process of evaluating the data

The Consultant in Public Health stated that local care pathways could have an impact on hospital mortality data. There were therefore many factors other than care quality which could affect the mortality rate of a hospital. There were two statistics which were commonly referred to in the literature concerning mortality rates. SHMI stood for Summary Hospital Level Mortality Indicator and HSMR stood for Hospital Standard Mortality Ratio. The SHMI measure had replaced HSMR as a national statistic in England and had been used quarterly since 2011. There were however

variants of HSMR and a further indicator called RAMI being used in Scotland and Wales. Internationally there was no agreement on the use of any statistic.

The Consultant in Public Health outlined the detail of the SHMI statistic, which was freely available on NHS Digital. The SHMI was the ratio between the actual number of patients who died following hospitalisation at the trust and the number that would be expected to have died on the basis of average England figures, given the characteristics of the patients treated there. The SHMI also looked at the method of admission. People that were admitted as an emergency were at a higher risk of death than if they were admitted as part of a planned care episode. The SHMI also looked at associated conditions such as diabetes and cancer. There was significant variation as to how these associated conditions were recorded across hospitals throughout the country. It was important to approach SHMI data with a critical mind and to consider all the possible explanations for a lower or higher than expected ratio.

The Consultant in Public Health gave an explanation of City Wide Mortality statistics. Data on deaths across the city was based on information recorded on death certificates, which was eventually reported by the Office for National Statistics within ONS Mortality statistics. The most important piece of information to be gained from the death certificate was the actual cause of death. He considered ONS Mortality data overall to be a more reliable and established dataset around deaths compared to hospital mortality data. The data had been used by Public Health teams for many years to identify the causes of early death in populations. There was some limitation to the data, which included the data being affected by population migration and the presence or absence of local end of life care facilities. People who lived in hospices had a higher chance of death in any one year than someone of the same age who lived at home. If there was a limited amount of hospices in the local area, then people could move out into a hospice in another locality, which would inflate the mortality figures for that area.

The Consultant in Public Health referred to the graphs in section 5 of the report which summarised the key themes around death in Wolverhampton from a City perspective and were based on ONS Mortality statistics. Death rates in Wolverhampton spread out over the last twenty years had generally been better than the comparative group. The comparative group was made up of Local Authority areas which had a similar deprivation rate. It was the associated aspects of deprivation which leaded to an earlier death, such as obesity. Over the last 5-6 years there had been an increase in the standardised mortality rate for persons aged under 75 within the Wolverhampton area. There had been some increase in deaths from circulatory diseases. Circulatory diseases, cancers and respiratory diseases accounted for the top 3 causes of death in Wolverhampton and shared many of the same key risk factors such as smoking and obesity. When compared to the West Midlands and the rest of England, Wolverhampton remained significantly high for overall death rates. The challenge was therefore how to address the vast inequality that existed in the country and more locally. Between the richest and poorest people there was an eight year gap in life expectancy, which applied both nationally and locally. Wolverhampton continued to show a high rate of deaths related to alcohol, which had been a persistent trend for the City for several years.

The Consultant in Public Health commented that there was a high percentage of people in Wolverhampton, compared to other areas, that died in hospitals. He

believed this statistic pointed to the structures and processes in Wolverhampton. Less people in Wolverhampton were dying in care homes compared to the national average in England.

A Member of the Panel asked if there was any particular group within the Wolverhampton area which was suffering more from alcohol related deaths. The Consultant in Public Health responded that deaths related to alcohol did vary through a number of risk factors including ethnicity. There were mixed communities effected in Wolverhampton, with Public Health not focusing on anyone particular ethnic group. There was a particular age group which seemed to have a higher risk of alcohol related death, which was from 40-60.

A Member of the Staffordshire County Council, Healthy Staffordshire Select Committee referred to the high number of people from the Indian Sub-continent living in Wolverhampton, who were genetically more predisposed to vascular disease. He asked what was being done within the primary care system to try and address the issue. The Consultant in Public Health responded that whilst there was an elevated risk, there was still the same themes of deprivation and inequality. Over the last 20-30 years the whole country's profile around weight and physical activity had seen a huge shift in the representation of circulatory diseases. There was clearly some more work to be done regarding NHS Health Checks. The uptake in Wolverhampton was relatively low but had improved dramatically in the last couple of quarters. Early intervention was key to preventing an early death. The Clinical Accountable Officer for the CCG commented that they were working with GPs on more preventative work. GPs were being asked to spend a longer time with patients as part of a programme, to discuss topics such as smoking cessation.

A Member of the Staffordshire County Council, Healthy Staffordshire Select Committee made reference to the lower than expected mortality rate in Wolverhampton care homes compared to the national average. She asked if a person was discharged from hospital into a care home and died within 30 days of the hospital admission, whether that death would be classed as part of the hospital mortality figures when using the SHMI indicator. The Consultant in Public Health confirmed that the death would be classed as part of the hospital's mortality overall figures. The Medical Director commented that it was clear there were people entering hospital to spend their last days, who would have had a better end of life experience within the care home they had been staying. This fact undoubtedly effected the Trust's mortality statistics. It was important to record people's preferred choices for their end of life care. Nationally this was something which the country was poor at doing. The Chief Executive of the RWHT commented that they wanted to give the right tools to the care homes for them to have the difficult conversations with residents and relatives about end of life care. He was considering using the Trust's transplant nurses, who were used to difficult conversations, to communicate with the care homes about end of life care.

A Member of the Staffordshire County Council, Healthy Staffordshire Select Committee asked why the alcohol related mortality rate had risen during the last 5-6 years, when it had seen a positive decline before this timeframe. The Consultant in Public Health responded that there was a drug and alcohol service which was commissioned by Public Health. Due to the numbers being relatively small, there was potentially an element of unfortunate chance in the figures, which could explain some of the variances. He however accepted that the variance might not all be down

to short-term unfortunate chance. He was happy to reflect and review the data to try and understand the reasoning for the upward trend more fully. The current drug and alcohol service was moving towards a population screening approach. The best way to prevent early death through alcohol and drug abuse was early intervention. Some people that died from drug and alcohol abuse had been exposed to them for over 20-30 years. It was therefore correct to say that groups of people could die at any one time, not because of something that had necessarily happened in their lives recently, but down to potentially sustained abuse over a long timeframe. He added that alcohol and drug abuse was an area which could be scrutinised in its own right.

The Director for Public Health commented that it was important to think about the context of drug and alcohol abuse within a system based approach. It was important to do the basics well. The Wolverhampton alcohol and drugs service was now in the top performing quartile in the country. Preventative work was also an important aspect of the work related to reducing drug and alcohol abuse. A huge amount of positive work was ongoing on increasing the amount of health checks within the City. Wolverhampton had been in the bottom 8% of the country for health checks. Working in partnership with the CCG and the Trust, in the first two quarters the number had dramatically risen, with 1942 people receiving a health check. The Council was also using more leverage around how licenses to premises were granted for alcohol.

A Member of the Panel commented that the cause of death on the medical certificate may not reveal an underlying reason such as alcohol abuse, which meant the data on deaths related to alcohol abuse could be underrepresented.

The Portfolio Holder remarked that a key ambition for Public Health was to reduce health inequalities and improving the quality of life people had in later life. This included ensuring people had a preferred choice of their place of death.

The Medical Director of the RWHT commented that the Summit held recently had been very helpful in bringing the various themes together surrounding mortality. He said that mortality statistics whether they be higher or lower than average were not an accurate reflection of quality of care. Higher than average mortality statistics were however treated as a smoke alarm by the Trust. They had not found any significant issues with the care that had been provided by the acute Trust. He in fact believed that care provision had improved steadily over the years within the Trust. He cited the seven-day service model as an example of the improvement that had been made. This meant Consultants presence on weekdays and at weekends was normal. There had been a considerable expansion of Consultant numbers over the course of the last few years to facilitate the seven-day service provision. The reviews of the deaths completed had generally shown good quality care, with some omissions, which were appropriately managed. The CQC had also recently rated the Trust as Good, who were fully informed of the mortality statistics.

The Medical Director of the RWHT said there had been a progressive rise in the SHMI statistic since the opening of the new Emergency Department. He had not seen any change in care provision over those years, which would account for the rise. There had been the introduction of a new assessment model within the Emergency Department, which meant acute physicians were now working alongside the emergency physicians. As a consequence, there had been a significant impact on the statistics in not admitting patients with lesser acuity of medical conditions.

These patients had been discharged with support at home, the community or into hot clinics. At the same time in England, admissions for the same categories had increased, leading to a lowering of nationally expected death rates. While SHMI adjusted for primary diagnosis on admission, it did not factor in the severity of the admitting diagnosis. The number of patients admitted to hospital in the Trust had progressively fallen over the last few years. This was significantly related to the new assessment process and effected the SHMI calculation.

The Medical Director of the RWHT stated that despite a reducing number of expected deaths at the Trust, local data suggested the population being admitted to the hospital was now increasingly frail and increasingly ill, suggesting that the expected death rate calculation was not adequately adjusting for patient profiles. Over the last three years there had therefore been a population of patients who were of a much higher acuity than had been previously admitted, which was associated with the rise in the SHMI.

The Medical Director of the RWHT stated they had completed significant work over the last 2-3 years to assess the care that was being provided by the Trust. There was an established process to investigate all deaths across the organisation. The Trust's own investigations and independent investigations had not found any systematic failings in care within the organisations that would account for the deaths. Whilst they did find some omissions in care, which they reviewed through the mortality review processes, those deaths on the whole were occurring in people who were very frail and elderly. From assessing their admission profiles, the likelihood of their survival had been low.

The Medical Director of the RWHT remarked that there was a large amount of people in Wolverhampton who were admitted to hospital with essentially end of life requirements. He believed this was an area which needed improvement, with more people being able to die at home or within a care home. The Trust also needed to ensure that the coding of patients across the organisation was fully accurate. There had been a contraction in the Specialist Palliative Care Team, which had caused the percentage of patients who had contact with the team to fall. The rest of the Country had increased their Palliative Care Teams. The decrease in the members of the Specialist Palliative Care Team had impacted on the overall statistics.

The Medical Director remarked that nationally about 3-5% of patients had omissions in their care when resident at an organisation. Whether the omission had a direct impact on their death was another matter. The Trust was in line broadly with the national picture in terms of omission in care. Omissions in care included a failing in communications between teams, which was a widespread national issue. The second was regarding recognition of a deteriorating patient, which was also nationally being recognised as an area for the NHS to improve. Across the Country and within Wolverhampton there were cases of sepsis which were managed late, which could have a detrimental impact on the outcome. The final area was with reference to documentation and clinical records. The Trust had been focusing on improving their documentation standards.

The Medical Director for the RWHT remarked that the Royal College of Physicians had been leading on the development of the National Mortality Case Record Review Programme. The method rolled out for reviewing deceased patients care was called the Structured Judgement Review (SJR). The main aim of undertaking the SJR

process was for clinicians to learn from aspects of care that could have been improved even when death was inevitable and in addition to identify areas of good practice. Patients who had died were given a care rating. Those that were considered to have received poor care went through a much more detailed analysis process. Leaning from deaths was a critical component of hospital business. The Trust was implementing a new Medical Examiner Role, which would play a key role in the undertaking of mortality reviews in the future. He believed this role would add even more analysis to the current assessment process of reviewing deaths.

The Medical Director referred to the governance processes in learning from deaths. The Trust had a multidisciplinary Mortality Review Group which oversaw case note reviews of deceased patients with senior clinical representation from all specialties and was attended by colleagues from the CCG and Public Health for further oversight. In addition, an Executive Governance Group met regularly to oversee the work and provide assurance, particularly in relation to quality of care.

A Member of the Panel asked about independent external support to analyse the mortality date and provide assurance. In response the Chief Executive of the RWHT stated that he was happy for the external experts already at the hospital analysing the mortality date to attend a future meeting of the Scrutiny Panel to give assurance.

A Member of the Staffordshire County Council, Healthy Staffordshire Select Committee recommended to the Panel, the book, “Being Mortal” by Atul Gawande. The book gave the view that in the western world death had been medicalised to the detriment of dying.

A Member of the Staffordshire County Council, Healthy Staffordshire Select Committee asked why the Palliative Care Team had been reduced at the Trust. The Medical Director responded that they were looking to expand the team and were currently undergoing a recruitment process. More generally there were 150 nursing vacancies at the Trust.

A Member of the Panel asked what would happen to a person who faced a certainty of death in the near future but did not wish to leave the hospital for a hospice or care facility. The Medical Director confirmed that they would respect the wishes of the patient.

A Member of the Panel commented that she was aware of cases where an elderly couple living at home would both see a decline in their health when one of them became ill, due to the extra strain the care needs put on the other. The Medical Director confirmed that this was a common occurrence and supportive care in the community was clearly something which would help in such an instance. The Chief Accountable of the CCG stated that she absolutely recognised it as a problem within the City and increasing partnership working was taking place to address the issue.

A Member of the Panel asked if the Trust talked to relatives of the deceased during a full SJR Review. The Medical Director responded that it was not routinely done but if significant issues came out of the review, then it would probably go through a root cause analysis which could involve the family. The new Medical Examiner role would introduce changes, with them meeting the family after the death to talk to them

about any concerns or issues. If there were concerns it would trigger a review process.

The Director for Public Health commented that after recent negative headlines in the Express and Star about mortality statistics at the Trust, it was important to establish public confidence in the work of the Trust and relay the complexity of the statistics.

The Chief Executive of the RWHT stated that "Dignity in Death" certificates could be issued to residential care homes and more training given to staff.

A Member of the Staffordshire County Council, Healthy Staffordshire Select Committee asked for statistics and targets on urgent referral and screening for cancer to be brought before Scrutiny in the future. The Chief Executive of the RWHT stated that he was far from happy with the performance of the Trust in relation to cancer. There were major issues with late referrals from other organisations and there was a problem with the target itself, which he thought was wrong. There was not a single Trust in the country that was meeting the national target. He thought reform was needed on a national scale, which included a national strategy being drawn up for robotic surgery.

