CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 18 January 2024

Attendance

Members of the Health Scrutiny Panel

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

Attendees

Gemma Jameson – Directorate Manager Royal Wolverhampton Trust
Sabita Nair – Clinical Director of Gynaecology
Martina Morris – Deputy Chief Nurse Royal Wolverhampton Trust
Vivek Khashu – Strategy and Engagement Director West Midlands Ambulance Service
Pippa Wall – Head of Strategic Planning
Mandy Poonia – Co-Chair Healthwatch
Andrea Cantrill – Volunteer Officer Healthwatch
Paul Tulley – Managing Director Wolverhampton Integrated Care Board
Tapiwa Mtemachani - Director of Transformation and Partnership for NHS Black Country Integrated Care Board
Jonathan Fellows – Chair of the Integrated Care Board and Integrated Care Partnership

Employees

John Denley – Director of Public Health
Madeleine Freewood – Public Health Partnership and Governance Lead
Ainee Khan – Consultant In Public Health
Riva Eardly – Principle Public Health Specialist
Natalie Davis – Senior Public Health Specialist
Lee Booker – Scrutiny Officer

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

Apologies were received from Councillor Mattu.

2 **Declarations of Interest**

There were no declarations of interest from the Panel.

3 **Minutes of previous meeting**

The minutes of the meeting which occurred on the 14th December 2023 were approved as a true and correct record.

4 **Gynaecology Services Review**

The Directorate Manager Royal Wolverhampton Trust began the presentation (a copy is attached to the signed minutes) which showed an overview of the current waiting times for Gynaecology services across the Royal Wolverhampton Trust (RWT) . She stated that they faced some challenges, attributing some of this to a backlog created by the Covid-19 pandemic. She stated they had outsourced some of their services to Health Harmony to give the RWT further support on tackling the backlogs. She said their backlog had reduced from being over 4500 patients to just under 4000 patients. Choice of access for Acute Services at New Cross Hospital were summarised as – Monday to Friday (8am – 4pm), out of hours via emergency department, direct access for patients (following telephone referral), they offered emergency surgery. Outpatient services were primarily at New Cross Hospital, although some were offered at Cannock Chase Hospital. Patients had a choice of a female doctor, although they reported that for some sub-specialities they were not able to provide that option due to a lack of females in the specific role. Initiatives they were currently working through included an endometriosis centre (with a robot for robotic surgery), nurse led triage for suspected cancer patients, expanding ambulatory gynaecology and other examples covered in the slides. They had been working collaboratively with the Black Country Integrated Care System (ICS) with the aim of reducing health inequalities across the Black Country, some examples given were – health hubs within the community, streamlining GP referral guidelines and a workforce review across the ICS. They had collaborated with OneWolverhampton around further education for GPs. The Directorate Manager Royal Wolverhampton Trust also reported on some things they did to support diversity which included: Sign language services, providing hoists for patients, access to the learning disability team, discussions with the transgender community around cervix screening, and providing interpreter services.

A Councillor wanted to know how the RWT gynaecology waiting times compared with the national average waiting times.

The Directorate Manager Royal Wolverhampton Trust stated they were working towards the NHSE National Target to reduce to 78 weeks. Based on patients that attended between January and December last year. When a patient had been seen and had treatment, the list displayed how long they would wait. They discussed with other Trusts within the ICS to compare and work together, as well as reporting to the National NHS their performance.

The Councillor stated that the question had not been answered.

The Clinical Director of Gynaecology replied that within the ICS, they had the longest

waiting times compared to other hospitals, she attributed this to a suspension of gynaecology services during the pandemic, with staff sent to support other services. There was also significant illness within the workforce which also added to the delays. Other hospitals did not close their gynaecology services for 2 years, unlike RWT.

The Councillor asked if other Trusts outsourced services, referring to the comment made earlier about outsourcing to Health Harmony, she stated she believed this would cost more than providing a service in house. She wanted to know if the cost comparison had been made and if it was deemed the most effective use of resources.

