CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 16 January 2020

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Tracy Cresswell
Sheila Gill
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Phil Page (Chair)
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Cllr Wendy Thompson
Dana Tooby

Witnesses
David Loughton (Chief Executive - RWT)
Steven Marshall (Deputy Chief Accountable Office – STP &
Director of Strategy and Transformation - CCG)
Vanessa Whatley (Deputy Chief Nurse - RWT)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director of Public Health)
David Watts (Director of Adult Services)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
On the STP item apologies for absence were received from the Black Country Partnership NHS Foundation Trust.

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

3 **Minutes of previous meeting**
The minutes of the meeting held on 7 November 2019 were approved as a correct record.

4 **Matters Arising**
The Chair of Healthwatch referred to the section in the minutes relating to homelessness. The Director for Public Health responded that he was intending to

arrange a meeting with Healthwatch to clarify all the issues raised during the last meeting.

The Chair of Healthwatch referred to the 18 weeks wait after an initial assessment for the Access to Psychological Services. She believed this was too long for a person to wait, who wished to access the service. The Director for Strategy and Transformation agreed that it was too long for a person to be kept waiting and added that they were working with the provider in reviewing the target.

The Chair of Healthwatch commented that she was pleased to have received the data from Dr Odum relating to the waiting times for the results of cancer scans. The two areas of most concern related to the results for gynaecology and lungs. She asked the Chief Executive of the Royal Wolverhampton Trust to comment on whether there were any plans to improve these two areas. The Chief Executive of the Royal Wolverhampton Trust responded that the waiting times for lung cancer results had really started to improve. They had not improved to the same extent in gynaecology, he was however hoping to appoint 3 new Consultants in this area.

A Member of the Panel commented that during a man's lifetime, more than half would be diagnosed with late prostate cancer. It would overtake breast cancer as the most diagnosed cancer in the country. The Chief Executive of the Trust acknowledged the Member's comments and added that if there was going to be a national or local campaign on prostate cancer, the service had to be ready for the additional people reporting with symptoms.

The Local Healthwatch Manager noted that cancer screening was on the work programme for the next meeting of the Panel. She wanted to ensure that Healthwatch's work on cervical cancer screening could be captured as part of the item. Adding to the discussion, The Director for Public Health stated that cancer screening was a key priority contained within the Public Health Annual Report.

5 **Accident and Emergency Department - New Cross Hospital (Royal Wolverhampton NHS Trust)**

The Chair and Vice-Chair of the Health Scrutiny Panel had submitted the following questions to the Royal Wolverhampton Trust in advance of the meeting:-

1. Can you explain the processes of the Hospital for declaring a level four and the response this initiates? In addition, how many occasions have you declared a level 4 in the last 12 months and for how long did the status stay at level 4.

2. Can you explain what steps the hospital are taking to improve the experience of mental health patients attending A&E?

3. What are you and your colleagues most proud of in the A&E Department?

4. What is staff morale like?

5. Do the staff in A&E take appropriate breaks?

6. How does the Hospital work with the Ambulance Trust?

7. Have the Security arrangements had to be enhanced in recent years and what are the associated costs?

8. Are there any campaigns planned on the appropriate use of A&E?

9. AFC Band 2 – HCA and AFC Band 5 - Have the most vacancies, how are you coping with this shortage and how is the recruitment process going?

10. Do you think patients receive enough privacy and dignity in A&E, where could things be improved?

11. Can you tell us more about the administration of notes, are they all scanned on the system and is there a back log?

12. What are your priorities to improve A&E moving forward?

The Chief Executive of the Royal Wolverhampton Trust extended an invitation to all Health Scrutiny Panel Members to visit the Accident and Emergency Department at some point in the future. He was also happy to host the Scrutiny Panel at the hospital for an official meeting of the Panel as well. He referred to the slides which had been circulated with the agenda. Daily attendances at Accident and Emergency were up by over 100. Ambulance daily attendance had risen to 180 in 2019 compared to 158 in 2018. Recently there had been over 200 ambulances attending on any one day. It was not the high number over 24 hours that was his major concern, it was more problematic when there was a rush of ambulances in a small-time frame, such as 17 in 30 minutes. It would take over two hours to clear this amount of ambulances in such a short time frame.

