CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

5 March 2020

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 Phil Page (Lab)
Vice-chair Cllr Paul Singh (Con)

Cllr Obaida Ahmed
Cllr Bhupinder Gakhal
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Susan Roberts MBE
Cllr Wendy Thompson
Tracy Cresswell
Sheila Gill
Dana Tooby

Quorum for this meeting is three voting members.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

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

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 3 - 12)
[To approve the minutes of the previous meeting as a correct record].

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

DISCUSSION ITEMS

5 **Cancer Screening**
[An open forum discussion with Health Partners about cancer screening, with a particular focus on breast, bowel and cervical. The general theme will be – "What can we do to make things better"].

6 **Patient Participation Groups**
[The Panel will receive the results of the survey sent to all Patient Participant Groups].

7 **Midwifery Services at RWT** (Pages 13 - 18)
[To receive a report on Midwifery Services at the Royal Wolverhampton NHS Trust].

8 **Stroke Services at RWT** (Pages 19 - 24)
[To receive a presentation on stroke services at the RWT. The presentation slides are attached which will be explained in full by representatives from the Trust at the meeting].

9 **Mortality Agenda at RWT** (Pages 25 - 34)
[To receive an update report on the Mortality Agenda from The Royal Wolverhampton NHS Trust].

10 **Work Plan** (Pages 35 - 38)
[To consider the Health Scrutiny Work Programme].

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 16 January 2020

Agenda Item No: 3

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.

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Health Scrutiny Panel

Meeting Date:	March 2020
Title:	Midwifery Services Report
Author	Tracy Palmer: Head of Nursing and Midwifery Women's and Neonatal Services.
Presented By:	Kate Cheshire – Matron for Maternity & Neonatal Services

Detailed Report

Item 1.0 **Midwifery Staffing and Birth ratio.**

1.1 Presently Birth to Midwife ratios are 1:27/28, this is a positive and sustained picture over the last quarter for RWT and meets the recommendations of the Birth rate + midwifery workforce / acuity review for the Trust in 2017. A further BR + review will take place in 2020.

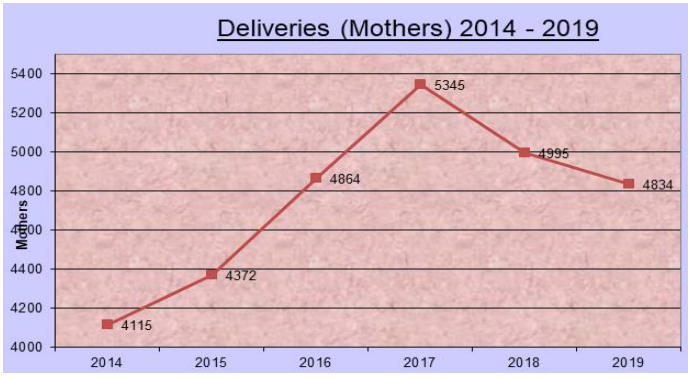
1.2 Successful recruitment has taken place throughout the year and all existing vacancies together with vacancies identified from the BR+ workforce review have been appointed into.

1.3 The Midwifery delivery suite coordinator has supernumerary status which is defined as having no caseload of their own during the shift; this is to enable oversight of all birth activity in the service and in line with best practice standards.

1.4 **Annual Birth rates**

1.5 A formal review of projected birth rates took place in September 2019 with the Chief Operating Officer. Capping arrangements have been successful in maintaining birth rates within manageable levels over the last year with birth rates just under agreed commissioned activity. Therefore it was agreed that capping restrictions would be lifted as from the 1st October 2019.

1.6 Annual Birth rates over the last 5 years.



1.7 Booking activity since capping restrictions have been lifted in October 2019.

Activity	Tolerance			Oct 19	Nov 19	Dec 19	Jan 2020
	Green	Amber	Red				
Number of Bookings	<450	450-470	>471	480	496	440	479
Number of Mothers Delivered	<416	417-419	>420	418	368	372	397

2.0 **Better Births: National Maternity Review – Improving outcomes of Maternity Services in England.**
Saving Babies Lives Care Bundle v 2

2.1 The key priorities set out within Better Births (2016) and The NHS long Term plan (2019) has been identified to tackle perinatal and infant mortality to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

2.2 The key priorities from the Long term Plan to achieve this ambition are to ensure that The Saving Babies Lives Care Bundle (SBLCB) is rolled out across every maternity unit in 2019. The care bundle supports the ambitions set out in *Better Births* (2016) and an independent evaluation of the care bundle has shown that a 20% reduction in still birth rates have been achieved in maternity units where the care bundle has been implemented.

2.3 RWT Maternity Service is working towards compliance with each element of the SBLCB. The 5 elements are as follows:

1. Reduce Smoking – this element provides a practical approach to reducing smoking in pregnancy by following NICE guidance.

2. Risk assessment and surveillance for fetal growth restriction – this element has made a measurable difference to antenatal detection of small for gestational age (SGA) babies.

3. Raising awareness of reduced fetal movements (RFM) – encourages awareness amongst pregnant women of the importance of detecting and reporting RFM.

4. Effective fetal monitoring during labour – Trust to demonstrate that all qualified staff who care for women in labour are competent to interpret cardiotocographs (CTG).