The Chief Executive of the Trust stated that he had been informed that the Telford Accident and Emergency Department was scheduled to close overnight from the 5 December 2018. The biggest impact would be on Wolverhampton. He had been informed that 30-80 ambulances a night would be re-directed to Wolverhampton. He had a concern that the Trust would be dealing with Paediatrics in Wales, where the Trust had no relationship with Social Services. The relationship would need to be developed. The overnight closure would also affect transfers across the Black Country, general waiting times and the winter contingency plans.

Resolved: That the Health Scrutiny Panel:-

A) Notes the uses and limitations of mortality statistics at both a city wide and hospital-level perspective and acknowledge the findings from the learning from deaths work at The Royal Wolverhampton NHS Trust.

B) Supports the shift in focus from 'hospital death rates' to 'healthy life expectancy' across the city, and the significant opportunity to prevent early deaths using a community Public Health model.

C) Supports the wider ambitions around optimising End of Life care in the city. This includes people being treated according to their wishes, with the correct documentation in place and their preferred designation of death clearly known.

Meeting closed at 2:30pm.

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CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 25 October 2018

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Tracey Cresswell
Sheila Gill
Cllr Jasbir Jaspal (Chair)
Cllr Milkinderpal Jaspal
Cllr Asha Mattu
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Dana Tooby

In Attendance
Cllr Sohail Khan

Witnesses
Margaret Collins – Black Country Coroner's Lead
Dr. Julian Parkes GP (RWHT)
Elaine Roberts (Patient Services Manager – RWHT)
Arshad Khan (Al-Mu'min Funeral Services)
X 2 Representative from Sandersons Funeral Services

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
Dr. Ankush Mittal (Public Health Consultant)
Martyn Sargeant (Head of Public Service Reform)
Dr. Majel McGranahan (Public Health Registrar)
Julia Goudman (Business Development Manager)
Arif Sain (Equalities Contractor)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology for absence was received from Cllr Martin Waite.

2 **Declarations of Interest**
There were no declarations of interest.

3 **GP Experience**

Dr Julian Parkes GP outlined his experiences of the death certification processes. He stated that Primary care was a list based system meaning that patients were registered with a practice and the practice took responsibility for their patients. The Alfred Squire Road Practice had 8400 registered patients. The average GP in England was responsible for 1850 patients. There were approximately 100 deaths per year from patients registered at the Alfred Squire Road Practice. Deaths in Primary Practice tended to fall into four distinct categories:

1) Sudden death where the patient had not recently been seen.
2) Deaths in Hospital.
3) Deaths at home but expected, the patient was often receiving palliative care for Cancer.
4) Deaths in Compton Hospice or following discharge from hospital to a nursing home, which was not their usual residence.

An audit of deaths in September 2017, over a three-month period, showed there had been a total of 25 deaths, 4 deaths were sudden and unexpected. The breakdown was as follows: -

- 12 deaths occurred in Accident and Emergency or as inpatients at Newcross Hospital and one at another Hospital.
- 2 deaths occurred at Compton Hospice.
- 3 deaths were in a residential or nursing home.
- 8 deaths at home, with 3 of those being sudden and unexpected, with the remaining 5 being on the Palliative Care Register and expected to die.

Dr Parkes commented that it was required by law that a Doctor notified the cause of death and not the fact of death. The specific circumstances of the death would affect whether a GP could issue a Medical Certificate of Cause of Death (MCCD). He outlined the circumstances where a death would have to be reported to the Coroner, as detailed in his written report which had been circulated with the agenda. He also outlined the formal procedures required if a patient was to be cremated.

A Member of the Panel enquired if it was still permittable to write, “old age” on the Medical Certificate of Cause of Death. Dr Parkes responded that Doctors tried to avoid the use of term as much as possible, but there were certain circumstances where it was permissible to still use the term.

Cllr Sohail Khan commented that GPs out of hours availability was vitally important. Contacting a deceased person’s GP out of hours, from experience, he found to be problematic. In response, Dr Parkes outlined that GPs were contracted to work from 8am - 6:30pm, five days a week, excluding bank holidays. There were out of hours GPs or paramedics who could confirm death after the closing hours of the surgery. Normally they would inform the family that they would need to contact the deceased person’s GP surgery during opening hours to arrange for a Medical Certificate of Cause of Death to be issued. An appointment with the Registrar could not be made until they had the Medical Certificate of Cause of Death. An out of hours GP would not be able to issue the Medical Certificate of Cause of Death unless they had seen the person in the last 14 days prior to death.

Cllr Khan stated that his expertise was in Muslim burials, where there was an expectation for burial to be 12-18 hours following the death of a person in palliative care. If a Medical Certificate of Cause of Death could not be obtained until the GP Surgery was open, then there was potentially a delay in the process, should the death happen out of hours. The delay could be significant if it happened on a Friday evening. Dr Parkes commented that it was an issue where religious need and the law were not connected. There were certain circumstances such as a GP being away on holiday for two weeks, who had been looking after a patient, where they would contact the Coroner to see if they would be permitted to issue a Medical Certificate of Cause of Death. But even this scenario would cause a delay in the process.

4 **Internal process for issuing Medical Certificate of Cause of Death (MCCD) - Royal Wolverhampton Health Trust (RWHT)**

The Patient Services Manager outlined the internal processes for issuing a Medical Certificate of Cause of Death at Newcross Hospital within the Royal Wolverhampton Health Trust. If a person died on a ward at hospital the deceased's relatives, if present, would be issued with a bereavement leaflet. The leaflet detailed the processes which needed to take place following a death. They were asked to contact the Bereavement Office on the following working day between 10am - 4pm, so the stages in the formal process could be properly explained.

The Patient Services Manager remarked that the Ward was expected to call the deceased's GP to notify them of the death, but not the cause of death. A Member of staff from the Ward would then enter the patients administration system and log the patient as deceased. They would then send the patient file to the Bereavement Office. The file would normally be received by the Office on the next working day. Should the person have died on a Friday, it would not normally reach the Bereavement Office until the following Monday. Once the Bereavement Office had safely received the Patient File, they would ascertain which Doctor or Doctors needed to be contacted to complete the Medical Certificate of Cause of Death. If the Bereavement Office knew the patient was to be cremated, they would ask the Doctor to complete the first part of the cremation form at that stage. It was however true to say that at this stage they may had not heard if the patient was to be cremated and families sometimes changed their minds, often due to financial reasons.

The Patient Services Manager stated that once the Medical Certificate of Cause of Death had been completed, the Bereavement Office contacted the relatives to arrange for collection of the certificate. The family could then contact the Registry Office to officially register the death. If the Patient was to be cremated, the Bereavement Office would continue to arrange for the necessary cremation paper work to be completed. The second part of the cremation form had to be completed by a Doctor who had been registered for five years.

The Patient Services Manager stated that the Trust did have a "Rapid Release Policy", which had been used within the Hospital, it formed part of the "Management of the Deceased Patient Policy." She had known the "Rapid Release Policy" to be used at weekends. She was happy to circulate the policy to the Panel along with the Bereavement Leaflet. There was always an on-call Director and an on-call Manager

working for the Trust, 24 hours a day, 7 days a week, who all knew about the "Rapid Release Policy". The Patient Services Manager commented that deaths referred to the Coroner would naturally normally cause a delay in the process for families.

A Member of the Panel asked about the number of staff working in the Bereavement Office and if they faced delays in obtaining the appropriate Doctor to complete the necessary paper work. In response, the Patient Services Manager confirmed there were four members of staff who worked in the Bereavement Office but they were not all full-time. She did not believe they were short of staff. On average there were seven deaths a day at Newcross Hospital. Delays in obtaining Doctors were sometimes caused due to a Doctor having worked nights, or a Junior Doctor being on their study day. The Trust had a target within their policy of issuing a Medical Certificate of Cause of Death within 72 working hours of the patient dying. Regular audits were completed and up to 90% of certificates were issued within 72 working hours. Those that hadn't been issued within 72 working hours were generally deaths which had been referred to the Coroner.

The Head of Public Service reform stated that given there was a statutory target of certifying a death with the Registration Service within 5 calendar days, whether the Patient Services Manager thought a RWHT Trust target of issuing the Medical Certificate of Cause of Death within 72 Working Hours was appropriate. The Patient Services Manager responded that she was aware of the 5-calendar day statutory deadline for the registering of a death. The Trust used working days as the Bereavement Office was not open at weekends. She understood the difficulty of the statutory deadline counting weekends and Bank Holidays as part of the five days.

A Member of the Panel asked if the Bereavement Leaflet given to relatives of the deceased contained reference to the "Rapid Release Policy." The Patient Services Manager responded that there was no reference to the policy within the Bereavement Leaflet. People tended to find out about the policy by talking to the nursing staff on the ward. Cllr Khan commented that he was not aware of the "Rapid Release Policy" at the RWHT. He was aware of Birmingham's and other areas, having worked in Funeral Services in the past. He asked if it was available to view online, as he thought it needed more publicity. Dr Parkes responded that it was an internal policy, which he was sure could be made available to the Panel. The Panel recommended that more publicity be given to the "Rapid Release Policy" at the RWHT and desired to receive assurances that it was up to date and working effectively.

A Member of the Panel commented that it was important to record patients' medical notes accurately to ensure there was a good audit trail, to help ensure the prompt issuing of the Medical Certificate of Cause of Death and assist during Coroner referral cases.

A representative from Sandersons Funeral Services commented that the area which they often received a delay was with receiving the correct documentation for a cremation, which was often received after the Medical Certificate of Cause of Death. It was distressing to families when they could only give a timeframe of when the cremation would be, rather than a fixed date. He asked if there was any way for the Medical Certificate of Cause of Death, to be completed together with the Cremation forms. The Patient Services Manager responded that from the 1 December 2018 that would be normal practice at the RWHT. From this date there would also be a

new Bereavement Centre at Newcross Hospital, which would have a Registrar desk and Medical Examiners staff. There would also be waiting and meeting rooms. The Medical Examiner would scrutinise the patient file, which she thought would arrive quicker to the Office than at present. The family would be offered the opportunity to question the Medical Examiner about the care of the deceased. The process would be more streamlined than previously. A Member of the Panel remarked it was important to communicate the changes to all relevant stakeholders.

A Member of the Panel asked how many Medical Certificates of Cause of Death were completed by the RWHT with 24 working hours of the patient being deceased. The Patient Services Manager responded that she believed it was in the region of 50-60%. Approximately 92% of certificates were completed within 72 working hours. Members asked for the RWHT Audit information on the time taken for the issuing of the Medical Certificates of Cause of Death to be provided to the Panel.

A Member of the Panel asked if there were times in the year where there were more deaths at the Hospital and therefore more demand on Bereavement Services. The Patient Services Manager responded that there was always an increase in deaths during the winter months.

5 **Registrar's Experience**

The Business Development Manager summarised the points contained in the briefing note that had been distributed. Legally deaths had to be registered within five calendar days, which included Weekends and Bank Holidays. Deaths had to be registered within the District where they occurred. A death had to be registered by a qualified informant who was usually a relative. When a relative was not available they could accept someone who was present at the death, the occupier of the house or an official from a public building where the death occurred, or the person making the arrangements with the Funeral Director.

The Business Development Manager commented that there were a number of reasons a death might have to be reported to the Coroner by the Registration Service. This included if the Medical Certificate of Cause of Death detailed an unnatural death.

The Business Development Manager remarked that in order to register a death the Registrar was required to see the Medical Certificate of Cause of Death from the qualified informant. Once this had been seen and the Registrar was content with the certificate being legally valid, they could issue a form which enabled the burial to take place. If the Coroner had been involved, the Coroner issued a separate form, rather than the Medical Certificate of Cause of Death.

The Business Development Manager detailed the latest statistics on the issuing of the Medical Certificate of Cause of Death and the registration of a death. 69% of Medical Certificates of Cause of Death were currently signed within two calendar days in Wolverhampton. 29% of deaths last year had been referred to the Coroner. 95% of Customers who contacted the Registration Office were offered an appointment within two days. This had slipped in January, due to the high demand for registration appointments. 71% of deaths not referred to the Coroner were registered within five days. The Registration Service performance target was 90%. The Registration Service was facing increased pressure from the Home Office to improve performance in this area. 28% of deaths that were referred to the Coroner,

where no post mortem or inquest was required, were registered within five calendar days. Where a post mortem was required, only five per cent of those deaths were registered within seven days.

The Business Development Manager commented that in the last two years there had only been one formal complaint made about the Registration Service. This had been in relation to a customer believing that the Service could not offer an appointment within a reasonable timeframe. They regularly measured customer service satisfaction through surveys. 98% or more of people said they were satisfied with the service they had received from the Registration Service. They had recently been asking a further question to customers, where the registration of the death had taken longer than five days, if they had been happy with the time taken. In September 2018, 94.1% had said they were happy.

A Member of the Panel asked if there had been an increase of cases, where there were no known relatives of the deceased. The Patient Services Manager responded there had been an increase in these cases, and the hospital arranged the funeral. The Business Services Manager commented that she had not noticed an increase in cases, but it did occur. The Council had made the funeral arrangements, if the person had not died in hospital. They were required to advertise to make people aware of the death.

Cllr Sohail Khan stated that in his experience the Registration Service had been very accommodating when an appointment was required promptly for religious reasons. He asked if there was a formal policy to ensure a rapid Registrar's appointment when a burial was required promptly. The Business Development Manager responded that there was a Registrar on call, Saturdays, Sundays and Bank Holidays, with the exception of Christmas Day and Easter. The Registrar was able to issue the "Green Form" in emergency situations, such as for specific religious reasons, to allow a burial to take place before the formal registration. They could not do this if the body was to be cremated. The On-Call Registrar could be contacted on the telephone between the hours of 8am-9am at Weekends and Bank Holidays (except Christmas Day and Easter). She remarked that it was expected from 1 December 2018 to have a Registration Office based at Newcross Hospital, which would allow for a more efficient service for families.