The Chief Executive of the Royal Wolverhampton Trust remarked that regionally the Trust was ranked third for the percentage of people meeting the 4-hour target. He understood that the Secretary of State for Health was considering removing the four-hour target. He was personally not in favour of removing the target as he saw it as a good way of helping to ensure the systems flowed. Sometimes it was clinically correct to miss the four-hour target, for instance if it meant keeping a person in the department for six hours, who could then go back home. He therefore thought the four-hour target should be tweaked, rather than removed entirely.

The Chief Executive of the Royal Wolverhampton Trust commented that where there were staff vacancies, 99% of those vacancies were filled with nurses from the nurse bank. The current staffing situation in Accident and Emergency was one over establishment because of a recruitment drive. There had been a problem towards the end of 2019, where some of the overseas nurses had not passed their English language test, but that had now been resolved.

The Chief Executive of the Royal Wolverhampton Trust commented that the first few weeks of 2020 had been a difficult and challenging time. There were signs that things were improving, the pressure had really started in the second week of December, a week earlier than the previous year. The Trust had a very good relationship with West Midlands Ambulance Service. The worst situation he had

seen in Accident and Emergency at the Trust had been last Friday, when the corridors were full of patients because of Ambulance batching. What they did differently to other Accident and Emergency Departments was in the efficient offloading of ambulances. Whilst privacy and dignity were not at its best, when patients were in corridors, at least ambulances were offloaded. The maximum ambulance offload waiting time in an NHS Trust in the West Midlands the day previous, had been 6 hours 15 minutes. He was confident that he would never allow such a long offload time in Wolverhampton. He saw it as a top priority to get ambulances back on the road to be able to respond to 999 calls.

The Chief Executive of the Royal Wolverhampton Trust stated that the Trust had been at Level 4, three times in the last twelve months. One of those was a day in December and the other two had been in January. There were some hospitals which frequently declared level 4 and so overall, he thought the Trust did well. Delayed discharges were often the main problem for having to declare level four, there had been significant delays in transfer of care with Staffordshire. He described the morale of staff as being very good despite the pressures people were working under and he paid credit to the staff of Accident and Emergency.

The Chief Executive of the Royal Wolverhampton Trust on the matter of security, commented that he had invested an additional £100,000 in the last three months of 2019 into the security arrangements at Accident and Emergency. He was of the view that there needed to be a security presence in the department 24 hours a day. There had been incidences of staff in reception having boiling hot tea thrown on them. In the past security was increased on Friday and Saturday evenings due to the threat posed by alcohol, but the threat had now changed. There was now a greater threat of people under the influence of behaviour changing drugs. A group had been setup looking at security and in particular the security arrangements at Accident and Emergency. He was involving West Midlands Police for further training of security staff on soft restraints. He was even considering working in partnership with the Police to have PCSOs (Police Community Support Officers) paid for by the Trust but working at the hospital. There was always extra education which could be done on the appropriate use of Accident and Emergency and some of this he believed should take place in primary care.

A Member of the Panel stated that people were queuing at the main reception desk of Accident and Emergency, for an appointment to receive an MRI scan. One of the MRI scanners was located in the Accident and Emergency Department. The Chief Executive of the Trust responded that he would ensure a notice was put in place to inform people that they could go straight though to the Radiology part in the Department. They were using the extra capacity of the MRI scanner in Accident and Emergency because it’s full use was not required for Accident and Emergency purposes.

A Panel Member commented that they were concerned that the Secretary of State was considering revoking the target of least 95 per cent of patients attending A&E being admitted to hospital, transferred to another provider or discharged within four hours**.** She asked how the staff in Accident and Emergency, accommodated children and young people with special needs who were likely to be very distressed and disruptive. The Chief Executive of the Trust commented that there was a quiet room in the department. Most of the problems were faced in the Adults section. The Deputy Chief Nurse commented that patients with learning disabilities and special

needs were identified by the patient administration system when they arrived. There was also a team of three staff members in the Learning Disability nursing team. They worked 9am-5pm but were available on-call to offer specialist support when required.

