CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 17 September 2020

Attendance

Members of the Health Scrutiny Panel

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

Witnesses
Professor David Loughton CBE (Chief Executive, RWT)
Paul Tulley (Managing Director of Wolverhampton, CCG)
Dr Salma Reehana (Chair of Wolverhampton CCG, Governing Body)
Sultan Mahmud (Director of Innovation, Integration and Research, RWT)
Marsha Foster (Director of Partnerships for the Black Country Healthcare NHS Foundation Trust)

In Attendance
Cllr Jasbir Jaspal (Portfolio Holder for Public Health and Wellbeing)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director of Public Health)
David Watts (Director of Adult Services)
Dr. Ankush Mittal (Consultant in Public Health)
Becky Wilkinson (Head of Adult Improvement)
Lynsey Kelly (Head of Communities)
Julia Cleary (Scrutiny and Systems Manager)
Earl Piggott-Smith (Scrutiny Officer)
Anna Blennerhassett (Public Health Registrar)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

Apologies for absence were received from Panel Members, Cllr Bhupinder Gakhal and Dana Tooby. Panel Member, Cllr Obaida Ahmed sent her apologies for part of the meeting.

The Portfolio Holder for Adults, Cllr Linda Leach sent her apologies.

David Watts, Director of Adult Services sent his apologies for part of the meeting.

Vanessa Whatley, Deputy Chief Nurse, the Royal Wolverhampton NHS Trust sent her apologies to the meeting.

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

3 **Minutes of previous meeting**
The minutes of the previous Health Scrutiny Panel meeting held on 23 July 2020 were approved as a correct record.

4 **Matters Arising**
There were no matters arising from the minutes of the previous meeting.

5 **Covid-19 Questions and Answers Session**
A Panel Member asked how the restarting of services was going at, The Royal Wolverhampton NHS Trust and in particular cancer testing and cancer treatment. In addition, she understood the Breast Surgery Unit was being considered for a possible move to Cannock Hospital, she asked for the reasons and whether this potential move was supported by the staff concerned. The Chief Executive of the Royal Wolverhampton NHS Trust responded that cancer services had been restored, but it would be a challenge for at least the next six months in relation to diagnostics. Endoscopies were a particular problem, where they were working at best at 63% efficiency. They would not be able to return to the efficiency of pre-Covid levels until social distancing had been halted. He had earlier in the week had to close Cannock Hospital due to a Surgeon and Junior Doctor testing positive for Covid-19. He had sent most of the theatre staff home to self-isolate. It was his intention to move breast cancer services to Cannock Hospital and the Nuffield. It was however on hold at the present time due to the fact that Cannock was no longer a clean site. They were still investigating how Covid-19 had entered the hospital. He had to move the service due to capacity reasons and was putting the patients first. All services were under pressure due to Covid-19, deep cleaning was required after every endoscopy. There was also a world-wide shortage of equipment, making it harder to expand service areas.

The Managing Director of Wolverhampton CCG stated that when the pandemic had commenced there had been a significant reduction in the number of cancer referrals into New Cross Hospital. At the height of the pandemic cancer referrals had reduced to 25% of normal levels. The referral rate had now recovered to normal levels for the time of year. Outpatient activity was also at usual pre Covid-19 levels. He echoed the points made by the Chief Executive of the Royal Wolverhampton NHS Trust that this was putting pressure on services at the Trust. They were working closely with the Trust and other Trusts across the STP (Sustainability and Transformation Partnership) footprint to help mitigate the pressures as much as possible. It would be a continuing challenge over the coming months.

The Chair asked if Health partners could explain their latest plans for asymptomatic testing, particularly in key sectors such as within Hospitals, Social Care and Schools. The Director for Public Health responded that asymptomatic testing was a potential ambition at a national level in the future. There was more of a narrative at the

present time to population level testing. There was currently a high demand for testing, which was linked to the fact that children had returned to school. There was currently an accelerating rate of Covid-19 infections in the population of Wolverhampton. Two weeks earlier, there had been 8-10 cases per 100,000 but it was now approximately 50 cases per 100,000. This would further increase the demand for testing. Wolverhampton had a number of testing sites, it was however also key to be able to analyse the swabs, which was very much dependant on lab capacity. At the present time asymptomatic testing was not being considered on a widescale at a national or local level. There was however a programme of asymptomatic testing in Care Home settings.

The Head of Adult Improvement at City of Wolverhampton Council responded that Care Homes were part of a national portal where they could register for Covid-19 testing every 21 days and complete proactive mass swab tests, which would pick up asymptomatic residents and staff. They were working with Care Homes across the City and colleagues in Public Health to ensure they were all signed up to the national portal. In addition, they did have access to a small amount of local tests which could be used. Where staff had tested positive recently there had not been any transmission to residents, which showed the PPE (Personal Protective Equipment) was being used effectively.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that there were not any plans for asymptomatic testing at the Royal Wolverhampton NHS Trust for the foreseeable future. He had been informed that the Trust would run out of reagents by the end of the following day. There would have to be some form of rationing by the Trust's lab until stocks were resupplied.

