CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

21 March 2019

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

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

Membership

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

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

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**

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 Services** (Pages 13 - 18)
[To receive a report on Cancer Services from the Royal Wolverhampton NHS Trust].

6 **Mortality and Learning from Deaths in Wolverhampton Update** (Pages 19 - 40)
[To receive a presentation on Mortality and Learning from Deaths in Wolverhampton].

7 **Presentation from Voluntary Organisation - Action Hearing Loss**
[To receive a presentation from Sarah Treadwell-Baker from the Voluntary Organisation – Action Hearing Loss].

8 **Black Country Partnership NHS Foundation Trust - Draft Quality Accounts**
[Report is marked: To Follow]

9 **Brexit Update**
[To receive a verbal update on the preparations for Brexit from attendees].

10 **Work Plan** (Pages 41 - 44)
[To receive the Work Programme for the Health Scrutiny Panel].

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 24 January 2019

Agenda Item No: 3

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
Cllr Paul Singh (Vice-Chair)
Cllr Martin Waite

Witnesses
David Loughton (Chief Executive of the Royal Wolverhampton NHS Trust)
Steven Marshall (Director of Strategy and Transformation)
Alan Duffell (Director of Workforce Royal Wolverhampton NHS Trust)
Alison Dowling (Head of Patient Experience and Public Involvement)

Employees
Martin Stevens (Scrutiny Officer)
David Watts (Director of Adults)
Dr. Ankush Mittal (Consultant in Public Health)
Martyn Sargeant (Head of Public Service Reform)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Tracey Cresswell (Healthwatch) and Dana Tooby (Healthwatch).

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

3 **Minutes of Meetings**

The minutes of the meeting held on 23 October 2018 were confirmed as a correct record.

The minutes of the meeting held on 25 October 2018 were confirmed as a correct record.

The minutes of the meeting held on 15 November 2018 were confirmed as a correct record.

4 **Matters Arising**

A Member of the Panel asked for some timescales to be circulated by email in due course, in reference to the recommendations from the Special meeting held on the processes to be followed after death.

A Member of the Panel asked for the current status of the Medical Examiner Role. The Chief Executive of the Royal Wolverhampton NHS Trust confirmed that seven members of staff had been appointed and he was considering appointing an eighth.

A Member of the Panel asked the Chief Executive of the Royal Wolverhampton NHS Trust, if a timetable was available for the construction of the new car park at New Cross Hospital. The Chief Executive responded that he was unable to provide a timetable at the current time, funding for the contractor lined up to commence in April had yet to be finalised. He commented that car parking was the worst part of the patient experience at Newcross Hospital.

5 **Cancer Treatment Services**

The Chief Executive of the Royal Wolverhampton NHS Trust gave a verbal report on cancer treatment services at the Trust. He stated that the Trust had very significant problems. They used to have 1300 referrals for cancer a month but were now averaging 1800. They had received 600 referrals in the last ten days. He did not understand why there had been a sudden increase in the number, but he had people working on trying to analyse why. A rise in referrals normally correlated with a TV soap storyline but he was not aware of a cancer related storyline at the current time. The last ten days had probably put the Trust two months behind on the plan they had to recover their position. There had been a significant increase in the DNA (Did Not Attend) rate in the run up to Christmas and the DNA rate between Christmas and the New Year was substantial. His team were working extremely hard but could not deal with the volume of work.

The Chief Executive of the Royal Wolverhampton NHS Trust commented there were a lot of people electing to come to Wolverhampton to have robotic surgery. In his position as Chair of the West Midlands Cancer Alliance, he wanted to ensure the Queen Elizabeth Hospital Birmingham (QE) fully utilised their robot. Coventry and Stoke were using their robot at full capacity. There needed to be an overall strategy for robotic surgery, as there was no national strategy in place.

The Chief Executive of the Royal Wolverhampton NHS Trust stated the Trust was not equipped to be able to deal with the current volume of cancer referrals. They had

four mobile scanners on site because the fixed MRI (Magnetic Resonance Imaging) and CT (Computerised Tomography) scanners were being used to capacity. He was also utilising the capacity at the Nuffield but was still having to use two mobile MRI scanners and two mobile CT scanners. For patients having to use the mobile scanners, it was not a pleasant experience because they had to be pushed on a trolley across the car park in all weather conditions. The Trust was going to have to invest in at least another two MRI scanners and two CT scanners, but he did not have the capital.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that they had been visited by the National Medical Director of NHSI (National Health Service Improvement) who concluded that they had a major capacity problem. In addition, they had a significant problem with the centres who referred into the Trust, who were referring in late and with incomplete information. NHS Improvement had said they would assist with this problem, as the Trust had no jurisdiction over the centres. The Trust had outsourced significant amounts of endoscopy work. Whilst the Trust had an endoscopy room at Cannock Chase Hospital, he did not have the finances available to equip the facility.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that thirteen years ago the Government had been proud to announce that they had acquired 45 linear accelerators from the Heritage Lottery Fund. Approximately five years ago he had commenced lobbying people such as the Secretary of State to try to achieve the same outcome again. Unfortunately, his proposal had not been implemented. The Trust had been forced to replace the linear accelerators themselves at a cost of £24 million. To have the extra required fixed MRI and CT scanners would cost £10 million.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that there was a problem in the workforce for cancer treatment services, as the Trust was four Consultant Oncologists short. This staff shortage situation was not unique to Wolverhampton, it was a national problem. They were prioritising the patients to the best of their ability. He would ensure the Health Scrutiny Panel received a detailed report on cancer treatment services for the next meeting of the Panel. He also invited anyone on the Panel to contact him if they wished to visit Newcross Hospital's Cancer Treatment Services.

A Member of the Panel asked if the Chief Executive of the Royal Wolverhampton NHS Trust had any information on the capacity of cancer treatment services across the West Midlands. He responded that they had tried everywhere to re-route some of the work but had not achieved any success. All the National Tertiary Centres were in trouble. It was not just the levels of capacity of the scanners, but also the problem of having to have a Consultant available to interpret the results of the scan. He did not want to send scan results overseas due to bad experiences in the past. Nationally, some Consultants were leaving the NHS when they reached their Pension Cap tax limit. He felt the cap limit being reduced had caused an adverse effect of consultants leaving earlier than they would have otherwise. They were losing highly skilled staff with twenty years or more of experience. The introduction of IR35 (UK's anti-avoidance tax legislation) had meant he could not pay people through a limited company. Consequently, people would work for an agency who would then charge 30% more.

A Member of the Panel asked why people would wait longer to have robotic surgery. The Chief Executive of the Royal Wolverhampton NHS Trust responded that it was because the recovery time was much quicker. He cited the example of a hysterectomy, where a person could be expected to be back at work on average in two weeks if the surgery had been completed by a robot. He saw robotic surgery as the way forward in the future, it did however take a long time to train the surgeons. It would take a highly skilled surgeon, 18 months to two years to become competent.

A Member of the Panel paid praise to their recent experience of cancer treatment services at Newcross Hospital. They highlighted that the one area which needed improvement was the waiting time for the patient to receive the results, which she was told stood at 2-3 weeks. They praised the staff at the hospital for doing their best in difficult circumstances.

6 **Patient Advice and Liaison Service**

The Head of Patient Experience and Public Involvement at the Royal Wolverhampton NHS Trust presented a report on the Patient Advice and Liaison Service (PALS). The team had undergone a restructure in September 2017. The Trust's policy set the complaints completion to be within thirty working days, beyond that timeframe they had the ability to negotiate with the complainant for an extension. A considerable amount of work on the compliance rate had taken place at the Trust over the last three years, which used to stand at 63% but for almost the whole of the financial year now stood at 100%. All complaints that were received by the Trust were now triaged by the central complaints team. The volume of complaints stood at almost the same as the previous six months. There had been 205 complaints compared to the previous six months of 203. They reported to NHS Digital on a quarterly basis on how they were performing on their complaint outcomes. The national average for complaints upheld on NHS Digital stood at 33.6%, the Trust upheld rate was considerably lower.

The Head of Patient Experience and Public Involvement commented that they had introduced a new telephony system which had greatly assisted in the resolution of complaints. PALS Concerns had steadily reduced over the last two years and the first six months of 2018 had indicated a reduction in volume of 40% from a six-monthly average of 928 (July –December 2017) to 553 for the first six months of 2018. She displayed a video of a Patient Story, it was of a woman who had been a sickle cell patient at the Trust for many years. Collecting Patient Stories was an important component in understanding how patients perceived the health care they have received and how the Trust could improve on the many different aspects of service delivery in their hospitals, and community-based health care programs.

The Head of Patient Experience and Public Involvement stated that the report detailed some actions for 2019. These included: -

a) Strengthening relationships with patient communities including increased Patient and user engagement.
b) Reviewing and enhancing the use of volunteers to aid a positive patient experience.
c) To be amongst the highest performing Trust's regionally and nationally in relation to the Friends and Family Test.

The Trust regularly met with key stakeholders to share patient feedback and learning. Reports were presented to the CCG on a quarterly basis. Staff from PALS attended the JEAG (Joint Engagement Assurance Group) which had representatives from the CCG and Healthwatch.

