CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 19 November 2020

Attendance

Members of the Health Scrutiny Panel

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

In Attendance
Cllr Jasbir Jaspal (Cabinet Member for Public Health and Wellbeing)

Witnesses
Professor David Loughton CBE (Chief Executive of the Royal Wolverhampton NHS Trust)
Paul Tulley (Managing Director of Wolverhampton CCG)
Tracy Harvey (Senior Commissioning Manager, Pharmacy, Optometry and Dental – NHS England and NHS Improvement – Midlands West)
Nuala Woodman (Deputy Head of Primary Care Commissioning, Pharmacy, Optometry and Dental – NHS England and NHS Improvement - Midlands)
Anna Lee-Hunt (Consultant in Dental Public Health – Public Health England)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
Emma Bennett (Director of Children's and Adult Services)
John Denley (Director of Public Health)
Becky Wilkinson (Head of Adult Improvement)
James Barlow (Finance Business Partner)
Julia Cleary (Scrutiny and Systems Manager)
Earl Piggott-Smith (Scrutiny Officer)
Madeleine Freewood (Development Manager)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Cllr Bhupinder Gakhal and Tracy Cresswell.

Vanessa Whatley, Deputy Chief Nurse at the Royal Wolverhampton NHS Trust and Marsha Foster, Director of Partnerships at the Black Country Healthcare NHS Foundation Trust also sent their apologies to the meeting.

2 **Declarations of Interest**

There were no declarations of interest.

3 **Minutes of the meeting held on 17 September 2020**

The minutes of the meeting held on 17 September 2020 were agreed as a correct record, subject to the reduction in the CCG Management Costs target figure for the current year reading 20% rather than 25%.

4 **Minutes of the meeting held on 22 October 2020**

The minutes of the meeting held on 22 October 2020 were approved as a correct record.

5 **Matters Arising**

Cllr Lynne Moran asked for it to be put on the official record, the Haven Refuge Centre being particularly grateful for the time invested by Public Health to help the refuge to operate safely throughout the Covid-19 pandemic. She also wished for her personal appreciation to Public Health, in helping the Third Sector to be written into the official record.

6 **Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024**

The Finance Business Partner introduced the report on the draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024. Appended to the report to the Scrutiny Panel was the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024, this had been received by Cabinet in the previous week. They were seeking feedback on how the budget relevant to the remit of the Panel aligned with the priorities of the Council. The report recommended that the response from the Panel to Scrutiny Board be finalised by the Chair and Vice Chair of the Health Scrutiny Panel. Scrutiny Board would then submit a final response to Cabinet.

The Finance Business Partner stated that there was a legal requirement for the Council to set a balanced budget each year. This had last been done when Council approved a balanced budget for 2020-2021 on 4 March 2020. At that time, it had been projected that the Council would be faced with finding further estimated budget reductions totalling £15.5 million in 2021-2022, rising to around £20 million over the medium term to 2023-2024. Work had been ongoing to close the budget gap since March with budget reductions or income generation ideas. However, Covid-19 had become much more of an issue than at that point, meaning there had been significant financial implications on both the finances and operating environment of the Council.

The Finance Business Partner referred to section 6 in the main report which summarised the Draft Budget and Medium Term Financial Strategy report. The report included details about the financial implications of Covid-19 and it agreed the core principles of how the Council would deal with any budget pressures going forward. The Council had a proven record of financial planning, being able to set a balanced budget and responding to any shortfalls in future budgets. The report included a table showing the one off grants the Council had received from Government for responding to the short-term financial pressures of Covid-19. The

table showed a shortfall of about £324,000 between the grants the Council had received and the financial cost pressures that were being forecast. This did not include any costs of a second lockdown or the "Relighting Our City Programme." Grants were changing on a weekly basis and so the financial situation was constantly evolving.

The Finance Business Partner stated that the main assumption for setting next year's budget was that in response to previous Government announcements, the Council assumed the Government would fund any financial pressures relating to Covid-19 in full. If this was the case, they were forecasting a gap to set a balanced budget next year of approximately £4.5 million. This was achievable and Directors had been given targets to work out budget reduction measures to try and close the gap. If the costs relating to Covid-19 were not met by the Government, the financial pressure could rise up to £23.2 million for next year. This would have a significant impact and would result in a fundamental review of all services in the Council.

