CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

19 November 2020

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

Venue Via Microsoft Teams

Membership

Chair Cllr Phil Page (Lab)
Vice-chair Cllr Paul Singh (Con)

Labour

Cllr Obaida Ahmed
Cllr Bhupinder Gakhal
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Susan Roberts MBE
Cllr Wendy Thompson
Tracy Cresswell (Healthwatch)
Rose Urkovskis (Healthwatch)

Quorum for this meeting is three voting members.

Information for the Public

If you have any queries about this meeting, please contact the Democratic Services team:

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

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

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

3 **Minutes of the meeting held on 17 September 2020** (Pages 5 - 22)
[To approve the minutes of the meeting held on 17 September 2020 as a correct record.]

4 **Minutes of the meeting held on 22 October 2020** (Pages 23 - 30)
[To approve the minutes of the meeting held on 22 October 2020 as a correct record].

5 **Matters Arising**
[To consider any matters arising from the minutes.]

DISCUSSION ITEMS

6 **Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024** (Pages 31 - 66)
[To receive a report on the draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024].

7 **Dentistry during Covid-19** (Pages 67 - 82)
[To receive the attached information pack. A presentation will be given at the meeting on Dentistry during Covid-19. A represensative from Public Health England and NHS England and NHS Improvement will be present].

8 **Update from Director of Public Health - Covid-19**
[To receive a verbal update from the Director of Public Health on the latest information regarding Covid-19 in the City of Wolverhampton].

9 **Local Outbreak Engagement Board Draft Minutes** (Pages 83 - 90)
[To consider the contents of the Local Outbreak Engagement Board draft Minutes from the meeting of 29 September 2020 and 12 November 2020].

[The Local Outbreak Engagement Board draft Minutes from the meeting of 12 November 2020 are marked – **To Follow**].

10 **Future Meetings**

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

14 January 2021 at 1:30pm

24 March 2021 at 1:30pm

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CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 17 September 2020

Agenda Item No: 3

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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CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 22 October 2020

Agenda Item No: 4

Attendance

Members of the Health Scrutiny Panel

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

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

Health Partners
David Loughton (Chief Executive of the Royal Wolverhampton NHS Trust)
Paul Tulley (Managing Director of Wolverhampton CCG)
Steve Philips (Group Director – Black Country NHS Foundation Trust)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director of Public Health)
Becky Wilkinson (Head of Adult Improvement)
Julia Cleary (Scrutiny and Systems Manager)
Earl Piggott-Smith (Scrutiny Officer)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Cllr Bhupinder Gakhal and Cllr Susan Roberts MBE.

David Watts, Director of Adult Services, sent his apologies due to him being on annual leave. Vanessa Whatley, Deputy Chief Nurse at the Royal Wolverhampton NHS Trust sent her apologies to the Panel.

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

3 **City of Wolverhampton Council - Winter Plan (Draft)**

The Chair commented that a Special Meeting of the Health Scrutiny Panel had been called to scrutinise and provide feedback on City of Wolverhampton's draft Winter Plan. The final version of the plan needed to be submitted by the end of the month.

The Portfolio Holder for Adult Services introduced the City of Wolverhampton draft Winter Plan. She stated that Adult Services had worked with Public Health to develop a Wolverhampton response to the Government's Winter Plan. The 2020-2021 Winter Plan set out 15 key actions for Local Authorities and NHS organisations and a further 10 expectations set out for providers. The Panel were asked to consider if any further detail was required to provide assurance that Wolverhampton was preparing for winter challenges in line with Government expectations.

The Head of Adult Improvement for City of Wolverhampton Council gave a presentation to the Panel on the draft City of Wolverhampton Winter Plan. She commented that it was key to consult the Health Scrutiny Panel, the Health and Wellbeing Board and key partners before a final plan was submitted. She stated that there was always a winter plan, it was not a new requirement for 2020/2021. The three main aims of the 2020/2021 plan were to ensure that everyone who needed care or support could receive high quality, timely and safe care throughout the autumn and winter period. The second key aim was to protect people who needed care, support or safeguards, the social care workforce and carers from infections including the Covid-19 virus. The third aim was to make sure people who needed care, support or safeguards remained connected to essential services and their loved ones, whilst protecting individuals from infections including Covid-19.

The Head of Adult Improvement commented that it would be an especially challenging period in the winter months, due to the additional pressures of Covid-19. The Council had engaged directly with the providers on the 10 expectations set out by the Government in their plan. There were 27 chapters in the Winter Plan and the Council had covered all points raised in the plan and not just the 15 key actions. The Council had to confirm to Government that there was a Winter Plan in place by 31 October 2020.

The Head of Adult Improvement thanked Wolverhampton CCG and the Royal Wolverhampton NHS Trust for their assistance in drawing up the plan. They had also received some valuable input from Primary Care Networks regarding how GPs would be supporting Care Homes. She was very pleased with the responses the Council had received from providers in the City during a very busy time; their input had been incorporated into the plan. She was grateful to Public Health who had helped to coordinate the details of the plan alongside the Commissioning team. The Integrated Care Partnership Board had received a draft version of Winter Plan in the preceding week and had given feedback. They had also used the Provider Support Group with a range of representatives to provide input into the plan.

The Head of Adult Improvement commented that they had given thought to how they could address inequalities in the Winter Plan. The Council and NHS organisations were completing equality impact assessments for each decision made and revised local authority equalities plans were underway. PPE (Personal Protective Equipment) had been a considerable concern for the system and the Health Scrutiny Panel in recent meetings. They were continuing to monitor stock and they would

direct providers to the national portal as had been requested. They intended to keep their own stock in place for emergency use.

The Head of Adult Improvement remarked that they had communicated with every single care provider encouraging take up of the flu vaccination. They were working with the CCG where there were logistical issues and were monitoring flu vaccinations on a daily basis. They were required by the Government Winter Plan to offer and make available the flu vaccination to every Care Home resident by the end of December 2020. They continued to support Covid-19 testing in Care Homes. Providers had to re-register for testing every 21 days, the Council were trying to relieve some of this pressure by offering their assistance. If there was any breakdown in the national testing route, they had the support of Public Health to provide pillar one testing.

The Head of Adult Improvement commented that Care Home visiting details were in the plan. Once a week the Council made a decision on reviewing visiting to Care Homes and earlier if required by the data. All providers who had residential provision were working with the Council to develop essential visiting policies that maintained social distancing and necessary levels of PPE.

The Head of Adult Improvement remarked that 130 providers in the City had responded to the questions presented to them in relation to the Winter Plan. Their main focus had been to keep their homes and residents safe throughout winter. Due to the comprehensive feedback received from providers, they had been able to identify a few areas of concern. They had been alerted to the fact that four homes had been struggling to register for the testing portal. The Commissioning team had been able to help them register on the portal. Some had been unsure on the requirements to use the PPE portal, which the Council had also been able to assist them with.

The Head of Adult Improvement stated there was one area in the Government Winter Plan, which the Council was not fully compliant. They had been asked by the Department for Health and Social Care to provide a few settings which they considered to be Covid-19 safe, which they would use to discharge people into from hospital. Within Wolverhampton the Council had been working with the discharge team at RWT and the CCG to make all of their Care Homes they used in the City, Covid safe and safe for receiving people being discharged from hospital. They did not believe it was in the best interests of Wolverhampton to only allow a few Care Homes to receive people being discharged from hospital. She also felt that they needed some legal direction regarding the Choice Based Policy, as someone being discharged from hospital had to be given a choice as to where they would be discharged. Concerns had been raised with the Cabinet Member and the Council's Strategic Executive Board.

The Head of Adult Improvement remarked that they were proposing a holding response whilst they conducted work on establishing the legal position and to make sure everyone was in safe settings. The Government were providing assurance that 500 inspections could be conducted by the CQC (Care Quality Commission) across the country for the designated settings, to make sure they were safe. There were 17,000 residential care settings across the country, so they were not assured that any Care Homes put forward to receive people being discharged from hospital would be inspected in time. So at the present time the discharge process as it stood would

remain in place, this discharge process had been signed off by RWT and the CCG. They would continue to work with the Department for Health and Social Care to understand what they needed. Their main aim was to keep everybody safe within Wolverhampton. They were confident that all the other requirements of the Government's Winter Plan were in place.

The Managing Director of Wolverhampton CCG commented that they had been involved in the development of City of Wolverhampton Winter Plan and were supportive of its contents. It demonstrated a good level of joint working and planning across Wolverhampton.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that they had worked well as a system together in the development of the plan.

The Manager of Healthwatch Wolverhampton commented that it was a comprehensive and inclusive plan and they were happy with its contents.

The Group Director of the Black Country Healthcare NHS Foundation Trust commented that he was pleased it was an inclusive plan which had involved a range of health partners.

A Member of the Panel commented that the plan was a good example of partnership working and a comprehensive report. She could not see anything which had been overlooked and therefore felt reassured. The plan referred to 3 Conversations, she asked what measures were in place to stop people having a too big of a caseload. She also asked about flu vaccine availability and the turnaround time for Covid-19 test results for Care Homes. The Head of Adult Improvement responded that they had noticed an increase in referrals between wave 1 of Covid-19 and the start of the second wave of Covid-19 for 3 conversations. They had consequently increased staffing capacity to manage the demand. She did agree that it did put a lot of pressure on social workers. Additional flu vaccine supplies were due to arrive mid-November with a view for a full roll out by the end of December. At the present for people aged 65 or over there had been a 52.9% uptake and for those falling in the at risk category it was 56.2%. There was still considerable more vaccinations needed. On testing there had been mixed results for turnaround times. Generally, they were receiving results back within 24 - 48 hours. There had been some issues, which had been escalated for pillar 2 testing, where it had taken up to 8 - 9 days to receive the result.

The Chair asked the Head of Adult Improvement three questions which were as follows:-

1. How can Health Partners use "Digital" to improve the lives of people in care in Wolverhampton? This includes people being able to keep in touch with their family and friends via digital platforms.

2. Can you provide some assurance to the Health Scrutiny Panel, that when people are discharged from hospital having suffered with Covid-19, that appropriate care provision is put in place from the first day of their discharge?

3. Can you provide an update on the figures in Appendix 1. It was clear that on 6 October 2020 that thermometers and certain masks were low in stock?

The Head of Adult Improvement responded that one of the key areas in relation to digital had been the promotion of iPads and iPhones. The NHS Digital Programme had made thousands of iPads available for Care Homes to apply to acquire. Adult Services were working with the CCG to determine which Care Homes had applied to the Digital Programme. Of the Care Homes in Wolverhampton eligible for the programme, 60% had applied. They had enlisted some support to call the Care Homes that hadn't applied to the programme to encourage them to apply. It was a very simple application form that had to be completed. Adults Services were also publicising the programme in their weekly communications. A Task and Finish Group was being setup with the aim of talking to friends and families of people resident in Care Homes. They wanted to hear from them on what they could achieve on a digital platform to help with the isolation that care home residents would feel throughout the winter months.

In response to the question on care needs after discharge, the Head of Adult Improvement stated they had been able to apply some lessons learnt from the first wave of Covid-19. They had created a different discharge pathway, in addition to this pathway there was extra guidance which they had been able to utilise. There was a system wide policy in place. If someone was Covid-19 positive and in hospital they would stay on a dedicated Ward for at least 14 days. They would be tested on discharge from the hospital and the place of discharge were notified of their level of health. They had learnt from the first wave of Covid-19 that recovery times could take longer. As a consequence, there was an extra check in with the discharge pathway to determine if the person was recovering as well as expected. This included soft observations such as temperature checks, mobility and general health. If their level of health was not improving as expected, then their case would be referred back to the Multi Disciplinary team to either increase their care package or for them to receive further hospital treatment or bed based care.

The Head of Adult Improvement in reference to the stock levels running low referred to in Appendix 1, remarked that thermometers were particularly low at the point of writing the report. They did however keep thermometers as an emergency because the CCG had distributed thermometers to all Care Homes as needed. They did have some more thermometers on order but she could reassure the Panel that all Care Homes that needed them had them available. There were only 54 masks of a certain type on the dashboard at time of the report being circulated, they had since ordered 24,000 and they would be arriving soon. She did not have any concerns about supplying masks to the care settings that required them.

The Vice Chair asked the Head of Adult Improvement three questions which were as follows:-

1. How do you ensure Care Homes are following the latest guidance in relation to Covid-19, given the significant amount of changes that frequently take place, sometimes in the same week or same day?

2. How is the uptake of the flu vaccination going in care settings?

3. When there is a visit to a Care Home on compassionate grounds, for example end of life, what is the guidance for Care Homes and how does the Council work with the care setting to ensure absolute compliance?

The Head of Adult Improvement responded that they met with Public Health Colleagues every working day. They were notified of any new guidance directly. They had a dedicated lead in Social Care who provided a summary of any changes in guidance and provided the correct communication material to distribute to Care Homes. If it was a significant change they would enlist their Quality Assurance team to contact each Care Home directly by telephone to ensure they were fully aware of the implications of the guidance change. There was also the Infection Prevention Team at the Royal Wolverhampton NHS Trust which could visit Care Homes. If any care setting had concerns about any guidance, they had fact sheets which listed the contact details for who to communicate with to deal with the enquiry. They had also provided flow diagrams to Care Homes, which were sometimes easier and quicker to follow than extensive guidance documents. Care settings had been given an email address for People Commissioning, where any concerns could be passed to Public Health for them to liaise directly with the Care Home on guidance matters.

With reference to the question on the uptake of the flu vaccination in care settings, this had been led heavily by the CCG and the Quality Team. GPs were entering Care Homes to undertake the vaccinations. There had been a few minor issues relating to GPs having to isolate, which then prevented them from entering the Care Home to carry out vaccinations. When this occurred, the CCG aimed to put in place alternative arrangements.

In answer to the question relating to visits to Care Homes on compassionate grounds, the Head of Adult Improvement responded that they took advice from the lead professional caring for the individual. There was a protocol in place, the Care Home was required to provide a risk assessment and they had to have a full understanding of what PPE was required. They always acted in the best interest of the individual and the family when a visit was requested as part of end of life care.

The Director of Public Health commented that there was an ambition to ensure the uptake of the flu vaccine was as high as possible for the year. There was a target of 75% coverage. A small study had shown mortality was increased if someone caught the flu and Covid-19 at the same time, which highlighted the importance of the flu vaccine.

The Director of Public Health stated that there were five steps which Wolverhampton residents could take to help protect them and other people from contracting Covid-19. Wearing masks, washing your hands and maintaining social distance were three simple actions. The other two were not visiting other households and not allowing other people to visit your own. If these were kept at the forefront of people's minds, it would help reduce the spread of the Covid-19 virus in Wolverhampton.

The Chairman stated that if Members of the Panel thought of any questions or comments after the meeting, on the draft Winter Plan, which they wished to raise, they could write to the Head of Adult Improvement directly with their points.

The Chairman thanked the Head of Adult Improvement for her excellent presentation and responses to the questions raised. He also thanked the Members of the Panel, Portfolio Holders and Health Partners for their attendance and contributions.

Resolved:

A) That the draft City of Wolverhampton Winter Plan 2020/2021 be noted.

4 **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 1:43pm.

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

19 November 2020

Report title	Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024
Decision designation	AMBER
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Public Health and Wellbeing
Corporate Plan priority	Confident Capable Council
Key decision	Yes
In forward plan	Yes
Wards affected	All
Accountable Director	Claire Nye, Director of Finance
Originating service	Strategic Finance
Accountable employee	Alison Shannon Chief Accountant Tel 01902 554561 Email Alison.shannon@wolverhampton.gov.uk

Recommendations for decision:

The Panel is recommended to:

1. Provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on the budget relevant to the remit of this Panel and how it is aligned to the priorities of the Council.

2. Provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024.

3. Approve that the Scrutiny Panel response be finalised by the Chair and Vice Chair of the Scrutiny Panel and forwarded to Scrutiny Board for consideration.

