Social Care and Health Overview and Scrutiny Committee

Thursday 27 October 2022 at. 6.00 p.m.

Conference room 2, Walsall Council.

Committee Members Present

Councillor K. Hussain (Chair)
Councillor V. Waters (Vice-Chair)
Councillor G. Clarke
Councillor S. Elson
Councillor R.K. Mehmi
Councillor K. Sears
Councillor A. Nawaz (substitute)

Portfolio Holder – Adult Social Care
Councillor K. Pedley

Officers

Walsall Council

K. Allward	Executive Director for Adult Social Care
T. Meadows	Interim Director of Commissioning
P. Stoddart	Lead Accountant – Adult Social Care & Public Health

Walsall Healthcare Trust and Wolverhampton Hospital Trust

D. Loughton	Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust

Black Country Healthcare NHS FT

M. Foster	Acting Chief Executive, Black Country Healthcare NHS FT

West Midlands Ambulance Service

V. Khashu	Strategy and Engagement Director

18/22 Apologies

Apologies were received from Councillors Rasab, Rattigan, Smith and Worrall.

19/22 Substitutions

Councillor Nawaz substituted for Councillor Worrall for the duration of the meeting.

20/22 Declarations of Interest and Party Whip

There were no declarations of interest or party whip.

21/22 Local Government (Access to Information) Act 1985 (as amended)

There were no agenda items requiring the exclusion of the public.

22/22 Minutes of the previous meeting

The minutes of the meeting that took place on 29 September 2022 were discussed.

Resolved

The minutes of the meeting held on 29 September 2022 were agreed as a true and accurate record subject to the minute numbers being added.

23/22 Emergency Access

The Chair invited the Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust to introduce the report.

The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust began by explaining that the national outlook for emergency care within the NHS was poor and that the average attendance at Walsall Manor Accident & Emergency (A&E) had gone from 7,000 to 8,000 patients per year. Furthermore, that the number of patients at Walsall Manor Hospital A&E being seen within four hours had fallen to 70% but this put the hospital within the top 25% of NHS Trusts within England.

Additionally, the transfer rates from ambulances to A&E and wards to social care were better in Walsall because of the partnership work through Walsall Together. The Chief Executive Walsall Healthcare Trust and Wolverhampton Hospital Trust also informed the Committee that the Hospital had employed 300 extra nurses and reduced its reliance on agency staff. Moreover, the new A&E being built would help to deliver further improvements. However, there were significant pressures building for the winter, such as flu, norovirus and covid increases. Finalising, the Chief Executive reiterated that the data should be seen through the lens of a worsening position for A&E departments across the Country.

The Chair then invited the Strategy and Engagement Director from West Midlands Ambulance Service (WMAS) to add to the report. The Strategy and Engagement Director for WMAS began by giving thanks to NHS staff in

Walsall and explained that from the view of WMAS Walsall Manor Hospital was the best in the region for ambulance handover performance. Also, one percent of patients were waiting for over one hour to admit patients to Walsall Manor Hospital, amongst the very best in the region whereas other hospitals in the region were close to 50% of patients waiting more than one hour

The Strategy and Engagement Director for WMAS explained to the Committee that WMAS had raised the national profile of Walsall NHS Trust due to the success of the transfer rates through the National Ambulance Leadership Forum.

The Strategy and Engagement Director clarified to the Committee that while figures for the service were getting worse overall due to increased pressure, relatively the Black Country was performing better than the other areas we serve (linked to handover performance). In addition, that the WMAS was conveying the same number of patients as it was five years ago but now had more alternative pathways in which to transfer patients.

In addition, within the West Midlands, the Black Country had the second lowest amount of lost handover delays. Furthermore, the area of the Black Country received the same amount of resourcing (ambulances) from WMAS as the Birmingham area.

For Category 1 callouts the WMAS average callout time for the Black Country was 6 minutes and 48 seconds and the target is 7 minutes. However, the figures were not as good for lower categories. Category 2 callout times for the Black Country averaged 22 minutes but the target was 18 minutes, but, as a trust the average was around an hour. Category 3 callouts averaged 2 hours and 30 minutes and the target is 60 minutes.

The Strategy and Engagement Director clarified to the Committee that while figures for the service were getting worse overall due to increased pressure, relatively the Black Country was performing well. In addition, that the WMAS was transferring as many patients as it was five years ago but now had more alternative pathways in which to transfer patients.

A Member asked whether it was possible to get a break down of the reasons why patients were seeking care from A&E and calling 999. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that it would be possible for that information to be provided to the Committee. The Members continued their questions by asking whether because residents were struggling to see GPs in person it was contributing to the pressure in A&E departments. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that the way in which patients accessed NHS health was different to way that they did before the Covid-19 pandemic. There was also worry amongst NHS leaders of the increase in the number of patients needing mental health support. There had been an increase in demand for mental health support and with the cost-of-living crisis this was expected to increase. The Acting Chief Executive of Black Country Healthcare NHS FT added that there had been an increase in

the amount of young people needing mental health care. Furthermore, there had been an increase in the number of patients presenting with eating disorders across all ages and that more patients with advanced dementia were presenting. Finally, the Acting Chief Executive of Black Country Healthcare NHS FT added that there had been an increase in the number of patients presenting with mental health issues that have had no previous contact with for mental health services.