The Clinical Director of Gynaecology answered that the RWT were the last within the ICS to adopt outsourced services with Health Harmony. She stated that they did not want to but harm to patients outweighed cost so they eventually decided to outsource services. She stated that this decision had been internally scrutinised and whilst it would cost them more money, it would generate a return. The Clinical Director of Gynaecology stated she did not have the fine details at hand to explain this point fully but stated she would be happy to come back to the Panel with the information. She stated that they had specific criteria of patients who they referred to Health Harmony, which were only straight forward/simple cases, not complex ones.

The Deputy Chief Nurse asked the Panel if they would like her team to share the numbers and broader context of details with them via email.
The Chair confirmed this.

A member of the Panel wanted to know what the longest waiting time was that someone had to wait, pointing out that the times listed in the presentation were averages. He also wanted to know what their collaborations had done to reduce inequalities in the poorest wards in Wolverhampton.

The Directorate Manager Royal Wolverhampton Trust answered that they met twice weekly with the Trust and they had to report patients that were waiting beyond 78 weeks to end their treatment date. She said they did have patients who were waiting over 78 weeks for their whole pathways. She said the statistics shown in the presentation were for those waiting for their first appointments only. She said she could provide information on waiting times based on the whole pathway to the Panel. She discussed the work being done with OneWolverhampton around menopause referrals, she gave an example of a menopause consultant who felt that many patients on waiting lists who arrived could have been dealt with at Primary Care level rather than being referred to her. The work they were aiming to do was around education to GPs on support they could give at a primary care level to avoid unnecessarily sending people to a secondary care pathway.

The Councillor stated he wanted the different statistics for first appointments rather than just averages displayed.

A Panel member asked if contributions to delay times were caused by any labour issues, resources issues or if it was simply demand outstripping supply.

The Clinical Director of Gynaecology stated that the workforce was a challenge, as she felt the NHS was not encouraging of newer staff due to pay and conditions. She

stated that in this field, as the workforce was reliant on people who had been in the profession for a long time, they were subjected to normal life cycles and at times when a staff member was off at length, this would cause issue as it was difficult to fill the gap. She cited cancer specialists in gynaecology as an example where they had advertised 4 times in the country for the role but could not get anyone for the role, she stated that often those with the expertise were going abroad for better pay and conditions. They also tried advertising abroad for the role and were still unable to fill the position.

The Councillor replied that given the issues discussed about providing services, he did not understand why the government were trying to move services from 5 days a week to 7 days a week. He felt this would be impossible. He asked what cost was generated by missed appointments.

The Directorate Manager Royal Wolverhampton Trust stated that there "did not attend" levels were at 9 percent and they had reduced it to 6.6 percent but utilising volunteers who called patients near the time of their appointment to aid the patient if they had issues with transport or other such problems which may cause them to miss an appointment.

The Chair stated she believed a number of people chose to wait because of the option of robotic surgery, she wanted to know if this affected waiting times.

The Clinical Director of Gynaecology replied that robotic surgery was niche and did not apply to all patients. She said they had specific criteria patients had to meet to receive robotic surgery and that only 3 consultants were trained to use them. She said robotic surgery was only for cancer cases and complex endometriotic cases. She said it would not be cost effective to offer robotic surgery to all patients and stated that the robot also covered several other departments, not just theirs.

The Directorate Manager Royal Wolverhampton Trust added that if it was the case patients were waiting longer than necessary for robotic surgery which caused delays, they would have a clinical review to address this issue.

The Vice Chair stated that he had disagreed with previous comments made by a Panel member in reference to the government trying to increase service delivery days from 5 days to 7 days. He felt it would be an improvement to offer more days of service for patients. He said he did not feel it was a correct analysis to compare the challenges at New Cross Hospital to all hospitals in the country when discussing the government's policy as other hospitals may have the staff to meet the longer days. He said New Cross Hospital may have challenges, but those challenges were to be met and overcome. He wanted to know if the RWT were collaborating with other Trusts and hospitals. He commented that the 78-week waiting time was awfully long and wanted to know why this was the case.

