CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 21 March 2019

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Sheila Gill
Cllr Jasbir Jaspal (Chair)
Cllr Milkinderpal Jaspal
Cllr Asha Mattu
Cllr Susan Roberts MBE
Dana Tooby
Cllr Martin Waite

Witnesses
David Loughton CBE (Chief Executive – Royal Wolverhampton NHS Trust)
Sarah Treadwell-Baker (Action Hearing Loss)
Stephen Marshall (Director of Strategy and Transformation – CCG)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
David Watts (Director of Adult Services)
Dr. Ankush Mittal (Consultant in Public Health)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Cllr Paul Singh and Tracey Cresswell.

2 **Declarations of Interest**
Cllr Susan Roberts declared an interest on item 5 – Cancer Services, as her husband was currently undergoing cancer treatment at the Newcross Hospital.

3 **Minutes of previous meeting**
The minutes of the meeting held on 24 January 2019 were confirmed as a correct record.

4 **Matters Arising**

The Chair asked for an update on the progress of the new car parking at the Newcross Hospital. The Chief Executive of the Royal Wolverhampton NHS Trust responded that work would commence on the drainage and electricity infrastructure for the new car park in two weeks' time. The major works would commence at the end of June during the school holidays, when there would be less demand on parking. A Member of the Panel asked if there would be a Bike Share docking station at the hospital. The Chief Executive of the Royal Wolverhampton NHS Trust responded that he had learnt about the initiative that morning. He had asked his staff to enquire further about the project. He was trying to encourage more of the staff at the Trust to use public transport.

A Member of the Panel commented that he had received reports that some Royal Wolverhampton NHS Trust staff had been abusive to residents on Victoria Road, Vicarage Road and other nearby roads over car parking issues. It was alleged that some staff members had been parking inconsiderately and blocking residents in their drives. He requested that the Chief Executive write to all Trust staff about the matter. The Chief Executive of the Trust responded that he would ask his security staff to carry out some patrols of the named streets and if number plates were supplied to him, he would be able to identify the staff members.

The Chair asked if there had been any developments regarding the pension cap tax limit. The Chief Executive of the Royal Wolverhampton NHS Trust responded that he had raised the issue again at a national level. It was clear that the NHS were being hit harder than any other public body. Consultants were leaving the Trust, some of which he regarded as irreplaceable, citing the example of a dementia specialist consultant who had recently left the Trust.

The Chair paid tribute to the work of Jeremy Vanes, Chairman of the Royal Wolverhampton NHS Trust, who was stepping down from the role at the end of the month. She would be sending a letter to him on behalf of the Health Scrutiny Panel. The Chief Executive of the Royal Wolverhampton NHS Trust commented that Mr Vanes would be taking up a position as Chief Executive of the Citizens Advice Bureau in Warwickshire. The new Chairman of the Trust's Board would be Professor Steve Field CBE, which he believed to be an excellent appointment.

5 **Cancer Services**

The Chief Executive of the Royal Wolverhampton NHS Trust stated that in his capacity as Chairman of the West Midland's Cancer Alliance he had been asked to attend a meeting with the Health Minister later that day about the deteriorating position nationally. The 62 day cancer target had not been hit since December 2015. The Trust was in a difficult position, particularly in relation to some of the specialist services it offered and in robotic surgery. The Queen Elizabeth and Heartlands Hospital in Birmingham were not fully utilising their robot. The robot at Newcross Hospital in Wolverhampton was virtually at full capacity. Some patients chose to wait longer for treatment, breaching the time standards themselves, so they could be operated on by a robot, rather than conventional surgery.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that a particular issue at the present time was late tertiary referrals. 66% of tertiary referrals

from the Black Country and beyond were coming in late. Late was defined by the national cancer waiting times as being received after 38 days. The fact that so many tertiary referrals were being received late meant it was increasingly difficult to meet the 62 day target. The recovery action plan had originally been based on average referrals into the Trust of 1380 per month. The figure had remained static for both 2016/17 and 2017/18. For 2018/19 referrals had been averaging in excess of 1550 per month. He did not believe that the numbers had reached a high peak and would fall down to previous levels. The high number of referrals were causing physical capacity issues both with the machines and lack of staff to cope with the demand. He believed that many of the staffing problems were down to not enough doctors being trained nationally over the last 15 years. The pension tax cap also deterred some consultant medical staff from working overtime.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that there was a particular concern about the spike in referrals at speciality level. The Breast Service had capacity to see 340 patients per month and ran additional lists at weekends to support short term increases. This model had been sustainable in the past. Referrals had reached 500 in the months of October, November and January. Some positive news was that the five year survival rate for breast cancer was very good and was levelling up to European partners.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that the mobile machines the Trust were using were only operating at 60% efficiency. They were costing £100,000 a week to run. He required £14 million in capital funding for two static MRI machines. There was a huge problem with capital in the NHS, he had raised it with the Health Minister. He had outsourced all non-cancer MRI work, to free up capacity for cancer services. He cited as an example a person needing an MRI scan for their back, which would now be done at the Nuffield. The Trust was using all of the available capacity in the private sector. There were certain limitations to what the private sector could do as they did not have the intensive care back up facilities. He was not prepared to send scan results oversees because the quality of work was not up to the high standard he expected, when it had been used in the past. 2,500 more doctors were in training, but it would take 12 years for this to have full effect. The Scrutiny Officer asked about the financial impact of having to use the private sector for scans. The Chief Executive of the Trust responded that the Trust was going to be £10 million in deficit at the end of the year, the Trust had not had a deficit in ten years.