The Strategy and Engagement Director for WMAS added that primary care was being accessed more than before the pandemic, with 30m appointments per month, a record, but there were fewer GPs than in 2015.

A Member asked what proportion of the Walsall Manor's budget was spent on A&E and whether this was going to be affected by budget cuts. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that GP services were under increasing pressure and the volume of patients being seen by GP's had increased. A Member had observed that patients attending A&E were being sent to the urgent care centre and weather this meant that patients should be encouraged to go to urgent care instead of presenting at A&E. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that it was not the policy of the trust to turn away patients from emergency care when they present instead it was better to see them when they presented rather than risk turning them away. Furthermore, it was probably more efficient for those patients to be seen at urgent care rather than sending them to other parts of the NHS.

The Strategy and Engagement Director for WMAS added that Walsall Manor Hospital's streaming of patients at emergency care was very good and that was why the wait times for transferring patients from ambulances in Walsall was low. Moreover, they agreed that the clinical risk of turning patients away that presented at emergency care was high and led to poor patient experience. In West Midlands Ambulance's opinion, it was more efficient to deal with a patient when they presented at emergency care, rather than assess patients, to only then turn them away

Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust added at the end of the discussion that there were no funding issues with emergency care at Walsall Manor Hospital and he did not foresee any funding issues in the future.

A Member asked whether the committee could be presented with the scripting the ambulance service used to identify the needs of callers and the way in which ambulances were dispatched. The Strategy and Engagement Director for WMAS informed the committee that all ambulance services have to follow set process called *NHS Pathways*. The process was used to determine the category of call out, if it was a category one or two call out an ambulance would be dispatched. Instead, if the call-out was categorised as category three or four then a paramedic at the call centre would contact the caller and determined the clinical needs of the patient, and to discuss other options if

possible. The Strategy and Engagement Director for WMAS also offered the Committee an invitation to the WMAS call centre to see the process first hand.

The Chair recalled a personal experience to the Committee and asked how the WMAS could be improved and if the number of incidents involving ambulance wait times had increased. The Strategy and Engagement Director for WMAS explained to the Committee that the given examples and experiences were less frequent two years ago as ambulance wait times were meeting their targets. Furthermore, that West Midlands ambulance service had been one of the most vocal services in the country regarding the pressures placed on the service and that it was one of the best resourced services in the country. The Strategy and Engagement Director for WMAS added that before the pandemic the average ambulance crew would see six to twelve patients per shift however now the average seen was two. Furthermore, the number of serious incidents that occurred two years ago was 84 for this year the number was heading towards over 400. These serious incidents included patient death and serious harm.

The Chair asked officers why the delays were occurring. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that delays were due to the slower transfer of patients out of the hospital and into social care. Because the hospital could not transfer patients out into the social care system it could not admit more patients as there was no spare capacity.

The Portfolio Holder for Adult Social Care added that while the report provided was detailed it did not contain much information about patient experience. In Walsall the patient experience measured through the *Friends and Family Test* was in the highest quartile in the region.

Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that most patients receive a good experience when seen at A&E but longer wait times didn't help with the overall patient experience.

A Member asked whether the reduction in the number of face-to-face appointments being offered by GP services were causing problems for emergency care. In response the Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust informed the committee that 60% of GP appointments were face-to-face in Wolverhampton however there were also a large number of nurse practitioners who could help manage the increased pressure on GP services. Furthermore, other healthcare professionals put also be used to help fill some of the gaps in GP provision, but the Committee should keep in mind that there was a national shortage of GPs.

In a follow up question, a Member asked why patients could no longer walk into a GP surgery to get face-to-face appointments. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that it was still possible for patients to get face-to-face appointments with GPs on the other hand they suggested that reform to the way appointments were allocated could it help improve the service.

The Chair asked whether access to emergency care would be affected in winter and how services would cope with increased winter pressures. The Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust responded that the trust had hired over 300 nurses and reduced reliance on agency staff however there was concern around the rise in new norovirus, flu, and COVID-19 cases. Despite this they believed that Walsall was performing well.

In response to a question from a Member of the Committee the Chief Executive of Walsall Healthcare Trust and Wolverhampton Hospital Trust explained to the committee that the current issues within the health service could not be laid at the feet of GP practises and a focus should be made on recruiting more GPs to help meet demand.

The Chair thanks NHS officers for attending the meeting and answering Members questions.

Resolved

- That NHS officers pass on the thanks of the Committee to hospital and ambulance staff.
- That officers organise for Committee Members to visit the WMAS call centre.
- That the Emergency Access report be noted.

24/22 Corporate Financial Performance – P5 August Financial Monitoring Position for 2022/23

The Chair invited the Lead Accountant for Adult Social Care & Public Health to introduce the report.