The Clinical Director of Gynaecology said that in reference to the 5 day service, this applied only to early pregnancy assessment unit working time. She stated there were doctors and nurses which were in 24/7 who provided emergency services, she said it applied to a dedicated area only. She said due to staffing levels it was not currently possible to extend the service to cover 7 days a week. She stated that they collaborated with the ICS and gave examples of where the RWT was leading and in other areas behind other partners in the ICS, she also gave examples of

collaboration with other hospitals, citing that they took referrals for cancer treatment relating to gynaecology from other areas such as Dudley, Shrewsbury and Walsall. She stated they had a patient focused service and addressed individual needs regarding questions of addressing diversity.

The Vice-Chair asked if it was standard practice that New Cross informed patients of the long waiting times and gave them a choice of options at other hospitals further away which may have a shorter waiting time.

The Directorate Manager Royal Wolverhampton Trust replied that patients were able to see their waiting times online and through the GP and could compare it to other hospitals where they could request their GP to try book them at another hospital.

A Councillor asked if they knew the reasons for missed appointments. She also wanted to know if cost implications were considered and if financed transport was offered to those patients that chose to travel further afield to other hospitals if referred there.

The Directorate Manager Royal Wolverhampton Trust stated they did not yet do this but this was part of the next stage of work they were doing with their new volunteers in tackling “Did Not Attend” cases.

The Councillor wanted to know how they handled isolated patients who were on their own. Citing an example of a “buddy service”.

The Clinical Director of Gynaecology stated that upon first appointment missed, in particular with cancer patients, they sent a letter to the GP informing them of the missed appointment, urging the patient to call them back and that they would offer a second appointment and did not cancel services right away.

The Chair wanted to know what services could they not offer a female consultant for.

The Directorate Manager of Royal Wolverhampton Trust stated that they only had 3 male consultants for sub specialist cancer treatment and could not offer a female consultant at this time. This specifically related to complex cases. She stated other areas within the service had mixed sex consultants and that it was subject to availability.

5 **West Midlands Ambulance Service Review Wolverhampton**

Strategy and Engagement Officer WMAS began the presentation (a copy is attached to the signed minutes) with a brief overview and summary of his role, he informed the Panel they had begun appointing specialists in maternity care to improve the West Midlands Ambulance Service’s (WMAS) care of pregnant women and that a lot of collaborative work and training had been put into developing staffs expertise in this area. He stated that WMAS served 6 Integrated Care Board (ICB) areas and that they were a partner member of the Black Country ICB. All ICB Chairs and CEOs were invited twice a year to meet with the WMAS Chair and CEO to discuss partnership working. He showed the Panel two comparative graphs of hospital hand over delays looking at West Midlands rates overall across different years and the Black Country rates overall across different years. He said before Covid, lost hours to handover were significantly lower compared to post Covid handover hours. He said that the delays have had an impact on their response times, before Covid they were

always meeting their response times across all categories and were the only ambulance trust able to do that. However, post Covid they were no longer able to do this. This contributed to late finishes for colleagues, contributed issues to phone call operatives unable to dispatch ambulances to people in time, and impacted on patients. They had been working with partners to improve pathways with the aim of reducing ambulance call outs. He showed postcode performance ratings, which were mostly in the red and not hitting target. He explained to the Panel that WMAS had expanded their electric vehicles and now had a fleet of them, in aid of the 2030 NHS England goal of zero carbon emitting vehicles. Strategy and Engagement Officer WMAS stated that electric vehicles were far more expensive than fuel powered vehicles, he said this was challenging and that the infrastructural challenges would cause further difficulties. He stated that violence and abuse to staff was a growing issue that in the previous year they had recorded 2000 incidents. He said that as of December 2023, they had recorded 2500 incidents and that the financial year was not over yet. In response they had been exploring different ways to protect staff, which included trialling stab proof vests and body worn cameras; however, staff had a wide range of views on these approaches and consultation was still underway.

