Worcestershire County Council

Agenda

Health Overview and Scrutiny Committee

Wednesday, 9 March 2022, 10.00 am
County Hall, Worcester

All County Councillors are invited to attend and participate

This document can be provided in alternative formats such as Large Print, an audio recording or Braille; it can also be emailed as a Microsoft Word attachment. Please contact Scrutiny on telephone number 01905 844965 or by emailing scrutiny@worcestershire.gov.uk

DISCLOSING INTERESTS

There are now 2 types of interests:
'Disclosable pecuniary interests' and 'other disclosable interests'

WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

NB Your DPIs include the interests of your spouse/partner as well as you

WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

NB It is a criminal offence to participate in matters in which you have a DPI

WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Simon Mallinson Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

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Health Overview and Scrutiny Committee
Wednesday, 9 March 2022, 10.00 am, County Hall

Membership

Worcestershire County Council	Cllr Brandon Clayton (Chairman), Cllr Salman Akbar, Cllr David Chambers, Cllr Lynn Denham, Cllr Adrian Kriss, Cllr Natalie McVey, Cllr Jo Monk, Cllr Chris Rogers and Cllr Kit Taylor
District Councils	Cllr Sue Baxter, Bromsgrove District Council Cllr Mike Chalk, Redditch District Council Cllr Calne Edginton-White, Wyre Forest District Council Cllr Mike Johnson, Worcester City Council Cllr John Gallagher, Malvern Hills District Council Cllr Frances Smith, Wychavon District Council (Vice Chairman)

Agenda

Item No	Subject	Page No
1	**Apologies and Welcome**	
2	**Declarations of Interest and of any Party Whip**	
3	**Public Participation** Members of the public wishing to take part should notify the Assistant Director for Legal and Governance in writing or by email indicating the nature and content of their proposed participation no later than 9am on the working day before the meeting (in this case 8 March 2022). Enquiries can be made through the telephone number/email listed in this agenda and on the website.	
4	**Confirmation of the Minutes of the Previous Meeting** (previously circulated)	
5	**Scrutiny Task Group Report on Ambulance Hospital Handover Delays** (indicative timing: 10:05am – 11am)	1 - 18
6	**Update on the Public Health Ring Fenced Grant 2022/23** (indicative timing: 11am – 11:20am)	19 - 24
7	**Dental Services Access and Oral Health Promotion** (indicative timing: 11:20am – 12:20pm)	25 - 50
8	**Work Programme** (indicative timing: 12:20pm – 12:30pm)	51 - 56

Agenda produced and published by the Assistant Director for Legal and Governance, County Hall, Spetchley Road, Worcester WR5 2NP. To obtain further information or hard copies of this agenda, please contact Emma James/Jo Weston 01905 844965,email: scrutiny@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's Website

Date of Issue: Tuesday, 1 March 2022

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
9 MARCH 2022

SCRUTINY TASK GROUP REPORT ON AMBULANCE HOSPITAL HANDOVER DELAYS

Summary

1. The Health Overview and Scrutiny Committee (HOSC) is to consider and approve the draft Scrutiny Task Group Report on Ambulance Hospital Handover Delays, and future monitoring of improvements/the issues involved.

2. This scrutiny was carried out on 18 November 2021 by a Task Group of HOSC Members, who met with representatives from West Midlands Ambulance Service University NHS Foundation Trust (WMAS), Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust, NHS Herefordshire and Worcestershire Clinical Commissioning Group and Worcestershire County Council

3. Representatives from the above organisations have been invited to attend the meeting to provide initial feedback on progress to date on ambulance hospital handover delays and urgent care pressures, as well as feedback on the Scrutiny Task Group's recommendations.

Reasons for the Scrutiny

4. Ambulance hospital handover delays at Worcestershire hospitals was identified as an area for further scrutiny following the attendance of Ambulance Service representatives at a meeting of the Committee in October 2021. The HOSC agreed to look further into the issue of significant ongoing ambulance handover delays to gain a better understanding of the situation and in view of escalating concerns in Worcestershire but also nationally.

5. It was agreed that a Task Group (not in public) of the Committee would be appropriate with system partners around the table, so that Councillors could understand the complexities of the issue from each organisation involved, gather evidence and ultimately report back to partners.

6. The draft Report at Appendix 1 encapsulates the findings and outcomes of that discussion.

Outcomes

7. The scrutiny discussion looked at the problems involved, what was being done to improve the situation and what more was needed. The main areas of the discussion with health and social care partners were around patient flow, the challenge of preventing people coming into the Emergency Department who did not require emergency care but alternative pathways, timely discharge of medically fit patients

from acute hospital settings, assessments being completed in a community (rather than an acute hospital) setting, and workforce pressures.

8. The Report recommends an update to the HOSC in May 2022, and makes a number of recommendations concerning:

- Discharge of medically fit patients by 10am
- Further resources to facilitate patient discharge
- Signposting to appropriate services from the Emergency Department Front door
- Patient assessments
- Monitoring the impact of the 2-hour Community Response Service on Ambulance Handovers
- Monitoring the fragility of the care sector Workforce
- Continuous learning from best practice and what is working elsewhere
- Healthwatch Worcestershire work on urgent care and the Emergency Department
- Education awareness relating to the night-time economy.

Purpose of the Meeting

9. HOSC Members are invited to consider, comment and approve the draft scrutiny report before it is submitted to the Overview and Scrutiny Performance Board on 23 March 2022 for discussion (and subsequently to the Cabinet on 24 March), and agree:

- whether any further information or scrutiny work is required at this time
- arrangements and frequency of future monitoring of the pressures on urgent care including ambulance hospital handover delays
- whether there are any comments to highlight to the relevant Health Partners or the Council's relevant Cabinet Member with Responsibility.

Supporting Information

- Appendix 1 – Draft Scrutiny Task Group Report: Ambulance Hospital Handover Delays

Contact Points

Emma James / Jo Weston, Overview and Scrutiny Officers, Tel: 01905 844964 / 844965
Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance) the following are the background papers relating to the subject matter of this report:

- Agenda and Minutes of the Health Overview and Scrutiny Committee on 18 October 2021, 27 June 2019, 14 March 2018 and 11 January 2017

All Papers are available on the Council's website: Weblink to all agendas and minutes

Health Overview and Scrutiny Committee Task Group

Ambulance Hospital Handover Delays Scrutiny Report (November 2021)

Health Overview and Scrutiny Committee Members:

Brandon Clayton (Chairman), Frances Smith (Vice-Chairman), Sue Baxter, Mike Chalk, David Chambers, Calne-Edginton-White, John Gallagher, Mike Johnson, Adrian Kriss, Natalie McVey, Chris Rogers

West Midlands Ambulance Service University NHS Foundation Trust
Mark Docherty, Executive Director of Nursing and Clinical Commissioning
Vivek Khashu, Strategy and Engagement Director

Worcestershire Acute Hospitals NHS Trust
Paul Brennan, Chief Operating Officer and Deputy Chief Executive
Dr Jules Walton, Medical Director for Urgent Care

Herefordshire and Worcestershire Health and Care NHS Trust
Rob Cunningham, Associate Director Integrated Community Services
Sue Harris, Director of Strategy and Partnerships

NHS Herefordshire and Worcestershire Clinical Commissioning Group
Mari Gay, Managing Director and Lead Executive for Quality and Performance

Worcestershire County Council
Rebecca Wassell, Assistant Director for Commissioning

Overview and Scrutiny Officers:

Samantha Morris (Scrutiny Co-ordinator) and Emma James (Scrutiny Officer)

The Reasons for the Review

1. Ambulance handover delays at Worcestershire hospitals was identified as an area for further scrutiny following the attendance of Ambulance Service representatives at a meeting of the Council's Health Overview and Scrutiny Committee (HOSC) in October 2021. Representatives from West Midlands Ambulance Service University NHS Foundation Trust (The Ambulance Service) highlighted hospital handover delays as a serious concern to the HOSC, and in particular the regular and significant delays at Worcestershire Royal Hospital.

2. The HOSC agreed to look further into the issue of ambulance handovers to gain a better understanding of the situation and in view of escalating concerns in Worcestershire but also nationally.

3. It was also agreed that a Task Group (not in public) approach would be appropriate with system partners around the table, so that councillors could understand the complexities of the issue from each organisation involved, gather evidence and ultimately report back to partners. Representatives were invited

from across the local health and social care sector and this report encapsulates the findings and outcomes of that discussion.

4. Key lines of enquiry for the Task Group were to understand the main reasons for the delays in handing over patients to the two Worcestershire Acute Hospitals, the impact of the delays on all related services, the impact on patient safety, escalation processes, the process for declaring a critical incident and how the system is working together to improve and maintain the situation, and any barriers.

The Problems

Ambulance Handover Delays

5. The Ambulance Service representatives pointed out that problems in urgent and emergency care were ongoing and not just a problem this year; a number of other things had changed and ambulance handovers were just part of the jigsaw. Covid-19 was a factor which had expediated the current handover problems, however the Ambulance Service representatives believed the same situation would have arisen, albeit at a later date. Pressure from Covid patients on Ambulance Services was gauged to be 11% of activity and the biggest risk moving forward was around booster take-up. Until recently, handovers in the West Midlands region were twice the problem of the East Midlands region, and worse than the rest of the country put together, although this was now levelling.

6. In terms of how hospital handovers in Worcestershire had changed, the Ambulance Service representatives advised that in an audit ten years ago, Worcestershire Acute Hospitals NHS Trust (the Acute Trust) had performed the best in the region, with some handovers taking place in under four minutes. Subsequently, there had followed a ‘rocky period’ over four-five years, but big improvements had been made as a result of considerable efforts by partners, and the Ambulance Service had written to the organisations involved to express their thanks. At the start of the pandemic, handovers in Worcestershire were in a good place and remained so for six months. During the early lockdown periods of the pandemic, handover delays were effectively eradicated, and Worcestershire performed exceptionally well.

7. The Ambulance Service representatives explained how patterns of activity had changed. Previously, the numbers of 999 calls would increase during the day, however any significant delays in the evening and night would have cleared by morning. This was no longer the case and there could still be 300 patients waiting for an ambulance in the morning across the region. January 2020 had been the start of deterioration. Availability of ambulances in the system was diminishing and the growing slide was a concern. It was at the point where any pattern in activity became irrelevant; out of 400 ambulances, none would be available.

8. Around the time of the HOSC meeting ie 18 November at 11am, the highest level of pressure would be reached (level 4), where around 200 people were in need of an ambulance across the region with none, available to send and at a time when staff meal breaks were required. At the time of being questioned, in Worcestershire, there were 38 ambulances with one free. In current times, the Service was never at level 1 and levels 3 or 4 were the norm. In the West

Midlands region there were usually 350–450 ambulances in circulation, with around 250 at night. Calls were categorised so that ambulances were directed appropriately meaning that those of less need would keep being pushed down the list.

9. At level 1, the Service would have access to several hundred paramedics who could be called on if needed. Response times for calls had targets according to the category of need, for example within 7 minutes for category 1, 15 minutes for category 2 and 60 minutes for category 3. Response times for category 2 used to be 50 minutes whereas currently, 15 hours was not unusual for category 3 and 4 calls, such as patients with falls.

10. The current situation was very serious as the Service was running at full capacity, and it was concerning that there was therefore no capacity if a major incident were to occur. In October 2021, 28,000 hours were lost to ambulance handover delays across the region for the month.

Patient Safety

11. The Ambulance Service told the Task Group that the patients most at risk from handover delays are those having to wait for an ambulance to attend because so many ambulances were queuing at hospitals – especially those in the highest categories of need for whom there were no ambulances available, or for whom an ambulance may arrive outside of the medical time window for intervention for conditions such as strokes. Some may not suffer at all from a delay but it was very concerning. The Ambulance Service had a rating system for risks, up to 25, and was now at the point where it was likely that patients would die or come to significant harm because ambulances would not reach them in time.

