CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 5 March 2020

Attendance

Members of the Health Scrutiny Panel

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

Witnesses
David Loughton (Chief Executive – RWT)
Steven Marshall (Director of Strategy and Transformation - CCG)
Mike Hastings (Director of Operations – CCG)
Dr Jonathan Odum (Medical Director – RWT)
Dr Ramachandra (Stroke Consultant RWT)
Shelley Gill (Primary Care Contracts Manager)
David Bailey (Group Manager - RWT)
Rachel Jones (Stroke Services – RWT)
Heather Hammett (Practice Manager – Probert Road Surgery)

Employees
Martin Stevens (Scrutiny Officer)
David Watts (Director of Adult Services)
Kate Warren (Consultant in Public Health)
Sophie Pagett (Principal Public Health Specialist)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for Absence**
Panel Member, Dana Tooby sent her apologies.

The Director of Public Health, John Denley and Consultant in Public Health, Ankush Mittal sent their apologies.

Dr Simon McBride (Clinical Director for Stroke Medicine) sent his apologies due to a long standing commitment.

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

3 **Minutes of previous meeting**

The minutes of the meeting held on 16 January 2020 were confirmed as a correct record.

4 **Matters Arising**

The Scrutiny Officer advised that the Royal Wolverhampton NHS Trust were working on the failed discharged figures for the last three years and the Panel would be provided with them upon his receipt of the statistics from the Trust.

5 **Cancer Screening**

The Principal Public Health Specialist introduced the item on cancer screening. She remarked that there was a priority in Public Health to halt the decline of cancer screening rates across the City. She was hoping that all health partners would agree to taking steps to halt the decline and hopefully take measures to see an improvement in the uptake. There were three main cancer screening programmes, breast cancer, bowel cancer and cervical cancer. For each of the programmes there was a specific cohort of those that were eligible. As an example she cited that breast cancer screening was for women that were eligible between the ages of 50 and 70. They were invited to a screening appointment every three years.

The Principal Public Health Specialist remarked that the screening rates for breast cancer in Wolverhampton were lower than the West Midlands and England average. The current rate for breast cancer screening in Wolverhampton was at 56.8% compared to 71.5% for the England average. For bowel cancer screening, the uptake nationally was starting to increase, it was at approximately 71%. In Wolverhampton the rate was at 69% and was not increasing, unlike in England and the West Midlands generally. For cervical cancer screening the rates in Wolverhampton were lower than the England average, but there was a smaller performance gap than in breast cancer and bowel cancer screening. She was aiming to try and fully understand why Wolverhampton was so consistently lower in cancer screening performance compared to the regional and country average.

The Wolverhampton Healthwatch Manager remarked that Healthwatch were producing a report on cancer screening, but it was not yet ready to be circulated. She was however willing to articulate the main headlines from the report. They had engaged with 177 females over a period of time. One of the key findings was that there was a fear of women not wanting to know whether they had cancer. Another area that had arisen was regarding the flexibility of appointments, for instance not always having to attend Monday – Friday. Some females had barriers due to their cultural needs and so they did not want to attend an appointment with a male physician. She also noted that the letters were not currently tailored to a person's ethnicity.

The Wolverhampton Healthwatch Manager commented that some women had said that they would welcome some peer support to encourage them to attend. Another headline from the report was that not all women knew the purpose of cervical screening. The invitation letter did not explain everything in plain or simple language. There were also some women who believed incorrectly that if they had received the HPV vaccine, then they did not require a cervical screening appointment. She was happy to share the full report when completed with health partners.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that he found it difficult to understand why the bowel cancer screening rate was falling behind the national and regional rates. He felt that part of the problem was not enough advertising. A story needed to be told of the consequences of presenting late with cancer symptoms. It was much better to be diagnosed earlier than later. He made reference to the strong campaigns that had been undertaken in relation to smoking and argued that this could be the way forward. He felt advertising needed to be pushed harder and for it to be more hard hitting, similar to the approach that had been taken for lung cancer.