The Chair wanted to know how the Trust was aiming to reduce the hand-over delays back to pre-pandemic levels. The Chair also commented that she would have liked WMAS to include a slide looking at the delay levels of Wolverhampton specifically.

The Strategy and Engagement Officer WMAS stated that he would share this information with the Scrutiny Officer to distribute to the Panel.

The Chair stated that the Health Scrutiny Panel wanted to ensure all NHS organs had a robust freedom to speak up process. She wanted WMAS to reassure the Panel that they had an excellent freedom to speak up system and to inform the Panel how they had learned from previous issues.

The Head of Strategic Planning WMAS replied that following the Lucy Letby case, nationally all ambulance services were required to do a review and provide information to the relevant governing bodies displaying how their freedom to speak up processes worked and performed. She said they had an improvement plan in place and had been working with internal and external colleagues to ensure compliance. She said they were always looking to improve the process and were engaging with staff to do so, this included using networks, freedom to speak up ambassadors and other promotional activities to encourage staff to feedback to them.

The Vice Chair wanted to know how the WMAS were progressing on the electrification of their fleet, relative to the 2030 deadline set by the NHS.

The Strategy and Engagement Officer WMAS stated that they had a whole range of vehicles which were electric. He said as and when opportunities had arisen to allow them to further increase their electric fleet, they were taken. He also stated they were increasing infrastructure for these. He said the NHS needed increased funding to meet these targets as capital was struggling at this time to meet the demands required to go green. He said the government delivered the mandate and so they should help more, he also hoped technology would become cheaper and would allow them to transition more economically.

A Panel member expressed his disappointment that ambulance staff were facing abuse and violence from the people they were trying to help. He noted that the infrastructure for electric vehicles was still in its infancy and wanted to know how this would impact on service delivery for the WMAS as they transitioned to a fully electric fleet. He also wanted WMAS to explain why there was such a huge rise in handover ambulance delays in the years following the covid 19 lock down period.

The Strategy and Engagement Officer WMAS stated that the current range of electric ambulances meant that they worked in largely urban areas, like the city of Birmingham. However, in areas like Shropshire which were largely rural, these vehicles would struggle to be effective in their current form. He said technology still needed to be developed further by the market. He said the large increase in hand-over delays were multi-faceted and gave a few reasons: pent up demand from people not having full access to health care during the lockdown period, primary care services saturated with higher demand but fewer doctors, 8 million people on the waiting lists nationally, hospitals had huge multi-level demand alongside workforce capacity issues, patients staying in acute beds longer in hospitals. He said the NHS structure now had a bottleneck issue.

A Councillor gave an example wherein Doctors were advising patients to get someone to drive them to the hospital rather than dial 999 for an ambulance because it would be faster to be seen. She wanted to know how important dialogue with Doctors at a Primary Care level was.

The Strategy and Engagement Officer WMAS replied that it was a concern that the public were losing trust in emergency services ability to deliver. He said that two years ago, WMAS had changed their call scripts to provide indicative waiting times for ambulance arrivals to callers so that they could decide as to whether they wanted to drive in or not should they have that option. He said there was a growing list of alternative pathways to care which meant they wouldn’t need to go to the emergency department. He said that one you stripped back those patients who could use those pathways however, waiting times would still be too long for those in need of emergency services at Accident and Emergency.

A Panel member asked the Strategy and Engagement Officer WMAS what his thoughts were on how they could reduce the 30-minute waiting times for ambulances to arrive at a patients location.

The Strategy and Engagement Officer WMAS stated they were meeting these times in 2020/2021 but that the rise in handover delays had caused the problem. He felt a restoration in patient flow was required. He said they were due to have an independent capacity review, something they hadn’t had since 2009. The Strategy and Engagement Officer WMAS said that the scale of the problem was NHS wide and whilst they could contribute, it would not fix the issue due to the interlinked nature of the problem.

