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Nottingham City Council
Health and Adult Social Care Scrutiny Committee

Date: Thursday, 17 November 2022

Time: 10.00 am (pre-meeting for all Committee members at 9:30am)

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Senior Governance Officer: Jane Garrard **Direct Dial:** 0115 876 4315

1	**Apologies for absence**	
2	**Declarations of interest**	
3	**Minutes** To confirm the minutes of the meeting held on 13 October 2022	3 - 10
4	**NHS and Community Dental Health Services**	11 - 46
5	**Primary Care Strategy**	47 - 64
6	**Work Programme**	65 - 72

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Nottingham City Council

Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 13 October 2022 from 10.00 am - 12.00 pm

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Kirsty Jones
Councillor Cate Woodward	Councillor Anne Peach
Councillor Michael Edwards	
Councillor Maria Joannou (Vice Chair)	
Councillor Dave Trimble	
Councillor Sam Webster	
Councillor Eunice Campbell-Clark	

Colleagues, partners and others in attendance:

Alex Ball	-	Director of Communications and Engagement, Nottingham and Nottinghamshire Integrated Care Board
Sarah Collis	-	Healthwatch Nottingham and Nottinghamshire
Kazia Foster	-	Deputy Director of Local Mental Health Services, Nottinghamshire Healthcare NHS Foundation Trust
Alex Julian	-	Senior Mental Health Commissioning Manager, Nottingham and Nottinghamshire Integrated Care Board
Alison Newsham-Kent	-	Eating Disorders Service Manager, Nottinghamshire Healthcare NHS Foundation Trust
Louise Randle	-	Head of Transformation Mental Health Services, Nottinghamshire Healthcare NHS Foundation Trust
Sara Storey	-	Director of Adult Health and Care
Mark Wightman	-	Director of Strategy and Reconfiguration, Nottingham and Nottinghamshire Integrated Care Board
Councillor Linda Woodings	-	Portfolio Holder for Adults and Health
Alison Wyld	-	Executive Director of Finance, Nottinghamshire Healthcare NHS Foundation Trust
Jane Garrard	-	Senior Governance Officer

30 Apologies for absence

Councillor Kirsty Jones – unwell
Councillor Anne Peach – other Council business

31 Declarations of interest

None

32 Minutes

The minutes of the meeting held on 15 September 2022 were confirmed as an accurate record and signed by the Chair.

33 Adult Eating Disorder Service

Kazia Foster, Deputy Director of Local Mental Health Services, Alison Wyld, Executive Director of Finance, Louise Randle, Head of Transformation Mental Health Services, and Alison Newsham-Kent, Eating Disorders Service Manager from Nottinghamshire Healthcare NHS Foundation Trust and Alex Julian, Senior Mental Health Commissioning Manager from Nottingham and Nottinghamshire Integrated Care Board attended the meeting to speak to the Committee about access to Eating Disorder Services for adults. They gave a presentation highlighting the following information:

a) Referrals have steadily increased over the last year, in line with national trends. As expected there was a slight drop in referrals during July and August, which was due to lower numbers of students living in the City during those months. It is anticipated that the number of referrals will continue to increase.

b) The number of referrals accepted largely tracks the number of referrals received. On average 70% of referrals in the City are accepted. Those that are not accepted are either signposted to another service or offered self-help as appropriate.

c) Across the Service the average referral to treatment waiting times have steadily increased over the last year and the Service is working to reduce this. For City patients there has been a slight increase in the average waiting time to assessment over the last year. The average waiting time to treatment was in line with this for most of 2021 but has increased at a higher rate during 2022 (with the exception of April 2022 when there was a very low number of City patients and they were assessed and treated very quickly).

d) There has been investment in the Service. A review of current and expected demand was carried out. This identified capacity gaps and a new staffing model was approved. There has been a growth in staffing posts from 10 whole time equivalents to 21.2 whole time equivalents. Some of these posts have been successfully recruited to while recruitment is still ongoing for other posts.

a) The impact of investment has included an increase in the therapeutic offer including occupational therapy, art therapy and sensory assessments; increase in reflective practice to support practitioners to consider patient needs alongside wellbeing of the team; an improved group offer; more community support workers to support with shopping skills and meal preparation etc; improved carer offer; and enhanced support for professional development and training for staff.

b) The Service is participating in a national pilot programme called First Episode Rapid Early Intervention (FREED), which aims to engage patients at an early stage with phone contact within 48 hours of the referral, an assessment within two weeks and treatment starting within four weeks. The benefits of the programme include people feeling validated by getting an assessment within a short space of time and having an early indication of whether the service is appropriate for their needs or if they need to be signposted to an alternative. Feedback received so far has been positive.

c) The Eating Disorder Service is included within the wider Severe Mental Illness Transformation Programme. The early access targets for severe mental illness services include eating disorders. At a national level there are a number of key deliverables from this Programme for Adult Eating Disorder Services including expanding clinical and non-clinical capacity; having dedicated pathways across primary care, secondary care, local authorities and the community and voluntary sector; removing barriers to access; increasing the number of patients seen; reducing waiting times; and accepting self-referrals.

d) The Trust will be looking at the issue of self-referral across all services next year.

e) In terms of governance for transformation activity, there is an All Age Eating Disorder Steering Group that feeds into the Severe Mental Illness Transformation Board and three task and finish groups that have wider representation: Medical Monitoring; Disordered Eating; and Avoidant Restrictive Food Intake Disorder (which is a relatively new classification of eating disorder).

f) The priorities for transformation in 2022/23 include continuing to enhance capacity and capability, improving service user engagement in pathway developments, continuing to monitor and evaluate the FREED model and providing training and raising awareness of eating disorders across the health and social care system.

During subsequent discussion and in response to questions from the Committee the following points were made:

g) While one of the national requirements for transformation of eating disorder services is removal of barriers such as weight and body mass index (BMI), BMI is not used as a criteria for access to eating disorder services in Nottingham. The Chair cited an example of a citizen who had contacted the Committee to say that they had received a letter from the Trust referring to a ‘BMI cut off’. The Trust assured the Committee that its policy is not to use BMI as a criteria for accepting referrals and offered to look at the specific case so that it can be learnt from.

h) When the Trust spoke to the Committee in 2021 about access to the Eating Disorder Service, the Trust indicated that it expected waiting times to have reduced by summer 2022. The data shows that waits for assessment and treatment actually increased during this period. The Trust explained that, in

addition to the backlog of cases, there continued to be a high level of referrals alongside staffing challenges. Although additional posts were funded, it proved challenging to recruit to them and even when individuals are appointed there is a 3-4 month lead in to them starting.

i) The Trust is unable to control demand and it is anticipated that it will increase further, especially in the child and adolescent mental health pathway.

j) Service user feedback is sought, for example when exploring how to carry out medical monitoring, but there is currently no patient voice within governance of the service. The Trust is looking at how to do this effectively, and this will be particularly important in terms of development of the Service.

k) While there has been agreement to increase the number of posts within the Service, it has been challenging to recruit to those posts. In addition, once new staff are in post it takes time to skill them appropriately. This means that it will take time for the increase in capacity to have an impact on waiting times.

l) Given the existence of the national programme for transformation, all mental health trusts are trying to recruit staff and this makes it very competitive.

m) Referrals are discussed at weekly multi-disciplinary team meetings and if an urgent case is identified then this will be escalated. People on the waiting list will be offered self-help support as part of the Waiting Well Programme. There is also a virtual offer provided by the voluntary sector called First Steps. Initial feedback is that this has not been taken up much by patients but more formal evaluation is awaited. A committee member suggested that having patient voice in development of the service would be helpful in this regard.

n) The Trust is looking at the transition from child to adult services. There has been a Transition Worker in place for a number of years working with young people from age 17. This post is currently vacant and this has prompted a review of whether this is still the right approach. People who have experienced the transition process are being consulted on this to help identify the best way forward for that aspect of the service.

o) In terms of support for students with an eating disorder, First Steps provides an eating disorder service accessible by students and the Unity Primary Care Network has mental health support for students in place. There is a practitioner who acts as a gateway to services. There are two new roles across the primary care networks and community teams and practices are skilled up to recognise signs and signpost to First Steps or refer to clinical services as appropriate.

The Committee expressed disappointed that despite assurance by the Trust in October 2021 that work was taking place to develop the service and improve accessibility, waiting times for assessment and treatment had increased during that period. The Trust and the ICB stated that they are both committed to reducing waiting times and aiming to meet the 8 week target that will be in place by the end of 2023/24, however there are significant challenges in doing so. In response to a question about when the Trust expects waiting times to reduce, the

Trust cited increasing demand, which is outside of its control, and challenges in recruitment as the main reasons for increasing waiting times and said that the situation is unlikely to improve until the Service is fully staffed. Given national recruitment issues, it is not known when this will be achieved. In recognition that many providers cite recruitment challenges in relation to their services, the Committee commented on the need for the NHS as a whole to tackle recruitment and retention issues because the situation from the perspective of a patient trying to access services is not great.

Resolved to review progress by Nottinghamshire Healthcare NHS Foundation Trust in reducing times for assessment and treatment by the Adult Eating Disorder Service in 2023.

34 Adult Social Care Outcomes Framework

Councillor Linda Woodings, Portfolio Holder for Adults and Health, and Sara Storey, Director of Adult Health and Care, presented the report about the Adult Social Care Outcomes Framework (ASCOF) and seeking the Committee's view on if, and how it wants to use the Framework to scrutinise care services. They highlighted the following information:

a) The ASCOF is a set of key measures collected for local authorities responsible for social care in England and is published annually. It therefore allows for benchmarking across all councils in England or for specific sub-sets, although in making comparisons there needs to be recognition that there is a level of variability in the data collection.

b) As things have changed over time, the ASCOF is not completely aligned with statutory duties and there have been some attempts to revise the framework, although this work was postponed due to the Covid pandemic. One of the aims of this work is to explicitly link it to the Care Quality Commission (CQC) assurance framework.

c) When CQC inspection is introduced, it is likely that inspectors will utilise ASCOF as one way of reviewing a local authority's performance.

d) The national set will be published in November.

e) Discussion is taking place about how to increase the visibility, and use of the ASCOF data within the Council. This may include linking measures to other work e.g. using it to help assess the outcomes of the transformation programme; or specifically reviewing performance against similar local authorities.

During subsequent discussion and in response to questions from the Committee the following points were made:

f) It was confirmed that ASCOF data can be mapped against deprivation indices.

g) Looking at currently available ASCOF data, Nottingham is not a high performing council. However, it is encouraging that measures reported on by

citizens who use services e.g. the proportion of service users that feel safe or the contribution of services to quality of life are more positive. There are lots of improvements that need to be made and transformation will need to deliver better outcomes.

h) It is important that data, such as ASCOF, is used by the organisation to learn and improve rather than just measuring performance for its own sake.

The Committee concluded that there would be benefit in using ASCOF data to inform its work, for example helping to identify areas for in-depth consideration.

Resolved to:

(1) use Adult Social Care Outcomes Framework (ASCOF) data as a way of holding to account for performance and to inform future work programming decisions going forward; and

(2) request that when ASCOF data is reported to the Committee, the following information is provided:
- **a. data in the context of transformation**
- **b. data compared with other comparative authorities in terms of indicators such as deprivation, age and ethnicity**
- **c. what the Service is learning from the data**

35 Integrated Care Strategy

Alex Ball, Director of Communications and Engagement, and Mark Wightman, Director of Strategy and Reconfiguration, Nottingham and Nottinghamshire Integrated Care Board gave a presentation informing the Committee of the proposed approach to developing an Integrated Care Strategy for Nottingham and Nottinghamshire. They highlighted the following information:

a) Each Integrated Care System is required to produce an Integrated Care Strategy that is evidence based and built on an assessment of population need, and that builds upon existing work and momentum. It must be refreshed annually in line with emerging national guidance.

b) The assessed needs of the population are as articulated in the Joint Strategic Needs Assessments produced by Directors of Public Health, which also form the basis of Joint Health and Wellbeing Strategies so these strategies should be aligned. The Integrated Care Board Forward Plan has to refer back to the Integrated Care Strategy so all of these plans should be linked and working towards the same core aims and ambitions. Historically, despite the consideration given to population health management, little has been done in this regard and this will be the first time that there is a 'golden thread' running throughout.

c) The vision for the Strategy is that every citizen will enjoy their best possible health and wellbeing. In order to achieve this neighbourhoods, places and systems will need to seamlessly integrate to provide joined up care and therefore priorities and priorities will need to be joined up.

d) This presents opportunities to do things differently, by having an approach that defaults to working better together with shared aims and ambitions. This should support delivery of some of the difficult things that have not be tackled to date.

e) There are four strategic aims for the Strategy: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and supporting broader social and economic development.

f) The challenge is to create specificity in the deliverables and accountabilities for these aims and this is being worked on at the moment. An idea being explored is to ring-fence a proportion of annual uplift to invest in prevention.

g) Enablers are being identified to address the reasons why progress hasn't been made before, for example having a shared common purpose that all partners pursue relentlessly.

h) The Health and Care Act 2022 requires the involvement of Local Healthwatch organisations and people who live and work in the area in development of the Strategy. This will happen through a three stage approach. The first stage will be collating what the system already knows through desk-top research so that citizens aren't consulted about things they have already expressed their views on e.g. what do existing strategies, that have been developed with citizen input, say. Gaps in knowledge will then be identified and the second stage will be to fill those knowledge gaps. This will be done through a range of methods including public events and questionnaires. The approach to this will be proportionate given that a lot of information is already known and there is a relatively short timescale for completing the work. There will then be consultation with Health and Wellbeing Boards, wider stakeholders and interested members of the public.

During subsequent discussion and in response to questions from the Committee, the following additional points were made:

i) It is important that resources are directed to populations that most require support and preventative activity. The Strategy will recognise that some people need more than equal access and resources will need to reflect this. Discussions are taking place with local authorities on how to achieve this.

j) All providers cite the challenges of recruitment and retention, and therefore an effective workforce strategy will be essential to delivering the services necessary to support good health and wellbeing.

The Committee supported the proposed ambitions of the Strategy but sought reassurance about how success will be measured to ensure that it really makes a difference to peoples' lives. There could be opportunities for the Committee to hold the system to account for doing this, and the Committee would welcome proposals from the Integrated Care Board on options for its involvement.

36 Proposed changes to acute stroke services

The Committee considered written information provided by Nottingham and Nottinghamshire Integrated Care Board about proposals to make changes to the configuration of acute stroke services provided by Nottingham University Hospital NHS Trust permanent. This included information about the patient and public engagement carried out and feedback from patients and carers.

The Committee did not raise any concerns about the proposal.

Resolved to support the configuration of acute stroke services provided by Nottingham University Hospitals NHS Trust being made permanent.

37 Proposed changes to neonatal services

The Committee considered written information provided by Nottingham and Nottinghamshire Integrated Care Board about proposed changes to neonatal services provided by Nottingham University Hospital NHS Trust. This included information about the targeted engagement carried out and the feedback from that engagement.

The Committee noted the update on work to expand neonatal capacity at Nottingham University Hospital NHS Trust through the Maternity and Neonatal Redesign Programme and did not raise any concerns.

38 Work Programme

The Committee noted its work programme for the remainder of municipal year 2022/23.