Cllr Sohail Khan asked if the On-Call timeframe was sufficient. The Business Development Manager responded that for the usage so far, she had not been made aware of any problems. She was of the view that it might not be the case in the future and considered that the timeframe probably did need consideration as to whether it should be extended. She had been having conversations with Bereavement Services on the matter who dealt with the staff at the Crematorium who prepared the graves. Cllr Khan commented that he thought the On-Call timeframe was inadequate. His experience was that other Registration Services across the country normally had an On-Call timeframe of 8am-12pm or 8am-1pm. The Business Development Manager commented that she had recently done a benchmarking exercise across the West Midlands Districts and the majority did operate the On-Call Service, 8am-11am or 8am-12pm. She was going to continue consultations with Bereavement Services to see if the timeframe could be extended.

The Consultant in Public Health asked if there was a pathway or system in place to ensure families were aware of the On-Call Registrar Service. He gave the example

of a family in a Hospital who's relative had just died on a Friday evening requiring a prompt burial, he wondered how they would be made aware of the service. The Patient Services Manager responded that the Bereavement Booklet given to relatives contained the numbers to contact the Registrar. She thought that if this number was called it would give the details for the On-Call Service. The Consultant in Public Health responded that he thought this was worthwhile checking, as it was a critical step. If people were fully aware of the On-Call Service, it would give a true picture of the demand for the service. A Member of the Panel commented that many residents believed the Council would not open until 9am, and so would probably call too late. The Business Development Manager commented that the existence of the On-Call Service was mainly communicated to the local Funeral Directors, who would signpost the customer to call the number. A Member of the Panel commented that it would be useful to review the policies, procedures and how information was shared by the Registration Service.

The Scrutiny Officer asked if the Registration Service had cases where the Medical Certificate of Cause of Death had been incorrectly completed by a Doctor. She confirmed that this did happen on occasion and in such circumstances, it would have to be referred back to the Hospital or to the Coroner.

Dr Parkes commented that in his experience delays could occur in booking a time slot for a cremation at the Crematorium. He was aware of people waiting up to three weeks during the winter season. A representative from Sanderson Funeral Services commented that sometimes they were told there would be a two-week delay at the Crematorium but when they went to the site, they found that there were slots available. He expressed an interest in understanding why there were delays at the Crematorium. The Chair stated that this was an area which the Panel could explore in the future and asked for it to be added to the recommendations.

Cllr Sohail Khan commented that the Funeral Directors he had spoken to recently had referred to delays being caused by a backlog at the Mortuary, in addition to paperwork delays and booking a time slot at the Crematorium. He made a general comment that the whole process needed to be made more efficient. A representative from Sanderson Funeral Services commented that one of the main causes of delay was due to paperwork and agreed that it needed to be more streamlined to reduce stress for families. The Chair stated that one of the recommendations should be for the Health Scrutiny Panel, working with relevant partners, to investigate how the official paperwork processes could be more streamlined.

A Member of the Panel asked about how the date of death was determined on the Medical Certificate of Cause of Death and on the official registry entry. Dr Parkes responded that on the Medical Certificate of Cause of Death, the date would be the same day the doctor certified the death. The Business Development Manager stated for the official registry entry the date was taken from the informant and so could differ to the Medical Certificate of Cause of Death, in certain circumstances. As an example, if a person had died at 11pm but a Doctor did not visit until 2am, whilst the Doctor would certify the death as the day after the person had actually died, the informant could give the date of actual death for the registry entry. The Medical Certificate of Cause of Death was normally provided to the Registrar by the family in a sealed envelope and so it was not normally seen by the family until the registration appointment. The Registrar was required to ask the informant registering the death, as a specific question, the date of the death. Several Members of the Panel felt that

the process needed to be clarified as they were of the belief that the family had to use the date that was on the Medical Certificate of Cause of Death. The Panel agreed to add it to the list of final recommendations. The Coroner's Lead for the Black Country remarked that the Coroner would always use the certified time of death given by a Doctor and not from what the family had said.

A Member of the Panel asked if the date of death in the official death registry entry could be corrected. The Business Development Manager responded that it was possible to correct the register, but it was a formal process which required evidence. The correction request had to be submitted to the General Registry Office based in Southport, who made the decision.

A representative from Sandersons Funeral Services remarked that it would be useful for families or next of kin to have all the relevant information on the processes following a death collated as one document, which could be given to them when their relative had died. Cllr Sohail Khan commented that practices varied amongst GPs, with some being more accommodating than others. A central document would therefore be useful. The Consultant in Public Health commented that there was potentially a need for a combined partnership-based information resource which could assist families following a death. He cited several areas it could cover, such as "Rapid Release Policy," explaining the Medical Certificate Cause of Death processes and registering a death requirements. It could cover all the processes from the death right up to cremation or burial.

The Head of Public Service Reform stated that there was clearly value in collaborative working regarding the provision of information. He requested that the Panel give some consideration to what key information the families required. He was mindful of not overloading families with information during what was often an emotional and difficult time. Certain information such as a "Rapid Release Policy" would be irreverent to many families. He understood that families relied heavily on Funeral Directors for guidance and in some cases, it was more important for them to have certain information rather than the families directly. A Member of the Panel felt that it was important to cover all eventualities, particularly given the diversity in the Wolverhampton area. They commented that Funeral Directors were often not involved until a certain stage in the process and it was vital to have key information at an early stage. There was a discussion about how much information should be given to families with differing views given. A Member of the Panel commented that a visual pathway, simplifying the process, would be of value. The visual reference could be supported with more detailed information.

The Patient Services Manager commented that in addition to the Hospital booklet, they also gave out a Government Booklet at the Hospital, which was titled "What to do after a death." She felt it was important to consider these documents in full before commencing work on any new resource. Cllr Sohail Khan commented that all the information needed to be publicly available all year round so people were well educated and prepared.

6 **Coroner Office Experience**

The Coroner's Lead for the Black Country outlined the Coroner's Service in Wolverhampton. It was the first time they had been asked to attend a Council Scrutiny Panel. Wolverhampton was one of the four areas covered by the Black Country Coroner, the other three being Sandwell, Dudley and Walsall. On average the Office dealt with 1200-1300 deaths from Wolverhampton per year. It was a small team of ten people, which included the Coroner. Every year they dealt with approximately 4,500 deaths.

The Coroner's Lead for the Black Country stated that since November 2015, they had introduced a new computer system called "Civica Coroners". The Coroner, Mr Siddique was appointed in September 2014 and had been very supportive of the move away from paper systems to electronic. A Portal had been added to the system in the latter part of 2016, which led to significant efficiencies. It allowed GPs and Hospital Doctors to report deaths 24 hours day, seven days a week into the Coroner's system. The Portal was also linked into Funeral Directors and Registrar's. The introduction of the system had significantly improved efficiency and had revolutionised the way the Coroner's Office worked. The Black Country area was one of the first Coroner's areas to go live with the Portal system. There were many Coroner areas in the country still awaiting to launch the Portal system. The Black Country Coroner's Service was considered a centre of excellence and were regularly consulted about the system.

The Coroner's Lead for the Black Country remarked that they operated a triage system in the Coroner's Office. As a death came through into the Coroner's system, there would be an initial triage exercise. If a death could be actioned quickly, a simple Form A would be issued. The Coroner by law had to investigate all deaths including the simple cases. Some cases required an investigation or an inquest. The Coroner Office Team was split in two different categories, those that dealt with community deaths and those that dealt with inquests. She stated that for all deaths referred to them, they always spoke to the family. This was not the case for all Coroner's in the Country. She felt it was important as it helped to keep a level of independence to the process.

Cllr Sohail Khan asked about the out of hours repatronisation phone service. The Coroner's Lead for the Black Country responded that they tried to mirror the service with the Registrar's, some of which were open 8am-1pm at Weekends and Bank Holidays. The Assistant Coroner's were available between these times and the four Registration Services that fell within the jurisdiction had their contact details.

Cllr Khan asked if the Coroner's Service, working alongside Registrar's, could have an out of hours service (where there were staff in the actual Coroner's Office) at Weekends and Bank Holidays. There was a discussion about an out of hours service. The Coroner's Lead for the Black Country said that at the present time they would not be able to carry out the investigations required. She gave the example of if a post mortem was required or a digital autopsy. These would be carried out by a pathologist, who were independent to the Coroner's Service. The resources could also not be justified to meet the needs, as it was rare for a death to be reported at Weekends. Cllr Khan commented that demand could increase in the future and it was important to make preparations. Discussions with Funeral Directors across the Black Country had led him to believe that a full out of hours Coroner's Service was

required. The Coroner's Lead for the Black Country offered to report his comments back to the Coroner.

The Coroner's Lead for the Black Country remarked that they did their best to accommodate families, but they had to ensure legal processes were followed, which included ensuring there was a correct cause of death. They always tried to explain the processes to families to ensure they had a good understanding and kept them up to date.

The Chair asked how long the processes normally took for a post-mortem. In response, the Coroner's Office Lead for the Black Country commented that they worked on a guideline of three days. The examination normally took place on the third day, where the cause of death would normally be known.

7 **Al-Mu'min Muslim Funeral Services**

Cllr Sohail Khan stated that in the Islamic faith it was a religious requirement to bury the body as soon as possible. There was an understanding though that the country was governed by laws that had to be followed before a body could be buried. In the Islamic Faith, the Funeral Directors were expected to take 90% of the burden away from families. It was paramount for organisations to work together to ensure a smooth and efficient service for families. He thought it was important for a standardised policy to be in place to help with families who had specific requirements for the deceased. It was important to plan for the future. He had some concerns about the new Medical Examiner Role, which he thought could potentially cause an added delay if a rapid release was required.

A Member of the Panel commented that the Muslim population was increasing and so it was important to ensure that mechanisms were in place to ensure as quick a burial as possible. It was very distressing if families were not able to bury the deceased quickly.

The representative from Al-Mu'min Funeral Services thanked the Registration and Coroner's Service for their accommodating behaviour in the past. He commented that if processes could be more streamlined in the future, then families would receive a more efficient service from them. He thanked the Panel for the invitation that had been extended to him to attend the meeting.

A Member of the Panel commented that it was important to have an item on burial places in the Wolverhampton area, added to the future Scrutiny Work Programme.

8 **Sandersons Funeral Services**

The representative from Sandersons Funeral Services thanked the Panel for asking them to attend and contribute to the meeting. He commented that they had a good relationship with all the relevant stakeholders. He stressed the importance of the family's needs. He remarked that in his experience things did not always go smoothly when there was a request by the family that did not fit into normal procedure. There were often delays in faith-based questions and if a repatrionisation was required. It was important to have a cohesive system to ensure that families received an efficient and professional service. Communication was important and people needed to have information available to them so they were fully aware of the polices in place.

9 **Next steps - Recommendations and Agreed Actions**

The Health Scrutiny Panel made the following recommendations:

Resolved:

A) That the RWHT circulate the "Rapid Release Policy" to the Panel along with the latest Bereavement Leaflet and the Government Booklet – "What to do after a death".

B) That more publicity be given to the "Rapid Release Policy" at the RWHT and to receive assurances that it is up to date and working effectively.

C) The RWHT Audit information on the time taken for the issuing of the Medical Certificates of Cause of Death be provided to the Panel.

D) That consideration be given to how communication can be enhanced to relatives of the deceased about the On-Call Registration Service, where a prompt burial is required.

E) That consideration be given to extending the On-Call Registration Service timeframe (currently 8am-9am) at Weekends and Bank Holidays (excluding Christmas Day and Easter).

F) That the Crematorium booking system, waiting times and delays particularly during the winter season, be added as a potential future item to the Health Scrutiny Work Programme.

G) That the Health Scrutiny Panel, working with relevant partners, investigate how the official paperwork processes surrounding death can be made more streamlined.

H) That Registrar's ensure there is absolute clarity given to a person registering a death, that the date of death used in the register entry can differ to that on the Medical Certificate of Cause of Death, in certain defined circumstances.

I) That a review be completed on the current resources given out to families following a death and suggestions made for improvement, such as a simple one-page flow chart.

J) That an assessment take place in due course, on how the new Medical Examiner Role and new Register Office being implemented from 1 December 2018 at Newcross Hospital, effects the expediency of the formal processes after death.

K) That an item is added to the future Scrutiny Work Programme on burial places within the Wolverhampton area.

Meeting closed at 12:15pm.

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CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 15 November 2018

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Tracey Cresswell
Sheila Gill
Cllr Jasbir Jaspal (Chair)
Cllr Asha Mattu
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Dana Tooby
Cllr Martin Waite

In Attendance
Cllr Hazel Malcom (Cabinet Member for Public Health and Wellbeing)
David Loughton CBE (Chief Executive of the RWHT)
Stephen Marshall (Director of Strategy and Transformation – Wolverhampton CCG)
Margaret Courts (Children's Commissioning Manager – Wolverhampton CCG)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director of Public Health)
Alison Shannon (Chief Accountant)
Andrew Wolverson (Head of Service for People)
James Barlow (Finance Business Partner)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology for absence was received from Cllr Milkinderpal Jaspal.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes**
Resolved: That the minutes of the meeting held on 20 September 2018 be approved as a correct record.

4 **Matters Arising**

The Chief Executive of the Royal Wolverhampton Health Trust (RWHT) informed the Panel that he had sold the old eye infirmary building at the Compton Road site. Contracts had been exchanged.

The Chief Executive of the RWHT commented that they had placed a contract for the steel works for the new car park. They had separated the work into two contracts because the other contractor couldn't start work on site until March and they wanted to ensure expediency. 250 car parking spaces would be lost for 19 weeks during the construction of the multi- storey car park at the front of the site. They had worked with the Council to ensure off-site parking during that timeframe. He was hoping it would affect staff car parking only and not reduce spaces for patients during the 19 weeks. He recognised that car parking at New Cross Hospital was far from ideal. The new car park was expected to be completed by the Summer of 2019.