The Principal Public Health Specialist was in agreement with the Chief Executive of the Royal Wolverhampton NHS Trust's points. The bowel screening process had changed, where only one sample was now required, rather than three. The new simpler testing process was something which had not been actively promoted in the Wolverhampton area.

A Panel Member commented that promotion and accessibility were key to improving the uptake of cancer screening. They were of the view that nurses and GPs should be talking to women about cervical cancer screening more. This was echoed by another Panel Member who commented that GPs should be given resources to promote cancer screening. If the promotion of cancer screening was linked to performance related pay, he believed there would be an improvement in uptake rates. He made a comparison to how the uptake in the flu vaccine had increased since their was a financial incentive for GPs.

A Member of the Panel echoed the point on promotion being key. They had worn a football top promoting bowel cancer screening and had been struck by the number of people that had said their test was still in a draw unused.

The Principal Public Health Specialist confirmed that a reminder letter was sent out, if the test had not been returned. By that point though, the test may have been lost by the person and therefore the reminder would not be acted upon. The Chief Executive of the Royal Wolverhampton NHS Trust commented that in his opinion the reminder letter should be sent to the persons GP. The Principal Public Health Specialist commented that they wanted to have discussions with NHS England to try and bring about some changes.

The non-executive Board Member of the Royal Wolverhampton NHS Trust commented that the testing for prostate cancer increased after celebrities, Stephen Fry and Rod Stewart went public with their diagnosis. He suggested that a more hard-hitting message would help to increase cancer screening rates. The Principal Public Health Specialist made reference to the Jade Goody effect on cervical cancer screening. Celebrity endorsements and making best use of the media platform to promote cancer screening services was important to utilise.

The Director for Adult Services made reference to the flu fighters work, he believed the communication campaign was the reason for engaging so many more people. Social media campaigns, looking at the places which the target population were frequenting and using notice boards in those areas would help. Through the Council's, Safeguarding Board, they had a
Faith Group Engagement worker, who could potentially help engage different communities. He spoke in support of pop up shops to help improve screening rates.

Last year Social Services had supported 4,500 people, with approximately 3,500 of them in the target age group. People were regularly going out to these individuals delivering care packages, if there was a simple way to ask certain questions which could then be fed back, he would be happy to assist. He thought care providers would also include this as part of their work.

The Chair thanked Health Partners for their contribution to the item.

Resolved: That Health Partners, including GPs, make all efforts to ensure that the uptake of cancer screening in Wolverhampton does not decline and use all their best endeavours, working in partnership, to try and improve the situation.

6 **Patient Participation Groups**

The Director of Operations at the CCG (Clinical Commissioning Group) introduced the item on Patient Participation Groups (PPG). He introduced the Primary Care Contracts Manager for the CCG and the GP Practice Manager for Probert Road Surgery.

The Chairman of the Panel had provided the CCG with a list of questions to conduct an online survey with all the PPGs in the Wolverhampton area. The responses had been collated into a presentation (the slides of which are attached to the signed minutes).

The Primary Care Contract Manager remarked that all GP Practices were contractually obliged to have a PPG. The CCG did monitor Practices to ensure that they had the appropriate group. They visited Practices on a rolling programme as part of the contract review. During the process they asked for agendas and minutes of meetings to ensure compliance. Whilst the Primary Care Networks were quite new, they were already actively communicating with their patients.

The Director of Operations at the CCG remarked that there were six Primary Care Networks across the City. Four out of the six Primary Care Networks had responded to the survey and 19 out of the 40 GP Practices across the City. Most GP Practices communicated with patients by phone, their website, email, letters and text messages. The text messaging service and the screens in waiting rooms had been funded by the CCG. 11% of GP Practices had setup a virtual group, this was generally by email.

The Director of Operations remarked that the Chairs of each of the PPGs would meet in their relevant Primary Care Network (PCN) Group. 75% of PCNs used email, letters and their website to communicate. With reference to the survey question on how often PPGs met, close to 75% of PPGs met quarterly and all of the PCNs met quarterly. Meetings were held at the Practice or within easily walking distance of the Practices. The survey had determined that generally 6-10 people attended, sometimes less than 5 and occasionally there were groups which had more than 10 people attending meetings. The survey results had shown that the Practices were not happy with the overall representation of people attending meetings. In general PPG meetings did not attract young people. It was felt that this was probably because most meetings were held in the day time, when people were working.