The Director of Partnerships for the Black Country Healthcare NHS Foundation Trust responded that the Trust were following national guidance, where there was no mass asymptomatic testing at the current time. In line with national guidance though they did test all of their inpatients entering a mental health or learning disability bed across the Black Country. If there was a particular outbreak they would also test people in the vicinity of that outbreak, regardless of whether they were expressing any symptoms.

The Vice-Chair asked Health Partners to explain their plans for flu vaccinations. The Managing Director of Wolverhampton CCG stated that they had been working with local General Practitioners and other partners to implement a comprehensive flu plan for the year. They were hoping for a higher percentage of the population of Wolverhampton to receive the flu vaccination. They hoped to complete the programme by the end of November. The amount of people eligible for the flu vaccination had increased as it was now being offered to the household contacts of the people on the NHS shielding list, children in Year 7, health and social care workers employed through direct payments and NHS staff. They were looking to maximise uptake this year in order to support the health service. The Chair of the Governing Body of Wolverhampton CCG commented that it was quite difficult to maintain social distancing during immunisations. General Practitioners were working closely with the other sectors within health care which included the community pharmacists to provide joined up working. The emphasis presently was on the higher risk patients and the remainder would follow. Most practices were opening at weekends in order to be able to meet the end of November 2020 target.

The Consultant in Public Health remarked that one of the biggest challenges was being able to vaccinate the high number of people in the groups that were now being targeted for the flu vaccination. There was also the possibility of having to vaccinate 50 – 65 year olds, where a formal announcement would be made in the future on whether they would be vaccinated later in the season. In some respects, the high amount of flu vaccinations required this year would be a good trial run for any forthcoming Covid-19 vaccination. There would be a third version of the Flu Fighters comic for young people to encourage uptake of the vaccination. The Director for Public Health praised the partnership working across agencies which had taken place last year with reference to flu vaccinations. Last year had seen the biggest rise in uptake in children and an improvement elsewhere. It was the highest rise across the West Midlands.

The Head of Adult Improvement at the Council commented that Adult Services had a support role with respect to flu vaccinations. They supported with access to residential and nursing homes. They also helped with communications in their weekly bulletins and stand-alone communications.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that they had three nurses working full time on vaccinating Trust staff and over 100 peer vaccinators trained. There was therefore plenty of resource available to ensure the Trust's staff had the opportunity of a flu vaccination. They were also setting up a drive through and walk-through. The kit required to test for flu, for people being admitted to hospital, was the same as for Covid-19. They would have to keep this under daily review as they needed to maximise the number of Covid-19 tests available.

A Member of the Panel stated that the demand at the community pharmacy she worked at had been unprecedented and they had now run out of flu vaccine. They had been informed they would not be resupplied until October. Anyone who was not on the NHS list had been informed to wait until the end of October. There were two local surgeries she worked with, one of which had not yet commenced flu vaccinations, the other one was giving out the flu vaccinations on the doorstep of the surgery, which she personally believed was not the correct setting.

The Director of Partnerships for the Black Country Healthcare NHS Foundation Trust stated that the Trust provided flu vaccinations for their staff and also for their inpatients who were in the eligible groups. Delivery of vaccinations was expected that week. They had peer vaccinators. They were also issuing staff with vouchers for those that preferred to receive their vaccination from a community pharmacy. This was important because many of their staff were working remotely at the present time.

A Member of the Panel asked about the arrangements for General Practitioners going into Care Homes. The Chair of the Governing Body of Wolverhampton Clinical Commissioning Group commented that traditionally multiple GPs entered Care Homes. They were now introducing a system where Care Homes were being allocated GPs as per each Primary Care Network (PCN). This has been agreed by all GP practices in Wolverhampton. The PCNs would work with all practices within their network to provide flu vaccinations to all patients in each Care Home that came under their area.

The Chair asked what strategy health partners, including Adult Social Care, had for PPE (Personal Protective Equipment). The Consultant in Public Health stated that Public Health had helped with some of the modelling for the orders of protective equipment for carers in care settings. The process was reviewed regularly and was working well. They had also supplied some modest stocks of PPE to other settings including to schools and key partners within the voluntary sector and community settings.

The Head of Adult Improvement commented that at the start of the Covid-19 pandemic there had been significant pressures with PPE. There were some national supplies received, but until they arrived, it was hard to determine what would actually be supplied, this had caused significant stress within the system. In the interim period the Council had sourced its own PPE to ensure at least Care Home providers could be supplied with a minimum amount. Before Covid-19, for residential Care Homes, their normal PPE had been aprons and gloves, their standard practice had not been to source masks. Consequently, masks for residential Care Home settings had been a significant focus for Adult Services over the last six months. A robust system was now in place, they were using the national supply and encouraging providers to do so. The Council was able to supply 14 days' worth of emergency PPE for any provider that contacted them. To date the Council had supplied over two million pieces of PPE to providers across the care system and where health partners had shortages they had been able to offer some assistance. The key was to ensure that the supply remained robust over the winter. They had worked in partnership with CCG colleagues to ensure there was appropriate training with providers on the use of PPE.

