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 17 November 2022 from 10.00 am - 11.55 am

Membership

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

Colleagues, partners and others in attendance:

Caroline Goulding	-	Interim Deputy Director Primary Care and Public Health Commissioning, NHS England
Rami Khatib	-	Derbyshire Local Dental Network Chair
Pavni Lakhani	-	Nottinghamshire Local Dental Network Chair
Liz Pierce	-	Acting Consultant in Public Health, Nottingham City Council
Carole Pitcher	-	Senior Commissioning Manager, NHS England
Dr Stephen Shortt	-	GP, representing Nottingham and Nottinghamshire Integrated Care Board
Diane Wells	-	Senior Commissioning Manager, NHS England
Jane Garrard	-	Senior Governance Officer

39 Apologies for absence

None

40 Declarations of interest

None

41 Minutes

The Committee confirmed the minutes of the meeting held on 13 October 2022 as an accurate record and they were signed by the Chair.

42 NHS and Community Dental Health Services

Pavni Lakhani, Nottinghamshire Local Dental Network Chair, Rami Khatib, Derbyshire Local Dental Network Chair, Caroline Goulding, Interim Deputy Director of Primary Care and Public Health Commissioning NHS England, Diane Wells, Senior Commissioning Manager NHS England, Carole Pitcher, Senior Commissioning Manager NHS England and Liz Pierce, Acting Consultant in Public Health Nottingham City Council attended the meeting to discuss NHS and Community Dental Services. They gave a presentation highlighting the following information:

a) Across the East Midlands NHS dental services were challenged before the Covid pandemic. In 2006 a new dental contract was introduced, which was a significant change from the previous contract. It sets targets for practices and payment does not reflect the work that takes place. This has created disincentives for practices to treat new patients.

b) There is no longer a formal patient registration system. While there is generally loyalty between practices and patients, practices are only responsible for a patient for two months since their last appointment, with treatment guaranteed for one year. There are common misconceptions about this amongst the public, which creates significant issues for those who are not regular attendees.

c) The Covid pandemic exacerbated the issues with access that already existed. Dental practices were initially required to close completely during the first lockdown and there was a period of three months when no patients were seen at all. Practices were then required to work out how to gradually re-open services. However, the enhanced precautions meant that each patient consultation took longer and therefore less patients could be seen and there was much reduced activity with routine check-ups not being carried out. Due to a lack of preventative activity and early intervention, some patients ended up requiring more treatment which compounded demands on the service.

d) In the City there are 38 general dental practices, some of which are now rolling out extended hours surgeries; three community dental services providing treatment for the most vulnerable; a secondary care service provided by Nottingham University Hospitals NHS Trust; one domiciliary provider; and three Intermediate Minor Oral Surgery sites providing a level 2 service that supports those needing secondary care.

e) Recruitment is a significant challenge. There are sufficient dentists in the country but many choose not to do NHS work due to contract difficulties. A lot of work has taken place to try and reform the dental contract. While some small changes are being made, and these are welcome, there is still a long way to go with reform. A lot of dental nurses left during the Covid pandemic.

f) Access issues were highlighted by the report from Healthwatch Nottingham and Nottinghamshire and in the City there are issues with access across all groups, especially the most vulnerable such as looked after children and those with severe multiple disadvantage (SMD). Work is taking place on a pilot for dental care for SMD groups who find it difficult to attend a dental surgery. The

Community Dental Service is looking at the possibility of a mobile dental surgery to help address these issues.

g) Last year, NHS England commissioned a scheme to improve access and support recovery from the pandemic. Unfortunately, there has been limited uptake from the 38 general dental practices operating in the City. It is understood that the main reason for this is workforce capacity issues. However, the scheme includes:
   i. a practice in Bulwell providing weekend appointments enabling approximately eight patients to be seen on a Saturday or Sunday
   ii. dedicated urgent slots which NHS111 can signpost directly to and there are two practices in the City keeping slots available for this
   iii. Additional 8-8 scheme which has an interim provider until the new provider starts in January 2023
   iv. Funding for oral health promotion and prevention
   v. Support practices working with the Community Dental Service and special care patients.