Health and Adult Social Care Scrutiny Committee
17 November 2022

NHS and Community Dental Services

Report of the Head of Legal and Governance

1. Purpose

1.1 To explore issues relating to access to NHS and Community Dental Services in the City.

2. Action required

1.1 The Committee is asked whether:

a) it wishes to make any comments or recommendations; and

b) any further scrutiny is required, and if so the focus and timescales.

3. Background information

3.1 Following anecdotal reports of difficulties in accessing dental services in the City, the Committee wanted to explore current access to NHS dental services, including recovery from the Covid pandemic. NHS England currently commissions all NHS dental services but local responsibility will be delegated to the Integrated Care Board from April 2023.

3.2 NHS England, Nottingham and Nottinghamshire Integrated Care Board and the Council's Public Health Team have submitted a paper outlining information about the provision of, and access to NHS and Community Dental Services, including current provision of dental services in the City, impact of the Covid pandemic on provision and access and restoration and recovery of services and oral health. Representatives from those organisations will be attended the meeting to discuss this with the Committee.

4. List of attached information

4.1 Paper prepared and submitted by NHSE Commissioning Team Senior Managers, NHSE Consultant in Dental Public Health and Public Health colleagues at Nottingham City Council.

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

8.1 Jane Garrard, Senior Governance Officer
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

Nottingham City Health Overview and Scrutiny Committee

17th November 2022

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1. Background and Information

1.1 The Nottingham City Health Overview and Scrutiny Committee (HOSC) has requested a report on access to NHS Dental Services, with particular focus on provision and recovery plans as services emerge from the COVID-19 pandemic, including a wider context of oral health prevention and the transition of NHS England (NHSE) Commissioning services to NHS Nottingham and Nottinghamshire Integrated Care Board from 1 April 2023. This report also includes oral health improvement initiatives and activities, which is the statutory responsibility of Nottingham City Council's Public Health team.

1.2 The Nottingham City HOSC is asked to note that NHS England is currently responsible for the commissioning of all NHS dental services, but local responsibility will be delegated to NHS Nottingham and Nottinghamshire ICB on 1 April 2023.

1.3 This report has been developed by:

- NHSE Commissioning Team Senior Managers
- NHSE Consultant in Dental Public Health
- Public Health colleagues at Nottingham City Council

1.4 Representatives from NHSE will be present at the Nottingham City HOSC meeting.

In addition, the Acting Consultant in Public Health from Nottingham City Council will also be in attendance.

2 National NHS Dental Contract

2.1 NHSE is responsible for commissioning all NHS dental services including those available on the high street (primary care dental services), specialist dental services in primary care e.g. Intermediate Minor Oral Surgery (IMOS) and Community Dental Services (CDS) as well as from Hospital Trusts. Private dental services are not within the scope of responsibility for NHSE.

2.2 Although NHSE is responsible for commissioning all NHS general dental services, there are certain limitations of the current national contract. However, flexible commissioning can be utilised where a percentage of the existing contract value is substituted (up to 10%) to target local needs or meet

local commissioning challenges. This approach requires a balance to ensure dental access is maintained.

2.3 The current NHS dental contract for primary and community dental care was introduced in 2006. Prior to that, dentists could choose to set up a dental practice anywhere in the country. They could also see and treat as many patients who attended, and they claimed for each element of the dental treatment that was carried out under the old 'Items of Service' contracting arrangements e.g. if a patient had two fillings, the dentist was paid twice the unit cost of a filling etc. However, the old dental contract did not work for various reasons, therefore, there was a reference period in 2005 which determined how many Units of Dental Activity (UDAs) each NHS dental practice that existed at that time would be allocated per annum and it was no longer possible for dentists to set themselves up as an NHS provider on an ad-hoc basis. Any new NHS dental service had to be specifically commissioned by the then Primary Care Trusts (PCTs) within their capped financial envelope.

2.4 In effect, the former PCTs, and subsequently NHS England, 'inherited' those practices that were already in existence and who wished to continue to carry out NHS dentistry under the new contracting arrangements. Sadly, a number of practices opted to become fully private at this time as they did not feel that the new UDA system would adequately recompense them for their work. This had a significant impact on the number of NHS appointments available. The PCT had no control over where these 'inherited' services were situated, or over the number of UDAs commissioned in each geographical area, as it was based on historical activity. Hence capacity did not, and in some areas continues to not, necessarily meet demand. Although there has been significant population changes in subsequent years, the number of UDAs commissioned (which is set contractually and cannot be amended without the agreement of both parties) has not always increased/decreased accordingly in order to meet the changing population need and demand.

2.5 Unlike General Medical Practice (GMP), there is no system of patient registration with a dental practice and patients are free to choose to attend any dental practice, regardless of where they live. Although dental practices are aware of this, there is still some misconception amongst the public regarding patient registration with dental practices. Dental practices are responsible for patients who are undergoing dental treatment under their care and once complete (apart from repairs and replacements that are guaranteed for 12 months and can be replaced with the same treatment), the practice has no ongoing responsibility. However, people often associate themselves with a specific dental practice. 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 GMP practices and patients are theoretically free to attend any dental practice that has capacity to accept them.

2.6 Prior to the pandemic, patients would often make their 'dental check-up appointments' at their 'usual' or 'regular dental practice'. During the pandemic, contractual responsibilities changed, and practices were required to prioritise:

- urgent dental care
- vulnerable patients (including children)
- those at higher risk of oral health issues

For many practices, there has not been sufficient capacity to be able to offer routine dental check-up appointments. The contract reform will seek to clarify the NICE recall guidelines. Patients may find in the future that they are offered personalised recall intervals depending on an assessment of their oral health risk.

3 NHS dental services across Nottingham City

3.1 NHS General Dental and Orthodontic Services

Nottinghamshire has 109 general dental practices which offer a range of routine dental services. 35% (n=38) of general dental practices are located within Nottingham City. None of the general dental practices within Nottingham City also provide orthodontic services, however there are 4 specialist orthodontic practices within Nottingham City.

3.2 Extended hours, urgent dental care and out of hours

3.2.1 There is an extended NHS urgent dental care contract within Nottingham City which provides access to patients: Monday to Friday 08:30 – 21:15, Weekends 09:00 – 21:00, Bank Holidays 09:00 – 21:00.

Following re-procurement of the current urgent dental care contract. A new 8-8 NHS unscheduled dental care contract will be in place from 1 January 2023 within Nottingham City providing urgent dental care from 8am to 8pm every day of the year (365 days).

3.2.2 At times of peak demand, patients may have to travel further for urgent dental treatment depending on capacity across the system. There is also an additional 8-8 NHS dental contract in Rainworth for urgent dental care.

3.2.3 Out of hours dental services only provide urgent dental care. Urgent dental care is defined into three categories as shown in Table 1 along with best practice access timelines for patients to receive self-help or face to face care.

Table 1: Timelines in accordance to dental need

Triage Category	**Time Scale**
Routine Dental Problems: • Mild or moderate pain: that is, pain not associated with an urgent care condition and that responds to pain-relief measures • Minor dental trauma	Provide self-help advice and access to an appropriate service within 7 days, if required.

• Post-extraction bleeding that the patient is able to control using self-help measures • Loose or displaced crowns, bridges or veneers • Fractured or loose-fitting dentures and other appliances • Fractured posts • Fractured, loose or displaced fillings • Treatments normally associated with routine dental care • Bleeding gums	Advise patient to call back if their condition deteriorates
Urgent Dental Conditions: • Dental and soft-tissue infections without a systemic effect • Severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice • Fractured teeth or tooth with pulpal exposure	Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates
Dental Emergencies: • Trauma including facial/oral laceration and/or dentoalveolar injuries, for example avulsion of a permanent tooth • Oro-facial swelling that is significant and worsening • Post-extraction bleeding that the patient is not able to control with local measures • Dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection • Severe trismus • Oro-dental conditions that are likely to exacerbate systemic medical conditions such as diabetes (that is lead to acute decompensation of medical conditions such as diabetes)	Provide contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition

3.2.4 If a person has a regular dental practice and requires urgent dental care:

- During surgery hours, they should contact their dental practice directly
- Out of hours, they should check their dental practice's answer machine for information on how to access urgent dental care. Most people are signposted to contact NHS 111 (interpreters are available). For deaf people, there is also the NHS 111 BSL Service (alternatively, they can also call 18001 111 using text relay). There is also an online option for contacting NHS 111 that will often be quicker and easier than phoning.

3.2.5 If a person does not have a regular dental practice and requires urgent dental care, they can contact:

- any NHS dental practice during surgery hours to seek an urgent dental appointment and this would be dependent on the capacity available at each dental practice on any given day. They can use the Find a Dentist facility on the NHS website
- NHS 111, either online or on the phone (interpreters are available). For deaf people, there is also the NHS 111 BSL Service (alternatively, they can also call 18001 111 using text relay)
- Healthwatch Nottingham / Healthwatch Nottinghamshire for signposting
- NHS England's Customer Contact Centre on 0300 311 2233

3.2.6 Patients with dental pain should not contact their GP or attend A&E as this could add further delays in gaining appropriate dental treatment as both GP and A&E services will be redirecting such patients to a dental service.

3.3 Community (Special Care) Dental Service

3.3.1 The Nottinghamshire Community (Special Care) Dental Service provides dental treatment to patients whose oral care needs cannot be met through NHS primary dental care due to their complex medical, physical, or behavioural needs. The service uses behavioural management techniques and follows sedation and general anaesthesia (GA) pathways. Dentists and/or health care professionals can refer into the service. There is one dental provider (Community Dental Service (CDS) CIC) treating children and adults from clinics across the Nottinghamshire system: there are 7 dental clinics, with 3 located in Nottingham City. The service is commissioned across the Nottinghamshire system footprint and although there are 3 clinics located in Nottingham City, patients do have the choice to attend the alternative clinics in the county. In addition, the provider is looking to deploy a mobile dental surgery which will further help to reach vulnerable groups and provide a treatment option where attendance in a clinic setting may be more challenging. The new Nottinghamshire Community Dental Services contract commenced on 1 April 2020.

3.3.2 The GA pathway for children and special care adults is managed between CDS-CIC and Nottingham University Hospitals (NUH) which is commissioned on a system area footprint.

3.3.3 CDS-CIC are also commissioned to provide NHS dental care and treatment for those who are unable to leave their own home or care home (triaged against special care criteria). Some limited dental care can be provided in a person's own setting such as a basic check-up or simple extraction, but patients may still need to travel into a dental surgery (as this is the safest place) to receive more complex dental treatment. If such patients require a dental appointment, they or their relative/carer can contact the local domiciliary provider via NHS 111.

3.4 Domiciliary Care (for patients unable to leave their own home or care home)

3.4.1 For residents of Nottingham City, there is also a dedicated General Dental Practitioner who is commissioned to provide dental care and treatment for care home residents and also for those who live in their own home. If they need more specialist dental care, they will generally be referred on to the Community (Special Care) Dental Service after this initial contact.

3.5 Intermediate Minor Oral Surgery (IMOS) Service

3.5.1 The IMOS service is a specialist referral service in primary care providing complex dental extractions for residents in the Nottinghamshire system. This service is for patients over the age of 17 years who meet the clinical criteria. There are 9 IMOS providers across the Nottinghamshire system with 4 located in Nottingham City.

3.6 Maps of location of dental providers

3.6.1 A map of the location of NHS dental practices or clinics (including orthodontic and community sites) in Nottingham City is in Appendix 1. In some cases, there are practices in close proximity and the numbers on the map reflect this as the scale does not permit them being displayed individually.

3.7 Hospital dental care

3.7.1 Secondary care dental services e.g. Orthodontics, Oral Surgery, Oral Medicine, Maxillofacial Surgery and Restorative services are commissioned from NUH to deliver complex dental (often multi-disciplinary) treatment to patients who meet the clinical criteria in line with the NHSE Commissioning Guides. Activity and contract values are agreed annually with acute trusts.

4 Nottingham and Nottinghamshire Integrated Care Board (ICB)

4.1 Nottingham and Nottinghamshire ICB assumed delegated responsibility for Primary Medical Services from 1 July 2022 and for Dental (Primary, Secondary and Community), General Optometry and Pharmaceutical services (including Dispensing doctors) from 1 April 2023, subject to formal sign-off by NHSE.

4.2 The Midlands Primary Care Operating Model has been co-designed to provide an approved framework for the delegation of the function to each Integrated Care Board (ICB). The Operating model provides an overview of the functions and sets out the key design principles that support the transition in 2022/23. Nottingham and Nottinghamshire approval of the model is one of the necessary gateways in the national NHSE delegation assessment framework

4.3 The Operating Model sets out the principles, pathway, key governance, workforce, and financial information that will be co-designed with Nottingham

and Nottinghamshire during the transition period for the safe and effective delegation of these functions. The transition process will:

- provide the detail that enables ICBs to undertake the workforce and contract due diligence as well as setting out the key financial principles for delegation of the commissioning budgets.
- manage the risk of moving from a regional budget to splitting across eleven systems.
- be transparent and ordered through finance governance groups to complete the due diligence and safe transfer to ICBs from April 2023.

4.4 A Governance structure has been proposed that enables ICBs to set the annual plan and strategic direction of the Pharmacy, Optometry and Dental functions and make localised decisions where possible, whilst the current team are enabled to deliver day to day contracting and commissioning functions. The process has been designed to ensure minimal disruption and smooth transition to support both services and patients.

5 NHS Dental Charges

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

- **Emergency dental treatment – £23.80** This covers emergency dental care 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.

More information is available here. All NHS dental practices have access to posters and leaflets that should be displayed prominently.

5.2 Exemption from NHS charges is when patients do not have to pay these costs, for instance when receiving certain benefits. If this is the case, then proof of entitlement would need to be presented at the NHS dental practice. It is the patient's responsibility to check whether they are entitled to claim for free dental treatment or prescription. Financial support is also available for patients on a low income through the NHS Low Income Scheme.

6 Impact of the pandemic

6.1 The ongoing COVID-19 pandemic has had a considerable impact on dental

services and the availability of NHS dental care; the long-term impact on oral health is as yet unknown but it is a cause for concern. All 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 (UDCs) was immediately established across the Midlands in early April 2020 to allow those requiring urgent dental treatment to be seen.

The UDCs have remained in operation since the height of the pandemic and referral numbers were very low volume, therefore in line with the Governments Living with COVID-19 strategy dental referral system pathways were closed from 24th August 2022. The UDCs remain on standby in case of future uncontrolled issues that may affect delivery of NHS dental services (such as staff shortages due to sickness – for example as a consequence of a COVID-19 outbreak). There were two UDCs located within Nottingham City.

6.2 From 8 June 2020, dental practices were allowed to re-open however additional infection prevention and control measures were needed to be implemented as well as social distancing requirements for patients and staff. A particular constraint was 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 which would include dental fillings or root canal treatment. This has had a marked impact on the throughput of patients and the number of appointments that could be offered. For a large part of 2020, many practices were only able to provide about 20% of the usual number of face-to-face appointments and relied instead on providing remote triage of assessment, advice, and antibiotics (where indicated). The situation improved in early 2021, with reductions in fallow time requirements and since then practices have been required to deliver increasing levels of dental activity.

6.3 NHS dental practices are currently required to offer dental services to patients throughout their contracted normal surgery hours (some practices are offering extended opening hours to better utilise their staff and surgery capacity). They are also required to have reasonable staffing levels for NHS dental services to be in place. Increases in capacity have been gained in line with subsequent changes to national protocols for infection prevention and control such as reducing social distancing requirements and the introduction of risk assessments for patients who may have respiratory infections.

