CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

30 June 2022

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

Venue Council Chamber - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Susan Roberts MBE (Lab)
Vice-chair Cllr Paul Singh (Con)

Labour	**Conservative**
Cllr Jaspreet Jaspal	Cllr Sohail Khan
Cllr Milkinderpal Jaspal	
Cllr Rashpal Kaur	
Cllr Asha Mattu	
Cllr Lynne Moran	
Cllr Sandra Samuels OBE	

Quorum for this meeting is three voting members.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**
[To receive any apologies for absence].

2 **Declarations of Interest**
[To receive any declarations of interest].

3 **Minutes of previous meeting** (Pages 3 - 14)
[To approve the minutes of the previous meeting as a correct record.]

DISCUSSION ITEMS

4 **Primary Care** (Pages 15 - 46)

[To receive a report from the Black Country and West Birmingham CCG on the changes to Primary Care since their last report to the Panel on Access to Primary Care, which was in December 2021].

[To receive a report from Healthwatch Wolverhampton, titled, *"An investigation into booking GP appointments in Wolverhampton: Have improvements been made']*.

5 **Date of Next Meeting**
The date of the next scheduled meeting of the Health Scrutiny Panel is the 22 September 2022 at 1:30pm.

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 10 February 2022

Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Greg Brackenridge
Tracy Cresswell
Cllr Jaspreet Jaspal (Via MS Teams)
Cllr Milkinderpal Jaspal (Via MS Teams)
Cllr Rashpal Kaur (Via MS Teams)
Cllr Sohail Khan
Cllr Lynne Moran
Cllr Susan Roberts MBE (Chair)
Cllr Paul Singh (Vice-Chair)

In Attendance

Cllr Jasbir Jaspal (Via MS Teams)

Witnesses

Mike Sharon (Strategic Advisor to the Royal Wolverhampton NHS Trust Board) (Via MS Teams)
Jane McKiernan, (Senior Programme Manager – Strategy, RWT) (Via MS Teams)
Sian Thomas (Deputy COO – Division 3, RWT) (Via MS Teams)
Harrison Marsh (Alzheimer's Society - Regional Public Affairs and Campaigns Officer - West Midlands)
Lee Allen (Alzheimer's Society – Local Services Manager)
Kielan Arblaster (Alzheimer's Society – Policy Officer) (Via MS Teams)
Paul Tulley (Wolverhampton Managing Director– Black Country & West Birmingham CCG) (Via MS Teams)

Employees

Martin Stevens DL (Scrutiny Officer)
John Denley (Director of Public Health)
Kate Warren (Consultant in Public Health) (Via MS Teams)
Parpinder Singh (Principal Public Health Specialist)
Parmdip Dhillon (Principal Public Health Specialist)
Julia Cleary (Scrutiny and Systems Manager)
Earl Piggott-Smith (Via MS Teams)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies and Substitutions**

Apologies for absence were received from Panel Members, Cllr Phil Page, Rose Urkovskis and Tina Richardson. No notification of substitutes had been received.

Cllr Linda Leach sent her apologies as the Portfolio Holder for Adults.

Professor David Loughton CBE, Chief Executive of the Royal Wolverhampton NHS Trust sent his apologies.

Marsh Foster sent her apologies as the Acting Chief Executive of the Black Country Healthcare NHS Foundation Trust.

2 **Declarations of Interest**

The Chair of the Panel, Cllr Susan Roberts MBE declared a non-pecuniary interest under the digitally enabled Primary Care item, as she lived in an area of Wolverhampton where the Babylon App had been offered as a Primary Care Service option.

Tracy Cresswell declared a non-pecuniary interest under the digitally enabled Primary Care item, as she lived in an area of Wolverhampton where the Babylon App had been offered as a Primary Care Service option.

3 **Minutes of previous meeting**

The minutes of the Health Scrutiny Panel meeting held on 16 December 2021 were confirmed as a correct record.

4 **Dementia**

From the Alzheimer's Society, Mr Harrison Marsh, the Regional Public Affairs Campaigns Officer for the West Midlands, Mr Lee Allen, the Dementia Connect Local Services Manager and Kielan Arblaster, Policy Officer gave a presentation on increasing access to a Dementia diagnosis.

The Regional Public Affairs Campaign Officer stated that the increasing access to a Dementia Diagnosis Project had been launched in September 2021. This followed on from the Alzheimer Society's pathway report in 2020 titled '*From diagnosis to end of life: The lived experience of dementia care and support.*' The Covid-19 pandemic had caused the national diagnosis rate for people with Dementia for people aged over 65 to drop by 6.3% in just one year. The target audience for the Dementia diagnosis project was for CCG areas that had a diagnosis rate below 62.5% as of June 2021. The diagnosis rate for the Black Country and West Birmingham CCG was 59.3% as of June 2021. All four Local Authorities in the area were contacted with details of the report. Wolverhampton to date had been the only Local Authority to invite them to a public meeting to discuss the project in detail. It was really positive that Wolverhampton Council had invited them, and he was hopeful other Local Authorities would do so in the future.

The Regional Public Affairs Campaign Officer commented that Wolverhampton was at or close to the national target diagnosis rate. The rate was 66.6% in December for Wolverhampton in comparison to the Black Country rate at 60% and the England figure of 61.8%. He wanted to encourage Wolverhampton to continue to improve its diagnosis rate with the aim of reaching the 73.4% rate which had been seen in Wolverhampton in July 2019. He was also keen for Wolverhampton to share any good practice within the wider area of the Black Country and West Birmingham.

The Regional Public Affairs Campaign Officer remarked that 3 reports had been written as part of the project. There was one on ethnic minority communities, a second on reducing variation of diagnosis rate and a third on hospitals and care homes. Evidence had been gathered from a wide range of sources.

For ethnic minority communities the community level barriers were listed as follows: -

- Language barriers affecting access to information
- Stigma and taboo contributing to low levels of awareness of Dementia, which itself leads families to ignore or conceal Dementia.
- Cultural perceptions – around Dementia, health and caregiving, limit knowledge and awareness of Dementia.

Service level barriers for ethnic minority communities were detailed as: -

- Lack of culturally appropriate service provision.
- Lack of culturally appropriate diagnostic tools.
- Lack of access to quality, interpretation services.
- Lack of demographic data to plan services.

The regional variation reasons for diagnosis were described. The regional barriers were listed as: -

- Deprivation affects prevalence and the identification of symptoms, both for person and clinician.
- Rurality affects prevalence identifying symptoms and access to services.

The systematic barriers to regional variation were described as: -

- People ‘out there’ with dementia, but yet to reach out to formal services.
- Memory services receive inadequate and inappropriate referrals.
- Patient reticence affects ability to access diagnosis.
- Demand for memory services impacts waiting times.
- People with MCI (Mild Cognitive Impairment) go without diagnosis.
- Lack of IT integration and agreement over coding underrepresents dementia.

The third report looked at increasing access to a Dementia diagnosis in hospital and care homes. The challenges in hospitals were listed as follows:-

- Distinguishing between Dementia and Delirium was challenging.
- It was difficult to prioritise Dementia identification / assessment as well as the original reason for admission.
- A lack of staff time, skill and confidence to undertake Dementia assessment.
- Difficulty in collecting patient information to support assessment.
- Fears over complicating discharge process.
- Lack of assessment post-discharge.

In care homes the challenges were described as follows:-

- Lack of staff skill and training identifying Dementia.
- Difficulty assessing GP services to assess Dementia.
- Difficulty assessing nursing services to support assessment.
- GPs unaware of tools (DiADeM) to assess Dementia.
- Difficulty assessing resident information, both for GPs and care homes.

The Regional Public Affairs Campaign Officer presented a slide listing a number of recommendations on how Wolverhampton could continue to improve its Dementia diagnosis rate. These were detailed as follows:-

- An assessment to identify possible barriers to diagnosis for ethnic minority communities.
- An assessment to identify possible barriers to diagnosis due to deprivation and to identify what additional support GP surgeries may need in those areas.
- An assessment of the reasons for the drop in referrals to Dementia Connect from GPs.
- Consider the provision of dedicated community link workers, if not already available.
- Ensure pre-diagnosis support is available for those waiting for a diagnosis.

The Principal Public Health Specialist presented some data slides on Dementia in Wolverhampton. Wolverhampton estimated diagnosis prevalence in 2021 was 63.8% for over 65s. It was therefore estimated that there were 36.1% of people over 65 in Wolverhampton who had Dementia but did not have an official diagnosis. In Wolverhampton, two thirds of Dementia patients were women (1283 – 64%) and 36% were male (727). There were higher numbers of people with Dementia in the more deprived areas of the City. Across the population of Wolverhampton, White British ethnicity were overrepresented with a diagnosis of Dementia. The Indian ethnicity was slightly underrepresented and also Pakistani. Those from an African background were also underrepresented. The Caribbean background was representative of the general population of Wolverhampton.

The Commissioning Officer, presented a slide on Dementia support in Wolverhampton. She spoke about the Dementia friendly community model which had been introduced prior to Covid-19. They had engaged with Schools, so children could have conversations with their parents about Dementia. A live broadcast with Sunny and Shay - BBC RWM had promoted some of the Dementia work taking place in the City. She detailed some of the other positive initiatives taking place in the City. They had been awarded Dementia Friendly City of the Year in 2018 by the Alzheimer's Society. There was a topic specific JSNA (Joint Strategic Needs Assessment) for Dementia. Following this in 2019, the Council had worked with the CCG to complete the Joint Dementia Strategy for Health and Social Care 2019-2024.