1.0 Purpose

1.1 The purpose of this report is to seek the Panel's feedback on the budget relevant to the remit of this Panel and how it is aligned to the priorities of the Council. In addition to this, the Panel's feedback is also sought on the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 that is due to be presented to Cabinet on 11 November 2020.

2.0 Draft Budget and Medium Term Financial Strategy Background

2.1 Since 2010-2011 despite the successive cuts in Council resources, which have led to significant financial challenges, the Council has set a balanced budget in order to deliver vital public services and city amenities. Over the last ten years the Council has identified budget reductions in excess of £235 million.

2.2 The Budget and Medium Term Financial Strategy (MTFS) 2020-2021 to 2023-2024 was presented to Full Council for approval on 4 March 2020. The Council was able to set a balanced budget for 2020-2021 without the use of General reserves. However, it was 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.

2.3 It is important to note that the budget was prepared prior to the Covid-19 pandemic. At the time of reporting to Council, the full impact of Covid-19 was not anticipated and the impact on both the finances and operating environment could not have been foreseen.

2.4 The Covid-19 pandemic has had a significant international, national and regional impact, and will continue to have, significant financial implications for the Council.

2.5 Since March 2020, work has been ongoing across the Council to review corporate resources assumptions, growth and inflation assumptions and opportunities in line with the Five Year Financial Strategy to support the budget strategy for 2021-2022 and future years, whilst also detailing the emerging pressures that the Council currently faces in response to the Covid-19 pandemic.

2.6 It should be noted that due to external factors, especially surrounding the Covid-19 pandemic and Brexit, budget assumptions remain subject to change. This could therefore result in alterations to the financial position faced by the Council.

3.0 Five Year Financial Strategy

3.1 The Council's strategic approach to address the budget deficit continues to be to align resources to Our Council Plan 2019-2024 which was approved by Full Council on 3 April 2019.

3.2 Our Council Plan, developed with the people of the City of Wolverhampton at its heart, sets out how we will deliver our contribution to Vision 2030 and how we will work with our partners and communities to be a city of opportunity. The plan includes six strategic

priorities which come together to deliver the overall Council Plan outcome of 'Wulfrunians will live longer, healthier and more fulfilling lives.' Over the medium term, resources will continue to be aligned to enable the realisation of the Council's strategic priorities of achieving:

- Children and young people get the best possible start in life
- Well skilled people working in an inclusive economy
- More good jobs and investment in our city
- Better homes for all
- Strong, resilient and healthy communities
- A vibrant, green city we can all be proud of.

3.3 All of the strategic outcomes will be supported by the 'Our Council' Programme, which will help us drive organisational improvement and development.

3.4 Covid-19 has had a significant international, national and regional impact and will continue to do so over the short and medium term. The pandemic has made the challenges faced in our local economy much harder. Alongside managing the emergency response to the pandemic, the Council has also undertaken extensive planning for recovery which was approved by Cabinet in September. It engaged with around 2,500 people including residents, young people, the voluntary and community sector and other partners, employees, Councillors and businesses across the city. This engagement has shaped the Council's five-point recovery plan, 'Relighting our City'.

3.5 The Financial Strategy, approved by Council in March 2019, consists of five core principles underpinned by eight core workstreams. Using the Core Workstreams as the framework for the Financial Strategy detailed delivery plans are being developed all with a lead director. The core principles are:

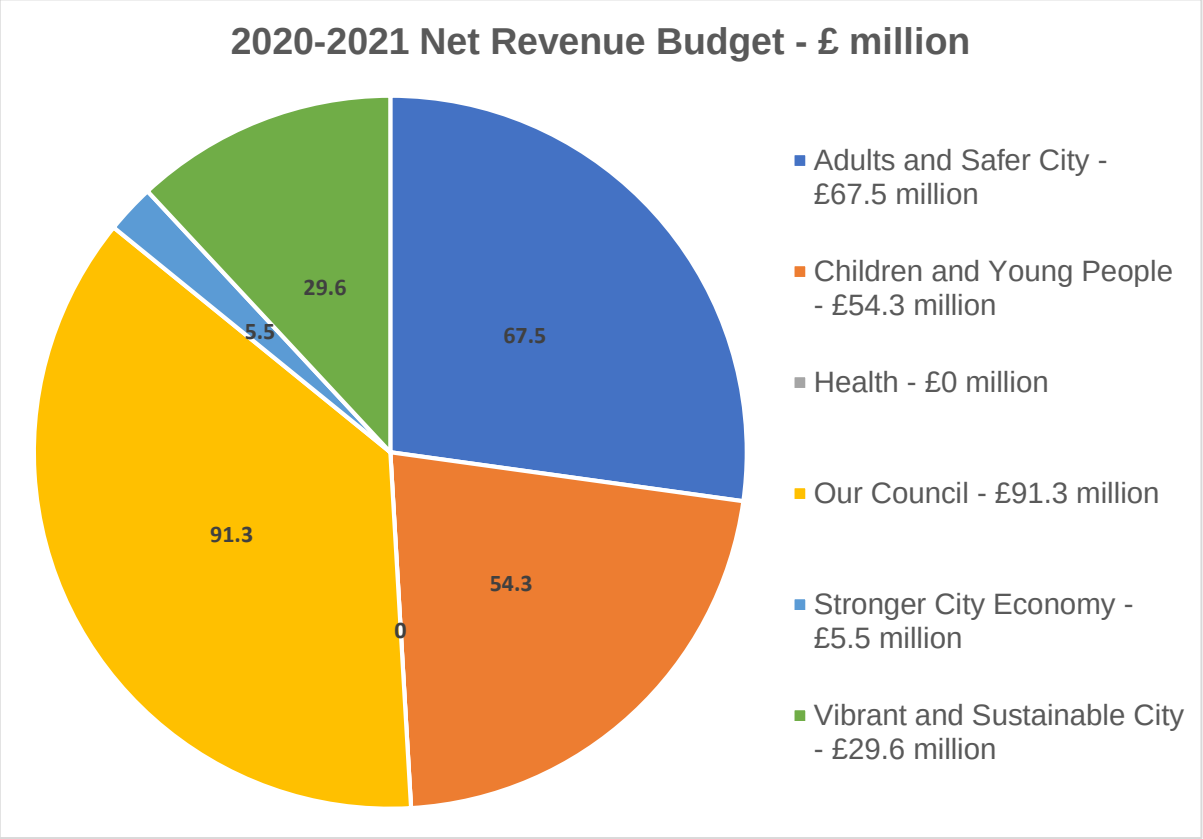
- **Core Principles:**
  - **Focusing on Core Business**. Focus will be given to those activities that deliver the outcomes local people need and which align to our Council Plan and Financial Strategy.
  - **Promoting Independence and Wellbeing**. We will enable local people to live independently by unlocking capacity within communities to provide an effective and supportive environment.
  - **Delivering Inclusive Economic Growth**. We will continue to drive investment in the City to create future economic and employment opportunities.
  - **Balancing Risk**. We will ensure we base decisions on evidence, data and customer insight.
  - **Commercialising our Approach.** We will boost social value in our City by maximising local procurement spend with people and businesses.

4.0 Budget – Health Scrutiny Panel remit

4.1 As detailed above, when addressing the budget challenge, the Council continues to focus on aligning its resources to strategic outcomes.

4.2 The Council holds a net revenue expenditure budget totalling £248.2 million for the 2020-2021 financial year.

Chart 1 – Net Revenue Budget 2020-2021



4.3 Contained within the net revenue budget for 2020-2021 is £21.0 million of Public Health grant funded expenditure. In addition, the Council has been allocated a Test and Trace grant of £1.9 million related to Covid-19.

4.4 Part of the conditions of the Public Health grant are to deliver mandated public health services. These include:

- Health Child Programme (Health visiting and school nursing services).
- Sexual Health open access.
- NHS health checks.

4.5 Additionally, the grant is used to commission substance misuse services, and a range of health protection services. The conditions of the Public Health Grant also include the offer of expertise, support and advice to local NHS partners.

4.6 Expenditure from the Test and Trace grant incudes:

- Infection prevention in educational settings and care homes

- Provision of testing sites
- Provision of face coverings
- Communication and promotional material
- Boosting the infection prevention team.

5.0 Key Strategies and Transformation

5.1 The revenue budgets allocated enable an approach to improve the health and wellbeing of the population that is outlined in the Public Health Vision 2030. The aspirations in the vision are closely aligned to the Health and Wellbeing Strategy 2018-2023 and the Council Plan 2019-2024, which has a commitment to Wulfrunians living healthier, longer, more fulfilling lives as its central objective.

5.2 There have been some notable successes in the past year. These include:

- The establishment of a range of test centres in the city - drive through, walk up, and ‘pop-up’
- Piloting testing in a range of settings such as businesses and faith settings
- Working with the Voluntary Sector and building partnerships to support a further 14,000 families who were disadvantaged during COVID
- Leading on partnership coordination and response on supporting homeless populations during the pandemic
- Facilitating a ‘cultural shift’ in the way tobacco use is perceived across the Royal Wolverhampton NHS Trust. The trust has been smoke free from 1 October 2020.
- Regional recognition for successful and consistent co-ordination of multi-agency approach to funeral director liaison, communication and data collection
- As part of the councils ‘recovery and reset’ programme we continue to develop a place-based approach to tipping the balance of deprivation

5.3 In the year ahead alongside responding to the pandemic we will prioritise inequalities in access to health services such as cancer screening which has been markedly impacted by COVID. This will be done in partnership with the NHS.

6.0 Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024

6.1 Since March 2020, Cabinet have been provided with two further Budget and Medium Term Financial Strategy (MTFS) updates in July and November 2020 to review corporate resources assumptions, growth and inflation assumptions and opportunities in line with the Five Year Financial Strategy to support the budget strategy for 2021-2022 and future years, whilst also detailing the emerging pressures that the Council currently faces in response to the Covid-19 pandemic.

6.2 In November 2020, Cabinet were presented with the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 report in which it was forecast that, after taking into account projected changes to corporate resources and emerging pressures, the projected remaining budget deficit for 2021-2022 would be in the region of £4.5 million, rising to £19.6 million over the medium term period to 2023-2024. This assumes the Government will fund Covid-19 pressures over the medium term. As detailed in the Cabinet report appended at Appendix 1, in the event that sufficient grant funding to meet the pressures arising as a result of Covid-19 is not provided by the Government to local authorities, this would have a significant impact on the Council and result in the Council undertaking a fundamental review of all services in order to identify budget reductions sufficient enough to set a balanced budget.

6.3 Appendix 1 provides a copy of the 'Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024' report for your consideration. Feedback from this and the other Scrutiny Panel meetings will be reported to Scrutiny Board on 8 December 2020, which will consolidate that feedback in a formal response to Cabinet on 13 January 2021. The feedback provided to Scrutiny Board will include questions asked by Panel members, alongside the responses received. Cabinet will take into account the feedback from Scrutiny Board when considering the final budget setting report in February 2021, for approval by Full Council in March 2021.

7.0 Panel Recommendations

7.1 The Panel are recommended to provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on:

- the budget relevant to the remit of this Panel and how it is aligned to the priorities of the Council;
- the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024;
- any other comments**.**

7.2 The Panel are also recommended to approve that the Scrutiny Panel response be finalised by the Chair and the Vice-Chair of the Scrutiny Panel and forwarded to Scrutiny Board for consideration.

8.0 Financial implications

8.1 The financial implications are discussed in the body of the report, and in the report to Cabinet.
[MH/10112020/Y]

9.0 Legal implications

9.1 The legal implications are discussed in the report to Cabinet.
[TS/10112020/W]

10.0 Equalities implications

10.1 The equalities implications are discussed in the report to Cabinet.

11.0 Climate change and environmental implications

11.1 The climate change and environmental implications are discussed in the report to Cabinet.

12.0 Human resources implications

12.1 The human resources implications are discussed in the report to Cabinet.

13.0 Corporate landlord implications

13.1 The corporate landlord implications are discussed in the report to Cabinet.

14.0 Health and wellbeing implications

14.1 The health and wellbeing implications are discussed in the report to Cabinet.

15.0 Covid implications

15.1 The Covid implications are discussed in the report to Cabinet.

16.0 Schedule of background papers

Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024, report to Cabinet, 11 November 2020

Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024, report to Cabinet, 29 July 2020

Final Budget Report 2020-2021, report to Full Council, 4 March 2020

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL	**Cabinet** 11 November 2020

Report title	Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024	
Decision designation	AMBER	
Cabinet member with lead responsibility	Councillor Louise Miles Resources	
Key decision	Yes	
In forward plan	Yes	
Wards affected	All Wards	
Accountable Director	Tim Johnson, Chief Executive	
Originating service	Strategic Finance	
Accountable employee	Claire Nye Tel Email	Director of Finance 01902 550478 Claire.nye@wolverhampton.gov.uk
Report to be/has been considered by	Strategic Executive Board	22 October 2020

Recommendations for decision:

The Cabinet is recommended to approve:

1. The updated draft budget strategy linked to the Five Year Financial Strategy, including changes to corporate resource assumptions and growth and inflation, for inclusion in the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024.
2. That work continues to further develop budget reduction and income generation proposals, in order to ensure that a balanced budget can be set for 2021-2022.
3. That authority be jointly delegated to the responsible Cabinet Member and the Cabinet Member for Resources, in consultation with the responsible Director and the Director of Finance to vary fees and charges in line with key priorities.

4. That authority be jointly delegated to the Cabinet Member for Resources, in consultation with the Director of Finance to establish supplementary revenue budgets funded by grant and approve any virements required to support the costs associated the second national lockdown. As detailed in paragraph 3.8, the Government have announced a number of grants for local authorities in response to the second national lockdown. At the time of writing this report, the full details of these grants were not known.

Recommendations for noting:

That Cabinet is asked to note**:**

1. That the Council needs the Government to provide confirmation of future years funding as soon as possible and by early December at the latest, in order to ensure that the Council has a clear direction of funding available over the medium term.

2. That, despite austerity since 2010, the Council has a strong track-record of managing money well, planning ahead and delivering excellent services. The financial implications of the pandemic have significantly distorted the budget and Medium Term Financial Strategy.

3. The impact Covid-19 has had and will continue to have a significant financial impact on the 2020-2021 budget and Medium Term Financial Strategy. However, following announcements made by Government it is assumed that sufficient grant funding will be provided to cover the cost pressures arising as a result of the Covid-19 pandemic. Taking this into account, the 2021-2022 projected budget deficit stands at £4.5 million.

4. That, in the event that the Government do not provide sufficient grant funding to meet the cost pressures arising as a result of the Covid-19 pandemic, the 2021-2022 projected budget deficit would be in the region of £23.2 million. This would have a significant impact on the Council and result in the Council undertaking a fundamental review of all services in order to identify budget reductions sufficient enough to set a balanced budget.

5. That, a number of assumptions have been made with regards to the level of resources that will be available to the Council as detailed in this report. It is important to note that there continues to be a considerable amount of uncertainty with regards to future income streams for local authorities over the forthcoming Comprehensive Spending Review period. At the point that further information is known it will be incorporated into future reports to Councillors. Any reduction in the Government's allocation of funding to the Council would have a significant detrimental impact and further increase the budget deficit forecast over the medium term.

6. That, due to external factors, budget assumptions remain subject to significant change, which could, therefore, result in alterations to the financial position facing the Council.

7. That the 2021-2022 budget timetable will, as in previous years, include an update on all budget assumptions and the outcome of the Provisional Local Government Settlement will be presented to Cabinet by January 2021, with the final budget report due to be approved by Full Council in March 2021.

8. That the overall level of risk associated with the 2020-2021 Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 is assessed as Red.

1.0 Purpose

1.1 The purpose of this report is to provide Councillors with an update to the Draft Budget and Medium Term Financial Strategy (MTFS) 2021-2022 to 2023-2024; the projected financial implications of the Covid-19 pandemic and agree the core principles and next steps that will be taken in order to address the financial pressures faced by the Council over the medium term.

1.2 This is the second report of the financial year on the Draft Budget and the Medium Term Financial Strategy (MTFS) for the period of 2021-2022 to 2023-2024.