The Director of Operations commented that one of the main issues raised at PPGs were appointments, which included availability and being able to contact the Practice on the telephone. The CCG had been assisting GP Practices by helping them introduce different methods for patients to be able to book appointments, which included online bookings and electronic systems via the telephone. They were also introducing video consultations to allow consultations to take place without the patient having to go into the GP Practice. Other issues which were often raised included DNA's (Did Not Attend), Patient Surveys, logistics and prescriptions. Primary Care Network Groups often talked about general Practice related issues and the future of Primary care.

Some examples where PPGs had led to improvements were fundraising, changes and updates to buildings, open days and leaflets, training of reception staff, telephone issues, encouraging the use of patient online. The PCN Group's had identified better patient communication, engagement events and marketing as areas which had improved since their existence.

In response to the question on whether any changes were planned for how PPG's worked in Practices and worked together in PCNs, the Director of Operations commented that some Practices were considering the use of text messages, Saturday morning meetings or meeting at a different time, encouraging a younger age range, a stronger ethnic diversity of people to attend and setting up a virtual group. The PCNs had responded to say they were discussing representation and the location of meetings. It was clear from the results of the survey that Practices and PPGs were making good efforts to grow their membership and make patient involvement more inclusive.

The Director of Operations at the CCG gave the results to the question, "Do you share ideas and best practice with other PPGs / PCNs as follows: -

Per Practice:
53% No
47% Yes – through PCNs and the CCG

As a PCN Group:
50% No
50% Yes – through Practice Management and Board meetings – verbally and written

Therefore only about half of PPGs and PCNs were sharing good practice. He recommended that Practices should support the PPGs to grow their membership to better reflect their Practice population and increase attendance. His second recommendation was that PPGs should continue their beneficial work and share best practice within their PCN Grouping.

The Chairman asked if GP Practices were contractually obliged to serve a set amount of days' notice to patients for meetings of the PPG and whether there was a requirement to display notices in the surgery and on their website publicising the upcoming meeting. The Primary Care Contracts Manager responded that where GP Practices had a very good operational PPG, the PPG would take on responsibility themselves for organising the meetings and advertising the meetings at the Practice and on the website. The CCG encouraged this, but they were aware that there were a lot of PPGs which could not support themselves and so they were reliant on the GP

Practice for support. The Practices as a rule did give good notice of the dates, it was sometimes difficult to establish dates though as it required collaboration with the Chair of the Group. Meeting dates could also be advertised on prescriptions and sent out by text message. The contract with GP Practices did not contain any detail on the amount of notice that had to served for meetings of a PPG Group.

The Chairman commented that he was only given two days' notice of a PPG meeting, with no agenda or minutes from the previous meeting. No room had been identified, with the meeting eventually taking place in a small consulting room. The date for the next meeting had not been identified and it was several months before the next meeting took place.

The GP Practice Manager for Probert Road Surgery remarked that at the last meeting of the year normally in November or December, the dates for the PPG Group at her GP Practice were all established for the following year. The dates were then displayed on the website and in a prominent point at the surgery by the front door. She invited any Councillor on the Panel to attend the forthcoming meeting of her PPG, which was taking place the following Thursday. Councillor Susan Roberts responded that she would attend the meeting.

There was a general discussion about the differences in quality of the PPG Groups across the 40 GP Practices in Wolverhampton. A Panel Member suggested there should be a minimum standard across all the PPG Groups. A Member of the Panel commented it was important to win the hearts and minds of GPs to obtain their full commitment to the PPG. The Chairman commented that the PPGs in the Bilston area required improvement.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that before they started working with a GP Practice, they always visited the PPG for the Practice, as it was a good indicator of the quality of the Practice. He would also sometimes personally visit the PPG. Working with the PPG was an excellent way of improving services and the Trust had achieved a great deal through close collaboration. He understood that the CQC (Care Quality Commission) would be giving more priority to PPGs in their inspection work in the future and it would form part of their rating system.