The Commissioning Officer said there were five key elements of the strategy framework based on the NHS Living Well Pathway. These were as follows:-

- Preventing Well – The City of Wolverhampton will be 'memory aware' and promote risk reduction through healthy lifestyles.

- Diagnosing Well – People living with Dementia in the City of Wolverhampton will receive a timely diagnosis with an offer of early support.

- Living Well – The City of Wolverhampton will be a Dementia Friendly City that supports people to continue to live well and connect to their community.

- Supporting Well – People living with Dementia will receive support that adapts to changing needs with access to good quality secondary care. The Trust will

continue to deliver excellence in Dementia care within the Trust, when hospital admission is unavoidable.

- Dying Well – People with Dementia in the City of Wolverhampton can die with dignity and respect.

The Commissioning Officer gave a breakdown of some of the current activity on Dementia. She was pleased that during the Covid-19 pandemic the Dementia Action Alliance partners continued to meet. They always had around 21 organisations from different sections of the community engaging. During the Covid pandemic they were able to develop a Dementia directory of services. This directory was available online and was updated quarterly. A mapping exercise had also been caried out to obtain feedback from people, providers, families and carers about available support. The strategy would be updated taking into account the feedback. They were working with the CCG to carry out a virtual reality experience in March 2022, this would be carried out on a bus. The Council had been approached by the University of Wolverhampton to become the first city to have a culturally inclusive Meeting Centre. Every care home in Wolverhampton had received a special digital reminiscence tool, which had been proven to have positive effects. The Council did commission the Dementia Connect Service from the Alzheimer's Society. This provided additional support within the City.

The Director of Public Health remarked that it was important not to underestimate the impact of Covid. The level of face-to-face consultations at Primary Care level had not taken place. Dementia was a part of the NHS Health Check programmes, which Public Health funded the NHS to complete in Primary Care. Systematic health checks reduced the probability of variation based on where you lived and access.

The Vice Chair asked if it would be possible to see at Ward level how Dementia was affecting the community and in relation to different ethnicities. He thought this would be useful for when health partners worked at a local place level. He also asked about the 247 care home residents who had died from 2020-2021, wanting to know how many of those deaths were due to Dementia or just down to end of life / natural causes. In addition, he asked for the care home death figures for 2019-2020, so a comparison could be made and to see the impact of Covid 19 on fatality levels in care homes.

The Commissioning Officer responded that she did not know the exact figures. As of 31 December 2021 there were 684 people living in care homes, who were aged 65 plus. 481 of those people were diagnosed with dementia. It was therefore inevitable that some people would die with dementia but the cause of death would be due to another reason.

A Panel Member commented on how grateful he was to receive the reports on Dementia and complimented Officers and partners on their work. He asked about navigators for ethnic communities. It was confirmed that there was a part time Dementia Connect Navigator from the BAME community working in Wolverhampton.

The Principal Public Health Specialist commented that the Public Health Team were already working with Primary Care on Practice-based data. This enabled them to determine which Practices were not diagnosing Dementia as much as other practices

and to try and determine the reasons. The One Wolverhampton Sub-Group were overseeing the work.

The Director of Public Health remarked that one of the positives of Covid had been an improvement in relationships and collaboration this included the care homes in the City and the providers of care.

The Chair on behalf of the Panel thanked Officers and the Alzheimer's Society for the reports.

RESOLVED:

a) That Health and Wellbeing Together consider their next strategic steps in regard to Dementia by way of receiving an update on the Dementia workstream. The current strategy strived for the City to become a Dementia friendly City which has been achieved, with the city winning a national award for the approach taken. Health and Wellbeing Together are asked to consider the Dementia journey and agree a refreshed area of focus such as increasing diagnoses and post diagnostic support.

b) That Primary Care be pro-active in Dementia diagnosis, such as going through their registers and contacting the most vulnerable patients to Dementia, to arrange an appointment to check for symptoms. The Panel suggests a pilot could take place.

c) That the Black Country Healthcare NHS Foundation Trust should employee staff to visit Care Homes to support people with Dementia and to check people if residents have developed Dementia whilst in care.

d) An assessment be carried out to identify possible barriers to diagnosis for ethnic minority communities.

e) An assessment be carried out to identify possible barriers to diagnosis due to deprivation and to identify what additional support GP surgeries may need in those areas.

f) An assessment be conducted to identify the reasons for the drop in referrals to Dementia Connect from GPs.

g) To consider the provision of dedicated community link workers, if not already available.

h) Ensure pre-diagnosis support is available for those waiting for a diagnosis.

5 **Update on the Merger of Urology Services at, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust**

The Strategic Advisor to the Royal Wolverhampton NHS Trust Board, and the Senior Programme Manager – Strategy presented an updated report on the merger of Urology Services at the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

The Strategic Advisor commented that they were not where they expected to be with the merger. The Senior Programme Manager – Strategy remarked that they had spoken to the Health Scrutiny Panel in July last year about the merger. The benefit of the merger would be to increase capacity across the two trusts and to provide a sustainable emergency Urology Service at Walsall. It was the case that nationally Urology Service waiting times were not good. The waiting times for Urology Services at Wolverhampton were particularly poor. It had been hoped that the merger would have been completed by January 2022, but this had not occurred. The major reason for the delay had been problems with the logistics and planning. The building works had been slow, with a delay in some of the resources and the supply chain. They were now working to a revised timetable, but she was not able to give the Panel an absolute completion date.

The Senior Programme Manager – Strategy commented that whilst waiting times continued to be poor and further decline marginally, they were working at 100% capacity in the month of February for the first time in two years. They had engaged with the bladder cancer support group about the merger since they had last attended the Panel. They were supportive of the merger proposal.

The Strategic Advisor to the Royal Wolverhampton NHS Trust Board added that the planning for the merger had been completely disrupted by Covid and in particular the Omicron variant. They were hesitant to provide a date because on the construction side of the project, some of the logistics were out of the Trust's control. He did not believe the merger would be completed in quarter 1 of next financial year, he would be disappointed if it was not completed by quarter 2.

The Healthwatch Manager stated that Healthwatch had been contacted by the bladder cancer group who had not been happy with the engagement that had taken place. Healthwatch did meet with them and working with the group submitted a number of questions to the Trust. These were answered and a meeting was held with a Urology surgeon. Healthwatch now had an agreement with the Trust to sit in outpatients to talk about any concerns the patients had.

A Panel Member stated that they thought it would be helpful to have a more definitive target date for the completion of the merger. The Strategic Advisor to the Royal Wolverhampton NHS Trust Board responded that they were working through a revised Project Plan and trying hard to get a clear date from their suppliers and contractors on the building works. He thought the Trust would be in a position to give a firm date within the next month.

A Panel Member asked for clarification on how bad the waiting times were. The Senior Programme Manager – Strategy responded that in March 2020 the number of people waiting for surgery in Wolverhampton were 756 and in December 2021 the figure was at 1405. For outpatients in Wolverhampton in March 2020 the number

was 1191, in December 2021 it was 2096. At the end of the previous year, Wolverhampton had just over 500 people waiting over 52 weeks, in comparison Wolverhampton had 100 patients.

The Panel Member did express a concern that Wolverhampton patients had long waiting times compared to Walsall. He was concerned about the poor service and the fact that there was no definitive date for the merger to be completed. The Vice Chair agreed that it was a concern there was no definitive date for the project completion and he was worried about the long waiting times in Wolverhampton. Panel Members commented that the local problems of Urology waiting times in Wolverhampton were a reflection of the national NHS position, where over 6 million people were waiting for elective surgery. The merger would clearly help the situation in the future.

The Strategic Advisor to the Royal Wolverhampton NHS Trust Board added that there was a national elective recovery plan. One of the emphases in the plan was to work across Trusts to try and equalise and make the best use of capacity within all the Trusts.

The Chair did express a general concern, not specific to Urology, about how patients would be transported to hospitals that were not close to where they lived. It was important to consult patients when changes occurred to their normal place of treatment.

The Chair asked for an update on the merger to be brought back to the Health Scrutiny Panel at an appropriate time in the new municipal year. When the Trust had a revised date for the merger to be completed, she asked for the Trust to send it to the Clerk to the Panel to distribute to Panel Members. She thanked the representatives of the Trust on behalf of the Panel for bringing the update report.

Resolved:

a) That the update report on the merger of Urology Services at the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust be noted.

b) That the Trust notify the Clerk to the Panel with the revised date for the completion of the merger once this was known and for this to then be distributed to Health Scrutiny Panel Members.

c) That a further update report be brought back to the Health Scrutiny Panel at an appropriate and practical point in the new municipal year.

6 **Digitally Enabled Primary Care (Report from the Royal Wolverhampton NHS Trust)**

The Deputy COO – Division 3 from the Royal Wolverhampton NHS Trust gave a presentation on digitally enabled Primary Care. The presentation had a particular focus on Babylon, who the Trust had launched a partnership with on the 5 October 2021. The Royal Wolverhampton NHS Trust covered 9 GP Practices, which were spread across the City and one just over the border in Staffordshire. The registered population was just over 55,000 patients. Babylon were a global digital health care company. They were a large and well regarded organisation. They were registered with the CQC (Care Quality Commission) and provided good quality care.

