

Health Overview and Scrutiny Committee
17 April 2012, County Hall, Worcester – 2.00pm**Minutes****Present:**

Worcestershire County Council:
Mr A C Roberts (Chairman), Mrs M Bunker,
Mr A P Miller, Mr J W Parish, Mr T Spencer

Bromsgrove District Council: Dr B Cooper
Worcester City Council: Mr R Berry
Wyre Forest District Council: Mrs F M Oborski

Officer Support:
Suzanne O'Leary – Overview and Scrutiny Manager
Sandra Connolly – Overview and Scrutiny Officer

Available papers:

- A. The Agenda papers and appendices referred to therein (previously circulated);
- B. Presentation on the Acute Ophthalmology Service Pilot August 2011-April 2012 (previously circulated);
- C. Presentation on Salaried Dental Services (previously circulated);
- D. The minutes of the meeting held on 13 March 2012 (previously circulated).

A copy of documents A-C will be attached to the signed Minutes.

**Chairman's
Announcements**

The Chairman welcomed guests and members of the public in attendance.

**549. (Agenda item 1)
Apologies**

Apologies were received from Maurice Broomfield, Brandon Clayton, Jan Marriott, Penelope Morgan and Gerry O'Donnell.

**550. (Agenda item 2)
Declarations of
Interest and of
any Party Whip**

Roger Berry declared a personal interest in relation to agenda item 5 as a shadow member of the Worcestershire Health and Care NHS Trust and a personal interest in relation to agenda item 6 as his wife had made use of the Worcestershire emergency ophthalmology service.

Terry Spencer declared a personal interest in relation to agenda item 6 as both he and his wife used Worcestershire's ophthalmology services.

551. (Agenda item 3)

None.

Public Participation

552. (Agenda item 4) Confirmation of Minutes

The Minutes of the meeting held on 13 March 2012 were confirmed as a correct record and signed by the Chairman subject to the amendment of the final minute number on page 8 from 541 to 548.

553. (Agenda item 5) Worcestershire Health and Care NHS Trust Foundation Trust Application Pre-Consultation

Attending for this item from Worcestershire Health and Care NHS Trust were Robert Hipwell, Company Secretary and Alison Roberts, Foundation Trust Programme Manager.

Members were advised that it was Government policy that all NHS Trusts needed to apply for foundation trust (FT) status. Since the first authorisation of a foundation trust in 2004, 144 NHS trusts had now achieved FT status with 108 organisations yet to complete the application process. The Government had set a deadline of 2014 for all aspiring NHS trusts to achieve FT status or merge to become part of another foundation trust. When Worcestershire Health and Care Trust (the Trust) was established in July 2011, it had been required to sign an agreement with the Strategic Health Authority (SHA) and the Department of Health to become a foundation trust by summer 2013 so the Trust was now working to a defined trajectory and milestones. A key milestone was consulting the public on the Trust becoming a foundation trust and how the proposed FT's facilities could be best used to benefit patients and the community. There were 3 distinct phases of activity during the FT application and assessment process and the Trust was currently in the first of these, working with the SHA and going through a series of tests before progressing to the next phases of assessment by the Secretary of State and then by Monitor.

The Trust's paper appended to the agenda report outlined the Trust's proposals for its public consultation on its application for FT status and Members' views were sought on those proposals. The Trust intended to hold 6 public meetings, 1 in each of the County's districts and the public consultation would run May-August. The Trust also needed to ensure that it fully consulted staff.

Each FT needed to develop a public membership and therefore a membership strategy and a target number of members to be achieved. The Trust's aim was to have 5,500 members, 1% of the County's population. Anyone over the age of 14 years could be a member although the minimum age to be appointed to the Council of Governors would be 16 years. In addition to the public membership, there would also be a staff constituency. Staff would automatically be opted-in to this, as was common practice

nationally, unless they indicated otherwise.