5. Reducing Pre-term Birth from 8% - 6% - This is an additional element to the care bundle.

2.4 RWT continues to report quarterly progress to NHSE against the five elements of the care bundle. RWT can demonstrate that the SBLCB is being considered in a way that supports delivery and implementation of each element. Quarterly surveys to assess against compliance for each element of the care bundle are submitted to NHSE.

2.5 Recommendations from the National Maternity Review: Better Births are being implemented through the Local Maternity Systems (LMS). These systems bring together local authorities, Clinical commissioning groups (CCG's), maternity providers and user groups; RWT continue to work together within the BCLMS with the aim of ensuring women and their

	families receive seamless care across the maternity pathway, including women and families that move between maternity and neonatal service Providers
3.0	**Continuity of Carer** In order to improve experiences and outcomes for women and families, improving continuity of carer across the whole maternity pathway is a further key recommendation from Better Births (2016) and The Long Term Plan (2019)
3.1	This requires providing a pregnant woman with consistency in the midwife and clinical team that cares for her and her baby throughout pregnancy, labour and the postnatal period. The woman will have a named midwife who takes responsibility for coordinating her care and with whom she can develop an ongoing relationship of trust. The woman will have Midwife she knows at her birth.
3.2	RWT have agreed the workforce models required to deliver the nationally expected trajectories for continuity of carer pathways.
3.3	Local Maternity Systems have been asked to ensure that most women (>51%) receive continuity of the person caring for them during pregnancy, birth and postnatally by March 2021, with 35% of women placed onto a continuity of carer pathway in March 2020.
3.4	The BCLMS have been working together to achieve the ambition of 35% trajectory by March 2020. In March 2020 data will be extracted from the Maternity Service Data Set version 2 (MSDSv2) to measure the number of women who are ***placed*** onto a continuity of carer pathway at booking appointment and the number of women who in March 2020 are placed onto a continuity of carer pathway after the antenatal booking appointment and up to 29 weeks gestational age. This trajectory will be achievable for RWT.
3.5	Workforce models for achieving 51% of women ***receiving*** continuity of carer by March 2021 are presently being developed and piloted at RWT and across the LMS. The most challenging aspect of care for delivery of COfC across the whole maternity pathway is the intrapartum element; where the guidance states a woman has a midwife ***known to her at her birth.***
3.6	This risk has been highlighted as a concern nationally and exists because of the acuity / dependency status of women in the Black Country and other regions with high socio-economic risk and depravation who may not meet the criteria for a COC pathway post booking due to the increased number of appointments required and therefore the decreasing likelihood of maintaining a consistent team to support them. . Other influencing factors are high sickness and maternity leave in current midwifery establishments across the LMS.
3.7	There is also an ongoing discussion with national teams surrounding import and export data (women who have either their ante-postnatal / intrapartum care at other maternity providers) and how this data is included / measured.
3.8	Heads of Midwifery and local teams are working collaboratively within the LMS to ensure a safe workforce model to support COfC with a focus to endeavour to achieve the 51% trajectory by March 2021

3.9	There is a lack of appetite for “case loading” models within the midwifery workforce as this requires significant changes to work life balance due to the requirement to be available for on calls and flexible working to meet the COfC service needs. Team Midwifery is the model of choice as this is less disruptive to work life balance, current workforce models, has minimum cost to implement and is less likely to require HR processes for management of change.
3.9.1	The team Midwifery model has a named midwife who works in a wider team to deliver a total care package across the 3 elements of the maternity pathway. These teams work in a more structured format of shift patterns and operate flexibly within existing working arrangements to deliver care to women in their team. As midwives are working in shift patterns they do not have the demands and needs of flexibility for on-calls that a case loading team of midwives would have.
3.9.2	RWT presently have COfC teams in place that are delivering on all 3 elements of the maternity pathway. Outcome data from the COfC models have proven to be positive thus far, specifically surrounding the national ambition of reducing term admissions to Neonatal Unit, improving skin to skin rates in theatre, breast feeding initiation rates, immediate postnatal management and enhanced recovery for women on an elective Caesarean section care pathway.
3.9.3	In order to work towards meeting the national trajectories further work is required to increase continuity teams. Presently RWT is introducing team midwifery across the community midwifery service and Midwifery Led Unit. This is achievable without the requirement to increase midwifery establishments, however may require some ‘double running’ costs as midwifery teams enhance their midwifery skills within the community and intrapartum settings.
3.9.4	This newly implemented midwifery staffing model is presently being piloted and a further update with regards to progress will be given to Trust board in the Summer of 2020.
3.9.5	It has also been acknowledged by the national team at NHSE that as an LMS total midwifery establishments are not meeting BR+ recommendations in order to deliver on the proposed staffing models. Therefore this risk has been accepted onto LMS and local risk registers. **NHS Resolution; Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.**
4.0	NHS resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme to continue to support delivery of safer maternity care.
4.1	The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of CNST. As in year 2 members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity inactive fund.
4.2	The scheme incentivises 10 maternity safety actions. If Trusts can demonstrate that they have achieved all 10 of the safety actions will recover the element of their contribution relating to CNST incentive fund and will also receive a share of any unallocated funds.
4.3	