In response to the specific question on what the Trust were doing to improve the experience of mental health patients in Accident and Emergency, the Chief Executive responded that they were working in partnership with the local mental health providers. He was also working with the national mental health Tsar at improving the systems to find available mental health beds throughout the country. He wanted to use a technological solution to improve the situation. The Director for Strategy and Transformation commented that one of the core requirements was a mental health psychiatry liaison service called 24 which was a 24 hours a day service placed in A&E. Wolverhampton had received additional funding to be able to offer a full 24 hours service. From the 1 January 2020 there should have been a full psychiatric model in place in A&E. The challenge that was being faced was a shortage of mental health nurses. There had been some slippage to the timescales but he was hoping this would be rectified soon. A new contracting model for the use of mental health beds would be in place from the 1 April 2020. This would allow people from Wolverhampton to have better access to the mental health beds within the Black Country.

The Director of Adult Services commented that only four NHS Trusts had achieved the target recently of at least 95 per cent of patients attending A&E being admitted to hospital, transferred to another provider or discharged within four hours. He did not think the target was sustainable. He asked the Director of Strategy and Transformation of the CCG if people from outside of the Black Country would be able to use the mental health beds within the Black Country area. He responded that all the beds would be blocked out in the future for use by only people resident in the Black Country area.

The Chair of Healthwatch commented that some feedback was positive, some mixed and some negative regarding patients experiences in Accident and Emergency. Healthwatch had made a number of recommendations about Accident and Emergency, following surveys. Some of the recommendations contained in the report had not yet been progressed by the Trust. She had that day received a press release from Healthwatch England about hospitals needing to do more to show patients how they were learning from their mistakes. There had been a commitment from the hospital to have regular dialogue with Healthwatch around how improvements were being made, but this had not yet been forthcoming.

The Local Healthwatch Manager commented that they had met three people from the Trust towards the end of November to discuss some of the complaints that had been received and how they were learning from them. Bi-monthly meetings had been agreed but these had not been established. She wanted to ensure that dates were established in the clinical professional's diaries. The Deputy Chief Nurse of the NHS Trust offered to speak to the Local Healthwatch Manager directly after the meeting to discuss the establishment of meetings regarding Accident and Emergency.

The Chief Executive of the Trust commented that they did put a great deal of effort into learning where things had gone wrong. 95% of litigation in Accident and Emergency stemmed from misdiagnosis. They would be announcing shortly the

introduction of artificial intelligence to improve the situation. Relative to other organisations, they had a relatively low level of litigation in Accident and Emergency and generally speaking it was small amounts of money rewarded. The Healthwatch Local Manager commented that there was nothing visible for patients to see that learning had been taken on board.

A Member of the Panel raised that there were issues in Staffordshire which were causing their patients to have to be treated in beds in Wolverhampton. The Chief Executive of the Trust commented that it was not just Staffordshire, only last week 17 ambulances had arrived from Shropshire. The Panel Member commented that it was important to monitor the situation at the Royal Shrewsbury and Princess Royal Hospital in Telford, due to the knock-on effect in Wolverhampton.

A Panel Member expressed concern about the extra security required in Accident and Emergency. No member of staff should have to face a personal safety threat. He was pleased that the Chief Executive was taking extra measures to protect staff. The Chief Executive of the Trust responded that it was his first duty to protect staff. There could be a security concern in any section of the hospital and maternity services was a further area of notable concern.

A Member of the Panel asked if the Panel could receive some data on early failed discharge in Accident and Emergency. The Chief Executive of the Trust confirmed that this could be provided. He did have one of the lowest admission rates in the NHS at 24%, which he was particularly proud to announce. They were also continuing to work on reducing the number of deaths in hospitals through the end of life care work stream.