h) Nationally, dental decay is the main reason for children being admitted to hospital for an anaesthetic.

i) There is currently no fluoridation of water in the City. Research has been carried out over many years in areas where fluoridation occurs naturally and areas where fluoride is added to water showing unequivocal evidence that fluoridation reduces the risk of children developing dental disease and up to 63% less likely to be admitted to hospital to have teeth extracted. While the largest benefit is for children, there are also benefits for adults. Changes have been made to the decision making process, giving the Secretary of State responsibility for approving fluoridation of water. This should make it easier for approval to be granted and it is hoped that this will happen in the future.

j) Since 1 July 2022 there have been joint commissioning arrangements and there will be full delegation for local commissioning to the Integrated Care Board from 1 April 2023. Stakeholder briefings about these changes will be issued.

k) Going forward there are two main areas to look at in work plans. These are:
   i. Improving access – contract reform is moving in the right direction but progress has been small so far. Consideration is being given to clarifying NICE Guidance about recall to say that people who are very stable can be seen less frequently than every six months to enable more appointments to be available for those who need them, with the maximum period before recall recommended to be 24 months. There will also be a focus on maximising the skill mix within dental teams so that more complex treatments can be available. This will require a change in mindset about roles.
   ii. Vulnerable groups – the Nottingham and Nottinghamshire Oral Health Steering Group will be looking at ways to improve access for those with SMD, including piloting a mobile dental practice.

Sarah Collis, Healthwatch Nottingham and Nottinghamshire, spoke about the report that Healthwatch published in June 2022 about access to dental care in Nottingham and Nottinghamshire. The report highlighted that there is a disparity for those on low incomes, there are particular challenges in access for those with SMD and it can be very difficult for those with disabilities to get an accessible appointment. It is a health inequalities issue that there are particular problems in access for those who already experience barriers in accessing healthcare. Local Healthwatch has worked alongside Healthwatch England as this is a national issue.

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

l) There has been a lot of investment in trying to increase access in the City, and across the East Midlands, but there have been issues with the workforce and dental practices taking up those opportunities. This indicates deeper and more long-standing issues with capacity and it hasn't been possible to persuade the workforce to do more. When responsibility for local commissioning is fully delegated to the ICB, the aim will be to use opportunities to work at a place-level, making links with pharmacies, GPs, optometrists etc in local areas. However, some of the barriers can only be addressed at a national level and it is hoped that will happen with contract reform.

m) Despite the challenges, the City has not had the level of contract terminations that have happened in other areas of the East Midlands. There have been no contracts handed back so the architecture is in place but professionals need to be persuaded to stay.

n) One of the challenges in improving access to oral surgery is a lack of access to surgical theatres and anaesthetic. This is a general NHS issue as all providers are focused on restoration of services, but NHS England is looking at commissioning more sessions for oral surgery and working with Nottingham University Hospitals NHS Trust to maximise capacity and access.

o) Consideration is being to the scope for improving pathways. For example, the practice support service is unique to this area and provides additional support by seeing those who might otherwise have to access the community dental service.

p) Some Committee members noted the discussions that have taken place in previous years about adding fluoride to water and encouraged NHS England to work with MPs and local authorities to progress this as soon as possible.

q) There has been recruitment of overseas dentists and the General Dental Council has tried to make the process as smooth as possible. One of the biggest issues is a lack of dental nurses and consideration is being given to using apprenticeships. Work is also taking place with Health Education England to go into schools to talk about careers in a dental team. There also needs to be a platform to enable dentists to return from private practice. In Nottinghamshire a Dental Care Professional Network has been established

and it will be looking at ways of addressing workforce issues and the Local Dental Network Chair will be working with others to improve the local position.

