Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
Tuesday 16 January 2024 at 10.00am

COUNCILLORS

Jonathan Wheeler (Chairman)
Bethan Eddy (Vice-Chairman)

Mike Adams
Sinead Anderson
Callum Bailey
Steve Carr - **Apologies**
David Martin
John 'Maggie' McGrath
Nigel Turner
Michelle Welsh
John Wilmott

SUBSTITUTE MEMBERS

None

OTHER COUNCILLORS IN ATTENDANCE

Councillor John Doddy

OFFICERS

Martin Elliott - Senior Scrutiny Officer
Noel McMenamin - Democratic Services Officer
Katherine Harclerode – Democratic Services Officer

ALSO IN ATTENDANCE

Rose Lynch	–	Nottingham and Nottinghamshire ICB
Victoria McGregor-Riley	–	Nottingham and Nottinghamshire ICB
Dr Pavni Lakhani	–	Chair, Local Dental Network, Nottinghamshire
Dr Tarun Sharma	–	DHU Healthcare
Susan Williamson	–	DHU Healthcare
Liz Cowley	–	Nottingham and Nottinghamshire ICB

Prior to proceedings, the Chairman asked the Committee to observe a minute's silence to mark the sad passing of Martin Gately. The Chairman noted that Martin served with distinction as Health Scrutiny Lead for many years and also worked closely with Health and Wellbeing Board colleagues. Martin was remembered as a professional, approachable and conscientious officer who would be sadly missed by all who knew him.

1 MINUTES OF THE LAST MEETING HELD ON 12 DECEMBER 2023

The minutes of the last meeting held on 12 December 2023, having been circulated to all members, were taken as read and signed by the Chairman.

2 APOLOGIES FOR ABSENCE

Councillor Steve Carr – Other reasons
Sarah Collis – Nottingham and Nottinghamshire Healthwatch

3 DECLARATIONS OF INTEREST

Councillor McGrath declared a personal interest in agenda item 4 (Access to NHS Dental Services) and in agenda item 5 (NHS 111 Service Performance in Nottinghamshire), as his daughter worked as a nurse for the NHS.

Councillor Eddy declared a personal interest in agenda item 4 (Access to NHS Dental Services) and in agenda item 5 (NHS 111 Service Performance in Nottinghamshire), as her husband works as an NHS Community Nurse.

4 ACCESS TO NHS DENTAL SERVICES

Rose Lynch – Senior Commissioning Manager, NHS England, Midlands (East); Victoria McGregor-Riley – Commissioning Delivery Director; and Dr Pavni Lakhani – Chair of the Local Dental Network, Nottinghamshire, attended the meeting inform the Committee of progress in respect of improving access to NHS dental services. Following on from discussions at its March 2023 meeting, the Committee requested this item to be presented for scrutiny with a view to discussing further the current state of access to NHS dental services nationally and within Nottinghamshire, and the proposed approaches to addressing these challenges.

Rose Lynch, Victoria McGregor-Riley, and Dr Pavni Lakhani delivered a presentation to the meeting on the approach being taken by the ICB to address issues and barriers to access to NHS dental services.

The presentation include a map of the locations of various NHS Dental Services that are delivered within Nottinghamshire. Challenges to access that Dental Services face nationally and within Nottinghamshire were described. National progress of proposed dental reforms was noted, as well as local progress in Nottinghamshire. Prevention efforts and proposals, including fluoridation of drinking water as a public health measure, were noted. Timelines of dentistry recovery following the pandemic were presented, including the transfer of responsibility for dentistry from NHS England to the ICB from March to July 2023.

Recovery initiatives were described including two ongoing initiatives that were carried over into 2023/24: Community Dental Services Support Practices and Intermediate Minor Oral Surgery (IMOS). Further initiatives added in 2023/24 focussed on delivery of dental treatment and care to individuals who are vulnerable due to multiple deprivation and/or homeless via a mobile dental unit.