2.0 Background

2.1 The Council has a strong track record over many years of managing its finances well, planning ahead and consistently setting a balanced budget, despite austerity, while maintaining an appropriate level of general balance reserves. Over the last ten years the Council has identified budget reductions in excess of £235 million.

2.2 On 4 March 2020, the Council approved the net budget requirement for 2020-2021 of £248.2 million for General Fund services. This was the sixth year running the Council was able to set a balanced budget without the need to make use of general reserves. It was 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. This budget was set prior to Covid-19 being declared a global pandemic and at the time of reporting, the full impact of Covid-19 on both the finances and operating environment could not have been foreseen.

2.3 Without the cost pressures arising as a result of the Covid-19 pandemic, it is estimated that the Council would currently be faced with a budget deficit in the region of £4.5 million for 2021-2022, as detailed in section 6, and be on track to deliver another balanced budget. However, the huge costs of dealing with the immediate implications of the pandemic and the likely ongoing costs caused by the resulting economic damage, the Council is faced with significant forecast financial pressures. Without additional government funding, this increases the projected budget deficit to be in the region of £23.2 million in 2021-2022, rising to more than £40 million over the medium term.

2.4 It is assumed that the Government will provide sufficient grant funding to cover these pressures following the Secretary of State for Housing, Communities and Local Government stating in a message to council leaders that committed the Government to do “whatever it takes” to ensure that local authorities have the resources needed to do what was being asked of them to help with the pandemic response.

2.5 The financial implications of the pandemic have significantly distorted the budget and Medium Term Financial Strategy.

2.6 In March 2020, Full Council approved that work started immediately to identify budget efficiencies for 2021-2022 onwards, in line with the Five Year Financial Strategy.

2.7 An update on the draft budget strategy, linked to the Five Year Financial Strategy, including changes to corporate resources assumptions and growth and inflation was presented to Cabinet on 29 July 2020. At that point, the revisions in assumptions resulted in the identification of £6.8 million towards the projected budget deficit for 2021-2022. Cabinet approved the incorporation of the draft budget strategy into the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024. Taking this into account, the remaining budget challenge to be identified for 2021-2022 stood at £8.7 million.

2.8 It should be noted that due to external factors, especially surrounding the Covid-19 pandemic and Brexit, budget assumptions remain subject to change. This could therefore result in alterations to the financial position faced by the Council.

2.9 This report provides an update on the progress towards the budget strategy for 2021-2022 and future years, whilst also detailing the emerging pressures that the Council currently faces in response the Covid-19 pandemic.

3.0 Our role in the crisis

3.1 From the earliest days of this national emergency, central government made it clear that councils would have a vital role to play in delivering the pandemic response (https://www.gov.uk/government/news/robert-jenrick-reaffirms-support-for-councils-in-their-coronavirus-response). The council, working alongside city partners, residents and businesses, heeded the government call to prioritise helping the most vulnerable in society and to support the local economy.

3.2 The Council considered evidence when drawing up a response to the pandemic to ensure that the right response was delivered at the right level to support the residents and businesses of Wolverhampton.

3.3 The Council's response included:

- Delivering 1.3 million food parcels to vulnerable people who were shielding.
- Setting up a 'Stay Safe Be Kind' helpline which had 17,000 contacts with the public seeking help or advice.
- 209 homeless people - or at risk of becoming homeless - supported with room and a roof.
- 2.8 million items of PPE sourced and delivered by council to local care providers.
- £45.2 million in business grants paid.
- £28.3 million in business rates relief processed.
- 8,500 calls to the business support phoneline
- Working alongside schools to achieve an average of 90% attendance when schools went back in September up to October half term

- Continuing business as usual services including emptying 2.7 million household waste and recycling bins and delivering 53,946 Meals on Wheels.

3.4 One-off grants have been provided to support the cost implication of the pandemic in 2020-2021, with £25.5 million of general Emergency Covid-19 funding received to date. In addition, Councils can apply for funding to part fund the loss of non-commercial income. This funding is not confirmed and subject to the submission of applications but is currently estimated to be in the region of £5.5 million. In addition to these grants, a number of grants with specific conditions attached have been provided to the Council during the Covid-19 pandemic. The Council has also been responsible for passporting grants to other parties. A full list of grants awarded or anticipated to be awarded can be seen in Appendix 1.

3.5 The current projections of the cost implications of Covid-19 in 2020-2021 are detailed in Table 1 below, further detail can be found in Appendix 1.

Table 1 - Projected Financial Implications of Covid-19 in 2020-2021

Category	**2020-2021 £000**
Expenditure including recovery costs	13,566
Loss of Income	10,416
Budget Reduction and Income Generation targets at risk	1,961
Provision for expenditure on activity to support current and future lockdown measures	6,118
Total potential impact	**32,061**
Confirmed Government Grant Funding	
Covid-19 Emergency Grant (general)	19,429
Covid-19 Emergency Grant (new allocation)	6,118
Rough Sleepers Grant	198
Emergency Assistance for Food and Essential Supplies Grant	393
Total Confirmed Government Grant Funding	**26,138**
Potential Shortfall before Sales, Fees and Charges Grant	**5,923**
Sales, Fees and Charges – claim 1 (April to July)	2,207
Sales, Fees and Charges – estimate of future claims (August to March)	3,392
Potential Government Grant	**5,599**
Potential Cost Pressure	**324**

3.6 On 31 October 2020, the Prime Minister announced that England would be entering a second national lockdown from 4 November 2020 until 2 December 2020. It has been

announced that local authorities will receive additional funding; the costs associated with this lockdown including, support for additional local test and trace operations, support for businesses and those residents who are clinically extremely vulnerable. Full details of these grants were not known at the time of writing this report, but current announcements indicate that all authorities will now receive tier three level funding which is £8 per head of population to support local test and trace operations. In addition, under a new local shielding framework, areas will receive £14 per clinically extremely vulnerable person to ensure they have access to essential supplies.

3.7 Councils have also been asked to distribute business grants worth up to £3,000 for the 28 day anticipated lockdown period to business premises forced to close, under a new local restrictions support grant. In addition, councils will receive £1.1 billion equating to £20 per head of population, for one-off discretionary payments to support businesses that are affected by the lockdown but which are not legally required to close.

3.8 The full details of these grants and the actual allocations for Wolverhampton were not known at the time of writing this report. Approval is sought in this report to delegate authority to the Cabinet Member for Resources, in consultation with the Director of Finance, to establish supplementary revenue budgets funded by grant and approve any virements to support the costs associated with the second national lockdown.

4.0 Challenges going forward – the Impact of Covid

4.1 The costs of dealing with the pandemic extend beyond the immediate support outlined above. It is not yet known how long the pandemic will go on for or what the level of future support required will be. In addition, the economic costs of the pandemic will place additional pressures on the Council's income collected from council tax and business rates for years to come.

4.2 As detailed in paragraph 2.4 above, it is assumed that the Government will provide sufficient grant funding to cover the cost of Covid-19 related pressures. Assuming that this is the case, the Council is faced with a budget deficit in the region of £4.5 million for 2021-2022 rising to £19.6 million over the medium term period to 2023-2024. A range of options will be explored to bridge the gap including setting efficiency targets to all Directorates. In the event that the Government does not provide sufficient funding, the Council would be faced with a budget deficit for 2021-2022 in the region of a minimum of £23.2 million, rising to over £40 million over the medium term. The increase in the forecast budget deficit has arisen as a result of the impact that Covid-19 has had on the economy to date and the ongoing impact it is likely to have in future years.

4.3 The Government has allocated grant totaling £25.5 million of Covid-19 Emergency grant to support the unprecedented financial situation that the Council finds itself in due to Covid-19. Further funding is required in order to meet the full costs of the pandemic that will be seen over the medium term. If further government funding is not forthcoming, the Council will need to identify significant budget reductions which could impact on service delivery.

5.0 Government Commitment

5.1 The Secretary of State for Local Government, Rt Hon Robert Jenrick MP, held a conference call with 300 council leaders from across the country on 16 March and committed the Government to do "whatever it takes" to ensure that local authorities have the resources needed to do what was being asked of them to help with the pandemic response. This was reiterated in an official media release from the MHCLG on the same day which quoted the Secretary of State making the following pledge: "As part of the national effort to keep the public safe and deliver essential public services, this government stands with local councils at this difficult time. My absolute priority is to ensure they are well placed to respond to coronavirus and protect vital services, including social care. Everyone needs to play their part to help the most vulnerable in society and support their local economy, and the government will do whatever is necessary to support these efforts."

5.2 So far, the Government has provided additional funding which will cover the immediate costs to the Council of tackling the pandemic. The Government have periodically reaffirmed their commitment to local authorities. It is now essential that further Government funding is provided to cover the considerable costs the pandemic will continue to have over the medium term.

6.0 Relighting Our City Agenda

6.1 Alongside managing the emergency response to the pandemic, the Council has also undertaken extensive planning for recovery which was approved by Cabinet in September. It engaged with around 2,500 people including residents, young people, the voluntary and community sector and other partners, employees, Councillors and businesses across the city. This engagement has shaped the Council's five-point recovery plan, 'Relighting Our City'.

6.2 Relighting Our City sets out the priorities which will guide the Council's approach as the organisation and the City starts to transition from the response to the recovery phase of the pandemic:

- Support people who need us most
- Create more opportunities for young people
- Support our vital local businesses
- Generate more jobs and learning opportunities
- Stimulate vibrant high streets and communities

6.3 It is vital that the city has the resources to be able to focus on recovery which will enable the city to address key challenges and assist the government to deliver its 'levelling up' agenda and capitalise on new opportunities as the city transitions out of the response phase of the pandemic. If the assumed further Government funding is not forthcoming, meaning the Council would need to make significant reductions to existing budgets and

potentially make use of earmarked reserves in order to balance the budget, this would compromise the Council's ability to deliver its Relighting Our City plan and deliver its priorities.

7.0 Five Year Financial Strategy

7.1 The Council's strategic approach to address the budget deficit is to align resources to Our Council Plan 2019-2024 which was approved by Full Council on 3 April 2019.

7.2 Our Council Plan 2019-2023 sets out how we will deliver our contribution to Vision 2030 and how we will work with our partners and communities to be a city of opportunity. The plan includes six strategic priorities which come together to deliver the overall Council Plan outcome of 'Wulfrunians will live longer, healthier and more fulfilling lives.' Resources will continue to be aligned to enable the realisation of the Council's priorities of achieving:

- Children and young people get the best possible start in life
- Well skilled people working in an inclusive economy
- More good jobs and investment in our city
- Better homes for all
- Strong, resilient and healthy communities
- A vibrant, green city we can be proud of

7.3 Covid-19 has had a significant international, national and regional impact and will continue to do so over the short and medium term. The pandemic has made the challenges faced in our local economy much harder. As detailed in section 6, the Council has developed it's five-point recovery plan, 'Relighting Our City' which sets out the priorities which will guide the Council's approach as the organisation and the City starts to transition from the response to the recovery phase of the pandemic.

7.4 The Financial Strategy, approved by Council in March 2019, consists of five core principles underpinned by eight core workstreams. Using the Core Workstreams as the framework for the Financial Strategy detailed delivery plans are being developed all with a lead director. The Core principles and workstreams are:

- **Core Principles:**
  - **Focusing on Core Business**. Focus will be given to those activities that deliver the outcomes local people need and which align to our Council Plan and Financial Strategy.
  - **Promoting Independence and Wellbeing**. We will enable local people to live independently by unlocking capacity within communities to provide an effective and supportive environment.
  - **Delivering Inclusive Economic Growth**. We will continue to drive investment in the City to create future economic and employment opportunities.
  - **Balancing Risk**. We will ensure we base decisions on evidence, data and customer insight.
  - **Commercialising our Approach.** We will boost social value in our City by maximising local procurement spend with people and businesses.

- **Core Workstreams:**
    - **Promoting Digital Innovation.** Improve access to digital services to empower local people to self-serve at a time and place that suits them whilst reducing 'traditional' operating costs.
    - **Reducing demand**. Through early intervention and closer collaboration with local people we aim to reduce demand for services and support greater independence and resilience.
    - **Targeted Service Delivery.** Our efforts will be focused in the areas and places that need us the most and where we can deliver the best possible outcomes within the resources available.
    - **Sustainable Business Models.** We will develop the most efficient and effective services possible, within the significant financial constraints we face, to meet the needs of local people.
    - **Prioritising Capital Investment.** Aligned to our strategic plan, investment will focus on the priorities that deliver the best possible return and outcomes for local people.
    - **Generating Income.** Better understanding the markets we operate in will enable us to develop new, innovative income generation opportunities with partners where appropriate.
    - **Delivering Efficiencies.** By reviewing our resources, business processes and better using technology, we will deliver services which meet customer needs efficiently and cost-effectively.
    - **Maximising Partnerships and External Income.** We will take a much more strategic role, working with our partners, to identify opportunities to collaborate, share resources, reduce costs and seize funding opportunities

8.0 Summary of financial position

8.1 Despite austerity since 2010, the Council has a strong track-record of managing money well, planning ahead and delivering excellent services.

8.2 The assumptions used in the preparation of the Budget and Medium Term Financial Strategy remain under constant review and update. Appendix 2 provides detail of the changes to corporate resource assumptions and growth and inflation, which are recommended for inclusion in the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024.

8.3 In light of the Covid-19 pandemic and confirmation that the Comprehensive Spending Review 2020 would be delayed, further work has been undertaken to assess the potential impact on the Council's 2021-2022 draft budget and Medium Term Financial Strategy.

8.4 The overall impact of the revisions to the draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 has been detailed in Appendix 2.

8.5 In response to government announcements, the Council assumes that the Government will provide sufficient grant funding to cover the cost of Covid-19 related cost pressures. Without the cost pressures arising as a result of the Covid-19 pandemic, it is estimated that the Council is currently faced with a budget deficit in the region of £4.5 million for 2021-2022, rising to £19.6 million over the medium term period to 2023-2024 and is on track to deliver another balanced budget for 2021-2022.

8.6 However, in the event that sufficient grant funding to meet the pressures arising as a result of Covid-19 is not provided to local authorities, this would have a significant impact on the Council and result in the Council undertaking a fundamental review of all services in order to identify budget reductions sufficient enough to set a balanced budget. The financial implications of the pandemic have significantly distorted the budget and Medium Term Financial Strategy.

8.7 As can be seen in the table below and in further detail at Appendix B, the projected budget deficit for 2021-2022 could rise to a minimum of £23.2 million for 2021-2022, increasing to over £40 million over the medium term. The increase in the forecast budget deficit has arisen as a result of the impact that Covid-19 has had on the economy to date and the ongoing impact it is likely to have in future years. This will be closely monitored, with updates provided in future reports. At this stage it has not been possible to fully quantify the potential impact of Covid 19 over the medium term. It is anticipated that pressures will emerge in many areas particularly in relation to adult social care.

Table 2 – Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 – Covid pressures not funded

	2021-2022 £000	2022-2023 £000	2023-2024 £000
Projected Budget Challenge as at July 2020	8,690	21,828	20,382
Changes to Corporate Resources	10,674	3,326	(1,000)
Changes to Growth and Inflation	3,818	1,530	1,300
Annual Change	14,492	4,856	300
Cumulative Change	-	19,348	19,648
Projected deficit after cumulative impact of revisions	23,182	41,176	40,030

8.8 It is important to note that there continues to be a significant level of uncertainty associated with emerging behavioural and operational changes arising as a result of the Covid-19 pandemic. This may have significant ongoing financial implications for services provided by the Council including, but not limited to, adult social care, public health and wellbeing and income generating services.

8.9 Work will continue over the coming months to review all assumptions in the Medium Term Financial Strategy and a further update will be presented to Councillors in January 2021.

8.10 The Council levies a wide range of fees and charges for many of its services. Some are discretionary and others are either specified or restricted by legislation or Government. Services continue to review their fees and charges policies in line with key priorities. It is therefore proposed that authority be jointly delegated to the responsible Cabinet Member and the Cabinet Member for Resources, in consultation with the responsible Director and the Director of Finance to vary fees and charges in line with key priorities.