The Chief Executive of the Royal Wolverhampton NHS Trust stated that the Trust did not currently have any problems with PPE and he did not envision a problem going forward.

The Managing Director of Wolverhampton CCG remarked that they had been supporting practices with the coordination of supplies. It had been particularly challenging at the start of the pandemic but broadly speaking the supplies were now in place for the practices.

The Director of Partnerships for the Black Country Healthcare NHS Foundation Trust, remarked that whilst it had been a challenge and considerable creativity had been required, they hadn't had any major problems with PPE at the Trust.

The Chair asked for reassurance that schools had enough PPE equipment to ensure they could operate safely and effectively. The Consultant in Public Health responded that a small supply of PPE had been provided to schools and that was because PPE was only needed to be used rarely, where there was a suspected or confirmed Covid-19 case that could not be managed from a two-metre distance.

The Vice Chair asked a question to Public Health representatives regarding the details of plans for any potential future local lockdown in Wolverhampton. The Director for Public Health commented that three weeks ago Wolverhampton was at a rate of 8 Covid-19 cases per 100,000 in the population. They were currently at 43-50 Covid-19 cases per 100,000. The true prevalence was unknown due to the limitations of testing. The infection rate was being driven by households mixing together inside other households. They had therefore taken the decision to ask

Wolverhampton residents to voluntarily adopt the preventative measures that were already in place in Birmingham regarding households mixing together inside other households. He did not currently have any concerns about infection control in health settings. In social care settings they were managing any single issues which were largely staff related. Schools had some single cases but there were no large outbreaks and there were no large outbreaks in work settings. The intelligence, including test and trace and local data, was showing that the infection in Wolverhampton was primarily spreading through household mixing. They were very close to discussing with the Government direct intervention and making certain measures mandatory.

A Panel Member asked whether a firmer stance should be taken than just voluntarily asking residents not to mix within households inside. The Director for Public Health responded that they had actively invited conversations with the Government and Region regarding measures that could be taken to help prevent the spread of the virus. They were in direct discussions with the Government about introducing direct interventions and were therefore well positioned.

It was asked if Public Health could explain their plans to enforce, working with the Police, the current Covid-19 laws and any future local lockdown rules. The Director for Public Health commented that he believed the City had reacted exceptionally well during the difficult times brought on by Covid-19. The Council had taken an enabling approach by supporting retail and handing out masks. At the same time, it was important to address the issue of compliance. The Consultant in Public Health added that the Council had a range of powers it could use in relation to compliance. Some of these powers had been used in business settings. They had also introduced measures to restrict certain types of social visiting in Care Homes, due to the vulnerability of the people staying at the homes. The main way to manage the spread of the virus in the community though was through a population behavioural enablement approach. It was important to relay the message that the cases were rising in Wolverhampton and therefore there was a need for people to change their behaviour to bring the infection rate down. The Council was also increasing the support available to vulnerable people, particularly people who had been identified through the test and trace system and were having to isolate. Increased support was also going to be given to small and medium sized businesses to help their premises run as safely as possible.

The Scrutiny Officer read the following question on behalf of Panel Member Dana Tooby who was unable to attend the meeting, “On Good Morning Britain they reported that Birmingham City Council had launched a Whistleblowing Hotline where employees can report any employers who don't adhere to Covid-19 guidelines. Offending businesses are issued with a written warning and if they continue to flout regulations may be served with a Direction Notice of Closure. Is this something that Wolverhampton Council could consider to prevent a local shutdown, especially as more people are being encouraged to return to their office base?”

The Director of Public Health responded that the key question was to ensure an appropriate balance and dialogue working with the people of Wolverhampton. They were an enabling Council and would put measures in place if appropriate to do so.

It was asked if Public Health could inform the Panel on the amount of suicides that had taken place in Wolverhampton since the start of March 2020 and how this

compared to previous years. It was also asked what additional steps were being taken to help prevent suicides at the present time. The Consultant in Public Health remarked that the Office for National Statistics (ONS) produced the data on suicides and it was published every September. The data published in September was however for the preceding year and so the most recent official data was for the period September 2018 – September 2019. He could therefore not answer officially what effect Covid-19 had had on the rates of suicide. For 2018-2019 there had been 21 suicides in Wolverhampton. For the preceding years before this, the average had been around 20, for each year, suicides were normally between 15-25 in Wolverhampton. There had been a point in the history of Wolverhampton when suicides were at a rate of 30-40.

The Consultant in Public Health commented that it was hard to judge the impact of the pandemic on the amount of suicides taking place. There had however been national surveys on mental health. Most of them had reported a higher level of anxiety and low mood. Levels of mental health normally correlated with suicide rates and so it was concerning that the surveys were reporting this fact. Social network restrictions would have an impact on mental health and there was also a concern about substance misuse during the pandemic. He felt that access to mental health services during the pandemic was important.

The Consultant in Public Health remarked that there had been a change recently in how suicides were classified. The process involved a Coroner making a decision on whether the death was a suicide based on reasonable doubt but it was now shifting towards the balance of probabilities method. It was therefore important to take this into account when analysing the new data. There was now an agreement with the Black Country Coroner's Office to receive real time data on suicides. This had been setup in January 2020 and meant they could receive more up to date data before the official statistics were released by the ONS.