The Deputy COO stated that the partnership with Babylon was within Primary Care. Babylon's cutting-edge AI powered technology combined with the local medical and clinical expertise to create an all-in-one healthcare digital offer from an electronic device such as a mobile, laptop or tablet. It was important to note that all patients remained registered with their local practice. Learning and experience from the partnership would be carried forward to help other organisations, as there was considerable national interest. There were no up front costs to install the infrastructure for the project. A multi-disciplinary project group had overseen the work and all information governance requirements had been met through the Partnership agreement.

The Deputy COO said that patients using the Babylon service were seeing RWT staff, such as GPs, Physios and Pharmacists. They were able to see a schedule of appointments and book in, without the need to call reception. Appointments were via video or on the telephone. The service also allowed access to digital self-care tools, this included a symptom checker, Healthcheck and monitor. The app helped the patient choose the most appropriate clinician to have an appointment.

The Deputy COO commented that one of the benefits of the App was the fact that it was 'always open.' It was not like a traditional surgery reception which you had to wait to open. Patients could also book and reschedule appointments around their needs. Patients had more choice over who they saw, such as the clinician type, gender or a specifically named person. Patients could also leave feedback after every appointment which gave them more granular and real time information.

The Deputy COO stated that to date nearly 2000 appointment had been delivered via the appointment system in the app. 82% of these appointments had been with a GP, 13% Pharmacy and 5% Physio. Over 2,500 people had also used the symptom checker. Patient feedback had been really positive. 95% of ratings had scored 4 or 5 stars out of a maximum score of 5. They were receiving a 44% response rate, which was favourable compared to the national survey response rate of 34%. Over 100 comments had been received as part of the feedback. 67 had been positive, 26 suggested an improvement, 6 neutral and 2 negative.

The Deputy COO remarked that the next steps were to explore additional Primary Care capacity by attracting new or more workforce who wanted to work digitally. They wanted to explore the opportunities for the app in planned care and cited, as an example, the Annual Asthma Review. They would continue to evaluate the impact on patients, staff and within the wider Wolverhampton system.

A Panel Member made reference to people who were digitally excluded and how the Babylon Service would not work for them due to this fact. She expressed a concern about the future of Primary Care relying on digital enabled care.

A Panel Member asked how the Trust had chosen Babylon. He was aware of some surgeries using other systems. The Strategic Advisor to the Board responded that GPs had always used different computer systems, there had never been a single system. The Trust had gone through a procurement process, a careful evaluation process, due diligence and Babylon was the company which offered capabilities which others didn't. He understood the concerns about the future of Primary Care. Face to face human contact could not be beaten. It was hoped that the Babylon App would free up clinicians to be able to offer more face-to-face appointments when needed. The Deputy COO added that it was important to see Babylon as an additional service rather than, instead of traditional services. They were mindful about equity of access and potential digital exclusion. They were working with colleagues to try and understand who was using the app and who was not.

A Panel Member commented that it was clear Babylon was a fantastic piece of software. The issue he had was that it required a generational change. It couldn't just be rolled out over night as it would disproportionately effect people. He asked for the average age of the people using the Babylon App in the Primary Care network and the consultation process. The Deputy COO responded that she recognised it would need to be a slow and iterative process. Four months into the partnership with Babylon, ten per cent of the practice's population had registered to use the app. She would provide the average age figure of users of the app after the meeting. The Trust worked with the Patient Participation Group and the Trust's engagement forum prior to the formal partnership with Babylon.

A Penal Member asked if people within the RWT Primary Network who did not use the app, whether it would prejudice their ability to access vital appointments. The Deputy COO responded that alongside the Babylon app project they had also been updating their phone systems. It was a cloud based telephone system, 8 practices now had the system and there was one further practice left to install the system. It allowed more call capacity. They had also worked with the practices to identify all the different type of appointments available. The app was accessible at any point during the day, but the cloud based telephone system would not be available 24 hours a day.

The Panel Member stated that people who did not have access to the Babylon App would be at a disadvantage as people who used the Babylon App could book appointments at any time, but you could not do this on the telephone. The Strategic Advisor to the RWT Board commented that the Trust needed to find a way to make sure the allocation of appointments did not disadvantage people who did not want to access Babylon. The Deputy COO agreed that more work needed to be done on the telephone system, including increasing capacity to answer phones. They were working hard with their Public Health unit to mitigate or remove the risks in relation to digital exclusion.

A Panel Member stated that technology was the way forward. They were mindful that Babylon had just been introduced and needed time to develop. They spoke positively about how it could free up capacity and in particular reduce demand on the telephone service. She endorsed the approach taken.

The Chair remarked that you had to opt out receiving information about Babylon rather than opting in. She was concerned about the use of Babylon in Primary Care. She wanted to speak to local clinicians rather than clinicians across the country. She feared that the local approach may disappear in the future. The Strategic Advisor to the RWT Board commented that they had been cautious and the Trust did share some of the concerns raised. Babylon had millions of pounds invested, rather than a smaller local system.

The Deputy COO commented that the need for some people to be seen face to face was integral to the Primary Care Offer. Currently all clinicians taking appointments on the app, within the Trust's Primary Care Network, were Wolverhampton clinicians. The app gave them the option in the future to hire people not within the area should the Trust wish. This was another tool to help with recruitment, which was a challenge within the NHS more generally. It was true that people had to opt out of the service, those that had opted out were listed within the EMIS computer system as having opted out and no information was shared with Babylon. Those that did not opt out had the option to register for Babylon, it was not an automatic registration. Registration was currently at 10%. Just under 5,000 people had opted out of the service, this was also at about 10% of the population covered by the RWT led practices.

A Panel Member remarked that whilst people were written to saying they had to contact the Trust if they wanted to opt out, those that had chosen to opt out were not given confirmation that an opt out had taken place. She suggested that a confirmation would have been beneficial, as she believed that some people who opted out were still receiving information about the Babylon service. The Deputy COO commented that she took on board the learning point and accepted the feedback. She was happy to have the details of any people that were receiving information about Babylon that did not wish to do so. All this information came direct from the Trust and not Babylon.

A Panel Member expressed concern about a private company being used by the NHS, she feared that the NHS was going down a future privatisation path. She did not endorse the Babylon approach.

The Chair stated her main concern was about equality of access. Access was particularly important in a City of high deprivation. She thought the process of introducing Babylon was going too fast. The Chair suggested that the CCG should monitor how well Babylon was working compared to other digital systems being used by other Primary Care Networks within the City. This was a point which she would ask the CCG to report on in the future. The Strategic Advisor to the RWT Trust Board, took on board the Chair's comments. He recognised that not everyone had access to a digital device. He didn't want people to feel forced down a path that they were not comfortable with.

The Chair on behalf of Panel Members thanked the representatives from the Royal Wolverhampton NHS Trust for bringing the report before the Panel.

The Chair stated she wanted the first meeting in the Municipal year to be a special meeting on Primary Care access as a whole, following the meeting that had been held in December 2021. The Panel agreed to the proposal. She thanked the people

involved in arranging for some Members of the Panel to visit GP practices recently within the City.

RESOLVED:

a) That the Health Scrutiny Panel do not endorse the current approach of the use of Babylon within, the Royal Wolverhampton NHS Trust, Primary Network of surgeries.

b) That the first meeting of the next Municipal year be a special meeting on Primary Care access as a whole.

The meeting closed at 4pm.

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NHS
Black Country and West Birmingham
Clinical Commissioning Group

Wolverhampton Heath Scrutiny Panel

Access to GP Services

30th June 2022

1. Introduction

1.1 The CCG attended a special meeting of the Health Scrutiny Panel in December 2021, which was held to discuss access to GP services. This report has been prepared to provide an update on the issues raised by the Panel and the wider work that has continued to move forward.

2. Background

2.1 When information was presented in December, Covid levels were still high. Covid vaccinations continued to be delivered by primary care and practices were working under guidance aimed to reduce the spread of the Covid virus and protect both patients and staff.

2.2 Since this period, progress has been made in the restoration and recovery of GP services, with all local and national targets that had been suspended temporarily now back in place. All national and locally commissioned schemes have been fully re-established for 22/23, including the provision of extended access.

2.3 Through the Winter Access fund, an additional 12,000 appointments were made available to patients in Wolverhampton over the period January – March 2022. These have been a mix of urgent and routine appointments, to help with levels of demand but also to tackle waiting times for routine interventions (e.g., smear tests). Additional appointments were also in place across both the Easter and Jubilee extended weekends (148 and 886 consecutively).

2.4 Practices are now working to ensure that their patients receive the proactive care they are used to in supporting management of their conditions and can access services when they need to, which includes being able to walk into the surgery and access face to face care, where clinically appropriate. Additionally, we can build on and embed the core digital offer which now forms part of each practice's contractual requirements.

2.5 We recognise that in certain areas there will be a backlog of patients who have missed their anniversary dates for particular services, such as cervical screening and childhood vaccinations. We are working with practices to understand this and ensure there are plans in place to catch up on this work and over the next 12 months we will be closely monitoring local and national data to provide assurance of a return to a usual cycle of care delivery for all patients.