A Member of the Panel asked how people could be referred to the Trust if they were expressing an interest in the Council of Members. The Head of Patient Experience and Public Involvement responded that there were leaflets and the Trust did hold drop-in sessions. She agreed to send Healthwatch some leaflets, so they could be distributed.

A Member of the Panel asked if there was a point of contact in reference to a bullet point in the report stating, “To undertake public consultations on key issues before service delivery change. The Trust are keen to involve local people in decisions which will determine how healthcare is provided”. In response, the Head of Patient Experience and Public Involvement responded that the person who normally fulfilled the role had recently just left the Trust. They did however have someone part time fulfilling the role and she would pass their contact details to the Chair of Healthwatch. A Member of the Panel asked if there could be a timetable of events or topics available on the website to make the information more easily accessible.

A Member of the Panel stated there were no statistics on feedback in the report from the Parliamentary and Health Service Ombudsman. The Head of Patient Experience and Public Involvement commented that these could easily be provided. In 2018, the Trust had gone through a six-month period where no complaint had been fully upheld by the Ombudsman. They only had three complaints that were partially upheld. They had every confidence in their complaint handling. The Chief Executive signed all complaint responses in person.

The Chair of Healthwatch stated she felt Healthwatch had a good relationship with the PALS team. It was also reassuring to know that the Royal Wolverhampton NHS Trust Board were shown patient story videos.

The Chair asked what was underlining the fact that the Trust’s partially upheld complaint figure was much lower than the national average. The Chief Executive of the Trust responded that it was due to the highly effective nature and robustness of the Head of the PALS team. A strict check list was followed to ensure complaints were fully answered.

7 **RWHT Staff Recruitment and Retention**

The Director of Workforce of the Royal Wolverhampton NHS Trust presented a report on staff recruitment and retention. It was clear that the supply of staff did not meet the current demand across all NHS Hospitals and the situation was not likely to change for the foreseeable future. It was therefore important to maximise the supply, have excellent retention, make the workforce as productive as possible and finally develop the workforce to the needs of the Trust.

The Director of Workforce commented that the Trust had held one stop recruitment sessions to help with recruitment. They had also engaged with the Armed Forces.

At the beginning of the next financial year, they would be embarking on an international recruitment initiative. He had spoken recently with Brendan Clifford (Service Director Health) at the Council to determine what the Council could do to assist getting younger people into the health workforce.

The Director of Workforce stated that retention was one of the biggest national issues being faced by Human Resources in the NHS. There were a whole range of initiatives taking place on flexible working to improve staff retention rates. Ideas such as rotating staff around departments were being explored, to prevent people leaving areas which were perceived as a more challenging environment. An electronic rostering system had seen great success and was being introduced into more areas within the Trust. The approval of the e-job planning business case, would provide a greater organisational understanding of consultant job plans.

The Director of Workforce remarked that the Trust had recently approved the first year of the new Nursing apprenticeship programme, in addition to progressing the nursing clinical fellows. The Trust was also piloting the new band four Nurse Associate role. In addition to Nursing Apprenticeships the Trust continued to make wider use of the apprenticeship mechanism, in line with the recently approved Apprentice Approach, which saw apprentices as a way of developing individuals and opening up opportunities to local people to work within the health sector. The expansion of the apprentice programme would also help towards establishing a career development pipeline.

The Director of Workforce stated that the Trust had seen a continuous improvement in reducing the overall vacancy rate to a position where it was currently below 7%. They were outperforming other NHS Trusts of similar size. They wanted to keep their staff turnover rate to as low as possible, they actively measured their retention rate and were meeting their internal target. They regularly reported the total net starters and leavers figures. He was pleased to report that they had a greater number of starters than leavers. The Trust were looking to increase their bank staffing levels as there would always be a need to have access to temporary staffing. The Trust in progressing their focus on workforce efficiency and productivity, were routinely reporting on the avoidance of unused hours and the ability of the Trust to ensure shift rotas were established six weeks in advance.

In response to a question from a Member, the Chief Executive of the Royal Wolverhampton NHS Trust responded that he had not used any nursing agency staff since 2005, as he was unable to ensure the level of quality. There were also no locum doctors in medicine employed by the Trust. He was particularly pleased with the employment of Clinical Fellows, which were saving the Trust £2.7 million, than if he had used agency staff. He was of the view that happy staff led to high quality of care.

A Member of the Panel asked for an update on Vertical Integration (VI). The Chief Executive of the Royal Wolverhampton NHS Trust responded that he was pleased with the progress that had been made. An area which needed improvement was the last 12 months of life. Meaningful discussions were needed with Nursing Homes. He had the idea of using the Trust's transplant nurses to have sensitive conversations with relatives at the Nursing Homes.

The Chair of Healthwatch praised the Trust for their work in the achievement of getting the vacancy rate down to below 7%.

The Director of Adult Services asked what planning and risk assessment the Trust had undertaken for Brexit and potentially a no deal Brexit. He also stressed the importance of the Trust working together with the Council's Social Care Department as they were effectively in competition with each for nursing staff. He was very happy to have an open dialogue with the Trust on staffing issues. The Director of Workforce responded that the numbers of staff which Brexit impacted on was not significant. The overseas recruitment by the Trust was mainly international. The Trust were not massively reliant on employment from the wider European Union. They had written to all of their staff explaining the mechanism for the settled status scheme. They had also set up some general workshops. The Chief Executive of the Trust stated that the Trust had a vested interest in working with the Council to ensure the nursing homes were appropriately staffed as they could not afford for them to fail.

The Consultant in Public Health offered to facilitate the sharing of some information on the Adult Education Sector with the Director of Workforce at the Royal Wolverhampton NHS Trust. There were a few thousand young people coming through this channel who would probably not go onto University to become Doctors or Nurses, but from an inclusive growth point, there would be a good cohort who had the potential to enter the Health Sector in a staffing job. The Director of Workforce responded favourably to the idea.

8 **NHS Long-Term Plan**

The Consultant in Public Health at City of Wolverhampton Council presented a briefing note on the NHS Long-Term Plan. The plan itself was a 120-page document which laid out the plan for the next ten years for the NHS, in seven chapters. He covered the main areas outlined in the briefing note.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that it was important to think about the practical realities of implementing the Government plan for the NHS. There were many different systems operating in places across the country. It was important not to get their local plans de-railed by the national plan. There was a discussion about overlapping pathways and where best to spend finances to achieve the best outcome.

The Director of Strategy and Transformation commented that the extra money which had been allocated to the NHS just maintained the current status of affairs. Any innovation would have to be funded as a system. The Director of Adults referred to the cyber security attack on the NHS last year, which the NHS were still recovering from. Digital innovation normally took years to implement.

A Member of the Panel asked if there were any plans for the WMCA (West Midlands Combined Authority) to have a greater involvement in the health system. The Director of Adults responded the main area the WMCA were involved, was on mental health. There were currently no plans for a Greater Manchester model.

9 **Brexit Preparations**

The Director of the Royal Wolverhampton NHS Trust, The Director of Strategy and Transformation at the CCG, the Consultant in Public Health at City of Wolverhampton Council and the Head of Public Service Reform at City of Wolverhampton Council outlined their respective knowledge of the Brexit preparations at their organisations.

The Chief Executive of the Royal Wolverhampton NHS Trust referred to the paper that had been circulated. He commented that there was a team in London of 200 people who were designing contingency plans for the NHS, but he had no knowledge of those plans. From a local perspective, the main area of his concern was medicines. This was because there was a significant amount of medicines that were manufactured in Europe. Most of the dressings used by the NHS were manufactured in China. All the Trust's heart valves were purchased from the United States of America. He hoped that the Brexit teams in London were ensuring that the supply of medicine would not be disrupted. He suspected that the goods and the consumables used by the NHS were 90% from global companies, who would want to keep their supply chain going.

A Member of the Panel asked if chronically ill patients should be stockpiling their own personal supply of medicine. The Chief Executive of the Royal Wolverhampton NHS trusted responded that he thought it would be disastrous if patients started to stockpile medicine because there was only a given amount of production capacity.

The Director of Strategy and Transformation of the CCG stated that they had to have an appointed Senior Responsible Officer for Brexit. Mike Hastings, Director of Operations had been appointed to this position. A meeting was planned shortly with the Trust, the CCG and the Local Authority to discuss the co-ordination of any disaster plans. Much of the work largely fell into existing disaster recovery plans. The CCG had an assurance role working in collaboration with NHS England. Costs of medicine could increase if tariffs were put on EU imports.

A Member of the Panel asked if there were any pharmacies that were having issues in receiving medicines. The representatives from the Trust and the CCG responded that they were not aware of any issues or stockpiling.

The Consultant in Public Health remarked that there was a Resilience Team within Public Health, which was working closely with health partners and the Head of Public Service Reform at the Council, to understand the local landscape and to make necessary preparations. They were also taking national direction on the requirements. They had been given a template, which looked at worst case scenarios such as fuel and food shortages and had been asked to consider how this would impact on services. The Resilience Team considered public anxiety over the implications of Brexit as probably being the major public health risk.

The Head of Public Service Reform stated that he was the Council's lead on the preparations for Brexit. He was of the view that civil unrest and community cohesion were considered the biggest risks by the Public Sector. The estimated European Nationals directly employed by the health sector across the West Midlands was

about 6-7% of the total workforce. There was a level of assurance that the health sector could cope with these numbers in their assurance plans. Where there was not the same level of assurance was with regard to contracted services in both health and social care. This was an area where he had established an action to try and understand further.