The Finance Business Partner stated that section 4 of the report contained details about the Health budget relevant to the remit of the Panel. The Health budget came almost entirely from a ring fenced £21 million Public Health grant. In addition, the Council had been allocated a Test and Trace grant of £1.9 million relating to Covid-19. Part of the conditions of the Public Health grant were to deliver mandated Public Health Services that included the Healthy Chid Programme, Sexual Health open access and NHS Health Checks. The grant was also used to commission substance misuse services and a range of health protection services. The conditions of the Public Health Grant also included the offer of expertise, support and advice to local NHS partners.

The Director for Public Health commented that it had been a difficult time delivering consistent strategies in the context of a global pandemic. The revenue budgets allocated enabled an approach to improve the health and wellbeing of the population that was outlined in the Public Health Vision 2030, which had been discussed at the Scrutiny Panel previously. How the money that had been allocated from the Test and Trace Grant was being spent and their general approach to the pandemic could be found in the Local Outbreak Control Plan.

The Director for Public Health referred to some notable successes in the past year. He was particularly pleased with the establishment of the Covid-19 test centres in the City. Wolverhampton had been the first to have a drive through Covid-19 testing centre and community swabbing service in the West Midlands. They had had the first walk in centre which provided a blue print for the Government. The Lateral Flow test pilot had just commenced. They had been investing in already established partnerships such as businesses and faith settings to help prevent the spread of the Covid-19 virus. Partnership working with RWT (the Royal Wolverhampton NHS Trust) and the CCG (Clinical Commissioning Group) had been critical. They had invested in partnership which had seen improvements in the Healthy Child Programme. There had also been some improvements in sexual health services. The pandemic had also increased infection control measures in Care Homes. Public Health had a good partnership with RWT for reducing smoking, the Trust had been smoke free from 1 October 2020. They were also looking at their place based approach, to see which areas of the City they could target and increase their efforts to improve health outcomes.

The Director for Public Health referred Members to three key documents for more information on their strategic approach these were the Council Plan, the Local Outbreak Control Plan and the Public Health Annual report.

A Member of the Panel congratulated the Director for Public Health and his team for their outstanding work in relation to their response to Covid-19. She had confidence in the future. Another area she wished to highlight was the excellent partnership working which had taken place, which had set a very high standard. She highlighted the place based approach and the work that had taken place in the St. Peter's Ward, which would undoubtedly make a difference to the lives of residents. She had a concern about substance misuse during the pandemic and particularly alcohol dependent persons. After attending a briefing with a member of the Public Health Team, she was concerned that the availability of hospital detox and rehabilitation was less than a decade earlier. She was mindful that only a few problem drinkers could cause problems for a great deal many of other people in their social network. She thought an investment in this area would be worthwhile to prevent further problems in the future. Members of the Panel endorsed the Councillor's view on the outstanding work completed by Public Health during the Covid-19 pandemic.

The Director of Public Health responded that he was pleased that drug related deaths had decreased compared to the previous year. In areas outside of Wolverhampton it had mostly increased. He was however concerned about the increased burden in relation to alcohol related illness and the costs in relation to alcohol treatment. They would therefore be looking as soon as possible at refreshing their alcohol strategy to see what they could do collectively to help tackle the problem, with prevention being key.

A Member of the Panel asked if the Public Health Grant was ring fenced. He also expected the Government to fund the financial pressures the Council was facing as a consequence of Covid-19. He asked why there was a deficit.

The Finance Business Partner confirmed that the Public Health Grant was ring fenced, so it could only be spent on Public Health expenditure within the terms of the grant. There was a deficit because the overall expenditure forecast exceeded the income. Costs did increase year on year which had to be included in the financial assumptions. He cited the example of a fee uplift to providers of adult social care to sustain the market and salary increases. This was why they were trying to identify budget reductions across the Council to help bridge the projected budget deficit gap. Inflation, service pressures, such as a demand in adult social care and a reduction in the income received from areas such as business rates and Council tax were also factors to take into account.