A Councillor asked if the rapid response team went out to serious mental health emergencies and if this helped lighten the pressure on the ambulances.

The Strategy and Engagement Officer WMAS said these were called Urgent Community Response Units (UCRU). He stated that UCRU’s were an example of increased alternative pathways to care which were helping to reduce pressure on

ambulances. He said these would only go so far in aiding the problem and stated that the change in demography, primarily aging population and frailty was the driver for high demand on services. He said Health and Social Care had not kept pace with the increase in people over the age of 85 and this was contributing to the situation the NHS was in now.

The Chair stated there were possible examples where alternative pathways to care, as designed to reduce burden on accident and emergency, could become a hinderance. She stated there may be issues with the sign posting, which could lead to multiple phone calls before the right service route is provided.

The Strategy and Engagement Officer WMAS replied he agreed there were complexities with the Health and Social Care system which made it difficult for them to navigate. He felt there was a degree of certainty of need predicted for patients. He said there was a phone number ambulance crews could ring if they thought a patient could use an alternative pathway, this service advised them on the route to set up for the patient. He said the whole system could be simplified and made better, especially for patients.

The Co-Chair Healthwatch Wolverhampton wanted to know if virtual wards had had any impact on conveyancing.

The Strategy and Engagement Officer WMAS felt the evidence had not been gathered yet to provide the information needed to be able to comment on this with anything substantive.

6 **Integrated Care System Review of Strategy, Performance and Priorities**

The Wolverhampton Managing Director ICB stated he was reporting to the Panel on oversight and strategy for the Integrated Care Board (ICB) in relation to the Integrated Care System (ICS).

The Director of Partnerships and Transformation ICB stated that the Integrated Care Partnership (ICP) was a statutory committee, a forum of local authorities and the ICB and this partnership was legally obligated to provide a strategy. They had had a series of development sessions held between autumn 2022 and spring 2023. The meetings led to the development of an initial Integrated Care Strategy, published in March 2023. Over the previous 4 months there had been developments, these were: the ICP now had a core membership, the ICP membership and partnership had recently met for the first time and approved its terms of reference, they had regularly been updating health and wellbeing boards on core issues within business plans. The ICP membership included representatives and partners from all relevant organisations within the Black Country, this added to collaborative partnership approaches.

The Chair of Black Country ICB & ICP stated that the ICP was an important part of the overall system. He said the previous system was competitive, with Trusts trying to maximise the number of patients they could take on and those not as competitive lost out on money given to them by the government. This has been changed and now the ICS aimed to get Trusts and partners to work in collaboration. He said that collectively across the Black Country, there were 650,000 people that fell into the most deprived 25% of the national population. He said the Black Country was the

second worst in these figures behind Birmingham. He said this was why it was important to change approach, otherwise they would keep getting the same result. He also stated that the aging population added more pressure on the service, as they would be more fragile and vulnerable to health issues, which would cost money and take up bed space. He said a stronger emphasis on prevention was required. He said it was important that place-based partnerships delivered the service and worked together locally and that the ICP would play an important co-ordinating role in this. The strategy the ICP set, the NHS partnership organisations would then need to deliver upon.

The Wolverhampton Managing Director stated that it was a complex system and that this complexity was added to at a Black Country level, given it contained 4 places and 4 hospitals. He said at a place-based level, Wolverhampton was a crucial component and that the smooth working of the health and wellbeing board was vital.

The Wolverhampton Managing Director said the ICB had been responsible for commissioning pharmacy, optometry and dental services, these had previously been commissioned by NHS England at a Midlands level. This team now worked for the ICB through an office in the West Midlands. The ICB also commissioned some specialised services. The ICB hosted the teams responsible for these at their office. They would be collaborating further with the West Midlands Ambulance Service. He stated that OneWolverhampton was an important part of the ICS.

The Chair stated that it was reported the previous May that there was a £69 million deficit in the Black Country ICB. She wanted to know where this figure now stood and how this would impact on services.