The Director of Strategy and Transformation of the CCG asked for some further clarification over what was expected in terms of civil unrest. The Head of Public Service Reform responded that there could be protests which could turn into riots. If Article 50 was extended European Elections could potentially have to be held in May. If they did proceed, then civil unrest at polling stations could occur. If there was a no deal scenario, there was a concern about access to food, medicine and fuel. If access was not available, then he considered there could be issues arising from the lack of supply. In parts of the country there could be aggravation to certain sections of the community.

10 **Work Programme**

A Member of the Panel commented that they wanted to receive an update on the STP (Sustainability and Transformation Plans) at some point in the future. West Park Hospital was also an item to be added for later in the year or as there were developments.

The Director of Adults made reference to the Transforming Care Programme, which related to people with complex learning disabilities coming out of secure settings. He had recently been discussing assessment and treatment unit availability. Wolverhampton did not have an assessment and treatment unit in the city. There were ongoing discussions about units available in Walsall and Dudley. The local transforming care programme wanted to engage in discussions about what should happen to those units but did not want to formally consult. NHS England advisors had said they did not need to formally consult, as long as there was agreement from the Health Scrutiny Panel, that engagement was satisfactory in the circumstances. He did not see it as a problem for Wolverhampton as there was not an assessment and treatment unit in the city. He wanted to secure the Panel's agreement that the Transforming Care Programme should engage but not formally consult on the units in the Walsall and Dudley areas. A formal consultation would take approximately 18 months and would delay the current plans for the Transforming Care Programme, which were scheduled to be completed in March 2019.

Resolved: That the Health Scrutiny Panel agree that the Local Transforming Care Programme need only engage and not formally consult on the assessment and treatment units in Walsall and Dudley.

Resolved: That the Health Scrutiny Work Programme be agreed.

11 **Future Meeting Dates**

The future meeting dates were reported as follows: -

Thursday, 21 March 2019 at 1:30pm

Thursday, 6 June 2019 at 1:30pm

Thursday, 12 September 2019 at 1:30pm

Thursday, 7 November 2019 at 1:30pm

Thursday, 16 January 2020 at 1:30pm
Thursday, 5 March 2020 at 1:30pm

Agenda Item No: 5

Health Scrutiny Panel

21st March 2019

Report title	Cancer Services
Report of:	Gwen Nuttall Chief Operating Officer
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 Royal Wolverhampton NHS Trust (RWT) has not consistently delivered the GP referral 62-day cancer standard. This report provides an update on the key issues and actions being taken to improve the position.

2.0 Background

2.1 RWT is a level 2 tertiary Cancer centre accepting referrals from the Black Country and beyond. We offer appointments for all cancer sites and are able to provide Radiotherapy, Chemotherapy and surgical interventions. Agreed clinical pathways are in place with all local providers and patients are frequently referred to RWT for more complex treatment following diagnostics and assessment at other centres.

Similar to most Tertiary cancer centres, achieving the 62-day cancer standard remains a constant challenge. Nationally, the 62-day cancer target has not been hit since December 2015, the pressures seen across the country are similar to those experienced at RWT.

In order to improve performance, the Trust has developed a Recovery Action Plan with Wolverhampton Clinical Commissioning Group (CCG) and has sought the support of the national cancer Intensive Support Team (IST) and the West Midlands Cancer Alliance Team. Their support has identified some opportunities for improvement and identified significant capacity constraints, it has also demonstrated the good processes and pathways currently in place.

Actions within the recovery plan continually seek to identify potential improvements across all pathways. However, the key issues that drive under-performance are:

1. Late Tertiary referrals
2. Growth in referrals (spikes in certain specialties)
3. Capacity Constraints at RWT

Tertiary Referrals

As a level 2 cancer centre, a number of patients get referred into RWT for more complex treatment. We also provide advanced surgical techniques and offer patients surgical options that are unavailable at other sites. This includes robotic procedures for Urology and Gynaecology patients. This results in a number of referrals into the Trust for patients who have already commenced their cancer pathway.

We have seen an increase in the number of tertiary referrals and a delay in the timeliness in which these are received. This means that we are receiving a number of referrals late. Lateness is defined by the National Cancer waiting times as received after day 38. In 2017/18 63% of tertiary referrals were received after day 38, we have seen this increase to 66% in 2018/19.

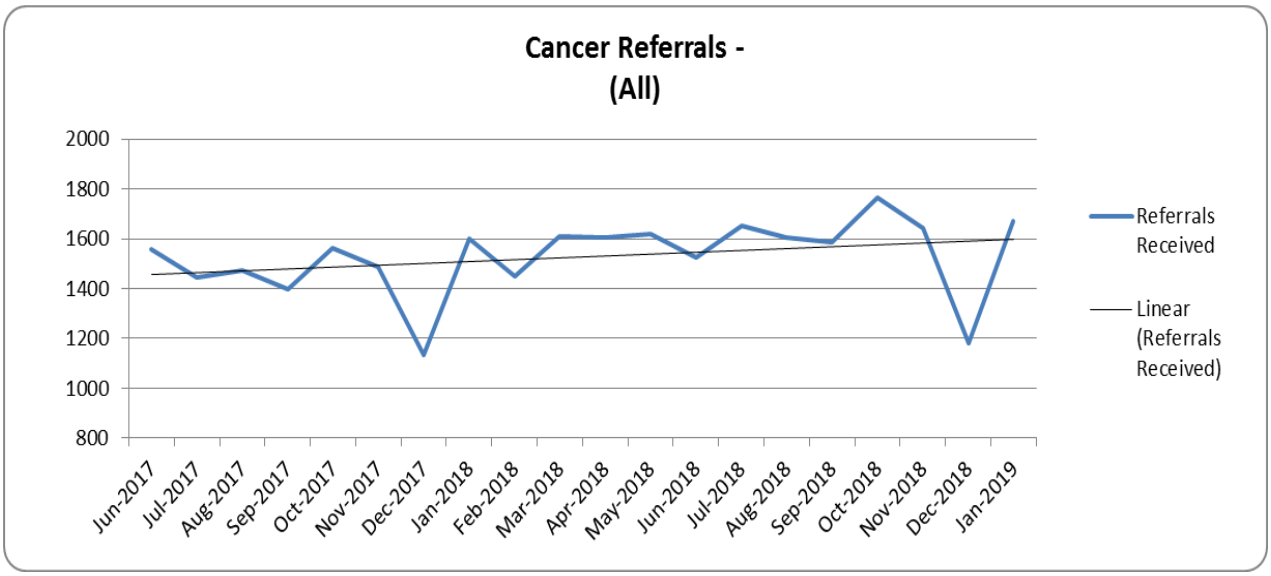
Tertiary Referral Numbers

Total Number Tertiary Referrals Received		Tertiary Referrals Received After Day 38	
17/18 (Apr-Feb)	18/19 (Apr-Feb)	17/18 (Apr-Feb)	18/19 (Apr-Feb)
161	218	102	143

With the support of the Cancer Alliance, we have recently undertaken a review of the tertiary referral process adopted by all providers. As a result of this, referrals are only accepted into the Trust once all relevant clinical patient information has been received; this enables us to discuss appropriate patients within our Multi-Disciplinary Team (MDT) meeting and ensures that the correct method of care is implemented. This should result in a more streamlined patient pathway and reduced delays for patients.

Growth in Referrals

Within RWT we have seen an increase in our referrals year on year. Whilst growth is evidenced in all Tumour sites, we have seen the biggest sustained growth within Breast with consistent growth in Upper GI and Dermatology. The main referral source is from Wolverhampton CCG patients although we have seen an increase from Cannock, South East Staffordshire and Seisdon.



The recovery action plan was originally based on average referrals into the Trust of 1380. This figure had remained static for both 2016/17 and 2017/18. As can be seen from the data (above), referrals have been rising steadily since this point, averaging in excess of 1550 for 2018/19.

Of more concern is the spike in referrals at a specialty level. The Breast service has capacity to see 340 patients per month and runs additional lists at weekends (max 70 patients per month) to support short term increases, this has been a sustainable model in previous years. However, the level of growth this year has seen referrals average 414 for the year to date and hit nearly 500 in each of October, November and January.

Capacity Constraints

The consistent increase in referrals has created capacity constraints in a number of areas. This has led to increased waits for patients and an inability to deliver performance within expected standards. RWT has requested support from a number of external parties including the IST, Cancer Alliance and CCG to understand and manage demand; however, to date this has not resulted in any changes.

The pressure from demand has required us to provide more detailed modelling of the capacity requirements across the trust. This has allowed us to examine the delivery models we provide and resources we have to deliver these.

The IST has completed an in-depth demand and capacity review across most of our core specialties, including key pressure areas such as Breast Radiology and Endoscopy. As a result of this we have been able to fully understand the capacity constraints across the various cancer sites including the deficit in diagnosis capacity. Whilst detailed proposals have been received at specialty level, it is most pertinent to note that the biggest single areas of concern relate to breast and our diagnostic capacity. Given that every patient will require some, and most will need a number of diagnostic tests to determine the

extent of their cancer diagnosis, the lack of capacity in diagnostics will significantly impact on achieving the cancer standard for all sites.