A Panel Member commented that the Government had awarded £45.2 million in business grants and £28.3 million in business rates relief, in addition to other grants as outlined in the report. She understood that there would be a financial statement in Parliament the following week which would help reveal additional grant funding. She was in support of the Public Health grant being ring fenced.

Resolved: That the Scrutiny response be finalised by the Chair and Vice-Chair of the Scrutiny Panel and forwarded to Scrutiny Board for consideration.

7 **Dentistry during Covid-19**

The Deputy Head of Primary Care Commissioning from NHS England and NHS Improvement and the Consultant in Dental Public Health from Public Health England gave a presentation on Dentistry during Covid-19. A briefing report had also been circulated with the agenda. The briefing note had contained a summary of pre-Covid Dental Services including maps. Detailed information on Dental fees had been provided in the note. NHS Dental fees had not changed due to Covid. Some private Dentists had increased their charges. You did not need to be registered with a Dentist like you did with a GP. In theory patients were able to attend any Dentist, it was however true that many Dentists did maintain a list of regular patients. Patients were able to find details of Dental practices on the NHS website, https://www.nhs.uk/service-search/find-a-Dentist

A range of specialist care was available through Hospital or Community Dental Services on referral. In the Wolverhampton area this was provided by the Royal Wolverhampton NHS Trust.

The Deputy Head of Primary Care Commissioning stated that services, due to the pandemic, at present were severely constrained due to limited capacity. This was because of the nature of the work of Dentistry, the need for social distancing and infection control and downtime required between treatments, to change the air. Certain Dentistry procedures were aerosol generating, such as when using drills. It was now normal to have remote telephone triage prior to or instead of being seen face to face. During Covid-19 there was currently no walk-in services available. Dentists had been told to prioritise urgent care and vulnerable patients rather than routine check-ups. Some patients were required to be seen at other centres due to Covid-19. There were some established urgent Dental centres, which could also be used for people in the vulnerable category. They were aware that obtaining care was difficult at present for those without a usual Dentist, but urgent care could be accessed via NHS 111. They were looking to try and improve this pathway as it was often the most vulnerable patients in this position.

The Deputy Head of Primary Care Commissioning remarked that local Dentists and services were working together to try and maintain and recover services. Guidance and support were being provided to Dentists and other services to help them adapt the way they worked. It was however a reality that patients were having to wait longer for the care they needed both at a high street or in a Hospital service and the range of options for treatment may have been more limited than was previously the case.

The Deputy Head of Primary Care Commissioning commented that since the report had been published with the agenda for the meeting, the team had contacted six practices previously identified as not providing a full range of services including aerosol generated procedures and had established that all of these were now offering these procedures and had been since September / early October. She provided the local information on levels of patients exempt from Dental charges as follows:-

Paying Adult Wolverhampton – 67.55%, Midlands – 77.30%, England -77.36%

Non-Paying Adult Wolverhampton – 32.45%, Midlands – 22.70%, England – 22.64%

The Chairman and Vice-Chairman of the Panel had submitted a number of advanced questions following receipt of the report. The Deputy Head of Primary Care Commissioning presented the answers on slides to the meeting.

The first question was as follows, “The report states that people need to be honest about their Covid-19 status when seeking treatment. Do you have any evidence to date that people are not being honest when seeking treatment?”

The Deputy Head of Primary Care Commissioning responded that they had received general anecdotal reports in the Midlands from Community Dental Services of children attending appointments who were off school due to cases of Covid-19 in their year group. They had also received reports from Dental practices regarding patients who had answered negative to Covid-19 screening questions but were later identified at the practice as being symptomatic or isolating. Patients who had symptoms could be seen, but at a location that was separate (either in time or place) to other non symptomatic or isolating patients. This was to protect other patients who were also attending the practice. Patients who were symptomatic or isolating would be turned away and asked to attend elsewhere. The practice would also be forced to close temporarily for deep cleaning and staff testing. This would further restrict care and other patients would have appointments cancelled. There had been little demand at the hot sites, for people with Covid-19.