A Member of the Panel asked if the Chief Executive of the Royal Wolverhampton Health Trust would still be providing a timetable on the construction of the new car parks. He responded that he would endeavour to try and provide a timetable to the Panel, he was however waiting for definitive timescales from the new contractor.

A Member of the Panel asked about the outsourcing of the management of the car park and security arrangements at New Cross Hospital. She had received a response from the Trust but did not feel the response had answered the point regarding what due diligence had taken place in the contractual arrangements. Healthwatch often received complaints about the fees for the car parks at the hospital. The Chief Executive of the RWHT responded that the main reference point for the due diligence was the British Airports Authority. The charges for the car parks were a political national government decision. Car parking charges for hospitals in Scotland and Wales had been removed. A considerable amount of income was gained from car parking fees which helped to support the security arrangements at the hospital. The costs for security at the hospital were rising each year. He did not wish to take the service for security back in-house. The security company contacted by the hospital had contingency for if people fell sick, which he would not have if the service was in-house.

There was discussion about encouraging people to use public transport to relieve pressure on car parks at the hospital.

5 **CAMHS Transformation Plan Refresh - Update Report**

The Children's Commissioning Manager for the Wolverhampton CCG presented an update report on the CAMHS (Child and adolescent mental health services) Transformation Plan. In the current year, the Local Authority and the CCG, along with some funding from Head Start had developed a tier two service which had been awarded to the Children's Society. The Service was called "Beam Wolverhampton". It had a couple of drop-in sessions each week and also had some more structured booked CYP improving access to psychological therapy appointments available. They had also put in place an on-line counselling service. The other area they were looking at doing was crisis intervention, which would help prevent young people being admitted to hospital.

The Children's Commissioning Manager for the Wolverhampton CCG stated that there were still some gaps in the CAMHS Service. One of these was the need for

an LD (Learning Disability) CAMHS consultant. Autism in general was also an ongoing issue. They were working hard to address where their workforce was across Wolverhampton, as within any emotional mental health and well-being system there was a need to focus on the universal mental health offer and not just specialist CAMHS Services. This included looking at what provision the schools had and the voluntary sector. There were many voluntary organisations across the City which provided intervention services which were not commissioned by the CCG or the Local Authority.

The Children's Commissioning Manager for the Wolverhampton CCG commented that one of the areas that NHS England had tasked them with was improving the evidence based interventions that young people were having. Consequently, this meant expanding the training for their workforce. They would be inviting the voluntary sector to some of the training being undertaken.

The Children's Commissioning Manager for the Wolverhampton CCG stated that there were currently three young people in tier four beds, which was a low number. Last year in total there had been fifteen, compared to ten in total in the current year. These numbers helped to demonstrate that the community services were improving. They were making some improvements to the Youth Offending Team to help improve services when people came out of detention.

A Member of the Panel asked who paid for the cost of beds for children needing mental health support. The Children's Commissioning Manager confirmed that the costs for the beds were met by Specialised Commissioning Services and not the Trust or the CCG. Depending on the bed required some children were placed well away from their home area due to bed shortages. If children, who had challenging behaviour, were being kept at a paediatric assessment unit at New Cross, then the RWHT Trust could ask for additional funding from the CCG to meet security costs. The Chief Executive of the RWHT Trust stated that it was scandalous that if ever they had a ten hour breach in the Accident and Emergency Department it was always related to them finding a mental health bed. The distances that people had to travel was horrendous, a problem which he had raised with the Secretary of State. Patients had waited 36 hours in Accident and Emergency, which required security staff to keep them and others safe.

The Director of Strategy and Transformation of the Wolverhampton CCG stated that the CCG were not legally permitted to commission mental health beds for children, this had to be done by Specialised Commissioning Services in NHS England. There were no beds located in the Wolverhampton area for children's mental health services.

A Member of the Panel commented that there were a number of younger people presenting with issues of gender fluidity. They asked if their needs had been anticipated. In response the Children's Commissioning Manager for the Wolverhampton CCG stated that the local CAMHS team had training from Mermaids, who were a specialist charity raising awareness about gender nonconformity in children and young people amongst professionals and the general public. Training was also being rolled out to local schools.

There was a discussion about the on-line counselling service and the different options available, further information was available on-line. There was a further

discussion about self-referral options within the CAMHS Service and the pros and cons of this option.

6 **Draft Budget and Medium Term Financial Strategy 2019-2020**

The Portfolio Holder for Public Health and Wellbeing introduced a report on the Draft Budget and Medium Term Financial Strategy 2019-2020. She stated it was a challenging year for the Council, in setting the budget for 2019-2020. The projected budget deficit for 2019-2020 was in the region of £6 million. There would be an update provided on the deficit in January next year. The report before the Scrutiny Panel asked them to provide feedback to Scrutiny Board on the draft budget proposals and on the overall scrutiny process of the budget.

The Portfolio Holder stated that the Council had identified a total of £695,000 budget reduction and income generation proposals, which were being formally consulted on. Within Public Health there was a saving of £288,000 to be delivered through the integration of Public Health Service Contracts. She asked for the Panel's feedback on the Draft Budget and Medium Term Financial Strategy and for feedback on the overall scrutiny process. It was intended for the Scrutiny Panels responses to be provided to Scrutiny Board on 11 December.

The Chief Accountant stated that some of the savings were being made through budget efficiencies which did not require consultation, as they did not impact directly on service users. As an example she cited the use of one off grants and vacancy management. The appendix to the report detailed the savings where there would be an impact on the public.

A Member of the Panel commented that her perception had been that there had not been the same amount of publicity for the budget consultation events as in previous years. The Chief Accountant responded that they had advertised in the same way as previous years. The consultation process was still open and would close in December.

A Member of the Panel stated the Secretary of State for Health had given a speech recently about the importance of prevention in the health sector. He asked if there had been any communications from the Department for Health since the speech. The Portfolio Holder responded that there had not been any direct communication from the Department for Health. There were however local discussions taking place about how to work better collaboratively with partners on the preventive health agenda.

The Director of Strategy and Transformation of the CCG asked if an impact analysis was being carried out on any proposed savings. The Director for Public Health responded that on the subject of the Integrated Health Public Service contracts, there were historically a number of mandatory functions the Council had to undertake. These included several commissioned services, such as goods and alcohol, the healthy childhood programme, which incorporated childhood measurement and health visiting services and finally sexual health services. Traditionally the Council used procurement and tendering processes to achieve the best value for money against the outcomes they wanted to achieve for the people of Wolverhampton.

The Director for Public Health stated that the health and social care environment was changing with many shared goals and shared outcomes, which could be worked on

together across organisations. Over the past year they had been working closely with the CCG on some of the key public health outcomes they were trying to improve. The joint working approach had been successful in improving the outcomes for health checks. They were also trying to do significantly more integrated working with the Royal Wolverhampton Health Trust, who currently held two core contracts, sexual health and the healthy childhood programme. A partnership approach rather than two separate contracts was essentially what was being proposed to help manage the budget, but also importantly to improve overall outcomes using a collective approach. It was this new approach which is what was being consulted on as part of an overall impact assessment. The Director for Strategy and Transformation of the CCG asked for the assessment and information gathered from the consultation to be shared with them. The Chief Executive of the RWHT added that the Trust was working very well in partnership with the Council's Public Health Department.

A Member of the Panel asked how far the work had progressed on the proposed integrated contracts. He was conscious that the new financial year was only four months away. He wanted to have a better understanding as to how much was aspirational compared to confident achievable proposals. The Director for Public Health responded that they had been having explorative discussions in relation to achieving the outcomes over the last year. Consultation would be required on the proposals and the legalities would need to be worked through. They were however confident that the approach was the correct one and work was going on at pace to achieve them within the next financial year.

A Member of the Panel asked about the oversight processes on the use of consultants and fixed term contracts. The Portfolio Holder responded that they received regular updates at Cabinet on short-term projects, the use of consultants and associated costs. Any consultants appointed had to be logical and add value. The Council had worked hard to reduce the number of consultants used to a manageable number.

7 **Winter planning/resilience plans - Update**

The Chief Executive of the RWHT gave an overview of the winter planning and resilience plans. He stated that they were currently having to revise the Trust's plans for the winter and hoped that the new plan would be ready for the 4 December 2018. Telford's Accident and Emergency Department was scheduled to close overnight from the 5 December 2018. The staffing situation at Telford's Accident and Emergency Department was getting worse. The additional capacity the RWHT had planned for the winter season would all be taken up by the extra ambulances arriving due to Telford's Accident and Emergency overnight closure.

The Chief Executive of the RWHT stated he was working very closely with West Midlands Ambulance Service and the Welsh Ambulance Service. He had a meeting the following day regarding the protocols drawn up at Telford, which he did not believe were suitable for use by the ambulance service. The protocol that had been drawn up, expected ambulance crews to take different action depending on the day of the week, which he thought would lead to confusion. He was most concerned with patients coming in from Wales, as a relationship needed to be established with the Welsh Social Services and the Ambulance Service. There was no provision for paediatrics at Shrewsbury's Accident and Emergency and so they would all be

coming to Wolverhampton. He was displeased with the situation as he had predicted the situation two years ago and felt action should have been taken earlier. He commented that his Deputy was currently at Dudley because the Care Quality Commission had some concerns about the Accident and Emergency Department. He was of the firm view that Dudley's Accident and Emergency Department should not close overnight as well, as this would create severe problems in Wolverhampton.

The Chief Executive of the RWHT circulated an information sheet from the BBC's NHS Performance Tracker Webpage. In the figures for October 2018 the RWHT was currently ranked 32 out of 131 Trusts for the target of patients admitted or treated within four hours of arrival at the Accident and Emergency Department. All the Trusts that were meeting the 95% target were specialist Trusts or Children's Trusts, with the one exception of Luton and Dunstable.

The Chief Executive of the RWHT stated that there had been a 10% increase in ambulance arrivals in the last 2-3 weeks in the Wolverhampton area. He hoped this would reduce as it was impacting on the performance of the Trust. A further issue had arisen with Shrewsbury and Telford Hospital NHS Trust being placed in special measures. The Care Quality Commission had some concerns with the maternity services at Shrewsbury and Telford. He had not removed the delivery cap in Wolverhampton.

The Chief Executive of the RWHT stated that not enough doctors had been trained nationally over the last fifteen years to cope with the current NHS Structures within the country. It was a long-term problem which would take at least 14 years to rectify. He was pleased to report that the Vice Chancellor at Wolverhampton University had increased the number of nurses in training. There were now 1100 Nurses in training at the University.

The Chief Executive of the RWHT Trust remarked that he Chaired the West Midlands Cancer Network. He was informing a number of District General Hospitals that they would be stopping Urology Services. This was due to the fact that when Urologists finished their training, they did not want to work in an organisation which did not have a surgical robot. He was of the view that there needed to be a hospital partnership chain for Dudley, Wolverhampton, Walsall and Shrewsbury and Telford. He believed this was the only way to sort out some of the staffing problems faced by the Trusts. The staff working in Pathology at City Sandwell, Walsall, Wolverhampton and Dudley had all transferred to his jurisdiction on the 1 October 2018. With that transfer, there were 23 Consultant vacancies. He had already managed to recruit 4 Consultant Pathologists earlier in the week.

A Member of the Panel asked why there had been a 10% increase in ambulance arrivals at the Trust and what campaigns the Trust had to encourage people to use Accident and Emergency Departments appropriately. The Chief Executive of the RWHT responded that the major issue was the extra ambulances arriving. Eighty percent of people arriving at New Cross Hospital by ambulance, were out of the hospital within four hours of arriving. This was an area which the Trust needed to work on and encourage alternative provision to hospital. People using Accident and Emergency as a walk-in medical centre were not so much of a problem. The Welsh Ambulance Service were very good at spending time with people in their homes to avoid the need for a long journey to Shropshire.

A Member of the Panel expressed concern about the pressure that the Trust would face when Telford's Accident and Emergency Department closed overnight. She was concerned that residents of Wolverhampton would be adversely affected, facing long waiting times and not receiving the appropriate standard of care they deserved. The Chief Executive of the RWHT Trust responded that the residents of Wolverhampton, benefited with New Cross being one of the four Tertiary Centres in the West Midlands. He acknowledged the Councillors concerns and was frustrated himself as he had seen the issue arising for the last two years. He would be working with the Ambulance Services to help manage the situation and updating some of the Trust's working practices. The Trust benefited from the fact that the West Midlands Ambulance Service was the only service in the country which had 100% Paramedics on all their ambulances. They were getting to a situation where Paramedics in the future would bypass the Accident and Emergency Department and go straight to the correct department such as X-Ray.

8 **Integrated Care Alliance in Wolverhampton**

The Director of Strategy and Transformation of the Wolverhampton Clinical Commissioning Group gave a verbal update on the Integrated Care Alliance (ICA) in Wolverhampton. The STP was going to be in future rebranded as the ICS (Integrated Care System). Sitting beneath the ICS was going to be the Integrated Care Provider. In its gestational state, it was being called the Integrated Care Alliance (ICA). There had been positive progress over the past six months. One of the key anchors of delivering successful integrated working was changing the way the NHS contracted. The discussions they had been having with the Trust were around not changing the integrity of the revenue to the Trust as an integrated provider of acute community services, but to align the way money flowed across it. As an example, he cited that non-elective services would be block aided. If non-elective services were to be block aided and community services were still with the Trust, it gave the Trust certainty on the money coming in and allowed activity in a non-elective area to be reinvested in the community sector to support people to stay at home and to help primary care practices.