	Trusts that do not meet the 10/10 threshold will not recover their contribution but may be eligible for a small discretionary payment to help support actions that they may not have achieved.
4.4	RWT demonstrated that in 2019 they fully achieved all of the 10 safety actions recommended within the Maternity incentive scheme. This means that RWT were fully compliant with each safety action and that NHS resolution were satisfied with the Trust Board sign off of the evidence
4.5	provided to achieve their contribution. RWT were therefore recovered the full element of their contribution related to the CNST incentive fund but also an additional share of unallocated funds. RWT maternity services have commenced working towards year 3 safety actions. Further updates regarding compliance with each safety action will be given to Trust Board in due course.
4.6	

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Health Scrutiny Panel
6th March 2020

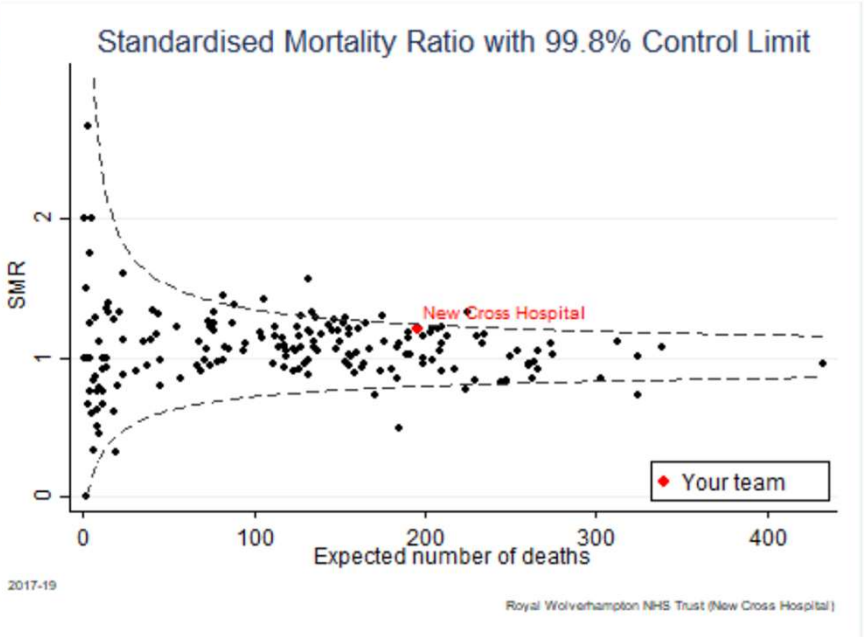
- Dr Soumya Ramachandra – Stroke Consultant
- Rachael Jones – Stroke Advanced Nurse Practitioner
- David Bailey – Group Manager

1/3 Identified Areas of Concern

Poor Performance on SSNAP

SSNAP score	D	
Case ascertainment	A:90%+	
Audit compliance	B:80-89%	
Total KI Score	D	D
D1:Scanning	D	D
D2:Stroke Unit	D	D
D3:Thrombolysis	D	D
D4:Specialist Assessments	C	D
D5:Occupational Therapy	C	D
D6:Physiotherapy	B	B
D7:Speech and Language	D	E
D8:Multidisciplinary team working	D	B
D9:Standards by Discharge	E	E
D10:Discharge Process	B	C

SMR on SSNAP Close to Being an Outlier



2/3 Improvements – Planned and Underway

- Overall Responsiveness:
  - Clinician response time,
  - Scans (CT and CTA),
  - Direct to ward admissions (incorporating discharge effectiveness), and
  - Assessments.

- Infrastructure and Support:
  - Paperwork re-design (efficiency and usability),
  - Training,
  - Establishing a middle tier of Doctors,
  - 7 day a week overnight on-calls, and
  - Data accuracy and completeness,

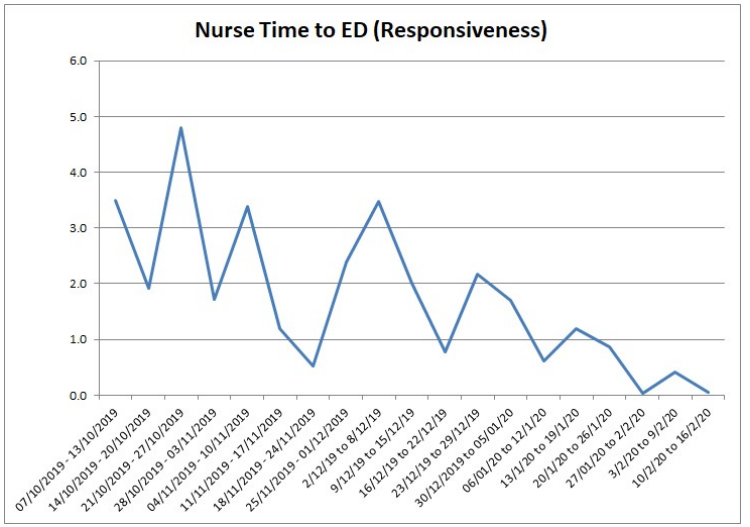
- Mortality specific:
  - Depth of coding, especially out- of- area,
  - External review requests,
  - Improvement of medical notes on RIP, and
  - Review of all Stroke deaths, not just on C21.

