CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 14 December 2023

Attendance

Members of the Health Scrutiny Panel

Cllr Carol Hyatt
Cllr Jaspreet Jaspal
Cllr Milkinderpal Jaspal
Cllr Rashpal Kaur
Cllr Sohail Khan
Stacey Lewis
Cllr Susan Roberts MBE (Chair)
Cllr Paul Singh (Vice-Chair)
Cllr Gillian Wildman

In Attendance
Andrea Cantrill (Volunteer Officer Healthwatch)
Debra Hickman (Chief Nursing Officer Royal Wolverhampton Trust)
Rebecca Hewitt (Transition Nurse Royal Wolverhampton Trust)
Paul Tulley (Managing Director Wolverhampton Integrated Care Board)
Dr Rashi Gulati (Lead GP Wolverhampton Integrated Care Board)
Corin Ralph (Head of Primary Care Black Country Integrated Care Board)
Sian Thomas (The Partnership Director OneWolverhampton)

Employees
John Denley (Director of Public Health)
Madeliene Freewood (Public Health Partnership and Governance Lead)
Lee Booker (Scrutiny Officer)
Jo McCoy (Finance Business Partner)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies and Notification of Substitutions**
Apologies were received from Cllr Khan and Cllr Mattu.

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

3 **Minutes of previous meeting**

Cllr Jaspreet Jaspal was incorrectly listed as not present during the meeting when she was in attendance. The minutes for the meeting held on 21 September 2023 were approved as a correct record subject to this correction.

4 **The Director of Public Health Annual Report 2023: The Power of Partnership**

The Director of Health summarised the importance of partnership working as a part of their health policy (a copy of the presentation is attached to the signed minutes). Partnership working contributed towards better health outcomes for the population. Achievements so far included: being in the top quartile for alcohol treatment completions, the infant mortality gap rating between the City of Wolverhampton and the English average was narrowing. The proportion of 2 and a half year checks assessing children's development was taking place within the target period above regional and national averages, a reduction in the number of rough sleepers in the city which was part of a longer term downward trend and a top performer for NHS health checks.

The Partnership Director OneWolverhampton explained that OneWolverhampton was not an organisation but was a partnership made up of multiple stakeholders in the City's healthcare service. Their purpose was to improve health outcomes across the City by working together and utilising data to ensure needs were met. All partners had made commitments to work together, treating their finances as one and the same, sharing data and information as well as to work together to design services. They were working on: adult mental health, care closer to home, children and young people, living well, primary care development, urgent and emergency care. A variety of tasks were set out on the presentation slides which evidenced what they were doing work towards the set out goals.

The Director of Public Health played a video to the Panel looking at how partners were supporting financial well being in the City at the One Community Stratton Street Community Centre. In the next 12 months they were committed to working together to address key priorities, which included: Improving physical activity rates in the City, increasing cancer screening uptake, improving children's vaccination uptake, providing weight management and smoking cessation services, growing the community and voluntary sectors, further developing the Love Your Community approach. They had launched ward based data mapping, which included QR code access for input.

The Volunteer Officer for Healthwatch stated they were pleased elements of community cooking were displayed in the report. They said it was vital for people who had poor mental health or were unable to cook for themselves had a way to get access to a healthily cooked meal.

The Manager for Healthwatch Wolverhampton cited the well being champions at the University of Wolverhampton as being positive for the City. She wanted to know if Public Health were going to continue funding for this scheme. She also stated that whilst rough sleeping may have declined in the City centre, it did not mean roughsleepers had not dispersed into other areas in the local authority and felt it should be considered.

The Director of Public Health stated that the partnership was broad and involved a lot

of competing interests and demands. He said it would not be possible to confirm funding for any one group due to the level of demand each year and finite resources available. He said that the data on homelessness was based around the entire Local Authority not just the City centre and that they often knew who regular beggars were. They would try to engage them to try find out what was driving them, many of the beggars had accommodation for the evenings.

The Chair stated that some rough sleepers in her experience had a property and chose to sleep rough in the streets.

The Vice Chair praised the new Local Assets tool and felt this would be very helpful to Councillors. He cited page 26 and asked if the statistics about smoking included people who vaped. He wanted to know if the Integrated Care Board (ICB) could provide data in the next report of people in wards who use their local GP and who travel to GPs further afield. He wanted to know if specific health conditions which were high in each ward could be included in the report next year.