9.0 Next Steps and Budget Risk Management

9.1 As stated in section 5 above, following announcements made by Government, it is assumed that the Government will provide sufficient grant funding to cover the cost of pressures arising as a result of the Covid-19 pandemic. However, in the event that sufficient grant funding to meet the pressures is not provided to local authorities, this would have a significant impact on the Council and result in the Council undertaking a fundamental review of all services in order to identify budget efficiencies sufficient

enough to set a balanced budget. This will be closely monitored, with updates provided in future reports.

9.2 It is important to note that the Council needs the Government to provide confirmation of future years funding as soon as possible and by early December at the latest, in order to ensure that the Council has a clear direction of funding available over the medium term.

9.3 Work will continue to take place to assess the financial position the Council finds itself in, namely identifying budget efficiencies to meet the anticipated £4.5 million budget deficit in 2021-2022, in order to ensure that a balanced budget can be set in each individual year.

9.4 A summary of the 2021-2022 budget setting process timetable is detailed below in Table 3.

Table 3 – Budget Timetable

Milestone	Deadline
Formal Budget Scrutiny	November – December 2020
Report to Cabinet following Local Government Finance Settlement	January 2021
Final Budget Report 2021-2022 to Cabinet	17 February 2021
Full Council Approval of Final Budget 2021-2022	March 2021

9.5 The overall level of risk associated with the Draft Budget and Medium-Term Financial Strategy (MTFS) 2021-2022 to 2023-2024 is assessed as Red. The following table provides a summary of the risks associated with the MTFS, using the corporate risk management methodology.

Table 4 – General Fund Budget Risk Register

Risk	Description	Level of Risk
Medium Term Forecasting	Risks that might materialise as a result of the impact of non-pay inflation and pay awards, uptake of pension auto enrolment, and National Living Wage.	Amber
Service Demands	Risks that might materialise as a result of demands for statutory services outstretching the available resources. This particularly applies to adults and childrens social care.	Red

	Risks that might materialise as a result of demands for non-statutory services outstretching the available resources.	Amber
Identification of Budget Reductions	Risks that might materialise as a result of not identifying budget reductions due to limited opportunity to deliver efficiencies.	Amber
Budget Management	Risks that might materialise as a result of the robustness of financial planning and management, in addition to the consideration made with regards to the loss of key personnel or loss of ICTS facilities	Green
Transformation Programme	Risks that might materialise as a result of not delivering the reductions incorporated into the budget and not having sufficient sums available to fund the upfront and one-off costs associated with delivering budget reductions and downsizing the workforce.	Amber
Reduction in Income and Funding	Risks that might materialise as a result of the multi-year Spending Review, and reforms to Business Rates Retention and the Fair Funding Review.	Red
	Risks that might materialise as a result of income being below budgeted levels, claw back of grant, or increased levels of bad debts. The risk of successful appeals against business rates.	Amber
Third Parties	Risks that might materialise as a result of third parties and suppliers ceasing trading or withdrawing from the market.	Amber
Government Policy	Risks that might materialise due to structural uncertainties including the impact of exiting the European Union.	Red

	Risks that might materialise as a result of changes to Government policy including changes in VAT and taxation rules.	Red
Covid-19	Risk that the financial implications of Covid 19 including the Council's recovery will exceed the grant allocations awarded by Government and place further financial pressures on the council financial position over the medium term.	Red

10.0 Evaluation of alternative options

10.1 In determining the proposed Five Year Financial Strategy, consideration has been made to the deliverability of budget reduction and income generation proposals and budget pressures. In the event that sufficient grant funding to meet the pressures arising as a result of Covid-19 is not provided to local authorities, this would have a significant impact on the Council and result in the Council undertaking a fundamental review of all services in order to identify budget reductions sufficient enough to set a balanced budget. This may therefore potentially impact upon service provision.

11.0 Reasons for decisions

11.1 It is recommended that the updated draft budget strategy linked to the Five Year Financial Strategy, including changes to corporate resource assumptions and growth and inflation, for inclusion in the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 is approved by Cabinet. Cabinet will be provided with an update on progress in the Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 report which will be presented to Cabinet in January 2021. In approving this strategy, the Council will be working towards identifying options to be able to set a balanced budget for 2021-2022.

12.0 Financial implications

12.1 The Financial Implications are detailed throughout this report.

[MH/03112020/Z]

13.0 Legal implications

13.1 The Council's revenue budgets make assumptions which must be based on realistic projections about available resources, the costs of pay, inflation and service priorities and the likelihood of achieving any budget reduction proposals.

13.2 The legal duty to spend with propriety falls under S.151 Local Government Act 1972 and arrangements for proper administration of their affairs is secured by the S.151 Officer as Chief Financial Officer.

13.3 Section 25 of the Local Government Act 2003 requires the Chief Financial Officer to report to the Council when it is making the statutory calculations required to determine its Council Tax. The Council is required to take this report into account when making its budget decision. The Chief Financial Officer's report must deal with the robustness of the budget estimates and the adequacy of the reserves for which the budget provides. Both are connected with matters of risk and uncertainty. They are inter-dependent and need to be considered together. In particular, decisions on the appropriate level of Reserves should be guided by advice based upon an assessment of all the circumstances considered likely to affect the Council.

13.4 The relevant guidance concerning reserves is Local Authority Accounting Panel Bulletin 77, issued by CIPFA in November 2008. Whilst the Bulletin does not prescribe an appropriate level of reserves, leaving this to the discretion of individual authorities, it does set out a number of important principles in determining the adequacy of reserves. It emphasises that decisions on the level of reserves must be consistent with the Council's MTFS, and have regard to the level of risk in budget plans, and the Council's financial management arrangements (including strategies to address risk).

13.5 In addition, Section 114 of the Local Government Finance Act 1988 requires the Chief Financial Officer to '…make a report … if it appears to her that the Authority, a committee or officer of the Authority, or a joint committee on which the Authority is represented':

> (a) has made or is about to make a decision which involves or would involve the Authority incurring expenditure which is unlawful,
> (b) has taken or is about to take a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency on the part of the Authority, or
> (c) is about to enter an item of account the entry of which is unlawful.

13.6 The Chief Financial Officer of a relevant Authority shall make a report under this section if it appears to her that the expenditure of the Authority incurred (including expenditure it proposes to incur) in a financial year is likely to exceed the resources (including sums borrowed) available to it to meet that expenditure.

13.7 These statutory requirements will have to be taken into account when making final recommendations on the budget and council tax requirement for 2021-2022.

[DP/02112020/A]

14.0 Equalities implications

14.1 The method by which the MTFS for 2021-2022 is developed is governed by the Council Plan priorities described in paragraph 7.2 which itself was guided by consultation and equality analysis. Development of budget reduction proposals for Cabinet's consideration will include an initial equalities screening for each proposal and, where necessary, a full equalities analysis which will provide for an initial understanding of the equality impact of

the draft proposals. All of this will enable Councillors to pay, “due regard” to the equalities impact of their budget decisions at that point in the budget development process. The resulting and final report to Cabinet and Council will contain a supporting equality analysis that will offer information across the whole range of proposals and in doing so enable Councillors to discharge their duty under Section 149 of the Equality Act 2010.

15.0 Climate change and environmental implications

15.1 There are no relevant climate change and environmental implications arising from this report.

16.0 Human resources implications

16.1 In line with the Council’s statutory duties as an employer under the Trade Union Labour Relations (Consolidation) Act 1992, an HR1 form was issued to the Secretary of State for Business, Innovation and Skills identifying the intention to reduce employee numbers by up to 500 across the Council in the period 1st April 2019 up to 31 March 2020. A further HR1 was scheduled to be issued on 1 April 2020 for the period 1 April 2020 – 31 March 2021, this was postponed due to the COVID19 emergency. A HR1 was issued on 1 August 2020 for the period 1 August 2020 – 31 March 2021. This will identify a further 500 posts. The reductions will be through both voluntary redundancy and budget reduction targets which could result in compulsory redundancies.

16.2 The numbers included in an HR1 include posts held by colleagues who, as part of business review, redesign and/or restructure, need to be included, as they will need to be put at risk of redundancy. However, many of these employees will apply for and be offered jobs in the new structure or elsewhere in the organisation and therefore the number of employees leaving the authority is anticipated to be far fewer than the number declared on an HR1.

16.3 As detailed in the report, budgetary reductions will be made through efficiencies with new and smarter ways of working, income generation and transformation initiatives.

16.4 If any reductions in employee numbers are required, these will be achieved in line with the Council's HR policies. Compulsory redundancies will be mitigated as far as is possible through seeking voluntary redundancies in the first instance, and through access to redeployment. The Exit Payment Regulations 2020 that came into force on 4 November 2020 have necessitated amendments to the Local Government Pension Scheme currently being consulted on by the Ministry of Housing, Communities and Local Government. Following the outcome of consultations CWC will be required to review the current voluntary and compulsory redundancy policies.

16.5 The Council will ensure that appropriate support is made available to employees who are at risk of and selected for redundancy, and will work with partner and external agencies to provide support. If any of the budget reduction targets require service delivery to move from direct Council management to private, community or third sector providers, this may

have implications under the TUPE regulations. If TUPE were to apply, appropriate consultation with relevant Trade Unions and affected employees, would take place.

16.6 There is on-going consultation with the trade unions on the impact of the Council's budgetary position and the targets being made to meet the challenges posed by it.

17.0 Corporate landlord implications

17.1 There are no relevant corporate landlord implications arising from this report.

18.0 Health and Wellbeing Implications

18.1 There are no relevant health and wellbeing implications arising from this report.

19.0 Covid Implications

19.1 The Covid implications are discussed throughout the body of this report.

19.2 The Covid-19 pandemic has had a significant international, national and regional impact, and will continue to have, significant financial implications for the Council.

20.0 Schedule of background papers

20.1 2020-2021 Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024, report to Cabinet on 19 February 2020 and Full Council on 4 March 2020

20.2 Capital Budget Outturn 2019-2020 including Quarter One Capital Monitoring 2020-2021, report to Cabinet on 8 July 2020

20.3 2020-2021 Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024, report to Cabinet on 29 July 2020.

21.0 Appendices

21.1 Appendix 1 – 2020-2021 Budget Update.

21.2 Appendix 2 – Budget Strategy 2021-2022 to 2023-2024 – Update on Assumptions.

APPENDIX 1

1.0 2020-2021 Budget Update

1.1 Since the 2020-2021 budget was set in March 2020, Covid-19 was declared a national pandemic. At the time of reporting to Council on 4 March 2020, the full impact of the Covid-19 pandemic was not anticipated and the impact on both the finances and operating environment could not have been foreseen. The financial implications of the pandemic have significantly distorted the 2020-2021 budget.

1.2 The Government has announced grant funding to help local authorities address the pressures they are facing in response to Covid-19. Wolverhampton's total confirmed funding allocation from the Covid-19 Emergency Grant is £25.5 million. Funding has also been received to support rough sleepers and to provide food and essential supplies to vulnerable residents. In addition to this, the Government have announced a co-payment mechanism for irrecoverable sales, fees and charges income. This funding is conditional upon grant claims and payable in three tranches. The first claim was submitted in September claiming costs of £2.2 million, but at the time of writing this report the actual amount awarded to Wolverhampton had not been confirmed. Based on current forecasts, the total additional grant that could be claimed under this fund is estimated to be in the region of £5.6 million. It is important to note that this is not confirmed income and is subject to change. A full list of grants awarded to the Council prior to the second national lockdown, during the Covid-19 pandemic, with specific conditions attached are detailed in the table below:

Table 1 – Specific Grants

Grant	Allocation £000
General Grants	
Covid 19 Emergency Grant	25,547
Enforcement Surge Funding	174
Grants with conditions / criteria	
Rough Sleepers (2 tranches announced to date)	209
Reopening of the High Street	234
Test and Trace	1,920
Emergency Food and Essential Supplies	393
Wellbeing for Education Return Grant	37
Active Travel Scheme (revenue and capital)	347
Home to School Transport	117
Grants passported to third parties	
Business Grant	53,518
Hardship Fund	3,272
Infection and Prevention	6,228
Business Improvement Districts	34
Test and Trace Support Payments	274
Estimated Allocation – amounts not confirmed.	
Sales, Fees and Charges	5,599
Contain Outbreak Management Fund (based on tier 2)	789

1.3 Under the Council's emergency decision-making powers, a range of short term initiatives have been implemented including: the distribution of food parcels to the city's most vulnerable residents, temporary accommodation for rough sleepers, additional financial support for adult social care providers and the procurement of additional personal protective equipment for key staff and partners.

1.4 All of these short-term new initiatives required additional investment and have been funded to-date by the funding received from Central Government.

1.5 In addition to the short-term initiatives, a number of services were suspended in response to Government requirements. Income streams have been adversely affected from the loss of fees and charges for services, such as car parking, leisure and cultural services.

1.6 At the time of setting the 2020-2021 budget, new service budget reduction and income generation targets totalling in excess of £10 million were approved. A number of these planned targets are now at risk because resources that would originally have been focussed on transformation programmes have been redirected to enable the Council to respond to the crisis.

1.7 The Council has played a proactive, leading role in responding to Covid-19. Some of the new initiatives implemented to support the City's residents may continue to require financial support. As the situation evolves and restrictions continue to ease, some of the new initiatives will cease entirely, ease or will transition into different services which will require financial support.

1.8 Our current projections demonstrate that the estimated grant funding for Wolverhampton will be sufficient to meet the immediate revenue cost pressures and loss of income, including the delivery of budget reduction targets, with a small in-year cost pressure.

1.9 The current projections of the cost implications of Covid-19 in 2020-2021 are detailed in Table 2 below:

Table 2 - Projected Financial Implications of Covid-19 in 2020-2021

Category	2020-2021 £000
Expenditure including recovery costs	13,566
Loss of Income	10,416
Budget Reduction and Income Generation targets at risk	1,961
Provision for expenditure on activity to support current and future lockdown measures	6,118
Total potential impact	**32,061**
Confirmed Government Grant Funding	
Covid-19 Emergency Grant (general)	19,429
Covid-19 Emergency Grant (new allocation)	6,118
Rough Sleepers Grant	198
Emergency Assistance for Food and Essential Supplies Grant	393
Total Confirmed Government Grant Funding	**26,138**
Potential Shortfall before Sales, Fees and Charges Grant	**5,923**
Sales, Fees and Charges – claim 1 (April to July)	2,207
Sales, Fees and Charges – estimate of future claims (August to March)	3,392
Potential Government Grant	**5,599**
Potential Cost Pressure	**324**

1.10 In addition to the costs above, Covid-19 has had an impact on development of capital projects. Given the unprecedented circumstances, there has understandably been some delay on capital projects due to the pandemic. The Council continues to assess the potential implications of Covid-19 on the wider capital programme in terms of delivery timescales and increase in costs. Any additional costs on the capital programme will

result in an increase in the Treasury Management revenue budget. The joint meeting of Cabinet and Cabinet (Resources) Panel on 23 June 2020, received a report on the Covid-19 impact on the Capital Programme. In order be prudent, additional capital budget has been built into the Capital Programme to cover potential risks associated with the Covid-19 pandemic. The potential annual revenue impact could be up to £430,000 per year, the impact of this will not be seen until after 2020-2021.

1.11 It is important to note, that the financial implications detailed above are subject to change and do not include the full cost of recovery work or any provision for changes in light of the national lockdown and the new three tier system.

1.12 On 31 October 2020, the Prime Minister announced that England would be entering a second national lockdown from 4 November 2020 until 2 December 2020. It has been announced that local authorities will receive additional funding the costs associated with this lockdown including, support for additional local test and trace operations, support for businesses and those residents who are clinically extremely vulnerable. Full details of these grants were not known at the time of writing this report, but current announcements indicate that all authorities will know receive tier three level funding which is £8 per head of population to support local test and trace operations. In addition, under a new local shielding framework, which councils will be asked to put into place by 4 November, areas will receive £14 per clinically extremely vulnerable person to ensure they have access to essential supplies.