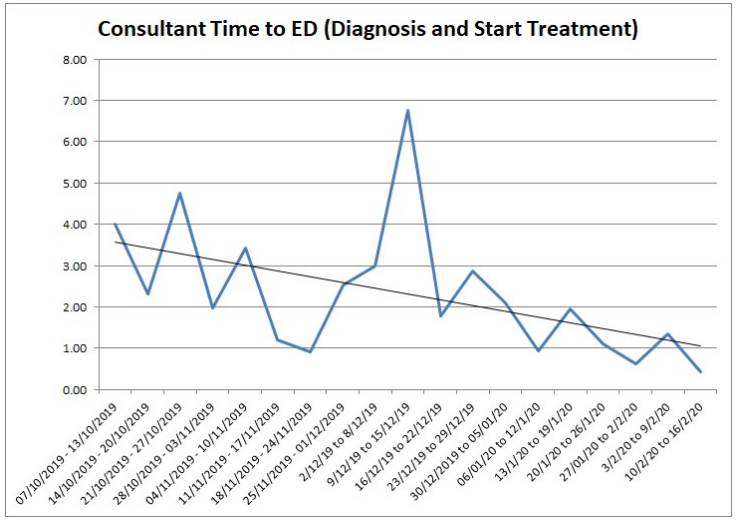
3/3 Performance Against Concerns

(Estimated) SSNAP Improved

	Actual Q2	Estimate Q3	Running Q4
Domain 1	B	A	A
Domain 2	D	C	C
Domain 3	E	D	C
Domain 4	B	A	A
Domain 5	C	B	B
Domain 6	C	B	B
Domain 7	C	D	C
Domain 8	D	A	B
Domain 9	D	B	A
Domain 10	A	A	A
Overall	**D**	**C**	**B**

Key Metrics Improving





		Actual Q2	Estimate Q3	Running Q4
Patients:	142	B	A	A
SSNAP KI Indicator 1.1 - Proportion of patients scanned within 1 hour of clock start:	50.00 %			
SSNAP KI Indicator 1.2 - Proportion of patients scanned within 12 hours of clock start:	97.66 %			
SSNAP KI Indicator 1.3 - Median time between clock start and scan (minutes):	59			
Patients:	142	D	C	B
SSNAP KI Indicator 2.1 - Proportion of patients directly admitted to a stroke unit within 4 hours of clock start:	57.03%			
SSNAP KI Indicator 2.2 - Median time between clock start and arrival on stroke unit (minutes):	206			
SSNAP KI Indicator 2.3 - Proportion of patients who spent at least 90% of their stay on stroke unit:	88.24%			
Patients:	142	E	D	D
SSNAP KI Indicator 3.1 - Proportion of all stroke patients given thrombolysis (all stroke types):	11.86%			
SSNAP KI Indicator 3.2 - Proportion of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis:	85.71%			
SSNAP KI Indicator 3.3 - Proportion of thrombolysed patients given it within 1 hour of clock start:	30.77 %			
SSNAP KI Indicator 3.4 - Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ("no but") for why it could not be given:	48.72%			
SSNAP KI Indicator 3.5 - Median time between clock start and thrombolysis (minutes):	65			
Patients:	142	B	A	A
SSNAP KI Indicator 4.1 - Proportion of patients assessed by a stroke specialist consultant physician within 14h of clock start:	94.44%			
SSNAP KI Indicator 4.2 - Median time between clock start and being assessed by stroke consultant (minutes):	99			
SSNAP KI Indicator 4.3 - Proportion of patients who were assessed by a nurse trained in stroke management within 24h of clock start:	95.92%			
SSNAP KI Indicator 4.4 - Median time between clock start and being assessed by stroke nurse (minutes):	60			
SSNAP KI Indicator 4.5 - Proportion of applicable patients who were given a swallow screen within 4h of clock start:	76.99%			
SSNAP KI Indicator 4.6 - Proportion of applicable patients who were given a formal swallow assessment within 72h of clock start:	82.76%			
Patients:	142	C	B	A
SSNAP KI Indicator 5.1 - Proportion of patients reported as requiring occupational therapy:	96.21 %			
SSNAP KI Indicator 5.2 - Median number of minutes per day on which occupational therapy is received:	30			
SSNAP KI Indicator 5.3 - Median percentage of a patient's days as an inpatient on which occupational therapy is received:	76.94 %			
SSNAP KI Indicator 5.4 - Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (Target = 45 minutes x (5/7) x 0.8 which is 45 minutes of occupational therapy x 5 out of 7 days per week x 80% of patients) (NICE QS Statement 7):	72.28 %			