12. Whilst clearly concerned about patients who required emergency care waiting for hours in ambulances, the representatives from the Ambulance Service and the Acute Hospital Trust reassured the Task Group that there are robust processes in place to monitor them and for concerns about patients to be escalated, therefore those waiting in ambulances being monitored by a paramedic at a ratio of 1:1 were comparatively safe. Nonetheless, all representatives present pointed out that a patient's risk remained increased while they were stuck in an ambulance and the best place for patients requiring emergency care was in a hospital and not in an ambulance, which lacked privacy, heat and food supplies for a patient. Furthermore, the patient at greatest risk of all was the patient waiting for an emergency response, with one not forthcoming due to the level of delays within the system.

13. The current inability to respond to 999 calls because of ambulances queuing at hospitals also led to increased call backs, since people requiring emergency treatment were advised to call back should their condition deteriorate. Additional staff had been hired to answer calls, and resources had been diverted away from the 111 system, further exacerbating the problems. On the busiest day for calls where the Ambulance Services received 6400 calls, around 1600 of those were call backs from patients querying where their ambulance was.

14. If a patient's condition deteriorated whilst waiting outside the hospital, the Ambulance Service and Acute Trust representatives said that processes were robust and that relationships on the ground between the two organisations were

strong. This was mirrored within the Urgent Care staff team, which was not the same at other hospitals. The Emergency Department (ED) staff had good working relationships and escalated any concerns, although clearly it was not good use of their time to go outside the ED.

15. The Medical Director for Urgent Care explained the processes in place for patients in queuing ambulances. When the ambulance arrived, the paramedic would speak to the ED, and patient details entered onto the computer system. Paramedics could also call ahead with any particular concerns. The patient's condition was then checked and recorded every 30 minutes. Whereas previously patients may have been moved to hospital corridors, this was no longer possible due to Covid infection control.

16. The representatives explained that escalation processes were co-ordinated across the system, since it was important not to work in silos.

17. The Ambulance Service's escalation system was called Resource Escalation Action Plan (REAP), which corresponded to other NHS systems, and activity could be predicted on an hourly basis based on historical data, with approximately 95% accuracy.

18. In terms of measures put into place on days when it is known that significant delays were building up with ambulance handovers, the Acute Trust representatives advised that delays were often predictable and patient flow was easily calculated. The Acute Trust triggered a category notification of level 1,2,3 or 4 taking account of the number of ambulances queuing and inpatient capacity, a process used by all Acute Trusts. The escalation process didn't happen in silo, the rest of the support services also needed to escalate to support the flow.

19. The Ambulance Service reported on serious incidents and this had gone up four-fold over the past 18 months. Audits of avoidable deaths were also carried out, and whilst not huge, the numbers were there.

Workforce Fatigue and Capacity

20. Across the board, the Task Group has heard that staffing is a significant concern and the effects of working through the pandemic mean that staff morale, resilience and recruitment is a huge concern. It is a challenge to attract and retain staff and the problems with ambulance handovers are just one of many pressures. The Task Group heard many comments about staff being 'on their knees', unable to take time off and more staff than ever being in tears, including senior staff. It was also highlighted that workforce fatigue meant it was challenging to drive continued improvements and responding to ongoing pressures gave little time to carry out transformational work.

21. The Ambulance Service and the Acute Hospitals Trust spoke about staff who were on the verge of burnout at all levels and felt very emotional about the current pressures including handover delays and being unable to attend to patients in need. In terms of Ambulance Service staff, it was currently not unusual for staff to finish a shift four hours after their shift should have ended and there had been incidents where vehicles had crashed where it was possible that this had been a factor.

22. Recruitment was not cited as a problem for the Ambulance Service - the issue was productivity from staff being stuck in queues. Previously, staff would have attended to a job every 1½ hours, currently they may now only complete one job per shift.

23. For social care staff, the Worcestershire County Council representative highlighted the crisis of the care sector, which was a focus nationally, with a major part of the problem being low pay rates as people could earn more elsewhere, for example working in a supermarket. Care staff had worked incredibly hard with very little recognition. Staff were leaving and there was a huge issue with capacity which could therefore lead to delays in providing support for people coming out of hospital, and people were having to rely on friends and family. The Council had worked hard to provide more care at home and prevent people going into hospital, however over the past month around 600 packages of care had been handed back to the Council as the market did not want to handle it anymore.

Pressures on the Emergency Department

24. The Acute Trust representatives were not aware of any particular factors creating pressures in admissions. Generally, the busiest days of the week were Saturday, Sunday and Monday and issues around alcohol and assaults were more prevalent during weekends. The Herefordshire and Worcestershire Clinical Commissioning Group (CCG) representative explained that speeding up the ED assessment process was difficult since the ED was full to the door. Ideally a patient would have a very rapid assessment and be streamlined away very quickly (within 20 minutes). Due to demand this was not happening quickly enough for this to occur.

25. Congestion within the ED was not helped by its location at the centre of the hospital site (the site at The Alex was better). The Acute Trust had Hospital Ambulance Liaison Officers (HALO) staff who worked between WRH and The Alex hospitals.

26. In terms of medium to longer term plans being considered to address ambulance handovers, with partners, the Acute Trust representatives explained that there was very little room to work with and the pressures were relentless – the ED was too small and completion of expansion was a year away. Only 9 beds were being used for elective care, and everything else for emergencies. This week, seven patients had remained overnight in the discharge lounge; the situation was not sustainable.

27. The Task Group was also advised that while the expanded ED would make things easier and improve the patient experience, it would not solve all of the problems such as patient flow through the rest of the system. The experience of the Ambulance Service representatives present backed up this view, since they had worked with other hospital trusts involved in expansion plans.

28. Commissioners (the CCG) were asked how it had reviewed the situation with ambulance handovers in terms of the level of resources available, and the representative was most concerned about levels of confidence. Diverting people away from the ED was important but difficult to achieve as nationally it had been shown that publicity campaigns such as ‘is A&E for me?’ did not work and had the reverse effect – which was the experience of all the organisations present.

29. The Ambulance Service representatives agreed that diverting people away from the ED where appropriate would help but they did not feel this was the root of the problem.

30. HOSC members also asked about the recent move of the majority of trauma care from the Alexander Hospital (The Alex) to WRH noting that an additional 19 emergency beds had been allocated. Members were concerned about the potential impact of this additional pressure on the ED at WRH, however the Medical Director for Urgent Care did not feel this would make a difference, but the situation would be monitored daily.

Inappropriate Use of Ambulance Services and the Emergency Department

31. Although most people used health services appropriately, inappropriate calls to 999 were highlighted as a problem and the Ambulance Service suggested that through the Covid pandemic, people had become more dependent, for instance calling for an ambulance for an inappropriate reason or because they were lonely and isolated. Society used services more, with those aged 20-30 using ambulance services twice as much. Excess alcohol also led to more problems. The 111 service was prepared to deal with two million calls a year, however this service too was now under pressure.

Pressures from Covid-19

32. The Task Group asked when pressures on capacity from the ring-fenced Covid wards were likely to improve, and the Acute Trust representatives advised that the trend of Covid-19 patients being admitted to hospital had not decreased and was effectively in the third wave of the pandemic. Compared to previous waves, hospitalisation compared to prevalence of Covid in the community was much lower and the length of hospital stay was much less. However, the majority of those in ITU were unvaccinated under the age of 60. Current modelling suggested Covid figures would start to fall, week commencing 29 November, however this remained to be seen. The effects of increased socialising during October half-term would soon fall away, however there would then be the Christmas period of socialising.

National Mandate to maintain Elective Care

33. Task Group members were aware of the additional pressure this winter to maintain elective (planned) surgery, which was normally postponed allowing services to cope better with additional winter pressures. Asked whether consideration would be given to not following this national mandate, the Acute Trust representatives acknowledged the multiple pressures at play, including numbers of people presenting at the ED, pressures on critical care being exacerbated by the need to separate wards with Covid-positive patients. However, the Trust endeavoured to balance elective care with emergency care and did not feel that pressure to continue elective care was the root cause of problems. There was also merit in maintaining elective care, to avoid cases quickly becoming emergencies. The majority of elective care had been moved from Worcestershire Royal Hospital (WRH), to the Alexander Hospital (The Alex) and Kidderminster Hospital and Treatment Centre.

What is Being Done to Improve the Situation

34. The feedback from the representatives present about what could help to improve the situation included addressing the reason for people coming to the hospital, discharging medically fit patients as soon as clinically possible and informing patients and relatives promptly. It was also important to stop assessments within hospital which should be completed by occupational therapist and Continuing Health Teams in community settings. It was important to be clear about why a patient was in an acute hospital. There were also some issues with partners' access to IT systems across the system in terms of access to discharge data.

35. The Ambulance Service and the Acute Hospital Trust told HOSC members they have good working relationships. In terms of working with stakeholders to improve the ambulance handover situation and the receptiveness of other organisations, the Ambulance Service representatives said that relationships were very good. WRH was the only hospital in the region to invite in the Executive Nurse of the Ambulance Service each month to undertake a walkaround of the hospital with the Acute Trust's Chief Nurse and to jointly talk to both sets of staff about issues and pressures; the Acute Hospitals Trust was exemplar in this respect.

36. All of the organisational representatives expressed their serious concern for the delays in ambulance handovers, in particular the Ambulance Service and the Acute Hospitals Trust, who are most affected. The representatives were aware that and concerned about the fact that patients were at risk from the current situation with ambulance handover delays. The Medical Director for Urgent Care stressed how very concerned the Acute Trust was about the ambulance handover delays and wanted the situation to be fixed. The delays were a symptom of the overloaded system.

37. There was agreement from all of the organisations that patient flow through the hospital system was one of the main areas which needed to improve in order to reduce ambulance handover delays, from diverting people away from the ED if emergency treatment was not required, to discharge of medically fit patients from acute hospital settings as soon as possible. The Task Group was told that significant work had been done, with improvements evident as the Covid-19 pandemic hit, however the system was now overloaded.

38. In general, the Acute Trust was confident that processes were good, and they believed issues to be more with patient flow. The Trust's conversion rate was 26% (numbers of patients coming into hospital versus those coming out) which was good, and in the upper performance levels.

39. Representatives from both the Council and the Health and Care Trust felt that variations in patient flow was an obstacle to ensuring patient transfer within agreed timeframes since the system worked better with a steady flow and was less able to cope with peaks and troughs in demand – this was being worked on across the system, with a good collaborative approach.

40. The importance of managing the public's expectations was also a factor pointed out. The Health and Care Trust representatives explained that since during Covid, many people had been placed in community hospitals according to which sites had capacity, but which may not be their local hospital; the situation was such

that it was no longer possible to accommodate families' preferences as this caused delays in the system.

Reducing the Pressure at the front door (the Emergency Department)

41. There was an acknowledgement of the need to divert people away from the ED where they did not require emergency treatment, however it was also recognised that this was very difficult to achieve. It had been explained that speeding up the ED assessment process was difficult since the ED was full to the door, whereas ideally a patient would have a very rapid assessment and be streamlined away very quickly.

42. Health and Care Trust representatives mentioned that there were regular communications to encourage the public to use Minor Injuries Units (where appropriate) instead of A&E, although changes to opening hours had been necessary during the pandemic, for example to redeploy staff.

43. The CCG representative highlighted the work of the Community Health Services 2-hour Response Team, (provided by Herefordshire and Worcestershire Health and Care Trust), which is key in diverting people from the ED and was now part of the national agenda[1]. HOSC members were aware of recent investment in these Teams, which went out to people's homes to prevent hospital admission. Worcestershire was well placed and capacity was being expanded, working with partners. HOSC was aware of difficulties in recruiting staff to this team, however staffing now stood at 50% although not all staff had started yet. Recruitment was continuing and with 70 staff across a mix of roles, while a further 35 staff would start in December/January. Services ran across 7 days a week, from 8am to 8pm and were currently receiving around 17 urgent referrals a day.