A graph of the numbers of new patients seen April 2022 to November 2023 was presented, along with a detailed description of next steps. These collaboration strategies to improve access would be informed by the forthcoming Oral Health Needs Assessment (March 2024):

- The role of Integrated Care Boards to commission services at the system level specific to the needs within Nottinghamshire.
- Place-based collaborations on oral health improvement.
- Communications campaigns by NHS Communications Team to communicate the challenges to access.
- Engagement with local Healthwatch colleagues to receive intelligence on local concerns or difficulties of patients in accessing NHS dental services.
- Strategic leadership and expertise of Consultants in Dental Public Health
- Collaboration with the East Midlands Primary Care Team to identify local areas and a targeted approach to specific issues.
- Local Dental Network (LDN) Chairs collaboratively working with Managed Clinical Networks at place and neighbourhood level, Integrated Care Systems, Consultants in Dental Public Health, Commissioners and Health Education England to ensure optimum provision of care for patients.
- Primary Care - Getting it right first time (GIRFT) to find and share best practice and reduce unwarranted variation in ways of working in Primary Care.

The Chairman thanked the presenters and sought clarification regarding a recent experience of phoning three local practices which according to the NHS website were accepting new patients and learning that the information on the website was not up to date. The Chairman also sought to understand the wording on the website regarding new patients being accepted ‘by referral only,’ and requested an update as solutions to issues around GP referrals for dentistry and online information were developed.

In the discussion that followed, members raised the following points and questions.

- Additional assurance was sought in respect of access to NHS Dental Services by Children who are encountering challenges to access.

- Further details were sought regarding the methodology for estimating the annual patient backlog of appointments.

- Additional information was requested in respect of how worsening health inequalities were being addressed as a matter of urgency, as 20% of five-year-olds in Nottinghamshire had significant tooth decay. Further assurances were requested around engagement with dental services among three-year-olds.

- A potential opportunity to partner with family hubs was noted.

- Accelerating the review of the dental contract was welcomed, specifically as it was felt that there were currently areas of Nottinghamshire where there were not enough dental practices to meet the needs of local residents.

- Further assurances around long term workforce development were requested.

- The feasibility of alternative delivery models for dental services was suggested as an area for further consideration.

- The desire for plans for dentistry provision to be included in the planning process for new housing estates and developments was expressed.

In the response to the points raised, Rose Lynch, Victoria McGregor-Riley and Dr Pavni Lakhani advised:

- Current discussions sought to ensure that information online was kept up to date in respect of practices that were taking on new patients. Although it had been mandated that practices keep the information online updated as to whether they were taking on new patients, this status could change quickly from one day to the next. A challenge was finding a solution which was user friendly and also did not add to the pressures on dental practices.

- Where practices had already fulfilled their contractual capacity to take on new NHS patients, there could be the option to see patients privately. It was acknowledged that, for some patients, this was not an affordable option. Therefore, the ICB was seeking to address this access issue through flexible commissioning to increase Units of Dental Activity (UDAs) and incentivise seeing more NHS patients. A solution would require collaboration with local providers.

- As an example of a referral-only contract, some general practices may refer a young patient to Community Dental Services (CDS) for an assessment. If the patient needed additional support, the CDS could refer the patient to a child-friendly support practice.

- It was noted that GPs did not frequently refer patients to dental services; GPs usually either prescribed antibiotics or referred a patient to emergency services. This was something that the ICB was currently working to address with Primary Care so that dentistry cases were referred to dental providers.

- A key aim was working with dentists to recall patients in line with the National Institute for Health and Care Excellence (NICE) recall guidance, rather than recalling a patient routinely every six months. This would ensure capacity remained available for new patients and for patients in need of urgent dental care.

- Currently public health reminders are shared with practices to prompt them to update data which is shared with the Secretary of State. The wording of online resources had been reviewed to ensure the information reflected online is consistently user friendly and relevant. Healthwatch colleagues also monitored provider updates as part of their efforts to help signpost patients.