2.6 Practices continue to follow the Infection Prevention Control guidance, with the publication of the Living with COVID-19 paper since the last HOSC discussion. This includes the requirement for staff, patients and visitors to wear a mask/face covering in healthcare settings. Communications toolkits are available for practices to enable messaging to patients in a cohesive manner.

3. General Practice Activity

3.1 The most up-to-date national data on general practice activity is from April 2022.

- NHSE restoration and recovery monitoring uses appointment numbers from April 2019 compared to April 2022 as an indicator of recovery status. This data indicates that 57% of Wolverhampton practices are providing more appointments when compared to April 2019

- The Wolverhampton average split between face to face and telephone is 66% to 33%, in comparison to the national figure of 62% face to face and 38% telephone. All patients are able to request a face-to-face appointment, and telephone triages are converted into face to face where clinically required.

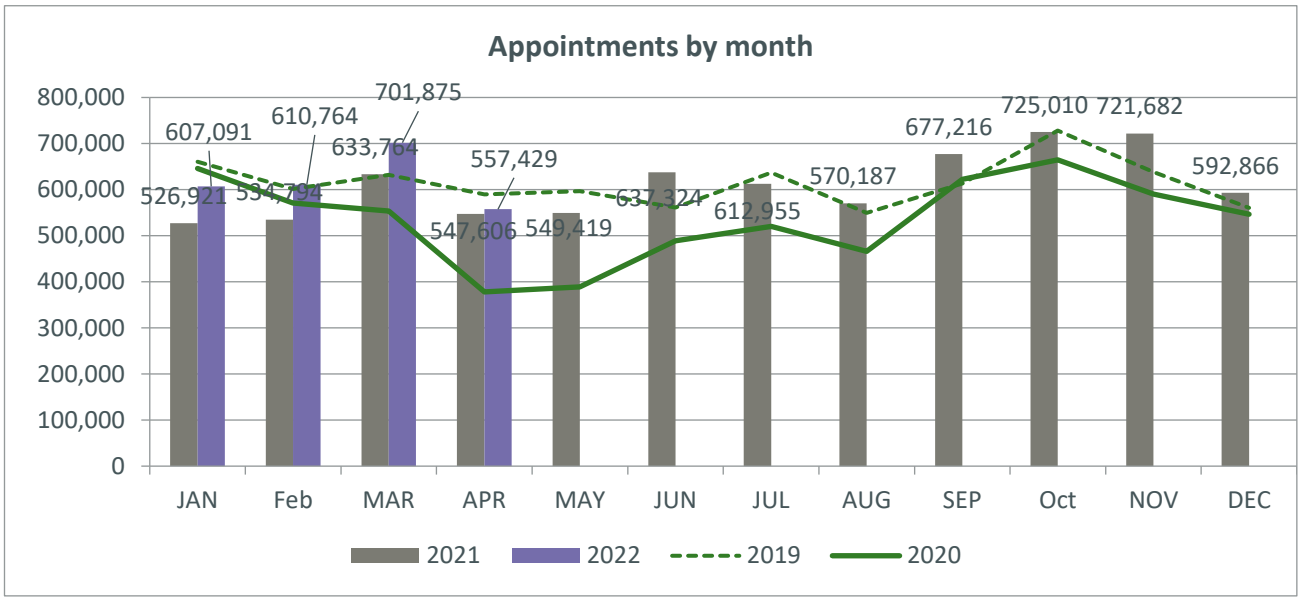
- 58% of appointments were with GPs. 25% were with Practice Nurses, and 18% were Other Direct Patient Care

- 47% of appointments are 10 minutes in duration, with 33% lasting 11-20 minutes.

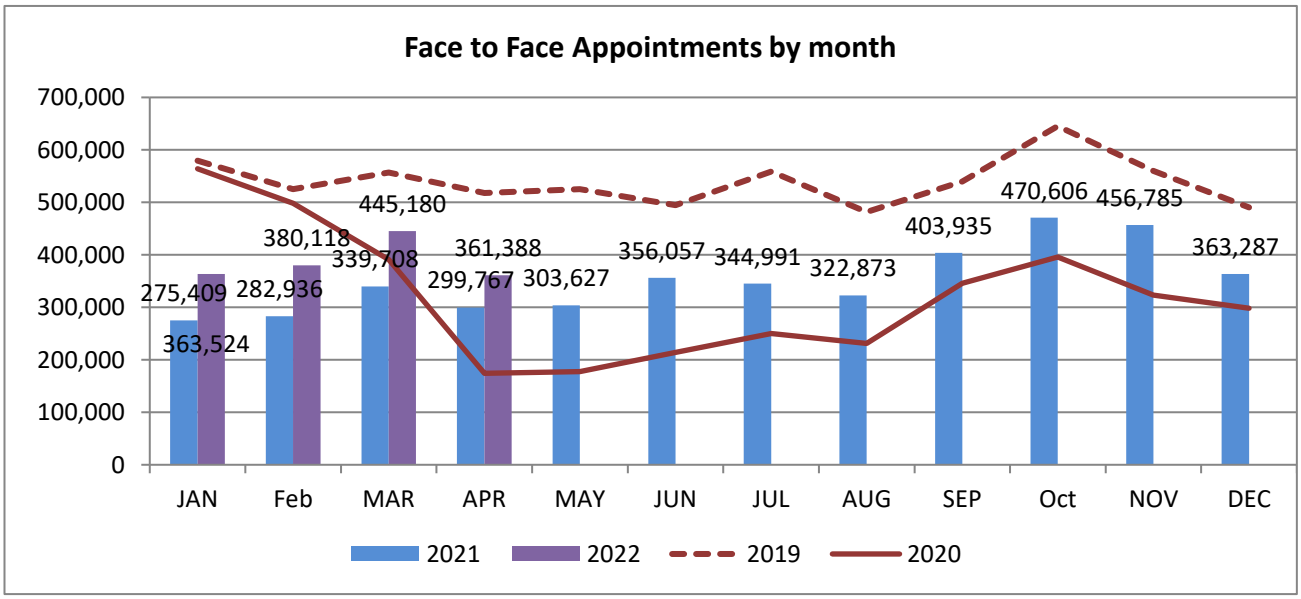
4. Appointments over Time

4.1 The table below shows the total number of GP appointment and GP face-to-face appointments over the last three years for Black Country and West Birmingham CCG practices.

4.2 After a significant reduction in the early part of the pandemic, from March/April 2020, it can be seen that GP appointments returned to pre-pandemic levels.



4.3 Face to face appointments have increased significantly in the most recent two-month period but remain below pre-pandemic levels. The position in the Black Country is similar to the national position. During the pandemic clinicians and patients have made greater use of remote (telephone and video) consultation and it is anticipated that a greater use of these alternative consultation methods will continue going forward.



5. Community Pharmacy Consultation Service

5.1 Referrals into the CPCS are increasing. For April, the BCWB area was the highest referrer in the Midlands region.

5.2 The Wolverhampton Prescribing Support Team are continuing to work with practices to increase uptake of CPCS. All practices have been contacted and have either received front line staff training or have it scheduled in. 27 out of 38 practices have completed this training to date and have been connected to local community pharmacies with referral routes in place.

5.3 Each PCN has practices referring to the CPCS and are noted as achieving national targets surrounding this.

5.4 As well as providing training to practices, the Prescribing Support Team are alsosupporting practices to identify patients suitable for electronic repeat prescribing and contacting patients to explain the process and support them to make use of it where they wish to do so, as part of the drive for efficiency.

6. Digital Access

6.1 The CCG Place and Digital teams are working in collaboration with the City of Wolverhampton Digital Wolves team. Utilizing the well-established trusted partner network from 100% wolves online, the CCG team will enable additional resources and devices to be channeled to these groups, so that patients get support to access services online.

6.2 This will incorporate a new digital champion initiative funded by the CCG, linking the trusted partners to community-based volunteers to support digital skills in the community. This will link to the voluntary sector, NHS and local libraries volunteer schemes, and the Digital skills training provided by the adult education service.

7. Patient Involvement

7.1 Practices are being supported to re-establish Patient Participation Groups (PPGs) where these were suspended, or their operation was changed over the last two years. It is for the practice (together with the members of the PPG) to decide on how to make sure meetings are appropriate and accessible, and we are contacting all practices to understand the current situation with regard to the operation of PPGs, including training and support needs, and make sure that they are fully supported in reinstating PPG groups.

7.2 The Engagement team has completed PPG chairs training sessions, with a number of Wolverhampton chairs attending.

7.3 We have also been able to offer training for practice managers on developing PPGs. Run in four bite size sessions, the course gives practices some tools and techniques to help to maximise the value of the PPG and gives support to practice managers. The aim of the programme is to confirm the remit of their PPG to ensure they are contributing positively to the work of the practice.

8. Health Scrutiny Panel Resolutions

8.1 Resolution 1a. To develop a consistent approach to messages left on answerphones, taking into account language barriers and accessibility.

8.1.1 Telephone messages are part of a wider consistency approach that is being taken as a system to primary care access, noting that it is for each practice to decide what message it wants to use for its own patients. Toolkits have been circulated as a support aid for practices that include national and local messages, and this is being increased to include changes in service e.g., patient access routes over bank holidays. However, it will be the practice's decision to utilize these resources.

8.1.2 As part of the mapping of the digital offer in primary care, patient contact points are being reviewed, including consistency of websites and telephony systems. An organization has been appointed to review websites as part of the wider review.