The high level analysis produced by the IST draws the following conclusions based on historical data:

Service	Av. weekly capacity	Av. weekly demand	Sustainable range	Capacity gap per week
Radiology (CT)	105 hours	120 hours	132-145 hours	27-40 hours
Radiology (MRI)	251 hours	290 hours	308-338 hours	56-66 hours
Breast 2WW	75 slots	86 referrals	102-107 slots	27-32 slots

To support this demand in the short term we are continuing to outsource non-cancer diagnostic work to the private sector, this will enable the Trust to prioritise cancer suspicious work. It should also be noted that the Trust expects this capacity gap to increase over the coming months and future plans to address this shortfall should factor in any expected growth.

Alongside this, we are continuing to undertake pathway reviews to understand the pressure points and ensure that we have robust established pathways in place; this work has been completed in Head and Neck, Radiotherapy and Skin to date.

Actions

We are continuing to work closely with external bodies. The IST continue to provide support and have expanded the demand and capacity work to include colorectal and oncology services. They are supporting the roll out and education of the new cancer operational policy, helping to deliver training for all staff and are providing specialist in-depth training for the cancer services department.

Recruitment is underway in a number of areas to create additional capacity, including for Radiologists and Breast Consultants. However, it should be noted that there is a national shortage of qualified individuals and securing additional resource is not going to be easy.

Other key developments that are being implemented as a result of the cancer recovery plan include:

- A new diagnostic pathway has been implemented in Prostate as result of a service review, including straight to mpMRI (mpMRI is a special type of scan that creates a more detailed picture of the prostate than a standard MRI by combining up to 3

different types of scan). This is in line with the new national pathway to enable delivery of the 28 day faster diagnosis pathway

- Following the successful pilot in the colorectal pathway we are looking to roll out the triage and straight to test pathway in the next financial year

- Following pathway reviews we are booking ENT, MaxFax, Haematology and Urology 1st appointment within 7 days of referral

- As part of the Trust's Governance system and process there is a monthly harm review of patients who have waited over 62 days for their treatment. This is a joint clinical process led by the Trust Cancer lead, Dr Simon Grummet, with colleagues from the CCG

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:

- Financial implications
- Legal implications
- Equalities implications
- Environmental implications
- Human resources implications
- Corporate landlord implications
- Risks

6.0 Schedule of background papers

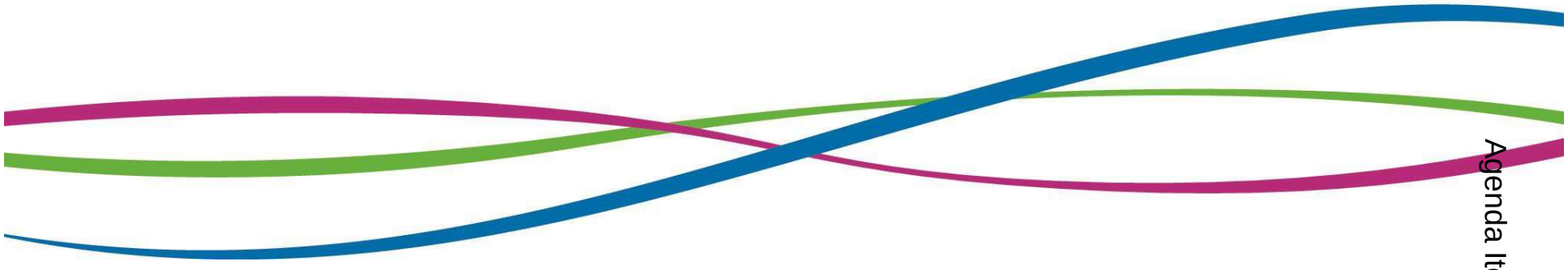
6.1 The background papers relating to this report can be inspected by contacting the report writer:

Gwen Nuttall
Chief Operating Officer
The Royal Wolverhampton NHS Trust
Telephone: 01902 695958

The Royal Wolverhampton NHS
NHS Trust

Mortality & Learning from Deaths update:

Wolverhampton



Safe & Effective | Kind & Caring | Exceeding Expectation

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Presentation Outline

- Hospital Mortality ratio (determinants)
- Governance set-up and assurance process
- Learning from Deaths (LfD) pathway
- Trust Mortality Strategy
- Trust Improvement plan (Mortality)
- Key developments 2019

SHMI

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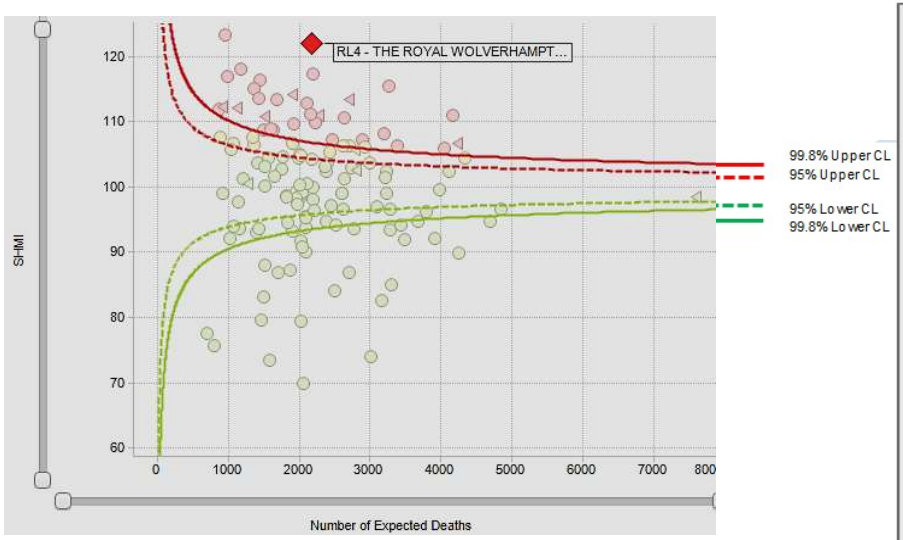
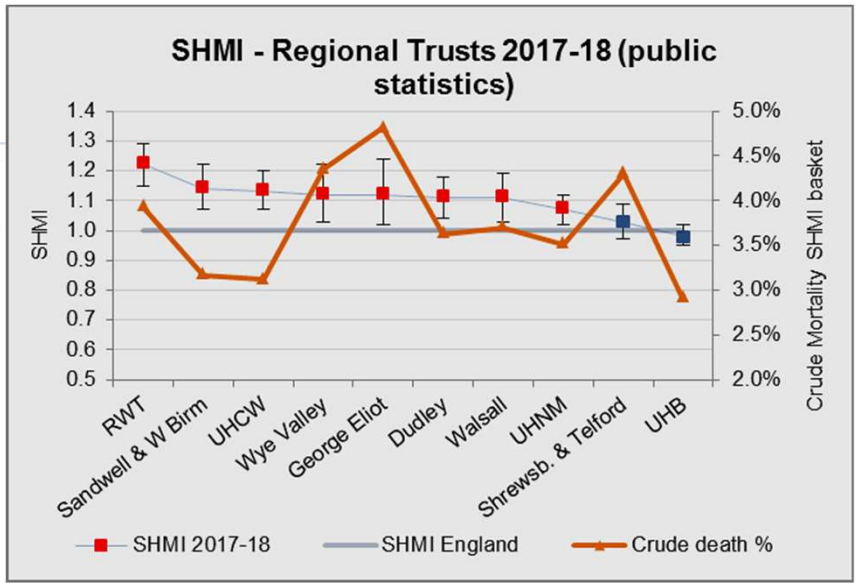
SHMI England Apr 17 – Mar 18 (published)



Circles – acute trusts in England; triangles – regional trusts

RWT value 121.94 – higher than expected



- RWT – 1 of 35 acute trusts in England with higher than expected SHMI (99.8 CI)
- Regionally, 8 trusts have higher than expected SHMI (99.8 CI)

Hospital Mortality Ratio (Determinants)

- **Quality** of Care
- **Pathways** (admission and discharge)
- **Severity** of illness of those admitted (not accounted in SHMI)
- **Coding** practices (primary diagnosis and co-morbidities)
- **Place** of Death (proportion dying in hospital)
- **EoL** infrastructure and care for the dying in the community
- **Deprivation** profile
- **Risk factors** (Un-modelled) in the population (e.g. smoking, alcohol)

City-wide ONS data

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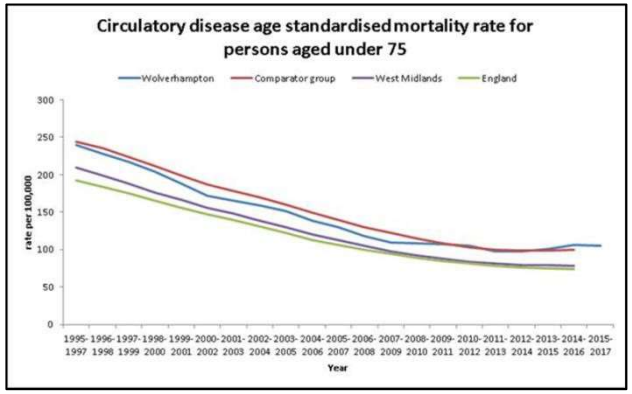