- In collaboration with Health Education England, ongoing work with dentists enhanced confidence and ability of practitioners to treat very young patients. Work was prioritised by urgency and with a view to expanding capacity for more patients with higher levels of dental care need. One of the ways to do this was by developing 'skill mix' within practices, so that more practitioners see adults as well as children. Child friendly support practices were commissioned expressly to ensure that children have options in addition to CDS.

- Parents were encouraged to take their children to the dentist by age 1, a message reinforced by health promotion teams in Nottingham and Nottinghamshire. These teams engaged with members of the wider health care workforce who then visit parents to deliver early interventions. This approach was designed to facilitate effective signposting. Early years oral health promotion within schools was also very important.

- Flexible commissioning would be informed by the Oral Health Needs Assessment in an effort to support more access by the youngest patients. The responsibility for commissioning prevention schemes sat with the local authority; therefore, collaboration was vital to an integrated approach. Prevention initiatives sought to reduce future access issues caused, for example, by the long term physiological and emotional impact of early extractions.

- Clarification was provided regarding the figures around access across the Midlands Regions. The figure was based on 24-month recall data compared with pre-pandemic levels. This data was used to derive the estimated appointment backlog.

- Because dental laboratories sat outside the NHS, commissioners did not have a direct link to the laboratories which did not hold an NHS contract. They were seen as independent businesses. When work stopped during the pandemic, the statistical impact of this was not directly available for this reason. However, the reason the ICB started engaging with members of the wider health sector was because of the pandemic. Although independent businesses did not hold an NHS contract, they played what was recognised to be an important upstream role in the provision of all care services.

- Clarification was provided in respect of the collection of data pertaining to five-year-olds due to the collection of this data as part of the national epidemiology report. Further regarding Nottinghamshire's youngest patients was offered in a future report subject to the findings of the Oral Health Needs Assessment.

- It was observed that drinking water fluoridation, as a prevention measure, would not address the imminent issues regarding access and significant tooth decay among very young children. Therefore, oral health engagement with families was ongoing through health visiting and health and wellbeing hubs.

- The Oral Health Needs Assessment forthcoming in March 2024 was expected to highlight the areas of high need, which would be used to direct targeted energy and funding toward the areas that need it.

- Central Government having acknowledged the challenges associated with the current NHS dental contract, professionals within the field likewise voiced concerns. Reforms were being introduced; however, changing the contract would take time. Meanwhile, a positive impact could be made for Nottinghamshire through flexible commissioning, to achieve as much as possible within the limitations that were in place due to the contract.

- Flexible commissioning could influence a percentage of the overall provision, dependent on contract constraints and take-up by local practices. To maximise the impact of this, outreach to vulnerable patients would be based on the Oral Health Needs Assessment.

- The Local Dental Network were keen to be involved in any local initiatives where dentistry might play a role in the shorter term. The ICB were taking a proactive approach during the intervening time until the contract is reviewed.

- Nonrecurrent funding did not allow long term planning and for that reason was less appealing to practices. The preference of practices was to ensure financial viability to deliver care over time. The risk associated with recurrent funding was instating permanent service provision in locations that may not be in the areas where there is highest need over time. Integration and collaboration would be necessary to create flexible solutions that were still financially viable for dentists.

- Currently the Local Dental Network and the ICB were examining ways of incentivising the workforce in all areas of the profession, seeking to make dentistry an attractive prospect to newcomers to the workforce, and, specifically to work within Nottingham and Nottinghamshire. This sometimes involved offers around reskilling and upskilling as seen in the development model adopted within Primary Care. Offers in other areas such as mentoring and peer support were also being considered.

- The benefits package and career progression, including training and development, were important parts of the decision to work in the profession. This was derived from feedback from engagement with professionals and stakeholders, which would be ongoing in respect of the impact of flexible commissioning. Insights garnered by local and regional teams involved in workforce transformation would be included in the next update.

- It had been raised that new housing estates and developments required additional dentistry provision, but the requirement for regeneration programmes to incorporate provision for primary care services did not include dental service provision.

The Chairman thanked Rose Lynch, Victoria McGregor-Riley and Dr Pavni Lakhani for attending the meeting and answering members' questions.