44. The Health and Care Trust hoped that 2-hour response teams would work with 40-45 referrals a day and was continually working to improve understanding, for example work with the Ambulance Service to parachute in support where appropriate with a view to receiving referrals directly from the Service. For September/October 2021, the 2-hour Response Team was the second best performing in the region.

45. The Task Group asked whether consideration had been given to patients being off-loaded from ambulances to a 'reception area' manned by doctors and nurses who could oversee patient care in more comfortable and safe surroundings thereby allowing ambulances to leave. However, the Acute Trust representatives did not support this suggestion, since there was no space for such a facility but also there were potentially more seriously ill patients in A&E who had not been assessed, whereas those in an ambulance had been assessed.

Reducing Pressure off the Back End (Discharge of Medically Fit Patients)

46. All organisations across the system agreed that improving timely discharge of medically fit patients would significantly improve pressures on the ED and

[1] NHSE definition: A crisis response is delivered by a community-based service typically provided by a multidisciplinary team to adults in their usual place of residence with an urgent care need (required within two hours), and involves an assessment and short-term intervention(s) (typically lasting up to 48 hours). This is a national standard.

consequently, the delays with ambulance handovers. The Health and Care Trust advised that work was underway to look at this to make discharge planning and processes slicker.

47. HOSC members queried the numbers of patients still on ward 24 hours after becoming medically fit for discharge (figures circulated for the meeting indicated 205 such patients were still on ward for week ending 31 October 2021). The Acute Trust representatives explained that there was a difference between being medically fit for discharge and being able to go home, to being medically fit for discharge but requiring equipment or reablement etc.

48. The Ambulance Service's Executive Director of Nursing and Clinical Commissioning took part in hospital 'walk arounds' with the Acute Trust's Chief Nurse and believed the solution was to further challenge patients remaining in hospital who no longer needed to be there.

49. The Task Group was advised that the daily cost of a patient staying in hospital was around £700-£800 per day. However, HOSC members are also aware that in terms of patients whose discharge had been delayed beyond national targets (stranded and super stranded), performance in Worcestershire was near the top nationally, as a result of investment, although numbers were increasing.

50. Initial patient assessment occurred at an early stage and the Onward Care Team, which was responsible for facilitating onward care, went into hospital wards. A considerable workforce was needed to support this cohort of patients, which was an issue.

51. The organisational representatives present were in agreement that the needs of patients who were medically fit for discharge but required onward care should be assessed in their home environment, however at present needs were quite regularly assessed while patients were in acute hospital beds – a change was needed, with greater focus on treating the underlying cause which had prompted hospital admission, rather than other health and care issues, which should be responded to once the patient had been discharged.

52. The Task Group asked whether there were any specific obstacles to improving discharge of patients who were medically fit and the reasons cited included workforce capacity and a risk averse approach in some staff.

53. Other reasons cited were peaks in flow to the Onward Care Team which caused problems. Community transport had also received considerable investment and was now available until 11pm. In the majority of cases, it was possible to have pharmacy and transport provision in place to enable a patient to leave.

54. In terms of the Council's role in managing patient flow and keeping residents out of hospitals, the representative explained that it was a graduated process and staff would know when a patient was at the point of getting ready to come out of hospital. It was explained that council systems would not know when someone went into hospital, since only 15% would need social care and it would be inappropriate to share personal information at this stage. The process was to alert the Onward Care Team as soon as possible after admission to hospital if a potential need was identified. Covid had disrupted some ways of working, but now Onward Care Teams were back onto hospital wards.

55. The Task Group was advised that the Council's staff worked 7 days a week and time taken to arrange onward care depended on the complexity of the person's needs, for example 1 day for a simple case and 203 days for more complex cases.

56. With regard to suggestions to improve efficiency of processes, for the Council, it was not ideal when a patient was discharged from a setting late in the day and there came a point where it was better for the patient to be discharged the next morning, although this did cause delays. Discharge planning from day 1 in hospital was important, for example to gauge whether a patient may need assistive technology, and earlier planning was something being worked on across the system.

57. The Council representative advised that the process of transferring patients from community hospitals to a care setting for ongoing support was constantly under review, although differences may not be dramatic. Streamlining health discharges had been the focus of work over recent months and Covid had brought a lot of change. Whilst this was working, an obstacle to improvement was capacity since domiciliary care was almost broken and demand had increased dramatically over the previous 4-5 months, from the previous steady increase.

~~58.~~ The important role of the Onward Care Team was explained in assisting patients' onward care needs. The Teams, which comprised social workers and nurses would be alerted as soon as possible after someone was admitted to hospital if a potential need was identified. The Health and Care Trust could see patient lists being looked at by its Onward Care Team, on a daily basis.

59. Speaking on behalf of the health and care system, the CCG representative reassured the Task Group that while there had previously been a huge problem with patients moving into care homes from acute hospital settings, this was no longer the case, since they would transfer to community hospitals.

60. Review of processes for transferring patients into community hospitals was a continuous process and managers were involved in calls every day to assess workload, with further checkpoints during the day to assess patients, 7 days a week. From personal experience of being on call at weekends, the Health and Care Trust's representatives knew that Covid made work so much more challenging and praised the Health and Care Trust's capacity management team which was constantly reviewing patients' status and whether they were ready to be discharged and maximising use of the community hospital estate.

61. Ambulance Service representatives pointed out that pushing to discharge someone late in the day was not necessarily helpful to the patient or staff.

62. The Task Group was reassured that the issue of determining whether someone's needs would be funded by health or social care was never an obstacle to discharging a patient as this would be finalised after their discharge.

63. The Ambulance Service representatives explained that the number of ambulances in circulation at any one time was being changed until handover delays were more under control. There would now be around 370 - 380

ambulances available in the west Midlands Region across 24 hours, whereas normally there were 350 - 450 during daytime and around 250 at night.

64. It was also important to fix the 111 Service, and considerable investment had been put in, with staff recruited in July and tangible improvements should be seen by Christmas.

65. The Acute Trust and CCG representatives said there was no clear evidence that increased numbers of people coming to the ED was due to them being unable to access face to face GP appointments. The CCG told us about early plans for hubs to give extra capacity and work to divert people to 111 to be able to book appointments. However, access to GP appointments was not felt to be a factor and there were 20% more appointments available now than in 2019/20, with half of them in Worcestershire being face to face.

What more is needed?

66. The main areas of the discussion with health and social care partners were around patient flow, the challenge of preventing people coming into the ED who did not require emergency care but alternative pathways, timely discharge of medically fit patients from acute hospital settings, assessments in a community setting, and workforce pressures.

67. Task Group members observed that discharge and admission of patients takes a lot of resource and that improvements in these areas would mean shorter hospital stays, more discharges and admissions, and therefore there will be a greater pressure on resources.

68. The CCG representative acknowledged that there was still work to do in terms of slicker working practices and checklists to improve prompt discharge of patients who were medically fit, whether it is to a community hospital or home. Discharging patients earlier in the day before 10am is also important as this prevents bottlenecks in the middle of the day, as had been shown to work well before. Some assessments are still being done in acute hospitals, which needs to change.

69. Working with partners such as the Health and Care Trust, the CCG said there were some big things on the table, in terms of doing things differently, which were being considered in view of the ongoing pressures being faced.

70. When asked what one thing was needed to bring ambulance the situation with handovers under control, the CCG representative highlighted the need for a stable, fresh workforce and staff having the time to transform the situation.

71. The Ambulance Service told us that availability of wraparound services 24 hours a day, seven days a week would be really helpful especially over the festive period. All of the organisations told us that staff worked across 7 days a week, and some were looking at evenings and nights.

The National Picture - Experiences of what is working in other regions

72. The Ambulance Service's Executive Director of Nursing and Clinical Commissioning was a member of several national groups. From experience, Walsall Hospital Trust seemed to cope in a way which other Trusts were unable to, although it was unclear whether this came from a change in culture but the nurses in the ED were extremely quick to get people through the system. In general hospitals which were coping better were smaller Trusts with less acute care. Walsall was mentioned and the fact that their patient flow works well. Stoke only transferred a third of 999 calls to hospital. The Acute Trusts representatives and the CCG representatives advised that they had looked at the hospital examples referred to, and the Acute Trust participated in peer reviews.

73. It may be that rural areas required different solutions, and the representatives cited the example of Scotland where people in rural areas accepted long waits. In terms of preventing hospital admission in the first place, schemes such as New Zealand's befriending service were referred to, which proactively identified vulnerable people living alone, especially over holiday periods. However, representatives also highlighted the work of Neighbourhood Teams and social prescribing in Worcestershire, as well as the tremendous effort from the voluntary sector.

Recommendations

74. The Task Group has identified a range of measures that could be put in place to help improve the situation. It is recommended that the Health Overview and Scrutiny Committee receives an update on the progress against the recommendations adopted and progress to improve ambulance hospital handover delays in 6 months' time from this report, in May 2022. The recommendations are:

Recommendation 1 – Discharge of Medically Fit Patients by 10am

Discharging patients who are medically fit for discharge earlier in the day will free up much needed bed space and improve patient flow, it is recommend that for those patients who are medically fit to leave hospital, an early discharge target of 10am is set and monitored accordingly.

Recommendation 2 – Extra Resources to Facilitate Patient Discharge

It is recommended that consideration be given to allocating additional resources to the areas which support discharge of patients and onward care, in order to facilitate the 10am focus on patients who are medically fit for discharge. It is acknowledged that a significant amount of resource has recently been invested to support discharge, however it is understood that improving patient flow provides a cost saving on unnecessary patient stays in hospital at around £700-800 a day per patient.

When the update on the Task Group's recommendations is received in 6 months' time, it would be helpful to include data relating to how the resources are achieving the relevant outcomes, including length of time taken to discharge patients, according to their condition or onward care needs.

Recommendation 3 – Signposting to appropriate Services from the Emergency Department Front Door

Whilst appreciating that there is evidence to suggest that publicity campaigns about the circumstances when it is appropriate to A&E can be counterproductive, the Task Group nevertheless thinks that educating the public and signposting to the most appropriate services is worthwhile. Therefore, the Task Group recommends that when people present at A&E they should be signposted at the front door to the most appropriate service if it is not A&E.

The Task Group also recommends that opening hours and services eg X-ray facilities available at the County's Minor Injury Units are standardised so that members of the public develop confidence in using them and there is an awareness of opening times and services offered.

Recommendation 4 - Patient Assessments

Providing hospital staff have established that the basic needs of a patient are in place to enable them to go home safely or to onward care eg transport, family/carer, immediate medicines, it is recommended that detailed assessments take place outside of the acute setting either on the day of discharge or the following day at the latest.

Recommendation 5 – Monitoring the Impact of the 2 Hour Community Response Service on Ambulance Handovers

It is recommended that in order the assess the impact of the 2 Hour Community Response Service on Ambulance Handovers, targets relating to the number of patients who would have otherwise needed to go the ED should be set and monitored accordingly.

In addition, the Committee requests a report back in May 2022 both on the progress of the Service target monitoring and long-term viability.

Recommendation 6 – Monitoring the fragility of the Care Sector workforce

The Task Group recommends ongoing monitoring of the situation with workforce fragility and fatigue through the Council's meetings of the Health Overview and Scrutiny Committee, as well as the Adult Care and Well Being Overview and Scrutiny Panel.

Following a Scrutiny Review of Care Work as a Career by a Task Group of county councillors in 2020, regular updates have been provided to Scrutiny on the care market and on the Council's work to promote care work as a career. The most recent update was to the Adult Care and Well Being Overview and Scrutiny Panel in September 2021.

Recommendation 7 – Continuous learning from best practice and what is working elsewhere

Acknowledging the sharing of best practice to date, the Task Group encourages ongoing research of areas where new ways of working have helped with the priority areas identified (patient flow, workforce, prompt patient discharge, alleviating pressure on the ED).

Recommendation 8 – Healthwatch Worcestershire work on Urgent Care and the ED

The HOSC is aware that Healthwatch is starting a piece of work on Urgent Care and the ED, to gather feedback from patients to understand their reasons for attending A&E, what factors contributed to this choice and what, if anything, can be done to influence patient's choice to attend A&E and provide the public with better information about the urgent care services available. Health colleagues are therefore asked to take on board the outcomes and any recommendations from this work.