The Vice Chair asked if Public Health could detail any extra support that had been given to combat domestic violence within Wolverhampton and asked for the data showing the effect of Covid-19 on domestic violence incidences within the City. The Head of Communities showed a slide with the data, which showed that when the UK first entered lockdown, reports of domestic abuse decreased in Wolverhampton. This was thought likely to have been due to victims having less contact with professionals and being unable to safely seek support. Since the easing of lockdown domestic violence reports had been increasing and were now back at expected levels. This was in line with regional data. Additional emails and calls had been made to the Haven, which was the main domestic violence provider in the City. During the lockdown period they had worked with the domestic violence refuge and some of their providers to make sure they had all the correct infection prevention measures in place. This allowed the key refuge service to continue during the pandemic. They had also assisted the Haven in obtaining extra funding from the Ministry for Housing, Communities and Local Government, to help alleviate any Covid-19 financial pressures on the service.

The Head of Communities commented that there had been a regional campaign launched by the Office of the West Midlands Police and Crime Commissioner. Wolverhampton had actively committed and supported the campaign. They had took the decision to continue training for their frontline services and had commissioned the Wolverhampton Domestic Violence Forum in partnership with Wolverhampton

CCG to continue to train professionals since March. They had also proactively recruited a domestic violence specialist into the authority, they were scheduled to start working for the authority in October. They would be tasked with driving the implementation of the Council's Personal Violence Strategy, building on the partnership with the Haven and leading on the implementation of the new Domestic Abuse Bill. Domestic violence services remained a key priority for the City. The Domestic Violence Security offer, which had been halted in the first few weeks of lockdown had now been reintroduced after thorough risk assessments had taken place. This service helped people stay safely in their properties, without the need to move into refuge. Additional security measures were provided in people's properties to help them remain there safely.

The Head of Adult Improvement commented that there had been an increase in the number of safeguarding concerns, where domestic violence was a factor. Throughout the Covid-19 Pandemic they had increased their staffing numbers to manage the referrals. They had also seen a large increase in the misuse of alcohol, which was often a factor in domestic violence cases. The CCG were looking at additional drug and alcohol services across the Black Country as winter approached.

The Vice Chair asked if the CCG and RWT could inform the Panel more about the use of digital appointments in Primary Care. The Managing Director of Wolverhampton CCG commented that when the Pandemic had first commenced the CCG had provided software to enable Primary Care to offer digital appointments in a consistent manner. The latest data was showing that up to 50% of contacts with Practices were now taking place via non physical methods such as video and telephone consultations. It was however important to remember that practices were still open for people that needed to be seen in the surgery. The waiting times for appointments during the course of the pandemic to date were shorter than before, this was an obvious benefit to using digital methods. The way patients felt about using digital methods would be built into their future plans.

The Chair of the Wolverhampton CCG Governing Body remarked that from a Primary Care perspective, it had worked well with patients having access to other consultation methods. It was however true to say that some patients struggled with the use of digital methods to make contact. Practices were willing to allow physical meetings at the surgery where this was the case. There were cases where language barriers or hearing difficulties sometimes meant a physical appointment was the most appropriate option. There were some occasions when a video call had been attempted, which had not worked, which then required a telephone call, this could sometimes add to the time pressures. Digital appointments had been helpful for staff working in surgeries who were shielding or self-isolating and had been able to continue to actively work via virtual means.

The Director of Innovation at the Royal Wolverhampton NHS Trust praised Primary Care for stepping up to the challenge of appointments during Covid-19. Wolverhampton had been the first in the country to launch a Digital First Covid Carer across the City in April, within three weeks of the first case at the hospital. All of the practices in Wolverhampton had better access to data than anywhere else. Access to digital services could actually help with the equalities agenda, due to the vulnerability of some patients. Digital exclusion was also a factor which needed to be addressed.

It was asked if Public Health and Adult Services could detail the work they were undertaking to combat loneliness during the Covid-19 era, including the use of digital connectivity. The Consultant in Public Health commented that loneliness had been a major issue during the pandemic. Finding the right balance between physical connections and keeping people safe from the virus was important. Using digital was one way of keeping people connected. When people did meet it was important to comply with the law and put safety measures in place. The Voluntary Sector Council had also been able to help people feeling socially isolated. He was pleased that parks had been able to stay open in Wolverhampton.

The Director for Adult Services remarked that social isolation was an issue. Visiting had been restricted to Care Homes at the height of the pandemic. They had worked closely with care providers to use digital methods so families could keep in touch. This method however did not work for everyone and so they supported Care Homes to have a visiting protocol when restrictions had eased. Sadly visiting restrictions had now been tightened again due to a rise in Covid-19 cases within the City. There were however exceptional circumstances when visiting could continue to take place. He praised the Community Support Team who connected people to their local communities. They were only a small team of three people but had completed extensive work to help people throughout the pandemic. Some of the excellent work that had taken place during the pandemic to help people with loneliness, he hoped would continue after the pandemic. He encouraged anyone with ideas to help with the challenge of social isolation to contact the service.