A Panel Member asked for a briefing to be given to the Panel on the CQC. The Chief Executive of the Royal Wolverhampton NHS Trust offered to help arrange for the Regional Head of the CQC to speak to the Panel in the future. He could also ask them to describe how they trained their inspectors.

The Chairman thanked the CCG and the GP Practice Manager on behalf of the Panel for the evidence that they had submitted to the Panel and for them helping to facilitate the innovative approach of an online survey to obtain data for the Panel.

Resolved: The Health Scrutiny Panel recommends that:

A) Practices should support the PPGs to grow their membership to better reflect their Practice population and increase attendance.

B) PPGs should continue their beneficial work and share best practice within their PCN Grouping.

7 **Midwifery Services at RWT**

The Matron (neonatal) from, The Royal Wolverhampton NHS Trust (RWT) introduced a report on Midwifery Services at the Trust. The present birth to Midwife ratio was 1:27/28. This was a positive ratio and met the recommendations of the birth rate and Midwifery acuity review of the Trust in 2017. They did not have an issue in Wolverhampton recruiting Midwives, unlike some other areas in the country. They had introduced the Midwifery Delivery Suite Coordinator, who had no caseload of their own during the shift, which allowed oversight of all birth activity in the area.

The Matron remarked that they had took a decision to cap births after reviewing the birth rate in Wolverhampton. Capping arrangements had been successful in maintaining birth rates within manageable levels over the last year with birth rates just under agreed commissioned activity. Capping restrictions had since been lifted in October 2019. Since the capping had been lifted, the bookings had started to rise but at a manageable level.

The Matron commented that there were some significant changes happening in Maternity Services across England. The Better Births Maternity Review and the NHS Long Term Plan (2019) had some ambitious objectives, which included a 50% reduction in still births, maternal mortality, neonatal mortality and serious brain injury by 2025. The Trust were working hard to achieve the target across the region. The key priorities to achieve the objectives were to ensure that the Saving Babies Live Care Bundle was implemented across every maternity unit in 2019.

The Matron stated that there were 5 key elements to this Care Bundle which were outlined in the report. The Trust reported quarterly progress to NHS England against the five key elements of the Care Bundle. Recommendations from the national maternity review – Better Births were being implemented through the Local Maternity System (LMS). The name was changing to Local Maternity and Neonatal System. These systems brought together Local Authorities, CCGs, maternity providers and user groups. They were aiming for women and their families to achieve seamless care across the maternity pathway, including between maternity and neonatal service providers.

The Matron remarked that one of the key recommendations from the Better Births Review was regarding continuity of care. This required providing consistency in the midwife and clinical team that cared for her and her baby throughout pregnancy, labour and the postnatal period. This was a key challenge for every maternity unit in the country. In Wolverhampton they were anxious that continuity of care was not at the cost of safety. They were therefore looking at the best model to support continuity of care but not at the expense of safety and quality. They needed to achieve 51% of women receiving continuity of care by March 2021.

The Matron commented that the Trust in 2019, fully achieved all of the 10 safety actions recommended within the Maternity Incentive Scheme. The Trust therefore recovered the full element of their contribution related to the CNST (Criminal Negligence Scheme for Trusts) incentive fund and also an additional share of unallocated funds. The money would be reinvested into the service to continue to improve standards.

The Midwife, stated that she was proud of the service. There was a Maternity Voices Partnership which allowed them to receive feedback and feedback was also received from the Baby Friendly audits.

The Chief Executive of the Royal Wolverhampton Trust commented that he had hoped the CQC (Care Quality Commission) would have inspected Maternity Services during their recent inspection because he believed it would have been rated as outstanding on all levels. He hoped they would return later in the year.