1.13 Councils have also been asked to distribute business grants worth up to £3,000 for the 28 day anticipated lockdown period to business premises forced to close, under a new local restrictions support grant. In addition, councils will receive £1.1 billion equating to £20 per head of population, for one-off discretionary payments to support businesses that are affected by the lockdown but which are not legally required to close.

1.14 The full details of these grants and the actual allocations for Wolverhampton were not known at the time of writing this report.

1.15 In addition, there are longer term implications for the Council's operating model, as the scale of the change post-Covid-19 will place new expectations and demands on service delivery in 2020-2021 and future years. At this stage it has not been possible to fully quantify the potential impact of Covid-19 over the medium term. It is anticipated that pressures will emerge in many areas particularly in relation to adult social care, public health and wellbeing and income generating services.

APPENDIX 2

1.0 Budget Strategy 2021-2022 to 2023-2024 – Update on Assumptions

1.1 Since the 2020-2021 budget was set in March 2020, work has been ongoing to review corporate resources assumptions, growth and inflation assumptions and to identify budget efficiencies to address the projected budget challenge of £15.5 million in 2021-2022, rising to around £20 million over the medium-term period to 2023-2024, as anticipated at that point. In July 2020, Cabinet received a report which detailed revisions in assumptions which resulted in the identification of £6.8 million towards the projected budget deficit for 2021-2022. Taking this into account, the remaining budget challenge to be identified for 2021-2022 stood at £8.7 million.

1.2 The assumptions used in the preparation of the Budget and Medium Term Financial Strategy remain under constant review and update.

1.3 The base assumptions built into the MTFS approved by Council in March 2020 including: assumed increases in council tax, pay awards, provision for inflationary growth and demand in social care remain unchanged.

1.4 In light of the Covid-19 pandemic and confirmation that the Comprehensive Spending Review 2020 would be delayed, further work has been undertaken to assess the potential impact on the Council's 2021-2022 draft budget and Medium Term Financial Strategy. The following paragraphs provide detail of updated assumptions in a number of areas. Work will continue over the coming months to review all assumptions in the Medium Term Financial Strategy and a further update will be presented to Councillors in January 2021.

Corporate Resources

1.5 A number of assumptions have been made with regards to the level of resources that will be available to the Council. It is important to note that there continues to be a considerable amount of uncertainty with regards to the future funding streams for local authorities. Any reduction in the Government's allocation of funding to the Council would have a significant detrimental impact and increase the budget deficit forecast over the medium term.

1.6 On 21 October 2020, HM Treasury confirmed that a one-year Spending Review will take place at the end of November 2020 in order to prioritise the Government response to Covid-19. It was stated that the Spending Review will build on support already provided in response to Covid-19 and focus on providing departments with certainty needed to tackle Covid-19, giving public services support to fight the virus and investing in infrastructure. The outcome of the one-year Spending Review will be reported to Councillors in January 2021.

Collection Fund Deficit

1.7 On 8 July 2020, Cabinet received a report detailing the final outturn on the Collection Fund for 2019-2020 which consisted of a cumulative deficit in the region of £532,000 on Council Tax and a cumulative deficit in the region of £939,000 on Business Rates. Of the accumulated deficit on the Collection Fund, the Council will retain a deficit in the region of £1.1 million. Due to the timing associated with collection fund accounting, the deficit retained by the Council will impact on the 2021-2022 budget. This has been recognised in the MTFS.

1.8 In addition to this, current projections indicate that there will be a significant reduction in the amount of funds that are collected in 2020-2021 from Council Tax and Business Rates; a result of the impact Covid-19 has had on the economy. As stated above, due to collection fund accounting treatment, any Collection Fund losses from 2020-2021 will not impact upon the Council's budget until 2021-2022.

1.9 Current working assumptions indicate that there could be a 15% reduction in the collection rate and appeals for remaining business rates, and a 6% reduction in the collection rate on Council Tax. In addition, it is forecast that losses will increase due to the increase in the number of Council Tax Relief cases; there has been a 1,500 increase in the number of working age claimants as at the end of September 2020, when compared to the start of the financial year. In total, the current projected 2020-2021 losses are expected to be in the region of £15.4 million.

1.10 The Government have announced that that the repayment of collection fund deficits arising in 2020-2021 can be spread over a three year period (2021-2022 to 2023-2024). Based on current projections this could result in an annual cost of £5.1 million.

1.11 Furthermore, it is forecast that losses of the same magnitude will be replicated in future years from 2021-2022 onwards, however the Government have not stated that any future losses could be spread over multiple financial years. The MTFS assumptions have therefore been updated to reflect the potential reduction in resources available to the Council.

One-off Funding Streams

1.12 Following a review of the anticipated level of reserves and grant balances, it is proposed that one-off funds totalling £1.1 million be released from the Business Rates Equalisation Reserve to help address some of the pressures detailed above on the Collection Fund.

Fees and Charges

1.13 The Council levies a wide range of fees and charges for many of its services. Some are discretionary and others are either specified or restricted by legislation or Government. Services continue to review their fees and charges policies in line with key priorities. It is therefore proposed that authority be jointly delegated to the responsible Cabinet Member and the Cabinet Member for Resources, in consultation with the responsible Director and the Director of Finance to vary fees and charges in line with key priorities.

Changes to Growth and Inflation

Emerging Pressures

1.14 In July 2020, Cabinet were informed that options were being explored on identifying efficiencies from potential technical financial transactions. High-level assumptions indicated that one-off efficiencies in the region £5 million could be generated in 2021-2022 reducing to £2 million over the medium term. However, in order to be prudent, the potential financial transaction has been removed from the current MTFS assumptions. Work will continue on these proposals over the next few months, with further reports to Cabinet in due course.

1.15 In depth reviews are being undertaken on existing budget reduction and income generation proposals in light of the Covid-19 pandemic and changes to the environment in which we currently operate. Current assumptions indicate that £2.5 million of savings will not be delivered in 2021-2022 as planned. Work is ongoing to ensure that proposals included in the MTFS are deliverable over the medium term. Further details will be reported back to Cabinet in the future reports.

1.16 Similarly, reviews are being undertaken on growth and inflation currently built into the MTFS. Current assumptions indicate that there is a net growth and inflationary requirement totalling £348,000 in 2021-2022. It is important to note, that detailed work continues to assess the impact that Covid-19 may have on the assumptions built into the MTFS.

Emerging Opportunities

1.17 As part of the detailed budget review, a number of one-off corporate budget efficiencies in 2021-2022 have been identified totalling £2.7 million. These efficiencies are primarily linked to the historic non-requirement of the auto-enrolment pot which has been held for the auto-enrolment of employees into the pension scheme, and other corporate contingencies. In addition to this, it is currently anticipated that the Council could see a net underspend against the 2020-2021 corporate budget. It is therefore proposed that the net underspend in 2020-2021 be transferred into a specific reserve to support the 2021-2022 budget strategy.

1.18 In addition to this, a number of one-off efficiencies have been identified totalling £530,000.

1.19 The Council has played a proactive, leading role in responding to Covid-19. The overall Covid-19 Emergency grant funding allocation for Wolverhampton to support the unprecedented financial situation that the Council finds itself in due to Covid-19 totals £25.5 million at the point of writing. However, further funding is required in order to meet the full costs of the pandemic that will be seen over the medium term. It is assumed that

the Government will provide sufficient grant funding to cover these pressures following the Secretary of State for Housing, Communities and Local Government stating in a message to council leaders which committed the Government to do “whatever it takes” to ensure that local authorities have the resources needed to do what was being asked of them to help with the pandemic response.

1.20 Without the cost pressures arising as a result of the Covid-19 pandemic, it is estimated that the Council is currently faced with a budget deficit in the region of £4.5 million for 2021-2022 and is on track to deliver another balanced budget. A range of options will be explored to bridge the gap including setting efficiency targets to all Directorates.

1.21 The overall impact of the revisions to the draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024, arising as result of the items detailed in the paragraphs above but with the Government funding the cost of Covid-19 pressures, have been reflected in Table 1 below.

Table 1 - Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 – Covid pressures funded

	2021-2022 £000	2022-2023 £000	2023-2024 £000
Projected Budget Challenge as at July 2020	**8,690**	**21,828**	**20,382**
Changes to Corporate Resources			
- Reduced Collection Fund forecast	14,674	(674)	(1,000)
- Collection Fund deficit 2019-2020	1,100	(1,100)	-
- One-off Funding Streams	(1,100)	1,100	-
- Government Covid-19 support	(22,733)	1,200	1,000
Changes to Growth and Inflation			
- Potential technical financial transactions	5,000	(3,000)	-
- Revisions to budget reduction targets	2,500	700	300
- Revisions to growth and inflation	348	(200)	-
- Potential underspends and corporate efficiencies	(3,700)	3,700	-
- Treasury Management	200	-	1,000
- One-off efficiencies	(530)	330	-
- Impact of Covid	TBC	TBC	TBC
Annual Change	**(4,241)**	**2,056**	**1,300**
Cumulative Change	**-**	**(2,185)**	**(885)**
Projected deficit after cumulative impact of revisions	**4,449**	**19,643**	**19,497**

1.22 Despite austerity since 2010, the Council has a strong track-record of managing money well, planning ahead and delivering excellent services.

1.23 However, in the event that sufficient grant funding to meet the pressures arising as a result of Covid-19 is not provided to local authorities, this would have a significant impact on the Council and result in the Council undertaking a fundamental review of all services in order to identify budget efficiencies sufficient enough to set a balanced budget. The financial implications of the pandemic have significantly distorted the budget and Medium Term Financial Strategy. As can be seen from the table below, the projected budget deficit for 2021-2022 could rise to a minimum of £23.2 million for 2021-2022, increasing to over £40 million over the medium term. This will be closely monitored, with updates provided in future reports.

Table 2 - Draft Budget and Medium Term Financial Strategy 2021-2022 to 2023-2024 – Covid pressures not funded

	2021-2022 £000	2022-2023 £000	2023-2024 £000
Projected Budget Challenge as at July 2020	**8,690**	**21,828**	**20,382**
Changes to Corporate Resources			
- Reduced Collection Fund forecast	14,674	(674)	(1,000)
- Collection Fund deficit 2019-2020	1,100	(1,100)	-
- One-off Funding Streams	(5,100)	5,100	-
Changes to Growth and Inflation			
- Potential technical financial transactions	5,000	(3,000)	-
- Revisions to budget reduction targets	2,500	700	300
- Revisions to growth and inflation	348	(200)	-
- Potential underspends and corporate efficiencies	(3,700)	3,700	-
- Treasury Management	200	-	1,000
- One-off efficiencies	(530)	330	-
- Impact of Covid	TBC	TBC	TBC
Annual Change	**14,492**	**4,856**	**300**
Cumulative Change	**-**	**19,348**	**19,648**
Projected deficit after cumulative impact of revisions	**23,182**	**41,176**	**40,030**

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Briefing to City of Wolverhampton Council's - Health Scrutiny Panel, 19 November 2020

NHS England and NHS Improvement (NHSEI) has been approached for an update on the position of dental services. The structure of this briefing follows the categories of interest as discussed with the Scrutiny Officer on 23rd October. This briefing is written as background reading and introduction to the current situation. At the November Committee a presentation will be given with high level information; the background briefing is intended to aid and promote discussion.

This briefing has been developed between NHS England and NHS Improvement Commissioning Team managers and colleagues in Public Health England; Consultants in Dental Public Health. NHSE/I was asked to answer questions or provide information in response to a number of specific questions.

Introduction

Firstly; it is important to clarify that NHS dental care, including that available on the high street (primary care), through Community Dental Services or through Trusts is delivered by providers who hold contracts with NHS England and NHS Improvement. All other dental services are of a private nature and outside the scope of control of NHSEI. The requirement for NHS contracts in primary and community dental care has been in place since 2006.

Secondly; there is no system of registration with a dental practice. People with open courses of treatment are practice patients during the duration of their treatment, however once complete; apart from repairs and replacements the practice has no ongoing responsibility. People often associate themselves with dental practices. Many dental practices may refer to having a patient list or taking on new patients, however there is no registration in the same way as for GP practices and patients are theoretically free to attend any dentist who will accept them. Dental statistics are often based on numbers of patients in touch with practices within a 24 month period and this in many cases be based on repeat attendances at a "usual dentist".

Wolverhampton has 31 general dental practices; which offer a range of routine dental services; six of these generalist providers also provide less complex orthodontic services. There are in addition 3 specialist Orthodontic practices; the orthodontist in these practices are specialists and provide more complex care. One local practice also provides extended or out of hours cover. Secondary care is provided by The Royal Wolverhampton NHS Trust (RWT) which also provides Community Dental Services for special care adults and children from a number of clinics in the area.

A map of the location of local dental surgeries is given in Appendix 1. In some cases there will be practices in close proximity and the numbers on the map reflect this where the scale does not permit them being displayed individually. The two maps have shading showing travel times by public transport or car.

Around 50% of the population are routinely in touch with NHS high street dental services; the numbers of people attending private services is not known; but is not expected to be 50% of the population. Many people with chaotic lifestyles or who are vulnerable may not engage with routine care and may instead use out of hours dental services. Individuals are free to approach practices to seek dental care and further information on NHS dental practices is available on the NHS website:

https://www.nhs.uk/service-search/find-a-Dentist although information provided by local dentists may not always be fully up to date.

Dental Charges

Dentistry is one of the few NHS services where you have to pay a contribution towards the cost of your care. The current charges are:

- **Emergency dental treatment – £22.70** This covers emergency care in a primary care NHS dental practice such as pain relief or a temporary filling.
- **Band 1 course of treatment – £22.70** This covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if clinically needed, and preventative care such as the application of fluoride varnish or fissure sealant if appropriate.
- **Band 2 course of treatment – £62.10** This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth but not more complex items covered by Band 3.
- **Band 3 course of treatment – £269.30** This covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges and other laboratory work.

Any treatment that your dentist believes is clinically necessary to achieve and maintain good oral health should be available on the NHS.

More information here: https://www.nhs.uk/using-the-nhs/nhs-services/dentists/understanding-nhs-dental-charges/ This poster should be displayed in all NHS dental practices:

NHS

NHS dental charges from 1 April 2019

The charge you pay depends on the treatment you need to keep your mouth, gums and teeth healthy. You will only ever be asked to pay one charge for each complete course of treatment, even if you need to visit your dentist more than once to finish it – either Band 1, Band 2 or Band 3.

If you are not exempt from charges, you should pay one of the following charges for each course of treatment you receive:

Band 1 course of treatment – £22.70
This covers an examination, diagnosis (eg X-rays), advice on how to prevent future problems, a scale and polish if needed, and application of fluoride varnish or fissure sealant. If you require urgent care, even if your urgent treatment needs more than one appointment to complete, you will only need to pay one Band 1 charge.

Band 2 course of treatment – £62.10
This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or if your dentist needs to take out one or more of your teeth.

Band 3 course of treatment – £269.30
This covers everything listed in Bands 1 and 2 above, plus crowns, dentures and bridges.

Free NHS dental treatment or help with health costs
You may be eligible for help with all or part of the costs of your NHS dental treatment. To see if this applies to you, see the leaflet *NHS dental services in England*, which is available from any NHS dental practice or visit the NHS website at **www.nhs.uk/healthcosts** or **call 0300 300 1343**.

For further information on NHS dental services and dental charges, see the leaflet *NHS dental services in England* or the dental services section of the NHS website (www.nhs.uk), or ask your NHS England Local Team for help.

https://www.nhsbsa.nhs.uk/sites/default/files/2019-03/Dental_Charges_Poster_2019_1.pdf

The proportion of adult patients who are exempt from NHS charges is just under a third but varies between practices.

Care Homes

Dental care to care home residents can be provided by either a general dental practitioner or a more specialist dentist usually from the Community Dental Services. Some dental care can be provided in the care home setting such as a basic check-up, but patients are often asked to travel into a dental surgery as this is the safest place to provide dental treatment. If a care home resident requires a dental appointment, they or their relative or carer can either contact their usual dentist or a local dental practice to see if they can provide care, or if they haven't got a regular dentist they can contact NHS 111 to find a dentist. If they need more specialist dental care they can be referred after this initial contact with a local dentist. During COVID dental practices are prioritising urgent care and people in care homes should be able to access urgent care through their usual dentist, a local dental practice or using NHS 111.