The Vice Chair asked if RWT could detail the findings to date of the review into hospital acquired Covid-19 infection and to explain the plans for the Nightingale Hospital in Birmingham. The Chief Executive of the Royal Wolverhampton NHS Trust responded, that extensive data analysis had been completed on hospital acquired Covid-19. It was important to be mindful of the inaccuracy rate of swab tests at the start of the pandemic, which meant it was harder to rely on any evidence. With reference to the Nightingale Hospital, it would be kept under review as to whether it would be utilised by the Trust. At the peak of the pandemic earlier in the year, he still had over 400 empty beds because elective surgery had been halted. He highlighted the fact that positive Covid-19 inpatients were now starting to increase at the Trust.

In response to the question, “Can Public Health detail any preventative Covid-19 measures that have been put in place in prison settings serving the population of Wolverhampton?” the Director for Public Health responded that he would ask Public Health England to provide a written response to the Panel. The Chief Executive of the Royal Wolverhampton NHS Trust stated that throughout the pandemic the Trust had continued to treat prisoners.

In response to the question, “are Health Clinics being setup in Wolverhampton for what the media have termed, “Long Covid?” the Managing Director of the CCG commented that he was not aware of any national guidance in relation to specific healthcare provision for this particular type of patient. Services were obviously available to people with healthcare problems, but no specific service was being commissioned for this condition. Should any guidance be released on the condition, then they would respond accordingly. The Chair of the Governing Body of Wolverhampton CCG commented that there was considerable uncertainty of the medical aspects of Long Covid as it had been termed. She had recently written to Dr

Odum, who was the Chair of the Clinical Leadership Group for the STP (Sustainability Transformation Partnership) to recommend a clinical discussion on the matter of Long Covid.

6 **CCG Merger Proposals**

The Managing Director of Wolverhampton CCG introduced the report on the CCG Merger proposals. He stated that the CCG in Wolverhampton had been very successful and had been rated as outstanding in the last four years by NHS England. There was a changing landscape in the NHS, with the development of Sustainability Transformation Partnerships (STP) and Integrated Care Systems (ICS). The expectation in national policy was that the ICS would play a key role in how the systems would work and that within the ICS there would be a single Commissioning voice. In order for Wolverhampton to be a successful Commissioner it needed to be part of an Integrated Care System with the national expectation of there being one single CCG across the Black Country and West Birmingham. As part of any Black Country and West Birmingham CCG, they did not want to lose the critical local relationships in Wolverhampton with General Practice, the local public, the local authority and local providers. Any future CCG would be organised with local decision making critical to its governance structure. They would continue to have a clinically led decision making body in Wolverhampton which would have governance responsibility. There would also be a management team, led by himself, which would support the decision making body and provide support to partners and the public.

The Managing Director of Wolverhampton CCG remarked that the Panel had previously asked for a list of benefits that a formal merger of the four CCGs would provide. Section 3.1 of the report circulated with the agenda listed the benefits. A clear benefit was the advantages of working at scale and collaborating, which could benefit Wolverhampton, but keeping certain elements which worked best at a local level within Wolverhampton.

The Chair of Wolverhampton's CCG Governing Body stated that whilst there were benefits of working at scale, including cost savings which could be re-invested into patient care, it was important to ensure that they did not become distant from local decision making and local care needs. There would be a local Wolverhampton based structure including a local Office, local GP and patient representation on the local board would continue irrespective of there being a single organisation at system level.

A Member of the Panel commented that it was hard to argue against an Integrated Care System and she questioned why this had not been put forward in previous decades. She also highlighted that reducing duplication and costs and increasing partnership working were all beneficial. She commented that smaller voluntary sector providers tended to lose some of their influence when organisations became larger. She sounded a word of caution that they needed to have good communication with them to ensure local need was fully taken into account.

The Managing Director of the CCG responded that he agreed with the Member on the importance of the voluntary and community sector. Ensuring they had a voice would be very much the responsibility of the local Committee and team. The structures that they were currently organising to support a single Management Team

across the Black Country, were actually looking to enhance the level of capacity within the Management Team for engagement with the Public and local voluntary organisations. The Chair of the Wolverhampton CCG Governing Body added that the voluntary sector would play a large role in the Integrated Care Partnership to ensure local needs were accounted for within Wolverhampton.

The Vice Chair asked how the Health and Wellbeing Board and Health Scrutiny Panel would work within any new system. He stressed the need for openness and transparency. He also asked how any new CCG would work directly with City of Wolverhampton Council departments and conversely how City of Wolverhampton Council departments would be able to engage directly with the new CCG on a daily basis in an efficient and productive manner. The Managing Director of Wolverhampton CCG responded that he would be based in Wolverhampton and it was his role to ensure that the system would work. They would continue to engage with the Health and Wellbeing Board, the Health Scrutiny Panel and other strategy groups within the City. He did not envision the Health Scrutiny Panel having to act differently and the Health and Wellbeing Board would remain a good place for partners to continue to work together.