The Chair of Black Country ICB and ICP replied that money was tight in the system. He said hospitals lost money on accident and emergency departments as well as maternity services but that these were essential services to offer. He said that some hospitals within the Black Country treated patients from other areas, such as Staffordshire, and hospitals were not allocated as much money for patients from those areas as they were Black Country residents. He said often, due to the Black Country hospitals having better handover times with the ambulance service compared to other areas within the Black Country, they often received diverted emergency patients from outside of the Black Country which contributed to the financial challenge. He stated that the deficit had now grown to a larger amount, inflation was a pressure on the rising deficit. He said industrial action had also added to their deficit. He said they had agreed as an NHS system a financial recovery plan in an attempt to try get the budgets to balance again in the future. He said this was an issue across the NHS nationally and was not a local phenomenon.

The Chair wanted to know if they had policies in place across the system should a Accident and Emergency department have to close at one of the hospitals in the region.

The Wolverhampton Managing Director ICB stated that they had a strategic centre that co-ordinated the management system. The ICB, ambulance service and the hospital trusts reviewed the operations of their system to allow them to co-ordinate as best possible their overall system performance.

The Chair referenced the report provided and noted other Trusts were struggling

more than others within the ICS. She wanted to ensure funds intended for Wolverhampton would not be removed to plug the gaps in other Trust services outside of its area.

There was general discussion and debate between the Panel and representatives of the ICB about finance. The overall position was that being part of an ICS meant funds were now treated as part of that entire system and therefore previously allocated money under the older NHS management format (Wolverhampton Clinical Commissioning Group) was no longer specifically allocated to Wolverhampton. The funds were now system wide across the Black Country and would be used in that manner.

The Chair referred to the Local Government Association (LGA) report on ICPs nationally, she wanted to know what the partners had learnt from the report and what they intended to put into practice from that, if anything.

The Director of Partnerships and Transformation ICB said there was a lot within the report to pull from in how they constructed their partnerships across the Black Country. He said there was lots of emphasis in the report on partnerships to tackle the issues in the local areas. He said supporting broader social economic value was a strong aim of the partnership. He said the Black Country ICB had been highlighted in the report on policies they had with social housing.

A Councillor said he was concerned about Walsall NHS Trusts economic performance and wanted reassurance they would improve as a partner of the ICS.

The Chair of the ICB and ICP stated that the report showed how Trusts were moving away from an individualist organisation approach towards a more collaborative approach, he cited the Black Country Trusts as an example in how they were working together to collectively improve pathways across the system. He said Walsall was improving as it was learning from its Black Country partners, who were also supporting it.

A member of the Panel asked where they could view the ICP's terms of reference and minutes from meetings.

The Chair of the ICB and ICP stated they were listed on their website.

A Councillor stated he believed pharmacies were due to be given permission to prescribe anti-biotics to patients. He wanted to know how much the ICB had a say over this and the roll out.

The Managing Director Wolverhampton ICB said an example of this had been brought to the Panel in December in the documents provided. He said without an expert in pharmacy present it would be difficult to give a detailed answer. He said the launch of pharmacy first was about extending the role of community pharmacies as an alternative to the general practice to allow them to prescribe some medicines and relieve pressure on GPs. He said he would look into the role of pharmacies in prescribing anti-biotics and provide a written response from the Wolverhampton pharmacy provider to the Panel.

The Councillor replied stating he understood that the government would be giving funds to NHS England for the pharmacy first scheme, he wanted to know if the ICB had any say over how the money would be distributed locally.

The Managing Director Wolverhampton ICB stated that the money would come through the ICB and they would have influence, but as it was a national policy, there would be expectations and criteria set to the money allocation.

The Vice Chair cited page 52 of the report, quoting the ICB deficit and how discussed the ICB making a surplus. He felt the finances displayed were confusing. He referred to page 27, and wanted to know when the phased delegations would be occurring. He also referred to page 36 and wanted an expansion on the work being done with local authorities in educating patients, working with schools and the university. He also asked for any Wolverhampton specific examples.