Recommendation 9 – Education awareness relating to the night-time economy

It was highlight to the Task Group that there was an increase in alcohol related incidents, during the night-time economy, particularly at weekends, which led to an increased demand on services (especially in 20-30 age group). Whilst appreciating the diversity of Worcestershire's night-time economy and the freedoms of almost 24hour access to alcohol, this should not adversely impact the healthcare system.

It is therefore recommended that partners work together to educate and inform the public about responsible use of drink and reducing drug related harm, which could help reduce demand on healthcare services. This includes Public Health, the Police and District Councils to review public health campaigns and licencing and communications as necessary.

Conclusions

The Task Group found the scrutiny discussion about ambulance handover delays extremely helpful and informative. The brief insight gained into the working lives of staff working in the health and care system is sobering and in setting out this report, Task Group members are very mindful of the immense pressures on staff across the sector over such a prolonged period of time. Task Group Members are extremely grateful to the representatives for their time and input to this exercise, but also to all health and social care staff for their ongoing contribution through unprecedented pressures.

There are escalation processes in place (which are triggered accordingly) when there are delayed ambulance handovers, however it is clear that there are no quick fixes to the current situation and it is concerning that whilst there is also consensus about the areas where improvements can be made, the system is extremely pressurised. It is important to note that prior to the pandemic, significant work had been done by partners to improve pressures on ambulance handovers, which was having a positive impact.

Information provided by System Partners

The Task Group has been provided with the following information from Health Partners for consideration:

- Summary Report provided by NHS Herefordshire and Worcestershire Clinical Commissioning Group, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire County Council (as at 12 November 2021)
- Presentation (including data) provided by NHS Herefordshire and Worcestershire Clinical Commissioning Group, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire County Council (as at 12 November 2021)
- Information provided by West Midlands Ambulance Service
- Examples of Media Articles
  Lives at risk from 'unacceptable' ambulance waits - BBC News
  Worcester patient died after five-hour wait in ambulance - BBC News
  People's Experiences of leaving hospital during Covid-19 (March 2020-April 2021) – Healthwatch Worcestershire (Summary August 2021)

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE 9 MARCH 2022

UPDATE ON THE PUBLIC HEALTH RING FENCED GRANT 2022/23

Summary

1. The Health Overview and Scrutiny Committee (HOSC) is to be briefed on the updated Public Health Ring Fenced Grant allocation for 2022/23.

2. The Head of Finance, the Director of Public Health and the Cabinet Member with Responsibility for Health and Well-being have been invited to the meeting.

Background

3. As part of the HOSC's budget monitoring, the Committee receives information on the Public Health Ring Fenced Grant twice a year and was last updated at its meeting on 3 November 2021, a record of which is available on the Council's website: weblink to agenda and minutes.

4. HOSC will therefore be aware that the Public Health function nationally transferred to local authorities in 2013. The Council receives an annual Public Health Ring Fenced Grant (PHRFG) of approximately £30m, with a typical increase of 1% over recent years.

Financial Position

5. On 7 February 2022, the allocations for 2022/23 were announced, with the total public health grant to local authorities being £3.417 billion, which is an increase of c2.8%. The grant will be ringfenced for use on public health functions, which may include public health challenges arising directly or indirectly from COVID-19. Details of the prescribed and non-prescribed functions that the grant can be used for are detailed in Appendix 1 to this report with full details on the government website at Public Health Grant 2022-23.

6. The value of the grant for the County Council totals £31,217,923, which is an increase of £853,016 from the 2021/22 value of £30,364,907. Details relating to allocation of this funding can be found at Appendix 2 to this report, which includes the proposal to use £3.2 million of the earmarked Public Health Reserve during 2022/23.

7. Regular half yearly updates will continue to be provided to the HOSC, with the year end for 2021/22 being reported at its meeting on 8 July 2022 and the half year position for 2022/23 at its meeting on 2 November 2022.

Purpose of the Meeting

8. HOSC members are invited to consider and comment on the information provided and agree:
    - whether any further information or scrutiny work is required at this time
    - whether there are any comments to highlight to the relevant Cabinet Member

Supporting Information

- Appendix 1 – Conditions for grant usage
- Appendix 2 – Public Health Ring Fenced Grant proposed spending

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance) the following are the background papers relating to the subject matter of this report:

- Agenda and Minutes of the Health Overview and Scrutiny Committee on 3 November 2021 and 30 September 2020, available on the website: weblink to agenda and minutes

Minutes and Agendas are available on the Council's website: weblink to agendas and minutes

Appendix 1 – Conditions for grant usage

Prescribed functions:

1) sexual health services – STI testing and treatment
2) sexual health services – Contraception
3) NHS Health Check programme
4) local authority role in health protection
5) public health advice to NHS Commissioners
6) national child measurement programme
7) prescribed children's 0 to 5 services

Non-prescribed functions:

8) sexual health services – advice, prevention and promotion
9) obesity – adults
10) obesity – children
11) physical activity – adults
12) physical activity – children
13) treatment for drug misuse in adults
14) treatment for alcohol misuse in adults
15) preventing and reducing harm from drug misuse in adults
16) preventing and reducing harm from alcohol misuse in adults
17) specialist drugs and alcohol misuse services for children and young people
18) stop smoking services and interventions
19) wider tobacco control
20) children 5 to 19 public health programmes
21) other children's 0 to 5 services non-prescribed
22) health at work
23) public mental health
24) miscellaneous, can include, but is not exclusive to:
    - nutrition initiatives
    - accidents prevention
    - general prevention
    - community safety, violence prevention and social exclusion
    - dental public health
    - fluoridation
    - infectious disease surveillance and control
    - environmental hazards protection
    - seasonal death reduction initiatives
    - birth defect preventions
25) test, track and trace and outbreak planning
26) other public Health spend relating to COVID-19

Appendix 2 - Public Health Ring Fenced Grant proposed spending

Strategic Functions

Strategic Functions	BUDGET 22/23
Public Health Team	3,107
Medicines Management	32
Public Health Recharges	328
Commissioning and Finance Support	335
Instant Atlas	15
Joint Funded Apprenticeship Scheme	60
Suicide Bereavement	35
Total	**3,912**

Adults Universal Prevention Services

Adults/Universal Prevention Services	BUDGET 22/23
Lifestyle Services	350
Community Engagement	60
Smoking in Pregnancy	164
Smoking	118
Health Checks	670
Walking for Health	25
Worcestershire Works Well	55
Obesity, Diet, Exercise	20
Carers Support	617
Stroke Contract	90
Info & Advice Contracts	250
Connect Services	312
Fluoridation	268
Healthwatch	275
Local Reform and Community Voice Grant	-224
Quell	120
Making Every Contact Count (Health Chats)	48
Time to Change	25
Substance Misuse Contract	3,942
Drug Intervention Programme Grant	-106
Support at Home	49
Social Prescribing	100
Loneliness Service	150
Strength and Balance	90
Warmer Worcestershire	53
Adults Housing Support	100
Oral Health	50
Learning Disability Reablement	60
Promoting Independent Living Service	273
Sexual Health Transformation	300
Sexual Health - Genitourinary medicine (GUM) Out of Area	300
Sexual Health (WHCT)	4,458
Total	**13,062**

Children's Prevention Services

Children's Prevention Services	BUDGET 22/23
Children's Targeted Family Support	850
Youth Services	595
Child Death Overview Panel (CDOP)	15
Young Adult Carers	35
Family Safeguarding Model	125
Domestic Abuse Working Network (Dawn's) Project	75
0-19 Health Services – Starting Well	12,328
Social Mobility Project	91
Total	**14,114**

Adults Universal Services

Adults Universal Services	BUDGET 22/23
Workplace Wellbeing including Flu & Immunisation	190
Libraries Service	998
Countryside Service	295
Quality Assurance and Compliance	132
Quality Improvement	140
Trading Standards	706
Planning Service	70
Adult Learning	211
Coroners & Registrars	130
3 Conversation Model	291
SENDIASS	74
Road Safety	109
Total	**3,346**

Total Expenditure and Funding	BUDGET 22/23
Total Public Health Spend (above)	**34,434**
Funded by:	
Ringfenced Grant (2.8% increase)	31,218
Funded from Public Health Reserves	3,216
Total Funding	**34,434**

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE 9 MARCH 2022

DENTAL SERVICES ACCESS AND ORAL HEALTH PROMOTION

Summary

1. The Health Overview and Scrutiny Committee (HOSC) is to receive an update on access to Dental Services, with particular focus on provision and plans as services emerge from the COVID-19 pandemic.

2. The update will also include oral health promotion work, which is an area of responsibility for the Council's Public Health Team.

3. Representatives will be present from NHS England and NHS Improvement (NHSE&I), which currently oversees Dental Services. The Council's Director of Public Health and the Cabinet Member with Responsibility for Health and Well-being have also been invited to the meeting.

4. This Report has been developed between NHSE&I Commissioning Team Managers and Consultants in Dental Public Health.

Background

5. NHS dental care, including that available on the high street (primary care), through Community Dental Services (CDS) or through Trusts, is delivered by providers who hold contracts with NHSE&I. All other dental services are of a private nature and outside the scope of control of NHSE&I. The requirement for NHS contracts in primary and community dental care has been in place since 2006.

6. Additionally, 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 (for adults) or 12 months for children.

7. Before the COVID-19 pandemic, patients would often make repeat attendances at a "usual or regular dentist". This would be the list of patients who would be recalled regularly for check-ups. During the pandemic, contractual responsibilities changed and in order to benefit from payment protection, practices are required to prioritise urgent care; vulnerable patients (including children) and those whose dental health makes it likely they would benefit from an opportunistic check-up. In many

practices there will not yet be sufficient capacity to be able to offer routine check-ups to those who generally have good oral health.

8. Worcestershire has 63 general dental practices which offer a range of routine dental services; 2 of these also provide orthodontic services. In addition, there are 8 specialist Orthodontic practices. Secondary care is provided by Worcestershire Acute Hospitals NHS Trust (WAHT) and Community Dental Services for special care for adults and children is provided by Herefordshire and Worcestershire Health and Care NHS Trust from a number of clinics across the area. Patients may have to travel to the Dental Hospital in Birmingham for more specialist services such as complex Restorative dentistry, oral medicine or to the Children's Hospital where a child has complex medical issues.

9. A map of the location of local dental surgeries is attached 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 map has shading showing travel times.

10. Prior to the pandemic, Worcestershire was one of the areas regionally where access was less good and particular issues had already been noted in 2 rural areas (Tenbury and Upton upon Severn). Efforts were made previously to commission additional activity from practices in those areas via over delivery but with limited success due to the impact of the pandemic in early 2020. There has recently been a small contract hand-back in Bromsgrove, however lost activity has been recommissioned from other local practices in the area. Many practices, particularly in rural areas, struggle to recruit staff (both dentists and nurses) and this is having an impact on the service they can provide. A project was undertaken during 2021 with Health Education England to try and attract salaried dentists to work locally. Although a number of local practices were keen to participate, no newly qualified dentists were interested in relocating to the area.

11. A strategic review of access is planned and NHSE&I anticipates having access shortly to a mapping tool to identify local areas which may have specific issues which may assist in a more targeted approach to tackle these.

12. Before the pandemic, around 50% of the population were routinely in touch with NHS high street dental services; the numbers of people attending private services is not known; but is not 50% of the population.

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

Dental Charges

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

- **Emergency dental treatment – £23.80** This covers emergency care in a primary care NHS dental practice such as pain relief or a temporary filling.

- **Band 1 course of treatment – £23.80** 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 – £65.20** 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 – £282.80** This covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges and other laboratory work.