The Scrutiny Officer asked for the CCG representatives to explain the governance process for the proposed formal merger of the four CCGs. The Managing Director of the Wolverhampton CCG outlined that the CCGs were membership organisations. As a merger was a change to the constitution the decision on whether to proceed with a merger proposal was made by the Member Practices. In Wolverhampton the Member Practices made decisions on a one practice, one vote basis. The Transition Oversight Group had been set up by the Governing Body to consider the outcome of the consultation and to manage the process of taking forward the merger proposals. The decision would be made through a vote by the practices in each of the CCGs areas, which would take place in mid-October 2020, the outcome of the vote would then be considered by the Governing Body. If a merger was supported, because it was a change in the constitution, the proposal for a merger for the four CCGs would then be sent to NHS England for approval.

The Chair of the Wolverhampton CCG Governing Body stated whilst the formal requirements had been outlined by the Managing Director, she was acutely aware of the need to take views from a wider area such as the Health Scrutiny Panel, local authority colleagues, multiple stakeholders, the acute trust, patient representatives and the general public. Engagement events had been held, where their views would be fed into a document that would be sent to all Member practices. If the GP Membership voted no to the proposed merger then the process could not continue. Once they had voted, it would go back to the Governing Body meeting in Common which had representation from each of the four CCGs. Any merger proposal would require ratification by this Governing Body meeting in common, before the proposal was sent to NHS England and NHS Improvement for a final decision.

A Member of the Panel commented that she had heard the phrase that “it was a done deal” in the community. She also asked about the various different GP Surgeries under different control, such as those within vertical integration. She asked if all GP surgeries would have a vote. The Chair of the Wolverhampton CCG Governing Body confirmed that all GP surgeries would have a vote including those run by the acute trust, those that were independent or sub-contracted. She also had heard people referring to the proposals as a “done deal.” She commented that the

reality was any CCG would have to work within an Integrated Care System as was the national long term requirement. They could therefore either continue as a collaborative unit working with other CCGs with its own difficulties of decision making or merge, which would make decision making easier with a more stream-lined governance process. It was not a done deal as any merger could not proceed unless there was a majority yes vote from the Members. The Managing Director added that the sense of a "done deal" had come from the fact that national policy was very much driving in the direction of mergers to give ICS's a single commissioning voice. The majority of other areas had already gone down the merger route, Wolverhampton would be an outlier if they didn't proceed with a merger.

It was asked how any new commissioning arrangements would help reduce health inequalities within Wolverhampton better than the current system. The Managing Director responded that a merger would bring into Wolverhampton the benefit of collaborating at scale and the opportunities arising thereof to do things differently. Working at scale would not take away from the work being undertaken in Wolverhampton to reduce health inequalities, it would hopefully support the current work and work in the future. As an example, he cited the work taking place within the new STP Academy with PCNs, on improving the uptake of cancer screening to ensure people had an earlier diagnosis. Cancer screening uptake was related to levels of deprivation.

The Chair of the Wolverhampton CCG Governing Body commented that it was important to compare Wolverhampton with the national picture and regional picture. Generally speaking the health outcomes within Wolverhampton were poorer than the national average. A merger would help all the four CCG areas to pool resources to help improve health outcomes and inequality. The work with the STP Academy on cancer screening would unlikely have been able to have been completed on a purely local Wolverhampton level. The other area of focus she referred to was the appointment of a Transformation Director, who's key role would be to work on health inequalities specifically. This extra resource had been made possible through the collaboration of the four CCGs.

A Panel Member commented that there was a considerable number of staff in the Black Country and West Birmingham CCGs Senior Management Team, which had been established earlier in the year and referred to at the last Panel meeting. She asked if all of these posts were actually required and whether the management costs, taking the four CCG areas collectively, had increased or decreased. The NHS seemed to have considerable management structures and her main concern was to ensure that funds went into delivering patient care for citizens. The Managing Director of Wolverhampton CCG declared an interest on this point as a member of the Black Country and West Birmingham CCGs Senior Management Team. They were going from four CCG management teams to one CCG management team, so there were fewer posts than there were collectively across the four CCGs. Management costs were set nationally and they had to operate within the limitations of that fund. For the current year they had been set a 25% reduction in their management costs, as had all CCGs nationally. One of the ways they had been able to achieve this reduction was through the benefits of working at scale. Some tasks were no longer being duplicated at each CCG as a consequence.

It was asked if there were any appraisal or options documents available which looked at the proposed merger, particularly form a pros and cons analysis, other than that

which was currently in the public domain. The Chair of the Governing Body commented that she didn't think there was anything available which was not already in the public domain. The majority of the work had commenced following what was in the NHS Long-Term Plan. A slide set had been used in some of the stakeholder events which outlined the pros and cons of the proposed merger. She was happy for these to be shared with the Panel. The King's Fund had completed some reports on the NHS Long-Term Plan and ICS systems. The Managing Director of Wolverhampton CCG commented that there had been an engagement exercise last year which looked at CCG Collaboration and working practices. The pros and cons had been set out in the documents through the merger engagement exercise.