r) All 38 general dental practices in the City are currently open. However, NHS England knows that some practices say they are not accepting new patients. When NHS England is aware of this happening, it will investigate and make sure that practices are aware of their contractual obligations. Feedback is also useful evidence for developing commissioning intentions.

s) A Committee member commented that according to the 'Find My Dentist' website, there were no dentists currently accepting patients in their area and the nearest dentist is 3.8 miles away. NHS England agreed to look at this and said that work was ongoing to improve the NHS website and the information about individual dental practices.

t) Concern was raised that increasing the length of time before recall could result in patients losing contact with the surgery that they normally attend because they are not formally registered and a practice only has a responsibility for two months after a course of treatment has finished. NHS England responded that practices will still demonstrate loyalty to patients but the benefit will be in freeing up appointments for those who need it.

u) NHS England agreed to look into concerns of reports that patients attending the Community Dental Service are being deregistered from that service once their course of treatment has finished. This would have implications for prevention work and also increase the workload of GPs in re-referring people. Concerns were also raised that there is no Community Dental Service centre in the city centre despite it having the worst health outcomes.

v) The main issues relating to access to dental care by looked after children are maintaining contact and ensuring attendance by those who move frequently and communication with previous dentists about past care and treatment. There is a proposal to have a paper record of dental treatment that stays with the child to try and overcome the later problem.

The Committee welcomed the intentions to improve access to dental care in the City, especially for vulnerable populations and those who already experience barriers in accessing healthcare, but raised concerns about the scale of what it has been possible to achieve so far.

Resolved to:

(1) request that NHS England provide:

i. up-to-date maps of services in the City; and

ii. contact information for councillors to report dental practices that say they are unable to accept NHS patients;

(2) recommend that NHS England:

i. ensure that its website contains up-to-date information on dental practices;

ii. review pathways for the Community Dental Service to ensure that patients aren't 'off-rolled' after a course of treatment has finished; and

iii. make a concerted effort to increase recruitment of dental practitioners in the City

(3) recommend that NHS England and the Council work together to identify what be done to progress fluoridation of Nottingham's water;

(4) recommend that the Corporate Parenting Board explore the issues looked after children are facing in accessing dental treatment; and

(5) request that once responsibility for local commissioning has transferred to the Integrated Care Board, the Board attend a meeting of the Committee to discuss how local commissioning can better meet local need.

43 Primary Care Strategy

Dr Stephen Shortt, Nottingham and Nottinghamshire Integrated Care Board, gave an overview of the emerging Primary Care Strategy for the Nottingham and Nottinghamshire Integrated Care System. He highlighted the following information:

a) The health and care system needs strong and effective primary care, aligned with other integrated care system models. When primary care performs well it saves lives, improves health outcomes, reduces health inequalities and reduces costs within the system as a whole. The Primary Care Strategy seeks to recognise this and identify what further improvements are needed over the next few years to support primary care.

b) The outgoing chair of the Royal College of General Practitioners has stated that current arrangements are not working for either patients or professionals and that, while primary care performs well, it is under duress and not meeting everyone's needs.

c) The Strategy needs to establish strategic intent, create motivation for significant system transformation, ensure a fairer distribution of resources that equitably reflects difference, outline a plan for recruitment and retention and support networking with other professionals. It must be realistic and optimistic.

d) The three themes are: laying the foundations to recover primary care; improving primary care quality; and making the system sustainable.

e) In terms of work to lay the foundations to recover primary care there is a need to establish a clear culture, narrative and purpose which sets out what primary care needs to do, reflecting patient complexity and expectation and the voice of GPs; the person-GP 'compact', which came under pressure during the Covid pandemic, needs to be restored; and ways of improving access, which lots of patients are dissatisfied with and data shows is hugely variable, in terms of days and times of access, methods of access and continuity of clinical professional need to be identified.

f) In terms of improving primary care quality enabling technology needs to be better utilised and buildings fit for purpose; there needs to be good access to records including by patients; clinicians need to be more easily able to talk to each other to analyse problems and effect solutions; and a population health management approach that supports prevention and wellbeing needs to be implemented. Good progress has been made by Primary Care Networks (PCNs) but things now need to move to the next phase under Integrated Care Teams. There is insufficient measurement, especially on outcomes, to ensure that patient need is being met.