Prior to COVID work was underway to look at new ways of collaborative working with primary care networks to strengthen support to care homes in accessing dental services or improving the oral health of their residents. This remains a priority area and some pilots have already been undertaken in other areas across the Midlands with the aim of extending successful schemes to cover other areas.

Impact of the pandemic

The ongoing COVID-19 pandemic has had a considerable impact on dental services and the availability of dental care; the long-term impact on oral health is as yet unknown. Routine dental services in England were required to cease operating when the UK went into lockdown on 23rd March. A network of Urgent Dental Care Centres (UDCCs) was established across the Midlands during early April to allow those requiring urgent treatment to be seen. There are now over 90 UDCCs and these remain operational.

From 8th June, practices were allowed to re-open however they have had to implement additional infection prevention measures and ensure social distancing of patients and staff. A particular constraint has been the introduction of the so-called 'downtime' – a period of time for which the surgery must be left empty following any aerosol-generating procedure (AGP). An AGP is one that involves the use of high-speed drills or instrument and would include fillings, root canal treatment or surgical extractions. This has had a marked impact on the throughput of patients.

Aside from the effects of reduced dental access, it is possible that the pandemic will have other long-term effects on oral and general health due to the impact on nutritional intake – for example, increased consumption of foods with a longer shelf life (often higher in salt or sugar), coupled with possible increased intake of high-calorie snacks, takeaway foods and alcohol. Increases in sugar intake and alcohol intake could have a detrimental effect on an individual's oral health. Again, those impacted to the greatest extent by this are likely to be the vulnerable and most deprived cohorts of the population, thus further exacerbating existing health inequalities. Finally, it is important to note that some of the most vulnerable in the population, whose oral health may have been affected by the pandemic as described above, are also those individuals who are at greater risk of contracting COVID-19 and of experiencing worse outcomes due to risk factors linked to other long term health conditions.

NHSEI is working with providers to ensure that they operate safely and within national guidelines and have shared national guidance and Standard Operating Procedures that give guidance on how care can safely be provided.

The Dental Team have surveyed dental practices on a number of issues so as to gain assurance that they have received and implemented the guidance that has been sent out. This includes:

- a statement of preparedness return
- information on air exchanges to support appropriate use of surgeries and 'downtime' between procedures
- information on risk assessment of staff

PPE and Fit Testing

NHSEI supported UDCCs throughout lockdown to ensure that they had access to all the necessary PPE – particularly early on when supplies were limited. Dental practices now also have access to PPE through a portal – this is to ensure ongoing supply should we see further pressures as cases increase. There were some issues reported early on about FFP3 masks with expiry dates that had been exceeded. All this equipment had been tested prior to release to ensure it was still safe and effective.

One of the barriers originally to getting practices back to delivering a full range of services was the need to fit test staff so they could safely use these protective FFP3 masks. NHSEI initially worked with PHE to fit test staff working in the UDCCs and OOH services and have subsequently worked with Health Education England (HEE) to train 90 dental practice staff across the Midlands who can undertake fit testing of masks for local dental practices. This includes 5 covering the Wolverhampton area. Some staff may not be able to use the standard masks either due to difficulties getting an acceptable fit or due to the wearing of beards for cultural reasons, and in these cases staff have the option of using special hoods instead. More and more practices are opting for reusable rather than disposable masks.

Access to Dental Care during the Current Pandemic

In line with national guidance issued in response to the COVID-19 pandemic, dental practices in the Midlands are currently not providing routine care in the same way as they were prior to the pandemic.

Practices continue to provide advice, assessment and to prescribe antibiotics and painkillers where required, as well as some face to face dental care where necessary. Most face to face care is for urgent cases. Practices have plans in place to restore routine services but are focussing initially on urgent care and those who have experienced dental problems during the lockdown period as well as vulnerable people. Where routine services have resumed, dental care for people who are more vulnerable and who need more frequent checks is being prioritised. Practices remain open to provide services during the current lockdown.

As of the beginning of October 2020 all 31 local practices were providing AAA and some level of face to face care. Six were still not providing the full range of AGP services. An update on the current position will be available at the meeting. For comparison, across the Midlands the percentage of practices now providing AGP is more than 90%. The capacity and number of appointments available will vary depending on the type of practice and the number of surgeries. Specialist Orthodontic practices continue to care for patients already in treatment and are now starting to take on the most urgent new patients. These patients are being prioritised based on clinical need (to avoid harm) rather than on length of time on a waiting list.

As a result of the pandemic, dental practices have undertaken risk assessments of their premises and have made changes to the way they provide dental care. This is to ensure the safety of both patients

and staff. These additional safety precautions mean that practices are able to see fewer patients than before due to required measures to ensure social distancing and prevent any risk of spreading of infection between patients. Surgeries require 'downtime' between patients to allow for air changes, droplets to settle and for cleaning.

As a result, not all practices or clinics are able to offer the full range of dental treatment. Patients may be referred on, particularly if the referral to another service will offer treatment in a safer setting for the patient. This may involve travelling further than would usually be the case.

It is important to note that no practices are providing walk in services and patients should expect to be contacted and asked to undergo an assessment prior to receiving an appointment. Patients need to be honest about their COVID status and whether or not they are experiencing symptoms or have been asked to isolate. They will then be directed to the most appropriate service. This is for their own safety and the safety of staff and other patients.

We are aware that some vulnerable groups are finding it harder than usual to access services – particularly as no walk-in options are available. We have been reviewing pathways and treatment arrangements for these patients to ensure that they can continue to access urgent care. Primarily this is through NHS 111 or local dental helplines. Many practices are operating with reduced capacity and will therefore be restricted in the care that they can offer to new patients. Arrangements are being put in place to ensure that telephone advice and triage is available and the Urgent Dental Care Centres (UDCCs) remain open across the Midlands to ensure access to urgent dental care where practices are unable to provide this to all patients.

Some patients who have previously accessed care privately may now be seeking NHS care due to financial problems related to the pandemic or due to the additional PPE charges that are apparently being levied by some private dental practices. This is putting additional pressure on services at a time when capacity is constrained. These patients are eligible for NHS care, however they may find it difficult to find an NHS practice willing to take them on and are likely to be able to access care instead through ringing NHS 111.

It should be noted that many dental practices operate a mixed private/NHS model of care and although NHS contract payments have been maintained by NHSEI the private element of their business may have been adversely affected by the pandemic. The Chief Dental Officer set up a short life working group who undertook an investigation into the resilience of mixed practices[1]. They concluded that whilst there would have been an interruption of income, the risk of a large number of practices facing insolvency over the next 12 to 18 months was low. There were however significant concerns raised about the viability of the dental laboratory sector who manufacture dentures. These businesses are wholly private and will have suffered a major interruption to income during the first lockdown and a significant reduction to their business subsequently due to the reduced numbers of patients being seen and treated. The group made a number of recommendations for actions to support the wider dental industry.

Definition of "Urgent Dental Care"

Urgent and emergency oral and dental conditions are those likely to cause deterioration in oral or general health and where timely intervention for relief of oral pain and infection is important to prevent worsening of ill health and reduce complications (SDCEP, 2013). Urgent dental care problems have been defined previously into three categories (SDCEP, 2007). The table below shows

1 http://www.bsdht.org.uk/publications/DHC/Investigation%20into%20the%20resilience%20of%20mixed%20dental%20practices%20following%20the%20first%20wave%20of%20the%20COVID-19%20Pandemic.pdf

current national information about the 3 elements of dental need and best practice timelines for patients to receive self-help or face to face care.

Triage Category	Time Scale
Routine Dental Problems	Provide self-help advice. Provide access to an appropriate service within 7 days if required. Advise patient to call back if their condition deteriorates
Urgent Dental Conditions	Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates
Dental Emergencies	Contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition

UDCCs and Out of Hours services have been set up to operate to provide care in line with the standards described above. Practices also apply the same criteria but routine dental problems (those not associated with significant pain or swelling) are unlikely to be deliverable currently within 7 days due to the need to prioritise those in pain. The availability of routine check-ups is likely to be limited to those who are vulnerable or who have ongoing dental issues. Many patients with generally good oral health would not be expected to require 6 monthly check ups under normal circumstances and these can safely be deferred at this time. Treatment options may be more limited than usual. This is due to the need for AGP (aerosol generating procedures) for restorative dentistry (e.g. fillings and root canals) which are limited due to the extended 'downtime' necessary between patients.

UDCCs

An exercise was undertaken initially with the local LDC and then subsequently with PHE to agree suitable sites for urgent dental care centres. Wolverhampton has 3 local UDCCs (with access also to other local sites close by such as in Willenhall) - please see Appendix 2. All provide a range of urgent dental care treatments; 1 is designated specifically for people who are vulnerable or shielding. The local Community Dental service continues to provide care for those with special care needs including some children. The UDCCS remain operational and continue to support other local practices in providing care to local patients – in particular those who do not have a "usual" dentist or are new to NHS dental care.

Some dentists may be having to isolate due to health conditions or as a requirement through Test and Trace due to community exposure to COVID. Isolating dentists can provide "AAA" which is telephone-based and offers analgesia, advice and anti-biotics and refer on for urgent face to face treatment.

There is currently no direct access into the UDCCs; they are required to follow distancing and appointment only face to face contacts. Following triage by their practice people can be referred to a local Referral Hub. The referral hub for Wolverhampton is provided currently by the Wolverhampton Community Dental Service but there are plans to move to electronic referrals so as allow the community service to better concentrate of recovering its own core services. The hub will assess the referral and direct it to either a UDCC or refer into the Community Dental services or where necessary to a hospital oral surgery service. The UDCCs contact patients directly to assess and organise appropriate interventions. People who are unable to get an appointment with a local dental practice (usually those who haven't visited their dentist for more than 2 years) can contact NHS 111 who can refer into a Referral Hub to gain access to a AAA assessment from a local practice and face to face care through a UDCC where necessary.

The site a person is referred to will depend upon an individual's COVID status and it is important for people to be honest about whether they are symptomatic or isolating to ensure they are directed to the correct service so as not to put themselves or other patients at risk. There have been particular difficulties in finding dedicated "hot" sites for symptomatic or isolating patients due to the need to ensure they do not mix with other patients using other services at the same location.

Activity in these "hot" sites was very low during the first lockdown. As a result, there are currently fewer of these sites (see Appendix 2) and patients may have to travel further to access care. There are now anticipated to be more patients in this category during the second lockdown due to widespread testing and the introduction of test and trace. As a result, we are reviewing provision and hope to open additional sites in the near future.

OOH Provision

Out of hours services provide urgent dental care only. People should check their practice's answer machine; information should be also be displayed inside the practice and on the windows. Most people contact NHS 111 who will alert the out of hours provider. There is an online option that will often be quicker and easier than phoning – particularly when NHS 111 is dealing with large numbers of COVID related calls. If using the phone, it is important to listen to all the messages and choose the appropriate option for dental pain.

Please be aware that patients with dental pain should not contact their GP or turn up at A&E as this could delay treatment as they will be redirected instead to a dental service.

People can attend any service in the Midlands area. In Wolverhampton there is a particular local dentist who provides this service and contact details for this dentist will be given out by NHS 111. Out of hours providers are encouraged to provide triage and AAA and are limited on the number of face to face contacts because of the COVID restrictions.

Dentures

If a person breaks their denture then they will need to contact their local dental practice. If they do not have a regular dentist they should contact NHS 111. During COVID dental practices are prioritising more urgent care and broken dentures do not classify as urgent care. Broken dentures can sometimes be fixed without a patient needing to see a dentist for an appointment – the dentist will assess the denture and if possible, send to the dental laboratory for the denture to be repaired. Some instances of broken dentures and all lost dentures will require new dentures to be made. This takes on average 5 appointments over a number of weeks with at least a week between appointments. This type of service is likely to be restricted at present due to COVID.

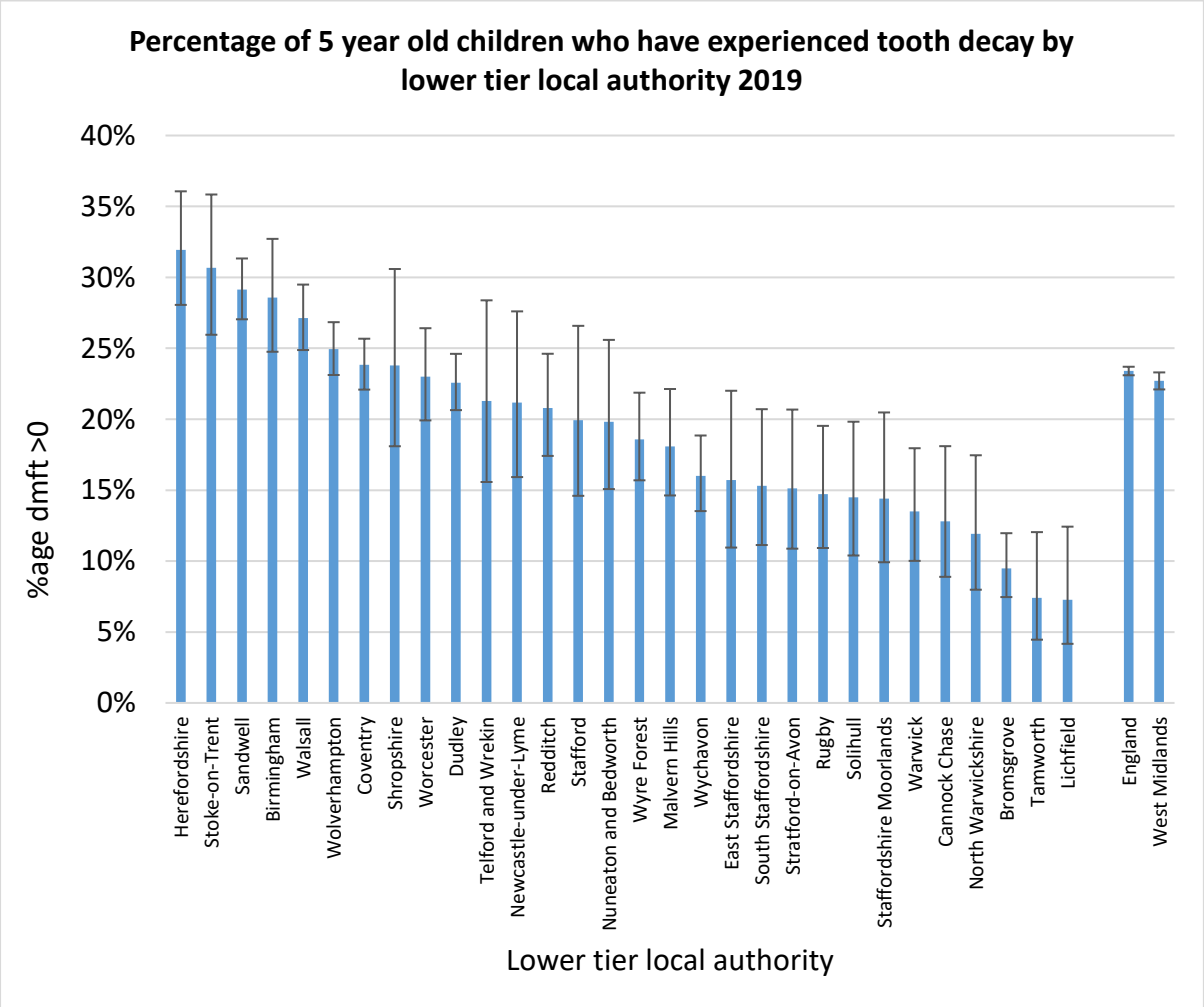
Vulnerable Patients

There are two groups of vulnerable patients – those vulnerable due to COVID and those who are vulnerable with respect to their oral health. For those in the categories who are vulnerable or shielded due to age or underlying health conditions special arrangements will be made to ensure they are able to access care safely. There are dedicated Urgent Dental Centres or care provided through the Community Dental Service. Some patients may be seen by their usual practice but will usually be offered an appointment at the beginning or end of a session.