8.1.3 We are in communication with Healthwatch regarding the telephone review they have concluded on behalf of the Panel. Their findings will also be used to support this work. Discussions have been held with PCN Clinical Directors as to the utilization of the data following the review, and how to support practices identified through this process. This work will continue over coming months, in collaboration with Healthwatch.

8.2 **Resolution 1b - To develop and enhance staff signposting knowledge and triage skills, including the introduction of a training programme to standardise provision.**

8.2.1 Primary Care access to mandatory training has been supported by the training hub. Clarity Teamsnet, which is an online portal to support knowledge and compliance and workforce management has been procured for all practices. This includes mandatory and additional training, appraisal, and revalidation of both clinical and non-clinical staff.

8.2.2 The training hub has a training calendar in place for all levels of staff that practices are able to access. This includes reception admin and clerical training, including support for practice managers. Previous sessions have included effective communication, managing conflict, care navigation and active signposting. Feedback is sought from practice staff as to what is beneficial, and the training hub are reviewing the needs of the current workforce, including a new starter programme, to inform the commissioning of the future training offer.

8.3 **Resolution 1c. To share with patients more information about the different times patients can contact the practice for urgent and non-urgent appointments.**

8.3.1 From a CCG perspective, this work is supported in a number of ways. Campaigns have been disseminated to both general practice and the public regarding appropriate use of services (see resolution 1e).

8.3.2 As noted above, practices are provided with resources to update websites and communication channels informing patients around 111 etc. consistency of the use of these tools will form part of the website review as previously discussed.

8.3.3 The digital work-stream supports access out of hours, as self-help advice access to booking, and repeat prescriptions can all be done at a time convenient to the patient online rather than necessarily being restricted to when the practice is open.

8.4 **Resolution 1d. To ensure that the vulnerable (including new-borns and young children) and elderly are prioritised for appointments and that face-to-face consultations for this group are as readily available as appropriate.**

8.4.1 Prioritisation in primary care is based on clinical need of the issue that is presented. Reception staff are trained to differentiate between urgent and routine appointments, and the conditions that are allocated to these slots. All virtual/ telephone appointments that require a physical examination are converted into a face-to-face slot; practices have processes in place to ensure this is the case.

8.5 **Resolution 1e. To communicate more with patients on the purpose of the 111, 999 service and the NHS App.**

8.5.1 During recent months, our focus has been to publicise the NHS 111 online platform as the first port of call for urgent care, in particular encouraging people to contact 111 before attending A&E or calling 999 if it is not a medical emergency or if they are unsure of where to go. National campaign materials have been circulated to partners to promote, alongside social media schedules and videos from local health care professionals promoting NHS 111. As seasonal urgent and emergency care pressures continue, we have continued to share public messaging promoting NHS 111 online, particularly during recent Bank Holiday periods. During March and April, households within a three-mile radius of an ED Department received a leaflet advertising NHS111 and information on the benefits of using a local pharmacist for minor ailments/queries.

8.5.2 NHS Digital funded local work with digital transformation specialists to complete research to understand how the NHS App might benefit key cohorts of patients who currently use NHS urgent and emergency care services more than most, for example parents of 0-5 year old and young people. This research has provided us with useful insights into the barriers, benefits, motivations and opportunities to influence NHS App usage locally. Using the insights, a campaign approach and communications toolkit were developed and have been delivered during April and May 2022 across Wolverhampton and the areas of the Black Country. The campaign messaging has been derived based on feedback from local people and the campaign has included social media advertising on Spotify, Facebook / Instagram and Snapchat. Alongside this campaign will be an additional resource that has been developed to help mitigate exclusion and mobilise a network of digital carers. This includes the development of a peer-to-peer support Facebook group, community tips and tricks, tools around NHS App features and a range of curated web links to help people access devices, connectivity and digital skills, in addition to finding out more about key NHS App features and benefits.

8.5.3 At the beginning of the campaign uptake for the NHS App was 17%, the BCWB uptake as of 1 May was 33.76% so there has been improvement, albeit we remain below the national average of 45%.

8.6 Resolution 2- That all PCNs monitor the new telephony system being introduced in the RWT PCN, with a view to potentially introducing a new system, working with partners, in other PCNs should it greatly improve the patient experience.

8.6.1 The new telephony system that has been introduced by the RWT practices is having a positive impact on patients' experiences and operational developments are still occurring.

8.6.2 The new system, and associated dashboard, enables performance to be reviewed within the trust. By using the performance dashboard, it can be identified that the call wait has steadily declined since January and is on average half of what it was (33.8 mins down to 12.8 mins). There has also been a significant reduction in the longest wait experienced which has reduced by two thirds. The number of dropped calls has also decreased, with an indication that the call back facility is easing this.

8.6.3 Practices have received positive feedback on the call back facility, and this has also helped ease the number of inbound calls as the dashboard identified that the same numbers were calling multiple times prior to this facility being installed.

8.6.4 Practices are grouped so that the calls are pooled, enabling patients at the busier practices to get through more efficiently. The practices are also currently recruiting call handlers, to increase capacity within the reception teams. This will enable appointment bookings to be diverted to a call group and reception queries dealt with separately.

8.6.5 The CCG is supporting those practices that do not have this level of functionality to access improved telephony systems where required (see section 8.8 for further details).

8.7 **Resolution 3- The CCG explore the possibility of introducing a specific role in each PCN to monitor access and quality across the surgeries and make recommendations where required.**

8.7.1 Each of the PCNs in Wolverhampton appreciate the need for business development and operational management. Each network has committed to this by employing managers to aid the transformation and day to day coordination of services delivered by the PCN.

8.7.2 These staff provide a central point of contact and work plans include identification of areas of issue and raising with the board of the PCN, including access.

8.8 **Resolution 4- That the CCG complete a facilities and technology audit of GP practices in Wolverhampton and facilitate improvements where necessary.**

8.8.1 We have assessed the telephony functionality of each practice's system against a maturity matrix, to review the system capability in each practice. The functionality we believe is a minimum requirement includes the following criteria-

- Call queuing
- Call backs
- Reporting Dash boards
- Patient record integration

8.8.2 To complement this, we have completed a procurement exercise to enable a preferred provider to be offered to practices. The offer is out to practices that we will support the capital costs of transferring to the new provider, redcentric, while practices will be responsible for the ongoing revenue costs.

8.8.3 there are a number of practices that have expressed an interest, and discussions are ongoing.

8.8.5 There is also a refresh occurring of Check in screens, enabling patients to check in via mobile phone check in, and pre appointment question prompts to reduce the time needed at reception or when arriving for your appointment.

8.9 **Resolution 5- With the increased use of digital services, the Panel seeks reassurances from the CCG on the safety of data such as images, audio and video files.**

8.9.1 As part of the procurement of digital technologies, providers must adhere to a number of principles in order to access the portal. Data protection policies and adherence to Caldicott principles are one of the conditions, if a provider does not meet the requirements, then procurement will not be accepted.

8.9.2 In order to gain agreement from relevant CCG committees, an extensive Data Protection Impact Assessment is also required.

8.9.3 There are also requirements for the standards of which personal records and information are protected through online security. Privacy policies can be found on each of the practice websites, and through the provider of video and e consult (Privacy notice | Patient Access Support Portal

9. Conclusion

9.1 Access to primary care services is important to patients and general practice in Wolverhampton is working hard, with support from the Clinical Commissioning Group, to address the challenges it is facing in continuing to provide a high-quality service to local people as we move towards full restoration of services.

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healthwatch Wolverhampton

An investigation into booking GP appointments in Wolverhampton: Have improvements been made?

June 2022

Contents

Any enquiries regarding this publication should be sent to us at info@healthwatchwolverhampton.co.uk

You can download this publication from healthwatchwolverhampton.co.uk

The Healthwatch Wolverhampton service is run by Evolving Communities CIC, a community interest company limited by guarantee and registered in England and Wales with company number 08464602. We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch Brand) when undertaking work on our statutory activities as covered by the licence agreement

About us

Healthwatch Wolverhampton is the city's health and social care champion.

We're here to listen to your experiences of using local health and care services and to hear about the issues that really matter to you. We are entirely independent and impartial, and anything you share with us is confidential. We can also help you find reliable and trustworthy information and advice to help you to get the care and support you need.

As an independent statutory body, we have the power to make sure that NHS leaders and other decision makers listen to your feedback and use it to improve standards of care.

Healthwatch Wolverhampton is part of a network of over 150 local Healthwatch across England.

Background

The long-standing issue of accessing GP services has been exacerbated by the COVID-19 pandemic, and it urgently needs to improve if GP practices are to meet patient demand.

In October 2021, the NHS announced a plan to improve GP access across the UK and issued a £250 million winter access fund. Between November 2021 and March 2022, this funding was directed towards increasing same day urgent care appointments and the variety of appointment types on offer for patients at GP practices.

Healthwatch England welcomed this decision and issued a press release, where Imelda Redmond CBE, the previous National Director at Healthwatch England, said: "People have told us about the delays they have faced while trying to get appointments at GP services, particularly with long waits due to outdated telephone systems.

"We have also heard about issues that people have faced in accessing the type of appointment which they believe is right for them."

Imelda also noted that delays in and issues with GP appointments are likely to put further pressure on the wider healthcare network.