g) The Strategy will also focus on making sure the system is sustainable in terms of workforce and leadership by identifying ways of retaining health care professionals, improving the workplace experience, extending roles and introducing new roles which has started through PCNs and offering career development. The system also needs to be financially sustainable with a re-profiling of resources between different sectors and different groups of patients. It is acknowledged that current resource allocation does not adequately address health need. In addition, most GP practices are small with fragile business models so need support to grow their resilience and increase their scope and scale without losing connection to their patients.

h) There has been a lot of engagement with GPs to inform the Strategy, which is not yet complete and more engagement will be taking place with stakeholders, including hospital trusts, local authorities and Healthwatch.

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

i) Noting that the existence of Patient Participation Groups is patchy and diversity of need is not always represented within them, the Healthwatch representative asked how patient voice will be heard in the Strategy. It was stated that there has been a deliberate approach of engaging with GP workers initially on professional issues, to activate and motivate them. Over 200 workers have been involved. This was important because effectiveness of the Strategy will rely on their engagement. Now that the content of the Strategy is broadly acceptable, wider and deeper engagement will take place. Healthwatch input on doing this will be sought.

j) The intention is to create panels for each of the ten objectives to validate observations, operationalise them and consider how to measure impact. The panels will involve both professionals and lay people, including significant patient representation.

k) The national funding formula favours headcount rather than need and opportunities to better reflect need will be looked at. The approach taken in Leicester linking resources to deprivation has been looked at and a local model for Nottingham and Nottinghamshire is being considered to rebalance between primary care and other sectors. As a consequence, there will need to be a redistribution of resources and preferential investment made. This is a

work progress but a commitment within the Strategy is that every investment will have an equity dimension.

l) It is recognised that continuity of care is important. There needs to be continuity of clinical records that everyone has access to and an evidence-based clinical model. Continuity will probably be through teams rather individuals, which is not always be possible, and the PCN will be responsible for understanding the needs of its whole population and not just those who receive care. The Committee's preference for continuity of individual is the 'gold standard' and the initial aim will be to try and achieve this for high intensity-use populations.

m) Issues with primary care in Nottingham and Nottinghamshire are common to other areas but there are variations. Nottingham and Nottinghamshire have some strong building blocks in place and the Strategy is starting from a relatively good position. The aim is to replicate and mainstream the things that are working well.

n) A committee member commented on the importance of engaging with other sectors, such as public health on preventative approaches and secondary care to ensure that those people who need more specialist care than primary care can provide, yet do not meet the threshold for a specialist service do not fall through the gap. It was acknowledged that transitions between one area of the system and another are not always managed well.

o) The Integrated Care Board has given indicative approval for development of an implementation and delivery plan, which will take into account local specificity. It has requested that a costed delivery plan is prepared for the new year.

p) Implementation of the Strategy is not mandatory and there are no contractual levers that can be used, but the intention is to motivate and incentivise engagement with it.

q) As a five year and beyond programme, the Strategy will be constantly refined to reflects what works.

Resolved to recommend that the Primary Care Strategy for Nottingham and Nottinghamshire Integrated Care System:

(1) develops a model of resource allocation that reflects need, population diversity and deprivation;

(2) focuses on effectively integrating primary and secondary care and those people who need more specialist care than can be provided in a primary care setting but who do not meet the criteria for a specialist service;

(3) focuses on reducing health inequalities and prevention; and

(4) encourages citizen participation in development and delivery, including by having panels that are representative of the diverse nature of the City population.

44 Work Programme

The Committee considered its work programme for the remainder of municipal year 2022/2023, and noted that at its meeting in December the Committee will be looking at the progress by Nottingham University Hospitals NHS Trust in addressing the issues raised in the Care Quality Commission inspection of Well Led.