The second advance question which had been submitted was, “We are concerned about the sustainability of the Dental labs. Can you give us the very latest information on what is being done to try and help them survive and is there anything the Health Scrutiny Panel can do to help?”

The Deputy Head of Primary Care Commissioning responded that this was a perceptive question. They had provided some information in the report on recommendations from a review nationally which identified a risk to Dental labs. She had asked for an update from the Deputy Chief Dental Officer, but he had not yet responded. The levels of face to face activity for routine care remained low including for work such as dentures and therefore the situation was unlikely to have improved significantly in terms of the volume of work available to Dental labs. The Dentals labs were entirely private and were used by the Dental practices. They were therefore an important part of the Dentistry system. She suggested that Members could work to raise awareness of the issue to ensure that work continued centrally to support vulnerable sectors and ensure sustainability of key support industries.

The Consultant in Dental Public Health from Public Health England remarked that the Dental labs were an important part of the system. She was very concerned about the sector because they would be vital in the future.

The third advanced question which had been submitted was as follows, “The report refers to you reviewing the position of hot sites, which are for people with symptoms or isolating patients. Do you think there will be additional sites in Wolverhampton and when will these be opened?”

The Deputy Head of Primary Care Commissioning responded that there was not currently sufficient demand to justify earmarking a specific site as this would necessarily mean that other services at the site would have to be stopped. They

were scoping a Black Country hot site that could be mobilised if necessary, at short notice. The location options were limited due to issues with suitable premises for aerosol generated procedures and with access due to co-location with other services. There were longer term plans to seek expressions of interest for weekend Dental slots at local practices and they anticipated some end of sessions slots being reserved for patients with symptoms of Covid-19 or patients isolating, if the demand increased.

The fourth advanced question which had been submitted was, "How can partners work together to improve the oral health of very young children?"

The Consultant in Dental Public Health from Public Health England commented that she was thankful for the opportunity to talk to the Local Authority about oral health and for the interest that the Scrutiny Panel had taken. She spoke about the "Little Trip to the Dentist Campaign (#ALTTTD)." The main focus of the campaign had been on communications to raise awareness with parents and carers of young children of the need to take children to the Dentist and also the key oral health messages for the age group. It had run between 2017 and 2020. All the key messages from the campaign remained applicable and could be accessed at the webpage link:-
https://www.england.nhs.uk/midlands/2019/06/20/campaign-a-little-trip-to-the-dentist/

She wanted the messages from the campaign to continue to be reinforced into the future. She also felt there was a real opportunity with the introduction of Integrated Care Systems and Primary Care Networks, that they could take a lead on improving the oral health of very young children. They would be able to influence GPs, their practice staff and pharmacists. She also believed there was an opportunity to develop a local Wolverhampton campaign or even at Town level such as Bilston. Such a campaign would try and influence the local population, with a particular focus on targeting groups locally with the greatest health needs. Local knowledge could be used to best influence the most in need groups. They knew that the more targeted the message and the approach, the more successful it would be in encouraging behavioural change in individuals. Co-production of information was key with simple key messaging. She was happy to work with the Council and health partners to help develop such a local campaign. She also felt it important that more voluntary groups help share the oral health messages. She hoped the resources available on the NHS website would be freely shared with them.

The fifth advanced question which had been submitted was, "The A Little Trip to the Dentist Campaign refers to identifying influencers. Who were the type of influencers identified in Wolverhampton?"

The Consultant in Dental Public Health from Public Health England responded that very young children did not make their own decisions, their carers or families did this for them. It was therefore important to influence this category of people. She displayed a slide listing the key influences but cited some of the main one's as being midwives, the antenatal visitors, early years practitioners and children's centres. When devising the campaign, they had also looked at the Influencers of Influencers such as Oral health promoters and teams, local Public Health teams and NHS England. They had ensured they were able to relay information.

The sixth advanced question which had been submitted was as follows, “The report highlights that at the time of writing the report, 42 patients had been waiting over 52 weeks and 2042 waiting over 18 weeks for surgery at RWT. Can we ask RWT to comment on these statistics and their plans for the future in relation to oral surgery?”

