Adult Social Care, Health and Wellbeing Sub-Committee

Monday, 7 November 2022

Present: Councillor J Kirwin (Chair)
Councillors M Fox, L Arkley, T Hallway, T Mulvenna, R O'Keefe, P Richardson, O Scargill and J Shaw

Apologies: Councillors J Montague

ASCH20/22 Appointment of Substitute Members

There were no substitute members.

ASCH21/22 Declarations of Interest

There were no declarations of interest.

ASCH22/22 Minutes

Resolved: That the minutes of the meeting held on 29 September 2022 be confirmed and signed by the Chair.

ASCH23/22 Availability and Access to NHS Dentistry Services in North Tyneside

Pauline Fletcher, Senior Primary Care Manager, NHS England, and Simon Taylor, Local Dental Network Chair for the Northumberland and Tyne and Wear, attended the meeting to provide a presentation on Provision of NHS General Dental Services in North Tyneside.

The presentation set out background information on the commissioning of NHS dental services which is activity and demand led. It was noted that pre-Covid, in 2019-20, around 91% of the total commissioned capacity in North Tyneside was utilised, demonstrating that at that time practices were meeting the expressed demand of the local population. The COVID-19 pandemic, and the requirement to follow strict infection prevention control guidance, has seen a significant impact on access to dental care over the last 2 years, with demand for dental care remaining high across all NHS dental practices.

The presentation set out the current pressures and challenges for the commissioning of dental services. These include the impact of COVID-19, NHS dental contract and dental system reform, and workforce recruitment and retention.

It was noted that Covid had caused a large backlog of unmet need and patients requiring more complex and lengthier treatment. This has made it more difficult for patients with low priority to get an appointment, such as those seeking check-up appointments. In addition, there were issues in relation to dental professionals choosing to retire early, move to private practice, or move away from dentistry all together. There have also been overseas recruitment difficulties and constraints in attracting trainees to rural and other areas that may

have a greater need, and this was impacting on the ability to deliver commissioned levels of service or additional access for patients.

It was noted that a package of initial reforms to the NHS dental contract had been published by NHS England in July 2022. These included:

- Prioritising care for patients with high needs by increasing the remuneration practices receive for more complex treatments.
- National minimum UDA value - £23 from 1 October 2022 (although rates in North Tyneside are above this).
- Greater flexibility in how dental funding can be used by enabling practices who can deliver more to do so and to release funding locked into practices who are unable to deliver the commissioned activity so that it can be moved to those who can deliver.
- Personalisation of recall intervals - move away from the default position of patients attending every 6 months to intervals that are clinically appropriate based on the oral health of the patient – create capacity for practices to take on new care.
- Making it easier for practices to introduce skill mix - utilising the skills of the wider dental care professionals (dental therapists and hygienists) to work within their full scope of practise thereby freeing up dentist time to focus on more complex treatments.
- Improving information for patients - requirement for dentists to update the NHS.

The Sub-committee was advised that all dental practices are able to safely provide a full range of treatments, however demand for care remains extremely high, with dental practices having to balance addressing the backlog of care with managing new patient demand. Practices are being incentivised to prioritise patients with the greatest clinical need, ie those requiring urgent dental care and delayed treatments including patients not known to the practice, as well as vulnerable/high risk groups such as children. Opportunities are being explored to increase the clinical capacity available and improve access for patients.

Members asked about the national minimum UDA value and why North Tyneside was above this level. It was noted that this was due to legacy arrangements and variations across contracts and this will be addressed through procurement going forward. The average UDA rate in North Tyneside was currently £27.

Members asked about any backlog prior to Covid. It was noted that pre-covid there were some waiting lists but the current backlog is a result of Covid and the need for additional treatment per patient which has led to non-priority patients having to wait.

There was some discussion about Foundation Dentists and the way that Health Education England appoints Foundation Trainers to mentor newly qualified dentists. It was noted that many Foundations Trainers are currently in more affluent areas and these areas attract more trainees but there is a need for more trainers in areas with higher need.

Members asked whether there had been a reduction in dentists in training. It was noted that access problems are not related to the number of dentists training and more dentists are currently on the register than in the past. However, there has been a change in the way dentists want to work, with a shift in expectations around work life balance, more dentists working part time and a shift towards private dentistry.

An issue was raised about difficulties for residents in knowing where to go for dental treatment, especially as the dental hospital walk in service is not available. It was noted that more information was needed to assist people in accessing services and for organisations such as 111 to play a greater role in signposting people to services.

The Chair thanked the officers from NHS England for the informative presentation.

ASCH24/22 Adult Social Care

1. Northumbria Health Care Trust Care Pilot

The Sub-committee considered a presentation which provided an update on the Health and Social Care Pilot.

The Sub-committee noted that the pilot had been initiated in the context of increased pressure on the home care market and a more complex health system and the need to consider new delivery models. The pilot was intended to increase communication between the social care and health sectors, to facilitate improved patient quality and continuity of care, and the development of new roles where one individual can deliver both health and social care tasks to patients in their home.