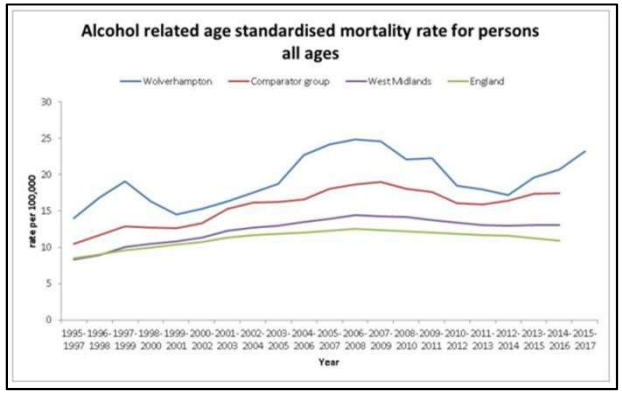

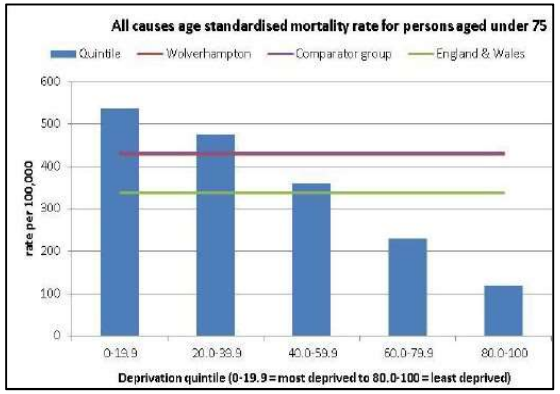

- Compared to similar Local Authorities (based on deprivation), Wolverhampton has a similar overall death rate (adjusted for age).
- There has been some increase in deaths from circulatory diseases (such as heart disease and stroke) in recent years. Circulatory diseases, cancers and respiratory diseases account for the top 3 causes of death in Wolverhampton, and share common risk factors (e.g. smoking, obesity).
- Wolverhampton remains significantly high for overall death rates, specifically for deaths related to alcohol, which has been a persistent theme for many years

Place of Death

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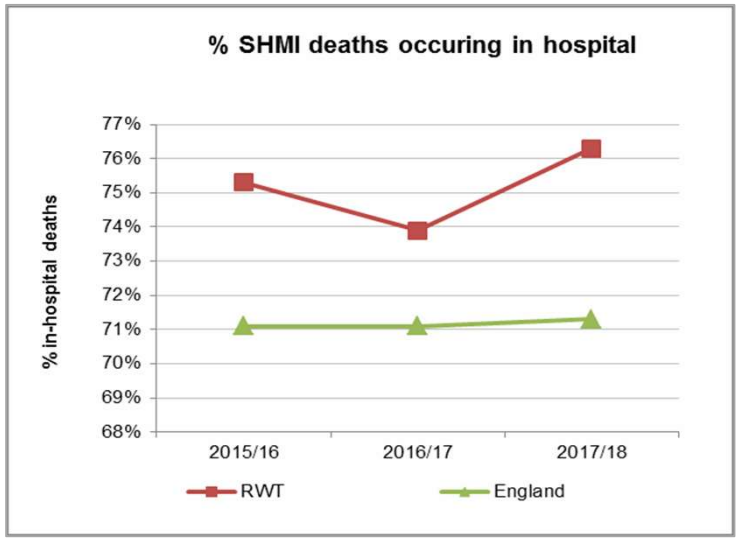

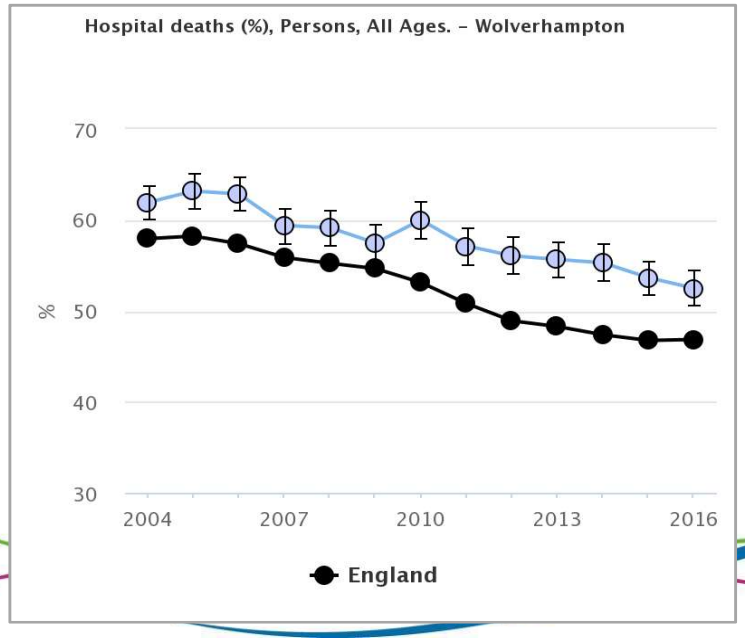

Compared with benchmark: Better, Similar, Worse | Lower, Similar, Higher, Not Compared

Benchmark: Value — Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Wolves			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital deaths (%), Persons, Aged 0 - 64 years.	2016	↓	267	56.3%	48.4%	45.6%	32.1%		60.3%
Hospital deaths (%), Persons, Aged 65 - 74 years.	2016	↓	228	54.0%	50.6%	49.2%	35.2%		64.5%
Hospital deaths (%), Persons, Aged 75 - 84 years.	2016	↓	382	53.9%	53.1%	50.5%	40.6%		67.4%
Hospital deaths (%), Persons, Aged 85 years and over.	2016	↓	472	48.9%	46.3%	43.8%	29.8%		66.3%
Hospital deaths (%), Persons, All Ages.	2016	↓	1,349	52.5%	49.3%	46.9%	38.3%		63.1%
Care home deaths (%), Persons, Aged 0 - 64 years.	2016	→	18	3.8%	2.5%	2.9%	0.7%		13.0%
Care home deaths (%), Persons, Aged 65 - 74 years.	2016	→	33	7.8%	7.9%	8.6%	2.6%		19.2%
Care home deaths (%), Persons, Aged 75 - 84 years.	2016	↑	110	15.5%	17.2%	18.7%	4.1%		27.8%
Care home deaths (%), Persons, Aged 85 years and over.	2016	↑	309	32.0%	34.7%	36.7%	11.2%		50.9%
Care home deaths (%), Persons, All Ages.	2016	↑	470	18.3%	20.1%	21.8%	5.2%		32.8%
Home deaths (%), Persons, Aged 0 - 64 years.	2016	↑	142	30.0%	32.4%	33.9%	21.8%		44.7%
Home deaths (%), Persons, Aged 65 - 74 years.	2016	↑	113	26.8%	29.4%	30.3%	19.7%		39.7%
Home deaths (%), Persons, Aged 75 - 84 years.	2016	↑	167	23.6%	23.0%	23.8%	17.4%		30.7%
Home deaths (%), Persons, Aged 85 years and over.	2016	↑	155	16.1%	15.9%	16.4%	10.0%		28.4%
Home deaths (%), Persons, All Ages.	2016	↑	577	22.5%	22.8%	23.5%	17.1%		29.7%
Deaths in Other Places (%), Persons, Aged 0 - 64 years.	2016	→	27	5.7%	6.7%	7.2%	2.6%		13.9%
Deaths in Other Places (%), Persons Aged 65 - 74 years.	2016	→	6	1.4%	1.8%	2.0%	0.6%		9.7%
Deaths in Other Places (%), Persons, Aged 75 - 84 years	2016	→	11	1.55%	1.17%	1.36%	0.44%		4.94%
Deaths in Other Places (%), Persons, Aged 85 years and over.	2016	→	5	0.52%	0.79%	1.01%	0.25%		6.52%
Deaths in Other Places (%), Persons, All Ages.	2016	→	49	1.91%	1.98%	2.20%	1.11%		6.66%
Hospice deaths (%), Persons, Aged 0 - 64 years.	2016	→	20	4.2%	10.1%	10.4%	0.5%		18.5%
Hospice deaths (%), Persons, Aged 65 - 74 years.	2016	↑	42	10.0%	10.2%	10.0%	1.1%		31.9%
Hospice deaths (%), Persons, Aged 75 - 84 years.	2016	→	39	5.5%	5.5%	5.6%	0.8%		18.1%
Hospice deaths (%), Persons, Aged 85 years and over.	2016	→	24	2.49%	2.23%	2.08%	0.35%		8.38%
Hospice deaths (%), Persons, All Ages.	2016	↑	125	4.9%	5.8%	5.7%	0.2%		14.3%