15. Any treatment that a dentist believes is clinically necessary to achieve and maintain good oral health should be available on the NHS. More information here: www.nhs.uk/using-the-nhs/nhs-services/dentists/understanding-nhs-dental-charges/

16. All NHS dental practices have access to posters and leaflets that should be prominently displayed – see weblink for examples: NHS dental charges from 1 April 2017 (nhsbsa.nhs.uk)

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

Impact of the COVID-19 Pandemic

18. 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 23 March 2020. 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. These UDCCs are not currently operational (as practices have now reopened) but remain on standby in case of future issues that may affect delivery of services (such as staff shortages due to sickness – for example because of a COVID-19 outbreak).

19. From 8 June 2020, practices were allowed to re-open however they 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 'fallow time' – 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 or root canal treatment. This has had a marked impact on the throughput of patients and the number of appointments on offer. For a large part of 2020 many practices were offering only about 20% of the usual number of face-to-face appointments and relying instead on providing remote triage of assessment, advice and antibiotics (where indicated). The situation improved in early 2021 and since then practices have been required to deliver increasing levels of activity.

20. In order to qualify for payment protection, practices are required to open throughout their contracted normal surgery hours (some practices are offering extended opening to better utilise their staff and surgery capacity) and to have reasonable staffing levels for NHS services in place. Increases in capacity have been phased in line with changes to protocols for infection prevention such as relaxing of restrictions on social distancing and the introduction of risk assessments for patients

who may have respiratory infections. During the latter part of 2021 practices were required to maximise capacity and to reach a minimum of 65% of normal activity for general dentistry and 80% of normal activity for orthodontics.

21. Infection prevention measures have been reviewed subsequently and new guidance issued recently which has increased the number of slots from January 2022. The revised arrangements for the early part of 2022 is for practices to reach a minimum of 85% of normal activity for general dentistry and 90% of normal activity for orthodontics. Practices must also meet a set of conditions that include a commitment to prioritise urgent care for both their regular patients and those referred via NHS111 and to prioritise additional capacity for vulnerable patients. There is the aim for services to be fully recovered to normal levels of activity from April 2022.

22. The graphs below and in Appendix 2 show the average pattern of delivery of activity over the course of the pandemic and how this has increased regionally, together with more local information for the Herefordshire and Worcestershire Integrated Care System (ICS) which has generally been one of the areas where access is less good. There is also regional information on the overall impact on access of the reduced levels of activity and the cumulative loss of access across the course of the pandemic.

Fig 1 Herefordshire and Worcestershire Primary Care Dental Activity vs Minimum Thresholds

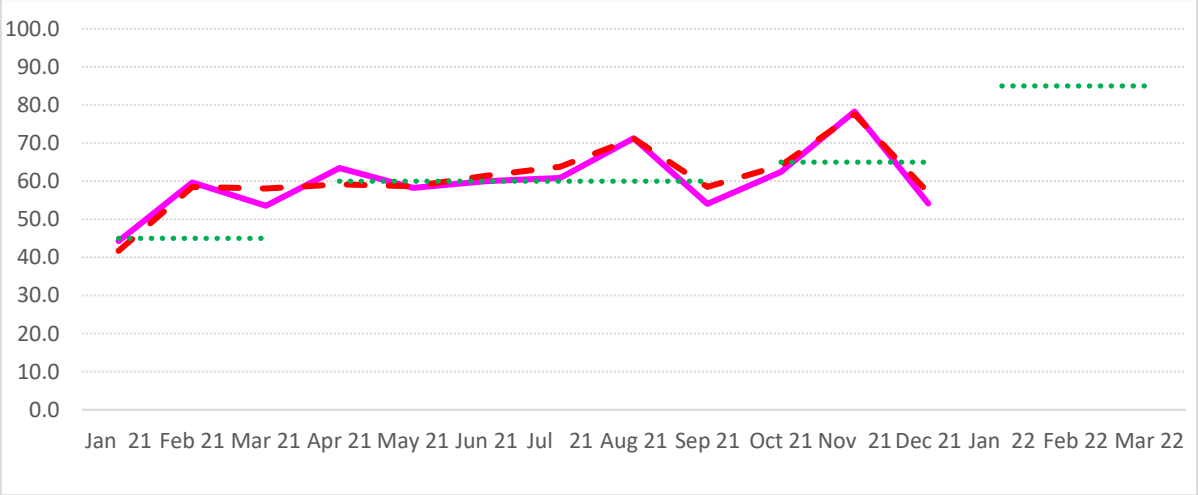


Fig 2 Change in Dental Access (from GP patient survey)

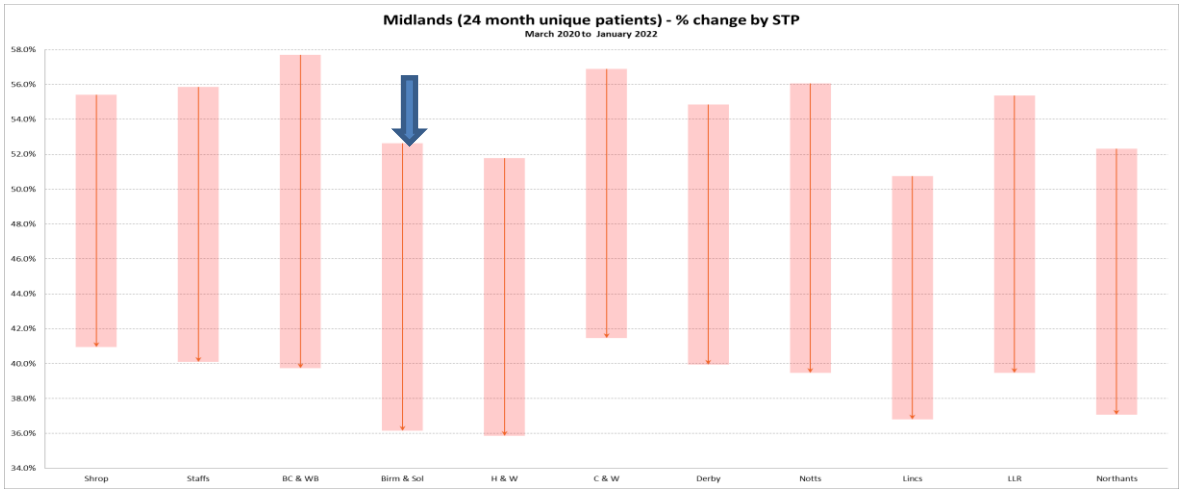
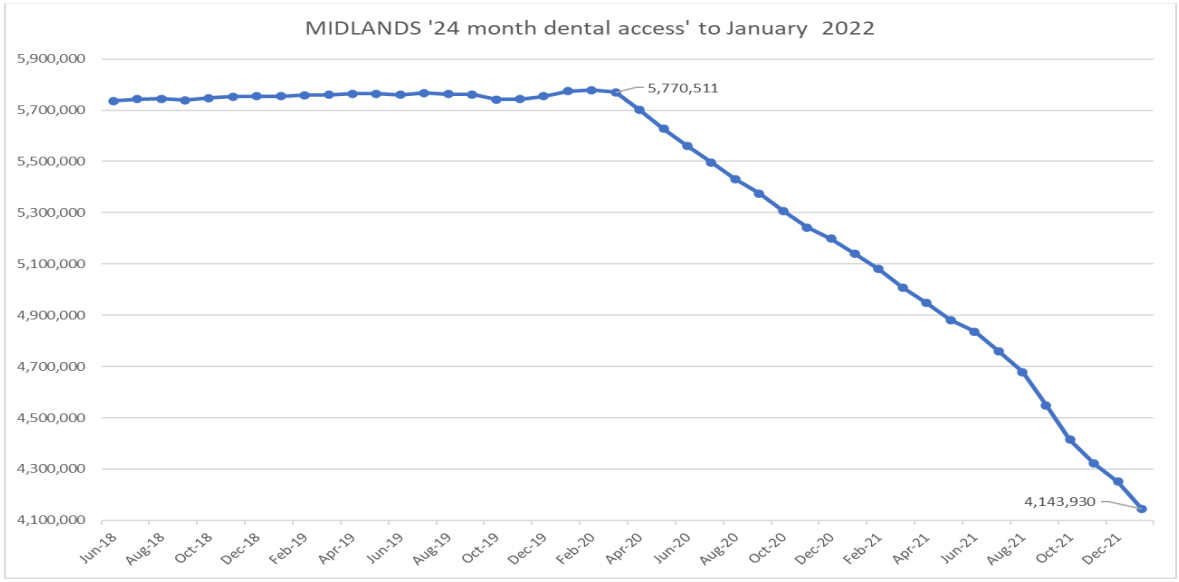


Fig 3 Midlands 24 Month Dental Access Trend



23. It is estimated that across the region there has now been the equivalent of a year's worth of appointments lost in primary care dentistry since the start of the pandemic. The effects have been similar in community and secondary care due to restricted capacity which can be because of staff absences or re-deployment of staff to support COVID-19 activities.

24. 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 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.

25. 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.

26. 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 (including financial support to get expert advice)
- information on risk assessment of staff within the practice (including vaccination status).

Restoration of Services

27. As explained previously, 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.

28. The capacity and number of appointments available will vary depending on the type of practice and the number and configuration of surgeries and waiting rooms. Specialist Orthodontic practices have continued to prioritise and care for patients already in treatment and have now successfully recovered to almost normal level of service allowing them to see new patients. These patients are being prioritised based on clinical need (to avoid harm) rather than on length of time on a waiting list. This means that there are longer than usual waiting times for patients awaiting routine treatment.

29. 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 “fallow time” or downtime between patients to allow for droplets to settle prior to cleaning. This will depend on the level of ventilation to the room.

30. As a result, not all practices or clinics will necessarily be able to offer the full range of dental treatment in all their surgeries. Practices have been offered a contribution to a survey to get expert advice on the ventilation within their practice and any changes that can be made to improve this.

31. It is important to note that patients should expect to be contacted and asked to undergo an assessment prior to receiving an appointment and that they are still required to follow advice around social distancing and mask wearing. The latest guidance is that patients will be treated differently depending on whether they have respiratory symptoms and that non urgent care should be delayed until the patient is asymptomatic. Patients need to be honest about their COVID-19 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.

32. 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 21 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.

33. 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.

34. 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.

Recovery Initiatives

35. A large investment has been made to facilitate initiatives designed to increase access in both primary, community and secondary dental care. Some of the schemes that have been supported are:

- Weekend Access – In Worcestershire, 9 practices are contracted to provide 423 additional sessions at an initial cost of £169,200 with a further additional 12 sessions to be added from Jan to Mar 2022. There has subsequently been further national money allocated as part of a national scheme and further applications are now being reviewed.
- Additional Orthodontic Case Starts – an offer has been made to practices with capacity for additional activity to tackle waiting lists – 2 practices in Redditch

and Evesham have been allocated funding to start treatment for a further 250 patients at a cost of £365,243.

- Community Dental Services (CDS) Support Practices – the team are about to recruit a number of practices to work collaboratively to provide additional capacity to assist in routine review and managing patients who are in the care of the CDS. One of these practices is in Kidderminster.
- Dedicated In Hours Urgent Care Sessions – additional capacity for NHS111 to signpost urgent patients without a regular dental practice. Two practices in Worcestershire are taking part and providing extra appointments.
- Additional non recurrent investment to support oral health improvement initiatives such as supervised toothbrushing with £11,000 allocated to the HWHCT oral health promotion team to expand existing schemes across Worcestershire. These include supervised toothbrushing and bottle swap schemes and toothbrushing packs for children being assessed as part of the epidemiology survey.
- Recurrent investment of £175,000 to further develop a joint ICS wide oral health promotion team for Herefordshire and Worcestershire who will work collaboratively with the two local authorities and other stakeholders to ensure that local people have access to the information and support they need to maintain good oral health.
- Investment for recovery initiatives locally in Secondary and Community Care including £118,320 for additional orthodontic activity at Worcestershire Acute Hospitals Trust (10 extra patients per day) and £26,146 for HWHCT for new patient assessments and recalls in the Community Dental Service.