The Director of Public Health stated they had done a recent lifestyle survey and that vaping added an additional 12 percent to that statistic. He said it was important to consider vaping in two ways: Youth vaping was problematic and needed to be tackled, but adult vaping was often used by former smokers to enable them to move from cigarettes and start to quit. He said there was no reason they couldn’t get the data about GP users into the ward profile page data. He said they could include data on health conditions in the next annual report.

A Panel member asked how they were going to promote the ward data page to residents to enable real time inputs.

The Director of Public Health said it was a part of the Love Your Community scheme, which he felt would be better than an advert as it would be incorporated through that.

A Councillor said he was glad the report covered what they had achieved and done right but wanted the report to show more of what wasn’t going well. He felt an annual report for scrutiny should focus on areas of concern. He wanted to know if the data listed on wards would be able to have in brackets the figures from the previous year. He was pleased Public Health were working with small community groups but he recognised further work in this area would cost more money when Council budgets were tight. He wanted to know how Public Health were going to deal with this challenge. He also thanked the team for their hard work.

The Director of Public Health said they were aware of the challenges being faced and cited the statistics on alcoholism in the City, which whilst they had improved significantly on previous years, were still high. All of these issues would need to be tackled in partnership. He said the challenge was that the finances for Public Health from Central Government were allocated yearly and they were unable to use long term planning due to this, he said this had been an issue since 2012. He said because of this, they had to take contracts on a risk basis. He said he would take the comments on board regarding the figures in future annual reports.

The Chair stated the ward figures were on the new ward boundaries and wanted to confirm if last years were the same ward boundaries or the old ward boundaries.

The Director of Public Health confirmed the 2023 report was based on the new boundaries, whereas old ones were not.

5 **Budget and Performance Update**

The Finance Business Partner set out the draft budget statement in the presentation (a copy of the presentation is attached in the signed minutes). The Council had a forecasted budget deficit of £16.4 million in 2024-2025 rising to £23.1 million across 2025-2026 announced in March 2023. Work had been undertaken by the Council to reduce the deficit, with the budget deficit updated in October, projected to be £2.6 million across 2024-2025. Work was still being undertaken to further reduce the deficit and create a balanced budget for the future. Economic uncertainties were: future funding, inflationary pressures, demand for services and future pay awards. Public Health Services were fully funded by a grant, the Public Health grant for 2023 – 2024 was £22.5 million.

The Director of Public Health stated that their performance was updated annually and results were published on the Public Health Outcomes Framework for viewing. Since the previous publication the Council had improved and demonstrated strong performance in the areas of NHS health checks for 40 to 74 year olds and alcohol mortality levels. He stated that recent data released showed that the Wolverhampton City population had moved from being one of the least physically active groups in the country to 61st most active in the country. He said he felt this was a result of the targeted work they had done. Data on domestic abuse was West Midlands wide and not Wolverhampton specific. The data showed that domestic abuse in the West Midlands had increased, although this may not have been because of a change in the amount of domestic abuse levels and may have reflected higher levels of reporting by victims. The City of Wolverhampton had some of the lowest suicide rates in the country. Notification had been received in December 2023 of an indicative allocation of the Public Health Grant 2024-2025, totalling at £22,758,935, an increase of 1.3%. Indicative funding of only one year impacted upon long term planning. The Strategic Risk Register relevant to the Panel listed: Asylum seekers and refugees, impact of future pandemics, climate change, financial wellbeing and resilience.

The Vice Chair thanked the Director of Public Health for the report, he was pleased suicide rates were lower in the area and hoped for further improvements to prevent loss of life. He was hoping to see domestic abuse decrease. He asked for clarification around the listing of asylum seekers and refugees in the risks area.

The Director of Public Health stated that the demography of the City had massively changed and that when listing asylum seekers and refugees, it meant the challenge of knowing who was living in the area and what their needs were. He said it was important to capture the City's changing demography to allow them to ensure they met the needs of those living in the area.

A Councillor asked the Director of Public Health to note that some services were statutory and none-statutory. With public funding pressures and tackling the deficit being an area of priority, he stated it would be prudent to take note of those functions which were statutory and had to be carried out, as the ones that were not always had a level of risk of being cut depending on decisions made at full Council.

A Member of the Panel cited a recent event she had been to, which raised awareness of domestic abuse and the services available for different communities and genders. She stated that one of the services was a Sikh Women's Aid service based in Birmingham, but a report showed the majority of people who were Punjabi speaking that used the service were from Wolverhampton. A representative from the organisation had spoken to the Panel member to express interest in wanting to work with the City of Wolverhampton Council to locate services in the local area; the Councillor stated she would like to sign post that representative to the Director of Public Health. The Director of Public Health said he would welcome the report.