6.4 All NHS dental practices are required to maximise capacity and also to prioritise urgent dental care for:

- their regular patients
- patients without a regular dental practice referred via NHS 111
- all vulnerable patients

6.5 Infection prevention and control measures have been regularly reviewed and the following minimum requirement for the recovery of dental activity has been imposed on NHS general dental contracts:

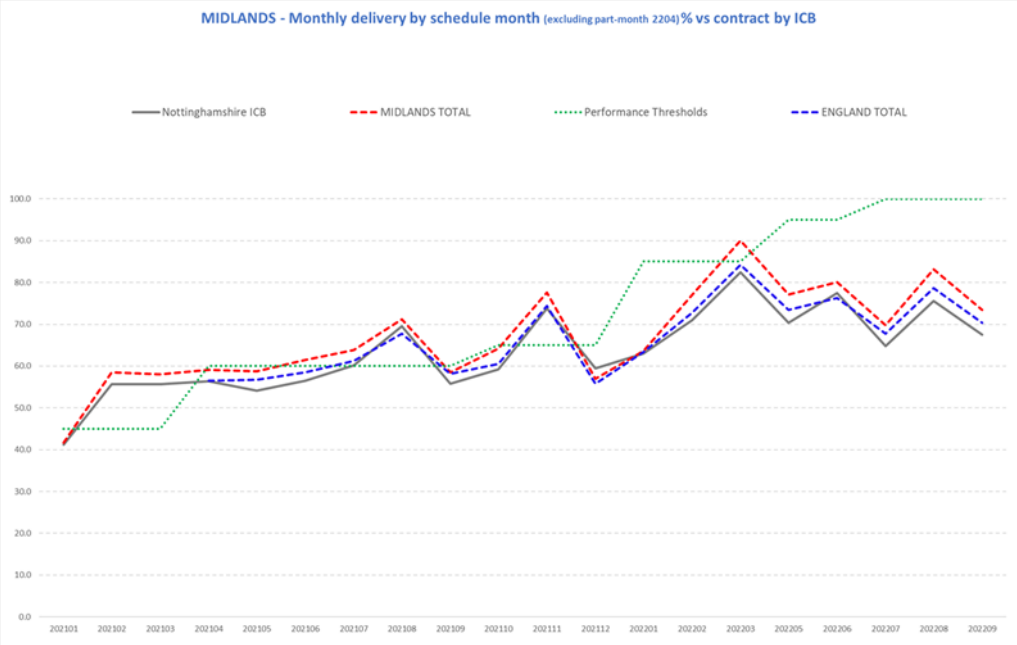
- Q3 2021/22: 65% of contracted activity
- Q4 2021/22: 75% of contracted activity

- Q1 2022/23: 95% of contracted activity
- Q2 2022/23: 100% of contracted activity

6.6 Figure 1 shows the level of NHS dental activity delivered across the Nottinghamshire system during the pandemic against the minimum threshold activity set by the national team and against the Midlands total. It can be seen that lower levels of activity have been delivered across the Nottinghamshire system as a whole when compared against the minimum thresholds set and the total Midlands activity. Unfortunately this data is only available at an ICS level, therefore data cannot be reported for Nottingham City.

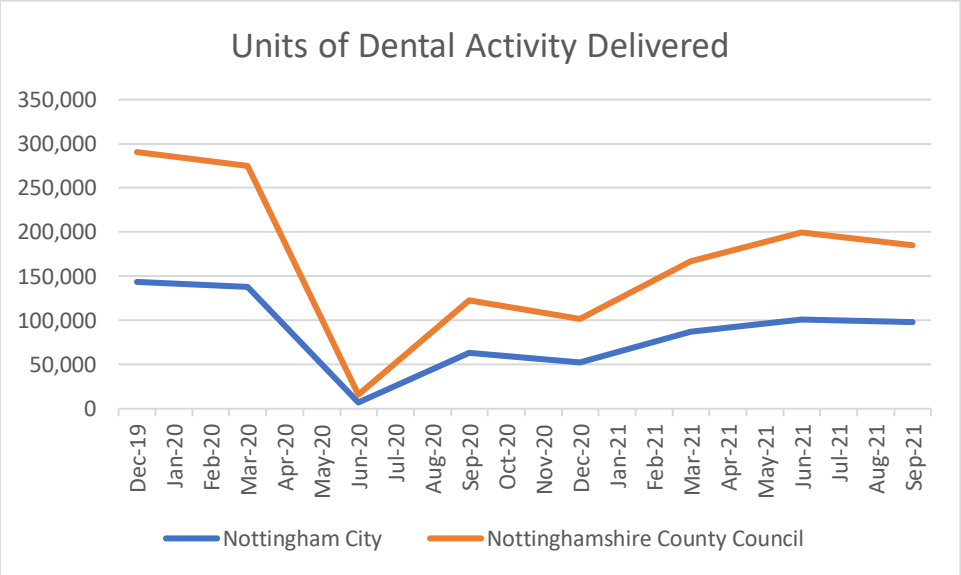
Figure 1: Nottinghamshire Primary Care Dental Activity vs Minimum Thresholds

Midlands Total
England Total
Nottinghamshire
Minimum Thresholds



6.7 Figure 2 shows the Units of Dental Activity (UDAs) delivered by NHS dental practices located in Nottingham City Council and Nottinghamshire County Council during the pandemic (although NHS dental practices are not contractually associated to them). By 30 September 2021, NHS dental practices in Nottingham City had recovered 68.5% of pre-pandemic dental activity, compared to NHS dental practices in Nottinghamshire at 63.7%.

Figure 2: UDAs delivered by local authority during the pandemic



6.8 The national minimum requirement for all NHS dental contracts was set at 65% for Q3 and 85% for Q4 2021/22. Tables 2 and 3 show Nottinghamshire dental practices achievement in comparison to Midlands' performance.

Table 2: Proportion of UDA delivery in Q3 and Q4 of 2021/22 by NHS General Dental Practices across the Nottinghamshire system *(unfortunately this information is not available at a lower level and we are therefore unable to report data for Nottingham City)*

	Period	Threshold	Nottinghamshire system performance
Nottinghamshire	Q3	65%	62.3%
Nottinghamshire	Q4	85%	73.1%
Midlands	Q3	65%	66.2%
Midlands	Q4	85%	76.9%

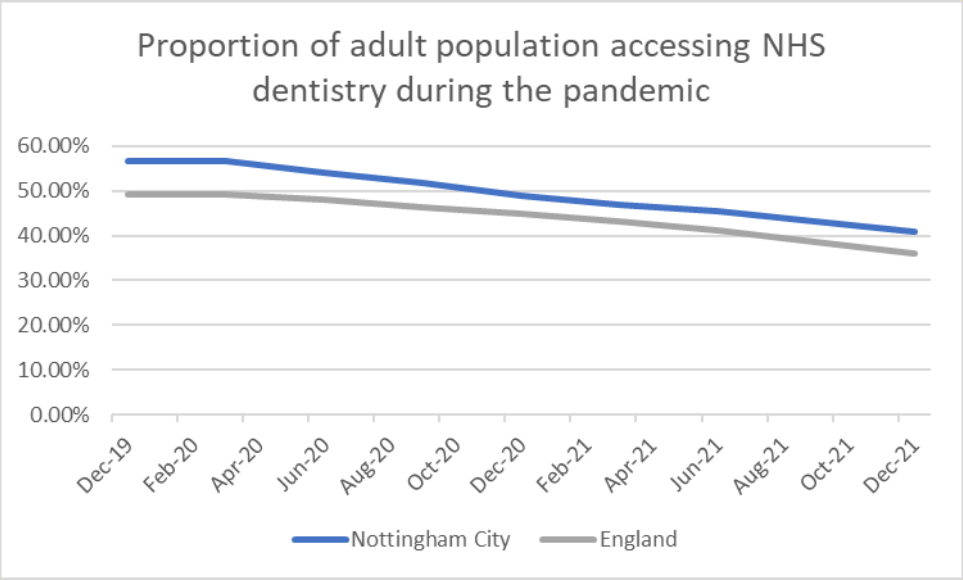
Table 3: No. of NHS dental contracts meeting / exceeding national minimum performance requirements during Q3 and Q4 of 2021/22 across the Nottinghamshire system *(unfortunately this information is not available at a lower level and we are therefore unable to report data for Nottingham City)*

	Period	Outcome – number meeting or exceeding thresholds
Nottinghamshire	Q3	64 out of 117 (54.7%)
Nottinghamshire	Q4	44 out of 117 (37.6%)
Midlands	Q3	718 out of 1,181 (60.8%)
Midlands	Q4	452 out of 1,181 (38.3%)

7. NHS Dental Access

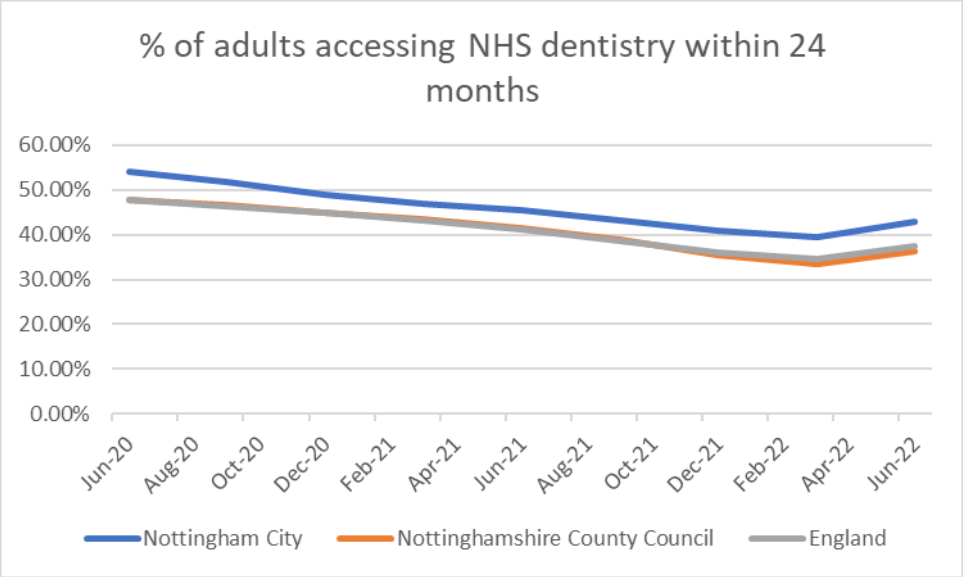
7.1 Figure 3 shows the percentage of adults accessing NHS general dental practices during the pandemic by local authority. It can be seen the proportion of adult residents in Nottingham City accessing NHS dental services has constantly been higher than England averages, prior to and during the pandemic.

Figure 3: Proportion of adults accessing NHS dentistry during the pandemic



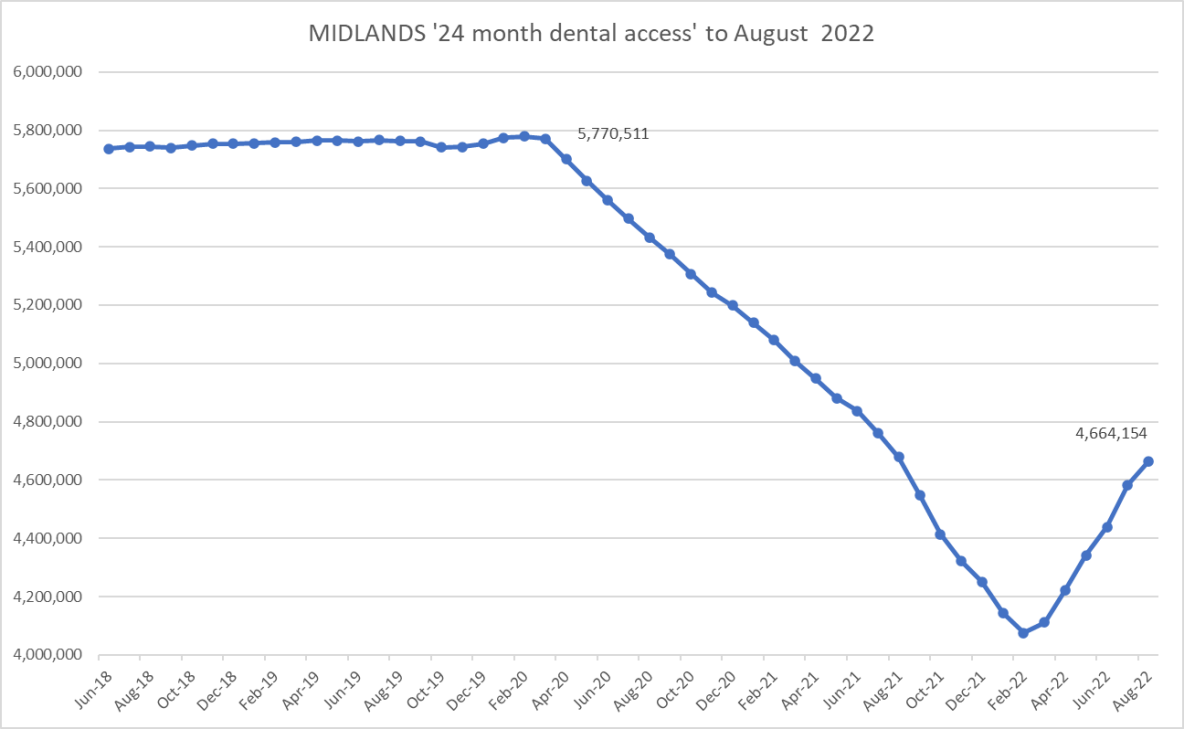
7.2 The National Institute of Health and Care Excellence (NICE) does not support routine 6-monthly dental check-ups universally for all patients. It recommends that dentists should take a risk-based approach to setting the frequency of dental check-ups and that the longest gap between dental check-up appointments for every adult (over 18 years) should be 24 months. Figure 4 demonstrates that the proportion of Nottingham City adults accessing NHS dentistry within 24 months (as per NICE recommendations) was higher than both the County (Nottinghamshire) and National (England) averages prior to and during the pandemic. However, when making comparisons of proportionate loss between June 2020 and June 2022, Nottingham City saw a loss of 11%, compared to Nottinghamshire at 11.6% and England at 10.5%.

Figure 4: Proportion of adults accessing NHS dentistry within 24 months



7.3 Figure 5 below demonstrates recovery access to NHS Dentistry since the covid-19 pandemic across Midlands.

Figure 5: 24-month unique patient count (NB: from July 2022, approx. 68,000 added by boundary changes (ICB))



7.4 It is estimated that across the Country there has now been the equivalent of a years' worth of appointments lost in primary care dentistry since the start of the pandemic. The effects have been similar in community and hospital care

due to restricted capacity from staff absences or re-deployment to support Covid-19 activities.

7.5 A strategic review of dental access is planned for 2022/23 and NHSE anticipate having access shortly to a mapping tool which will help to identify local areas which may have specific issues in order to assist with a more targeted approach in tackling them.

7.6 NHSE are aware that information provided by local dentists on the NHS website may not always be up to date, but it is unfortunately at present not a contractual requirement for dental providers to do so, however going forward as part of the new NHS Contract reform it will be a requirement for dental providers to update their information. NHSE are continuously working with all local dental providers to improve the accuracy of this information for the public. The Nottinghamshire Local Dental Network Chair has also engaged with Find a dentist - NHS (www.nhs.uk) regarding improvements to dental practice profiles planned for September/October 2022 which will assist for all users of the platform.