The Director of Strategy and Transformation of the Wolverhampton Clinical Commissioning Group stated that as part of the new collaborative approach they would need to change the way some services were delivered. They were initially focusing on four areas. He said the first area was how people were supported with frailty to live more at home. He said that over a certain age, ten days in hospital was equivalent to eight years degenerative muscle tissue. Hospital was a dangerous place for older frail people, in terms of their general wellbeing, the risk of acquiring secondary infections and their future independence. Ensuring that frailty was treated in a different way and that the clinicians from the secondary care environment and GP clinicians together with Community Services were agreeing how the services would be setup to support people with frailty was vitally important.

The Director of Strategy and Transformation of the Wolverhampton Clinical Commissioning Group remarked that the second area they were looking at was the End of Life Service. The current service saw too many people going into hospital to die, instead of dying at home. This was sometimes due to there being no provision to support the person to die at home.

The Director of Strategy and Transformation of the Wolverhampton Clinical Commissioning Group commented that the third pathway they were working on was

around short stay paediatrics. Wolverhampton was a substantial outlier when it came to 24 hours stays for younger children with respiratory problems or lower GI. There was a deficit in GP training for paediatrics and a deficit in pro-active community paediatric care, both of which were being addressed. The final key area was regarding mental health, where people in crisis were presenting at the Accident and Emergency Department. There needed to be more support for people in crisis from a crisis liaison perspective.

The Director of Strategy and Transformation of the Wolverhampton Clinical Commissioning Group stated that he realised the new integrated working approach did rely heavily on Public Health to assess the relevant data. There was a sub-group which was working on matters of governance. It was important to look at services from an end to end perspective, rather than individual parts. There were risks to the new approach, with the highest being working relationships. Trust and collaboration would be key to ensuring it was a success.

The Chief Executive of the RWHT commented that there would be people spending their last few hours in the assessment unit at New Cross Hospital, which he saw as a failure of the NHS. More work was required from the NHS working with the local nursing homes around end of life care provision. He was happy to provide his transplant nurses to have conversations with the nursing homes and families. He was thinking about introducing a “Dignity in Death” certificate for nursing homes on a similar model to the infection prevention certificates.

Meeting closed at 3:05pm

Agenda Item No: 6

The Royal Wolverhampton NHS Trust

Health Scrutiny Panel

24 January 2018

Report title	The Royal Wolverhampton NHS Trust Patient Experience PALS and Complaints Report
Report of:	Alison Dowling, Head of Patient Experience and Public Involvement
Portfolio	Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Be assured of current service delivery status.
2. Support plans for future development which require cross organisation collaboration
3. Accept for information.

1.0 Introduction

1.1 The purpose of this report is to inform the Health Scrutiny Panel of the functions of the PALS and Complaints Service at the Royal Wolverhampton NHS Trust and detail activity, mechanisms for measurement and outcomes.

2.0 Background

2.1 Outline of responsibilities of the service and key people

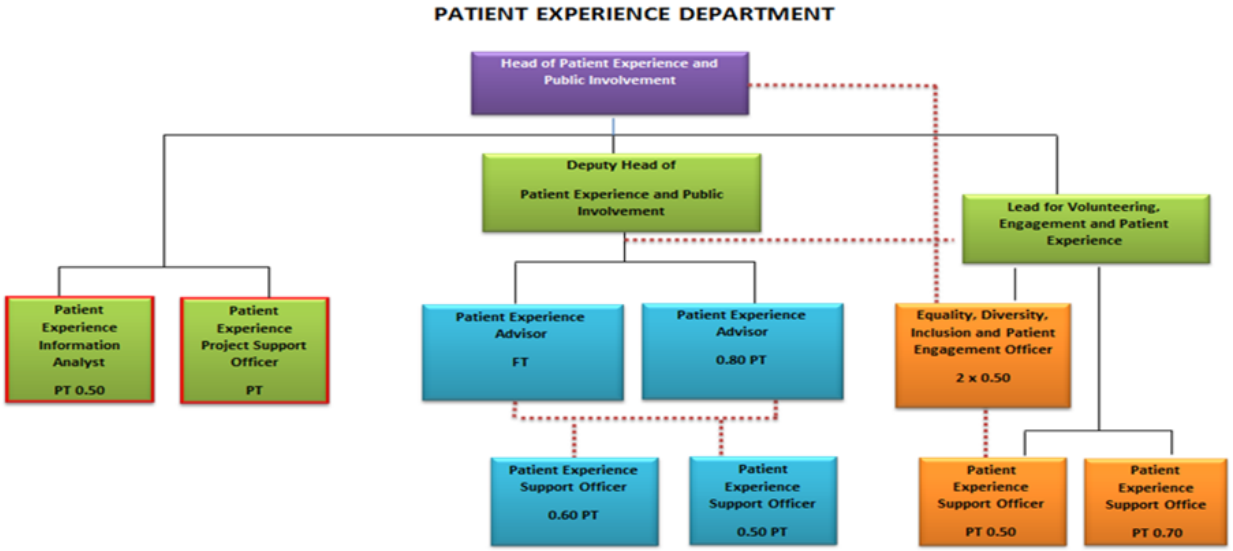
The provision of the PALS and complaints service is delivered partly by a multidisciplinary patient experience team whose roles also cover the provision of other methods of patient feedback and engagement, all with the aim to improve the patient experience.

The Patient Experience Team underwent a restructure in September 2017 to align the services provided by the Department to accurately reflect the requirements of the Trust

and to mirror the governance structures in how support is offered to the Divisions.

The Patient Experience Team had not undergone any restructure for several years and as the Trust has expanded by the addition of services from Cannock Chase Hospital and Primary Care (Vertical Integration) it was felt that the roles and structure needed to accurately reflect how services are delivered Trust wide. This also included the complexities around complaints which fail to meet Section 42 of Safeguarding regulations and therefore are managed within the Trust's statutory complaints procedure.

As a result of the restructure (and further amendment) the patient experience team now consists of the following:



Progress against key priorities for the service during 2017/2018 – extracts from the summary of the Trust's Quality Account Annual Report.

A patient's experience is influenced by every interaction they have with us - from the first contact to the last, and therefore each milestone in a patient's journey provides an opportunity for the experience to be positive or negative.

This previous year, the Trust has focused on the holistic approach to patient experience recognising that a positive patient experience is not solely reliant on a good clinical outcome.

Several initiatives have been implemented which focus on improved processes and communication not only between Trust departments but also with stakeholders and patients and their carers.

These have included:

- Increased patient and user engagement by the introduction of a patient voice through the establishment of a Council of Members, and delivering local bespoke surveys.
- Progression through goal 2 of the EDS2 – Improved Patient Access and Experience.
- Publication of the Trust's Equality, Diversity and Inclusion report. [1] in addition to the

[1] http://www.royalwolverhampton.nhs.uk/patients-and-visitors/patient-experience-team/equality-diversity-and-

Trust's Patient Experience Report.

- Introduction of mandatory training on Equality, Diversity and Inclusion.
- Redesign of the Trustwide Patient Feedback Posters containing several patient experience metrics for public information.
- Refining the complaints policy further to enhance how the Trust responds to complaints and other forms of patient feedback and included a further level of scrutiny for cases where complainants remain dissatisfied and incorporated this into the complaints management process.
- The introduction of enhanced technology to support the overall patient experience feedback mechanism by the review and implementation of a new telephony system resulting improved average response time for PALS queries.
- The introduction of extended visiting hours where friends and family will be able to visit their loved ones from 12pm until 7pm, recognising that visits and support from family and friends can help aid a patient's recovery. Flexible visiting promotes family involvement in the care of patients such as mealtimes, encouraging visitors to assist the patient they are visiting. Exceptions to this are the children's ward, neonatal unit and maternity. Visiting times will also differ for surgical wards and day case surgery to ensure adequate provision of rest time for patients post-surgery.

Complaints' Management and Performance

Whilst the Complaint Regulations 2009 state that the timescales for complaint resolution are to be negotiated with the complainant, the Trust monitors its performance against its policy of 30 working days.

We aim to respond to all complaints within 30 working days. The investigating officers continue to make contact with complainants directly to renegotiate timescales for complaints where a delay is anticipated due to extenuating circumstances or complexity. This approach shows that the Trust is putting the complainant at the heart of the process ensuring good communication and involvement in how their complaint is handled. The agreed timescales are recorded on the online complaints monitoring system (Datix).

As a result of the amendments to the policy, the Trust has experienced a positive part year in relation to complaints. Complaints management training was delivered to investigating officers, which included Matrons and Directorate Managers. Feedback received regards the training was extremely positive.

Recognising the need for thorough and consistent approaches to investigations for safeguarding concerns which do not meet the Section 42 criteria, these complaints are now investigated in line with the Trusts formal complaints process.

All new complaints are triaged by the central complaints team with the aim of providing complainants with the opportunity to have their experience addressed informally by PALS, where intervention is felt possible.

Complaints are graded on receipt according to likelihood and consequence and grading is undertaken on the basis of the content of the complaint prior to investigation by directorates. In

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inclusion/equalities-information/

line with Trust policy, directorates re-grade complaints where appropriate once issues have been explored.

Volume

In terms of volume of Formal Complaints, the first six months of 2018 have shown a volume of 205 in comparison to 203 for the previous six months.

Timeliness

Formal complaints are managed in accordance with the relevant statutory regulations.[2] With the amendments made to the Complaints' Management Policy in August 2017 and, and following bespoke training, we have again seen a dramatic improvement in the timeliness of complaint handling and informing the complainants of the progress of their complaint.

For the first six months of 2018, 100% of complaints were closed either within the organisational timeframe of 30 working days or were given consent to breach due to extenuating circumstances or complexity. This is reinforced by putting the complainant at the heart of the process and ensuring that they are communicated to and involved in how their complaint is handled. Over the last three years there has been continual improvement with the compliancy rising from 63% to 100%.

Outcomes

The Trust returns the required quarterly KO41a collections to NHS Digital (formally known as the Health and Social Care Information Centre (HSCIC). The returns record the number of written complaints received about hospital and community services made by (or on behalf of) patients. The data includes the outcome of all complaints which are upheld, not upheld or partially upheld and is broken down by service area (who was complained about) and by subject area (what was complained about) and is available on the public website[3].

The methodology used by NHS Digital in order to determine the outcome of a complaint is that if a complaint is received which relates to one specific issue and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld. Where there is no evidence to support any aspects of a complaint this should be recorded as not upheld. If one or more of the issues complained about are upheld (but not all), the complaint should be recorded as partially upheld.

For the period January to June 2018, results of complaints closed are as follows:

Jan – March 2018

Upheld 5%
Partially upheld 21%
Not upheld 72%
Subject to an RCA Investigation 2%

April – June 2018

Upheld 5%
Partially Upheld 27%
Not Upheld 68%

This is significantly lower than the national average of 33.60% for cases upheld.

[2] http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf
[3] http://content.digital.nhs.uk/

PALS Concerns (Patient Advice and Liaison Service)

PALS has maintained its position with patients, the public, staff and external organisations as a department that is responsive and pro-active to queries and concerns. PALS remains an effective resource in supporting patients, their representatives and staff respond to 'real time' queries and concerns.

PALS Concerns have steadily reduced over the last two years and the first six months of 2018 have indicated a reduction in volume of 40% from a six monthly average of 928 (July – December 2017) to 553 for the first six months of 2018.

PALS concerns are correlated against the formal complaints and FFT (Friends & Family Test) and highlighted to the respective divisions for remedial action to be taken. Any Trust wide learning identified will be brought to the attention of the governance department to be included in their Risky Business newsletter.

During 2018, the Trust has strengthened it's approach to undertaking outreach to gather the views of patients in a variety of community and healthcare settings. This has included bespoke surveys and attendance at community sub groups and charities.

Other forms of patient feedback – Patient Stories

Collecting Patient Stories is an important component in understanding how patients' perceived the health care they have received and how we can improve on the many different aspects of service delivery in our hospitals, and in our community-based health care programs.

Patient Stories assist staff in improving the experience for patients and can assist staff through education and reflection. These are collected and used on a monthly basis at a variety of forums, including Trust Board, and are easily accessible for all staff.

Patient stories can be positive or negative and detailed action plans for improvement are written for negative stories and best practice is shared for positive stories.

Areas for action in 2019

Trust's priorities for financial year 2018/2019 have been agreed as part of the Trust's Quality Account 2017/18. These have included:

1. **Strengthening relationships with patient communities including Increased Patient and User Engagement.**

Whilst the Trust has made some significant improvements with increasing patient and user engagement, in particular the creation of a Council of Members, ensuring that the voice of the patient is embedded throughout the organisation at a strategic level, the Trust aim to build on key relationships with the community and empower patients from every background to embrace and engage in the process.

Our aim during 2017/18 was to increase public and patient engagement, in particular to

- Have a patient voice heard at Trust Policy Group for every policy change ensuring that

the patient is always at the centre of service change.

- To undertake public consultations on key issues before service delivery change. The Trust are keen to involve local people in decisions which will determine how healthcare is provided.
- Increase membership of the Council of Members ensuring that members reflect the diverse population of the patients we serve.
- To undertake a series of engagement sessions to community groups specifically to gain views of patients accessing services for protected characteristic groups.
- Continue to implement a broad range of initiatives to encourage patient involvement and utilizing various methods and platforms to ensure inclusivity.

2. **To review and enhance the use of volunteers to aid a positive patient experience**

This has included:

- A comprehensive audit of the volunteer base.
- Working with stakeholders, community groups and education facilities to promote the benefits of volunteering to a younger audience.
- Devise an audit tool in order to measure the effectiveness of volunteers in correlation to a positive patient experience.
- Explore different software packages to assist in the administration of recording of volunteer base

3. **To be amongst the highest performing Trust's regionally and nationally in relation to the Friends and Family Test.**

   This has included:

   - Benchmarking ourselves against our peers with aim to show continual improvements and narrowing the gap where applicable
   - Having robust systems in place to evidence actions and improvements for lower performing areas
   - The recruitment of a data analyst to undertake more detailed analysis of the FFT metrics at divisional level

Relationship with Stakeholders

The Trust regularly meets with key stakeholders to share patient feedback activity and learning. Reports are presented on a quarterly basis to the CCG of which the Joint Engagement Assurance Group (JEAG) forms part of this.