A Councillor added that when he last checked data for Wolverhampton, it had the 2nd largest Sikh population in the country.

A Councillor asked what could be achieved if the Council had a grant indicator of 5 years, rather than a year, for planning. The Director of Public Health said it would allow for greater certainty and in areas like the charity and voluntary sector when they worked in partnership with Public Health, it allowed them to know their contracts were longer and more secure, thus providing job stability, benefitting mental well being and the local economy.

A Member of the Panel stated that the need for services was so high in the City and yet the resources available to fund services so few. She said she would not like to see none-statutory services cut and they were beneficial to the people of the City.

6 **Child to Adult Transition Services**

The Transition Nurse for Royal Wolverhampton Trust stated that following a 12 month pilot, the role of Transition Nurse at the Royal Wolverhampton Trust (RWT) had been made permanent, they had also set up a transition steering group and a transition policy. A Ready-Steady Go transition plan had been developed, with improved pathways for the transitional period. Transition Clinics had been set up in acute clinics. In collaboration with the Living Well Team, the RWT had set up a transition group at Compton Care for people with life limiting health conditions. An action plan was being developed following recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report. They were awaiting further national reports to receive further recommendations. Gaps in transition service provision were: children who were based on medical equipment at home and that services were not appropriate for all children (specifically vulnerable children). They were working on a plan to address these gaps. Qualitative experience based stories were read out by two patients relating to the service gaps to the Panel.

A Councillor enquired what was happening with child mental health. She cited an example of a constituent who had a child who needed mental health support but upon becoming an adult they had informed the team they were fine, but the parent believed them to still be requiring support. She also wanted to know if they could give timelines for the actions covered in the report.

The Transition Nurse for Royal Wolverhampton Trust said she could not speak for Child and Adolescent Mental Health Services (CAHMS) but she was aware they

were working on their transition services. They tried to encourage teenagers to provide a list of questions as part of the Ready-Steady Go programme to get the children to learn how to self-advocate, understand their position and report. For the action plan, they were looking at around 12 months for the goals.

The Vice-Chair stated that in the event of shortages of counsellors and psychologists, how were the RWT child to adult transition team getting to the none medical and clinical diagnosis before prescription started.

The Transition Nurse for Royal Wolverhampton Trust replied that they had a youth worker who took referrals from schools nurses. For children who did not meet the threshold for CAHMS, they had requested and received funding from the ICB for 5 youth workers for 12 months to implement preventative support for those children.

The Vice-Chair referred to page 103, which showed a graph displaying data for barriers relating to transition, he wanted to know when the survey was done to attain the data.

The Transition Nurse for Royal Wolverhampton Trust replied that the survey was begun to 2019 but was impacted by the pandemic during its time frame.

7 **Hospital at Home**

The Partnership Director OneWolverhampton opened the presentation (a copy is attached to the signed minutes) and stated that Wolverhampton was known nationally as being ahead of the curve in delivering virtual wards and digital care to patients. She then summarised the history and development of the service at Wolverhampton; which began as a response to the Covid-19 Pandemic in 2020. They had added 6 additional care pathways since 2020, as well as a number of care and support services to the virtual ward and digital care. For 2024 they planned to add a further 3 services. Wolverhampton currently operated 98 virtual ward beds as part of their service and this was in line with national guidance. The virtual ward team was nurse led, but they also worked with the wider multi-disciplinary team such as pharmacy and therapy professionals, with medical insight provided by consultants within the hospital. All patients had an initial face to face visit, lack of digital equipment or confidence by the patient was not a barrier to the service. They delivered care 7 days a week 8am until 10pm. The service was currently overachieving in its bed availability, regularly exceeding the 98 beds target. Service referrals were increasing month on month, with the top referrals coming from Paediatrics (41%), Accident and Emergency (23%), Respiratory Medicine (11%). All patients were given an option to feedback from their virtual wards on their experience with the service.

The Vice-Chair wanted to know if in the event of a loss of communication with a digital patient, did the RWT have a system in place to reach them and were they sufficiently resourced to do this as the service expanded. He also wanted to know what provision was put in place for digital systems which recorded and flagged errors in the monitoring system.