Last year, Healthwatch Wolverhampton were asked by the Health Scrutiny Panel to call all GP practices in the city to find out information around booking appointments through the telephone. This report was published in December 2021.

The Health Scrutiny Panel asked Healthwatch Wolverhampton to repeat this exercise six months later to review the situation. As the new provider for Healthwatch Wolverhampton, we did not have access to the original methodology or the data used for analysis in the previous report therefore to some extent we have been unable to make direct comparisons.

We conducted this consultation in May/June 2022 and repeated the telephone calls to GP surgeries in Wolverhampton. Calls were carried out between 10am and 2pm so as not to impact on the busiest time of the day. This report presents our findings and assessment of whether patient access to GP appointments in Wolverhampton has improved since December 2021. We have also identified which Primary Care Networks (PCNs) have or have not made changes to improve patient access in the last six months.

What we did

Between 18 May and 1 June 2022, we telephoned the 56 GP practices in Wolverhampton and used a standard set of questions to find out how easy it is to speak to a receptionist, book an appointment, choose the appointment type (e.g. telephone, face-to-face) and be directed towards an appropriate service (e.g. a pharmacist/A&E).See the Appendix for the full list of questions.

We had previously met with the PCN Clinical Directors to inform them of our intended contact with each practice, so that they could let them know to expect our call.

To keep calls consistent, we introduced ourselves using the same script, confirmed that we were talking to the right practice, selected the appointment line (where possible) and spoke to a receptionist (where possible). We marked calls as 'unanswered' if they did not pick up within an hour and marked those as 'refused' if they did not want to answer our questions. If a receptionist passed us on to another member of staff, we noted their role. We obtained observation data for all practices, even if the call couldn't connect or they refused to answer the survey questions.

If a practice refused to answer our questions because they did not think they would have the information required, we gave them the first question as an example. If a practice refused to answer because they were too busy, we explained that the survey would take two or three minutes to complete.

PCNs and their practices

PCN	Number of practices
Total Health	12
Wolverhampton South East	11
Wolverhampton North	10
RWT	8
Unity West	6
Unity East	9

Out of the 56 practices, 23 refused to take part. This is largely because they were too busy, and/or did not believe, as receptionists, they'd have the information or authority to answer our questions. Some practices were reluctant to divulge any information.

Key messages

- More practices are now offering a greater variety of appointment types, particularly increasing the number of face-to-face appointments.
- More practices are offering appointment types according to patient preference, as opposed to solely allocating appointment type based on clinical need.
- More practices are signposting people to the wider healthcare network when no appointments are available, such as booking at sister sites or visiting pharmacists, opticians, and dentists. The majority still signpost people to NHS 111/A&E/urgent care centres.
- Improvements still need to be made to improve the quality of pre-recorded messages on call systems.

  In particular, all ten practices in Wolverhampton South East had neither a message explaining that patients will need to outline their symptoms nor a message asking patients to call the practice at different times for different reasons. Unity West and Unity East PCNs could also improve in this area.
- For medical practices that share a central patient phoneline, the majority were unwilling to answer our questions on behalf of their sister practice. If patients are being denied information about a sister practice, it will add an additional barrier between themselves and their care.
- Some of our calls were cut off or took longer than an hour to be picked up, and it is likely that patients are also experiencing long waits at times, particularly in busy hours.

Recommendations

We will share our findings with the clinical directors for each PCN to highlight any issues identified.

The Black Country and West Birmingham CCG is already working with PCNs to make improvements to practice telephone systems. Healthwatch Wolverhampton could support this work to ensure patients are able to influence these improvements based on their experiences. Our findings tell us that improvements should include:

- Providing an appointment line where possible so a patient can speak directly with a member of staff to book an appointment.
- Ensuring that all practices have the pre-recorded messages on their call system, to explain that receptionists will ask a patient their symptoms in order to book them in with the appropriate clinician, and to call the practice at different times for different reasons. This will improve booking efficiency and reduce the number of patients calling at one time.
- Removing any outdated phone numbers from the GP practice website and the internet.
- Introducing call waiting systems if not already in place, so that people know where they are in the queue and how long they need to wait.

Other recommendations include:

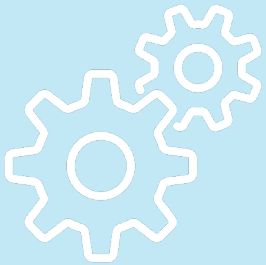
- Ensure all call handlers are trained in booking appointments. This would reduce the need to put callers on hold, or redirect them to someone else.
- Consider having more staff members to cover the practice during busy periods to make sure calls are answered in a timely way.
- Raise awareness of the role that Healthwatch Wolverhampton plays in using patient and public feedback to improve services. Encourage participation by the GP practices in future work programmes.
- Provide GDPR training for staff members so that they can clearly differentiate between the information they should and should not give to patients or callers as this was an issue raised as a reason not to participate in the survey.

What people told us

Total Health PCN

Out of the **12** practices we telephoned:

- **Three** practices could not be contacted
- **Five** refused to answer our questions
- **Four** answered our questions.



The majority of call handlers were obstructive, in that they would list various reasons as to why they could not answer our questions, despite us providing an example of the first question. Some others were dismissive, in that they appeared to ignore the importance of this survey. However, some call handlers were polite and helpful.

Five practices refused to take part

Why did they refuse?

Three practices said they do not have the information to answer our questions. They either told us this, or it was evident because they wanted to put us straight through to someone more senior. Two of these practices said that this is because the manager deals with appointment bookings.

The other two practices refused to take part because they said they were too busy, and they needed to be answering patient queries.

Four out of these five practices said that survey questions have to be sent in writing via email and they cannot be answered over the phone.

Call observations

Did all calls connect?

In December 2021, three of the calls in Total Health PCN were cut off but eventually calls to all 12 practices connected.

Yet in May/June, three calls could not be connected. One practice did not pick up the call within the hour, another practice hung up on us twice, and the third could not be contacted as we were informed it is not a surgery in itself but it comprises of three other practices. This surgery is therefore not included in the below analysis.

Average time to answer call

Out of the nine calls that did connect, the average time taken for a call to be picked up was **seven minutes and 22 seconds**. The shortest time for a call to be picked up was **one minute and ten seconds**, while the longest time for a call to be picked up was **26 minutes and 16 seconds**.

Calls were picked up quicker in December. The average time taken for a call to be picked up was **four minutes and 45 seconds**, the quickest time for a call to be picked up was **one minute**, while the longest time for a call to picked up was **18 minutes**.

Messages on the call system

Out of the 11 practices, ten had a message on their call system saying that receptionists will ask patients what their symptoms are to direct them to the most appropriate clinician.

Ten out of the 11 practices had a message on their system asking people to call the practice at different times for different reasons. This is an improvement on the eight that did in December.

Call waiting

Out of 11 practices, only seven had a call waiting message. Of these seven, only four said what number we were in the queue. For the three that did not, one picked up fairly quickly, so it may have been too soon for the queuing system to initiate. For the other two, we were on the call for enough time to expect a queuing system.

In December 2021, 11 had call waiting, so it appears that less practices are using a call waiting system. Three indicated where we were in the queue, so this has improved to four.

The queuing position did not necessarily indicate how soon you would be connected to a receptionist. For instance, after four minutes waiting, we reached number one in the queue for one practice, but our call wasn't answered until after 25 minutes on the line. For another, we were number one in the queue after 20 minutes waiting, but after one hour the phone hadn't been picked up. Despite joining the phone line for another practice at number two in the queue, our call wasn't picked up until after 26 minutes.

Availability of appointments

Out of the four practices that answered our questions, three said they have specific appointments available for children.

Two practices had no appointments left at the time we called, one could not answer the question and the other had seven appointments left. Similarly, in December one practice had appointments available at the time we called.

All four practices said they offer routine appointments, two said these can be booked within one week, one said within a week and a half, and another said between one and a half to two weeks.

In December, several practices said they offer routine appointments, but some did not. The average length of time that an appointment could be booked in advance was a week, similar to what the four practices told us recently.

Type of appointments

Three of the practices said they offer all four types of appointments (telephone, face-to-face, video and home visits). The other practice said they offer all types apart from video appointments. In December, the practices told us that they mainly offer telephone calls, and only offer face-to-face appointments if they are needed.

When asked how they decided what type of appointment to offer, all practices said it was down to patient preference. This is different to the responses given in December, where most practices said it is the GP who decides the appointment type.

Signposting

Signposting is where patients are directed if no appointments are available on the day.

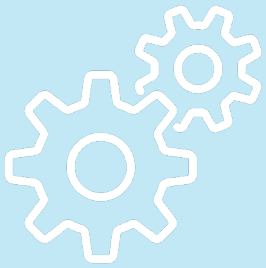
Out of the four practices that responded, two mentioned that they signpost patients to the cross-organisational booking system if no appointments are available (to be booked into a different GP practice in the PCN). Just one practice mentioned that they may refer a patient to a clinical pharmacist. Two out of the four mentioned that it depends on urgency, and if it is urgent, they would direct patients to a walk in centre, 111, 999 or A&E.

This is similar to the types of signposting that practices in the Total Health PCN told us back in December.

Wolverhampton South East PCN

Out of the **11** practices we telephoned:

- **Two** practices could not be contacted
- **Six** refused to answer our questions
- **Three** answered our questions.