The Trust has agreed a memorandum of understanding with Healthwatch enabling a positive and productive relationship, sharing information where appropriate to improve the patient experience.

Where possible the Trust meet with Healthwatch representatives to seek the views shared with them around the services and experiences. Action is taken upon such feedback, and where applicable, is fed back to the relevant parties.
The Trust also has a joint policy with the Local Authority in relation to complaints management and this works particularly well with complaints which cross organisational boundaries.

Representatives from the team regularly attend regional Complaint Manager Forums sharing best practice with peers from other Trusts and utilising the forum for support and advice.

Positive relationships are also present with colleagues at NHS England for complaints which may be in relation to Primary Care Services which come under the Trust remit and of course the Parliamentary Health Service Ombudsman (PHSO).

3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	☐X
Alcohol and Drugs	☐
Dementia (early diagnosis)	☐
Mental Health (Diagnosis and Early Intervention)	☐
Urgent Care (Improving and Simplifying)	☐X

4.0 Decision/Supporting Information (including options)

5.0 Implications

None

6.0 Schedule of background papers

6.1 Any background papers relating to this report can be inspected by contacting the report writer:

Alison Dowling
Head of Patient Experience and Public Involvement
The Royal Wolverhampton NHS Trust

Direct Line Telephone: 01902 695363

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City of Wolverhampton Council Scrutiny Panel	
Meeting Date:	24th January 2019
Title:	Staff Recruitment & Retention
Purpose of the Report:	The purpose of this report is to outline the approaches being applied to address workforce resourcing challenges within RWT and provide an overview on the progress being made with regards to recruitment & retention, along with other workforce related metrics.
Summary:	The NHS workforce continues to be one of the greatest challenges nationally, as well as for the Trust and is currently one of the highest rated risks within the organisation. In addressing this challenge, RWT is currently focusing on 4 key areas: • Supply • Retention • Productivity • Development Although the Trust is performing well against many of the workforce related metrics, including our overall vacancy rate which is now below 7%, it will continue to be a key area of focus for many years to come.
Author	Alan Duffell Director of Workforce
Related Trust Strategic Objectives	Attract, retain and develop our staff, and improve employee engagement

Staff Recruitment & Retention

1.0 Background

From a survey undertaken by NHS Providers in November 2017, 66% of trust leaders indicated that the workforce is their most pressing challenge to delivering high-quality care for patients at their trust. As a result, workforce resourcing has become one of the most significant challenges, both nationally and locally.

1.1 National Context

NHS Vacancy Statistics England, as reported through NHS Digital, show that in March 2018 there were 28,998 advertised vacancies (full-time equivalents) in England, this compares to 30,613 in 2017, 26,424 in 2016 and 26,406 in 2015. This is outlined in Figure 1 below:

Figure 1: Number of advertised vacancy full-time equivalents in England published between October and March from 2015 to 2018

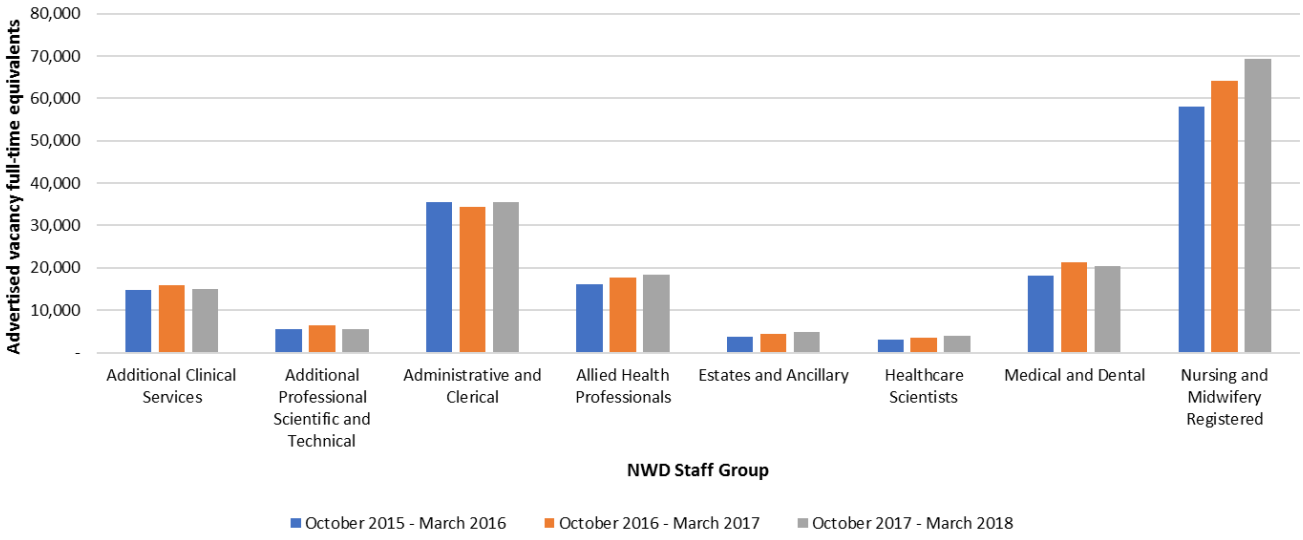


Figure 1

The number of advertised vacancies varied between the different National Workforce Data Set (NWD) Staff Groups. In March 2018 the highest percentage was seen in the 'Nursing and Midwifery Registered' Staff Group which accounted for 40 per cent (11,483 out of 28,998) of vacancy full-time equivalents followed by 21 per cent (6,092 out of 28,998) in the 'Administrative and Clerical' Staff Group.

It was widely reported in September 2018 that one in 11 posts were vacant and that the situation in nursing was particularly difficult. NHS Providers have suggested that if no action is taken to reduce demand through prevention or through better productivity and service transformation, the NHS workforce will need to grow by 190,000 clinical posts by 2027 to meet demand.

1.2 Local Context

Within RWT we have continued to see an improving position on the overall vacancy rate, which was reported at 6.87% as at Nov 2018 and for registered nursing, midwifery & health visiting it is 7.18%. This is also supported by an improving normalised turnover rate for the same period.

Although the RWT may compare well with some of our local Trusts, it is recognised that resourcing will continue to be an area of challenge. As such, along with many NHS Trusts, workforce resourcing is one of our greatest organisational risks.

2.0 RWT Approach

In understanding how RWT is addressing the resourcing challenge, efforts are currently being focused in four key areas, although in a number of projects there will be some overlap. These four areas are outlined in the model below:

2.1 Supply

In order to maximise our supply opportunities, the Trust is progressing with a range of options. Firstly, to maximise attraction from our local market, for a number of months we have been running large scale recruitment events/days (focusing on registered and unregistered posts) where potential staff are able to either just drop in or book a time slot. These events help to both outline what opportunities exist within the organisation and learn more about what we do as a Trust. As far as possible, we have made these events one stop shops, whereby documentation can be checked, interviews take place and relevant tests completed, so that candidates can leave the event with a potential conditional job offer.

To date, these events have been extremely successful for the Trust. Examples of this include a children's & paediatric event where 19 job offers were made, an HCA recruitment event where 66 job offers were made and a registered nursing event where 18 job offers were made.

Outside of our local market for staff, the Trust has also been successful with overseas medical recruitment through the Clinical Fellows programme, whereby individuals come to RWT in support of their professional development and at the same time covering gaps with much needed skills. Such has been the success with this approach, it is currently being expanded to incorporate nursing clinical fellows. As the Trust heads into next financial year, the aim is to also progress with a further cohort of international recruitment for registered nurses.

Recognising that there will always be some need for a more flexible/temporary workforce, the aim for this and next financial year will be to expand the Trust bank, particularly for medical staff but also for nursing staff. As well as bank staff, the Trust may still require a level of agency medical locum support.

2.2 Retention

As well as looking to identify and maximise workforce supply, it is equally important that we have a focus on retaining the staff we already have. There is a significant national focus on the retention agenda given the limited supply of available workforce.

In support of this agenda, the Trust is part of cohort 4 of the NHS Improvement Nurse Retention Programme and whilst the focus of this programme is nursing, analysis is underway into other staff groups and lessons learned and interventions are considered both transferable and impacting beyond the nursing workforce.

In focusing this agenda, there are a number of actions that are currently being progressed, including:

- Improved access to flexible working
- Establishment of staff support groups
- Implementation of long service awards
- Development of a wider staff benefits package
- Encouraging and supporting staff to take up flexible retirement options rather than leaving the service altogether;
- Implement a 'career surgery' approach for staff to discuss career options and development opportunities
- Reviewing the option of rotational posts and/or internal transfer options.

2.3 Productivity

As well as improving the supply options and retaining our existing staff, it is equally important to ensure we are able to improve the effectiveness/productivity of our workforce. Much of the workforce productivity agenda has been in relation to e-rostering, with a focus on improving; unused hours, spread of annual leave and time scale to signing off rotas. The reduction of sickness absence is also a key component. Looking forward, following the approval of the e-job planning business case, this will provide a greater organisational understanding of consultant job plans.

2.4 Development

Growing our own will be a key factor for the Trust in addressing the current and future workforce challenges. We have recently approved the funding for the first year of the new nursing apprentice programme, as well as progressing the clinical nursing fellows.

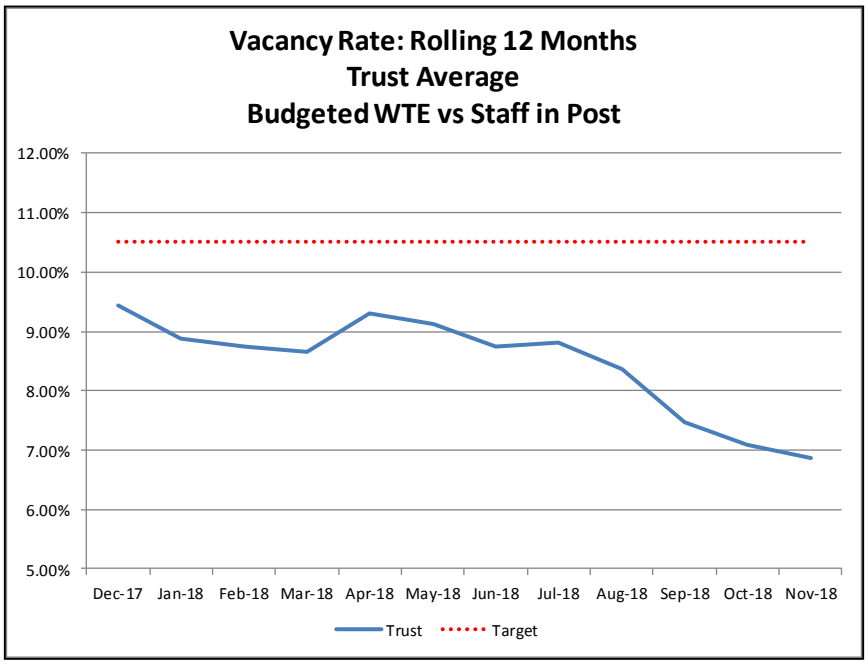
Linked to both development & role redesign, RWT is also piloting the new band 4 Nurse Associate role and a wider working group has been established to review how the Trust makes best use of the many new roles which are becoming available.

As well as nursing apprenticeships, the Trust continues to make wider use of the apprenticeship mechanism, in line with the recently approved Apprentice Approach, which sees apprentices as a way of developing individuals and opening up opportunities to local people to work within the health environment. The expansion of the apprentice programme will also help towards establishing a career development pipeline.

In order to further expand our workforce supply options, as well as part of our development agenda, RWT has signed the Armed Forces Covenant and signed up to the national Step into Health initiative, all with the aim of taping into the skills and experience of ex-service personnel and provide some developmental support, which may help address some of the workforce gaps within RWT.

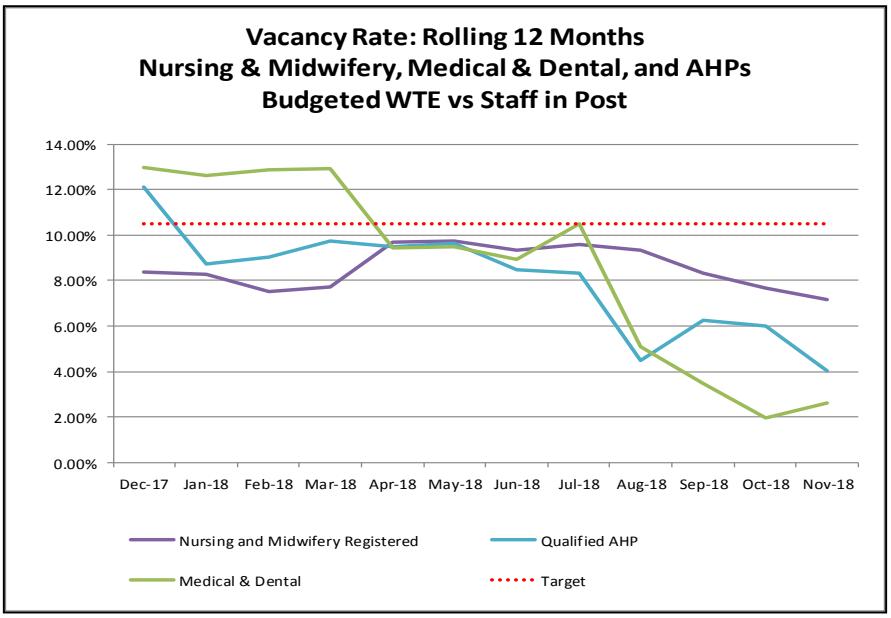
3.0 RWT Workforce Performance

The Trust routinely tracks a wide range of performance metrics with regards to our workforce, in order to understand if the approach being taken is having the desired effect. Graph 1 shows that RWT has seen continuous improvement in reducing our overall vacancy rate to a position where it is currently below 7%.



