CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 10 February 2022

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.