The majority of call handlers were obstructive, in that they would list various reasons as to why they could not answer our questions, despite us providing an example of the first question. Some others were dismissive, in that they appeared to ignore the importance of this survey. However, some call handlers were polite and helpful.

Six practices refused to take part

Why did they refuse?

One practice refused to take part because they said they wouldn't know the information required to answer our questions. Two practices refused to take part because they said they were too busy. Another practice said they could not answer our questions without authorisation, while two others said questions like this have to be sent to them via a professional email account.

Did the call go through to another centre than expected?

Calls to four of the practices were answered by a different GP surgery, and this could confuse patients.

Call observations

Did all calls connect?

We could not connect our call to one practice. When we called their telephone number, we were told that no patient line exists for that practice. This practice is not included in the analysis below.

Our call to another surgery was not answered within an hour, so we ended the call. We have included the call data for this practice below, because they may have answered the call if we stayed on the phone longer.

In December, we could not connect to three practices after waiting for a considerable amount of time.

Average time to answer call

Out of the ten practices that we obtained data for, the average time taken for a call to be picked up was **seven minutes and 36 seconds**. The shortest time for a call to be picked up was **two seconds**, while the longest time for a call to be picked up was **22 minutes and ten seconds**.

Calls were picked up quicker on average than in December, where the average time taken to pick up was **13 minutes**. The shortest time for a call to be picked up was **less than a minute**, while the longest time for a call to be picked up was **46 minutes**.

Messages on the call system

Out of the ten practices, none had a message on their call system saying that receptionists will ask patients what their symptoms are to direct them to the most appropriate clinician. Zero practices had a message on their system asking to call the practice at different times for different reasons.

Call waiting

Out of the ten practices, seven had a call waiting system. Out of those seven, three practices did not indicate our position in the queue. All three of these practices picked up the call after four minutes and 30 seconds, so we would have expected there to be a queuing system in place.

Availability of appointments

Out of the three practices that answered our questions, none had appointments left for the remainder of the day. Yet, one practice mentioned that they have space for children under the age of one to see a doctor if necessary.

All three practices said that they offer routine appointments. One practice said the average wait for a patient to secure a routine appointment is within a week, while the other two practices said it is around one and a half to two weeks.

Type of appointments

All three practices said they offer all four appointment types. Two practices said that the type of appointment offered was decided by patient preference, while the other practice said initially it is decided based on the symptoms provided, but it will always be down to patient preference.

All three practices said that they don't offer specific appointments for children, but two of the practices added that if a child under the age of one needs to see someone urgently, they will make sure that happens.

Signposting

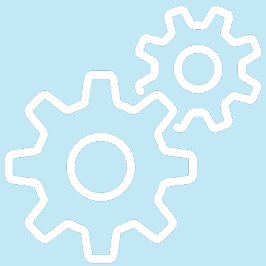
Two of the practices said they would signpost patients to NHS 111 or to a walk-in/urgent care centre. The other practice said they would refer patients to Ettingshall Medical Centre or a walk-in centre.

In December, a few practices explained that they would advice patients to contact NHS 111, call back at 8am the following morning or prebook an appointment for the following day. One practice refused to answer the question because they felt uncomfortable.

Wolverhampton North PCN

Out of the **ten** practices we telephoned:

- **Zero** practices could not be contacted
- **Four** refused to answer our questions
- **Six** answered our questions.



The majority of call handlers were helpful and polite, and could understand the importance of our survey. Some others were obstructive, in that they would list various reasons as to why they could not answer our questions, despite us providing an example of the first question. One call handler was dismissive, in that they appeared to ignore the importance of this survey.

Four practices refused to take part

Why did they refuse?

One practice refused to answer because they said the questions must be sent via email using a professional email account. Another practice refused because they were too busy and had patients in the queue. The remaining two practices refused because they believed a manager had to answer these questions, and their manager was not available.

Call observations

Three practices share a phone line, so a patient could ring and end up speaking to any one of the three practices.

Did all calls connect?

All calls connected, but four practices refused to answer our questions.

Average time to answer call

Out of the ten practices that we obtained data for, the average time taken for a call to be picked up was **four minutes and 54 seconds**. The shortest time for a call to be picked up was **one minute and 18 seconds**, while the longest time for a call to be picked up was **20 minutes and 18 seconds**.

This is similar to the call wait times in December, where the average time taken for a call to be picked up was around **four minutes**, the shortest time was **one minute** and the longest wait was around **16 minutes**.

Messages on the call system

Out of the ten practices, six had a message on their call system saying that receptionists will ask patients what their symptoms are to direct them to the appropriate clinician. Nine practices had a message on their system asking patients to call the practice at different times for different reasons.

Call waiting

Out of the ten practices, all had a call waiting system and nine practices told us what position we were in the queue. In December, eight out of ten practices had a call waiting system, so it appears that this has improved.

Availability of appointments

Out of the six practices that answered our questions, four had no appointments left for the remainder of the day. However, one practice informed us that they close at 1pm on Thursdays (the day we called). One practice had 15 appointments left, and the other had a few appointments available with the duty doctor.

In December, one practice that we talked to had appointments left.

All six practices said they offer routine appointments, and that the average wait time ranges between ten days and two weeks.

Type of appointments

All six practices said they offer all four appointment types. Five practices said the appointment type is chosen according to patient preference, and the remaining practice said the doctor assesses the situation and makes a decision. This same practice said they are currently trialing a new system to offer more and more face-to-face appointments.

In December, practices also said they offer a mixture of appointments for adults but two practices said appointments for children are face-to-face only.

Out of the six practices, two said they offer specific appointments for children. Those that said they do not told us they give children priority and squeeze them in to appointments if necessary.

Signposting

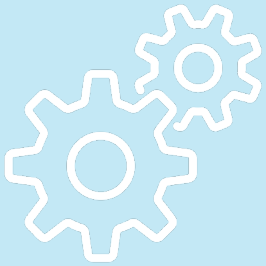
Four practices said they would direct patients towards NHS 111, four practices mentioned they would signpost patients towards A&E/walk in clinics/urgent care centres/999 if necessary, and two said they would refer patients on to pharmacists, opticians and dentists.

This is similar to what we were told in December. However, in December signposting patients to services such as a pharmacy, opticians or a dental practice was not mentioned.

RWT PCN

Out of the **eight** practices we telephoned:

- **One** practice could not be contacted
- **One** refused to answer our questions
- **Six** answered our questions.



The majority of call handlers were polite, warm and helpful. One call handler was initially resistant, but polite. Another call handler was polite, but unwilling to participate.

One practice refused to take part

Why did they refuse?

One practice answered our call but refused to answer our questions. A receptionist argued that answering our questions would result in a GDPR data breach. We explained that this is not the case, as no personal information is being shared.

Call observations

Did all calls connect?

Out of the eight calls that were made, seven connected. The remaining practice cut off our call while we were waiting (at position four in the queue). This is an improvement from December, where our calls only connected to three practices.

Average time to answer call

Out of the seven calls that did connect, the average time taken for a call to be picked up was **three minutes and 22 seconds**. The shortest time for a call to be picked up was **two seconds**, while the longest time for a call to be picked up was **ten minutes and 37 seconds**.

This is an improvement on the calls made in December, where the average time taken for a call to be picked up was **35 minutes and 20 seconds**, the shortest was **under a minute**, while the longest was **one hour and 25 minutes**.

Messages on the call system

Out of the eight practices that we called, eight had a message saying that receptionists will ask patients what their symptoms are to direct them to the appropriate clinician. They all had a message asking patients to call the practice at different times for different reasons.

Call waiting

Of the eight calls that connected, all had call waiting and highlighted our position in the queue. In December, out of the three practices that were contacted, one had call waiting and highlighted our position in the queue.

Availability of appointments

Out of the six practices that answered our questions, three had no appointments left for the remainder of the day, one had eight left, one had two left and the other had seven left.

Four of the practices said they offer routine appointments, two said they did not. Of the two practices that said they do not, one said that all appointments are made by telephoning the surgery on the day (unless you use the Babylon app) while the other practice said that only same day appointments are available.

Four practices answered the question regarding the average amount of time it takes to wait for a routine appointment, and two skipped it. Out of those four, one practice said the wait is approximately 48 hours, another said it is within a week, another said two weeks, and the remaining practice said three to four weeks.

Type of appointments

Five practices said that initially they just offer telephone appointments. The other practice said that both face-to-face and telephone appointments are offered.

Five out of the six practices said a doctor makes a call first and then decides if a face-to-face appointment is needed. The other practice simply stated the doctor decides the appointment type.

This is slightly different to the responses we got in December, where we were told adults receive telephone consultations only, and only children are able to have face-to-face appointments (at the discretion of the GP).

Out of the six practices, one said they offer specific appointments for children while five said they don't. All six said that if a child urgently needs to be seen, they will normally fit them in or get someone to see them.

Signposting

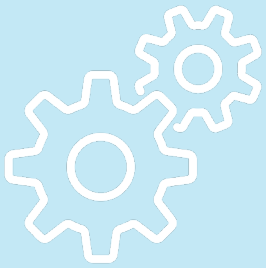
Out of the six practices that answered our questions, four mentioned that they may direct people towards NHS 111 if no appointments are available. All six said that they would refer people to out-of-hours services or the nearest walk in centre. Two mentioned they would direct people to a pharmacist or optician, if appropriate. One practice mentioned they would direct people to the Babylon app to try book appointments, while another would recommend prebooking or calling back the next day to see if appointments are available.