Vulnerable Groups

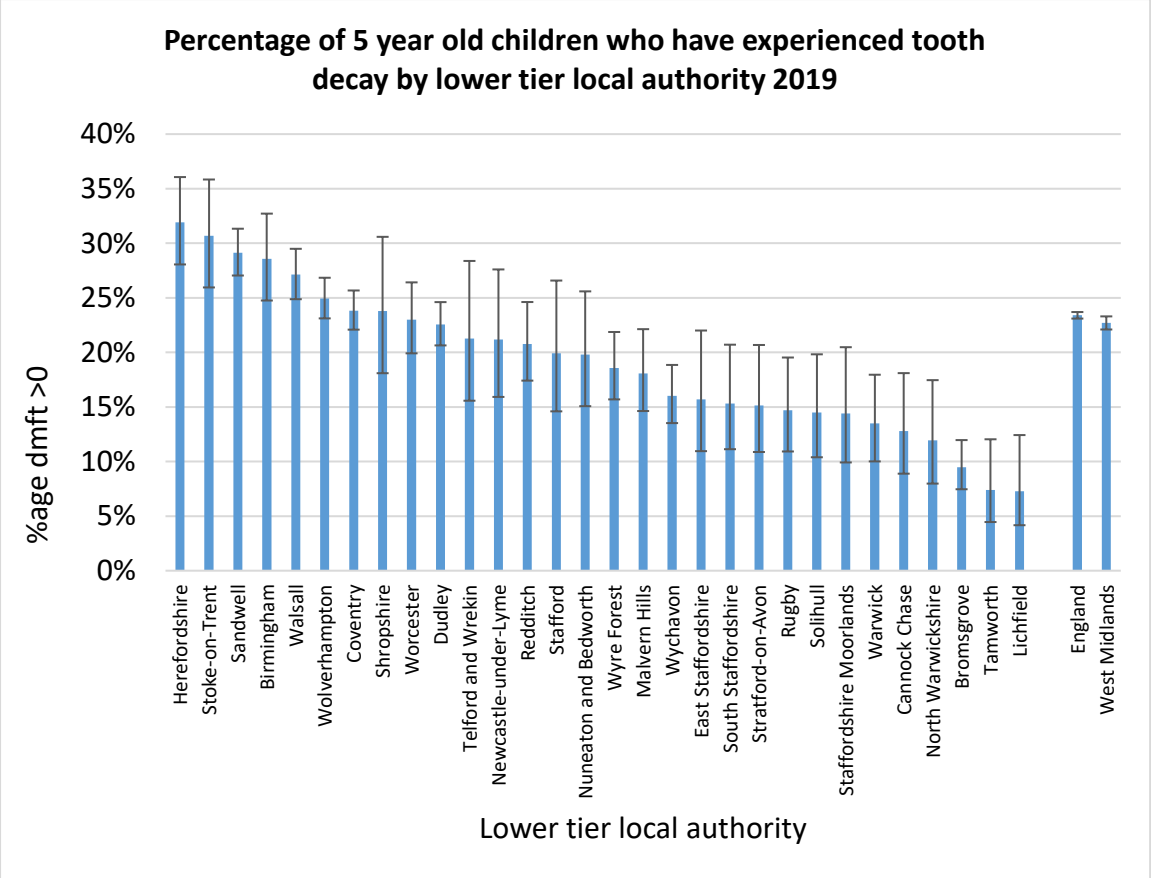
36. There are two groups of vulnerable patients – those vulnerable due to COVID-19 and those who are vulnerable with respect to their oral health. For those in the categories who are vulnerable or shielded due to age or underlying health conditions special arrangements will be made to ensure they are able to access care safely. Some patients may be seen by their usual practice but will usually be offered an appointment at the beginning or end of a session.

37. 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

38. 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. Only part of the population in Worcestershire 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]

39. The local dental commissioning team works collaboratively with colleagues in Worcestershire County Council (the Council) around prevention initiatives linked to Oral Health Promotion and further information has been provided by the Council's public health team on the local oral health steering group and initiatives in Appendix 3.



40. NHSE&I is aware that some vulnerable groups are finding it harder than usual to access services – particularly as no walk-in options are available. We are continuing to review pathways and treatment arrangements for these patients to ensure that they can continue to access urgent care. Primarily this is through NHS111. Many practices are operating with reduced capacity and will therefore be restricted in the care that they can offer to new patients. Arrangements have been put in place for 6 additional dedicated urgent care sessions locally to help facilitate access for those who may not have a regular dentist. These are provided by 2 practices in Worcestershire. In addition the CDS has been ensuring access for vulnerable patients through their network of local clinics and dental access centres.

41. Additional dental capacity was also commissioned to support Afghan refugees repatriated to the UK and housed in local hotels. This was by way of dedicated domiciliary support to quarantine hotels and ongoing additional capacity at a local practice in Bromsgrove (to ensure the additional workload did not negatively impact on wider patient access).

42. 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 NHS111.

43. 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 NHSE&I 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. 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 have been anecdotal reports of some practices being reluctant to offer NHS appointments (particularly routine) and instead offering the chance to be seen earlier as a private patient. Practices are required under the terms of the payment protection arrangements currently in place to maximise capacity and should not be pressuring patients into private care. The contracting team will investigate any such reports but will need detailed information on the date and time of any instance so that this can be raised with the practice for a response.

Access

44. Access and satisfaction with dentistry is measured through a regular GP survey. For adult access, Worcestershire was typically at around the regional average for adult and above both regional and national averages for child access. Please see latest available figures below for June 2021.

Access (% patients accessing care in latest period)	Adult (24 month)	Child (12 month)
Worcestershire County Council	43.6	28.8
Midlands	41.9	32.4
England	41.1	32.8

And the previous year figures for Jun 2020 before COVID had a chance to have an impact.

Access (% patients accessing care in latest period)	Adult (24 month)	Child (12 month)
Worcestershire County Council	48.6	59.6
Midlands	48.4	52.9
England	47.7	52.7

45. It became apparent early in the pandemic that children's access had been particularly badly affected and this is clear from the tables above. This was due both to dental practices focussing less on routine care and on parents being reluctant to bring children to medical/dental appointments – the pattern was consistent across other services too.

Midlands overall trend – 12-month children's access

Dec 2019	March 2020	June 2020	Sept 2020	Dec 2020
58.2%	58.6%	52.8%	43.1%	29.3%

46. Local Worcestershire Data for Dec 2020 % seen 0-17 yr olds (note this is during the pandemic when services were most constrained)

Code	Name	12-month access
18C	Herefordshire and Worcestershire CCG	28.1%

47. The picture is similar to other areas and regional / national – there was a decline to a low point in March 2021 with degree of recovery by June – the numbers of children being seen remain lower than pre COVID. Worcestershire however has recovered better than some other areas for children's access.

48. Prior to the pandemic the local commissioning team had been working on encouraging parents to take children to the dentist early.

49. The main aim of this Starting Well scheme 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

50. 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. 10 Worcestershire practices were offered additional funding for 2019/20 and 2 managed to deliver additional activity despite the impact of COVID-19 in the early part of 2020.

51. As capacity is currently restricted and whilst children's appointments should be prioritised it may not be possible at present for very young children to be seen in the way that was originally being promoted. However, the commissioning team have been working on a new scheme to encourage child friendly practices locally to provide support to local Community Dental Services to work in a shared care model to free up capacity for specially trained staff to focus on tackling backlogs of patients requiring complex treatment. NHSE&I will be seeking two practices locally and additional training will be provided.

52. Work is also underway to strengthen local prevention initiatives and the dental team have been working closely with colleagues in the Council to further develop oral health promotion and to merge existing teams to provide a more resilient service across the new ICS area.

Out of Hours (OOH) Provision

53. Out of hours services provide urgent dental care only.

Urgent Dental Care

54. 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 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

55. People should check their practice's answer machine; information should also be displayed inside the practice and on the windows. Most people contact NHS111 who will alert the out of hours provider. There is an online option that will often be quicker and easier than phoning – particularly when NHS111 is dealing with large numbers of COVID-19 related calls. If using the phone, it is important to listen to all the messages and choose the appropriate option for dental pain.

56. Patients with dental pain should not contact their GP or attend A&E as this could delay treatment as they will be redirected instead to a dental service.

57. People can attend any service in the Midlands area and for Worcestershire the nearest sites are at Worcester, Redditch, Dudley or Birmingham. At times of peak demand patients may have to travel further for treatment depending on capacity across the system.

<u>Domiciliary Care (For patients unable to leave their own home or care home)</u>

58. Dental care to care home residents or patients unable to travel for dental care to a practice will be provided by a specially commissioned general dental practitioner, or a more specialist dentist from the Community Dental Services. In Worcestershire there is a dedicated GDP provider who covers both care homes and patients in their own home. Some limited dental care can be provided in the care home setting such as a basic check-up or simple extraction, but patients are often asked to travel into a dental surgery as this is the safest place to provide more complex dental treatment. If a care home resident requires a dental appointment, they or their relative or carer can contact the local domiciliary provider via NHS111. If they need more specialist

dental care they will generally be referred on to the Community Dental Service after this initial contact.

59. Prior to the pandemic, 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.

Dentures

60. 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 NHS111. During COVID-19 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 the pandemic.

Secondary and Community Care

61. 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.

62. 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 the situation in Worcestershire suffered less than in some other areas as the local CDS managed to retain regular theatre lists and were even able to repatriate local children waiting for surgery in Birmingham. 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. Although there has been a good degree of recovery in Worcestershire over recent months the picture may deteriorate again in the coming weeks due to the as yet unknown impact of the latest increase in COVID-19 infections.

63. 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 the position in December. WAHT was at that time reporting 359 patients waiting over 52 weeks and 2035 waiting over 18 weeks with 9 waiting more than 104 weeks. NHSE&I is aware also that there are a significant number of patients who have been waiting for more than 104 weeks for orthodontic treatment at the hospital and NHSE&I is currently working

to commission additional capacity through some Consultants also working in primary care to help get more patients into treatment more quickly. The overall proportion of patients for the Herefordshire and Worcestershire ICS that are waiting over a year is currently 21%. The position had been improving significantly early in the year but has recently plateaued due to the effect of winter pressures and the impact of the latest wave of COVID-19 infections. These backlogs for patients waiting over a year are not unexpected due to the complete cessation of routine care earlier in the year and the limited capacity subsequently which has meant prioritisation of more recent urgent cases over those less urgent who have been waiting longer (please see Appendix 4). Referrals into secondary care have started to recover (see Appendix 5) but remain at lower than previous levels due to the reduction in routine appointments in primary care. There are concerns that some conditions may be missed due to the smaller number of patients being seen face to face.

64. In order to address these concerns the Local Dental Network have taken the opportunity to publicise Mouth Cancer Awareness month and to distribute a set of key messages to dental practices to help them raise awareness, identify patients with symptoms, and ensure they are aware of how to refer patients quickly to the appropriate services. This is as a proactive local follow up to a dental bulletin issued by the Chief Dental Officer in May 2021 Dental Bulletin

65. 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

66. Dental contractors have undertaken COVID-19 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. The team monitor vaccine uptake amongst practice staff and the latest figures from a recent survey show relatively good uptake compared to the region as a whole.

ICS	Responses	Practices	%	eligible	1st		2nd		booster		flu	
Herefordshire and Worcestershire	31	95	32.6%	412	398	96.6%	388	94.2%	296	71.8%	168	40.8%
Grand Total	**460**	**1149**	40.0%	**5884**	**5432**	92.3%	**5381**	91.5%	**3530**	60.0%	**2058**	35.0%

67. There is a local offer in place through a scheme organised by the CCG to provide Wellbeing support and resources to staff in primary care locally and dentists are able to access this.

Collaborative working with local Dentists

68. There have been regular meetings with the local dental committee 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. This has included joint working between the local Community Dental Service and practices.