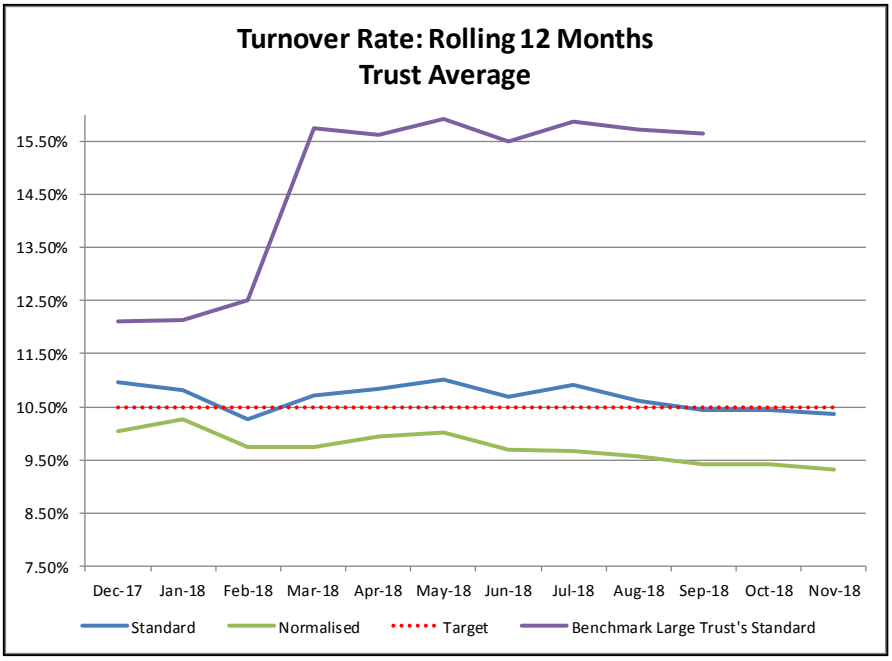
Graph 1

Graph 2 provides a further analysis of vacancy broken down into professional groups.



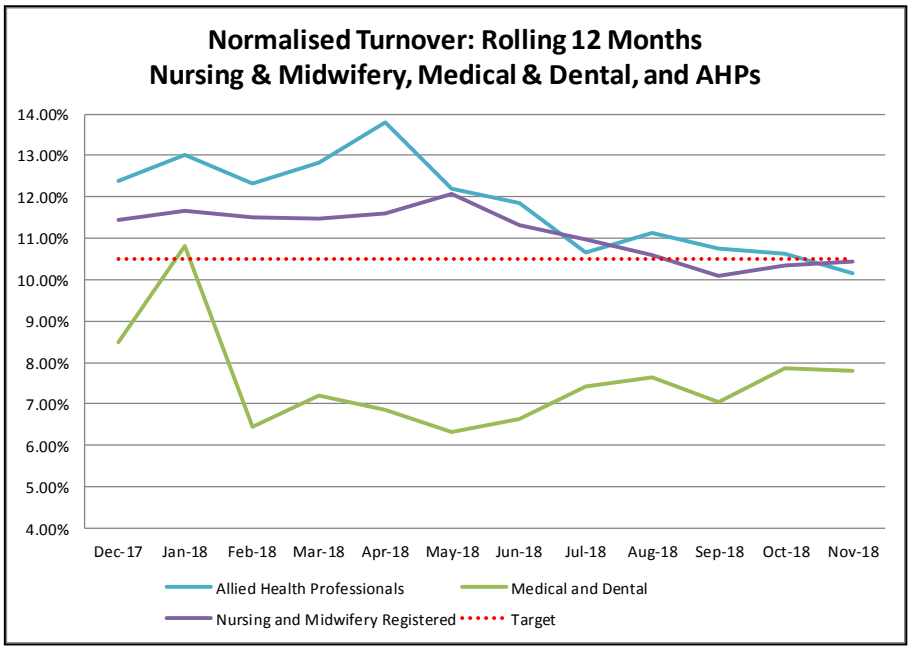
Graph 2

When reviewing our staff turnover rate, Graph 3 clearly shows that we are below our target and outperforming other NHS Trusts of similar size.



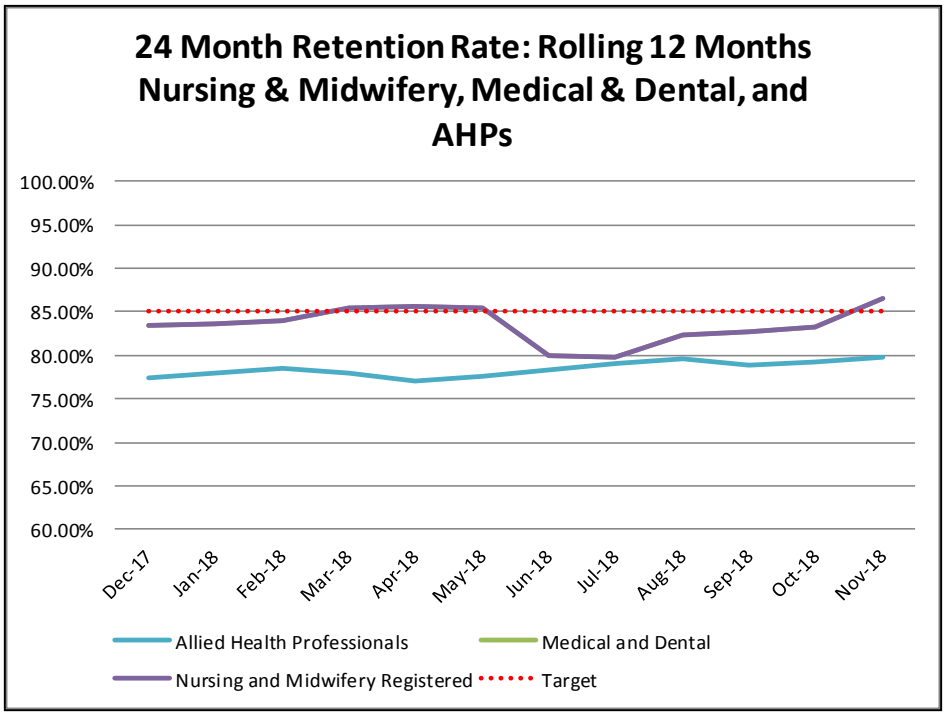
Graph 3

Again reviewing turnover by specific staff groups is outlined at Graph 4:



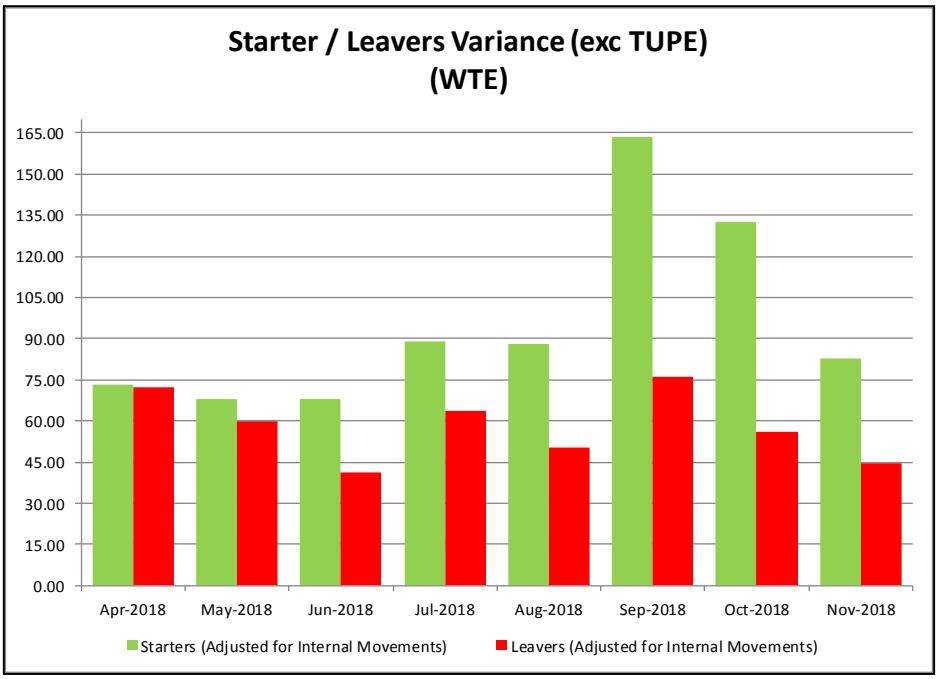
Graph 4

Section 2.2 highlights the work being undertaken with respect to retention and in support of this at a Trust level we track our retention rate at the 12, 18 and 24 month position. Shown in Graph 5 is the retention rate for the 24 month position.



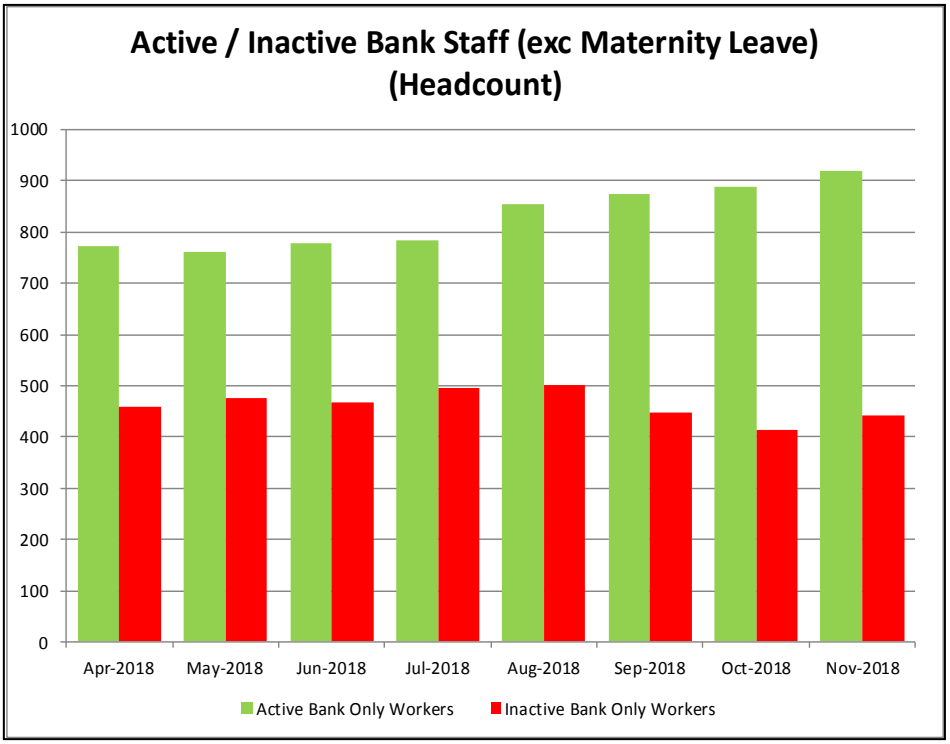
Graph 5

The information in Graph 5 is further supplemented though measuring our net starters and leavers, as outlined in Graph 6. This clearly shows that each month we have a greater number of starters than leavers.



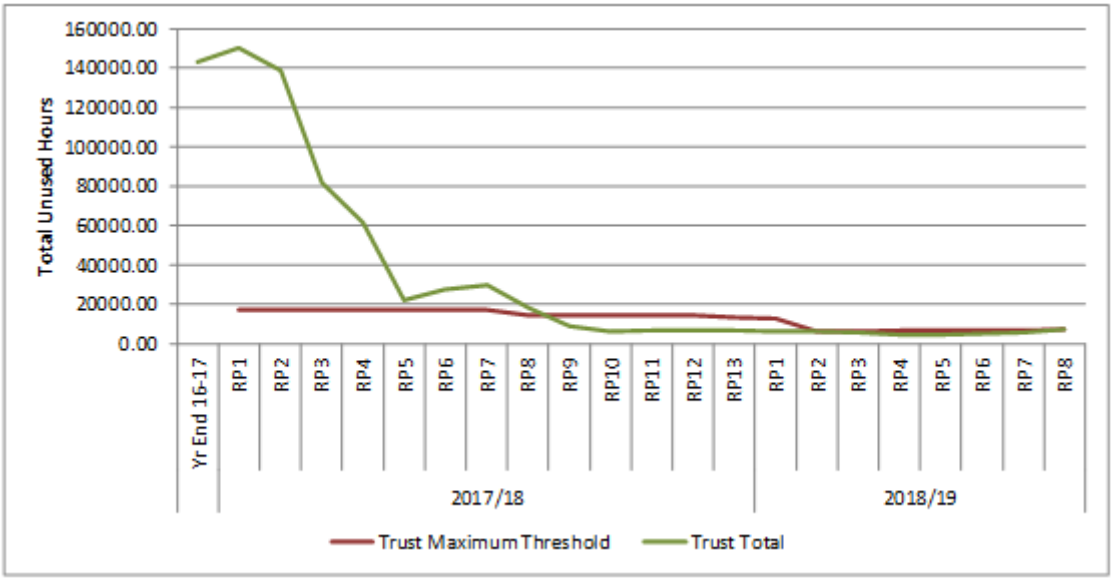
Graph 6

As well as improving our substantive staffing position, there will always be a need to have access to temporary staffing and to support that need, we have been looking to increase our bank staffing levels, as outlined in Graph 7.