7.7 NHSE also recognise the backlog of NHS dental care which has accumulated during the period where dental services have not operated at full capacity. Many NHS dental contractors are already delivering over 100%, and it is critical for those providers who are not to make progress as quickly as possible. Unfortunately, many practices are struggling to recruit staff (both dentists and nurses) and this is having an impact on capacity. Nevertheless, NHSE are expecting all NHS general dental practices to reach a minimum of 95% of contracted activity during Q1 of 2022/23 with full (100%) delivery of contracted dental activity from July 2022.

8 Private Dentistry

8.1 Private dental services are not within the scope of responsibility for NHSE. Therefore, NHSE are unable to provide any information on activity uptake within the private dentistry sector.

8.2 It should be noted that dental practitioners are independent contractors to the NHS and therefore many dental practices operate a mixed private/NHS model of care and although NHS contract payments have been maintained by NHSE during the pandemic, the private element of their business may have been adversely affected.

8.3 The Chief Dental Officer for England set up a time limited working group who undertook an investigation into the resilience of mixed economy practices. They concluded that whilst there would have been an interruption of income, the risk of a large number of dental practices facing insolvency over the next 12 to 18 months was low.

8.4 Some patients who have previously accessed dental care privately may now be seeking NHS dental care due to financial problems related to the pandemic or due to the additional Personal Protective Equipment (PPE) charges that have apparently been levied by some private dental practices. This is putting additional pressure on NHS services at a time when capacity is constrained. Although these patients are eligible for NHS dental care, they may have difficulty in finding an NHS dental practice with capacity to take them on.

8.5 There have been anecdotal reports of some practices' reluctance across the Midlands region in offering NHS appointments (particularly routine) and are offering the option to be seen earlier as a private patient instead. NHSE does not support any stances of pressurising patients into private dental care. NHSE will investigate any report of this nature but will need detailed information so that this can be raised with the practice for a response. Any such concerns can be raised via a complaint about any specific practice/s by contacting the NHS England Customer Contact Centre on 0300 311 22 33 or www.england.nhs.uk/contact-us/.

9. Dental contract hand-backs

9.1 Since the start of the pandemic, one NHS general dental contract from Nottinghamshire has been handed back to NHSE. The dental activity from the terminated contract was not lost as NHSE undertook a review of dental access data within the surrounding area of the terminating dental contract hand-back to recommission the activity by dispersal to surrounding local dental practices in the area.

9.2 As part of the dental activity dispersal process, the NHS dental practice that is handing back their NHS activity must agree a communication letter for their patients with NHSE. This letter notifies patients that the dental practice will no longer be providing NHS dental care and provides appropriate sign posting on how to continue gaining access to NHS dental care from elsewhere. This provides assurance to NHSE that there is no inappropriate/forced signup to private dental services and enables informed patient choice.

10. Restoration of NHS Dental Services

10.1 NHSE is working with the local dental profession to restore NHS dental services and to deal with the inevitable backlog of patients that has built up since the COVID-19 pandemic. In line with national guidance issued, all NHS dental practices in England are currently working towards providing routine dental care in the same way as they were prior to the pandemic, with the expectation of full (100%) delivery of contracted dental activity from July 2022.

10.2 Reduced access to NHS 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 may have struggled to gain access to NHS dental care.

Some who were part way through dental treatment will undoubtedly have suffered and may have lost teeth they would not have otherwise - temporary fillings placed pre-lockdown, for example, and only intended as temporary measures, may have come out causing deterioration in outcome.

10.3 Aside from the effects of reduced dental access, it is possible that the pandemic will have other long-term impacts on oral and general health due to changes in 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 and alcohol intake could have a detrimental effect on an individual's oral health. Those impacted to the greatest extent by this are likely to be vulnerable population groups and those living in the more deprived areas, thus further exacerbating existing health inequalities.

10.4 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, could also be at greater risk of contracting COVID-19 and of experiencing worse outcomes due to risk factors linked to other long term health conditions.

10.5 For those in the vulnerable or shielded categories due to age or underlying health conditions, special arrangements have been made to ensure they are able to access NHS dental 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.

10.6 In addition, there are groups of patients particularly those experiencing Severe Multiple Disadvantage who are less likely to engage with routine dental services and likely to experience worse oral health. NHSE are working with the Nottingham and Nottinghamshire Oral Health Steering Group to address this inequality, with work on undertaking an options appraisal currently underway.

10.7 NHSE is also aware that other vulnerable groups are also finding it harder than usual to access services. We are continuing to review pathways and treatment arrangements for these patients to ensure that they can continue to access urgent dental care, should they need to. Primarily, this has been facilitated through NHS 111. The special care dental provider has also been ensuring access for vulnerable patients through their network of local clinics and dental access centres.

10.8 The Nottingham and Nottinghamshire Oral Health Steering Group is also looking at new ways of collaborative working with primary care networks to strengthen support to care homes in improving the oral health of their residents and also access to NHS dental services as a priority agenda.

11. NHS Dental Services recovery initiatives

11.1 A large additional financial investment has been made to facilitate initiatives designed to increase access across primary, community and hospital dental care, as follows:

2021/2022

- Weekend Sessions – General Dental Services
  Across the Nottinghamshire system, 8 NHS general dental practices have been contracted to provide 64 additional sessions at a cost of £25,600. Out of the 8 practices, 4 practices are within Nottingham City providing 36 additional weekend sessions.
- Weekday Sessions – General Dental Services
  Across the Nottinghamshire system, 5 NHS general dental practices have been contracted to provided 100 additional sessions at a cost of £40,000. Out of the 5 practices, no practices offered additional sessions within Nottingham City.

- Additional NHS dental sessions – 8-8/Extended Access NHS Dental Providers
  Across the Nottinghamshire system, 1 NHS 8-8/Extended Access dental practice has been contracted to provide 144 sessions at a cost of £94,176. This practice is located within Nottingham City.

- Dedicated Urgent Care slots during surgery opening hours – General Dental Services
  Additional NHS dental capacity has been contracted in order for NHS 111 to be able to signpost patients who do not have a regular dental practice requiring urgent dental care. Five practices across the Nottinghamshire system are taking part and providing extra appointments. Two practices are within Nottingham City offering 14 additional urgent care appointments per week.

- Oral health improvement funding for local authorities
  - £150,000 recurrent for 2 years (21/22 and 22/23) to support oral health improvement initiatives and activities
  - £40,000 non-recurrent to support purchase and distribution of toothbrushing packs to food banks and other venues
  - £5,000 non-recurrent to support Oral Health Promotion training resources to improve delivery of services

  The above funding has been jointly allocated between Nottingham City and Nottinghamshire County Councils. Agreement on the spending of the funding is being discussed and agreed at the Nottingham and Nottinghamshire Oral Health Steering Group to ensure alignment with oral health needs of the area.

- Support Practices - Community Dental Service:
  NHSE have commissioned a number of dental practices across the Midlands to work collaboratively with local dental providers delivering special care dental services. This pilot is intended to provide additional capacity to assist in routine review and support the management of special care dental patients who are in the system. Unfortunately, there was no uptake from NHS dental providers in Nottinghamshire system, however NHSE have secured additional funding to re-run the pilot for financial year 2022/23 and hope to encourage uptake from NHS dental providers within the Nottinghamshire system and Nottingham City. NHSE has been trying to understand the reasons for the lack of interest and at present the main reason appears to be the lack of practice capacity.

- Waiting list initiative - Community Dental Service:
  Non-recurrent investment of £56,562 was secured for the Nottinghamshire system Community (Special Care) Dentistry provider in reducing the waiting list in 2021/22. The waiting list initiative has been running additional sessions for new referrals, first and follow up appointments for patients with open courses of treatment. Furthermore, additional dental hand pieces (dental drills) were also purchased to support improving efficiency of dental clinics resulting in reduced fallow time between patients. Prior commitment of £38,899 has been secured for 2022/23 to support the on-going reduction of waiting lists and NHSE is currently in discussion with the provider on the allocation and delivery of additional clinical sessions during this year.

- Waiting list initiative - Intermediate Minor Oral Surgery (IMOS)
  Non recurrent investment in 2022/23 was introduced to support IMOS providers in reducing waiting times for patients to be seen within 18 weeks of referral into the specialist service. At August 2022, there were 878 Nottinghamshire patients accepted onto the IMOS pathway and 48 (5%) had been waiting over 18 weeks to be treated. This has been reduced from 221 as at June 2021 when the original waiting list initiative was launched. The Nottinghamshire system has one of the lowest IMOS waiting lists for patients waiting over 18 weeks to be treated across the East Midlands. As this is a specialist service commissioned on a system area footprint, data for Nottingham city residents is unfortunately not available.

- Waiting list initiative – Hospital Dental Care
  Trusts are currently monitored on referral to treatment (RTT) times within 18, 52, 78 and 104 weeks, due to the impact of the pandemic. All Trusts are required to clear any 104 week waits by July 2022 and 78 week waits by March 2023. As at July 2022, there were zero patients waiting over 104 week waits and 16 patients waiting over 78 week waits for Oral and Maxillofacial Surgery at NUH. Please see Appendix 3 for Midlands Oral Surgery RTT trends but as this service is commissioned on a system area footprint, data for Nottingham City residents is unfortunately not available. Referrals into secondary care have started to recover (Appendix 4), however, these remain lower than previous levels due to the reduction in

routine appointments in primary care. There has been a non-recurrent investment of £36,934 to address the 104, 78 and 52 week waits across the secondary care dental specialities e.g. Orthodontics, Oral Surgery and Maxillofacial. Prior commitment of £35,076 has also been secured for 2022/23 to continue to support the waiting list initiatives.

2022/23

- Weekend Sessions – General Dental Services
  Across the Nottinghamshire system, 2 NHS general dental practices have been contracted to provide 140 additional sessions at a cost of £70,000. Out of the 3 practices, 1 practice is within Nottingham City providing 40 additional weekend sessions.

- Dedicated Urgent Care slots during surgery opening hours – General Dental Services
  Additional NHS dental capacity has been contracted in order for NHS 111 to be able to signpost patients who do not have a regular dental practice requiring urgent dental care. Five practices across the Nottinghamshire system are taking part providing an extra 39 appointments. Two practices are within Nottingham City offering 14 additional urgent care appointments per week.

- Oral health improvement funding for local authorities
  As mentioned above, this funding is recurrent for 2 years.
    - £150,000 recurrent for 2 years (21/22 and 22/23) to support oral health improvement initiatives and activities

  The above funding has been jointly allocated between Nottingham City and Nottinghamshire County Councils. Agreement on the spending of the funding is being discussed and agreed at the Nottingham and Nottinghamshire Oral Health Steering Group to ensure alignment with oral health needs of the area.

- Support Practices - Community Dental Service
  NHSE have secured additional funding to re-run the pilot for financial year 2022/23, where 3 practices within Nottinghamshire have been approved providing 6 sessions per week. One of the three practices is within Nottingham City providing 2 sessions per week.

- Golden Hello Scheme
  NHSE have secured additional funding to assist local NHS dental providers in the recruitment and longer-term retention of dentists in targeted areas where the recruitment of additional dentists is most challenging. The overarching aim of the scheme is to increase the number of dentists in targeted areas and ultimately increase local NHS dental access for patients. Under the terms of the scheme, a lump sum Golden Hello payment of up to £15,000 will be available for each eligible new full-time NHS dentist recruited within the target area from non-targeted areas.

The targeted area within the Nottinghamshire system is East Bassetlaw. There are currently no applications received for Nottinghamshire.

12 Oral Health and Inequalities

12.1 Whilst NHSE is responsible for commissioning NHS dental services, local authorities have a dental public health function as per Statutory Instrument 2012 No. 3094 *The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012:*

"(1) Each local authority shall have the following functions in relation to dental public health in England.

(2) A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area –

(a) to the extent that the authority considers appropriate for improving the health of the people in its area, oral health promotion programmes;

(b) oral health surveys to facilitate –
(i) the assessment and monitoring of oral health needs,
(ii) the planning and evaluation of oral health promotion programmes,
(iii) the planning and evaluation of the arrangements for provision of dental services as part of the health service, and
(iv) where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.

(3) The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.)(49) so far as that survey is conducted within the authority's area."

12.2 In addition, Local Authorities and ICBs have equal and joint duties to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) through the health and wellbeing board. Oral health is one of the health needs that may be assessed. The responsibility falls on the health and wellbeing board as whole and so success will depend upon all members working together throughout the process. In Nottingham City the oral health needs assessments are available here and were published in 2020

12.3 Oral diseases continue to be a leading public health problem with significant inequalities. Those living in more deprived areas and vulnerable individuals are more at risk, both of and from, oral diseases. Whilst there has been an overall improvement in oral health in recent decades, further work is needed to improve oral health and reduce inequalities. Over a third of children in Nottingham have visible dental problems by the age of 5 years This is significantly worse than England and is preventable. This will mean pain and often expensive treatments, including General Anaesthetic, and may result in

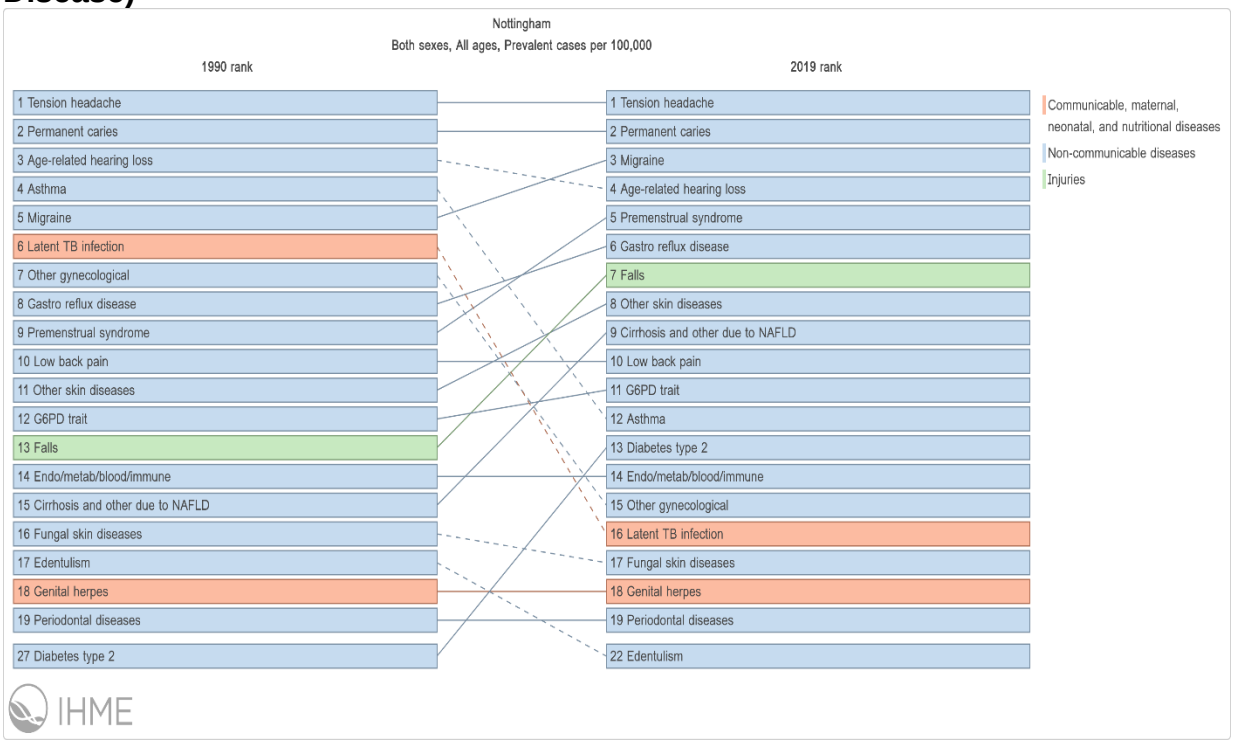
time off school This is likely to have worsened during the pandemic, and is worse in some areas of the city- we have undertaken a larger survey this year and await results

12.4 Figure 5 shows that oral health remains in the top 20 rankings of the most common health problems affecting the overall health and wellbeing of people living in Nottingham City from 1990 to 2019:

- staying at rank 2 – dental decay (caries)
- staying at rank 19 – periodontal (gum) disease)
- down 5 ranks from 17 to 22 – edentulism (no teeth)

In most cases these problems are preventable.