The Deputy Head of Primary Care Commissioning stated that the most recent data for the Royal Wolverhampton NHS Trust for September showed the position had improved slightly from figures quoted previously in the report, with 42% being seen within 18 weeks and 1718 waiting longer (a reduction of 324) however there were 70 patients waiting more than 52 weeks (an increase of 28). The number of patients waiting more than 52 weeks had increased across all Trusts, it was not localised to Wolverhampton. Trusts had been asked to prioritise care needs, which meant some people were waiting longer than others. The total waiting list had increased slightly by 65 patients. The position for 18 weeks was improving, with referrals being lower than normal, although recovering. Trusts continued to provide urgent care based on prioritisation. There were concerns that the second wave would further restrict elective care due to staffing pressures.

The Chief Executive Officer of the Royal Wolverhampton NHS Trust commented that they were doing better than many Trusts in the West Midlands at the present time. Nationally there was now over 142,000 people who had waited more than 52 weeks for surgery. His priority focus was on cardiac surgery and cancer services.

The final advanced question which had been submitted was, “Do you think Covid-19 has changed the future course of Dentistry Services permanently. For example the increased use of Digital in service provision and more of a focus on required care rather than routine appointments?”

The Deputy Head of Primary Care Commissioning responded that she hoped that it had changed the future course of Dentistry Services. There had been a number of positive areas which had occurred as a consequence of the pandemic. She thought it was a positive move that there would be more of a focus on personalised recall schedules and those with greatest need. Not everyone needed to be seen every six months. It was important to prioritise care for those that needed it most in a targeted manner. The second example of positive change was in the use of digital technology such as virtual consultations, advice and guidance and sharing photographs. This had now become an accepted part of care and could improve the efficiency of services. Covid-19 had accelerated the progression in the use of digital in services, which had been part of the improving services agenda but had not been occurring at a rapid pace, which Covid-19 had forced. The pandemic had further strengthened existing collaborative working through local networks including Local Dental Committees and Managed Clinical Networks. These collaborations were an important part of the Commissioning system. There was now a better holistic approach and innovation had improved.

A Member of the Panel complimented the representatives from NHS England & Improvement and Public Health England on their report and presentation to the Panel. He agreed that Dentistry Services needed to take a more targeted approach based on needs. He spoke positively about the Dentistry Services the NHS provided and commented that the fees charged did not represent the actual costs, which were much higher. He thought prevention was key which would help reduce overall costs for Dental work. He asked for their thoughts on returning to School Dentists.

The Consultant in Dental Public Health from Public Health England commented that prevention was key. The "A Little Trip to the Dentist Campaign", had tried to succeed in getting children and their families used to going to the Dentist from a very early age, with the right recall schedule based on need. The best place to receive treatment was in a clinical setting. In the past mobile services may have been used, which was still an option in some areas. The best and safest place to receive Dental treatment though was within a Dental Clinic. They still did some work with schools which included providing advice. Wolverhampton still had water fluoridisation, which was key to prevention. Dental Practices in Wolverhampton were able to put on fluoride varnish 2-4 times per year for any child aged 3-16, which helped to prevent tooth decay. There were services available to children that needed a general anaesthetic which were linked to the Royal Wolverhampton NHS Trust and the Community Dentist Service. There was therefore an established system to try and capture the children and bring them within the system so they could receive treatment and also to help prevent tooth decay from starting in the first place.

The Member of the Panel in response asked whether a specialist children's Dentist in each Town would be of benefit. The Deputy Head of Primary Care Commissioning responded that specialists were in short supply. There were some talented individuals that worked in the Community Dental Service who provided specialist support for paediatric Dentistry. They had recently conducted a review of Community Dental Services across the region and they were completing work to redesign the service. One of the big issues was regarding sustainability and workforce. She thought there was not enough specialists being trained, with many ending up working in Dental Schools and Children's Hospitals. One of the challenges was to make sure Community Dental Services had access to specialist Dentists. It was important that specialists were used to their maximum potential and efficiency to help the children which required specialist care. Many children would never require access to specialists. Investment in prevention was important, which was why there had been such a focus on the "A Little Trip to the Dentist Campaign." By the time a child had reached school age, habits had already formed, so early intervention was key to establish routines. Some children already had significant Dentistry problems before they even reached school. The Consultant in Dental Public Health from Public Health England added that her view was all Dental practices should be child friendly.