The Local Healthwatch Manager stated that it was important for the Trust to be transparent about how they had learnt from complaints and this needed to reach the public and not just internally within organisations. The Chief Executive of the Trust acknowledged the point and commented that twice a year the Trust could provide an anonymous complaints newsletter showing how they had learnt from them.

There was a discussion about fines and how the money was distributed. It was confirmed that when the Trust was fined the money was re-invested back into the Trust.

The Chief Executive of the Trust confirmed that all notes were scanned in Accident and Emergency and there was currently no administrative back log.

The Chief Executive of the Trust remarked that one of his main priorities was to enable people to die at home within the community. They had appointed four more Palliative Care Consultants. They would also be working on improving technology and using artificial intelligence to triage patients. More information on this subject would be announced soon.

6 **STP (Sustainability and Transformation Partnership) Update**

The Chair and Vice-Chair of the Health Scrutiny Panel had submitted the following questions in advance to the Deputy Chief Accountable Officer of the STP, Mr Steven Marshall.

1) Who do you see the STP as being accountable to?

2) Where does the Chair and Lead Officer get their support from?

3) How do you see the STP evolving into an ICS (Integrated Care System)?

4) What Governance arrangements do you foresee for the future ICS?

5) What role do you see for Local Government in the ICS?

6) The CCG in Wolverhampton has been rated as outstanding in the last four years. This is partly due to excellent finances. How do we ensure that Wolverhampton does not suffer financially in the future, with money being allocated in other areas at the expense of Wolverhampton?

7) How can we ensure that the future ICS will not make some health services worse in Wolverhampton?

8) Will the meetings of the future ICS Board meet in public?

9) Where do you see the future leaders of the ICS originating from?

10) How far should the ICS take on responsibility for quality and financial performance as opposed to planning and implementing the transformation of care?

11) What are your views on legislating for ICS's?

In relation to question 1, the Deputy Chief Accountable Officer of the STP responded that the STP was not a statutory body, it was just a mechanism which brought a group of statutory bodies together for a common planning and organisation consideration. The STP did not have any legal authority, each organisation within the STP had their own accountability structures.

The Deputy Chief Accountable Officer, in response to question 2 remarked that the Chair and Lead Officer had a small Project Management Office, housed at the Science Park. There were currently discussions taking place about how it might need to change following the evolution of the STP.

With reference to question 3, the Deputy Chief Accountable Officer responded that fundamentally an integrated care system was about devolving decision making authority, as to where funding should be spent, to a more localised footprint. In order for the STP to evolve into the ICS there were a series of hurdles which needed to be crossed during the financial year 2020-2021, in order to demonstrate to the regulators of the NHS that it had the mechanisms in place to become self-regulating. Once it had achieved this the ICS would then decide how it would run the Black Country ICS. The ICS also had to be made up of Local Authorities and the voluntary sector.

With reference to the Governance arrangements of the ICS (question 4), the Deputy Chief Accountable Officer commented that a paper had been presented to the STP Board in November 2019 which proposed a move to recognise the importance of

place. Each place, including Wolverhampton, had been asked to establish an ICP (Integrated Care Partnership) Board. This was a work in progress and discussions were ongoing. The Voluntary Council, the Local Authorities, BCPFT (Black Country Partnership Foundation Trust), RWT (Royal Wolverhampton NHS Trust) and the GPs were all part of the discussions. Each place has been asked to nominate three board members to the STP Board. There would also be a non-executive Member from one of the acute Trusts and a lay member from one of the four CCGs. In total the Board for the STP would have 31 Members. The proposal also included a recommendation to broaden the involvement to a partnership forum involving wider representation that would meet 3 or 4 times a year.

In response to question 5, the Deputy Chief Accountable Officer responded that Local Authorities were partners in the ICS and the ICP. He saw Local Authorities as being very important in the partnership.