Figure 5: Ranking of prevalent cases per 100,000 affecting overall health and wellbeing of people living in Nottingham City (Global Burden of Disease)



12.5 In 2017/18, the National Dental Epidemiology Programme undertook an oral health survey of adults attending general dental practices in England. It provided data to inform joint strategic needs assessments and oral health needs assessments to plan and commission oral health improvement interventions and services for adults. Adults attending general dental practices for any reason, aged 16 years and over, were recruited to take part in the survey. The survey consisted of a questionnaire on the impact of oral problems on individuals, use of dental services and barriers to receipt of care and a brief clinical examination conducted by trained local epidemiology teams under standardised conditions. Only 9 people in Nottingham City participated in this survey and therefore no local summary of findings can be reported.

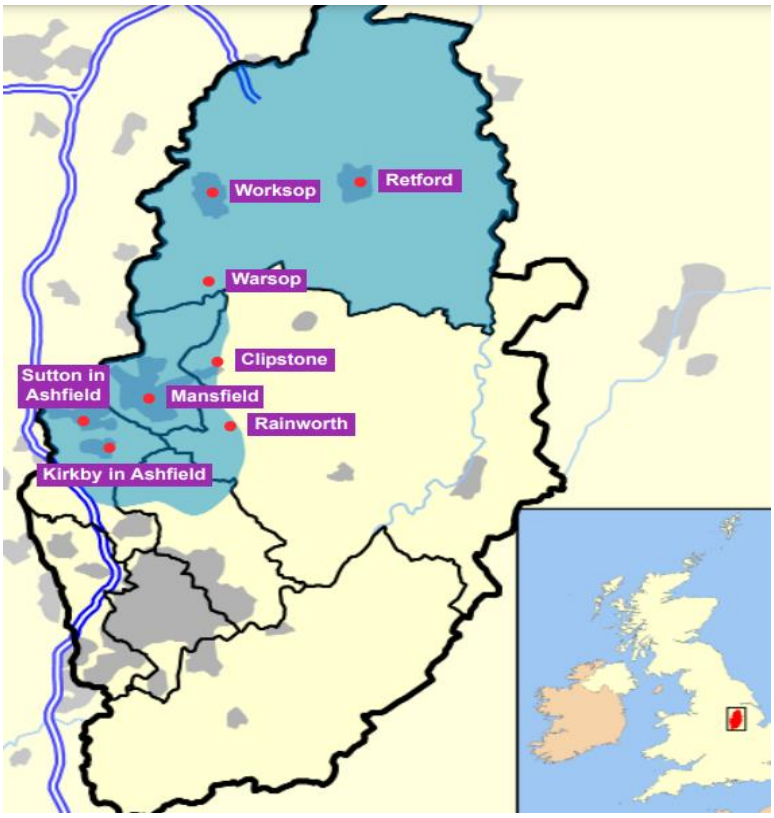
12.6 Vulnerable groups are those people whose economic, social, environmental circumstances place them at high risk of poor oral health or make it difficult for them to access dental services. This includes people who are old and frail, have physical or mental disabilities as well as the homeless. These groups may require special treatment or treatment in a special setting to accommodate their needs. The 2015/16 Oral Health Survey of Older People presented the results of a questionnaire and standardised dental examination of older people (aged 65 years and older) with mild dependency who live in "extra care" housing establishments. This was the first and only oral health survey of this population group and the method was implemented as a pilot. At the time of this survey of those taking part in Nottingham, 59% of participants had not seen a dentist within the last two years, 7% reporting being able to find an NHS dentist and 9.5% reporting difficulty getting to and from the dentist. 8.5% of those surveyed reported that their oral health often adversely impacts their quality of life, 5% reported being in pain with their mouths, and 4% requiring domiciliary treatment. 14.3% reported being unable to afford NHS dental charges.

12.7 Overall, national surveys have demonstrated that:

- The oral health of adults has improved significantly over the last 40 years with more of the population retaining their natural teeth throughout life
- Poorer oral health disproportionately affects older people and those living in more deprived areas
- Men from materially deprived backgrounds are more likely to experience higher levels of tooth decay and gum diseases but least likely to visit a dentist
- Adults with learning disabilities are more likely to have poorer oral health than the general population
- Adults with learning disabilities living in the community are more likely to have poorer oral health than their counterparts living in care
- Homeless people are more likely to have greater need for oral healthcare than the general population

12.8 Water fluoridation is an effective and safe public health measure to reduce the frequency and severity of dental decay, and narrow oral health inequalities. Fluoridated water is currently supplied to ten percent of the population in England and this includes some parts of Nottinghamshire (Figure 6). There are no water fluoridation schemes benefitting residents of Nottingham City.

Figure 6: Water fluoridation in the Nottinghamshire system



12.9 The responsibility for water fluoridation has recently changed from being the responsibility of Local authorities to resting with the Secretary of State as a result of the Health and Care Act 2022. This will include responsibility for public consultation on proposed new schemes, which may in future be developed at larger footprints than Local Authorities. As confirmed by the UK Chief Medical Officers, water fluoridation is a safe and evidence based approach to reduce dental decay at population level, with the greatest potential benefit in the most deprived communities.

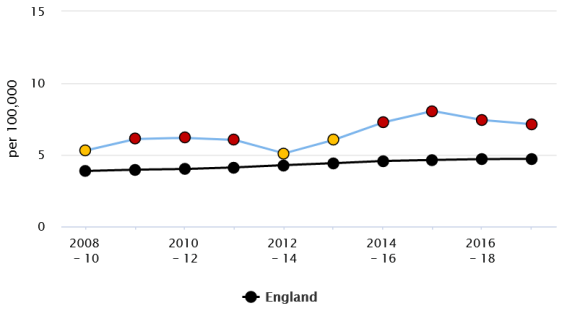
Recent analysis by the Office for Health Improvement and Disparities identified that the risk of dental decay in children living in deprived areas was 25% less in areas with fluoridation, and up to 56% of child hospital admissions to have decayed teeth removed could be avoided in more deprived areas through water fluoridation schemes.

12.10 Nottingham City has a higher incidence (18.09 per 100,000) of oral cancer over 5-years (2012-2016) relative to the national average (14.55 per 100,000) and a higher mortality rate (6.35 per 100,000) from oral cancer relative to the England average (4.54 per 100,00).

Nottinghamshire has a comparable incidence (13.69 per 100,000) and mortality rate (4.09) relative to the England average.

Figure 7 shows that mortality rates from oral cancer in Nottingham City (Red and yellow dotted line) have been increasing over the years at a faster rate than observed nationally and in the county. In 2015/17 period there were 8.1 deaths from oral cancer per 100,000 people in Nottingham. Although this has fallen slightly since then, it is still far higher than the national rate of 4.7 oral cancer deaths per 100,000 population across England.

Figure 7: Oral cancer mortality rates



Recent trend: Could not be calculated

Period		Nottingham Count	Value	95% Lower CI	95% Upper CI	East Midlands	England
2008 - 10		31	5.3	3.6	7.6	3.5	3.9
2009 - 11		36	6.1	4.3	8.5	3.6	4.0
2010 - 12		36	6.2	4.3	8.6	3.8	4.0
2011 - 13		35	6.0	4.2	8.4	4.1	4.1
2012 - 14		31	5.1	3.4	7.3	4.1	4.3
2013 - 15		37	6.0	4.2	8.3	4.2	4.4
2014 - 16		45	7.3	5.3	9.7	4.3	4.6
2015 - 17		50	8.1	6.0	10.6	4.5	4.6
2016 - 18		47	7.4	5.4	9.9	4.6	4.7
2017 - 19		46	7.1	5.2	9.5	4.6	4.7

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid Year Population Estimates

Oral cancer disproportionately affects males and its incidence and mortality increase with deprivation and age. The reasons for these increases are poorly understood but may be partially explained by trends in risk factors linked to social determinants.

Known risk factors for oral cancer linked to social determinants include smoking, other ways of using tobacco such as chewing, drinking alcohol and infection with the human papilloma virus (HPV). Where oral cancer is suspected on the basis of clinical examination or symptoms, the diagnosis is confirmed by biopsy.

The data and trends in this report identifies the geographic areas (Nottingham City) and population groups (especially men living in areas of high deprivation) most at risk to facilitate the planning of health improvement initiatives for prevention and clinical services for early diagnosis and treatment.

12.11 The Local Dental Network publicised Mouth Cancer Awareness month in November 2021 and distributed 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 was a proactive local follow up to a dental bulletin issued by the Chief Dental Officer in May 2021 https://bit.ly/3vK70Ez.

13. Collaborative working

13.1 NHSE works collaboratively with Public Health colleagues in Nottingham City Council around prevention initiatives linked to oral health improvement and in amplifying key oral health messages. Further information has been provided by the Council's public health team on the local oral health improvement initiatives across Nottingham City in Appendix 5.

13.2 There have been regular meetings with the profession via the Local Dental Committee. NHSE are grateful for the co-operation received from the dental profession across the Nottinghamshire system in mobilising local Urgent Dental Care Centres and co-producing solutions to help manage the restrictions in NHS dental services during the pandemic which included joint working between the local Community (Special Care) Dental Service and General Dental Practices.

13.3 NHSE has appointed a Nottinghamshire Local Dental Network (LDN) Chair who is currently involved in working with the Local Dental Committee to address challenges that practices are facing to improve access for patients experiencing Severe Multiple Disadvantage. Furthermore, the LDN is working to improve the links between the Special Care Dental Service and local dental practices in order to improve access for children.

13.4 The NHSE commissioning team have also 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 NHS dental services. These have been distributed to local authorities, Directors of Public Health and CCGs. Examples of tweets that have been shared on Twitter are given in Appendix 6.

13.5 NHSE have also engaged with Healthwatch Nottingham and Nottinghamshire and they have shared intelligence on local concerns or on difficulties people may be having accessing NHS dental services. Following feedback from Healthwatch regarding the confusion for patients on the '*accepting new patients on referral'* category of each dental practice profile, a decision has been made to remove this as part of updates planned for September/October 2022.

14 Supporting Information

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

16 Contact Points

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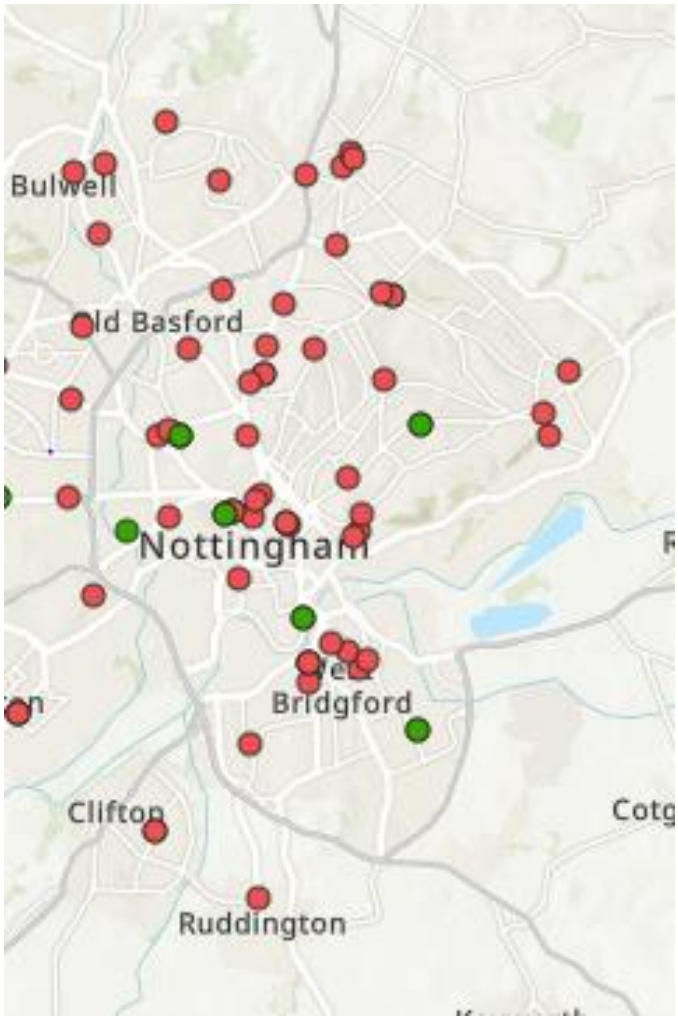
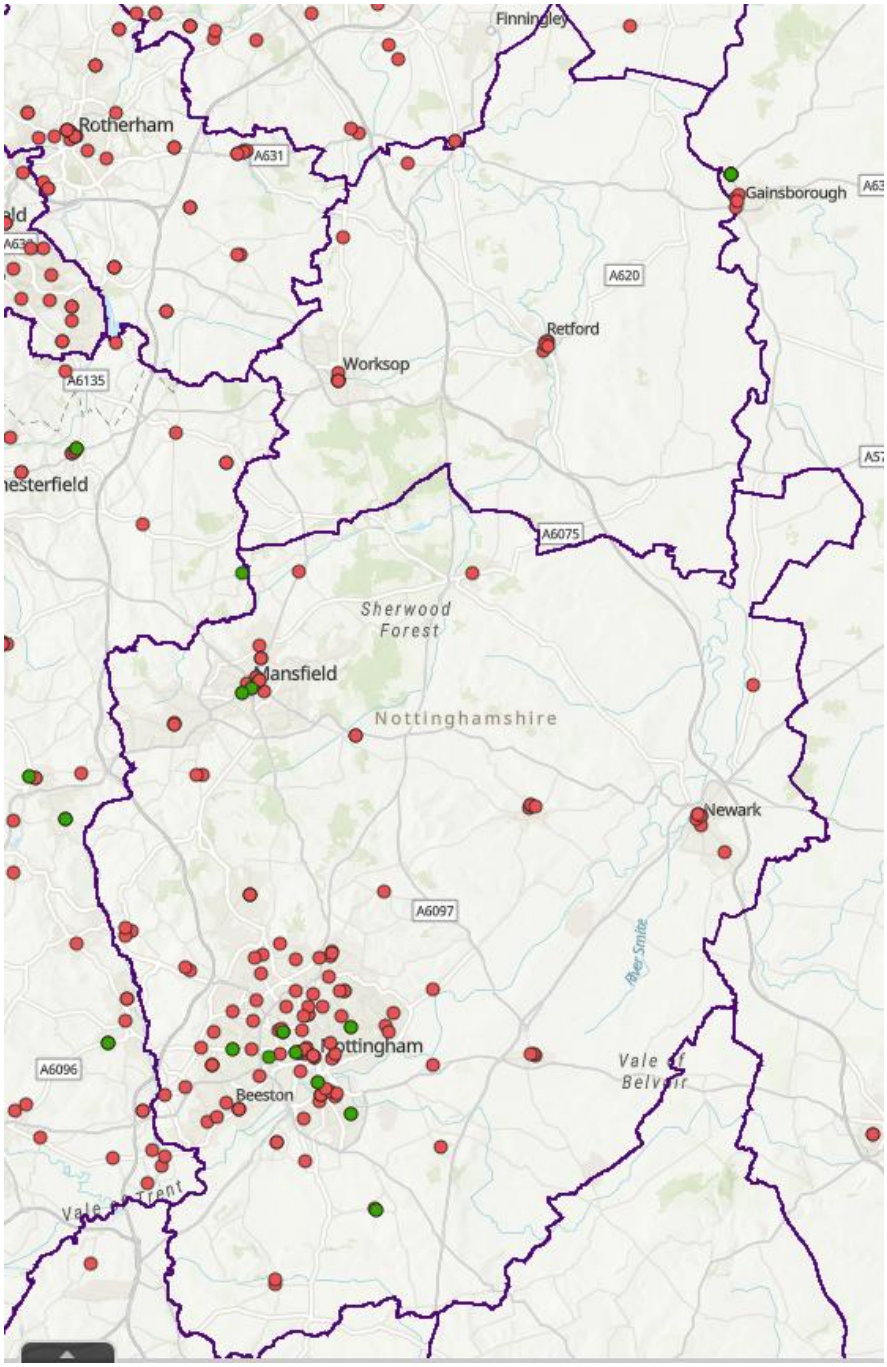
Appendix 1: Location of dental practices or clinics including orthodontic and community sites