The Trust proposed to have 14 public governors on its Council of Governors, 2 each from Bromsgrove, Malvern Hills, Redditch, Worcester and Wyre Forest and 3 from Wychavon to recognise the different population sizes. There would be 1 further governor to represent patients from outside the County's boundary. In addition to the 14 public governors, there would also be 8 staff governors and 4 stakeholder governors. Two of the stakeholder organisations had not yet been identified as the Trust was open to proposals as it worked with a large number of organisations. One of the stakeholder governors would be a local authority representative and this would be from Worcestershire County Council.

As part of its application, the Trust would be required to submit to the SHA a summary of its consultation process, the issues raised by the consultation and how the Trust had responded to those.

During the ensuing discussion, the following main points were raised:

- Members asked about the election process for public governors. It was explained that Worcestershire residents could nominate themselves as candidates. The election process would be through an arms-length organisation to ensure that it was completely independent. Candidates would issue personal statements and these would be the basis on which the electorate would vote and it was hoped that they would have plenty of candidates to choose from;
- it was noted that the Trust's predecessor organisation had previously started its application for FT status and it was questioned what had been learned from that experience. Members were advised that there had in fact been no let-up in the FT application process since it had started in 2004 and that there had actually been more activity recently, possibly following events in Mid-Staffordshire. It was noted that the FT application process was very demanding and the Trust was working hard to engage the public, highlighting that NHS trusts effectively belonged to the public as tax payers and they were encouraged to get involved. Members could be as passive or as active as they wished depending on their level of interest;
- Another lesson learned was to ensure that the Foundation Trust was of a reasonable size. The Trust's priorities were quality, safety and financial sustainability. The Trust was aiming to avoid repeat applications as it was a very wearing process.

- Members were advised that the Council of Governors was responsible for overseeing the Board's non-executive directors (NEDs) and would also be consulted on the Trust's annual reports and accounts. Whilst governors would also have the power to remove the chairman and NEDs, such a step would demonstrate that there were clearly problems within an organisation. The relationship between governors and the electorate was very important and thought would need to be given to how best to support governors in their role, particularly as over time there would be more and more focus on governors and their oversight of FTs;
- it was queried whether the proposed size of the Council of Governors might be too large. Members were advised that there had been much discussion nationally about the size of the councils and lessons had been learned from the early FTs and their 40-50 strong councils of governors. In determining the size of the Trust's proposed Council of Governors, it was felt appropriate that each of the County's 6 unique districts needed to be represented. It had also been agreed that the patient voice was what was fundamentally important as well as that of staff and the stakeholder representation had therefore been taken down to 4;
- it was noted that the actual costing of the process and establishment of the FT would be good to see for transparency;
- concern was expressed that even if the Health Overview and Scrutiny Committee's (HOSC) response to the public consultation on the Trust's FT application was not favourable, it would make no difference. Members were advised that it was an inherent challenge in the process that whilst consulting, it was Government policy that NHS trusts had to become FTs. However, it was highlighted that during the consultation on how the proposed FT would operate and its proposed Council of Governors, if there were concerns and alternative views and suggestions were offered, the Trust would listen and consider all constructive critiques;
- whilst the Trust was to be applauded for encouraging the participation of young people, it was suggested that although some 14 year olds were more mature than others, there could be concern about how they would deal with the complexities of issues. Members were advised that the age of 14 years had been chosen because some of the Trust's services did interact with children and adolescents. The Trust was conscious

that it needed to encourage the interest of young people in the Trust and reiterated that Governors would need to be at least 16 years old. Members highlighted that young people were under a lot of pressure around this age, for example with GCSE selections, and it was suggested that whilst a few year 8-9 pupils were very bright, most would still be considered children with not many being as mature as the Trust would need and that in making information accessible to 14 year olds the Trust would need to be aware of accusations of dumbing-down;