Following a question from a Panel Member, it was confirmed that the perinatal (pertaining to the period immediately before and after birth) mortality rate was higher in Wolverhampton than the national average. The Chief Executive of the Royal Wolverhampton Trust commented that this was due to the characteristics of population that the Trust served, which had higher levels of deprivation than many places. People presenting later and smoking and alcohol intake during pregnancy were other factors. The Trust did however take perinatal mortality very seriously and were working hard to improve the mortality rate.

The Matron remarked that they had secured some funding to work on a smoking cessation programme for pregnant women. This has been extremely successful and figures for reducing smoking in pregnancy had improved. They had also worked hard to ensure that a woman delivered their baby in the correct hospital with the right facilities available to avoid them having to be transferred between hospitals. This ensured better outcomes. It was however undeniable that there were high levels of women in Wolverhampton classed as high risk. The Midwife commented that at the beginning of 2019, smoking at time of birth was at 17-19%. The latest figures for February 2020 were 13.6%. So, it was clear the support service was effective. The Trust site would be smoke free before the end of 2020. A poster campaign was ongoing, “Think of Me.”

Panel Members complimented the RWT Staff on the Maternity Service and the success they had achieved with the smoking cessation project.

A Panel Member commented that it was important to also consider life changing circumstances in addition to perinatal mortality. The Matron responded that there were changes happening currently that would impact on this area. Currently and over the last few years babies were resuscitated at 24 weeks gestation, but this was going to change to 22 weeks. Extreme prematurity did have associated risks with areas such as learning disabilities in the future. The Chief Executive of the Royal Wolverhampton NHS Trust commented it was very much a political question and one for politicians to consider. Holland had a completely different view on when babies were offered neo-natal intensive care.

The Healthwatch Manager stated that they had completed a report on pregnancy. Overall the report was positive, there were a few areas for suggested improvement. Support for partners was one of these and information on baby care such as feeding support. The report also referred to the length of time health visitors continued to visit new mothers after birth. The report had not yet been published and she would send it to the Trust for their comments before publication.

The Matron commented that they had recently reintroduced bath demos on the ward. There weren’t facilities for partners to stay on post-natal wards, but they did in some

cases use a side room in specific cases. There was also a Transitional Care Ward, for babies that needed additional care, partners were able to stay on this ward. Midwife visits in the community would normally take place up to ten days, but could be extended up to 28 days. They were working on a video on baby care for Mothers and were working with the LMS on a video for Fathers.

The Chair commented that he thought Maternity Services at the RWT were excellent. He asked if any learning had been taken on board by the Trust following the problems with the Maternity Services in Shropshire and other areas. The Chief Executive of the Trust responded that when there was a public inquiry it would be revealed one of the biggest problems was people making the wrong decisions about when to transfer women to specialist centres for delivery. There were only four Level 3 neo-natal units in the West Midlands, Stoke-on-Trent, Coventry, Birmingham and Wolverhampton. He didn't know the reasons why decisions had not been taken to transfer certain women.

Resolved: That the Midwifery Services report be noted.

8 **Stroke Services at RWT**

The Group Manager of the Royal Wolverhampton NHS Trust introduced a report on Stroke Services at, The Royal Wolverhampton NHS Trust. He gave a summary of the ongoing improvement work in Stroke Services. The service had 39 beds, which were based at New Cross Hospital. In April 2018 they had merged with Walsall's Stroke Provision providing hyper acute and the acute aspects of stroke care. The rehabilitation aspects were retained at Walsall on a well-established stroke pathway. There were four hyper acute
beds on the unit.

The Group Manager commented that the biggest challenge with the merger was staffing. They were now at the point where staffing levels were appropriate. He commented that there was an extensive data failure in the latest quarter's information which was included with the agenda pack. The metrics were significantly attributable to a failure of the Trust to record information accurately. They had improved the data quality since this time. He described the statistics in great detail. An A Unit meant the service was doing very well, an E Unit corresponded to poor. Extensive training was taking place on the ward. The gold standard was to give a stroke patient a bed within 2 hours and there was a target of 4 hours.