In December, just one practice answered this question, and said they would direct people towards an urgent care/walk in centre.

Unity West PCN

Out of the **six** practices we telephoned:

- **Zero** practices could not be contacted
- **Four** refused to answer our questions
- **Two** answered our questions.



The majority of call handlers were dismissive, in that they appeared to ignore the importance of this survey. However, two call handlers were willing to help.

Four practices refused to take part

Why did they refuse?

Three practices refused to answer our questions because they said they were too busy. The remaining practice said they were told the manager would have to answer these questions, and the manager wasn't available.

Call observations

Two practices share the same telephone line. The second number advertised for one practice is not valid.

Did all calls connect?

Our calls connected to all six practices, but four refused to answer our questions.

In December, our calls connected to four practices. Two practices couldn't be reached because one was temporarily closed and the other did not pick up despite us calling them nine times.

In both December and May/June, no calls were cut off by a practice prior to, or during, a call being connected.

Average time to answer call

Out of the six calls that did connect, the average time taken for a call to be picked up was **three minutes and 34 seconds**. The shortest time for a call to be picked up was **2 seconds**, while the longest time for a call to be picked up was **five minutes and 50 seconds**.

In December, the average time to pick up was lower, around **two minutes**, the shortest time was **less than a minute** and the longest time was **six minutes**.

Messages on the call system

Four out of the six practices had a message on their phone saying that receptionists will ask patients what their symptoms are to direct them to the most appropriate clinician. Two out of six practices had a message on their phone asking patients to call the practice at different times for different reasons.

Call waiting

Of the six calls that connected, five had a call waiting system. Out of those five, four told us where we were in the queue. One practice did not, however they picked up the phone very quickly.

Similarly, in December, three of four practices had a call waiting system and indicated our position in the queue. The practice that did not have call waiting picked up very quickly.

Availability of appointments

Out of the two practices that answered our questions, one had five appointments left and the other had none left.

Both practices said they offer routine appointments, and that they could be booked within a week, often just a few days. In December, all four that were contacted said they offer routine appointments, and that patients had to wait anywhere from one week to four weeks. This suggests that waiting times for routine appointments may have improved.

Type of appointments

One practice said they offer all four types of appointments, while the other said they offer all types apart from video appointments. One practice said the appointment type is decided by patient preference, whereas the other practice said children have face-to-face appointments and all routine appointments take place via telephone.

Out of the two practices that answered, one said they offer specific appointments for children and one said they do not. However, they explained that appointments for children under one get created if necessary.

In December, the practices who answered said they offer mainly a mixture of telephone and face-to-face appointments.

Signposting

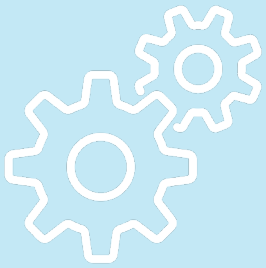
Both of the practices that answered mentioned they would direct people to book appointments at other GP practices within their PCN through Unity, and would direct people to the local urgent walk in centre. One of the two also said they would think about directing people to a pharmacist.

In December, those that answered did not mention that they would direct people to book through Unity, but they did mention they would direct people to walk in centres or NHS 111.

Unity East PCN

Out of the **nine** practices we telephoned:

- **Zero** practices could not be contacted
- **Three** refused to answer our questions
- **Six** answered our questions.



The majority of call handlers were polite and willing to help. Two call handlers were new members of staff, but they were polite nonetheless and asked for help. A small number of call handlers were obstructive, in that they would list various reasons as to why they could not answer our questions, despite us providing an example of the first question.

Three practices refused to take part

Why did they refuse?

Two practices refused to take part because they said the practice manager would have to answer the questions, and they were not available at that moment. The other practice refused to answer because they said they were too busy.

Call observations

Did all calls connect?

Our calls connected to all nine practices, and six of these accepted to answer our questions. While one practice had an engaged tone and immediately cut off during our three attempted calls, our call eventually connected with the practice on the fourth attempt.

In December, we connected with and had answers from seven practices and no calls cut out while calling.

Average time to answer call

Out of the nine calls that did connect, the average time taken for a call to be picked up was **four minutes and 21 seconds**. The shortest time for a call to be picked up was **22 seconds**, while the longest time for a call to be picked up was **26 minutes and 31 seconds**.

In December, the average time taken was **two minutes**, the shortest time was **less than a minute**, while the longest time was **eight minutes**. This suggests that the average waiting time may have increased.

Messages on the call system

Just three out of the nine practices have a message explaining that receptionists will ask patients what their symptoms are to direct them to the most appropriate clinician. Just four have a message requesting that patients call the practice at different times for different reasons.

Call waiting

Out of the nine practices, three have call waiting on their phone system. Out of these three, two did not let us know our number in the queue. However, one of these practices picked up too soon to tell if they use a queuing system.

Availability of appointments

Out of the six practices that answered our questions, five practices had appointments left, ranging from three to 34 appointments. The practice that did not have appointments left informed us that they have NHS 111 call slots left.

All six practices told us they offer routine appointments, and one practice added that appointments can be prebooked until the end of the year. While two practices said patients can be booked in for routine appointments the same or next day, two other practices said it normally takes around a week, another said two weeks, while the remaining practice said two to three weeks.

Similarly, we found out that the length of time to wait for a routine appointment also varied between practices in our December consultation.

Type of appointments

Four practices said they offer all four appointment types, and two said they offer all but video appointments. One of these practices said they probably could offer video appointments, while the other told us that they are considering introducing video appointments.

Three practices said a doctor would call a patient to begin with and then triage them an appropriate appointment, while the other three practices said the type of appointment given is determined by patient preference.

Out of the six practices who answered us, four said they have specific appointments for children, two said they do not. The other two practices said they would make space for a child if they needed to be seen urgently.

Signposting

Out of the six practices that answered our questions, three said they would direct people to book an appointment at another practice through Unity. One practice said they would consider putting a patient on a triage query list. Another suggested they would put a patient on a cancellation list. Five of the practices said they would direct patients to NHS 111/A&E if necessary. One practice mentioned they would suggest the patient prebook for another day, with another practice recommending the patient to call at 8am the next morning.

This is an improvement from December, where three practices said they would not signpost patients to other services and another refused to answer. Those that did would suggest a patient could call back in the afternoon or direct them to NHS 111/A&E/walk in centre if necessary.

Stakeholder response

This report is being presented to Wolverhampton's **Health Scrutiny Panel** at their meeting on 30 June 2022. They will be invited to include a formal response to our findings afterwards. This report will be updated to include their comment and then published to the Healthwatch Wolverhampton website.

Individual practice data will be shared with each PCN to ensure they can use the findings to share good practice and improve the experiences of their patients.

Acknowledgements

Thank you to all the staff at the medical practices who gave up their time to respond to our questions.

Limitations

We could not directly compare the survey answers in December 2021 to the survey answers in May 2022 because not all practices took part in both surveys. Also, calls were made at various times in the day, meaning we contacted some practices at busier times and other practices at quieter times.

Appendix

GP access - telephone consultation

1. What is the name of the GP practice?
2. What PCN is it in?
   - ☐ Total Health
   - ☐ Wolverhampton South East
   - ☐ Wolverhampton North
   - ☐ RWT
   - ☐ Unity West
   - ☐ Unity East
3. On what date did you contact them?
4. At what time did you contact them?
5. What is the name of the person you spoke with?
6. Was there a message left on the answering machine before you got through to the practice explaining that patients will be asked why they need the appointment?
   - ☐ Yes
   - ☐ No
7. Was there a message around times to call the practice for different reasons, for example results of blood tests etc?
   - ☐ Yes
   - ☐ No
8. How long did it take to answer the call?
9. Was call waiting available?
   - ☐ Yes
   - ☐ No
10. Did it tell you what number you were in the call?
    - ☐ Yes
    - ☐ No
11. Were you cut off whilst waiting?
    - ☐ Yes
    - ☐ No
12. What number were you in the queue when you were cut off?
13. How long had you been waiting?

14. Did you just get an engaged tone while calling?
    - ☐ Yes
    - ☐ No
15. How many calls did it take before you were answered?
16. How many appointments did you have available today (from the time that they were released this morning)?
17. How many appointments are left today (from this time of calling onwards)?
18. Do you have specific appointments available for children?
    - ☐ Yes
    - ☐ No
19. Which of the following appointments do you offer (in general)?
    - ☐ Face-to-face appointments
    - ☐ Video appointments
    - ☐ Telephone appointments
    - ☐ Home visit appointments
20. How do you decide which appointment type is offered?
21. If there are no appointments available, what services do you refer people to or what advice do you give?
22. Can patients make a routine appointment (not same day and not urgent)?
    - ☐ Yes
    - ☐ No
23. How far in advance (on average) do you have to wait for a routine appointment?
24. Did you know we (Healthwatch Wolverhampton) would be calling you at some point?
    - ☐ Yes
    - ☐ No
25. A question to ask ourselves:

    Do I have any reflective comments regarding the call e.g. was the person polite?

    Did I have to be redirected to another practice?

healthwatch Wolverhampton

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