SHMI Trend

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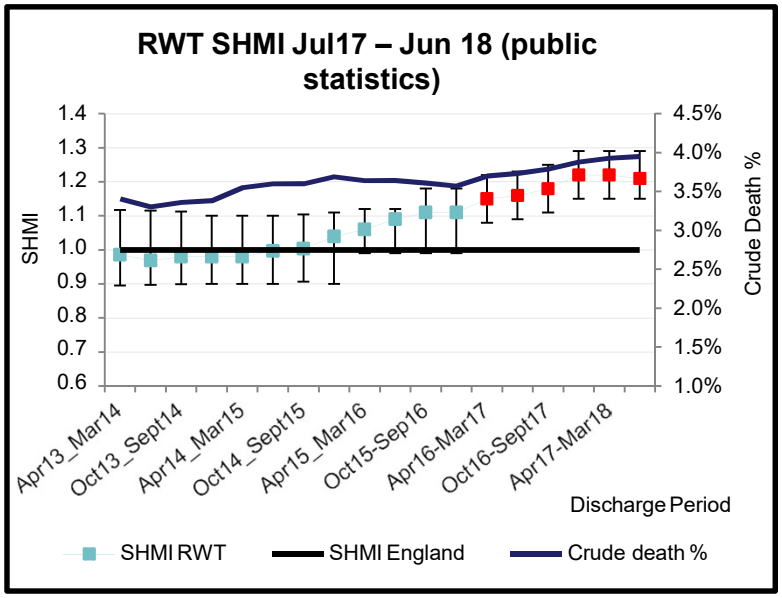

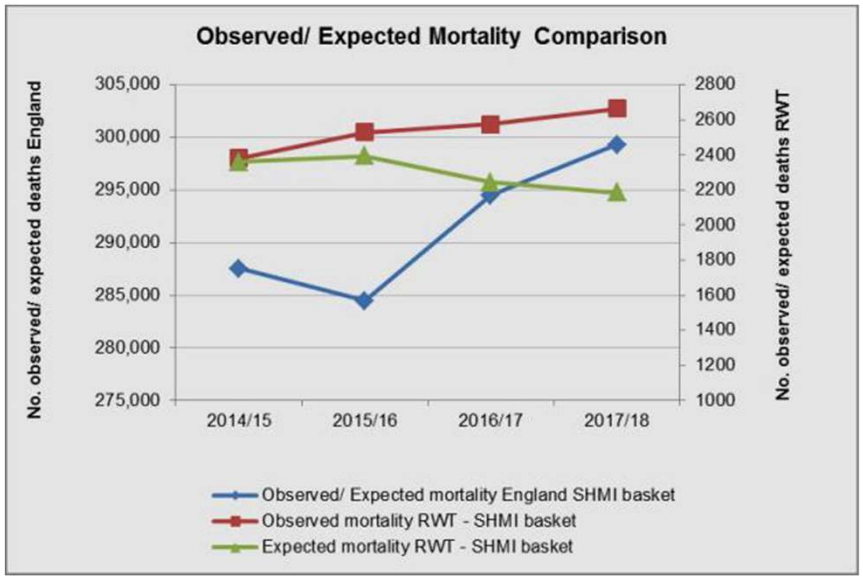

$$\text{SHMI} = \frac{observed\ deaths}{expected\ deaths}$$

- **Expected mortality** is calculated for each admission to hospital at diagnosis group level
- Statistical construct based on the interaction between age, gender, diagnosis group and comorbidity score; all based on coded clinical information recorded at the time of admission to hospital

Change in Admission Pathway

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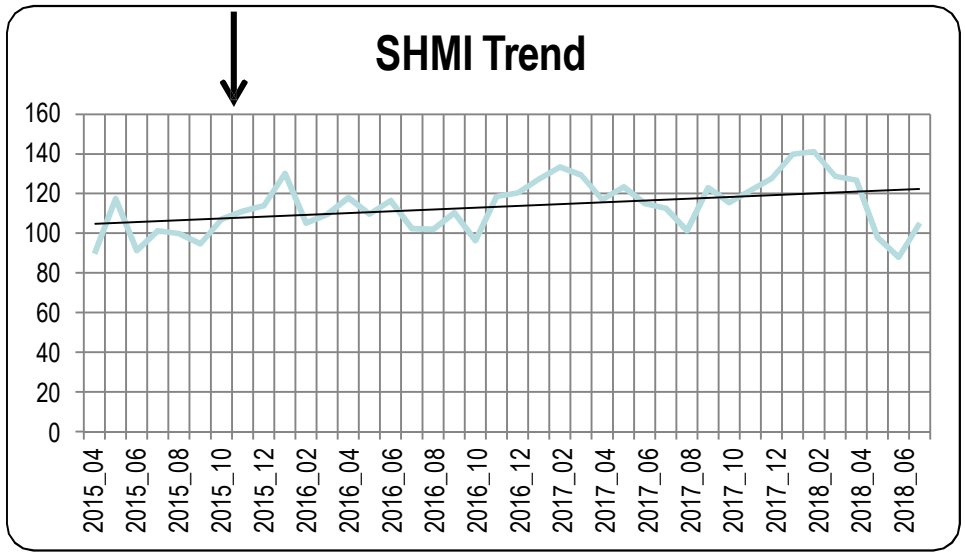
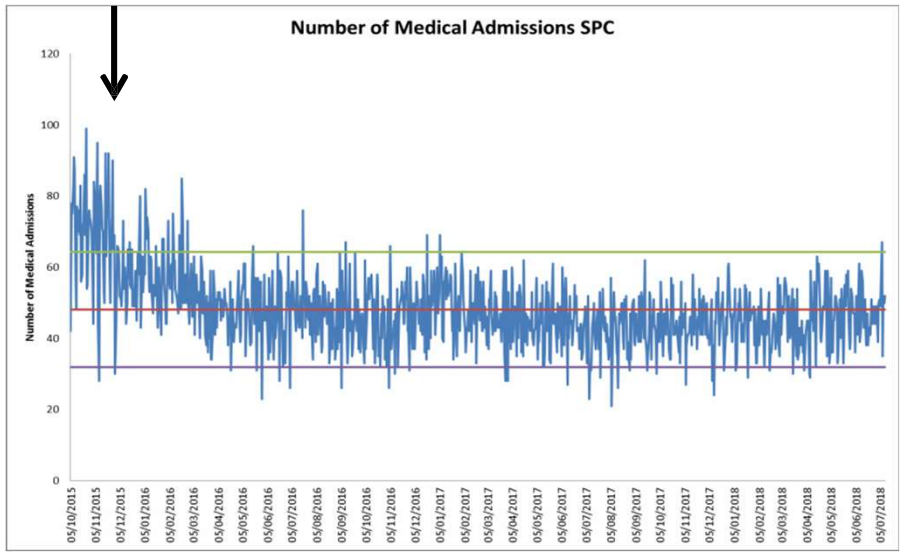
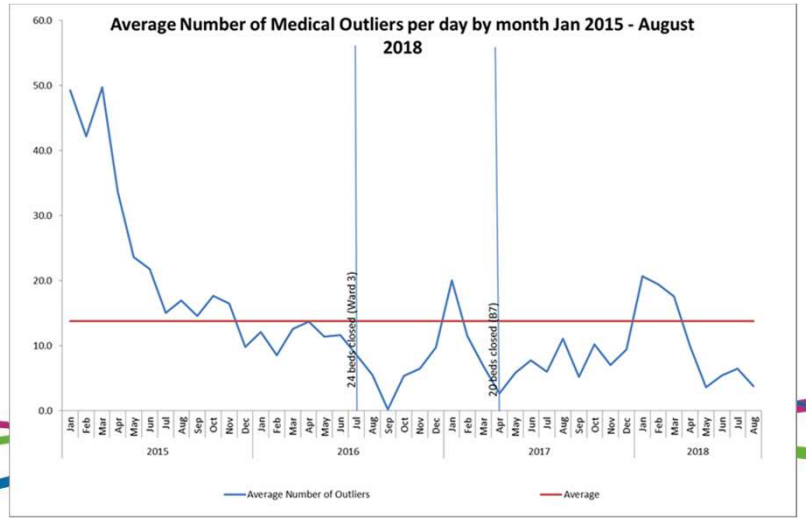
Physician A model in ED







Coding Co-morbidities

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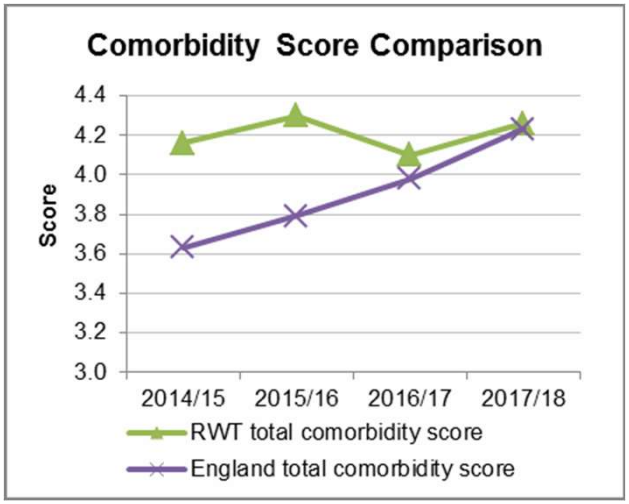

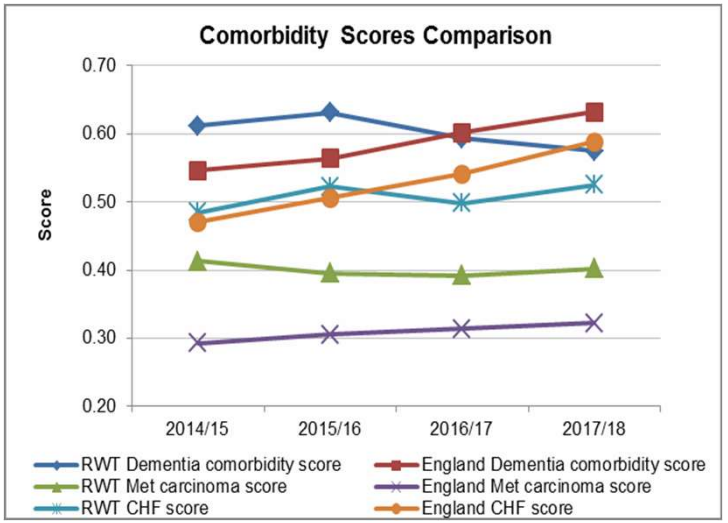

- Co-morbidity score recorded during the 1st episode of care for admission n the SHMI dataset.
- Dementia, Congestive Heart Failure and Metastatic Carcinoma have the highest scores when recorded as a comorbidity.
- For metastatic carcinoma, RWT is higher compared to England, but there hasn't been any increase. For dementia and CHF, the scores are lower than National average and there hasn't been an increase either; a drop is seen in 2016-17.