A Member of the Panel commented that she had been displeased with her husband's standard of recent cancer treatment at Newcross Hospital. Not knowing the appointment times long enough in advance had been particularly problematic. Whilst accepting that the staff were working hard, she was critical of the communication between them. The Chief Executive of the Royal Wolverhampton NHS Trust advised her to contact the Patient Advice Liaison Service (PALS) with any specific complaints. Overall scheduling within cancer treatment services would improve in the next three weeks, after the service had received their new linear accelerator.

A Member of the Panel asked about patient pathways and at what stage they were informed about their life prospects. Her concern was to ensure that patients received the right level of support at the appropriate time. The Chief Executive of the Royal Wolverhampton NHS Trust commented that processes would vary depending on the nature of the cancer and the patient. He suggested that Healthwatch representatives

should come into the Trust to talk to the staff working in cancer treatment services about pathways and support. The Panel requested that Healthwatch report back to the Panel, the information they obtained from the visit. The Chief Executive commented that it was important to be mindful of the heavy workload and pressures staff were under. Asking staff to continuously work overtime did not improve the service or communication, as efficiency would decrease.

The Consultant in Public Health remarked that Public Health were aiming to increase the number of people undertaking cancer screening in the City. The uptake of screening in Wolverhampton was low compared to other areas in the West Midlands. There was a risk of putting even more pressure on cancer pathways, however this risk was outweighed by the fact that early diagnosis gave better outcomes for the patient and generally reduced overall treatment costs. There was no doubt that prevention was better than cure. The Chief Executive agreed with the Consultant in Public Health's analysis. There were some hard to reach people in some of the communities in Wolverhampton, who were presenting late with cancer symptoms and consequently had poorer outcomes.

A Member of the Panel raised the point that the publicity about the importance of bowel screening needed to be improved. The Consultant in Public Health reported that the NHS were changing bowel cancer screening to a single sample test, which he hoped would improve the uptake. The Chief Executive of the Royal Wolverhampton Trust stated that the Trust working collaboratively with Public Health needed to increase their efforts to improve cancer screening throughout the City. There needed to be a hard-hitting message. He suggested that there should be a new effort in about three months' time, after he had put some more resources in place in cancer services. He was acutely aware that Public Health had received significant cuts to their resources, which made it harder for there to be people pushing the message in communities. The later people presented with cancer symptoms the more it cost the NHS. Investment in cancer screening would change the financial profile of the NHS in the future. The Consultant in Public Health agreed that there had been a reduction in their resources, but they did have an absolute resolve to improve cancer screening. He was pleased that the Trust wanted to work with them to improve cancer screening rates, as it was an absolute priority for Public Health. A Member of the Panel commented that cultural attitudes towards cancer screening needed to change to improve uptake. The Director for Strategy and Transformation at the CCG commented that at a care home in Germany he had previously worked at, it had been a requirement to record the stools of the residents each day.

The Director of Strategy and Transformation of the CCG stipulated that the referral rate from the primary sector had increased into cancer services, particularly for breast cancer. He was happy to confirm that there was nothing to suggest that these had been inappropriate referrals. The Chief Executive of the Royal Wolverhampton NHS Trust also confirmed that the referral rate had increased, which coincided with the confirmed cancer diagnosis rate, proving that they were not inappropriate referrals.

6 **Mortality and Learning from Deaths in Wolverhampton Update**

The Chief Executive of the Royal Wolverhampton NHS Trust presented a report on mortality and learning from deaths in Wolverhampton. A phenomenal amount of work had taken place in conjunction with Public Health on the area of mortality and in part the situation was improving. Deaths relating to alcohol were particularly high in Wolverhampton and this had been a persistent theme for many years. Smoking related illness over time would decrease, which they were already starting to observe. The Trust had not gamed the clinical coding system to drive their income. Improvements had been made to the coding of co-mobilities, the Trust had been an outlier but were now coming into line.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that he was particularly proud of the implementation of the Medical Examiners at the Trust. Deaths were now investigated by someone who had not had any involvement with the patient. A new Bereavement Centre had also been established at the Newcross Hospital. He had received many thank you letters from bereaved families, complimenting the Trust for the way they had received information on the death of their loved one. This had been one of the real benefits of the new method of working.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that there had only been three cases at the Trust where care had been less than satisfactory. This was proportionately what would be expected when analysing the published literature on mortality at hospitals. There was a city-wide work programme, with Sally Roberts at the CCG trying to replicate the work that she had completed at Walsall in the care homes. Too high a proportion of people died in hospital in the Wolverhampton area, when it would have been more suitable for them to have died in a care home or at home. In Shropshire the numbers were half that of the Wolverhampton area. He wanted people to have dignity in death and it was important for suitably trained Trust staff to have the difficult conversations with family members about end of life care.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that they had identified with the GP practices that the Trust worked with, all the people that were assumed to be in the last twelve months of their life. He was using his transplant co-ordinators to train staff in primary care about having difficult conversations. Proper end of life care plans needed to be put in place for each person to ensure that they didn't spend their last hours unnecessarily in hospital. Families expectations needed to be appropriately managed. A Member of the Panel asked if there were any timescales for the "dignity in death" proposals. The Chief Executive of the Royal Wolverhampton NHS Trust responded that work was taking place but needed to progress faster. He was acutely aware that care homes were also facing enormous pressures in relation to their workforce capacity. They did not always have the rightly skilled people on shift when someone was close to death, which meant 999 was called unnecessarily. There had been some excellent infection prevention control work that had taken place in the nursing homes in the past.