A Panel Member stated that in 2013, 152 Primary Care Trusts had been abolished and 211 CCGs had been created. He said the key issue was a local service was needed for local people and the local community. The service needed to make a difference to the medical needs of the local community. If the new structure was going to provide this, then he would be in favour. It was important to address the key health issues which he felt different commissioning systems had not done enough of in the past. Policy and strategy formulation and how these were implemented were very important in ensuring a positive impact on people's health within the City. He believed the Government were keen to have bigger Commissioning organisations to make cost savings.

The Managing Director of Wolverhampton CCG responded that the proposed merger would help to ensure that the health system worked effectively at a neighbourhood, local and regional level. The Chair of the Governing Body of Wolverhampton CCG commented that whilst cost savings were part of the reasons for a merger, the public's healthcare needs were vitally important. People's health needs were becoming more complex as people lived longer, which required effective partnership working at scale to cope with the demands. The improvements to breast cancer treatment in Wolverhampton was testament to how working at scale could have a positive impact.

Clarification was sought on whether Wolverhampton patients would be sent out of area for certain services which were currently delivered locally. The Chair of the Governing Body of Wolverhampton CCG reassured Members that patients would still be able to request treatment where available, such as at New Cross Hospital.

Resolved Unanimously: The Health Scrutiny Panel:-

a) Asks for the report going to the CCG Governing Bodies on the proposed merger to be sent to the Scrutiny Officer to the Panel for circulation to Members of the Health Scrutiny Panel.

b) Requests any detailed appraisal and options documents on the proposed merger arrangements to be sent to the Scrutiny Officer to the Panel for circulation to Members of the Health Scrutiny Panel.

c) Asks the Wolverhampton CCG Governing Body and the Black Country and West Birmingham's CCGs Leadership Team to note that the Health Scrutiny Panel wants to ensure that "Local needs" are not lost in any potential new commissioning arrangements. High quality Health Services need to be delivered for the people of Wolverhampton and inequalities addressed.

d) Asks the Black Country and West Birmingham's CCGs Leadership Team to note and provide a written guarantee to the Health Scrutiny Panel, that Wolverhampton would not suffer from any decline in available finance, currently allocated to improve the health of the Wolverhampton's citizens, as a direct consequence of any new commissioning arrangements and asks them to detail the safeguards in place to ensure this would be the case not just in the short-term but also long-term future.

e) Asks the Black Country and West Birmingham's CCGs Leadership Team for a formal detailed written response on the strategy of how any new commissioning arrangements would help reduce health inequalities in Wolverhampton, better than the current commissioning system.

f) Asks the Black Country and West Birmingham's CCGs Leadership Team for a formal detailed written response on the working arrangements for how any new CCG would work directly with City of Wolverhampton Council departments, which have responsibility for health matters and conversely how City of Wolverhampton Council departments would be able to engage directly with the new CCG in an efficient and productive manner.

g) Requests from the Black Country and West Birmingham's CCGs Leadership Team a formal written response about their views on the role of Health Scrutiny Panels and Health and Wellbeing Boards in any new proposed commissioning arrangements.

h) Reserves judgement on whether it supports or is against the proposed merger of the four CCGs, until it receives the further information requested and hears more from the City's General Practitioners.

i) Reserves its right to write directly to NHS England with its views regarding a potential merger, after the formal vote of each of the four CCGs on the merger.

7 **Healthwatch Annual Report 2019-2020**

The Healthwatch Manager presented the Healthwatch Annual Report 2019-2020. The Chair and Vice-Chair had submitted a total of eight advance questions to the Healthwatch Manager for a response to be given at the meetings. The first question was, “the Annual Report refers to making 192 recommendations for improvement, do you keep track on whether these recommendations have been implemented and do you publish the outcomes?” The Healthwatch Manager responded that as part of their 2020-2021 enter and view visits, they were planning to conduct re-visits. They had however suspended enter and view visits in March 2020 due to Covid-19 and ensuring the safety of volunteers, many of which fell in the vulnerable category and for the safety of patients. It was later recommended by Healthwatch England to suspend all enter and view activities and it still remained their advice. Their parent company Engaging Communities Solutions were exploring ways that might enable people living and using services to share their stories using digital technology. More generally some of the recommendations effected the wider Black Country area and so there was a need to liaise with other areas when following up recommendations. For other report recommendations, they would form part of their work plan for next year.

The second question submitted was, “can you explain how you choose which places to “enter and view” and the role of the Healthwatch Advisory Board in this process?” The Healthwatch Manager responded that there were various ways the enter and view locations were chosen. The location choices were based on the intelligence they received through a number of channels including patient experience and feedback. They worked with the quality teams at the local authority, CCG and CQC and were currently meeting them virtually. She advised that the Healthwatch Advisory Board (HAB) must approve the decision on which visits should be undertaken and she added that they had recently refreshed the decision making policy and process to ensure that the process in which a visit is determined and agreed upon is fully transparent. The rationale behind the decision was recorded in their HAB meeting minutes, which was a public document available on their website. However, whilst they always tried to plan ahead and obtain HAB approval on premises to visit, there were some occasions when an urgent visit was required, as the Healthwatch Manager she could make a recommendation to the HAB Chair if time was of the essence. The Chair could agree the visit as a Chair’s action, which would be recorded retrospectively in the HAB meeting minutes at the next available meeting. In reality this only happened on rare occasions.