The Group Manager stated that they had been looking at how they could improve the SMR (Standard Mortality Ratio Figures) for stroke patients. Several external reviews had taken place, both at their request and those that were mandated. Extensive work had taken place to improve medical notes. They currently had an external Medical Consultant working on the ward, reviewing all the medical notes for RIP patients. They were challenging themselves to see if there was anything they could have improved in a patients care.

The Group Manager commented that in the third quarter, the SSNAP (Sentinel Stroke National Audit Programme) requirement was for a patient to see a suitably trained stroke nurse within 24 hours, the Trust in the previous week achieved it within less than 15 minutes. The requirement for a Doctor Review was within 14 hours and in the previous week the Trust had achieved it within 30 minutes. They often would

have a nurse and a Doctor waiting in the Emergency Department for the patient to arrive. They had established a middle tier of Doctors using the Trust's Clinical Fellow Scheme, which had been hugely successful. They currently had four Clinical Senior Fellows who would be training over the next two years to become Consultants.

The Stroke Consultant commented that she had started working as a Stroke Consultant at the Trust in 2012. There had been numerous changes to the service in this timeframe. Consultant numbers had vastly improved and there had been an increase in beds. They now provided an overnight Stroke Consultant and so a Consultant was available 24 hours a day.

Members asked some technical questions about the performance statistics to which the Group Manager gave a full explanation.

A Panel Member commented that his personal experience of the Stroke Department at the RWT was a positive one. The Medical Director commented that whilst there had been some staffing issues in the department, which were related to the merger, they were now almost all resolved. He believed the Trust were providing an excellent stroke service. He thanked all the teams for completing a very difficult job under sometimes difficult circumstances.

Resolved: That the Stroke Services at RWT report be noted.

9 **Coronavirus (Covid-19) - Urgent Item**

The Principal Public Health Specialist introduced the urgent item on Coronavirus (Covid-19). She stated that there were now a number of Coronavirus cases in the UK and there had been some reports the previous day of cases in the West Midlands. Within Wolverhampton there was a key Multi-Agency Group consisting of the Local Authority, The Royal Wolverhampton NHS Trust, the CCG and Public Health England. Regular communications were taking place. Covid-19 was also a regular item on the Council's, Strategic Executive Board (SEB) and there was a tactical co-ordination group that was below SEB.

The Principal Public Health Specialist stated that, The Royal Wolverhampton NHS Trust had setup a Pod service where patients could be tested at New Cross Hospital away from the Emergency Department. A Community swabbing service had also been setup that was testing people with suspected cases at home. They were moving forward with plans for maintaining these services in the long-term. They were looking at setting up drive through swabbing services to be available from the following week. This would take some of the pressure off the Trust so they could prepare for increased Covid-19 cases. Internally at the Council all of their guidance and communications were coming from Public Health England. This was the same for the rest of the country.

The Principal Public Health Specialist remarked that the country was currently in the containment phase. It was a new virus to humans and evolving. It appeared to be similar to seasonal flu and so they could use their pandemic flu plans to help provide them with a baseline for preparedness. They were in regular contact with NHS England and Public Health England. The key message to residents at the present time was practicing good hygiene and the "Catch It, Bin It, Kill It" campaign.

The Chief Executive of The Royal Wolverhampton NHS Trust stated that the messages were being carefully controlled by Public Health England, so they were somewhat limited as to what they could do and say. He was sceptical about the effectiveness of the Pod system. New Cross Hospital had 127 entrances and people would not find their way to the Pods, without walking through large sections of the hospital, irrespective of good signage. He was procuring considerable building work in the Accident and Emergency Department, as they did not have enough places to isolate patients. This was not unique to New Cross Hospital, no Accident and Emergency Department in the country had enough isolation areas.