Patients:	142	C	B	A
SSNAP KI Indicator 6.1 - Proportion of patients reported as requiring physiotherapy:	96.99 %			
SSNAP KI Indicator 6.2 - Median number of minutes per day on which physiotherapy is received:	28			
SSNAP KI Indicator 6.3 - Median percentage of a patient's days as an inpatient on which physiotherapy is received:	87.21 %			
SSNAP KI Indicator 6.4 - Compliance (%) against the therapy target of an average of 27.3 minutes of physiotherapy across all patients (Target = 45 minutes x (5/7) x 0.85 which is 45 minutes of physiotherapy x 5 out of 7 days per week x 85% of patients) (NICE QS Statement 7):	78.51 %			
Patients:	142	C	D	B
SSNAP KI Indicator 7.1 - Proportion of patients reported as requiring speech and language therapy:	75.70 %			
SSNAP KI Indicator 7.2 - Median number of minutes per day on which speech and language therapy is received:	30			
SSNAP KI Indicator 7.3 - Median percentage of a patient's days as an inpatient on which speech and language therapy is received:	51.68 %			
SSNAP KI Indicator 7.4 - Compliance (%) against the therapy target of an average of 16.1 minutes of speech and language therapy across all patients (Target = 45 minutes x (5/7) x 0.5 which is 45 minutes of speech and language therapy x 5 out of 7 days per week x 50% of patients) (NICE QS Statement 7):	77.35 %			
Patients:	142	D	A	B
SSNAP KI Indicator 8.1 - Proportion of applicable patients who were assessed by an occupational therapist within 72h of clock start:	100.00 %			
SSNAP KI Indicator 8.2 - Median time between clock start and being assessed by occupational therapist (minutes):	1230			
SSNAP KI Indicator 8.3 - Proportion of applicable patients who were assessed by a physiotherapist within 72h of clock start:	100.00 %			
SSNAP KI Indicator 8.4 - Median time between clock start and being assessed by physiotherapist (minutes):	1222			
SSNAP KI Indicator 8.5 - Proportion of applicable patients who were assessed by a speech and language therapist within 72h of clock start:	84.62 %			
SSNAP KI Indicator 8.6 - Median time between clock start and being assessed by speech and language therapist (minutes):	1442			
SSNAP KI Indicator 8.7 - Proportion of patients who have rehabilitation goals agreed within 5 days of clock start:	100.00 %			
SSNAP KI Indicator 8.8 - Proportion of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days:	100.00 %			
Patients:	142	D	B	A
SSNAP KI Indicator 9.1 - Proportion of applicable patients seen by a dietitian by discharge:	75.00 %			
SSNAP KI Indicator 9.2 - Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start:	85.71 %			
SSNAP KI Indicator 9.3 - Proportion of applicable patients who have mood and cognition screening by discharge:	96.61 %			
Patients:	142	A	A	A
SSNAP KI Indicator 10.1 - Proportion of applicable patients receiving a joint health and social care plan on discharge:	95.59 %			
SSNAP KI Indicator 10.2 - Proportion of patients supported by a stroke skilled Early Supported Discharge team:	61.76 %			
SSNAP KI Indicator 10.3 - Proportion of patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation:	100.00 %			
SSNAP KI Indicator 10.4 - Proportion of those patients who are discharged alive who are given a named person to contact after discharge:	97.06 %			

The Royal Wolverhampton NHS Trust

Agenda Item No: 9

Health Scrutiny Panel

Report title:	Update on Mortality Agenda at RWT: 5th March 2020
Report of:	Dr Jonathan Odum, Medical Director
Portfolio	Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

Note the report

1.0 Introduction

1.1 The Trust has reported a position of elevated standardised mortality ratio. This paper reports the recent improvement in the mortality metrics and presents the work that has been being undertaken in the last year to scrutinise and act upon the potential causes for the outlier status of the Standardised Hospital Mortality Index (SHMI) indicator. The Trust board has been reassured through data analysis that the increased SHMI is not an indicator of avoidable mortality. However, work continues to review and where possible, enhance quality of care provision across admission pathways with elevated SMR's.

Work also continues to address coding and data capture with respect to accuracy and quality of completeness.

This report provides an update on the impact of these initiatives so far and describes future work envisaged.

2.0 Background

2.1 Trust Mortality rate

The Standardised Hospital Mortality Index (SHMI) is the most commonly used indicator to compare the number of deaths in the Trust with the number expected on the basis of average England figures, taking particular characteristics e.g. age profile into account. The score includes the deaths in hospital as well as those that occur within 30 days of discharge over a rolling year. As previously described (presentation to Health Scrutiny Panel February 2019), there are limitations to the measurement, for instance the index does not take deprivation of the population into account or severity of illness at the time of hospital admission. Nevertheless a high score should act as a smoke alarm and an opportunity to scrutinise all aspects of work within the trust that could contribute to the mortality rate.

2.2 The Trust has seen a SHMI score that has been an outlier since the reporting period April '16 - March '17. At its peak the SHMI was 1.22, but since reporting period April '18 to March '19, the trend has seen an improvement, so that the latest position shows a score of 1.097(categorised as 'as expected', within the control limit), October '18 to September '19 (Fig 1& Fig 2).