Administrative Data in the 1st FCE do not accurately reflect the characteristics of admitted patients

FCEs/spell

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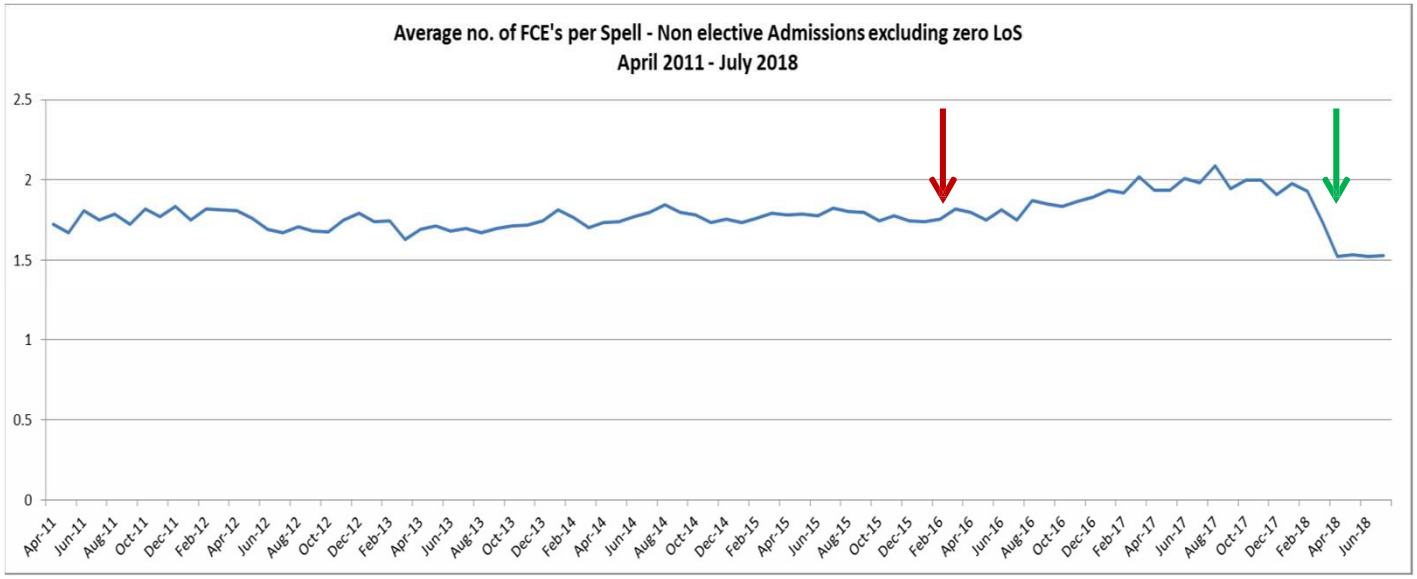

- The multiple short episodes on admission to the acute medical unit were leading to the suboptimal coding of primary and secondary conditions.
- Changes were made from April 2018 to address this; the acute medical admission is now recorded as one episode until the patient moves to another ward or is discharged.

Learning from Deaths

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Key Components

Scrutiny/Assessment

Death Certification

↓

Reviews/ Investigations

↓

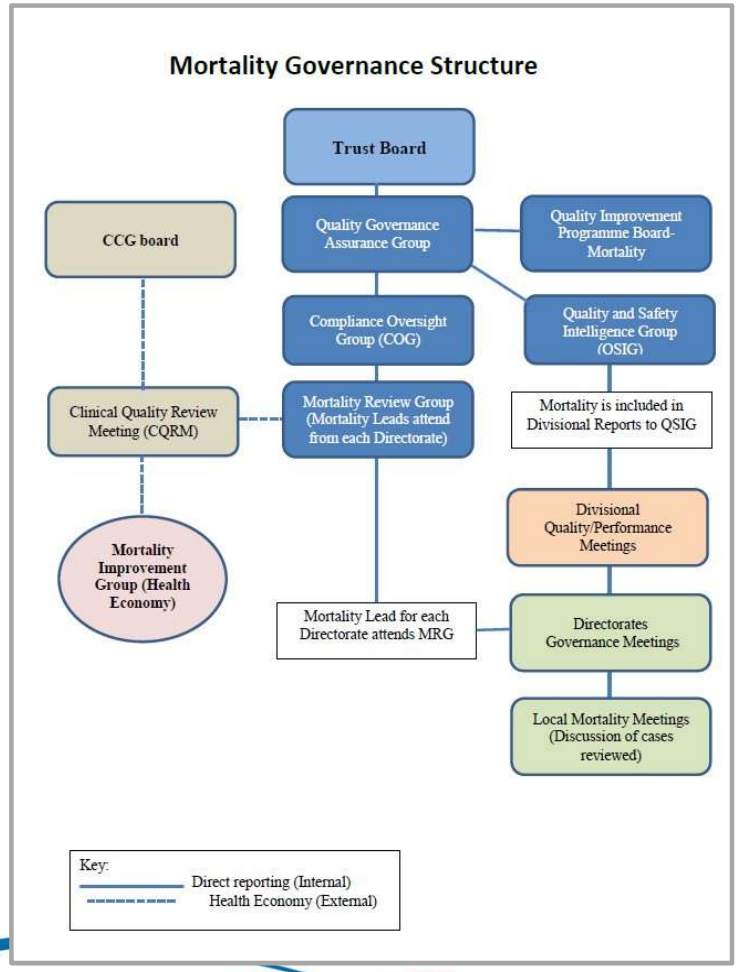
Learning

Thematic analysis

↓

Quality Improvement

Governance Structure



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Process: Scrutiny/Review/Investigation

Medical Examiners	Case note review	Investigation	National Mortality Review
• Accurate death certification • Discussion with bereaved families • Proportionate scrutiny of records • Identify deaths for SJR review	• SJR methodology • 2 Stage process • Multidisciplinary approach • Quality assured	• RCA • Serious incident framework • Systematic analysis of what, how and why? • Identify changes to reduce future risks	• LeDeR programme • MBRRACE • Child Death review programme

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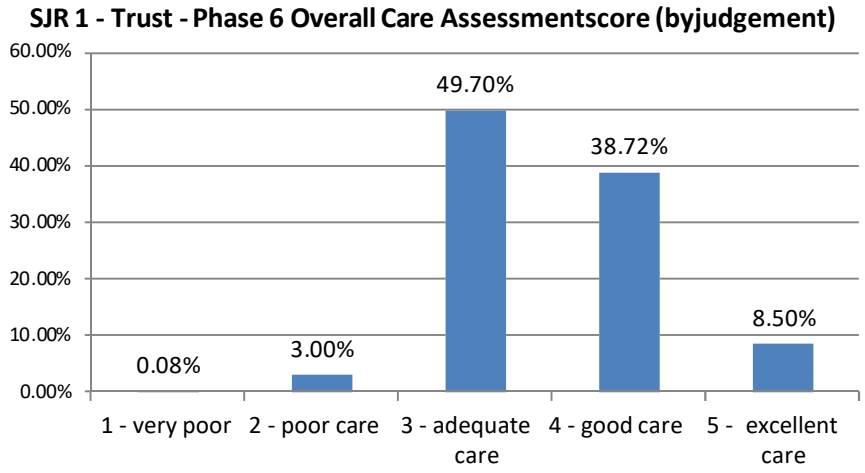
Outcome of SJR

- Around 2000 hospital deaths/year
- Roughly 70% of all hospital deaths reviewed



Poor/very poor care triggers Stage 2 Review

Outcome of Audits

- Over 250 deaths audited
- Roughly 2% of cases care was not satisfactory

NCEPOD Grading	Grade Description	No. Cases
1	Good practice	183
2	Room for improvement (Aspects of clinical care that could have been better)	33
3	Room for improvement (Aspects of organisational care that could have been better)	6
4	Room for improvement (Aspects of clinical and organisational care that could have been better)	8
5	Less than satisfactory (Several aspects of clinical and/or organisational care which were below acceptable standards)	3

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Mortality Reviews-Thematic Analysis