The Chief Executive of The Royal Wolverhampton NHS Trust remarked that he was now applying the principle of "Plan for the Worst and Hope for the Best." Over the next two to three weeks he would be planning for the worst. The modelling that he had seen had led him to the conclusion that the situation was going to be awful. A major concern was that there was not enough ventilator capacity to cope with the expected numbers. This would mean applying what used to be referred to as "Three Wise Men System," to decide who would receive treatment and who did not. His second major concern was regarding staffing. If schools and colleges were closed, as had happened in Italy, it would cause staffing issues. He would not be able to setup a temporary creche facility as he ordinarily would for a situation such as heavy snow. He was working on the assumption that 20% of the Trust's staff would not be able to attend work at anyone time. Elective surgery during the height of the crisis would all be postponed, which would also cause its own problems. The Chief Medical Officer at the Select Committee earlier in the day had as good as indicated that the containment phase was coming to an end.

The Director for Adult Services commented that a large proportion of the people dealt with in social care were at a higher risk if they contracted the virus. They were working close with Public Health Colleagues and the NHS to think about different ways of managing them to reduce their risk of becoming infected with the virus. They were contingency planning as many social care staffed worked around school hours.

The Principal Public Health Specialist commented that there were no confirmed cases of Covid-19 at the present time in Wolverhampton. Nationally NHS 111 were taking calls from people that suspected they may have caught the virus and confirmed cases were being managed by Public Health England. They had strict guidance about self-isolation which applied to people who had travelled to certain places abroad and whether they were exhibiting any symptoms. She believed that many people would be able to self-care at home if they caught the virus. She thought many of the symptoms were similar to seasonal flu. It appeared that older people were much more vulnerable to the virus than children and younger people. There was no vaccine currently available.

A Panel Member commented that the Chinese had been picking up two strains of the virus, one which was mild and one which was aggressive.

The Chairman thanked everyone for their contribution to the urgent item.

10 **Mortality Agenda at RWT**

The Medical Director introduced a report on Mortality rates at, The Royal Wolverhampton NHS Trust. It was a positive picture. Over the course of the last 18 months, through the programme of work, the mortality statistics had declined steadily and were now in expected limits with the latest SHMI (Summary Hospital Level Mortality Indicator). Extensive reviews of case records had taken place, they hadn't found any evidence of avoidable deaths.

The Medical Director explained that there had been a decline in the observed death rate, which they thought was related to the work in the community with nursing homes. This was identifying patients where their end of life care could be managed at home rather than being transferred to hospital. The patients that died in hospital in Wolverhampton was significantly higher than the national average. But there had been an improvement over the last three years of observed deaths in hospital, which suggested more people were receiving their end of life care at home or their preferred place of death.

The Medical Director commented that they had extended the number of the new Medical Examiners to allow them to work more comprehensively. They were aiming to have 90% of the deaths in hospital reviewed by the Medical Examiner.

The Medical Director stated that they had completed a review of the quality of coding. There had been some significant improvement over the last two years, which partly accounted for the better expected death rate. They had been working with Price Waterhouse Cooper over the last 18 months who had reviewed the data collection systems, identified areas for change and provided intelligence with their predictive models to identify potential data quality issues on a case by case basis. The independent Consultant had now left the organisation.

The Medical Director commented that a significant piece of work was taking place on how they engaged with families. It had been supported by Healthwatch.

There were some questions to the Medical Director about the Medical Examiner Role and standards of care.

The Scrutiny Officer commented that the digital monitoring of sepsis was being trialled in some hospitals, he asked the Medical Director to comment. He responded that his thoughts were positive. They currently used the traditional early warning scoring system to identify patients at risk of sepsis. At the front door they had very good data, capturing most patients and they were treated in line with guidance. There was a little fluctuation, but even at the busiest times they did very well. He believed there was a particular problem with data capture inaccuracies when looking at the inpatient population, so he couldn't comment on the performance for inpatients. They were looking at some of the new digital technologies, which looked at tissue to try and indicate if the patient had sepsis. They were going to trial them out soon and they had been given some samples. A meeting was setup in the coming weeks with one of the companies. He thought digital monitoring probably was the future, but it was still early days. The Chairman paid tribute to the excellent work that had been completed to date to improve the mortality statistics.

Resolved: That the report on the Mortality Agenda be noted and tribute be paid to the excellent work that had taken place.

11 **Work Plan**

Resolved: That the Health Scrutiny Work Programme be agreed.