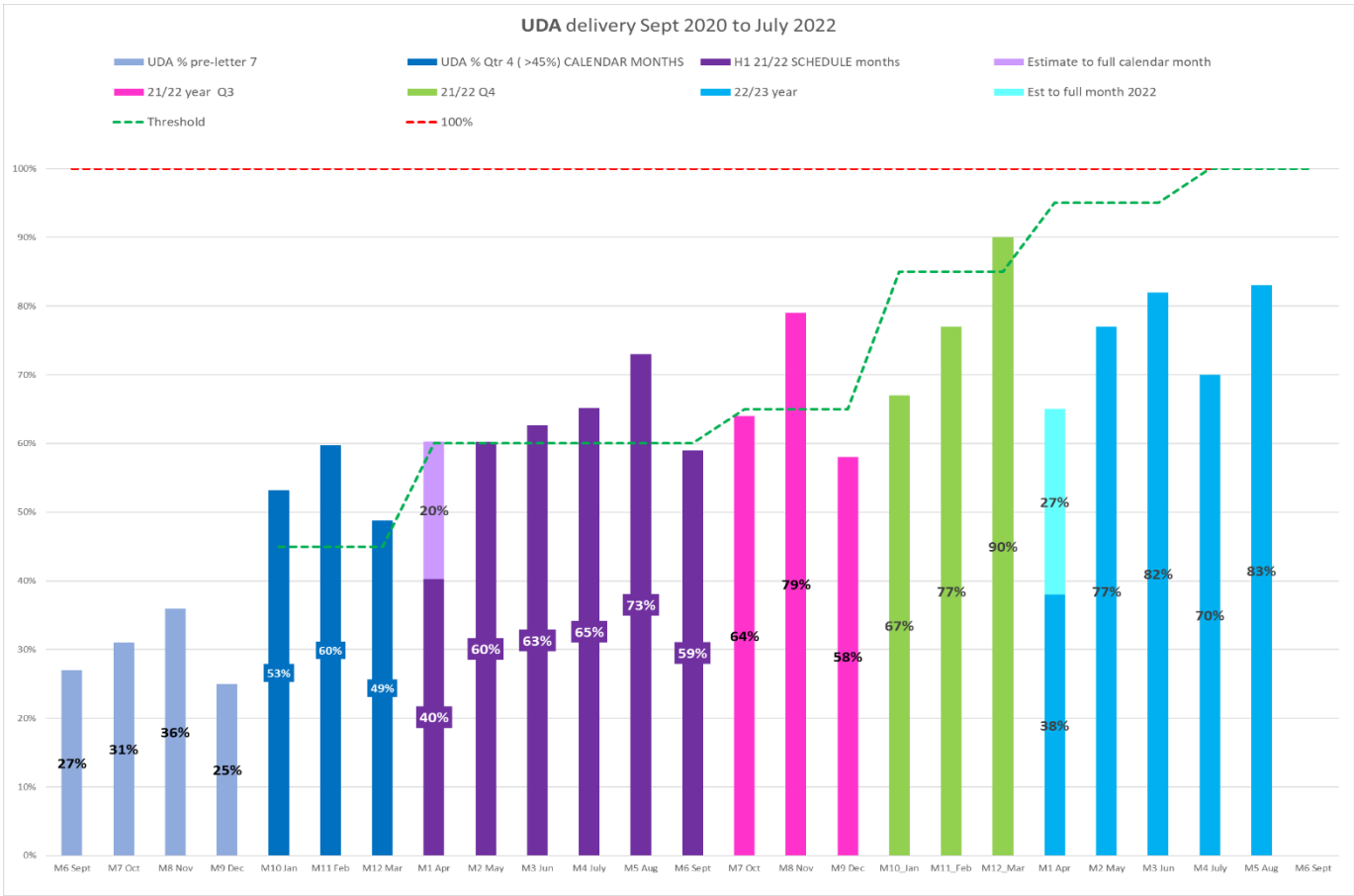
Map 1: Location of NHS dental practices and clinics (including orthodontics and community sites in Nottingham city



Map 2: Location of NHS dental practices and clinics (including orthodontics and community sites in Nottinghamshire



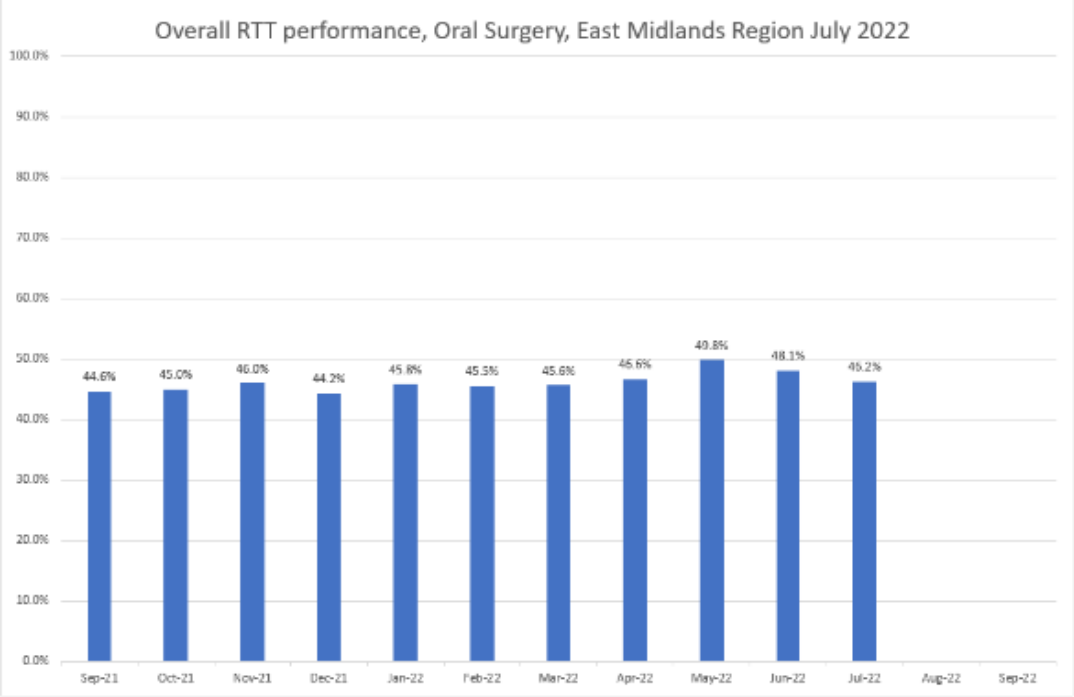
Appendix 2: Activity Trends in Primary Care for Units of Dental Activity (UDA) - Midlands

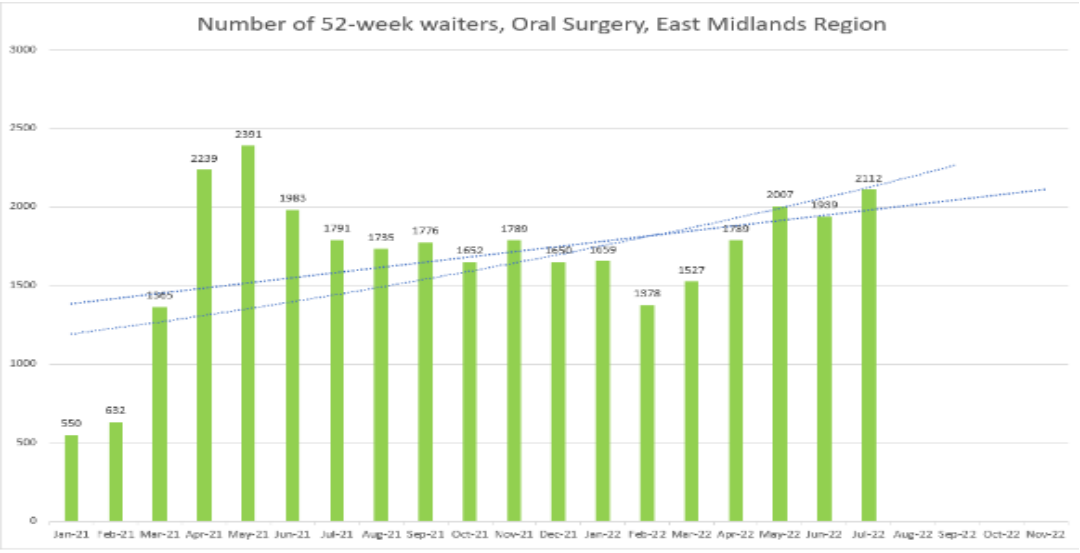


Appendix 3: East Midlands Oral Surgery Referral to Treatment (people waiting 18 week and 52 weeks)

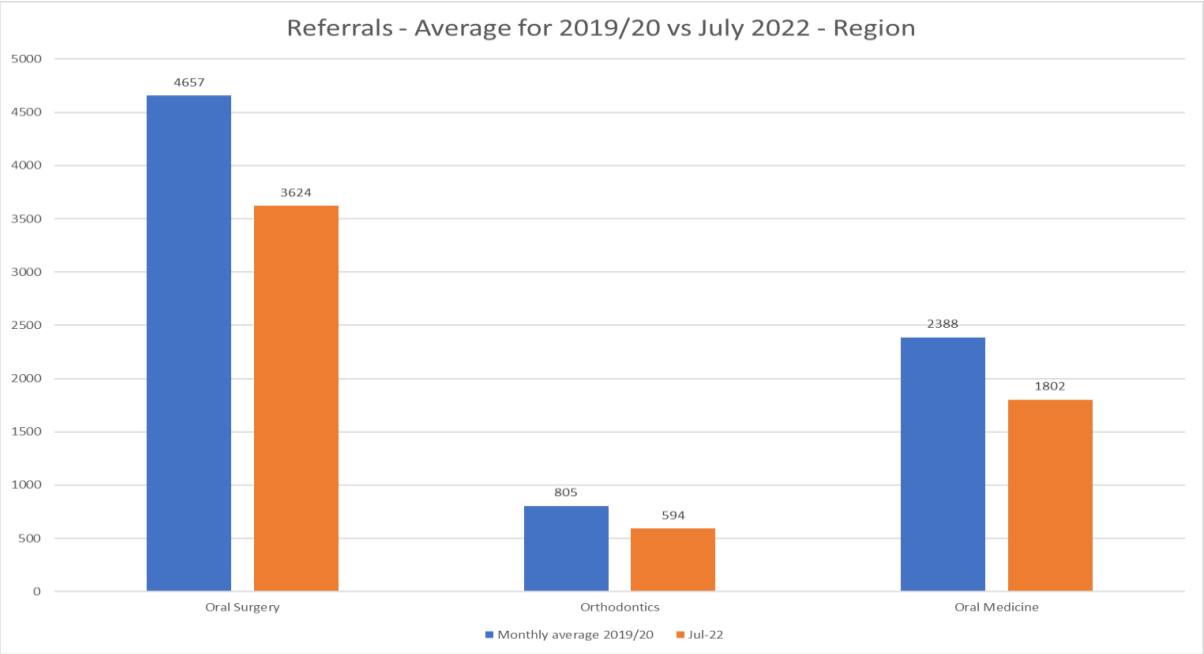
Note – The updated July RTT position for Oral Surgery shows that the recovery in respect of the performance against the 18-week standard remains plateaued between 45 and 50 percent. (The figure for July is 46.2%, a decrease from 48.1%). The number of 52-week waiters has increased from 1,939 to 2,112. The proportion of the total waiting list that has been waiting 52 weeks decreased to 10% for July from 11% in June 2022.

Data cannot be split to report for Nottingham City.





Appendix 4: Midlands Secondary Care Dental Referral Trends



Appendix 5: Nottingham City (Public Health led) Oral Health Promotion Briefing

1. **Oral health strategic approach**
   Aim: To improve oral health and reduce inequalities in oral health in Nottingham City
   Taken forward across 3 'pillars
   - ***Evidence based***. This includes needs assessment, dental epidemiology and understanding evidence of effectiveness
   - ***Prevention and reducing inequalities*** Plan for services and actions to reduce inequalities and improve oral health, particularly in children and vulnerable adult populations
   - ***In partnership*** work to build shared understanding across system partners and advocate for action on improving oral health

2. **Nottingham and Nottinghamshire Oral Health Steering Group**
   Public Health coordinate and chair this multi agency group which brings together commissioners, providers and Healthwatch. The group has recently received reports on dental access, on oral health for children in care, on antibiotic resistance and oral health promotion.

3. **Oral health surveys and needs assessment**
   In 2022 Nottingham City funded an enhanced dental survey of 5 year old children to better monitor changes to oral health after the pandemic. The results will be published and will allow comparison with other areas. The next survey planned is of 11 year old children. Oral health needs assessments were published in 2020 and are available on Nottingham Insight here. These describe inequalities in oral health and trends over time. They describe oral health needs in children and in vulnerable adults. They will be refreshed after the children's epidemiology survey data is published.

4. **Oral health promotion service**
   Nottingham City currently has an oral health promotion service which covers the Small Steps Big Changes wards and is delivered by Nottinghamshire Healthcare Trust. Nottingham City Council Public Health plans to commission an oral health promotion service focussed on children and vulnerable adults which will be procured shortly.