RESOLVED 2024/01

1) That the presentation, including information in respect of recovery following the pandemic and the collaborative approach to flexible commissioning, be noted.

2) That a further update be received regarding activity informed by the forthcoming Oral Health Needs Assessment.

5 NHS 111 SERVICE PERFORMANCE IN NOTTINGHAMSHIRE

Dr Tarun Sharma and Susan Williamson – DHU Healthcare and Liz Cowley – Nottingham and Nottinghamshire ICB attended the meeting to provide a progress report on the performance of the NHS 111 Service in Nottingham.

Dr Tarun Sharma, Susan Williamson and Liz Cowley made a presentation to the meeting which outlined the achievements and performance of the service. The presentation highlighted that the Service had been the first CQC Outstanding rated 111 Service in the country. A summary of the call process and highlights regarding performance figures were provided. These figures included the prevalence rates of various 'dispositions' which identified the pathway determined by the 111 Health Advisor after completing the triage process with each caller. For example, a caller may be in need of emergency department, primary care, or dentistry. The Service average for speed of answering calls was around thirty seconds, compared to the national average of 120 seconds. Abandonment rates for Nottinghamshire had been 2.7 percent for 2023.

The Service strove for continual improvement and aimed to signpost the patients to the right care the first time. Health advisors were trained for eight weeks prior to taking any calls, and the Service was always recruiting, especially in preparation for winter pressures. The planning process for winter pressures, which ramps up in the late summer, was described in detail. Some events cannot be foreseen; however, plans were in place to ensure the Service could respond to the levels of calls received. This ensured the Service was prepared for peak call volumes in December 2023 and early January 2024, which had not approached the overall record call volumes of 18,000 calls per day.

The Chairman thanked the presenters and expressed interest in seeking a further breakdown of calls from various parts of Nottinghamshire, with a view to identifying how service delivery may be received differently across various districts. The desire to know more about call backs and the effectiveness of pathways was expressed. The performance of the website and app were also noted as relevant areas for possible future scrutiny.

In the discussion that followed, members raised the following points and questions.

- The service was commended for being among the best in the country. Members thanked the Service for answering the calls and recognised the importance of the Service as a front door and safety net. It had been noted that GP services and emergency services at times direct patients to ring 111.

- Additional information was sought regarding the messaging around when it was appropriate to ring 111. Some individuals called 999 when they should ring 111, whilst others ring their GP when it would be appropriate to ring 111. The importance of clear, simple messaging around use of the 111 Service was emphasised. Further details regarding communications work around this were requested.

- Members sought additional data regarding the amount of time that elapses prior to a caller receiving a call back, particularly for calls regarding children who become ill after 6.30pm, with a view to informing service commissioning and public messaging. Further detail was also requested regarding waiting times for a call back depending on the hour of the day, and the relative demand during various hours of the day and night.

- More information was requested regarding how information collected was being used to address health inequalities.

- Information on how many people who had rung 111 regarding access to dental care was requested.

- Further clarification was requested regarding disconnected calls and unsuccessful call backs.

- Members also sought additional assurances around workforce recruitment and development.

- Members expressed concerns about the pressure on the service which was integral to NHS service delivery.

In the response to the points raised, Dr Tarun Sharma, Susan Williamson and Liz Cowley advised:

- The Service was commissioned at a county level. Data could be compiled by patient postcode, although the service was currently commissioned to report on county-wide data. Data could also be presented by GP surgery. Where several surgeries served a district, these could be combined to provide indicative figures for the district. It was noted that some calls are fielded for other areas of the country.

- Historic activity levels informed Service commissioning, to ensure sufficient staff levels to handle all the incoming calls. The pathways information would

likely provide insight into the needs that exist and could aid Members in understanding how different areas may use the service differently.

- Utilising service data to address health inequalities was supported by Place based Partnership working and could be included in a future report.

- The Nottinghamshire teams provided feedback which informed the national messaging, although there were limitations around how much this messaging could be tailored locally.