It was noted that, in order to be selected for the pilot, patients were required to have both health and social care needs and to be currently on the brokerage list. The team supporting the pilot included one matron and seven health care assistants and the main areas of support provided included: assistance with meal preparation, support with confidence and competence to maintain daily living skills, mobility, medication prompts and monitoring, low level wound care, personal care, phlebotomy, health checks, nutrition assessment and dietary advice, moving and handling assessments, provision of low-level aids and adaptions.

The Sub-committee was advised that 7 patients had taken part in the pilot altogether and the current caseload is four patients. An evaluation of the pilot against quality indicators had taken place in relation to non-elective hospital admissions, A&E attendances and long-term admissions to care, and the indicators were that the pilot had reduced attendance at hospital and hospital admissions but this was based on the very small numbers involved. An evaluation had also taken place with staff and patients and the responses had been positive.

It was noted that a number of challenges and opportunities had been identified as a result of the pilot, including:

- Difficulties of identifying patients on the brokerage list with low level health needs;
- The team was limited to 3 calls per day, therefore were not able to include those requiring 4 daily visits;
- Limited resource due to restricted time visits i.e. breakfast, lunch, teatime, influencing downtime

The following opportunities had been identified:

- Continuing to foster relationships across the two organisations sharing appropriate training and communication pathways;
- Using the skills and resources of the team to enhance current or new models of care delivery;
- Sharing the learning from the pilot to inform future service design.

It was noted that an evaluation report is currently being finalised for submission to respective chief executives. The formal report will provide opportunities for learning and will outline an options appraisal for the future function of the team. There is a continued commitment for health and social care to work together in this area.

Members expressed some disappointment at the small numbers involved in the pilot and the limits on the pilot due to staff resources and the need for patients to meet quite limited criteria in terms of their social care and health needs to be eligible to take part. The Sub-committee was advised that it had been more difficult than expected to find patients who met the criteria for health and social care need, as many either had health issues that were too complex for the pilot or did not have enough health need to require health support.

There was some discussion about staff recruitment. It was noted that the roles within the pilot were healthcare assistant roles with additional training provided in social care. The pilot had been coordinated by a Team manager with a district nurse background.

It was noted that the final report on the pilot has not yet been finalised but further consideration will be given to next steps. Members asked for the evaluation report to be submitted to the Sub-committee in future, once it is available.

2. Care Northumbria

Representatives of Northumbria NHS Foundation Trust attended the meeting to provide information on Care Northumbria, a new domiciliary care service established by the Trust.

It was noted that the service will offer support with personal care to people in their own homes and will be commissioned to provide services in both Northumberland and North Tyneside, with work allocated through the usual local authority pathways. The service will aim to support the local authorities and the care provider market with gaps within Northumberland and North Tyneside.

It was noted that there are substantial gaps in the availability of care provision and people are often in hospital awaiting care packages or placed in step-down facilities while they await a care home. This can increase the risk of dependence upon services and can reduce the opportunity for patients to return home. Care Northumbria is being established to address some of these issues and also aims to deliver high quality NHS care and give value back to the caring role in which moral has been severely damaged.

It was noted that progress has been made to establish the service. To date personal care had been added to Northumbria Healthcare Foundation Trust's Care Quality Commission (CQC) registration, a registered manager is in post, and the structure for the Care Northumbria service has been agreed. A phased recruitment is now in progress and an induction and training programme in place.

The Sub-committee was advised that this was a new area of work for the Trust and they are aiming to provide support in this area in a way that does not de-stabilise or threaten existing provision. However, it was recognised that there is likely to be some disruption. It was noted that staff will be employed on NHS terms and conditions and will be part of the broader organisation but will be paid at prevailing market rates. There will also be a need for greater understanding of personal care at an organisational which will be a change for the organisation.

There was some discussion about the planned rates of pay and how this compares with other care providers in the region. It was noted that rates may be slightly lower than some providers, but this would be balanced by the offer of NHS terms and conditions, enhancements for weekend and work after 8:00 pm and mileage payments. In addition, the Trust will be looking to put in place career pathways for care workers with increased training and pathways to nursing, and a greater recognition of care staff.

Members welcomed the initiative but cautioned about the impact on other providers. Members also highlighted the need to ensure communication with other providers as the service develops.

Members asked whether any other health trusts were also doing this. It was noted that it was believed that Northumbria were the first, but there had been a lot of interest nationally about what they are doing. It was suggested that the Trust be invited back to a meeting to provide an update to the Sub-committee once the service is established and has been operation for some time.

The Chair thanked officers for attending the meeting and for the informative presentations.

ASCH25/22 Joint OSC for the NE&NC ICS and North and Central ICPs'

The Sub-committee received an update from member's following the meeting of the regional health scrutiny meeting which was held on 17 October 2022.

It was noted that the presentations from the meeting had been circulated to the Sub-committee with the agenda and papers.