69. There is a Local Dental Network (LDN) covering the Herefordshire and Worcestershire ICS but there is currently a vacancy for the LDN Chair and this is being covered temporarily by Steve Claydon who is a network chair in Northamptonshire whilst the post is readvertised. There are also a number of Managed Clinical Networks (groups of local clinicians) who still meet virtually to plan care and agree guidance to help practices to manage their patients. The Urgent Care Network met weekly early on in the pandemic to help to plan and deliver ongoing access to urgent care.

70. 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.

71. Examples of tweets that have been shared on Twitter are given in Appendix 6.

PPE and Fit Testing

72. NHSEI supported Urgent Dental Centres throughout lockdown to ensure that they had access to all the necessary PPE – particularly early on when supplies were limited. Dental practices now have access to PPE through a portal – this is to ensure ongoing supply should we see further pressures as cases increase.

73. 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 Urgent Dental Care Centres (UDCC) and Out of Hours services and have subsequently worked with Health Education England (HEE) to train 91 dental practice staff across the Midlands who can undertake fit testing of masks for local dental practices. 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.

COVID-19 and outbreaks in dental settings

74. There have been only occasional COVID-19 outbreaks in dental practice setting in Worcestershire. 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). NHSEI ran a webinar last year to raise awareness of good practice in IPC and to share learning to prevent outbreaks in dental settings.

75. 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.
Nationally all the latest guidance for dental practices can be found here:
https://www.england.nhs.uk/coronavirus/primary-care/dental-practice/

76. Latest IPC guidance for dental practices can be found here: COVID-19: infection prevention and control dental appendix - GOV.UK (www.gov.uk)
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

77. 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.

78. 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. NHSEI is 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.

Purpose of the meeting

79. HOSC members are invited to consider and comment on the information provided and agree:

- whether any further information or scrutiny work is required at this time
- whether there are any comments to highlight to the relevant Cabinet Member

Supporting Information

- Appendix 1 - Location of dental practices or clinics
- Appendix 2 - Activity Trends in Primary Care
- Appendix 3 - Oral Health Promotion Briefing
- Appendix 4 - Oral Surgery Referral to Treatment (18 and 52 Week Waiters)
- Appendix 5 - Dental Referral Trends
- Appendix 6 - Examples of tweets shared by the NHS England Communication Team

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance) the background papers relating to the subject matter of this report are:

- Agenda and Minutes of the Health Overview and Scrutiny Committee on 18 September 2019– available on the website: weblink to agendas and minutes

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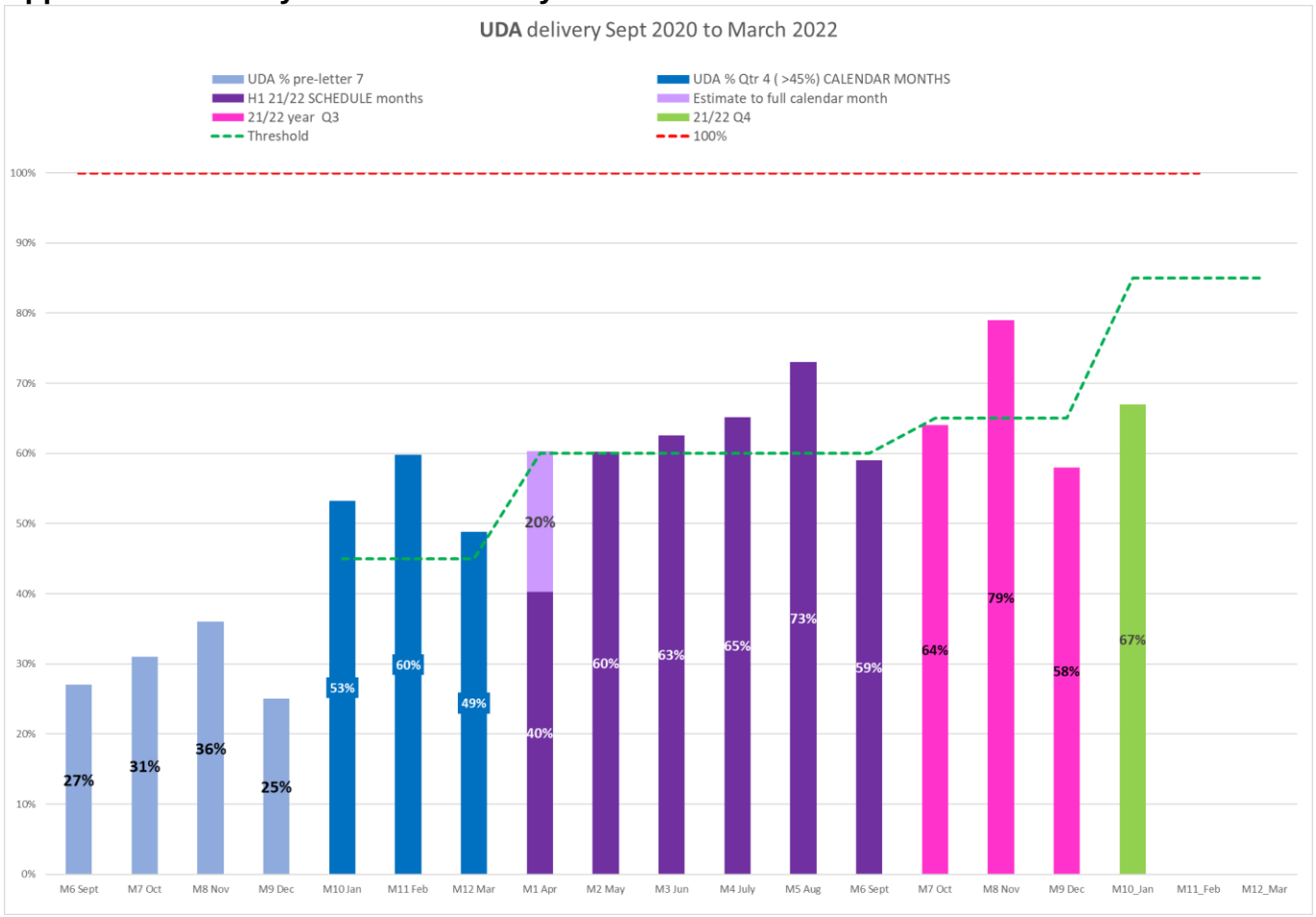
Appendix 1 Location of dental practices or clinics including orthodontic and community sites

Appendix 2 - Activity Trends in Primary Care



Appendix 3 - Oral Health Promotion Briefing

Background

Since 2013 when the duty to improve public health became the responsibility of Local Authorities, NHS England has been working with local authorities and Public Health England to develop and deliver oral health improvement strategies and commissioning plans specific to the needs of local populations.

Worcestershire County Council has a duty to improve the health of the whole population, this includes oral health which is a key factor of overall health (Health and Social Care Act, 2012). The Council inherited two statutory duties within the NHS Bodies and Local Authorities Regulations Statutory Instrument United Kingdom, (2012) specifically related to oral health:

1. Provide or commission oral health promotion programmes to improve oral health in the local population.
2. Provide or commission oral health surveys.

In response to these duties in 2017 a Worcestershire Oral Health Steering Group was formed, and an Oral Health Needs Assessment (May 2017) was carried out that informed the Joint Strategic Needs Assessment. A number of oral health promotion programmes have also been implemented.

Oral Health Promotion Programmes

There is currently a dental services contract in place between NHSE&I and Herefordshire and Worcestershire Health and Care NHS Trust, oral health promotion forms part of this contract. Based on the findings of the oral health needs assessment the Health and Care NHS Trust are commissioned to deliver three bespoke oral health promotion programmes.

Supervised toothbrushing in early year settings - The aim of this programme is to improve oral health and reduce inequalities, by preventing tooth decay in young children, through the implementation of a supervised toothbrushing scheme. The scheme is delivered in targeted early years settings based on what areas in Worcestershire have a higher number of dental carries in the under 5 population.

Activity update - The Smile Squad, which is part of the Worcestershire Community Dental Service has delivered the programme to 15 early years settings, creating presentations and training videos. There was a slow start to the programme due to the pandemic, as many nurseries were initially closed and when they did reopen were reluctant to allow external people access to the building. Majority of the settings have been engaging and keep regular commination and are very happy with the quality of resources provided. Some settings have not been so engaging, either because they feel it is not the responsibility of the nursery or there are staff shortages and limited delivery time. The Smile Squad are making contact with these nursery's through the Quality Assurance visits to see what additional support they can offer.

Oral health training for the wider professional workforce - The aim of this programme is to improve oral health and reduce inequalities through oral health training for the wider professional workforce, with a focus on education, health, and social care. This training will improve their knowledge and skills to support oral health improvement and ensure key messages and signposting is appropriate and consistent.

Activity update - Training has been delivered to 131 staff across the wider professional workforce, which has been well received. The training was delivered by the Oral Health Coordinator, this role has recently been vacated due to retirement. The Worcestershire Community Dental Service are in the process of recruiting an Oral Health Promotion Officer who will continue the training. It has been proposed there will be a focus on training residential and care home staff over the next 12 months, supporting the oral health promotion of older people across the county.

Engagement via social media - The aim of this programme is to improve oral health and reduce inequalities, by engaging with the wider professional workforce through social media. This includes promoting national, regional, and local oral health campaigns and resources.

Activity update - Currently two social media platforms are being maintained: Facebook and twitter, and nearly 40 campaigns and resources have been promoted. It will be the role of the Oral Health Promotion Officer to further develop these platforms to improve their reach, post regular social media updates from the Smile Squad and further promote campaigns and resources.

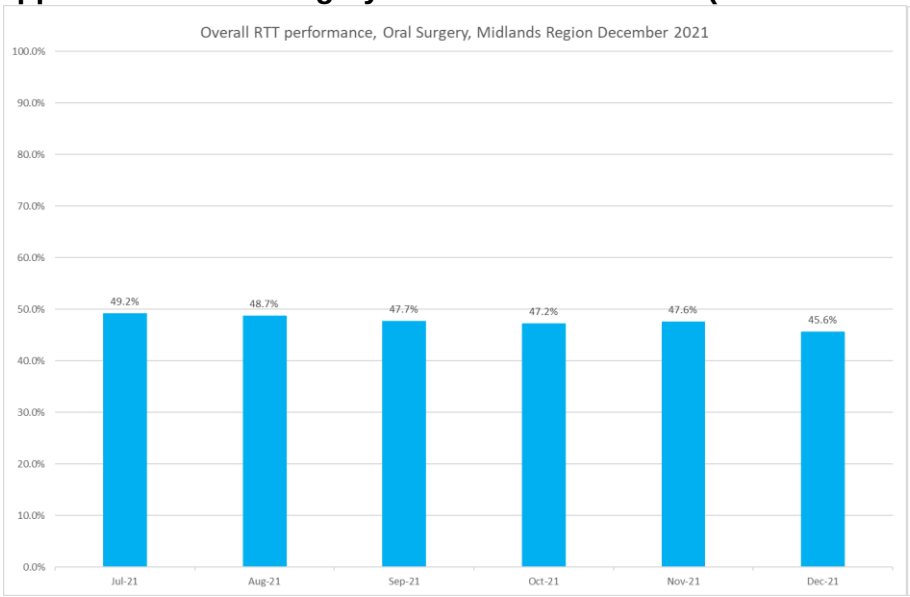
Worcestershire Oral Health Steering Group