- In respect of disconnections and abandonment rates, there are many reasons a caller may decide to put down the phone or choose not to continue with a call or a call back. The team fielded calls where the person was on the phone during a developing emergency. Calls were prioritised by urgency, yet 111 received increasing numbers of calls regarding dental care, refused prescriptions, and GP surgeries that could not be reached by phone. 111 was not the correct service for these calls, which required a clinician to negotiate to resolve the situation.

- Any call relating to a person under age five was automatically a high priority. It would be rare for one of these calls not to receive a call back from a clinician. The same was true for the elderly.

- Data relating to dental services was collected and regularly reviewed. Data could also be presented by age and by symptom. Distributions were examined by the clinical teams to assess how these calls are being handled. These breakdowns are available.

- Data could be broken down by hour of the day, and there were noticeable peaks, with 10-11 am and 5-6 pm being daily peak times. This is evenly distributed across the week.

- After triage, it was sometimes discovered that the individual had called 111 when they were unable to speak with their GP. This increased the workload of the 111 team, and often led to a negotiation which took time. Team members were cognizant of prioritisation of urgent and emergency calls, but no calls were turned away. This was the reason many people called 111, even when their issue was not within the remit of 111.

- The aim of the Service was to work with communications colleagues to get the messages out when there is a critical incident and to help people know which service would be the right service to contact in their situation. Whenever possible, the Service worked to tailor communications in different localities to suit this purpose. Occasionally, callers might make the wrong choice, often based on previous experience, repeating a choice that worked previously. During the COVID-19 pandemic, 111 was made the single point of contact, and this messaging continues.

- It remained important for the general population to understand the distinctions between urgent, non-urgent, and emergency situations. Sometimes callers required support with making those distinctions.

- 25 percent of calls required involvement from an emergency department or an ambulance. Many people called 111 because they do not want to bother the ambulance. That is why the triage questions asked first about any difficulty breathing or significant blood loss.

- The 111 training was described as intense and was heavily audited, both live and in retrospect. The 111 team members were required to have at least a 90% pass rate. They received calls from frustrated patients, and they had very good communication skills to negotiate these situations. There was an emotional toll which resulted in high attrition within the role. Many team members used this role as a springboard to a health career because they gained so much knowledge. They had access to a clinical line and could get clinical advice within seconds, with some situations where they were required do so where there was a known health condition, for example. NHS pathways changed regularly due to new pathways and new clinical outcomes. Information was fed back from 111, and pathways were adjusted if there was a risk.

- The 111 Services utilised all platforms to deliver national and local communications. NHS England had recently adopted Nottinghamshire's local communications around winter pressures. 111 received the same kinds of calls that 999 received in addition to the non-urgent 111 calls.

The Chairman thanked Dr Tarun Sharma, Susan Williamson and Liz Cowley for attending the meeting and answering members' questions.

RESOLVED 2024/02

1) That the comments of Members on the information in respect of NHS 111 Service delivery and performance be noted.

2) That an update including a further breakdown of data be submitted to a future meeting, to be developed in consultation with the Chair and Health Scrutiny Lead.

3) That consideration be given to how 111 service data may inform the Health Scrutiny work programme.

6 WORK PROGRAMME

The Committee considered its Work Programme, discussing timescales for future areas for consideration by the Committee. The Chairman advised that there would be a further update on current Maternity Service provision, either in June or July 2024. Members emphasised the importance of contacting the families to ensure they are aware of the scrutiny discussion.

Members requested additional details around the definitions constituting critical incidents, and the Chairman suggested that a briefing note be requested in respect of this topic.

The review of school readiness was in initial stages, with the first meeting to be scheduled shortly.

The Chairman noted that the forthcoming item in respect of Mental Health Services Support to Schools had been requested and would be scheduled in consultation with partners.

RESOLVED 2024/03

1) That the Work Programme be noted.

2) That further consideration be given to the timescales of requested items for scrutiny in consultation with Chairman and Scrutiny officer.

The Chair noted the continuation of the new start time of 10.00am for future meetings and closed the meeting at 12.52 pm.

CHAIRMAN