The Managing Director Wolverhampton ICB replied that the information provided on page 27 was very early in the process and was still being formulated in partnership. He said work had been done with OneWolverhampton to encourage people to take up cancer screening. He said the way they commissioned services needed to be done in a collaborative manner, emphasising partnership working to draw up their outcomes.

The Director of Public Health emphasised that OneWolverhampton enabled them to bring to the ICP Wolverhampton's needs and avoided an approach where strategies were at a Black Country level generally, without looking at the specifics of an area.

7 **Healthwatch GP Services Survey**

The Manager Healthwatch Wolverhampton reported to the panel that access to GP services remained an issue locally and that this was their third time bringing an item on primary care access to the Panel as requested. Over the last quarter, 46% of information they had collated involved general practices, with 61% of the information collated being a negative sentiment. The feedback received concerned access to GP appointments, communication pathways and issues, as well as response times. They also looked into the running of Patient Participation Groups (PPGs). She listed some limitations of the research which was listed in the methodology. The Manager of Healthwatch Wolverhampton stated that 65% of respondents preferred to book a GP appointment via the phone as opposed to using website/app bookings, despite knowing that phone bookings could take a considerable length of time. She stated that from her perspective this showed it was important that patients had a choice in the ways they wanted to book appointments, despite a push towards digital from within the NHS. She said that call times varied in some Primary Care Networks (PCNs) which had worsened, whereas some had improved. In terms of engagement with Healthwatch, some PCNs had significantly improved results: she cited Royal Wolverhampton Trust (RWT) as an example, in December 2022 only 3 of their 8 PCNs would engage with the Healthwatch survey via the phone, whereas for the recent research, all 8 participated. More generally, there had been improvements in signposting across GPs, in particular to pharmacies, which was in line with the GP Recovery plan where pharmacies were set to play a bigger role. She informed that Panel that a number of practices had said they did not know when the last PGG group had been held or that it had been a long time since one had last been held, one PCN said they did not know if they had a PPG. For website booking, the majority of respondents said they found it to be a positive experience. However, 50% of

respondents also said they could not book an appointment online via their practice website, with many stating they couldn't get same day appointments if they used the online service. A barrier to digital inclusion was people aged over 65, most of whom reported they were not able to use the online service and needed to use the phone to book appointments. Healthwatch recommended all practice websites should be updated with guidance to make them clearer to patients how they could access services and book appointments easier, practices to involve patients in how to improve websites, ICB to continue to ensure practices inform patients about PPGs.

The Chair asked if any practices refused to engage with Healthwatch when they called them.

The Manager Healthwatch Wolverhampton that within the Wolverhampton North PCN, 3 practices refused to engage with them, which was also the number that refused to engage in the December 2022 survey, Unity West PCN had one refusal. She stated that overall 6 practices refused to engage.

The Chair stated that she wanted the Managing Director Wolverhampton ICB to write to the practices which would not engage with Healthwatch Wolverhampton to inform them they have a legal responsibility to engage with Healthwatch Wolverhampton.

The Managing Director Wolverhampton ICB stated he was happy to work with the Manager Healthwatch Wolverhampton to understand which practices were not engaging. He stated it should be noted that overall engagement had improved across the Wolverhampton PCNs and said that there may be issues with receptionists not understanding questions around PPGs so that they could not give an answer.

The Chair stated that she wanted the ICB to deliver a small project where they trained GP receptionists about PPGs to ensure they had the knowledge. The Chair referred to the survey report and stated that one of the reasons given for PPGs not occurring in some areas was a lack of uptake from patients to get involved. She wanted to know what the ICB were going to do to engage with patients and increase uptake.

The Managing Director Wolverhampton ICB said they had brought to the Panel previously information at work they were doing with Chairs of PPGs to improve PPG activity. He said the Healthwatch survey was helpful as they could now concentrate further on areas where PPGs are not active or not active enough to improve them.