- in response to a question about whether the Trust anticipated any problems with its business plan, Members were advised that the Trust had to develop a robust integrated business plan and long-term financial model and if it did not, it would not progress through the FT process;
- it was noted that NEDs were currently appointed by the national Appointments Commission and in the proposed FT would be appointed by the Council of Governors, through a nominations committee, and that NEDs were remunerated. It was confirmed that NED vacancies were already and would continue to be advertised;
- it was suggested that some of the questions the Trust proposed to include in its consultation document might cause confusion to some of the public, but it was recognised that the Trust was obliged to include them;
- it was questioned how the Trust intended to engage with the minority ethnic groups in Worcestershire which included Polish, Bangladeshi and Pakistani populations, etc. Members were advised that the Trust employed staff who were familiar with a number of these groups across the County and was aware that it needed to try very hard to engage them and produce material which would be accessible. It was suggested that it would be necessary to produce information in alternative language formats;
- further to discussions about the minimum age of the proposed FT membership, it was highlighted that many young people were very bright and those who were interested would come forward to be involved in the Trust if given the opportunity and the Trust was encouraged to engage with schools as there was support amongst the HOSC membership for the proposed 14 year minimum age.

The Chairman thanked all guests for their attendance.

**554. (Agenda item 6)
Worcestershire's
Emergency
Ophthalmology
Service**

Attending for this item were Chris Emerson, Deputy Director – Delivery, NHS Worcestershire and from Worcestershire Acute Hospitals NHS Trust were Dr Graham James, Consultant Oral and Maxillofacial Surgeon and Clinical Director Head and Neck, Ophthalmology and Dermatology and Jo Tomlinson, General Manager - Head & Neck/Ophthalmology/Dermatology.

Members of the Health Overview and Scrutiny Committee received a presentation outlining the background to the service pilot, the service configuration, the evaluation of the pilot to-date, evaluation criteria and points for further consideration.

Members were advised that, prior to the pilot, the service had been experiencing difficulties recruiting substantive members of the team and had needed to employ locums. This had impacted on service quality and clinical risk with one locum needing to leave the Trust promptly shortly before the new service model was piloted. It was also identified that there were huge over-capacity issues resulting from the delivery of the service on 3 sites. The Trust had considered that it needed to make a decision about future service provision based on the clinical risks identified and discussed the service with clinicians and commissioners and agreed a change would be necessary. The options were to either stop providing the service in-county or to concentrate the in-county service on a single site.

Whereas the service had previously been provided in Worcester, Redditch and Kidderminster, under the pilot it was now provided only in Kidderminster. The location had been selected based on facilities and capacity. Under the pilot there had been no change in the hours of service provision and the out of hours service continued to be provided by Birmingham Midland Eye Centre (BMEC) as it was under the 3-site model. Rather than being delivered primarily by agency locum staff, under the pilot the service was now led by one of the Trust's own doctors and by consolidating the service it had been possible to reduce the number of sessions each week from 27 to 15. All referrals now went through a single point of access and were dealt with consistently and through a common pathway. It was also highlighted that under the previous model, patients were not necessarily seen locally, but rather at the site where there was capacity.

In evaluating the pilot, 2 patient surveys had been undertaken in November and February with 100 questionnaires offered to patients randomly which provided a 50% response rate. Patients were asked questions about referral pathways, travelling, parking, information provision,

signage, care provided and the department overall. Analysis of the surveys showed that the main referrers to the service were GPs, that 86% of patients travelled less than 20 miles to the service, that 97% of patients were either satisfied or very satisfied with the service, that the referral system worked well and overall care was considered either excellent or good.

GPs were also surveyed a few weeks prior to the meeting so that there had been time for the service to have bedded-in. Whilst the pilot would not end until the end of April, initial analysis of the GP survey showed scores out of 5, with 5 being extremely satisfied, were most commonly 3 or 4 and so there appeared to be a general satisfaction amongst GPs with the pilot service. GPs had also provided comments on the service and there had been both positive and negative comments.