5. **Examples of recent partnership work**
   - With funding provided by NHS England, and in partnership with Nottinghamshire County Council, oral health products and information were distributed to food banks, food clubs and other community services across the City and County. In total 25,512 toothbrushes, 18,864 tubes of toothpaste and 3800 leaflets were received by 51 food banks and 5016 toothbrushes, 3696 tubes of toothpaste and 1200 leaflets were delivered to 22 food clubs across Nottingham and Nottinghamshire.

Materials circulated with tooth brushing packs to foodbanks:

- As part of the work to support people in severe and multiple disadvantage a survey of dental health needs was undertaken by community dentistry and in partnership with local support services. This illustrated high levels of unmet need. For example over half had dental pain at the time of the examination, almost all needed dental treatment, and almost a third had done 'DIY dentistry'. The information has been used to advocate for an adapted service to support this group further in meeting oral health needs which is being planned at present.

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

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Health and Adult Social Care Scrutiny Committee
17 November 2022

Primary Care Strategy

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the development of a primary care strategy for the Nottingham and Nottinghamshire Integrated Care System.

2. Action required

1.1 The Committee is asked whether:

a) it wishes to make any comments or recommendations; and

b) any further scrutiny is required, and if so the focus and timescales.

3. Background information

3.1 Access to primary care has been a focus for the Committee for a number of years and therefore the Committee has an interest in the future development of the sector. The Integrated Care System is developing a primary care strategy and representatives of the ICS will be attending the meeting to discuss the emerging strategy with the Committee.

4. List of attached information

4.1 Briefing paper from Nottingham and Nottinghamshire Integrated Care Board 'Developing a Primary Care Strategy for Nottingham and Nottinghamshire Integrated Care System'

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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NHS
Nottingham and Nottinghamshire
Integrated Care Board

Developing a Primary Care Strategy for Nottingham and Nottinghamshire Integrated Care System

Briefing for Nottingham Health and Adult Social Care Scrutiny Committee

November 2022

1 Introduction

This briefing aims to provide an overview to the Health and Adult Social Care Scrutiny Committee on the emerging Primary Care Strategy for Nottingham and Nottinghamshire Integrated Care System (ICS). Specifically, this paper will inform the Committee of our vision, ambition, objectives and next steps.

2 Context

Patients are changing both in the complexity of their conditions and in their expectations of the health and care that they receive. If Primary Care is going to continue to provide an essential contribution to our local health and care system, it must innovate and evolve.

Our vision for a strong and effective ICS can only be achieved with strong and effective Primary Care, with clinicians providing first-contact, continuous, collaborative and co-ordinated care to citizens. This commitment over time saves lives, improves health outcomes and the experience of care and reduced inequalities.

The ICS Primary Care Strategy needs to be compliant with the NHS Long-Term Plan[1] and the Fuller Stocktake report[2], and needs to:

a) Establish a 5+ year strategic intent, against which every idea will be tested.
b) Create the motivation for system transformation.
c) Ensure a fairer distribution of resources which equitably reflects difference.
d) Outlines a credible plan for recruitment and retention.
e) Create mechanisms to engage and work with other independent contractor professional networks.

3 Our ambition

Our ambition is to deliver:

"A picture of transformed and sustainable primary care in Nottingham and Nottinghamshire."

Primary Care will remain the bedrock of the health and care system, central to transforming people's health and wellbeing outcomes and experience. Key attributes of future Primary Care in Nottingham and Nottinghamshire will include:

[1] https://www.longtermplan.nhs.uk/
[2] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

a) Partnership working: practices will work with each other in an increasingly integrated and community-oriented way and also with other local health and care services.
b) Patients as partners: patients and carers are core members of the care team.
c) Strong health promotion and illness prevention: good joined up wellbeing policies and plans across sectors.
d) Excellent population and patient segmentation and stratification: tailoring equitable support to enable citizens to enjoy their best possible health and wellbeing.
e) Continuous personal, integrated health and care for our elderly, frail citizens and those with complex needs: provided seamlessly at or close to home and funded fairly.
f) Community-based mental health services: recognising the societal and personal importance of mental health, and interdependency with physical health and wellbeing.
g) Excellent evidenced-based care plans and pathways: developed by clinicians and patients, supported by improvement science.
h) Scaled primary care working: more resilient with the capacity and resources to deliver more services where this makes sense. Scaled up primary care will have access to diagnostics and treatments provided in fit for purpose facilities and supported by integrated neighbourhood teams.
i) Accountability: through the registered list and for outcomes not activity.
j) 'Hub and spoke' services: care in communities where possible but consolidated when necessary to improve outcomes and efficiency.
k) Workforce training development and motivation: delegation of skills from both the perspectives of patients and providers and achieving a positive workplace and workday experience for all

Further details can be found in Appendix 1.

4 Emerging strategic themes and objectives

The Primary Care Strategy will be built on the detailed insight obtained through co-creation and strong engagement with a broad range of existing stakeholder groups, including Primary Care Network (PCN) Clinical Directors, Place-based Partnership (PBP) Leaders, Locality Directors, the Local Medical Committee (LMC), GP Federations, Primary Care Commissioners, General Practice providers, Trust Clinical Directors and Patient Participation Groups (PPGs).

Deliberations have been structured around three overarching strategic themes:
a) Laying the foundations to recover primary care
b) Improving primary care quality
c) Making our system sustainable

Each strategic theme has a number of objectives. To achieve our ambition for high performing primary care, we will have a focus on at scale provision and integrated new models of care, delivering a person-centred approach.

The ten objectives of the strategy are distinct but are interdependent and mutually reinforcing, set out in Table 1.

Table 1 Ten objectives of the Primary Care Strategy

Theme 1: Laying the foundations to recover primary care
1. Establishing the clear culture, narrative and purpose
2. A focus on the person, patients and population; restoring the person - professional 'compact'
3. Enhancing access to primary care services

4. Improving communication, enabling information technology, sharing records and securing fit for purpose estate
Theme 2: Improving primary care quality
5. Supporting clinical transformation; the adoption of the population health management model
6. Supporting PCNs and establishing integrated care teams
7. Quality, data, and performance; research and innovation
Theme 3: Making our system sustainable
8. Workforce development and motivation; engaged and visible leadership
9. Evolving the finance and contractual model
10. Supporting provider and business model reform; green primary care

5 Enablers

To achieve our ambition for high performing Primary Care, we will have a focus on at scale provision and integrated new models of care, delivering a person- centred approach. Key enablers include:

a) Provider developments with particular attention to PCNs enabling service and workforce integration.
b) Local workforce priorities and actions which support development of an expanded workforce and Multi-Disciplinary Team (MDTs).
c) Maximising and improving our estate, use of digital technology, and analysis and information to increase access for patients.

6 Delivery of the Primary Care Strategy: next steps

The Primary Care Strategy will describe the health and care system we wish to create working with all local partners to deliver it. Implementation will require us to build transformational leadership capacity and capability, supported by building a change platform for innovation and improvement to spread progress in a more dynamic way than we have been able to do previously.

Implementation will be led and sustained by providers, not from a top-down managed process or hierarchical leadership model, requiring local planning and customisation.

Delivery of the Primary Care Strategy aims to overcome silo working and make connections between ICS programmes including the community, mental health and hospital transformation programmes, Place and PCNs. Delivery will be taken forward at both a local level by PCNs and Place, and as a system for sharing good practice and common solutions.

We propose the establishment of a Primary Care Transformation Board to provide strategic oversight and testing from across the ICS and ensure the strategy is ambitious enough to meet the needs of the people and professionals in the ICS. We will recruit both clinicians and caregivers to test rigour and practicality of the plan, and patients and public to provide insight and direction.

We will identify headline programme monitoring indicators e.g., patient and staff satisfaction, system impact, clinical outcomes, investment profile, change registered in the service offer.

Finally, we propose identifying an evaluation and learning partner e.g. a local university, and establishing development opportunities to improve quality improvement capability.

7 Recommendations to **Nottingham Health and Adult Social Care Scrutiny Committee**

Delivery of the Primary Care Strategy will see more efficient and effective services, improved financial stewardship and excellence in outcomes, and will enhance the trust, support and confidence of our population.

It is recommended that the Adult Social Care and Health Scrutiny Committee:

- Note the contents of this briefing.

Appendix 1: Benefits and risks

Benefits

Attribute		Details	Benefits
a)	**Partnership working**	Enhance integrated working within GP federations, with PCNs, place, secondary care and wider health and care services. Build from strong existing PCN base. Facilitate PCNs to evolve into Fuller "integrated neighbourhood teams*".* Develop and embed best N&N ICS primary care medical standards that recognise the whole practice team contribution of continuity to quality of care. Strong focus on MDT working, information sharing and care planning. Build a culture of collaboration and co-production across organisations and sense of belonging to and accountability for the system. Embed strong primary care leadership and influence in the ICS. Build more productive, less competitive relationships.	Ongoing PCN development will enable practices to: • meet complex needs, improve access, and reduce unwarranted variation through standardised care pathways and consistent delivery through an MDT approach • Empower communities to develop asset-based interventions to improve health and wellbeing (e.g., dementia networks, social prescribing initiatives) • Develop alternative access opportunities and care pathways utilising ARRS roles will create capacity for GPs to manage patients with complexity. Further developing a primary care model which is less dependent on GPs, sharing responsibility for patient care across lower cost professionals will increase value (as defined by quality/cost) Well recognised benefits of continuity of care including: • increased satisfaction, both for patients and staff • reduced costs: prescriptions, tests, ED attendance, and hospital admissions • reduced the 'collusion of anonymity', where a succession of clinicians deals only with what is most immediately pressing • increased trust within the clinician - patient relationship • increased willingness to accept medical advice, including adherence to long-term preventive regimens

Attribute		Details	Benefits
			• increased willingness to accept 'wait and see' management of non-specific symptoms that are often self-limiting • improved problem recognition and quality of management Cross-organisation collaboration and relationship building will: • facilitate development of standardised streamlined patient-centred pathways • accelerate system development and innovation • overcome system roadblocks
b)	**Patients as partners**	Ensure a strong patient voice, both as individuals receiving care and as stakeholders. Ensure patients and carers are core members of their care team. Shared decision making embedded as standard. *"No decision about me without me".* Co-production in design, delivery, and governance of primary care. Development and embedding of PROMS and PREMS to assess the quality and experience of healthcare, as reported by patients. Enhance the role of PPGs within practices to ensure patients voice is heard in the way services are delivered to best meet their needs, and the needs of the local community.	Building trust between patients and primary care will: • facilitate the restoration of the social contract • create opportunities to agree and enact reasonable and mutual expectations • facilitate ongoing calibration of patient experience and expectations with service delivery Evaluation of shared decision making has shown the potential to: • Improve communication and establish trust between patients and clinicians • Improve outcomes (including decreased anxiety, quicker recovery, and increased compliance with treatments) through engagement and empowerment of patients • Reduce costs as people who are fully informed about the risks and benefits of treatments tend to choose less-invasive, less-costly interventions and are happier with their decisions • Reduce unwanted clinical variation and enhance allocative efficiency

Attribute		Details	Benefits
			Use of PROMS and PREMS will enable primary care and the wider system to make informed changes to their services Enhancing the role of PPGs can: • help clinicians to develop an equal partnership with their patients and the wider community • help to improve services and resource utilisation by identifying changes that the practice may not have considered, which reflect what patients want and need • nurture mutually supportive networks for patients and the practice • play a role in encouraging healthier communities through the provision of information and support
	Health promotion and illness prevention	Ensure all members capitalise on the many opportunities in primary care to promote health and well-being, as the first point of contact for most patients. Embed as standard, a "*Making Every Contact Count*" approach. Adopt a person-centred approach to empower individuals to take actions for their own health, utilising appropriate support tools. Utilise our network of social prescribing link workers to effectively signpost and our PPGs to promote healthier communities through the provision of information and support. Ensure localised tailoring and delivery of system-wide strategies including our N&N ICS Health Inequalities Strategy.	Supporting individuals to make healthier choices will reduce the risk of developing ill health, disease, and premature death from preventable diseases caused by behavioural factors such as smoking, poor diet and excessive alcohol consumption. Adopting a person-centred approach improves patient engagement and activation. Tailoring strategies and resources to take account of local priorities will potentially increase impact on populations with greatest needs. Ongoing evaluation will help to shape further interventions.

Attribute		Details	Benefits
		Undertake evaluation and monitoring of approaches.	
d)	**Segmentation and stratification**	Use knowledge of the health and care needs of local populations to target interventions and resources to best effect. Provide the right amount of the right care, neither too much nor too little care, rather than meeting a minimum standard for all segments. Understanding which individuals and cohorts are at greatest risk of needing certain types of care and interventions.	Providers can take responsibility and create bespoke services for populations with heightened risks as determined by analysis of local population needs. Tailoring services to local population needs can improve health outcomes and experience for both groups of patients and individuals. Ensuring resource and capacity are better distributed to where most needed will promote equity of access to and quality of care. Developing specialist expertise can ensure the optimal response to the needs and preferences of a specific population segment.
e)	**Integrated care for frail elderly**	Coordinated responsive pathways which focus on holistic person-centred care and not just disease-specific interventions and treatments. Care will be underpinned by a strong evidence base around effective assessments and interventions for frailty. Strong focus on prevention (for example falls, UTIs) and early identification of frailty Development of registries and registry managers to identify and manage care gaps.	Evidence-based, person-centred care with a strong focus on prevention: • enables people to live better and more independently with frailty • supports a reduction in the number of unscheduled primary and secondary care contacts Potential costs savings can be realised through: • reducing avoidable hospital attendances and admissions, and reducing lengths of stay • reducing or delaying the need for home care and residential care

Attribute		Details	Benefits
		Patients will be listened to and treated with dignity and respect. *"What matters to me"* not *"What is the matter with me".*	Facilitating early medical assessment (within 2 hours) followed by appropriate care and treatments for unwell frail patients, is associated with lower mortality, greater independence, and reduced need for long-term care.
f)	**Enhanced mental health services**	Embed a cultural shift (as outlined in the ICS All-age integrated mental health and social care strategy), so that all staff see mental health as their business, understanding the issues people face, the support they need and the resources available to provide that support. Responsive holistic services which deliver care in an integrated way to ensure that a person's mental health, physical health and socioeconomic needs are addressed together. Deliver parity of esteem so that mental health is placed on a par with physical health. Ensure timely access to effective crisis management both within primary care and with the wider system. Ensure comprehensive access to talking therapies through Improving Access to Psychological Therapies (IAPT) Improve mental health awareness and understanding through delivery of mental health awareness training to all health care professionals in line with our ICS aim Ensure that there is high quality, comprehensive primary care mental health support for children and adolescents, and for older people, and that there is	A responsive holistic approach to mental health care can improve outcomes and experience, and reduce costs through: • encouraging the prompt uptake of treatment • promoting mental health awareness and faster diagnosis • identifying and addressing a person's needs more quickly and accurately • reducing a person's use of physical health services • improving relationships within teams and services • empowering people to manage their condition and access appropriate support Efficiencies can be realised through: • reducing the number of frequent attenders and repeat assessments • decreasing the likelihood of people not attending appointments • increasing the quality of referrals whilst reducing the demand for specialist services • effective management of transitions between services • supporting people to access/remain in employment, thereby increasing economic productivity Talking therapies help to improve self-management and health outcomes in people with long-term conditions, who also have with anxiety and depression. Successful therapy can help to reduce reliance on primary and emergency care. There is also strong evidence for the use of therapies to support people with medically unexplained symptoms.