There are in addition a number of groups of patients who are less likely to engage with routine dental services and likely to experience worse oral health.

Oral health and inequalities

Oral health is an important public health issue, with significant inequalities still evident. Deprived and vulnerable individuals are more at risk, both of and from, oral disease. The findings of the 2017/2018 survey of adults attending general dental practices in England showed that poorer oral health disproportionately affected those at the older end of the age spectrum and those from more deprived areas.[1] Whilst there has been an overall improvement in oral health in recent decades, further work is needed to improve oral health and reduce inequalities. The 2019 national oral health survey of 5 year old children showed wide variation in both the prevalence and severity of dental decay among young children (Figure 1).[2] The West Midlands benefits from water fluoridation across a large part of the geography; this means that children in those areas are significantly less likely to experience tooth decay compared to their peers elsewhere in the region or country. The whole of the population in Wolverhampton benefits from water fluoridation. It is worthy of note that dental decay remains the most common reason nationally for hospital admissions in children aged 5-9 years.[3]



Starting Well – A Little Trip to the Dentist

In order to tackle some of the issues described above the West Midlands dental team have implemented a national initiative aimed at getting children to the dentist early.

The main aim of this project was to increase access to NHS Dentistry in the NHS West Midlands geography in the very young (0-2 age group). There were four objectives:

1. To identify 'influencer' groups and individuals who can play a part in encouraging and facilitating parents / carers of children aged 0-2 to visit an NHS dentist.
2. To equip influencers with resources and information to influence parents / carers of children aged 0-2 to visit an NHS dentist.
3. To equip and encourage dental teams to see more 0-2-year olds
4. To ensure sufficient capacity for practices to take on additional young patients for check ups

Apart from media campaigns, joint local working with health visiting teams and training and resources for practices there was funding made available to ensure capacity to take on additional children for check ups before the age of 2. 15 practices in the Black Country were offered additional funding for 19/20 and 11 managed to deliver at least some of this despite the impact of COVID in the early part of 2020.

Recovery and Restoration

Dental teams and commissioning teams across the country are working hard to restore services and deal with the inevitable backlog of patients that has built up over the last 8 months. There is significant potential for the reduction in access to services to have disproportionately affected certain population groups and therefore to have further widened existing inequalities. Those with poorer oral health and/or additional vulnerabilities are likely to have suffered more from being unable to access dental care than those with a well-maintained dentition. Furthermore, there is ongoing concern about a reluctance amongst some people to present for care because of the pandemic either because they do not want to be a burden on the health service or because they fear getting coronavirus. A campaign reassuring people that it is safe to attend appointments has recently been launched. Again, this delay in seeking care is likely to have affected some of the more

vulnerable population cohorts more than the general population thus further exacerbating the health inequalities.

Reduced access to dental care over the course of the pandemic will have resulted in compromised outcomes for some patients. Due to the duration of the lockdown and the length of time during which routine face to face activity ceased, a number of patients who ordinarily would have had a clinical intervention, will have instead received antibiotics; possibly repeated courses. Some who were part way through treatment will undoubtedly have suffered and may have lost teeth they would not have done otherwise - temporary fillings placed pre-lockdown, for example, and only intended as temporary measures, may have come out and some of those affected teeth will subsequently have deteriorated further as the required treatment was simply not available. Orthodontic patients who are routinely seen for regular reviews will have missed appointments, though harm reviews and remote consultations should have helped identify any urgent issues. The ongoing backlog and ever-increasing waiting lists do however mean that there is still a risk of those recall intervals being extended to try and free up capacity to see new patients. Patient compliance with the required oral hygiene measures may wane over time and consequently there is an increased risk of decay developing around the orthodontic appliances if treatment is prolonged in this way

Secondary and Community Care

Infection control measures in place to protect patients and staff also mean that there is reduced capacity in clinics and hospitals for certain procedures particularly those requiring a general anaesthetic or sedation. As a result, the wider NHS system is prioritising theatre capacity and treating the most urgent cases – for instance those with cancer. This means that some specialist services will only be available at a more limited number of centres. There may also be additional requirements for prospective patients around swabbing or isolating at home prior to treatment. This is to ensure the safety of patients undergoing surgery and those already in the hospital.

There were problems initially in getting access to regular lists for children requiring dental treatment under general anaesthesia (as is the case across the country) but it is our understanding that the situation in Wolverhampton has now improved with some regular lists now being scheduled. Despite this only those children with the most urgent needs will be prioritised as services have to compete for theatre space with other patients who may have more urgent needs. The impact of rising hospital admissions for COVID means the situation is unlikely to improve further in the short term.

There will be a backlog of care and treatment given that most provision is for urgent care and / or completion of care begun before the first lockdown. The most recent data available on 18 week waits for Oral Surgery is for the position in August. RWT were at that time reporting 42 patients waiting over 52 weeks and 2042 waiting over 18 weeks. This is not unexpected due to the complete cessation of routine care earlier in the year. The position locally is slightly better than the Midlands average and has improved since July. Referrals into secondary care have started to recover (see Appendix 4) but remain at about a third of previous levels due to the reduction in routine appointments. There are concerns that some conditions may be missed due to the smaller number of patients being seen face to face.

The dental team have been working with local groups of clinicians through the Managed Clinical Networks to explain to local dentists how patients are being prioritised by services and what can be done to manage them in the interim whilst they are waiting for treatment. The aim is to keep patients safe and ensure they are being regularly monitored and that the practice knows how to escalate if the situation changes and needs become more urgent.

Staff issues

The Midlands region as a whole is highly diverse, and Wolverhampton has a diverse population. This is reflected in the staffing for local practices. In order to ensure that staff are not at risk all dental contractors have undertaken COVID risk assessment on their staff. Working arrangements have been altered to keep people safe where necessary and staff who are unable to see patients face to face have been involved with telephone triage or have been redeployed to help in other services such as NHS 111.

Communication with dentists

There have been regular meetings with local dental committees (LDCs) since April and the dental team is grateful for the co-operation received from the profession in mobilising urgent dental care centres and seeking solutions to help manage the current restrictions in services. LDCs have continued to update their members regularly to share information as guidance is updated. Managed Clinical Networks (groups of local clinicians) have continued to meet virtually to plan care and agree guidance to help practices to manage their patients. The Urgent Care MCN in particular met weekly between April and August.

Every year the dental team engages with practices to gain assurance about practice opening over holiday periods so as to ensure services will be in place for patients. Information is currently being gathered for this year to ensure that services are in place over the Christmas period.

The Dental Commissioning team have been working with colleagues in the Communications team to draft a series of stakeholder briefings to update key partners and the public on the situation with respect to dental services. These have been distributed to local authorities, Directors of Public Health and CCGs. We are also engaging with local Healthwatch organisations to encourage them to share any intelligence on local concerns or on difficulties people may be having accessing services.

Examples of tweets that have been shared on Twitter are given in Appendix 3.

COVID 19 and outbreaks in dental settings

As of 29/10/2020 there had not been a COVID outbreak in a dental practice setting in Wolverhampton. Dental practices are well equipped to manage risk relating to COVID as all staff are trained in infection prevention and control as part of their role in delivering dental services. 'Donning and doffing' PPE should be very familiar to them. A dental Standard Operating Procedure for outbreak management has been circulated via all contract holders and also to the Local Dental Committees to support practices manage any positive cases in their practices, whether visitors or staff. However as with all primary care settings, the risk is staff to staff transmission when they are outside their immediate clinical setting such as in shared reception areas or staff rooms or through community contacts outside work (such as with family or friends). NHS EI is planning a webinar to raise awareness of good practice in IPC and to share learning to prevent outbreaks in dental settings.

Nationally all the latest guidance for dental practices can be found here:
https://www.england.nhs.uk/coronavirus/primary-care/dental-practice/

IPC guidance for dental practices can be found here:
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Support is being provided to practices who have staff who are symptomatic or have been asked to isolate through Test and Trace. This is to ensure they take the relevant actions through their

business continuity plans to continue to operate safely and provide care to their patients. Where a practice is unable to remain open then patients may be redirected to an alternate local practice or to a UDCC.

Opportunities for Innovation including Digital

There have been some positive impacts through the pandemic including the way in which local services and clinicians have worked together collaboratively to maintain and recover services.

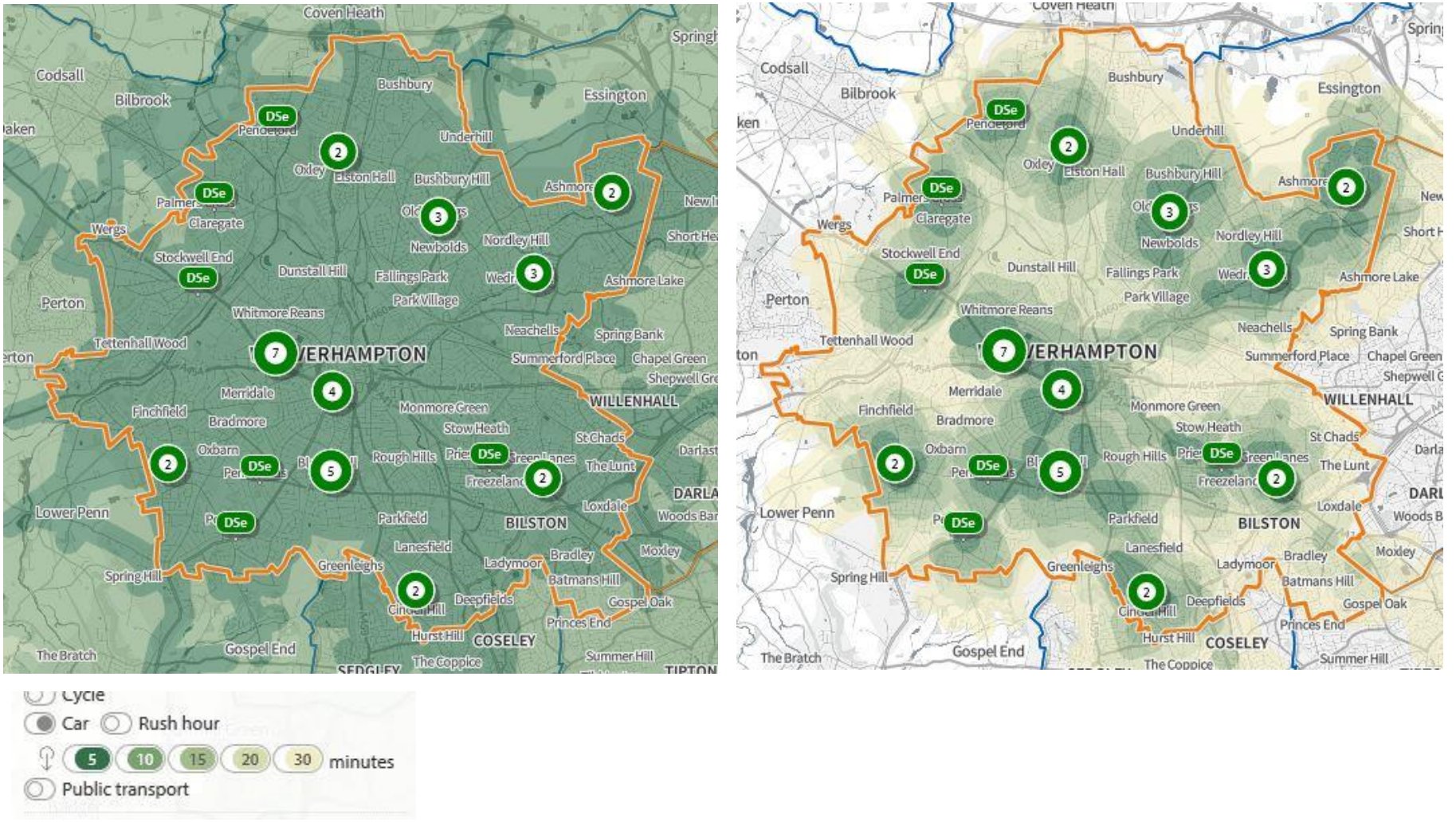
The other opportunity has been the widespread acceptance of innovative ways of providing care remotely by using digital methodologies such as video consultations. This has been widely used by Secondary and Community services, and also by Orthodontic practices, to provide support and advice to patients already in treatment.

125 dental practices across the Midlands have signed up to a six-month pilot to make use of video technology. This includes 7 in Wolverhampton. This is part of a wider initiative covering Pharmacies and Optometrists. Further details are available at this link:
https://www.youtube.com/watch?v=rXtykDGljjk

There are also innovative plans to offer advice and guidance through clinician to clinician video calls at the Birmingham Dental Hospital and we are exploring options to increase the use of advice and guidance through the electronic Dental Referral Management system (REGO), including the facility to upload photographs with referrals.

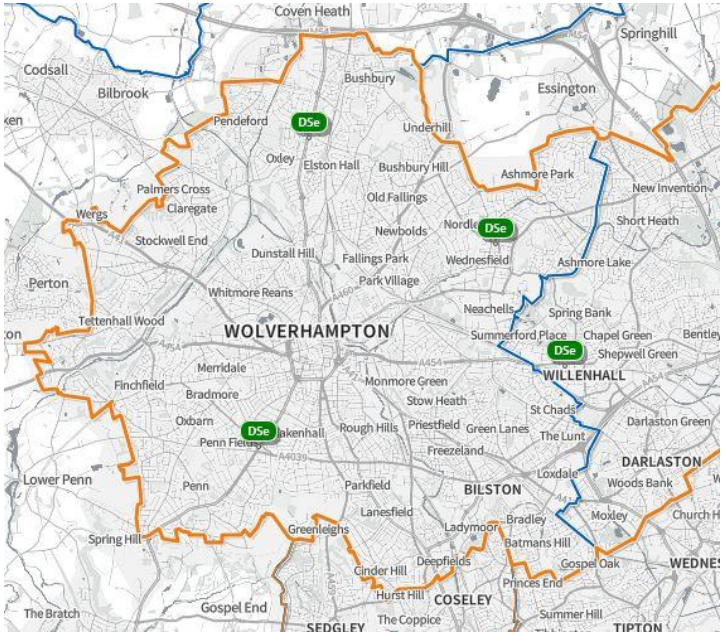
Appendix 1

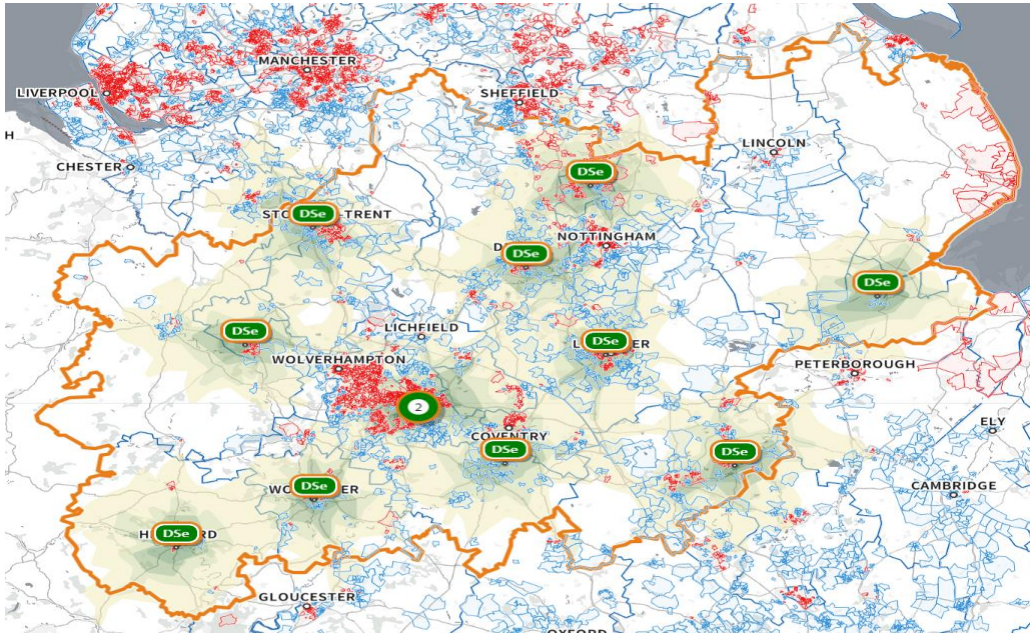
Fig 1 – Location of dental practices or clinics including orthodontic and community sites (travel times by car or public transport).