The Chair stated that Healthwatch Wolverhampton made a number of recommendations to improve the service, she wanted to know if the ICB accepted those recommendations and if they were going to produce an action plan displaying how they were going to implement them.

The Managing Director Wolverhampton ICB stated that they had not had the time to fully review the recommendations so he could not commit to accepting them until they had been reviewed fully.

The Chair stated that she would like it noted and raised at the next Health Scrutiny meeting during the minutes segment to ask the ICB again about the recommendations.

A member of the Panel wanted it noting that the average time to answer phone calls had more than doubled and he wanted the ICB to look into that too.

A Councillor stated he would be interested in seeing the numbers of missed appointments at GP services, as well as stats on incidents of abuse towards staff.

8 **Tuberculosis In Wolverhampton – Stats and Review**

The Principle Public Health Specialist began the presentation (a copy is attached to the signed minutes) by explaining what tuberculosis (TB) was, what caused it and how it was cured. An infectious disease, caused by bacteria, which was deadly if left untreated and could kill. Most cases were curable with a 6-month case of anti-biotics, although some cases of TB were becoming drug resistant. She informed the Panel that there was also latent tuberculosis (LTB) where the disease could lie dormant in a person and not show symptoms, until a time when they got ill with something else, it would then develop. The risk of developing TB was much higher in people who had AIDS. England was a low incident country with a 3 year average of 7.7 cases per 100,000 population but Wolverhampton was much higher than the English average for cases of TB, recorded at 19.9 cases per 100,000 population. However, recently the gap between Wolverhampton instances of TB and the English average was starting to reduce. Everyone was at risk of catching TB, but it was more common in people with weakened immune systems, people who had migrated from countries with high instances of TB and men, who were 4 times more likely than women to catch TB. Social risk factors for a higher likelihood of TB included those from the 10% most deprived backgrounds, people born outside of the UK (13 times more likely to develop TB), those who abused drugs and alcohol, were homeless and those imprisoned.

The Principle Public Health Specialist stated that whilst Wolverhampton had higher than average rates of TB in the population, its services and outcomes to tackle TB ranked higher than the national average, meaning they were better.

Senior Public Health Specialist gave a LTB patient journey example: a migrant from Afghanistan arrives in the UK is eligible for LTB testing and is invited to a clinic, upon arrival they were tested and if LTB was found in them, treatment began and across several weeks they returned to give blood samples and were monitored until the LTB was no longer detected in their system. For TB cases, they were reviewed by a GP, then referred to the TB team, within one day they were tested, isolated and their family referred to have TB screening, they would then be treated and monitored for several months for TB until they no longer tested positive.

The Principle Public Health Specialist stated that partnership working across the ICS would be essential to tackle TB in Wolverhampton.

The Vice-Chair thanked the Public Health team for their presentation. He stated that he had had developed TB in the past after having LTB unknown in his system and recognised the importance of testing. He wanted assurances that new arrivals to the country had the support needed to ensure they were checked for LTB and given the healthcare needed to stop it developing further.

A Councillor stated that some people, such as foreign students studying in the area who had VISAs, had rules to follow prior to coming to the UK, to have TB tests and

treatment 6 months before entering the UK. Whereas in other instances of migration this was not always the case, he wanted to ensure migrants placed in local hotels had access to and were encouraged to have LTB testing and treatment, should they test positive.

A member of the Panel stated that Wolverhampton's figures were high. She said that the area had high levels of migration and in different wards, there were differing levels of integration. She wanted to know if there was data available for the wards showing trends of migration and those who were newly arrived.

The Director of Public Health responded saying that TB and LTB could affect all people, ages and communities. He said it would not be appropriate to use data specific to a certain characteristic as it could generate conclusions which were biased or incorrect if not taking into account all other characteristics. He highlighted the reducing figures of TB instances in the City and stated that partnership approaches were working.

A Councillor said he agreed with the Director of Public Health and said there were high instances of TB in the country prior to initial waves of large migration and said it was not fair to focus solely on migrants.