Fig. 1 RWT SHMI Trend

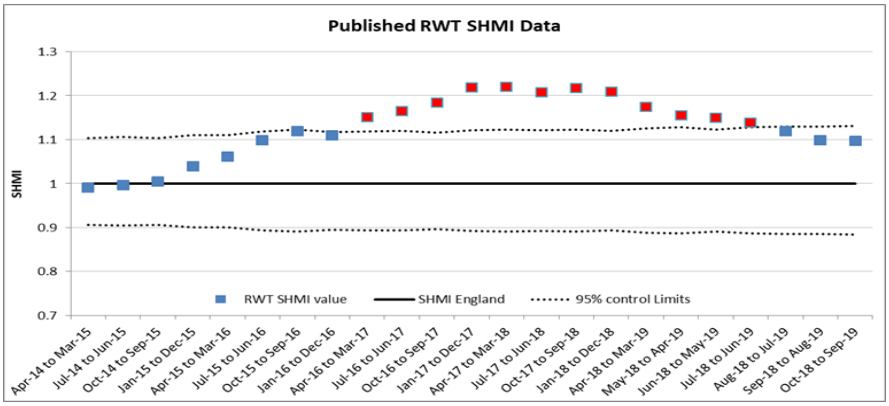
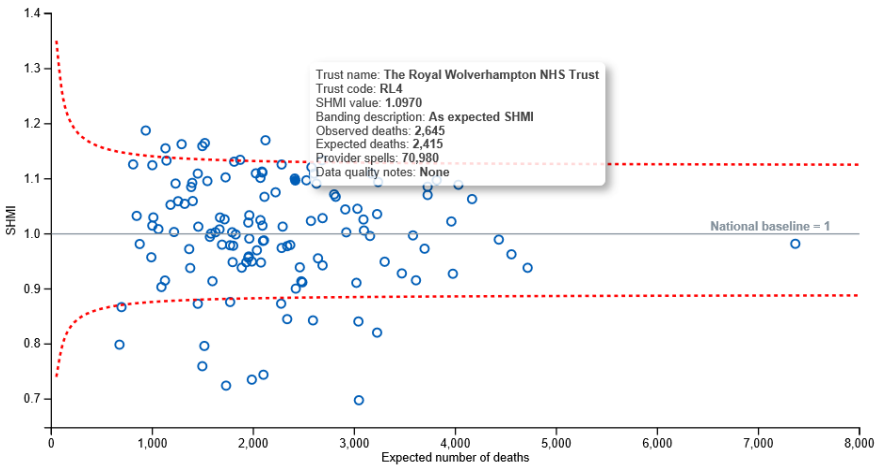
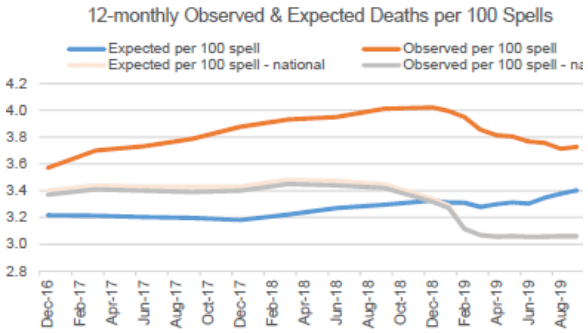


Fig. 2 Funnel plot comparing RWT SHMI with other English Trusts



The change in SHMI score has coincided with a reduction in observed deaths and an increase in expected deaths bringing the two metrics closer in line (Fig 3). The score when the two lines converge will be 1.0

Fig. 3 Observed and Expected Deaths at RWT compared to national average.



The Trust crude mortality rate has shown the same pattern, a rise in 2017/18 and now a decreasing trend, Table 1

Table 1 Trust crude mortality rate (inpatients only)

Period	No of Ordinary Discharges	No of Inpatient Deaths	Crude Mortality
2015/16	68888	1908	2.77%
2016/17	69538	1914	2.75%
2017/18	67758	2078	3.07%
2018/19	69558	2004	2.88%
2019/20*	59910	1564	2.61%

*part year April 2019-Jan 2020

2.3 The Trust has a programme of work designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon, gaps in quality of documentation are identified and corrected and systems of care provision are developed to the benefit of individual patients and the wider population. This programme of work has developed over the last 12 months and includes;

- Scrutiny and review of deaths in hospital (the medical examiner process)
- Focus on specific diagnostic groups including assurance of clinical pathways
- Quality of coding and documentation
- Learning from deaths including listening to the bereaved
- Provision of end of life care in patient's homes and care homes with an emphasis on admission avoidance where appropriate
- External Review

The work programme in each of these areas is discussed.

2.3.1 Scrutiny and review of deaths in hospital

In January 2019 the Trust was one of the first organisations in the country to introduce the role of the medical examiner (ME). A description of this service was provided to the Health Scrutiny Panel in November 2019. In summary the purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate referral of deaths to the coroner
- Provide an opportunity for the bereaved to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification

Scrutiny: The introduction of the ME role has meant that over 50% of in hospital deaths are scrutinised by an independent medical colleague within days of the death (Table 2). The aim is to achieve scrutiny in over 90% of cases. The current obstacles to achieving this target include vacancies on the ME rota and variable use of the process by directorates. From January 2020 an additional 4 sessions of ME time has been recruited to, with the expectation that these will be in post and start to make an impact from March 2020. The lead ME has started a series of education sessions with clinical staff.

Table 2 Scrutiny and review of deaths

Period	% of total deaths scrutinised by Medical Examiners	% of total deaths referred for further review (from July 19 to Mortality Reviewers)
January-March 2019	43.8%	15.9%
April to June 2019	59.5%	20.7%
July to Sept 2019	53.5%	16.5%
October to Dec 2019	53.6%	17.1%

Review: The Trust's policy, in line with national guidance, is that where potential areas of concern with care are picked up at scrutiny, the Medical Examiners refers cases on for more detailed review and from July '19 this was to a team of mortality reviewers. This process is called a Structured Judgement Review (SJR) and is a standard national process. SJR reviews will include cases where relatives have raised issues as well as a group of conditions were mandatory referral is required i.e. patients who die following an elective procedure, patients with specific mental health conditions and those with learning disabilities. In addition to the mandated criteria, a random selection of 10% of cases are also chosen for review.