Attribute		Details	Benefits
		timely and seamless access to specialist services when required.	Timely access to primary, community and specialist services reduces the need for crisis services.
g)	**Care plans and pathways**	Pathway development and implementation will be clinically led. There will be adequate funding for both development and implementation of pathways. Pathways will be standardised and based on best available clinical evidence. Pathways will be holistic and person-centred, and will include all stages of care including prevention, primary care, and specialist care, ensuring delivery of the right care at the right time in the right place. There will be a focus on managing transitions between different parts of the system. Pathways will be supported by patient and clinician information and education. Pathways will be digitally enabled to facilitate data sharing among providers. Pathway implementation will be supported an effective governance structure to ensure clear, pathway-wide accountability for outcomes and costs.	Widespread use of standardised evidence-based pathways has many benefits including: • Reducing unwanted clinical variation • Improving outcomes through clinical adherence • Increasing system delivery efficiencies through more appropriate use of specialised services and reducing duplication and waste • Facilitating close working between primary care clinicians, specialists, and other health and care professionals Clinical involvement in pathway development builds support and buy-in from clinicians for the changes to care delivery. Evidence based clinical pathways enable systems to determine the interventions' relative importance, prioritise how resources are allocated, and identify the outcome metrics that will help ensure optimal care delivery. Patient education is important, especially for chronic disease care pathways, because it strongly influences whether patients are willing to adopt healthier behaviours, comply with treatment, and engage in other forms of self-care. An effective governance structure ensures accountability as patients are transferred between providers.
h)	**Delivering primary care at scale**	Primary care 'at scale' brings groups of general practices together to provide care, working within	Delivering primary care at scale offers many benefits including increasing resilience in primary care and improving quality and clinical outcomes for patients.

Attribute	Details	Benefits
	multidisciplinary teams to support first-contact with patients. PCNs are the key delivery vehicle for primary care 'at scale'. Accountable clinical directors from each PCN are the link between primary care and the wider system. Primary care 'at scale' should be large enough to have impact and economies of scale, but not so large to lose the personal care ethos valued by both patients and primary care clinicians. Primary care 'at scale' will take a proactive approach to managing population health and assessing the needs of their local population.	Improved quality and clinical outcomes can be achieved through: • working at scale to meet agreed best practice standards for access and for continuity of care • releasing resources for front-line patient care by delivering efficiencies through economies of scale • realising opportunities to expand the range of services to patients and to easily integrate with the wider health and care system Greater resilience within primary care can be achieved through working at scale to: • managing financial and estates pressures and enabling better use of the primary care estate. • achieving efficiencies from shared admin/business support functions, facilitating growth in capacity and capability • streamlining fixed cost base (e.g., workforce, estates) • improving the ability of practices to recruit and retain staff • planning and mobilising rapid 'at scale' delivery of services in times of crisis • volume consolidation through specialist generalist role reduces specialist utilisation without a reduction in outcomes or experience Primary care 'at scale' supports the expectations and preferences of younger GPs, many of whom want to combine General Practice with other clinical work and prefer not to take on the administrative demands of partnership. It also offers opportunities to get involved in innovation and transformation that will improve patient care in the longer term.

Attribute		Details	Benefits
i)	**Accountability**	Embed a culture of accountability based on common values and motivations, as an integral part of primary care. This includes a culture of safety rather than blame. Ensure a culture of transparency and clear communication. Leaders will demonstrate honesty and integrity and the opinion of everyone will be valued. Clear channels for feedback and reporting will be developed. Develop and embed a formal code of conduct for the workforce as part of staff induction and ongoing rolling training programmes. Develop a set of standards which primary care is measured against (e.g., access, patient experience) to measure progress. Create incentives for clinicians to accept some fiscal responsibility for influenceable spend through continuous quality improvement.	A culture of accountability improves clinician-patient trust, reduces the misuse of resources, and helps organisations provide better quality care. Outcomes-based accountability to drive improvements and efficiencies. Accountable organisations can learn from mistakes and continuously improve. If primary care leaders model accountability, transparency, and ethical behaviours, they set an example for other staff and provide a strong trusted voice within the system. Staff are more likely to go above and beyond when they feel heard and empowered. A culture of accountability also provides greater professional satisfaction by improving the work environment.
j)	**Hub and spoke services**	Hub and spoke models facilitate delivery of care by the right person, in the right place, first time. Services may be: • centrally managed and centrally delivered • centrally managed but locally delivered • locally managed and locally delivered Hub and spoke models support the delivery of both primary care services and more specialist services being delivered in primary care settings.	Hub and spoke services can deliver integrated services working in partnership with primary care and with the wider system Benefits of the model include: • provision of patient-sensitive access offers, based on needs and preferences, including F2F and virtual (synchronous and asynchronous) • shared expertise, accountability and risk across providers • quality improvements through standardisation of care and greater continuity of team-based care

Attribute		Details	Benefits
		.	• increased efficiencies through minimising duplication of services and increasing economies of scale • increased treatment capacity • mitigation of unwarranted use of and pressure on other services (e.g., UEC)
k)	**Workforce plan**	The workforce plan for primary care is aligned to the wider N&N ICS People and Culture Strategy 2019-2029 Priorities include: • Growing a sustainable workforce with the right skills, knowledge and capacity, making effective use of people's skills and experience. • Developing robust recruitment and retention plans, promoting the ICS as a vibrant and progressive place to work. • Providing training and development opportunities, ensuring people are working at the top of their licence, and supporting new starters and newly qualified staff. • Providing career planning and development. • Building teams and leaders within primary care with the confidence and capability to work in partnership across the ICS. Developing general practice management capability. • Equipping the workforce with the skills to take forward digitalised care and work with new technologies and artificial intelligence	Primary care will benefit from a motivated, passionate and diverse workforce which supports service delivery and improvement. Benefits of an effective and comprehensive workforce plan which include: • ensuring adequate capacity, flexibility, skill mix, and capability within the workforce, to support delivery of clinical excellence, aid recruitment and retention and ensure a better workday experience for all • developing new roles and innovative ways of working • widening participation and ensuring equity of opportunity for all, through a comprehensive EDI strategy • providing career development opportunities including clinical leadership training and mentoring • embedding and supporting the specialist- generalist model to support career development opportunities and aid retention

Attribute		Details	Benefits
		• Demonstrating a commitment to strong EDI values, including opportunities for the diverse workforce to develop and to progress into senior roles. • Provision of quality health and wellbeing support for everyone. • Facilitating flexible and remote working to support work-life balance. • Ensuring the workforce feels valued and has a voice, through the development of the “immersion programme” • Reconnecting GPs with traditional values and increasing ‘caring’ Develop a set of performance metrics, including retention and vacancy rates, skill mix of teams, sickness levels, reasons for leaving.	
l)	**Improving primary care infrastructure**	Investment in primary care estates will provide modern, efficient buildings, equipped with the latest technologies. Investment in digital infrastructure will facilitate the expansion of virtual consultations including online consultation tools and provide patients and professionals access to electronic health and care records.	Investments in estates has been shown to have a significant, measurable impact on the quality of care and patient experience including reducing patient harm (especially falls). Improved estates can also improve workplace experience for staff and reduce staff sickness and turnover. New and improved estates can help the move towards being net zero by 2050.

Attribute		Details	Benefits
		Development of digital technologies and data analytics will support development, implementation and monitoring of services. Estate transformation will consider factors including: ▪ Inclusivity – ensuring everyone can use the building safely and with dignity, regardless of their age, gender, mobility, ethnicity, or circumstances ▪ Flexibility – ensuring different people can use the building in different ways Planning and designing a net zero estate will be a part of estate transformation plans in line with UK commitments to being net zero by 2050.	Developing primary care infrastructure can facilitate the expansion of services and MDT working. It can help to reduce siloed working and can support small practices with high rents and service charges and can also mitigate against the 'last man standing' scenario in GP owned premises. It can also provide opportunities to provide joined-up out of hospital care for patients. Investment in technology will support better consultation tools and workload management systems and support the development of record sharing technologies across organisations.

Risks

Overall risks to implementation of the primary care strategy	Enormous undertaking which will need to be implemented at pace Significant financial investments needed to develop and sustain new model Insufficient transformation and implementation capacity and capability Dependent on culture change within primary care, within our patients and public and across our ICS Requires building of trust between primary care and patients to develop a model which is less dependent on GPs and asks patients to take more personal responsibility for their health Tired and demoralised workforce post pandemic Serious recruitment and retention challenges within GP and nursing workforce Current significant socioeconomic challenges which may create barriers to behaviour change Potential for confusion about roles and responsibility between GP Federations and PCNs

	Whilst prevention can be cost effective, some interventions can also increase costs

Health and Adult Social Care Scrutiny Committee
17 November 2022

Work Programme

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the Committee's work programme for 2022/23 based on areas of work identified by the Committee at previous committee meetings and any further suggestions raised at this meeting.

2. Action required

1.1 The Committee is asked to note the work that is currently planned for the municipal year 2022/23 and make amendments to this programme as appropriate.

3. Background information

3.1 The purpose of the Health and Adult Social Scrutiny Committee is to act as a lever to improve the health of local people. The role includes:

- strengthening the voice of local people in decision making, through democratically elected councillors, to ensure that their needs and experiences are considered as part of the commissioning and delivery of health services;
- taking a strategic overview of the integration of health, including public health, and social care;
- proactively seeking information about the performance of local health services and challenging and testing information provided to it by health service commissioners and providers; and
- being part of the accountability of the whole health system and engaging with the commissioners and providers of health services and other relevant partners such as the Care Quality Commission and Healthwatch.

3.2 As well as the broad powers held by all overview and scrutiny committees, committees carrying out health scrutiny hold the following additional powers and rights:

- to review any matter relating to the planning, provision and operation of health services in the area;
- to require information from certain health bodies[1] about the planning, provision and operation of health services in the area;
- to require attendance at meetings from members and employees working in certain health bodies[1];
- to make reports and recommendations to clinical commissioning groups, NHS England and local authorities as commissioners of NHS and/or public health services about the planning, provision and operation of health services in the area, and expect a response within 28 days (they are not required to accept or implement recommendations);

[1] This applies to clinical commissioning groups; NHS England; local authorities as commissioners and/or providers of NHS or public health services; GP practices and other providers of primary care including pharmacists, opticians and dentists; and private, voluntary sector and third sector bodies commissioned to provide NHS or public health services.

- to be consulted by commissioners of NHS and public health services when there are proposals for substantial developments or variations to services, and to make comment on those proposals. (When providers are considering a substantial development or variation they need to inform commissioners so that they can comply with requirements to consult.)
- in certain circumstances, the power to refer decisions about substantial variations or developments in health services to the Secretary of State for Health.

3.3 While a 'substantial development or variation' of health services is not defined in legislation, a key feature is that there is a major change to services experienced by patients and/ or future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. Health scrutiny committees have statutory responsibilities in relation to substantial developments and variations in health services. These are to consider the following matters in relation to any substantial development or variation that impacts on those in receipt of services:

- whether, as a statutory body, the relevant overview and scrutiny committee has been properly consulted within the consultation process;
- whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
- whether the proposal for change is in the interests of the local health service.

Where there are concerns about proposals for substantial developments or variations in health services, scrutiny and the relevant health body should work together to try and resolve these locally if at all possible. Ultimately, if this is not possible and the committee concludes that consultation was not adequate or if it believes the proposals are not in the best interests of local health services then it can refer the decision to the Secretary of State for Health. This referral must be accompanied by an explanation of all steps taken locally to try and reach agreement in relation to the proposals.

3.4 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.5 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.6 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.7 The current work programme for the municipal year 2022/23 is attached at Appendix 1.

4. List of attached information

4.1 Health and Adult Social Care Scrutiny Committee Work Programme 2022/23

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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Health and Adult Social Care Scrutiny Committee 2022/23 Work Programme

Date	Items
12 May 2022	• **Nottingham University Hospitals NHS Trust Maternity Services** To review progress in improvements to maternity services. • **'Tomorrow's NUH'** To consider the findings of pre-consultation engagement. • **Work Programme 2022/23**
23 June 2022	• **Adult Social Care Transformation Programme** To consider an overview of the programme and review progress of the first six projects • **Services for individuals with co-existing mental health conditions and addictions** Progress since most recent Prevention of Future Death Notices to seek assurance that what is needed is in place • **Quality Account comments** To note the comments submitted to Quality Accounts 2021/22 • **Work Programme 2022/23**
14 July 2022	• **Integrated Care System Equalities Approach** To review Equalities Approach of the ICS • **Neurology Services** To consider access to neurology services provided by Nottingham University Hospitals Trust • **Changes to Colorectal and Hepatobiliary Services** To review proposals to transfer colorectal and hepatobiliary service to City Campus • **Work Programme 2022/23**

Date	Items
15 September 2022	• **Step 4 Psychological Therapies** To review progress in reducing waiting times for assessment and treatment for Step 4 Psychological Therapies • **Maternity Services** To look at how the local system and region is doing to address the issues with maternity services provided by Nottingham University Hospitals. • **Work Programme 2022/23**
13 October 2022	• **Adult Eating Disorder Service** To hear about how the Service has developed to improve accessibility and reduce waiting times for treatment • **Integrated Care Strategy and Integrated Care Board Forward Plan** To consider engagement and consultation on development of the Integrated Care Strategy and Integrated Care Board's Forward Plan. • **Adult Social Care Outcomes Framework** To consider if, and how to use the Adult Social Care Outcomes Framework to hold to account and inform the Committee's work programme. • **Changes to Neonatal Services** To consider proposals for changes to neonatal services • **Reconfiguration of Acute Stroke Services** To consider to make reconfiguration of acute stroke services permanent • **Work Programme 2022/23**
17 November 2022	• **Access to NHS and Community Dental Services** To explore issues relating to access to NHS and Community Dental Services • **GP Strategy**

Date	Items
	• **Work Programme 2022/23**
15 December 2022	• **Nottingham University Hospitals NHS Trust – Well Led** To review progress in addressing issues raised in the CQC inspection of Well Led. • **Work Programme 2022/23**
12 January 2023	• **Adult Social Care Winter Review** At mid-winter point, to review position of adult social care • **Nottingham City Safeguarding Adults Board Annual Report 2021/22** To receive evidence from the Safeguarding Adults Partnership Board regarding work to safeguard adults in the City; scrutinise the work of the Board, including consideration of its 2020/21 Annual Report; and identify any issues or evidence relevant to the Committee's work programme. • **Medium Term Financial Plan – Adult Social Care and Public Health** To review in-year position; and proposals for MTFP as part of wider consultation • **Work Programme 2022/23**
16 February 2023	• **Work Programme 2022/23**
16 March 2023	• **Work Programme 2021/22**

To be scheduled:

- Tomorrow's NUH – Proposals for Family Care and Outpatients; findings of public consultation and final proposals.
- Improving immunisation rates. Potential areas of focus: lessons learnt from Covid vaccination programme: accessibility of consent for school-age vaccination: effectiveness of new City and County Health Protection Board in providing assurance rates
- Support for people with co-existing substance misuse and mental health issues
- Adult Social Care Workforce and Organisational Development Strategy
- ICS Equalities Plan
- Trans healthcare/ Gender Identity Clinics

2023/24

- Implementation of Mental Health Transformation in the City (year 3 of programmes)
- Adult Eating Disorders Update