Themes for improvement:

Documentation

Sepsis screening and management

Identification, review and escalation of deteriorating patient

End of Life Care

Delayed transfer of care

MCA/DOLs knowledge and implementation

Areas of Good Practice:

7DS- weekend consultants ward rounds

Pressure ulcer management

Early medical intervention in ED

Examples of service improvement:

- Physician A model in ED
- 7 day service
- Consultant expansion (Medicine)
- Clinical Fellowship programme
- Additional doctors to cover medical wards during weekends
- E- prescribing
- Patient flow initiatives: SAFER/R2G/Stranded patients
- Pathway specific (reduction in number of cardiac arrests)
- Proactive nurse recruitment
- Nursing metrics: reduction in HAPU, falls with harm and late observations

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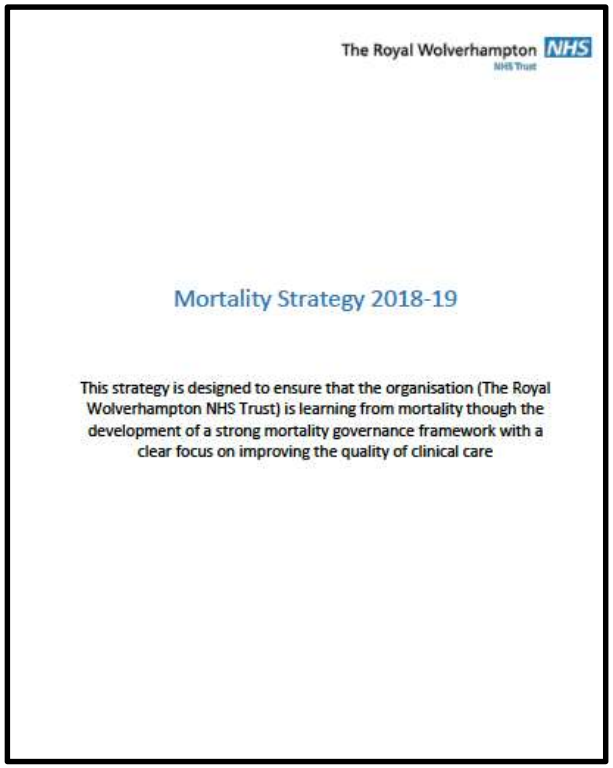
Trust Mortality Strategy

- Timely mortality reviews and/or RCAs to identify learning from deaths
- Lessons learnt are shared and linked to the quality improvement agenda
- Clinical pathways to deliver high quality care
- City wide implementation of End of Life Care in line with Gold Standard framework
- Engagement with bereaved families and relatives
- Accurate capture of administrative data to reflect the population being treated through robust coding and documentation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Mortality Strategy 2018-19

This strategy is designed to ensure that the organisation (The Royal Wolverhampton NHS Trust) is learning from mortality though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care

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Trust Improvement Plan (Mortality)

Workstreams:

- Programme Management
- City Wide Programme Approach
- Standardised Policy and Processes
- Quality and Safety of Care
- Education
- Workforce
- Communication

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Improvement Plan- Workstreams

Programme Management

- Establish programme board and action plan
- Agree TOR for MRG
- Develop Mortality Strategy
- Analytic support
- Monitor impact of intervention
- Board assurance

City-Wide Approach

- Agree TOR for MIG
- City-wide mortality strategy
- Scope EoI activity and re-design pathway
- Care Home in-reach support and evaluate impact on admissions

Policy & Process

- Re-establish RWT EoI group
- Update Death certification and LfD policy
- Monitor compliance with mortality policy
- Establish process for primary care reviews

Workforce

- Expansion of Palliative care and critical care outreach teams
- Support for Sepsis, Stroke & VTE management
- Review staff recruitment plans
- Monitor vacancies

Education & learning

- Training for Medical examiners and mortality reviewers
- Mortality Learning log
- Share learning from mortality reviews

Quality& Safety

- Monitor compliance with 7day service standards
- Care pathway audits
- Monitor complaints and incident trends - establish SIG

Key Initiatives 2019

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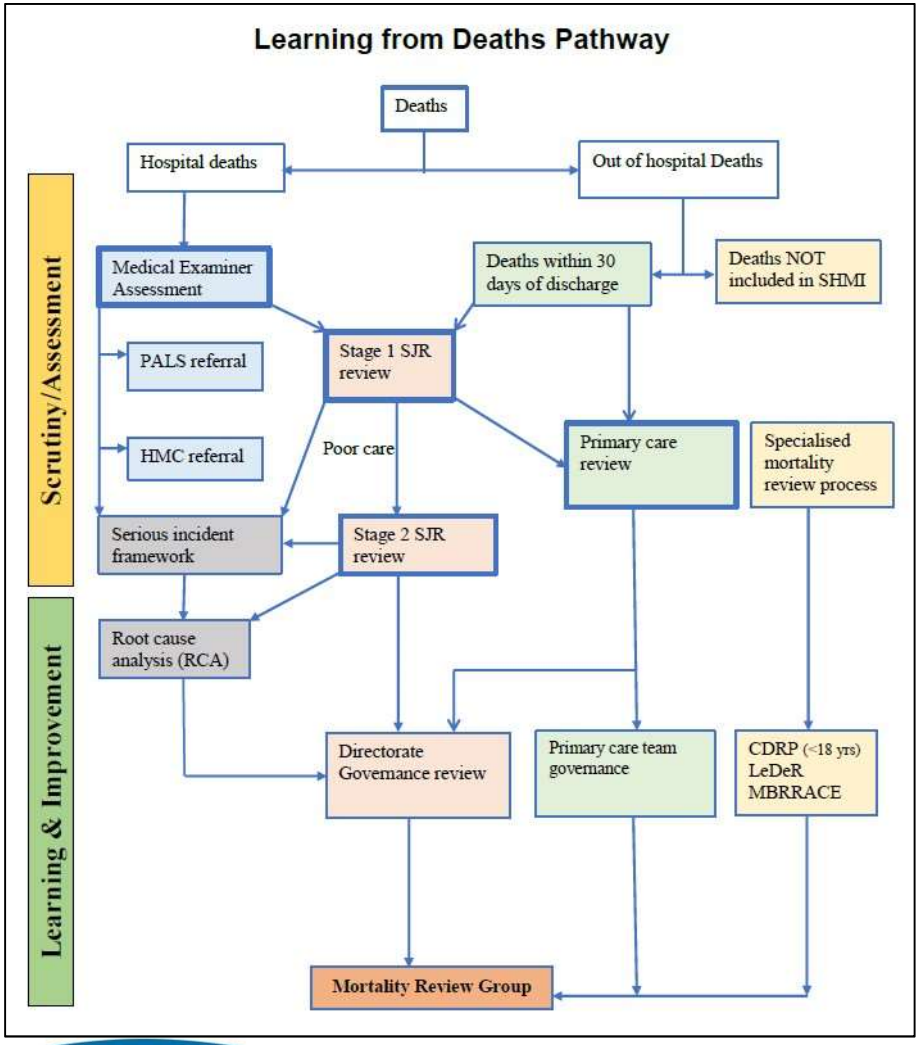
- Medical Examiners
- Out of Hospital Deaths (Primary Care mortality reviews)
- Review of deaths with low mortality risk
- Dedicated Mortality Reviewers
- Bereavement service (lead nurse appointment)
- IT platform (LfD pathway)
- Coding:
  - Clinician/coder co-working (pilot on AMAU)
  - Co-morbidity proforma
- Mortality Dashboard



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Mortality Dashboard

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Thank you for your attention

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Scrutiny Work Programme

Health Scrutiny Panel

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

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

Date of Meeting	Item Description	Lead Report Author	Notes
21.03.2019	• Mortality and Learning from deaths in Wolverhampton – update	Dr Odum, The Royal Wolverhampton NHS Trust	http://www.wolverhampton.gov.uk/health
	• Cancer Treatment Services	The Royal Wolverhampton NHS Trust – David Loughton	
	• Hearing Checks	Presentation Sarah Treadwell-Baker – Action Hearing Loss	
	• Black Country Partnership NHS Foundation Trust – Transforming Care Partnership – update and Quality Accounts 2018/19 – progress against priorities	Tony Smiley – Compliance Lead Lesley Writtle, Black Country Partnership	
	• Brexit Update		

6 June 2019	• Suicide Prevention • Child Deaths Overview Panel • Ward sizes, age, transition arrangements for a young person moving to an adult ward • Public Health Vision – Review of Progress against national performance targets	Parpinder Singh Public Health The Royal Wolverhampton NHS Trust Public Health	

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

1. West Midlands Ambulance Service - Quality Accounts - (tbc)
2. The Royal Wolverhampton NHS Trust - Quality Accounts– September 2019 (Provisional)
3. Black Country Partnership NHS Foundation Trust – Quality Accounts – (tbc)
4. Reconfiguration of hyper acute and acute stroke services – CCG / RWT
5. Pharmaceutical Ordering
6. Item on the review of the impact of the new Medical Examiner Role and the Registrar's Office at Newcross Hospital
7. Maternity Services – Quality Assurance
8. GP appointment waiting times – involve Wolverhampton Healthwatch (November 2019)

Work Plan Version: 12/03/19 15:23