The SJR process reviews against standards of care and scores from very poor to excellent across five stages. These reviews allow the organisation to record both good and poor practice. During 2019, 497 cases had been reviewed (reported at 16th January 2020). 32 cases were judged to have had some deficiencies in care and 40 cases were judged to have had excellent care.

Areas of poor practice are usually related to quality of care and have not affected the clinical outcome.

In cases where there had been some deficiencies in care recognised, opportunities for improvements in care have been identified:

- Recognition of deterioration in patient condition
- Compliance with clinical guidance
- Lack of evidence of use of formal end of life documentation
- Delay in investigations
- Improvement in communication with relatives

This system sits alongside the existing 'serious untoward incident' (SUI) process where cases that are identified by the team involved in the care or following family complaint are referred for route cause analysis (RCA). The RCA lead will complete a 'determination of mortality due to problems in care assessment'. This assessment is reviewed alongside an executive team for confirmation and agreement of action plan.

Following RCAs that have been completed for the period of Q4 18/19 to Q2 19/20 4 cases were identified where there was a 50% or more likelihood that care, or omission in care contributed to the death of the patient. Each of these cases are subject to robust action planning including local and trust wide improvement plans.

2.3.2 Focus on specific diagnostic groups

During 2019, in response to alerts of high SHMI for specific diagnostic groups, the Trust reviewed a cohort of cases and clinical pathways related to the following:

- Cerebrovascular disease (CVD)
- Pneumonia
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Renal Disease
- Sepsis
- Senility and organic mental health disorders
- Iron deficiency and other anaemia
- Skin and subcutaneous tissue infections

There was specific learning in each diagnostic group, for example improvement required in time to antibiotic from identification (sepsis) and improvement in timeliness of referral for non-invasive ventilation (COPD) but common themes included:

- Requirement for improvement in quality of documentation that would support correct labelling of primary diagnosis
- Requirement to improve recording of co-morbidities
- Requirement for improved support for patients to allow end of life care to occur in their own homes (or nursing homes) rather than reliance on admission to hospital

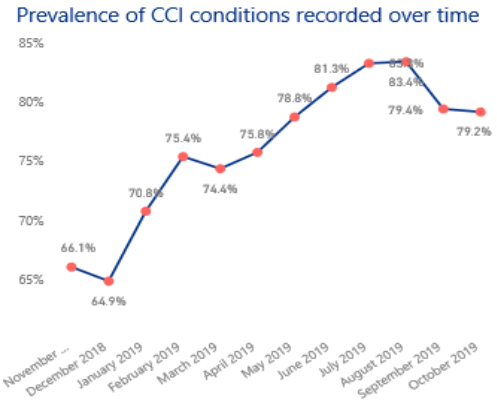
- Quality improvement programmes have been commenced across the organisation with positive outcomes seen in the areas of sepsis, pneumonia, and CVD. There is also quality improvement work with acute kidney injury and congestive heart failure to improve services for patients.

2.3.3 Quality of coding and documentation

It is important that the clinical data documented throughout a patients stay in hospital, and particularly at admission, is accurate and complete as this data feeds the algorithm which produces the deaths that are expected within the trust over a given period and this in turn affects the SHMI. The Trust has previously demonstrated that the depth of coding produced was good but that specific morbidly scores (Charlson comorbidity) were not captured as completely as required. This has led to a number of initiatives including redesign of the trust coding protocol, education of clinicians, regular meetings between coding and emergency portal clinical teams and retrospective case note review.

The effect has been to improve the Charlson comorbidity capture, see Fig 4

Fig. 4 Increase in Charlson Comorbidity (CCI) conditions at RWT



This along with other coding initiatives has served to more accurately describe the mortality risk of patients at admission and has contributed to the increase in the expected deaths with the subsequent impact on SHMI. Works continues to maintain this level of accuracy in an efficient and timely fashion.

2.3.4 Learning from Deaths including engagement with families

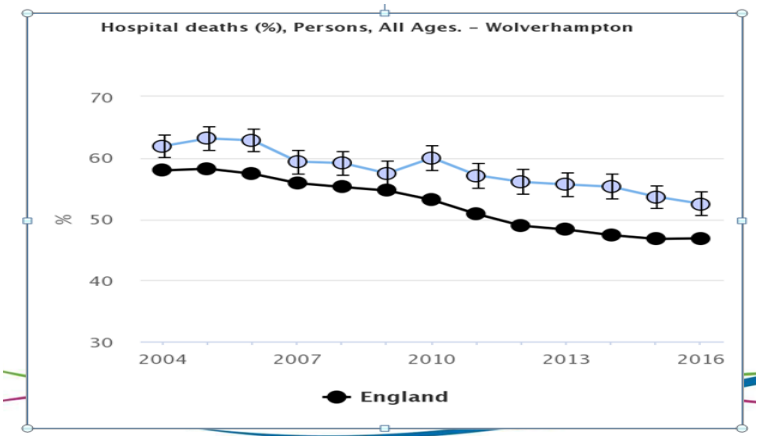
Through the medical examiner process the Trust is now proactively speaking with families within days of bereavement to hear their experience of care provided to their loved ones. For instance during the period September to December 2019, 226 families were contacted from the Bereavement Centre. Most families appear to be grateful for this contact and see it as a positive care initiative. 12 of these families were supported by PALs to discuss the care provided with the clinical specialties. The discussions will have included requests for clarity about treatment as well as potential concerns in care. The opportunity for improvement continues to be that of improving communication between Trust staff and families or patients.