The Deputy Chief Accountable Officer, in response to question 6, remarked that Wolverhampton would be part of the ICS system. The demand from regulators would be that the system worked well. It was important to note that there would be sovereignty of place as part of the ICP, before it moved to an ICS. He saw it as part of his role and others working in Wolverhampton to ensure there was sufficient funding in Wolverhampton for the needs of the residents. What was key was the active involvement of Wolverhampton partners to ensure adequate funding. There would be opportunities for capital funding as part of the ICS.

In response to question 7, the Deputy Chief Accountable Officer stated that no one wanted to see any health services becoming worse in Wolverhampton and he didn't think anyone would accept this state of affairs. They had a duty under the 2012 NHS Act to continue to improve health services and any place structure would continue to fulfil this aim.

The Deputy Chief Accountable Officer, in response to question 8, remarked that a decision had been made that the ICS Board would meet in public.

In reply to question 9, the Deputy Chief Accountable Officer commented that the future leaders of the ICS would be determined by the Partnership. It was clear that changes to the CCG landscape were ongoing and these needed to be resolved before decisions were taken about the leadership of the ICS.

The Deputy Chief Accountable Officer, in response to question 10, remarked that the aspiration was for the majority of the ICS capacity to centre around transformation, which needed effective planning. What would continue to happen would be the holding to account of quality and financial performance at a local system level.

In response to question 11, the Deputy Chief Accountable Officer commented that he thought the Government's agenda would be focused on legislation not relating to the NHS. He didn't see an agenda for legislation at the present time. He thought the Government were trying to convey that the way the NHS was constructed currently with a supplier and provider relationship had run its course. He thought they saw the future as one of a more clarity of working, with organisations working together in collaboration to deliver health services. He thought the Government wanted clinicians and managers to have more of a say in how funding was distributed.

A Panel Member commented that she had recently read the publicly available King's Fund document entitled, "Leading for Integration – If you think competition is hard, you should try collaboration." She commented that integrated collaborative working had to be the best wherever or whoever you were, as that was how you made services most effective. The third sector, she felt were often unequal partners in partnership working. It was her view that organisations integral to the delivery of health services could not deliver them without the contribution of the third sector, who provided excellent value for money. She therefore felt it was important that the voluntary sector was sufficiently involved in partnership working.

The Deputy Chief Accountable Officer responded that the Member had made a valid point. He added that it was important that some of the smaller community organisations should also have a sufficient voice as well as some of the better known national charitable organisations. The question was therefore how they created a shadow ICP Governance Board that was ready to mature in April 2021, whose Membership could resolve how to work effectively together. An important element of focus would be to ensure how the third sector was fairly represented.

The Director for Public Health commented that there was a positive opportunity ahead. Partners had been working together over the past year quasi informally to improve health outcomes. As an example, he cited the Healthy Child Programme, where the five indicators were better than ever before within Wolverhampton. He also made reference to the significant performance improvement in health checks that had been brought about by working in partnership.

The Director of Adult Services stated that he agreed about the importance of the voluntary sector. He also thought there was a risk in Local Authorities involvement in future integrated care systems. With Boards of over 30 people, the reality was there would only be 4 or 5 representatives from Local Authorities, with the rest taken up by health bodies. The role of Health and Well-Being Board's and Health Scrutiny would be equally important in challenging, scrutinising and holding to account the whole integrated care system. In relation to the question on legislation and the ICS, he saw it as a real opportunity to be at the forefront to shape policy. He could see Wolverhampton as leading the Black Country in this area.

A Member of the Panel asked about the mechanism for PPG (Patient Participation Groups) to scrutinise the STP. The Deputy Chief Accountable Officer responded that the PPG's could feed back into the Communication Lead at the CCG.

A Panel Member asked for an update on the vascular services that had moved to Dudley. He wondered if they would ever be returned to Wolverhampton. The Chief Executive of the Royal Wolverhampton NHS Trust responded that it was not currently one of his priorities. However, it could change in the future should capacity allow.

7 **Work Plan**

Resolved: That the Health Scrutiny Work Programme be agreed.

The Meeting closed at 3:10pm.