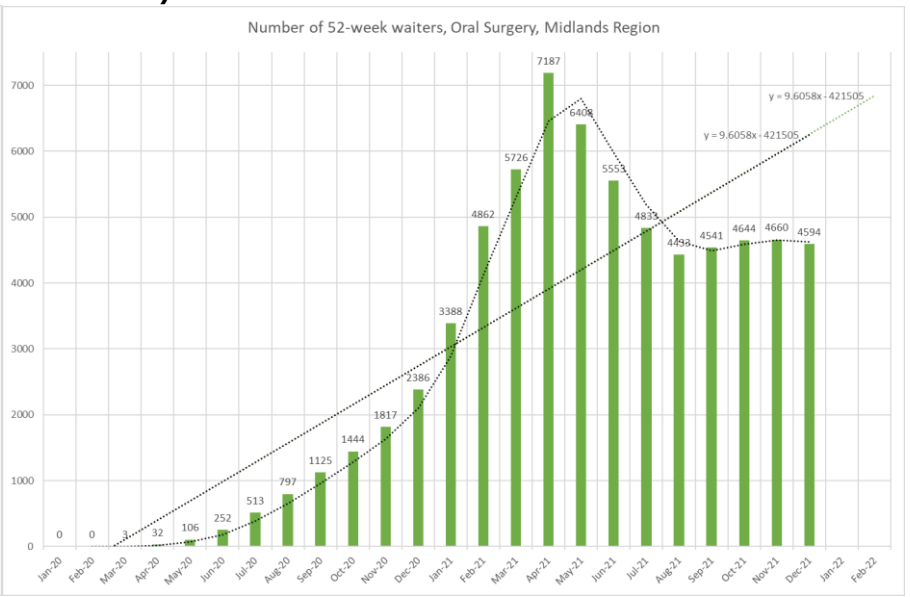
As noted above the Worcestershire Oral Health Steering Group was formed in 2017 that delivered against an Oral Health Action Plan (2019/21). The plan had three main aims:

- Primary prevention – providing clear information, raising awareness and targeted promotion
- Access to care – promoting access and referral pathways and improving supported access to dental care for people with additional needs
- Outcomes – reducing the demand for general anaesthetic in children and vulnerable adults

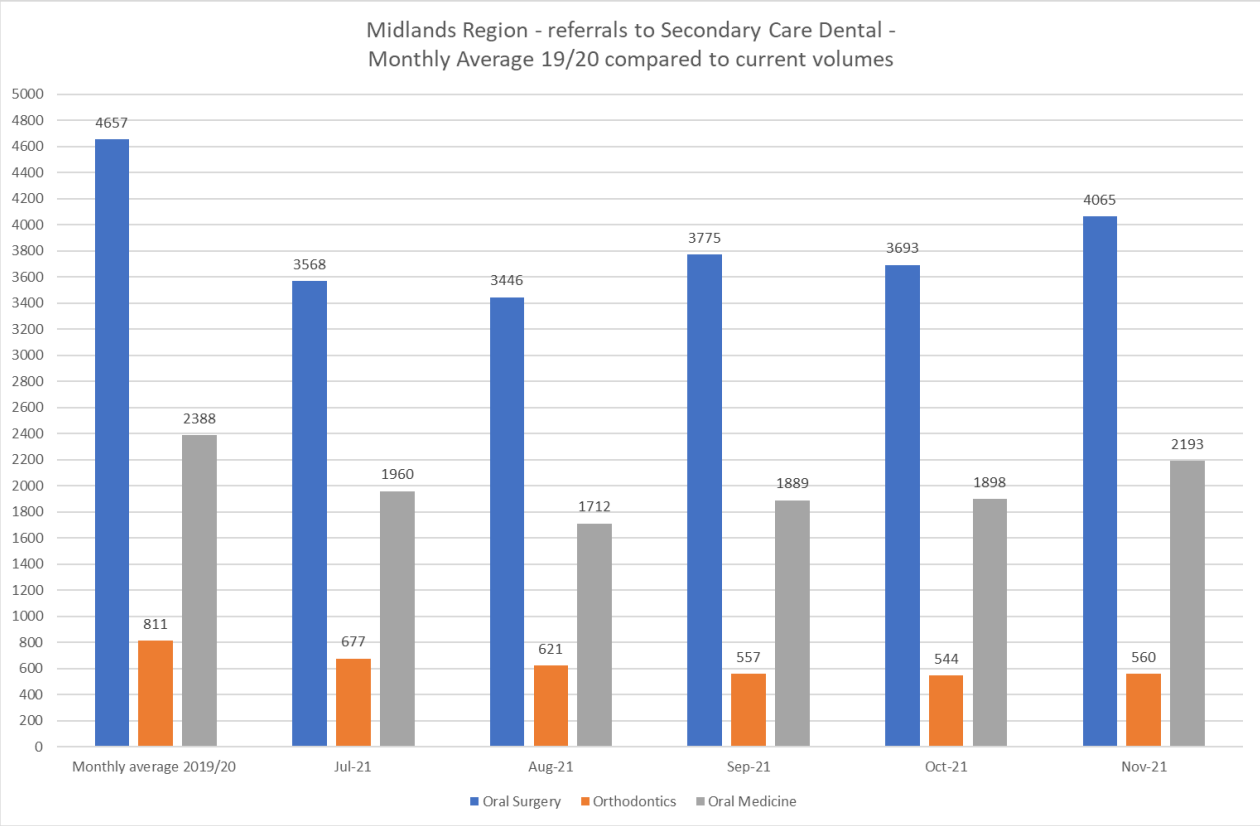
Due to the pandemic the group has not met since 2020. The next meeting of the Oral Health Steering Group will be taking place on the 30th March 2022, where it will determine what activity has taken place against the plan since 2020 and identify the impact COVID-19 has had on access to dental services. Local evidence on access to care will also be captured through engagement with local communities that is being conducted by the public health team and recent enquiries made to Healthwatch Worcestershire.

Appendix 4 – Oral Surgery Referral to Treatment (18 and 52 Week Waiters)

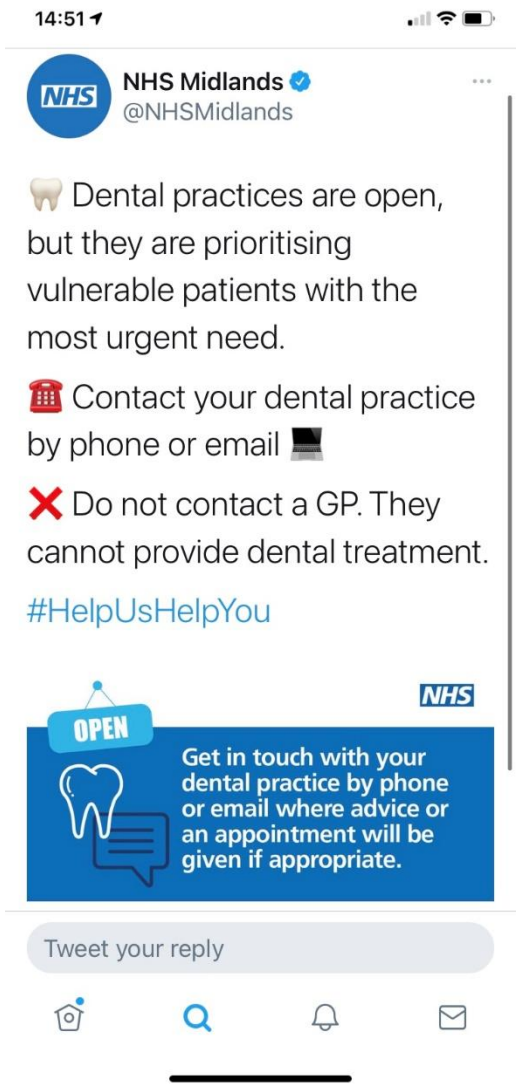




Appendix 5 - Dental Referral Trends



Appendix 6 – Examples of tweets shared by the NHS England Communication Team



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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
9 MARCH 2022

WORK PROGRAMME 2021/22

Summary

1. From time to time the Health Overview and Scrutiny Committee (HOSC) will review its work programme and consider which issues should be investigated as a priority.

Background

2. Worcestershire County Council has a rolling annual Work Programme for Overview and Scrutiny. The 2021/22 Work Programme has been developed by taking into account issues still to be completed from 2020/21, the views of Overview and Scrutiny Members and the findings of the budget scrutiny process.

3. Suggested issues have been prioritised using scrutiny feasibility criteria in order to ensure that topics are selected subjectively and the 'added value' of a review is considered right from the beginning.

4. The HOSC will need to retain the flexibility to take into account any urgent issues which may arise from substantial NHS service changes requiring consultation with HOSC.

5. The Health Overview and Scrutiny Committee is responsible for scrutiny of:

- Local NHS bodies and health services (including public health and children's health)

6. The current Work Programme was discussed by the Overview and Scrutiny Performance Board (OSPB) on 21 July 2021 and agreed by Council on 9 September 2021.

Dates of Future 2022 Meetings

- 9 May at 10am
- 8 July at 10am
- 19 September at 2pm
- 2 November at 10am

Purpose of the Meeting

7. The Committee is asked to consider the 2021/22 Work Programme and agree whether it would like to make any amendments. The Committee will wish to retain the flexibility to take into account any urgent issues which may arise.

Supporting Information

Appendix 1 – Health Overview and Scrutiny Committee Work Programme 2021/22

Contact Points

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Background Papers

In the opinion of the Proper Officer (in this case the Assistant Director for Legal and Governance), the following are the background papers relating to the subject matter of this report:

- Agenda and minutes of OSPB on 21 July 2021
- Agenda and minutes of Council on 9 September 2021

All Agendas and Minutes are available on the Council's website: weblink to Agendas and Minutes

SCRUTINY WORK PROGRAMME 2021/22

Health Overview and Scrutiny Committee

Date of Meeting	Issue for Scrutiny	Date of Last Report	Notes / Follow-up Action
9 March 2022	Scrutiny Task Group Report on Ambulance Hospital Handover Delays		
	Update on the Public Health Ring Fenced Grant 2022/23	3 November 2021	
	Dental Services Access and Oral Health Promotion	18 September 2019	
9 May 2022	Stroke Services		Suggested at 12 January 2022 meeting
	New Arrangements for Mental Health Services resulting from the development of the Integrated Care Systems (ICS) Dementia Services		
	Maternity Services (to monitor progress of the Acute Trust's Action Plan for improvement)	10 March 2021 21 September 2021	
	Hospital at Home Service	21 September 2021	
8 July 2022	Draft Worcestershire Joint Health and Wellbeing Strategy Consultation (feedback on the Consultation)		Requested at 3 November 2021 meeting
	Screening and Immunisation (including an update on the Covid Vaccination Programme)		Suggested at 19 July 2021 Meeting
	Health Inequalities resulting from the Covid-19 Pandemic		
	Update on End of Life Care	30 September 2020	

19 September 2022	Integrated Care Systems (ICS) Development	12 January 2022	To include the plans for the commissioning of Pharmacy, Dentistry, Optometry, Specialised Acute, Specialist Mental Health and Prison Health
	Urgent Care Update including Winter Planning and the role of community hospitals	3 November 2021 18 November 2021	
	Update on Onward Care Team	2 March 2020	
	Draft Worcestershire Joint Health and Wellbeing Strategy Consultation (final draft)	9 May 2022	
2 November 2022	Workforce Pressures		
Ongoing	Monitoring temporary service changes (and new ways of working) as a result of COVID-19	10 March 2021 19 July 2021	
Ongoing	Integrated Care Systems (ICS) Development	12 January 2022 10 March 2021	
Possible Future Items			
TBC	Update on Garden Suite Ambulatory Chemotherapy Service	19 July 2021	
TBC	Health impacts of the pandemic		Notice of Motion from Council 13 January 2022
TBC	Mental Health - the impact of COVID on children and young people - Dementia Services - Preventative measures, for example peri-natal mental health - Mental Health Needs Assessment (when complete)	21 September 2021 19 September 2018 (CAMHS)	Ongoing updates on restoration of services during the Covid pandemic have also been provided (from June 2020 - present)

TBC	Public Health Outcomes, including promoting active lifestyles, targeting rising obesity levels, prevalence of alcohol use during pregnancy etc		Suggested at 19 July 2021 Meeting
TBC	Physiotherapy Services?		Suggested at 19 July 2021 Meeting
Standing Items			
TBC	Substantial NHS Service Changes requiring consultation with HOSC		
TBC	NHS Quality Accounts Quality and Performance		
TBC	Performance Indicators (Quarterly) and In-Year Budget (Public Health Ring Fenced Grant) Half Yearly		
TBC	Annual Update from West Midlands Ambulance Service	27 June 2019	
TBC	Review of the Work Programme		

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