The Chair thanked the representatives from NHS England & Improvement and Public Health England for an excellent presentation and report. The Scrutiny Officer also paid his complements to the representatives, who had provided the Panel with all the information requested in advance of the meeting.

Resolved Unanimously: That Health Partners give consideration to developing a local Wolverhampton campaign to raise awareness with parents and carers of young children of the need to take children to the Dentist and the key oral health messages for this age group. Clearly it would need to launch at an appropriate time because of the ongoing Covid-19 pandemic.

8 **Update from Director of Public Health - Covid-19**

The Director for Public Health gave an update on Covid-19 in the City. The weekly case rate per 100,000 in the West Midlands was currently at 319.2. In Wolverhampton it was at 330.0. He expected that figure to rise to somewhere

between 360.0 to 365.0 the following day. He showed a graph showing the rise in cases from the 30 August 2020 across England, the Black Country and Wolverhampton. Towards September and October 2020 there was a significant rise in the curve in Wolverhampton. The dip on the graph from 13 November 2020 could probably be explained by the lag in lab results coming through. The case rate in Wolverhampton had not accelerated at the rate of its Black Country neighbours, it was doing comparably better, although cases per 100,000 still remained high and it was still accelerating. Wolverhampton's case rate was higher than the average for the Country. The average for England for the 7 days up to 16 November was approximately 250 Covid-19 cases per 100,000. Dudley and Sandwell had the highest rates in the Black Country.

The Director for Public Health presented a slide on Covid-19 case rates by ward area in Wolverhampton in the 14 days up to 16 November 2020. The key point from the slide was that if there was a ward which was showing a low number of Covid-19 cases, this didn't mean the infection wasn't within the ward area. It was often a sign that more testing was required. As an example, Heath Town ward had been showing a low rate a few weeks ago. When targeted testing was undertaken, a higher amount of cases was found within the ward area. The Covid-19 infection had spread across the City, it was not contained to any particular wards. It was key to encourage people to undertake a PCR test if they had symptoms and when they did not have symptoms they could receive a lateral flow test at one of the pilot areas.

The Director for Public Health displayed a heat map showing the Covid-19 age specific confirmed case rate per 100,000 in Wolverhampton in the 7 days up to 12 November 2020. Where there was a darker shade it indicated a higher rate for each of the five different age groups differentiated. The 60 plus age group was starting to show a darker bracket, which was the group which needed to be the most protected. This was because this age group were more likely to have to receive hospital treatment and to have poorer outcomes if they caught the virus. Protecting the most vulnerable was key.

The Director for Public Health presented a slide on responding to the second wave. The fact that the vaccine was in development was positive news but it was important that this did not distract from the immediate issues of the importance of compliance with guidance, testing, contract tracing and ensuring systems were in place as a bridging strategy before a vaccine was rolled out. There were now six PCR testing sites within the City, which had increased the testing capacity within the City. The testing rate was very good at 2,700 per 100,000 people. This equated to approximately 1000 tests each day within the City. A new test site in Wednesfield at the Community Hall (Gurdwara) was now open. A testing site at Whitmore Reams Library would be opening on the present day. Lateral Flow Testing had also been introduced, with a site on Sedgley Street at the Gurdwara opening for a pilot between the 19 November to 30 November. In addition, there were a number of other possible pilots being planned. Lateral Flow Testing was a tool to enable identification of people with Covid-19 that were asymptomatic and therefore to be able to reduce the spread of virus by informing the individual to self-isolate if they tested positive.

The Director for Public Health spoke on the matter of contract tracing. A local enhanced contract tracing offer complimented the national system. This meant that 91% of positive cases were being picked up and support offered. Key messages were also able to be relayed to the person.