The third question which had been submitted was, “what are your plans for “Enter and View” because it was paused during Covid-19?” The Healthwatch Manager responded that it was currently paused, but this had not prevented them engaging with the public via virtual engagement meetings, coffee mornings, and their annual planning meeting.

The Chair had submitted the question, “can you explain the process for how you identify and recruit volunteers?” The Healthwatch Manager remarked that there were various ways they recruited volunteers. Before Covid-19 they went into the community as part of their engagement activity. The website had details of the volunteer jobs and there was a volunteer handbook. There was an online form which could be completed. Social media also promoted volunteers particularly in volunteer week in June, it also asked if people wished to volunteer. Word of mouth was also important and she cited the example of a student who had conducted work experience who had told a family member. This family member had now been recruited and they would have a leading role in the Youth Healthwatch.

The fifth question which had been submitted was, “can you give the Panel the definitive number of how many active volunteers Healthwatch Wolverhampton currently have?” The Healthwatch Manager responded that as of the preceding Monday, they had 27 active volunteers. Throughout lockdown they had received 10 queries through websites and social media. Four were interested in Youth Healthwatch. Out of the 10 people, five people had gone forward for an interview. The remainder they had followed up on their initial enquiry but had not had any further communication from them. Out of the five people they had interviewed, one had been fully inducted and there were plans for the other four to be inducted by the end of September 2020.

The Vice Chair had submitted the question, “can you detail, where the additional income of £30,635.31 came from please?” The Healthwatch Manager responded that they had carried out a General Practice Nurse Project with the CCG across the Black Country. They received an income of £10,000 but £7,500 of costs had been

distributed to Healthwatch Sandwell, Healthwatch Dudley and Healthwatch Walsall. £7,025 came from the CCG End of Life Project, which they had been commissioned to undertake. £3,250 was received from Healthwatch England as part of the long-term plan. £514.31 was for a student nurse placement. £9,846 was deferred income from previous years, surplus carried forward. Any decisions about projects going forward went through the HAB as part of the decision making process to ensure there were no conflicts in taking on projects.

The Chair had submitted the question, "have all volunteers and staff received Suicide Awareness Training, if not what are the plans for them to do so?" The Healthwatch Manager responded that Suicide Awareness Training was not mandatory. However all the staff had received the training. Details of the training had been shared with HAB Members and volunteers had been asked to let their volunteer lead know if they had undertaken the training. However only a small number of volunteers had responded. Some volunteers had commented that they would be uncomfortable completing the training. It was offered to all the work experience students. 18 of them had undertaken the training. The training had also been shared at the College and their own Membership. Details of the training was available on the website. Compton was carrying out some training along with the University. This was face to face training which when deemed safe to run again, would be offered to all Healthwatch Staff and volunteers.

The final question which had been submitted was, "how do you see the relationship of Healthwatch with other health partners and do you see your role as an organisation evolving as part of the overall health system?" The Healthwatch Manager responded that they had a good relationship with all social care and health partners. As an example, she commented that the Chair of the HAB and herself met with the Chief Executive and Chair of RWT on a six monthly basis. They met with the Patient Experience Team and the Deputy Chief Nurses on a quarterly basis. They had been involved in extensive CCG work regarding primary care commissioning and the Integrated Care Partnership. They had also been involved in the Discharge to Access process meetings. They also met with the Black Country Healthcare NHS Foundation Trust and the voluntary sector. They had recently worked with the CCG to ensure homeless people were registered with a GP Practice, following difficulties with homeless people accessing healthcare. They were involved with restoration and recovery talks and frequent discussions with Healthwatch England.

8 **Connected City Presentation**

The Scrutiny and Systems Manager gave a presentation on "Connected City." A Cross cutting them had been agreed by City of Wolverhampton Council's Scrutiny Board at the meeting held on Tuesday, 14 July 2020. Scrutiny Board had asked Scrutiny Panels to consider connectivity and digital considerations as part of all items addressed in the Work Programme. The outcomes and recommendations from the Scrutiny Panels would then be fed back to Scrutiny Board to unify into one comprehensive report based on the connected city theme. The final report and any recommendations made would then be submitted to City of Wolverhampton Council's Cabinet for consideration. She presented a slide on the digital revolution in Wolverhampton. Change was progressing fast and it was important to keep up support for the citizens of Wolverhampton. The important question for the Health

Scrutiny Panel to continue to ask was, “How do we use and engage connectivity and digital means to help support the areas that fall under the remit of the Panel.”

The Vice Chair commented that it was important for Members to take into account digital and connectivity when the Health Scrutiny Panel looked at items throughout the municipal year.

9 **Future Meeting Dates**

The future meeting dates of the Health Scrutiny Panel were confirmed as follows: -

19 November 2020 at 1:30pm

14 January 2021 at 1:30pm

24 March 2021 at 1:30pm

The meeting closed at 4:12pm.

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