NHS Worcestershire, the service commissioner, had provided a number of evaluation criteria to be applied covering attendance levels, inappropriate referrals, numbers of patients the service could not treat, onward referrals to BMEC, locum-led sessions, cancelled appointments and clinics, complaints, patient and GP feedback, serious untoward incidents and safety and quality concerns. The pilot had seen a 21% reduction in new patient numbers compared against the same period in the previous year. This was considered to be as a result of an increased provision of advice to GPs by telephone to enable them to manage patients in the GP surgery which was considered better both for the patient and the GP. The need for the service to follow-up had also reduced significantly with follow-up under the pilot being undertaken in the appropriate clinics, near to patients' homes, rather than by the emergency service. Overall the pilot had seen a 45% reduction in attendance so whilst some patients had needed to travel further to the service, the number of people attending the service was a lot less.

There had been a number of patients who could not be treated by the pilot service and had been referred on to BMEC, but these needed super-specialist services and would have been referred on under the previous model too. Whilst a number of sessions had been delivered by locums during the pilot, this had only been for 7.6% of sessions and those sessions had had the support and supervision of the team's substantive doctors. No one worked unsupervised or in isolation under the pilot model. During the pilot to-date there had been no complaints, serious untoward incidents or safety/quality concerns.

Taking the pilot forward, questions in the patient survey had been refined as had the evaluation criteria. Consideration was being given to suggestions made about extending the

service's hours towards the evenings, recognising that patients were travelling from across the County. Further revisions would be considered under the Joint Services Review (JSR) which would need to consider the service's location as the potential location of other services was also reviewed.

The pilot service had had no risks identified, no complaints or serious incidents and offered improved governance, 97% patient satisfaction, some concerns about travel from GPs rather than patients and there had been a significant reduction in the number of attendances. Further consideration would be given to the service's location and improved evaluation would remain on-going. It was proposed to extend the pilot to address transport issues through the JSR process which would see services being delivered differently and was an ideal opportunity to look at transport issues. Transport issues were included within the patient survey of the service.

Worcestershire Local Involvement Network (LINK) had undertaken an unannounced visit to the service and had found a warm and friendly atmosphere which patients commented on and really appreciated. The only adverse comments received from patients related to car parking and transport with one patient having to have paid £22 to a community transport scheme. A plea was made for reasonable transport provision for patients to access health services.

Patients returning to the service for checks and follow-ups were also met. They were very positive about the service and full of praise for it and for the staff.

Worcestershire LINK had made a number of recommendations but none of these were very major other than the parking and transport issues.

During the ensuing discussion, the following main points were raised:

- it was queried whether there was any way that an approximate length of appointment time could be given to help patients in determining how many hours of car parking they needed when parking at Kidderminster. Members were advised that the LINK had spoken about this issue with Worcestershire Acute Hospitals NHS Trust's Chairman and previous and current Chief Executives, highlighting that if a clinic was over-running, patients had to go out of the hospital to buy more parking time in £3 chunks. The LINK intended to follow-up this issue with the Trust;

- concern was expressed that attending an appointment at Kidderminster Hospital could be a confusing experience and the LINK's report had commented on a patient's experience where the number of notices had caused problems. Members were advised that the notices had been an issue for a partially-sighted patient and having been brought to the attention of the clinic, the notices had been tidied up. The LINK recognised that patients attending at Kidderminster were often not sure whether to book in at the ground floor reception or go straight up to the relevant clinic and this was something the Trust ought to be able to clarify in letters to patients;
- a Councillor with experience of the service at various locations throughout the County, supported the principle of it being brought together under 1 roof. However, the Councillor's experience at the Kidderminster Treatment Centre had been that it was a disaster in terms of car parking, checking-in, clinics over-running, waiting areas being over-run with patients and their families and patients finally being seen by a locum with no clue about what was going on. Members were advised that today's discussion related only to acute ophthalmology services and the pilot was to address the problems experienced as a result of the use of locums. The whole ophthalmology service was under review as part of the JSR and there was an emerging view that the whole service might be better delivered from a single site as providing a service from multiple sites made it more difficult to organise services and deliver them efficiently. The changes made under the pilot service had demonstrated many positives and there was no reason why the same benefits would not be seen by bringing the whole service into a single location;
- the Chairman advised Members that today's discussion was to consider the Acute Trust's pilot emergency ophthalmology service. Members would subsequently be able to contribute to the JSR and the possible decision to centralise all ophthalmology services as well as the potential location. It was questioned why the review of acute ophthalmology had not waited for the JSR process. Members were advised that the Trust had been very conscious of the complaints about the service and had not been able to ignore the concerns of staff once they had been raised. Members were advised that the concerns about locums had related to those at mid-grades and the Trust was confident it would be able to recruit sufficient to maintain the service;
- a view was expressed that supported the pilot model, although recognised that the location may be