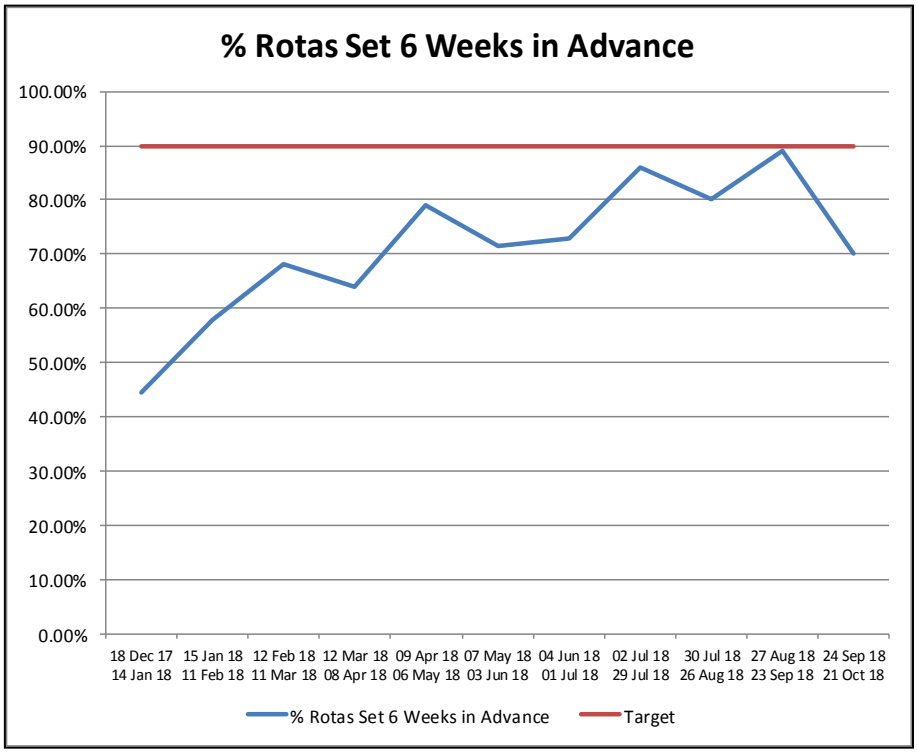


Graph 7

In progressing our focus on workforce efficiency/productivity, two of the areas that are routinely reported against are the avoidance of unused hours (shown at Graph 8) and the ability of the Trust to ensure shift rotas are established 6 weeks in advance, shown on Graph 9.

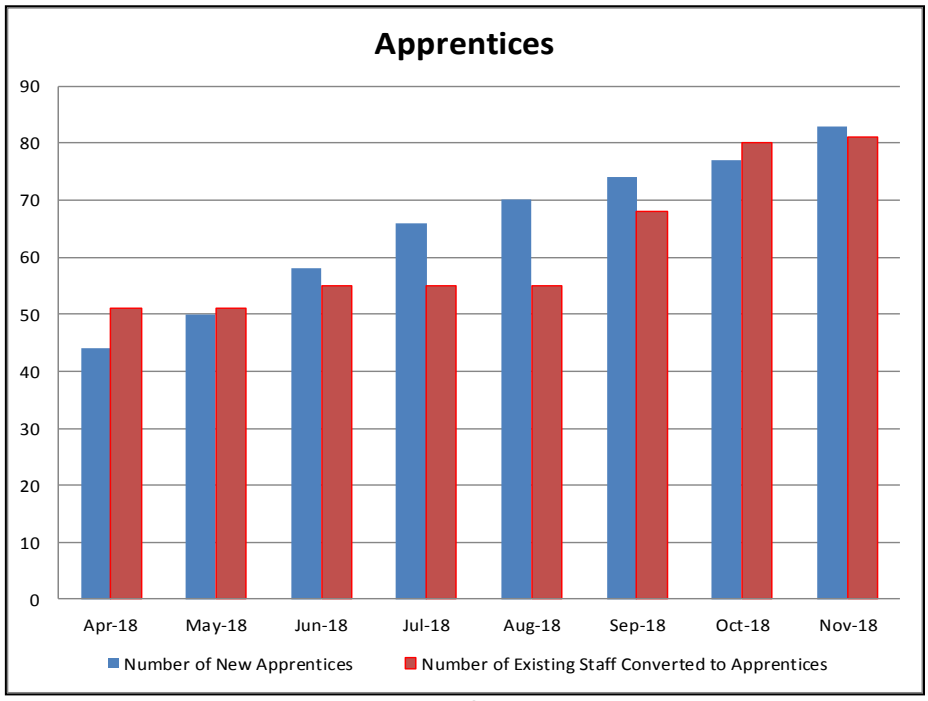


Graph 8



Graph 9

Finally, when looking at staff development, Graph 10 provides an overview of the progress that RWT is making with regards to apprenticeships.



Graph 10

4.0 Conclusion

Although workforce continues to be an area of significant challenge, both locally and nationally, as well as being the area with one of the highest risks, there is a clear four pronged organisational approach to addressing this issue, which will continue to require a wide range of interventions, as opposed to a single solution, which appears to be having some success.

Briefing Note

CITY OF WOLVERHAMPTON COUNCIL

Title: NHS Long Term Plan – Briefing Note **Date: 15.01.2019**

Prepared by: Dr. Ankush Mittal **Job Title: Consultant in Public Health**

Intended Audience: Internal ☒ Partner organisation ☐ Public ☒ Confidential ☐

Purpose or recommendation

To brief Health Scrutiny on the headline considerations of the NHS Long Term Plan (Jan 2019).

Background and Overview

The NHS Long Term Plan sets out the path for the NHS in the next 10 years, highlighting key areas of focus within 7 chapters.

In terms of resources, the plan has been much awaited since Government announcements of an additional £20bn a year for the NHS within 5 years (NHS budget currently ~ £114bn).

The plan places an increasing emphasis on primary care and community care systems and prevention in general, with closer partnerships between the NHS and LA on public health spending. Prevention continues to be a running theme amongst NHS papers, including the NHS Five Year Forward View and the more recent Department of Health and Social Care 'Prevention is better than cure: our vision to help you live well for longer' (2018).

There is also a compendium of targets and delivery objectives for care quality in various groups, including cancer, diabetes, stroke, children and mental health, with associated care targets (e.g. a shift towards earlier diagnoses of cancer, moving from 50% to 75% diagnosed at an early stage).

In terms of structures there is a drive for all Integrated Care Systems to develop by 2021, and a push for an integrated place-based primary care model consisting of 'primary care networks' covering 30-50,000 populations.

In term of processes there is also significant emphasis on digital innovation in healthcare delivery, with ambitious targets around virtual consultations for both primary care and outpatient settings.

Some uncertainties remain in the wake of the social care and prevention Green papers and a wider Spending Review and Workforce Implementation Plan.

Chapter Summaries

The NHS Long term plan considers key areas within 7 chapters, as summarised below:

Chapter 1:

Service Models:

- Every patient will have the right to online 'digital' GP consultations
- redesigned hospital support will be able to avoid up to a third of outpatient appointments
- GP practices – typically covering 30-50,000 people – will be funded to work together to deal with pressures in primary care with community health and social care staff.
- Community health teams and urgent and integrated care systems to reduce hospitalisation and delays in discharge
- 2.5 million more people will benefit from 'social prescribing', a personal health budget, and new support for managing their own health

These reforms will be backed by a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget. This commitment creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24.

Chapter 2:

Prevention and health inequalities:

- Smoking cessation pathways in hospital and mental health settings
- Plans to limit alcohol-related A&E admissions
- Uptake of screening and early cancer diagnosis
- Funding to address and reduce population obesity
- Plans to double enrolment in the successful Type 2 NHS Diabetes Prevention Programme
- Supporting people with mental health conditions in the community
- Providing outreach services for people experiencing homelessness
- Plans to lower air pollution through revision of systems and processes in the NHS

Chapter 3:

Care quality and outcomes improvement in various areas, including:

- cancer
- mental health
- diabetes
- multimorbidity
- healthy ageing, including dementia
- children's health
- cardiovascular and respiratory conditions
- learning disability and autism

Commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24.

Chapter 4:

Workforce pressures and staff development. Actions to be overseen by NHS Improvement. These will be included and confirmed in the comprehensive NHS workforce implementation plan published later this year.

- Expand the number of nursing and other undergraduate places, ensuring that well-qualified candidates are not turned away as happens now.
- Expansion of clinical placements of up to 25% from 2019/20 and up to 50% from 2020/21.
- New routes into nursing and other disciplines, including apprenticeships, nursing associates, online qualification, and 'earn and learn' support, are all being backed, together with a new post-qualification employment guarantee.
- International recruitment will be significantly expanded over the next three years, and the workforce implementation plan will also set out new incentives for shortage specialties and hard-to-recruit to geographies.
- More flexible rostering will become mandatory across all trusts
- Funding for continuing professional development will increase each year
- Action will be taken to support diversity and a culture of respect and fair treatment
- More workforce flexibility across an individual's NHS career and between individual staff groups.
- The new primary care networks will provide flexible options for GPs and wider primary care teams.
- Staff and patients alike will benefit from a doubling of the number of volunteers also helping across the NHS.

Chapter 5:

Digital:

- Rapid upgrade in technology and virtual access
- Better access to care records for all staff
- Improvements in digital decision support tools
- Integration and linkage of data

Chapter 6:

Financial path:

- Taken account of the current financial pressures across the NHS, which are a first call on extra funds.
- Realism about inevitable continuing demand growth from our growing and aging population, increasing concern about areas of longstanding unmet need, and the expanding frontiers of medical science and innovation.
- No assumption that increased investment in community and primary care will necessarily reduce the need for hospital beds. Instead, taking a prudent approach, we have provided for hospital funding as if trends over the past three years continue.
- Establishment of new Financial Recovery Fund and 'turnaround' process, so that on a phased basis over the next five years not only the NHS as a whole, but also the trust sector, local systems and individual organisations progressively return to financial balance.
- Save taxpayers a further £700 million in reduced administrative costs across providers and commissioners both nationally and locally.

Chapter 7:

Next steps in implementation:

- Establishing the new NHS Assembly in early 2019.
- 2019/20 will be a transitional year, as the local NHS and its partners have the opportunity to shape local implementation plans for their populations
- A detailed national implementation programme by the autumn so that we can also properly take account of Government Spending Review decisions on workforce education and training budgets, social care, councils' public health services and NHS capital investment.
- This Plan does not require changes to the law in order to be implemented but recommends changes to create publicly-accountable integrated care locally, to streamline the national administrative structures of the NHS, and remove the rigidness of the competition and procurement regime applied to the NHS.
- NHS and partners will be moving to create Integrated Care Systems everywhere by April 2021, which bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

Proposal/Options

1. LA public health and social care systems to continue to integrate with NHS through established routes, including the STP, ICA, and BCF.
2. Prepare for further place-based changes to the delivery of NHS community and primary care services, and continue to mobilise our social care and public health offers to adapt to these changes
3. Revisit joint targets and outcomes with the NHS via partnership groups, and consider the detailed guidance in the plan alongside those within current plans, and prepare for any gaps and renewed ambitions
4. Await wider literature essential to understanding how LAs will complement this plan, including social care and prevention green paper.

Scrutiny Work Programme

Health Scrutiny Panel

The Panel will have responsibility for Scrutiny functions as they relate to:-

- All health-related issues, including liaison with NHS Trusts, Clinical Commissioning Groups, Health and Wellbeing Board and HealthWatch.
- All functions of the Council contained in the National Health Service Act 2006, to all regulations and directions made under the Health and Social Care Act 2001, the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002,
- The Health and Social Care Act 2012 and related regulations.
- Reports and recommendations to relevant NHS bodies, relevant health service providers, the Secretary of State or Regulators.
- Initiating the response to any formal consultation undertaken by relevant NHS Trusts and Clinical Commissioning Groups or other health providers or commissioners on any substantial development or variation in services.
- Participating with other relevant neighbouring local authorities in any joint scrutiny arrangements of NHS Trusts providing cross border services.
- Decisions made by or actions of the Health and Wellbeing Board.
- Public Health – Intelligence and Evidence
- Public Health – Health Protection and NHS Facing
- Public Health - Transformation
- Public Health – Commissioning
- Healthier City
- Mental Health
- Commissioning Mental Health and Disability
- HeadStart Programme

Date of Meeting	Item Description	Lead Report Author	Specific Questions for Scrutiny to consider
24.01.2019	• Cancer treatment services – performance against national targets	The Royal Wolverhampton NHS Trust	Performance against local and national targets
	• RWHT – staff recruitment and retention	The Royal Wolverhampton NHS Trust	Maintaining staff levels to deliver safer care and better patient experience
	• Patient Advice and Liaison Service (PALS)	Alison Dowling | Head of Patient Experience and Public Involvement The Royal Wolverhampton NHS Trust	
	• Briefing Note on NHS Long-Term Plan	Ankush Mittal	
	• BREXIT Preperations	Verbal Update from attendees	
21.03.2019	• Learning from deaths in Wolverhampton – update	Dr Odum, The Royal Wolverhampton NHS Trust Ankush Mittal, Public Health Consultant	
	• Public Health Vision – Review of Progress against national performance targets	John Denley, Director of Public Health	http://www.wolverhampton.gov.uk/health

	• GP appointment waiting times – involve Wolverhampton Healthwatch • Eye and Hearing Checks • Black Country Partnership NHS Foundation Trust – Transforming Care Partnership – update and Quality Accounts 2018/19 – progress against priorities	Wolverhamton CCG and Healthwatch Molly Dillon (CCG) Neeraj Malhotra (City of Wolverhampton Council) Sandra Smith (CCG) Lesley Writtle, Black Country Partnership	
6 June 2019	• Suicide Prevention • Child Deaths • Ward sizes,age,transition arrangements for a young person moving to an adult ward • Public Health Vision	Parpinder Singh Public Health RWHT Trust Public Health	

List of potential topics - dates and method of scrutiny to be agreed by the panel

1. West Midlands Ambulance Service - Quality Accounts 2017/18 - June 2019 (tbc)
2. RWHT - Quality Accounts 2017/18 – June 2019 (tbc)
3. Black Country Partnership NHS Foundation Trust – Quality Accounts – June 2019 (tbc)
4. Walsall CCG - Reconfiguration of hyper acute and acute stroke services
5. Pharmecuatical Ordering
6. Burial Places in Wolverhampton
7. Crematorium booking system, waiting times and delays particularly during the winter season

Work Plan Version: 15/01/19 13:43