The Director for Strategy and Transformation stated that there was a joint programme, which had been operating for the last few months, where primary and secondary care clinicians were working together to improve end of life care. An Epack solution had been agreed, where if a person had been flagged at being end of life, there would be a medical record to state they need to be treated in a different

way and not admitted to hospital unnecessarily. It had also been agreed that £400,000 in collaboration with the Trust, for investment in end of life community response had been set aside. A gold standard framework had been reinstituted, to ensure that patients recognised they were on a end of life care pathway and treated accordingly.

The Chair of Healthwatch asked for some further information on how the end of life care messages were being managed from a communication perspective. The good work taking place needed to be shared with the wider public. The Chief Executive of the Royal Wolverhampton NHS Trust offered to come back to her with further information in the future. It was obviously a sensitive subject and there had been some issues in Liverpool with end of life care communications. He wanted to ensure patients and families were fully informed before wider communications.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that on the issue of Brexit he was not overly concerned, the situation reminded him of the Millennium Bug. The most important part was to ensure the continuous supply of drugs. He understood the Government had made contingency plans in this area. The Trust was fortunate in that they were in a consortium with the Hospital Corporation of America for purchasing.

7 **Presentation from Voluntary Organisation - Action Hearing Loss**

Sarah Treadwell-Baker (Development Projects Manager) from Action Hearing Loss gave a presentation on the work of the charity. A copy of the presentation slides are attached to the signed minutes. The Chair, on behalf of the Panel, thanked her for the excellent presentation. The Consultant in Public Health commented that it was important to increase awareness of what was available for hearing tests, as there was no single national screening for all ages model. The third sector could play a valuable part in improving people's lives, particularly in the higher risk areas such as care homes. The Director for Adult Services welcomed any sort of screening programme as it was clear people disengaged more socially when their hearing was poor.

8 **Black Country Partnership NHS Foundation Trust - Draft Quality Accounts**

The Chair asked for any questions on the Black Country Partnership NHS Foundation Trust draft quality accounts to be submitted to the Scrutiny Officer by the middle of April. She intended to submit a written response on behalf of the Panel, which was required by 1 May 2019. The Chair of Healthwatch confirmed that they would also be submitting a response. She was concerned about the amount of time and resource that had been wasted over potential mergers. She was aware of a lack of support from CPNs (Community Psychiatric Nurses), difficulty in accessing appointments, problems in mental health in maternity and particularly postnatal support. They had a lot of intelligence about the lack of support for young people, some of which had stemmed from changes in contracts. She was particularly concerned about the waiting times and the links with GPs for referrals. She was aware of some young people, who unless were in immediate crisis, were waiting twelve months for an appointment.

The Director for Strategy and Transformation of the CCG stated that there was a spectrum of problems relating to young people's mental health, that were not all in the remit of the Black Country Partnership NHS Foundation Trust. There had been a reduction in non-statutory services in recent years, so it was important to fully

understand that some issues were not treated as a health problem and therefore did not fall within the remit of the Trust.

Resolved: That representatives from the Black Country Partnership NHS Trust be invited to a Special Informal Health Scrutiny Panel meeting to be held at a date to be confirmed in April 2019 at the Civic Centre.

9 **Brexit Update**

The Director for Adult Services – City of Wolverhampton Council and the Director for Strategy and Transformation of the CCG gave an update on the preparations their organisations were taking with reference to Brexit.

The Director for Adult Services commented that every Head of Service had been asked to produce business continuity plans, that had Brexit type issues. From an adult social care perspective the Council had used the same guidance which had been issued for health providers to frame their contingencies. Their biggest concern was the supply of medication. This was supposed to be being dealt with nationally by the NHS. There was not a high prevalence of EU workers in Wolverhampton and so uncertainties over EU workers status was not causing a large amount of concern. There was a regional resilience forum which was helping to co-ordinate preparations.

A Member of the Panel commented that the biggest concern members of the general public had was regarding access to medicines. It was important that a message of confidence was relayed to the public that preparations were in place.

10 **Work Plan**

Resolved: That the Health Scrutiny Work Programme be agreed.

The meeting closed at 3:30pm.