contentious. However, another view was expressed that changes in services often appeared to mean moving towards centralisation and were often due to safety or staffing issues and there was concern that this was the face of things to come and people could expect to see highly centralised services in the future;

- It was understood that under the pilot service, Worcester's patients were now having to spend half a day on a Kidderminster appointment rather than a couple of hours when the service was also available in Worcester. As a significant number of the service's patients were elderly and travelling was a major problem for them, it was suggested that there would need to be very good justification for centralising services. Also the location of the service would be key and it was highlighted that Kidderminster was at one end of the County and not central. Worcester's residents who had previously had a dedicated eye hospital were now having to travel to Kidderminster for emergency ophthalmology services and there was concern about what might happen to other services as a result of the JSR. Members were advised that GP feedback had also shown concern about the location and in future each Clinical Commissioning Group would be concerned about the location of services for its own population. It was important that the service and its location was added into the JSR rather than looking at this acute service in isolation and transport links would be key if services were to be more centralised. Members were also assured that additional questions had been added to the patient survey to gather data about difficulties attending appointments and patient satisfaction with the treatment received. Members welcomed this as it would provide more data on the patient experience;
- it was highlighted that rather than talking about "centralising" services, it was more appropriate to discuss "concentrating" services;
- it was also highlighted that the service at Kidderminster was still a local service when the alternative option had been to stop the service and have all provision out-of-county and despite the need for some patients to travel further, it remained local. The safety and quality issues of services should not be under-estimated and a single site for the acute ophthalmology service had been the only way to deliver a high quality service. It was highlighted that this same point had been used historically about services in Kidderminster and there remained cynicism about this argument in Worcestershire;

- concern was expressed that in the current economic climate and with the JSR's parameters it would not be possible to achieve the necessary financial savings and maintain services on all of the Acute Trust's sites and there had to be a concentration of the Trust's services. Members were advised that it was important to bring together expertise and for commissioners to work with other service providers on local delivery;
- there was support for the suggestion that the acute ophthalmology service's operating hours should be extended. It was considered that closing at 5pm was too early and this should be extended to 8pm so that most people with even a late appointment with a GP would be able to travel to Kidderminster on the same day if necessary. Members were advised that part of the evaluation of the pilot to-date was a key recommendation that the service should coincide with GP hours. It was highlighted that if the service was provided on 3 sites it would be impossible to extend the service's hours. Consideration of the extension of the service's hours was the next step and such discussions were not confined to this service and the culture within the NHS was changing with some services possibly operating 7 days a week in the future;
- it was suggested that whatever emerged from the JSR, there would be a need to look at transport in Worcestershire;
- it was questioned whether the 45% reduction in patients attending the acute ophthalmology service was all due to the new model of providing telephone advice to GPs or whether some GPs were referring their patients to other service providers, for example in Cheltenham. It was also questioned how outcomes were being measured as there was concern that telephone advice might end up not being the best for a patient and whilst the patient surveys conducted had gathered views about the service provided in Kidderminster, how were views of those not attending Kidderminster being captured? Members were assured that whilst activity in the acute ophthalmology service had reduced, the total activity levels delivered had not changed and since the pilot, patients were now signposted to the appropriate services, going straight to the relevant sub-specialty area. As the evaluation of the pilot was not yet complete, commissioners had not looked at the number of patients now accessing a service out-of-County but would look to see if there had been any change in this number. Members were also assured that it was recognised that it was critical to consider patient outcomes in evaluating the service; and

- on behalf of the Vice-Chairman who had been unable to attend this meeting, the Chairman queried the option of commissioners using out-of-county providers to provide the service for Worcestershire, for example, neighbouring trusts in Birmingham and Gloucester. Members were advised that out of hours and highly specialised ophthalmology services were provided by Birmingham and traditionally patients from the south of the County often attended services in Cheltenham. Commissioners would really need to analyse the data to see if referral patterns were changing due to a reluctance to travel to Kidderminster.