The Lead Accountant for Adult Social Care & Public Health highlighted the salient points to the committee. These included that at the end of August 2022 there was a predicted overspend of £2.36 million, of that just over £0.61 million was due to business-as-usual spending and £1.75 million was due to a shortfall in saving targets. The business as usual overspend was mainly attributable to the provision for bad client debt. Regarding the transformation plan, of the savings target of £13.6 million, as of end of August 2022 £6.6million of savings is currently projected to be achieved.

The Interim Director of Commissioning clarified for the Committee the term used in the report; *reduction in packages of care* did not mean a reduction in the care offered but meant that the delivery of the care had changed. The council was still providing care to the legal standard.

A Member asked for an update regarding the high category risk contained within table 4 of the report. The Executive Director for Adult Social Care

responded that the risk was refereeing to an historical agreement between the Clinical Commissioning Group (now the Integrated Care Board) to provide nonmedical care to residents. However, issues had arisen because the Integrated Care Board (ICB) needed to clinically validate the care it delivered before releasing funding. There had also been a issues with a tool both organisations used to determine the amount of care given and ICB no longer wanted to use the tool. The Section 151 Officers and the Director for Adult Social Care had written to their counterparts at the ICB to resolve the debt however if this was unsuccessful the Council would explore formal dispute resolution. Furthermore, the Council had a duty to provide care for example, section 117 care. But the joint working done between the Council and ICB there was no legal duty to carry out this care, but it was advantageous for both to continue with the joint working arrangements.

A Member asked why disability aides provided to residents were not recycled after their use but instead were scrapped, therefor, costing the Council more money. The Executive Director for Adult Social Care responded that the Council had one of the highest recycling rates in the country and the ICB performed this function for the Council and could provide a report to the Committee if needed. However, for some equipment it was not cost effective to recycle.

A Member asked what cuts the Council were making to the Adult Social Care. The Executive Director for Adult Social Care responded that no services had been cut but efficiencies had been made. The Lead Accountant for Adult Social Care & Public Health added that there had been some delay in delivering the efficiencies due to the pandemic, but income generation was also important for delivering savings.

A Member asked why there was a shortfall in the planned savings. The Lead Accountant for Adult Social Care & Public Health responded that the difference was due to the money received from national government for the pandemic. The Executive Director for Adult Social Care added that the Council were not seeking any further savings than the ones already planned. Furthermore, that the shortfall this year can be made up the following year and that nearly £7 million had been found already. The use of reserves had helped to mitigate the undelivered savings further.

The Portfolio Holder for Adult Social Care added that the overall experience for those receiving care would not change but would instead there would be different ways of working. Furthermore, that the use of technology would help to deliver these efficiencies. In addition, the social care sector was not an attractive place to work, and a focus on prevention was needed to help reduce future demand.

The Chair asked if Adult Social Care was prepared for the winter period and the increased pressure that this can bring. The Executive Director of Adult Social Care responded that the Social Care sector was struggling to recruit and retain staff due to better wages being offered in other sectors. In addition, in the view of the Executive Director the service was prepared as it could be

and the focus in the winter would be hospital discharge. The Interim Director for Commissioning added that adult social care experienced pressures throughout the year.

A discussion took place around the pay of carers and their working conditions. Members were concerned about the pay of carers and asked why pay could not increase for careers to help retain existing staff and recruit more staff. In addition, Members asked why more overseas careers had not been hired to help boost numbers.

The Executive Director for Adult Social Care responded that carers pay was a national issue and that an increase in pay would mean a significant rise in costs for Local Authorities. Furthermore, there was a lack of understanding from both residents and government on how the social care system worked. The Executive Director did not agree that an NHS led service would be better for residents as the approach could become too clinical and not care led.

The Executive Director for Adult Social Care also added that the Council did not employ careers directly and that the Council paid £15.80 per hour per person for domiciliary care. Furthermore, that the Council had undertaken a Fair Cost of Care exercise, and this had led to a 20% increase in the rate paid and that there was a built-in profit margin. In addition, due to Home Office rules it was not possible to recruit more careers from overseas. The Interim Director for Commissioning added that to compete with the likes of Amazon for wages it would involve a 30% increase in the cost of care. Additionally, that the gross profits for companies who provided domiciliary care was around five to eight percent.

A Member asked how the Council was supporting family Members who supported those with care needs. The Executive Director for Adult Social Care responded that this support was a key strand of the transformation plan and that this support will be built upon.

Resolved

That the Corporate Financial Performance – P5 August Financial Monitoring Position for 2022/23 be noted.

25/22 Recommendation Tracker

The Democratic Services Officer informed the Committee of the items added to the recommendation tracker and that these changes had been reflected in the work program.

Resolved

That the Recommendation Tracker be noted.

26/22 Areas of Focus

The Democratic Services Officer informed the Committee of the added items regarding the corporate finance monitoring and the budget scrutiny.

Resolved

That the Areas of Focus were agreed by the Committee.

27/22 Date of next meeting:

The next meeting of the Committee was scheduled to take place on the 29 November 2022.

Termination of Meeting

The meeting terminated at 19:58pm

Chair: .....

Date: .....