Appendix 2 – UDCC Locations

Cold Sites



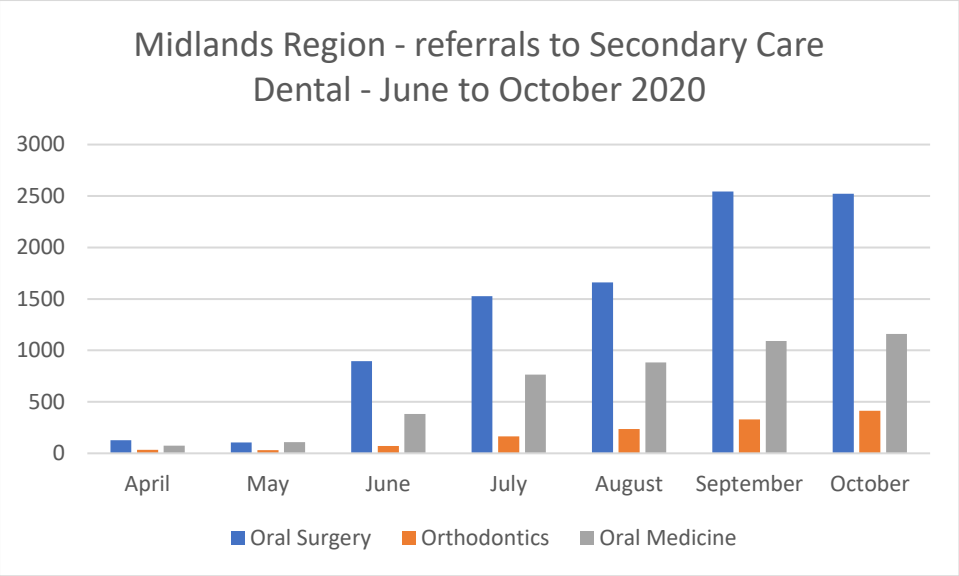


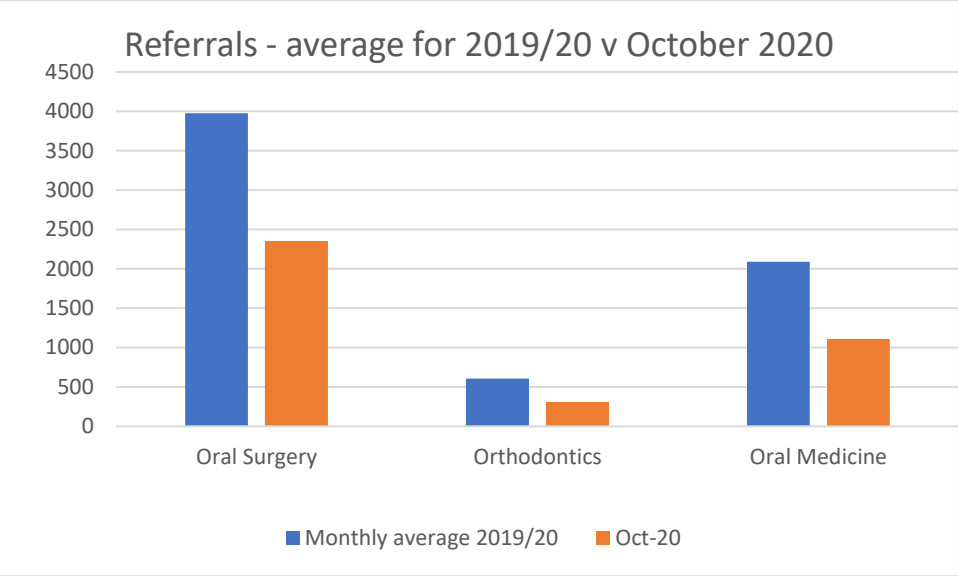
Hot Sites

Appendix 3 – Examples of tweets shared by the NHS England Communication Team

Appendix 4

Dental Referral Trends





Local Outbreak Engagement Board

Agenda Item No: 9

Minutes - 29 September 2020

Attendance

Members of the Local Outbreak Engagement Board

Councillor Ian Brookfield (Chair)	Leader of the Council
Councillor Jasbir Jaspal	Cabinet Member for Public Health and Wellbeing
Emma Bennett	Director of Children's Services
Professor Ann-Marie Cannaby	Chief Nurse, Royal Wolverhampton Hospital Trust
Tracy Cresswell	Healthwatch Wolverhampton
John Denley	Director of Public Health
Marsha Foster	Director of Partnerships, Black Country Healthcare NHSFT
Councillor Wendy Thompson	Opposition Leader
Paul Tulley	Managing Director, Wolverhampton CCG

In Attendance

Madeleine Freewood	Development Manager - City Health
Joanna Grocott	Systems Development Manager
Shelley Humphries	Democratic Services Officer
Neeraj Malhotra	Consultant in Public Health
Dr. Kate Warren	Consultant in Public Health
Richard Welch	Head of Partnerships and Commercial Services (Education)

Item No. *Title*

1 **Apologies for Absence**
Apologies were received from David Watts and Katrina Boffey.

2 **Notification of substitute members**

3 **Declarations of interest**
There were no declarations of interest.

4 **Minutes of the Previous Meeting**
Resolved:
That the minutes of the meeting of 6 August 2020 be approved as a correct record.

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

5a Urgent Business Item: Board Membership

It was noted that the Board was newly established and evolving constantly to incorporate cross-partnership working and engage with communities across the City. Following consultation with the Chair and Vice-Chair, it was therefore proposed that membership be extended to include representatives nominated by the Wolverhampton Voluntary Sector Council and the Ethnic Minority Council - Wolverhampton Equality and Diversity Partnership. It was agreed that the terms of reference would be amended accordingly and the nominated representatives would be invited to future meetings.

It was acknowledged that this would encourage wider diversity and ensure that communities could be reached therefore the proposal was endorsed.

Resolved:

1. That Local Outbreak Engagement Board agree for the membership to be extended to include representatives nominated by the Wolverhampton Voluntary Sector Council and the Ethnic Minority Council - Wolverhampton Equality and Diversity Partnership.
2. That the Local Outbreak Engagement Board Terms of Reference be amended to reflect the new appointments.
3. That the Local Outbreak Engagement Board agree for nominated representatives to be invited to future meetings.

6 **COVID-19 Situation Update**

Dr. Kate Warren delivered the COVID-19 Situation Update presentation which outlined the current COVID-19 situation within the City.

The vast majority of cases were in the community with hospital cases low yet increased over last week or so.

The rate per 100,000 was 69.5 which, in relation to statistical neighbours, put Wolverhampton behind Birmingham and not much further ahead of the rest of the Black Country.

It was acknowledged that cases had risen across the country and not just in Wolverhampton.

Data still showed that older people were more at risk from the effects of the disease. Proactive testing within care homes had picked up more older adults. Older adults living in multigenerational households were at risk as it often spread easily within the household via younger people living there.

Despite schools reopening, there had been a very small number of positive COVID-19 cases among young children.

A shaded map of Wolverhampton provided a ward-by-ward overview; the darker the shading the higher the infection rate in that ward. It was noted that the data in some of the wards may have been skewed by a large household in that ward testing positive. The map shown was correct at 17 – 23 September 2020; the latest data available at the time of the meeting.

It was reported that NHS capacity was being monitored closely and extra precautions were being taken with staff in the older adult age range. Staff absence had increased but wasn't as high as levels experienced in March – April 2020.

Not all patients in intensive care were using ventilators however many were receiving Level Three Care which was the highest level of care and monitoring.

It was noted that there may be a lag between the intervention measures currently being introduced and the stabilisation or reduction of cases. This was due to the time taken between initial infection and for symptoms to show to prompt a test, therefore new cases would continue to emerge.

In terms of mortality, levels had dropped to rates which were normal for this time of year. The disease had been circulating more prevalently amongst younger age groups and they had not been as affected as older adults might be.

It was highlighted that extensive work to prevent the spread was continuing as, if it was not mitigated, infection rates could potentially rise to similar to those seen in March and April 2020.

Resolved:

That the COVID-19 Situation Update be noted.

7 **COVID-19 Strategic Coordinating Group Update Report**

John Denley, Director of Public Health presented the COVID-19 Strategic Coordinating Group Update Report. Every Local Authority is required to produce a Local Outbreak Control Plan specific to COVID-19 as outlined in the August 2020 national framework.

The report provided an update to the Wolverhampton Local Outbreak Engagement Board on progress relating to the delivery of the local COVID-19 Outbreak Control Plan. The information within the report covered the time period from the date the Wolverhampton Outbreak Control Plan was published, 30 June 2020, to publication date of this report, 18 September 2020.

Particular attention was drawn to the Emerging Risks highlighted on page 11 of the agenda pack. It was noted that in respect of access to testing, issues had been experienced nationally as well as locally however local issues were close to being resolved as additional walk-through and drive-through testing stations had been introduced.

There had been some negativity on social media where it had been perceived that the public were receiving mixed messages over testing stations being closed. Reassurances were offered that none had been closed, however availability had recently been low due to Wolverhampton testing stations taking pressure off other areas who had run out of testing capacity.

It was important to reinforce the message to get tested as soon as symptoms show and not be dissuaded by perceived difficulties.

It was noted that the testing infrastructure was in its early stages nationally however, five sites had been set up around the City for use by the public to increase availability.

Resolved:

That the Wolverhampton COVID-19 Outbreak Control Plan Report be received.

8 **Escalation Intervention Plan**

John Denley, Director of Public Health provided an update of the Escalation Intervention Plan. It was outlined that the rise in infections was being monitored throughout the Black Country and required immediate response, therefore a Citywide Incident Management Team (IMT) had been established to control the risk.

It was important to establish what was driving the increase and how it could be tackled collectively to drive it back down by working in partnership with representatives throughout the City such as CCG, NHS, WVSC, WEDP, business groups, Chamber of Commerce, Wolverhampton and Bilston BIDs, University of Wolverhampton, to name but a few.

It was reported that a five-pronged approach had been devised with an overarching communications plan to enhance and build upon contact tracing data to understand what is driving the rise in infection rates and to reinforce compliance.

It was agreed that there should be a maintained focus on the City's most vulnerable residents. Those identified as vulnerable had been written to with advice on how to safely conduct as normal a life as possible in an effort to support them to recover and live through the pandemic. It was reported that an initial 10 – 15,000 emergency food parcels had been placed on standby to supply to foodbanks or residents as needed.

It was acknowledged that a tremendous amount of intensive work had been undertaken over the last two weeks with many positive outcomes achieved, most notably that Wolverhampton had achieved eighth highest testing rate in the country and highest in the region.

Resolved:

That the update on the Escalation Intervention Plan be received.

9 **Education Settings Update**

Emma Bennett, Director of Children's Services delivered the presentation on the Education Settings Update.

It was reported that all schools were now open and had shown promising attendance, although some parents had exercised extra caution around sending children in who were feeling unwell.

A robust attendance pathway was currently in place with the Attendance Team taking a proactive approach and engaging well with families.

There had been an increase reported in elective home learning, which had been expected as families either had found they preferred this method of learning or had concerns around possible infection in school. A dedicated Home Education Officer

had been appointed to provide support and initiate conversations with parents around what home education entails, its benefits and pitfalls.

Numbers were constantly evolving however at the time of the meeting, 3,000 children across the City were self-isolating and 67 incidents of positive cases had been reported.

The Authority had been working closely with the Department for Education to support schools and headteachers in navigating the guidance and making informed decisions on isolating the right bubbles. It was noted that it was important to balance safety with avoiding the risk of too many pupils missing school unnecessarily.

It was noted that schools needed to have a Remote Learning Plan in place by the end of September 2020. Many schools across the City had them finalised already and School Improvement Advisors had been analysing them to ensure they met the National Curriculum.

It was noted that the Authority were having daily conversations with the Department for Education to raise any issues.

It was reported that support for vulnerable learners was being continued by ensuring safe school transport for children and testing availability in special schools.

A concern was raised around the numbers of children self-isolating and the impact this had on teaching staff in terms of staff needing to self-isolate if their own children had to. It was noted that, to date, 50 pupils and 16 staff had tested positive which had resulted in 3,000 pupils and 200 members of staff self-isolating. This situation was being closely monitored and, as intelligence such as ‘Test and Trace’ became more efficient, it would become possible to safely send home smaller bubbles and fewer pupils and staff would be affected. In addition, guidance had been issued around childcare bubbles to assist and headteachers had been reporting promptly on positive cases as they became more familiar with the process.

In response to a query around what provision there was in place to support home-schooling due to the national increase in elective home learning as a result of COVID-19. It was clarified that all parents had the right to elect to home school their child for varying reasons and support was made available from the Authority, including learning resources, support group contacts and home visits. Parents did not have to accept support, although each case was cross-referenced with other vulnerabilities, checked to ensure parents were home-educating for the right reasons and that the arrangement was sustainable. It was important to stress to parents the great responsibility to make this decision.

Resolved:

That the Education Setting Update be noted.

10 **Communications Plan Update**

Richard Welch, Head of Partnerships and Commercial Services (Education), provided an update on the Communications Plan. Key communications activities to date had been divided into two categories: Universal (messages aimed at the general population such as wearing masks, testing, avoiding house to house contact) and Targeted (aimed at specific groups or settings, such as schools or care homes).

It had been identified that messages around staying safe and following guidelines had begun to get lost in repetition and not cascading effectively through communities.

It was proposed that, in order to strengthen communications, Councillor and Community leads be appointed as Champions to play a part in leading communities through the COVID-19 crisis. The Champions would engage with residents, acting as a bridge between local communities and the Authority, to provide information and advice, facilitate support and identify areas of vulnerability.

In addition, Local Outbreak Engagement Board members were asked to agree, adapt and promote 10 key messages to communities across the City on how to prevent the spread of COVID-19.

It was noted that the decision to appoint Board members from Wolverhampton Voluntary Sector Council and the Ethnic Minority Council - Wolverhampton Equality and Diversity Partnership had been timely as this would further the reach across the City's communities.

The Board agreed to nominate representatives to be part a task and finish group to further develop a toolkit to inform the activity of Councillors and Community Champions. It was agreed that they did not have to make a decision today, but anyone wishing to nominate a representative for or volunteer to contribute to the task and finish group could contact Madeleine Freewood, Development Manager for further details.

The Board also agreed to endorse the proposed role and principles of Councillors and Community Champions.

Resolved:

1. That members of the Local Outbreak Engagement Board agree to nominate representatives to be part a task and finish group to further develop a toolkit to inform the activity of Councillors and Community Champions.

2. That any member of the Local Outbreak Engagement Board wishing to volunteer or nominate a representative for the task and finish group contact Madeleine Freewood, Development Manager in the first instance.

3. That members of the Local Outbreak Engagement Board agree to endorse the proposed role and principles of Councillors and Community Champions.

11 **Other Urgent Business**

There was no other urgent business raised.

12 **Dates of future meetings**

13 **Exclusion of the Press and Public**

Resolved:

That in accordance with Section 100A of the Local Government Act 1972 the press and public be excluded from the meeting for the following item of business as it involved the likely disclosure of exempt information contained in

paragraph 2 of the Act, namely information that is likely to reveal the identity to an individual.

14 **Detailed COVID-19 Situation Update (Exempt)**
This item was exempt as it involved the likely disclosure of exempt information contained in paragraph 2 of the Act, namely information that is likely to reveal the identity to an individual.

15 **Other Urgent Business (Exempt Information)**
There was no other urgent business.

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