The Chairman highlighted that the discussion about acute ophthalmology services was a prelude to the forthcoming JSR and his personal preference was for excellent centralised services, rather than inferior local ones and that patients essentially wanted good treatment. The concerns about this service's opening hours and the possibility of them being extended had been noted. Transport and parking issues remained outstanding and it was noted that they kept getting raised yet nothing appeared to happen and a patient being charged over £20 for community transport to attend a hospital appointment was extraordinary. It was also noted that there was a high level of patient satisfaction and that this had been corroborated by the LINK's work for which the HOSC was very grateful.

The Chairman thanked all guests for their attendance.

555. (Agenda item 7) Salaried Dental Services

Attending for this item were Nigel Crew, Dental Commissioning Manager, NHS Worcestershire and from Worcestershire Health and Care NHS Trust, Alan McMichael, Consultant in Dental Public Health, Finbarr Costigan, Clinical Director, Salaried Dental Services, Rod Smith, Assistant Clinical Director, Salaried Dental Services and Lorna Hollingsworth, Assistant Clinical Director, Salaried Dental Services.

Members of the Health Overview and Scrutiny Committee received a presentation outlining the dental market, access to NHS dentistry, patient satisfaction, salaried dental services, the commissioning vision, milestones for the dental anxiety management service, key messages and the estates review.

Members were advised that a lot of progress had been made in increasing access to NHS dentists and that whilst there was still a perception that it was not possible to get an NHS dentist, this was untrue. Roadshows had been held and visits to schools undertaken and bit by bit, perceptions were starting to change and this was also being evidenced

in attendance data.

To increase supply, £1.4 million had been invested in additional dental capacity in Worcestershire since 2010 which was showing up to an additional 25,000 patients now being treated. Risk-based re-attendance had also increased capacity, with patients being seen between 3 months to 2 years on a patient-need basis. Additionally, an incentive payment was now included in dental contracts. Practices could be accredited as child-friendly, for example with good access and baby-changing areas and reception staff had also been able to undertake customer care training and there had also been advanced dental nurse training.

The trajectory of patients accessing dental services continued to increase and since dental access centres (DACs) were established 10 years ago, the dental supply had changed and commissioners and providers were looking at restructuring this service to better fit and support other services. Patient surveys undertaken by the Dental Practice Board showed that patient satisfaction with services in Worcestershire was high at 96%.

Under salaried dental services (SDS), there had been community clinics providing dental services in a number of locations and more recently, 10 years ago, DACs were established in response to a shortage at that time of NHS dentists. This situation had improved and also continued to do so. SDS accounted for 5% of dental activity in the County. Between September and December a patient survey had been undertaken at the DACs and a key finding had been that the Malvern Hills and Tenbury DACs operated in a different way to the other 3. The broad commissioning vision for SDS highlighted the desire of the service to complement general dentistry rather than be an alternative to it, focussing on client-groups more suited to a specialist service than general dentistry. SDS was the primary provider of out of hours dental services and aimed to focus on increasing the complexity mix of the service's patient portfolio, dental anxiety management and referral-based services. SDS was trying to move from the provision of routine care to the provision of care for those individuals who would always have difficulty receiving dental care. There was no intention to reduce the service's budget but to increase the focus on the service's areas of expertise.