The Partnership Director OneWolverhampton replied that for patients who did not submit monitoring readings they would utilise the same procedure they had if a district nurse was undertaking a visit and could not reach the patient. This included multiple communication contact methods, identifying a next of kin, identifying if they

had access to a key safe and she confirmed they had clear escalations in place with emergency services. For system services, they were provided with regular data which displayed a clear line of regularity to the staff, if anomalies began to show up, the staff would respond to this. They also had the ability to provide digital technology such as smartphones to patients for the duration of the service usage.

The Chair stated that asthma was one of the services offered within digital care, she wanted to know how it was decided within the health care process that someone needed and could have that healthcare at home service.

The Chief Nurse for Royal Wolverhampton Trust replied that they had a set criterion which community nurses and clinicians followed to rate a patient by for a referral. This was a clinical decision, made in the same way a discharge would be made. This would be a way of giving additional support for a set period of time whilst they returned home.

The Volunteer Officer for Healthwatch asked if the face-to-face meetings were done in physical format or if some or all were done via webcam communication services.

The Partnership Director OneWolverhampton replied that all patients had an initial face to face meeting where they discussed and decided how they wanted their service, which was tailored on a case-by-case basis. They would decide if they wanted to submit readings digitally via a smart phone, or by phone call. Many patients would have additional issues which were not being covered by the digital ward and this would be a cross service situation, with district nurses.

The Volunteer Officer for Healthwatch stated she was concerned having people go out for the service was costly and wanted to understand the benefit of it, citing concerns around capacity.

The Partnership Director OneWolverhampton explained that the Digital Care and Virtual Wards were an additional service. They worked alongside the District Nurses but they were two different services. The Virtual Ward supported acute healthcare issues where those issues had been exacerbated and allowed the patient to have the care best suited to them (further choice in treatment setting). She said it was not an ineffective service model.

8 **Healthwatch GP Services Survey**

The Vice-Chair informed the Panel that due to unforeseeable circumstances, Healthwatch were unable to provide their survey report to the Panel and would be bringing the survey to the next Health Scrutiny Panel on 18 January 2024. The Managing Director of Wolverhampton from the Integrated Care Board (ICB) would still be delivering his report however. The Vice-Chair asked The Manager for Healthwatch Wolverhampton to confirm they would be bringing their report to the next Health Scrutiny Panel.

The Manager for Healthwatch Wolverhampton confirmed the report would be delivered at the next Health Scrutiny meeting.

Managing Director Wolverhampton ICB summarised the report to the Panel. He said there had been a year-on-year increase in Primary Care activity, with 2023 being the

highest year in activity since the records began. The proportion of patient appointments that were being seen face to face showed a steady increase since the end of lock down and Wolverhampton was slightly higher than the national average. They reported community consultation at pharmacies and that further pharmacy advisory services would be expanded in the future to reduce demand on GPs; pharmacies played a role in Primary Care too. They were currently working to implement a 2-year program in GP Practices to encourage a more standard approach and to utilise their resources better. Across the Black Country they had a "Digital First" Program which was designed to support the full implementation of the digital offer built into GPs contracts. Across 2023 they had looked at website reviews to ensure the various practices websites were easily accessible to patients. They had continued to support practices who were moving to cloud based telephone systems. The Patient Participation Group training that the ICB had delivered to practices earlier in the year had received positive feedback.

A Panel member asked for an explanation about a graph on P.9 of the report on full modern practice scoring.

The Head of Primary Care responded that as part of the recovery plan, they had tried to understand the position of their practices and the processes those practices utilised. They had done a baseline assessment of the practices against 10 components; these components once combined would improve the operational efficiency of practices. These components included: the practices ability to use their data to understand the demands they had, that they had the capacity set up in the right ways to meet the demand from the public, to understand that they used their triage properly, which included sign posting. The practices were asked to grade themselves against these components, with Level 4 being the level required. If they had not met these levels, the ICB was working with them to progress them towards the right level. They were currently at the stage of looking at the plans submitted to them from GP Practices which displayed how they intended to get to a higher level rating.

The Manager of Healthwatch Wolverhampton stated she felt it was important that the public were informed about the terms, changes and reasoning to the Modern General Practice to ensure there was no misunderstanding from the public.

The Head of Primary Care stated they had put a Ambassadors Team together to represent the public and interrogate the language they used to ensure the language was understandable by the general public. She hoped to streamline access to Primary Care Services.

The Volunteer Officer for Healthwatch Wolverhampton asked about digital information. She wanted to know if digital data was provided to people when systems were provided.

The Head of Primary Care confirmed they did do this.