2.3.5 Provision of end of life care in community settings

The Trust has previously reported that more people die in hospital in Wolverhampton than the national England average, see Fig 5, source Public Health England.

In 2018, 52.5% of the population died in hospital compared to the national average of 45.4% and West Midland 48.1%. The greatest contributor to this difference between Wolverhampton and national rates, being the number of patients that die in care homes (19% vs 22.5%) and hospice (4.0% vs 5.9%).

Fig. 5 Percentage of hospital deaths occurring in hospital compared to England 2004-2016



A variety of initiatives have been initiated between RWT community teams, Wolverhampton CCG and other community providers e.g. Compton Care and nursing homes, in an attempt to support an increase in use of advanced care planning with the intention of avoiding admission to hospital for end of life care. We intend to measure the impact of ongoing interventions working collaboratively with our partners (Wolverhampton CCG and Public Health).

2.3.6 External Review

Throughout the last year the Trust has used external, independent review and opinion to assure the board of the progress against this agenda. This includes:

- Working with a senior surgeon in the NHS who has held a range of management and leadership posts including Royal College of Surgeons Director for Professional Affairs, Medical Director at West Midlands Strategic Health Authority, and Deputy Medical Director at NHS Improvement. As a result, he had wide experience in clinical governance, patient safety, medical leadership, and medical engagement. He held a yearlong post at RWT, acting as reviewer of clinical pathway delivery across the organisation, recommending areas for change including quality improvement methodology and provided mentorship for clinical and medical leads. He reported regularly to the board.

- Working with Price Waterhouse Cooper, who have reviewed the data collection systems, identified areas for change and now provide intelligence with their predictive models to identify potential data quality issues on a case by case basis.
- Regular submission of review of alerting diagnostic groups to CQC when requested.
- Audit of Learning from death processes via Trust auditors Grant Thornton UK

2.4 Future work

2.4.1 Monitoring of SHMI

Through its predictive modelling work with PWC the Trust believes that the SHMI will continue to fall towards the figure of 1.0 during 2020. Nevertheless the Trust will continue to monitor the mortality rates in specific diagnostic groups and where a rising trend is seen will instigate case note and clinical pathway review. The Trust is also committed to continuing the quality improvement methodology that it started in 2019.

2.4.2 End of Life Care

As described above provision of end of life care in community settings rather than in hospital has been a constant theme in case note reviews and we know that Wolverhampton is an outlier compared to other English CCGs. Through the ICA the partners will continue to develop the ongoing work in an effort to identify and provide services for those people at the end of life and in their preferred place of care

2.4.3 Review of Out-of-Hospital Deaths

Most primary care providers currently review the care of patients who subsequently die in their population. However there is no systematic methodology which allows for recording of outcome or learning across organisations. The Trust has begun discussion across the Primary Care Networks and will pilot a system in the RWT primary care practices during 2020.

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		☐
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

Please detail any known implications in relation to this report:

None identified

6.0 Schedule of background papers

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

Dr Jonathan Odum
Medical Director
Royal Wolverhampton NHS Trust
Direct line 01902 695898
jonathan.odum@nhs.net

Further information can be found at https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

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Scrutiny Work Programme

Health Scrutiny Panel

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

All functions of the Council contained in the National Health Service Act 2006, the Local Authority (Public Heath, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations") - which came into force on 1st April 2013, the Health and Social Care Act 2012 and related regulations.

- 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	Notes
5 March 2020	• Mortality Statistics	Royal Wolverhampton NHS Trust	Non-Executive Director to be invited.
	• Patient Participation Groups		Invite two or three PPG groups to the Panel.
	• Cancer Screening	Royal Wolverhampton NHS Trust / Public Health	Presentation will be given.
	• Maternity Services – Quality Assurance	Royal Wolverhampton NHS Trust	Invite Midwives. Show DVD.
	• Reconfiguration of hyper acute and acute stroke services	CCG / Royal Wolverhampton NHS Trust	

Potential Future Items: -

1. Black Country Partnership NHS Foundation Trust Merger – Possible an informal meeting will be arranged
2. June 2020 – Review of the new Patient Experience, Engagement and Public Involvement Strategy.
3. Healthy Child Programme
4. Independent Reconfiguration Panel – Briefing Note about the process
5. Blakenhall Dementia Day Services (Tom Denham is contact point)
6. West Midlands Ambulance - To address priorities identified in the Quality accounts and in particularly those on Maternity Care in the pre-hospital environment.
7. Unions – On particular matters
8. CQC Report on RWT – First meeting in the new Municipal year (Report was published in mid-February)
9. Pharmaceutical Ordering

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