The Director for Public Health stated that over 1,300 business had been issued Covid compliant stickers. This indicated they had completed a risk assessment with the Council and were “Covid compliant.” The stickers gave consumers more confidence. They were recruiting an additional 8 Covid support workers which would bring the total number to 20. Their role was to bolster compliance with the public and businesses in the City, which was a vital part in managing the spread of the virus.

The Director for Public Health commented that the Government had replaced the Shielding Scheme with writing letters to vulnerable people communicating the latest advice and guidance. The Council had worked with the CCG in writing to 9,000 extremely clinically vulnerable people and offered support.

The Scrutiny Officer asked the Director for Public Health how he thought the infection was being driven in the City. The Director responded that the situation had changed considerably over the last two months. When they had been entering Tier 2 it had been clear that it was spreading within households and between households. At that point there weren’t any significant issues in workplaces, educational settings, Hospitals or Care Homes. It then became clear that the community infection was spreading amongst younger working age people and then all working aged people in the age group 19-59. From there it had gone forward. There were now some significant outbreaks in a number of the City’s Care Homes, but they were confident they had a grip on the situation. The place with the greatest number of outbreaks at the present time was within workplaces. It wasn’t that there wasn’t good guidance in the workplaces, the virus was spreading due to human behaviour, such as a person letting their guard down during their lunch hour in a communal area. The same principles applied in faith settings, such as entering, exiting, mingling afterwards and the travel to and from the venue.

A Panel Member commented that she had received a letter from the National Education Union expressing a concern about workplaces in education settings. The Director for Public Health responded that when there were the first infections at the beginning of the school term in September there had been about 18 infections and 2000 children off school. The Director for Children’s Services had led an Incident Management Team (IMT) for the City to see how they could work with schools to keep them secure but to also allow school children to attend wherever possible. As a consequence of this effective work more children had been able to attend school and there were very few actual Covid-19 outbreaks.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that it was very important that New Cross Hospital was not overrun. The situation was different to March and April earlier in the year, he now also had to carry on with other treatments instead of cancelling them. At present there were 16 Covid-19 patients in the Intensive Care Unit (ITU). There had been a total of 326 deaths at the Trust relating to Covid-19. This was a mortality rate of 24% of people who were being treated for Covid-19 at the Trust. It was an awful disease; it was therefore important to stop people having to be admitted to Hospital wherever they could. At the weekend the Trust had taken 3 ITU patients from Stoke. He had not come across a disease with the same mortality rate as Covid-19 in his time. The next 6-8 weeks would be crucial. The average length of stay for someone in an ITU bed with Covid-19 was two weeks plus.

The Chairman paid tribute to the Director of Public Health for his work during the Covid-19 pandemic.

9 **Local Outbreak Engagement Board Draft Minutes**

The Scrutiny Officer reported that the minutes from the September meeting of the Local Outbreak Engagement Board had been circulated with the agenda. The minutes from the 12 November 2020, Local Outbreak Engagement Board had unfortunately not been approved in time for the meeting. Members of the Panel had however been sent a link to the recording of the November meeting.

The Chairman referred to the Communications Toolkit to Councillors and Community Champions recently mentioned at the Local Outbreak Engagement Board meetings. He asked for some more information on the initiative and asked who the Community Champions were. The Development Manager gave some context to the Local Outbreak Engagement Board. The Government had required the establishment of Local Outbreak Engagement Boards as part of the Local Outbreak Plan development work. Wolverhampton's Local Outbreak Engagement Board was Chaired by the Leader of the Council and was a Sub-Board of the Health and Wellbeing Together Board. The public meetings were currently taking place every two months, with the option for additional meetings as appropriate. The meetings were live streamed. The purpose of the Board was to have oversight of plans and actions to prevent and manage Covid-19 outbreaks in the City, as well as providing leadership around communications and public engagement.

The Development Manager commented that three Councillors had put themselves forward as Champions. These were Cllr Rupinderjit Kaur, Cllr Zee Russell and Cllr Simon Bennett. They had been working with these Councillors on what resources they felt would be beneficial to Councillors. In development was a key numbers / key messaging document which would be able to be shared with colleagues. They were also looking at the role of social media and how Councillors could create videos to spread the key messages wide in the community. They were also looking at how they could work with the community and voluntary groups. They had been working in partnership with the Learning Communities Partnership which had a wide membership. The Learning Communities Partnership had established a Task and Finish group which were considering which resources would be beneficial to the community. The toolkit was an ongoing process, messages changed and so a clear network which was dynamic was important.