A number of key milestones were outlined for the dental anxiety management service (DAMS) including referral guidelines, an IV sedation pilot and limited service, a cognitive behavioural therapy pilot run by SDS dental nurses and a full service specification for the DAMS. A working group had been established to define the categories the DAMS would work with and to ensure that

any gaps between categories were minimised.

Walk-in access was a well-liked aspect of SDS as demonstrated in the patient surveys and some sites might need to be extended and opening hours were also being reviewed. When possible, patients would be referred back to general dentistry via a patient incentive scheme.

Worcestershire Health and Care NHS Trust was undertaking an estates review and the SDS hoped to increase its usage of domiciliary and mobile care. The review also aimed to reduce duplication, with for example, 2 sites each in Evesham and Kidderminster and 3 in Worcester. The review aimed to ensure equitable access across the County and the HOSC would be consulted further when there were definitive proposals.

A lot of work had been done on the proposed changes with the dental community and they were very supportive and also with the Local Dental Committee.

During the ensuing discussion, the following main points were raised:

- it was confirmed that whilst both the DACs in Tenbury and Malvern operated differently to the other DACs in the County, only the DAC in Tenbury was being proposed for closure;
- it was noted that given the population, there was relatively high usage of the Kidderminster DAC;
- whilst Members were advised that plenty of NHS dentists were actively looking for patients, in Kidderminster there was only visible advertising by a dentist based in Kingswinford and it was suggested that it would be helpful for Councillors to know which NHS dental practices had vacancies. Members were advised that there was an interactive map on the internet where practices with vacancies could be found. Additionally, a mailshot had been sent to all households about NHS dental services;
- it was highlighted that many people, particularly those with an element of dental phobia, would have remained with their dentist if the dentist had left the NHS and it would be difficult for those patients to transfer to a new NHS dentist and have to start to develop a new relationship again. Members were advised that it was estimated that approximately 10% of the population were not registered with a dentist and it was likely that a significant number of those had a dental phobia;

- it was queried how phobic patients would access specialist services. Members were advised that the normal referral route to specialist services was via a general dentist but could also be through a patient's GP or another health specialist. Once the specialist service was firmly established, there could be capacity to enable the option of self-referral;
- it was noted that there would be some people who did not want to change their practice of accessing DACs and register with a dentist. Members were advised that networks would be set up with each DAC to ensure there were very clear ways for patients to register with one of at least 2 available dental practices;
- in response to a question about the frequency of dental check-ups, Members were advised that since 2004, NICE guidance was that dentists should schedule check-ups based on individual patient need, with, for example, patients who were drinkers or smokers and were at high risk of cancer, being seen 6 monthly or more frequently;
- concern was expressed that some older people would have had their dentures for up to 50 years without being replaced and this was questioned. Members were advised that there had historically been an inertia regarding dentures with a perception that once someone's teeth had all gone, they no longer needed to see a dentist. It was now recognised that this was short-sighted as dentures wear out. In Worcestershire there had been a new innovation to visit care homes in the County to treat the more vulnerable patients and find those people who had simply continued to struggle on. It was important that people with dentures remained in regular contact with a dentist;
- it was confirmed that DACS did not develop an ongoing relationship with people who presented there and did not undertake check-ups and recalls and this was another reason people needed to register with a general dentist and maintain regular attendance;
- Members were advised that much work had been done with the homeless population as they were a group who had historically been poorly looked after. A lot accessed the Worcester DAC on a casual basis. Work was ongoing to build a rapport with the homeless and the hope was to increase attendance levels, possibly with the use of a mobile unit to take the service to homeless hostels;
- it was noted that nationally there were only 200 specialist dentists registered with the Dental Council

**556. (Agenda item 8)
Health Overview
and Scrutiny
Committee
Round-up**

and not all of these would be full time equivalents. It was the newest specialism, having been established in 2009 and being so new there was not much data available. Many of those previously resident at Lea Castle were now patients of this new service;