A Member of the Panel commented that in his view he thought key messages needed to be delivered from one body rather than multiple champions. He suggested the Cabinet Member or Director needed to take the lead in relaying messages rather than individuals as he was concerned the messages could be diluted and cause confusion.

The Chair asked the following question, "A recent BBC Article - identified that people with learning disabilities were up to six times more likely to die from Covid-19 during the first wave of the pandemic. A report from Public Health England found the death rate for those with a learning disability was 30 times higher in the 18-34 age group. What action is Wolverhampton taking as a health and care system to help safeguard this vulnerable group within the City and will the Local Outbreak Engagement Board be able to have some oversight of this moving forward within Wolverhampton?"

The Director for Public Health responded that they looked at any vulnerable group within the City and protecting them was at the core of what they did in Public Health. The BBC Article had referred to people with learning disabilities being up to six times more likely to die from Covid-19, he thought it important to address the difference between absolute and relative. It was an issue, but the strategy had targeted the vulnerable groups and used key networks to relay messages. They could monitor the situation as requested by bringing it through the Local Outbreak Engagement Board. Evidence focussed on the most at risk was the key point. Keeping vulnerable groups safe until the vaccine had been rolled out and cases had declined was critical.

The Vice-Chair asked if there was any data on people who were aged over 65, obese and possibly had a learning disability. The Director for Public Health responded that there was a range of data. Working with partners, the various intelligence teams had access to a tapestry of information, which allowed the targeting of particular groups. He could provide a detailed analysis from an epidemiological point of view in the future.

The Vice-Chair asked at what point did a Care Home become closed to new admissions due to a Covid-19 incident. The Head of Adult Improvement gave a summary of the latest Covid-19 testing taking place in Care Homes. If a Care Home had one positive case, it was placed onto a Watch List and the Infection Prevention Team were sent into the Care Home to complete an audit. They were particularly focussing on clusters to see if there was any transmission between staff and residents. If there were two or more cases the Care Home was closed for a period of up to 28 days. They were however looking at each Care Home on a case by case basis and acting based on the circumstances.

The Vice-Chair asked for the detail of any plans for the rollout of any Covid-19 vaccine within the City. The Director for Public Health responded that the CCG were leading on the vaccine rollout with the help of Public Health. It would likely be a mixed model with larger sites complimented by GP surgeries. He would happily provide an update at the next meeting.

The Managing Director of Wolverhampton CCG stated that the CCG were working with Primary Care Colleagues to identify sites where they would be able to deliver the vaccine when it was ready. The National Joint Vaccine Committee had identified the priority groups that would receive the vaccine. They had not received confirmation of the timing of when a vaccine would be available, but they were making preparations in readiness for when it could be delivered.

A Member of the Panel referred to one of the vaccines having to be kept at minus 70 degrees centigrade. He asked if all sites would have the appropriate storage. The Managing Director of the CCG commented that whilst one of the vaccines did have to be kept at a very low temperature, once the vaccine had been delivered to the administering site there were a number of days when it needed to be used by, if it was not at minus 70. Therefore, all the administering sites did not require the special freezers, as long as the vaccine was administered within a set timeframe.

The Scrutiny Officer commented that the Vice-Chair would be visiting the first lateral flow testing site in the City the following day and had offered to report back to the Health Scrutiny Panel at the next meeting if requested.

10 **Future Meetings**

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

14 January 2021 at 1:30pm

24 March 2021 at 1:30pm

The Scrutiny Officer commented that the Chair and Vice-Chair of the Panel had indicated that they had requested Mental Health during Covid-19 to be an item at the January meeting in the New Year. They wanted the item to be in two parts, adult's mental health and young people's in schools mental health. The other item suggested had been an update on the progress of the CCGs merger.

The Chair wished all Members and Health Partners a happy and safe Christmas.