- it was confirmed that specialist dental services would see more patients being treated in-County. Patients with profound learning difficulties who could only access dental treatment under anaesthetic could be treated at a monthly clinic in Kidderminster. Others with a less profound disability who could receive treatment like the majority of the population tended to attend wherever Lorna Hollingsworth, as the County's specialist dentist, was working. The aim was to establish a specialist team to widen access across the County and it was believed that the necessary expertise existed within the County already, although some training would be needed. Members were advised that some patients would continue to need specialist treatment in Birmingham and that specialist care was all about shared care;
- in response to a question about public health dentistry, given the transfer of public health to local authorities in 2013, Members were advised that Alan McMichael, as the County's Consultant in Dental Public Health, was currently part of Richard Harling's public health team, but under the future model would be part of Public Health England, along with all other public health dentists.

The Chairman advised that HOSC Members were comfortable with the changes being proposed and welcomed the success achieved to-date in increasing access to NHS dentists. The Chairman thanked all guests for their attendance.

The Chairman updated Members on issues he had been involved in since the last meeting:

- the Chairman had met informally with Sarah Dugan, Chief Executive, Worcestershire Health and Care NHS Trust and been updated on a number of matters;
- the Chairman had met informally with Harry Turner, Chairman, Worcestershire Acute Hospitals NHS Trust who had advised that the Trust had been hurt by recent comments by a Member of the HOSC reported in the media, and had highlighted the importance of the Trust being successful in its bid for foundation trust status. The HOSC Chairman had advised the Trust Chairman that if Members talk to the media they did so as an

individual Councillor and not as a representative of the HOSC. The HOSC Chairman advised Members that it was for their own judgement how they spoke about the Trust.

Cllr Oborski advised that it was her comments which had upset the Trust. Cllr Oborski was concerned that the Trust had needed to borrow £21 million from the Department of Health yet was still failing in terms of employing locums and agency nurses and considered that the HOSC was entitled to an explanation of how the Trust had got into this financial situation. Cllr Oborski's concern was compounded by the Trust's imminent JSR consultation which needed to achieve significant savings and the picture did not balance at the moment and the Trust should be invited to the HOSC to explain the need to borrow £21 million, why locum costs were rocketing and how the Trust could expect to achieve sufficient savings through the JSR.

The Chairman acknowledged the need for Members to be objective and considered the concerns outlined to be objective. Members were urged to request that issues were included on future HOSC agenda if they had concerns rather than having trial by newspaper or Members acting under misinformation.

Cllr Oborski suggested that the financial issues facing the Trust were discussed at the Trust's most recent Board and these papers should be put to the HOSC with the Trust invited to explain how the situation had arisen and how the Trust proposed to deal with it.

Ongoing issues around the County were discussed:

- in Bromsgrove, a new Health and Wellbeing portfolio was to be established with the relevant cabinet member having responsibility for all health and wellbeing issues in the District;
- in Wyre Forest, the main focus was the forthcoming local election. Following a national campaign about the global shortage of helium which was being linked to the excessive use of helium balloons, a local campaign group had now been established. The shortage had already impacted nationally with MRI scans postponed and a research project in Oxford delayed; and
- in Worcester, the possibility of a new swimming pool was being considered and the main focus at the moment was the forthcoming local election.

Members were advised that issues to be discussed at the next meeting would include:

- the emerging options from the Joint Services Review;
- Quality Accounts, with lead Members having informal pre-meetings with the relevant Trust;
- Acute stroke services.

Issues to be discussed at future meetings included:

- Worcestershire Health and Care NHS Trust's integrated business plan;
- Health and Wellbeing Board priorities and Joint Strategic Needs Assessment;
- Worcestershire Health and Care NHS Trust's application for foundation trust status – HOSC response to consultation;
- Joint Services Review – HOSC response to consultation;
- Cardiac rehabilitation services scrutiny;
- Lessons from the Mid-Staffordshire inquiry. Cllr Bunker had recently attended a meeting where the lead campaigner from Mid-Staffordshire was present. There would be lots of lessons from the inquiry and there had been criticism of the local HOSC and councillors.

The meeting ended at 4.15pm.

Chairman