HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 3 October 2024

PRESENT:

Councillors Colin Belsey (Chair), Councillors Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson and Alan Shuttleworth (all East Sussex County Council);
Councillor Dr Kathy Ballard (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Christine Brett (Lewes District Council) and
Councillor Graham Shaw (Wealden District Council)

WITNESSES:

NHS Sussex

Charlotte Keeble – Director of Primary, Community and Urgent Care Commissioning

Ashley Scarff – Director of Joint Commissioning and ICT Development (East Sussex)

Garry Money – Director of Primary Care Commissioning and Transformation

Carole Carthern – Head of Primary Care East Sussex

Kate Symons – Deputy Director of Primary Care

East Sussex Local Dental Committee

Nish Suchak

Margaret Case

East Sussex Healthcare NHS Trust

Richard Milner – Chief of Staff

David Garrett – Divisional Director for Core Services

LEAD OFFICER:

Martin Jenks and Patrick Major

10. MINUTES OF THE MEETING HELD ON 30 JULY 2024

10.1 The Committee noted that it was awaiting various pieces of information and updates from NHS Sussex under 6.6, 6.8, 6.11, 6.17, and 6.25 of the minutes of the previous meeting.

10.2 The minutes of the meeting held on 30 July 2024 were agreed as a correct record.

11. APOLOGIES FOR ABSENCE

11.1 Apologies for absence were received from Councillor Abul Azad, Councillor Terry Byrne, and Jennifer Twist.

12. DISCLOSURES OF INTERESTS

12.1 There were no disclosures of interest.

13. URGENT ITEMS

13.1 There were no urgent items.

14. ACCESS TO NHS DENTISTRY SERVICES

14.1 The Committee considered a report from NHS Sussex providing a progress update on work underway to enhance routine and urgent dental care access for people across the county.

14.2 The Chair requested that future reports from all NHS organisations should reference data that covered East Sussex only and avoid Sussex-wide data wherever possible.

14.3 The Committee commented that the current levels of provision were unacceptably low and asked how NHS Sussex were working to increase the number of units of dental activity (UDA) across the county.

14.4 Charlotte Keeble, NHS Sussex Director of Primary, Community and Urgent Care Commissioning outlined that nationally the Government had committed to review the NHS dental contract and address known challenges with it which currently presented issues for dental professionals. Locally, there were challenges attracting new NHS dentists to the area, and NHS Sussex was undertaking targeted action to address this. This included uplifting the minimum UDA rate and engaging with local dental providers to encourage them to overdeliver on their NHS contracts, which they were able to do by up to 10%. Providers had also been encouraged to take on temporary UDA, as sometimes they did not want to take these on permanently. An urgent dental care ‘test and learn’ pilot approach, which combined UDA and sessional payments, encouraging providers to take on more complex patients, had proven popular and been extended for the rest of the year. Given there had been five dental contract hand backs in East Sussex, there were plans to hold a market engagement event in Lewes in November to both procure new contracts and understand what would encourage greater take up from providers.

14.5 Nish Suchak, General Dental Practitioner and Chair of the East Sussex Local Dental Committee outlined that the current national contract meant that where practices failed to deliver their number of UDA in a year, they were required to make these up the following year, and the contract was not fit for purpose. There was insufficient funding for the system to meet the level of need and the national contract did not provide sufficient funding to support dentistry practices' costs, including staff.

14.6 Cllr Turner suggested that dentists should be required to accept new patients onto their books even if they were full, just as GPs were required to do. Nish Suchak commented that dentists were unable to take on more patients because the funding they received from the NHS was ringfenced and cannot afford to do any more NHS work.

14.7 The Committee commented that some people struggled to pay for certain treatments and asked how these people could be better supported.

14.8 Charlotte Keeble commented that NHS Sussex supported there being reforms made to the national contract. The feedback from dental professionals had identified three key drivers causing contract hand backs, which were the low UDA rate, the NHS dental contract and workforce recruitment and retention. NHS Sussex had tried to address these challenges where it was able to, but there were structural issues with the national contract, and there was no dental training school in the entire South East which meant trainees were not being attracted to the region or county.

14.9 Nish Suchak commented that patient charges for NHS dental work went up every April, and working in an area of high deprivation he noted that many patients asked for the minimum level of treatment to avoid higher costs. There was high level of tooth decay within children and prevention work in schools would be important in addressing this.

14.10 The Committee asked how NHS Sussex collaborated with ESCC to deliver a preventative approach to dental health in schools.

14.11 Charlotte Keeble explained that the NHS Sussex Dental Plan had been developed in partnership, including with Public Health teams in ESCC. There had also been discrete pieces of work, including working with ESCC to review the Looked After Children pathway, given the specific complexities related to their dental health. The new Government had committed in its manifesto to a toothbrushing campaign for 3-5 year olds, and public health consultants would be working on that campaign. Prevention was also embedded into the urgent dental care pilot, which was ringfenced for children, young people and clinically vulnerable people who had difficulties accessing dental services and needed longer appointments.

14.12 The Committee asked what the time delay until the workforce benefits were realised from the work with the NHSE Workforce Dental Deanery.

14.13 Charlotte Keeble explained that she had recently met with the Dental Deanery and Chichester College to explore the viability of a proposal for a dental school with the Deanery, as well as to test out the costs of such a development. A fully costed business case would need to be developed and discussions on this were ongoing. Nish Suchak added that it took five years to train a dentist followed by an additional year, which meant it took six years for newly qualified dentists to come onstream.

14.14 The Committee asked whether there were plans to increase the number of 'golden hellos'.

14.15 Charlote Keeble explained that there was a national allocation to each region for golden hello posts. Twenty eight were allocated to the South East and NHS Sussex took eleven, three of which were allocated to East Sussex. As this was centrally administered there was nothing NHS Sussex could do to increase the number of golden hello posts in East Sussex. Dental providers also needed to be willing to take on the golden hello posts, which required support and training and there were three providers in East Sussex which came forward to accept. Nish Suchak, added that the golden hellos required practitioners to stay for a minimum of three years, and if they did not stay for that length of time the money would be clawed back from practices, which many were not willing to risk.

14.16 The Committee asked when the issues in East Sussex would be in less of a crisis situation.

14.17 Charlotte Keeble explained that performance in East Sussex had been improving due to the programmes and interventions outlined in the report. A lot of progress was still required but it would never be the case that 100% of activity for dental contracts was delivered, and this had been the case prior to the pandemic. Despite work done locally, changes made at a national level were required for there to be the level of improvement that people were hoping for.

14.18 The Committee noted that there was a gap in appointment availability and the needs of patients and how this was managed.

14.19 Charlotte Keeble explained that NHS Sussex monitored all activity it commissioned, so every practice was being monitored to ensure they delivered the expected amount of activity, and the dental contract allowed for reviews to take place to address underperformance. If a dental provider chose not to deliver its NHS activity there was very little that commissioners could do in-year to address this, beyond working with the provider to develop an action plan for it to deliver its expected activity. Commissioners had very few contractual sanctions to enforce delivery of activity, particularly in the early part of the year. NHS Sussex also monitored availability of appointments, and where these did not change then NHS Sussex would make direct contact to confirm when providers would next be making new appointments available.

14.20 The Committee asked whether a national requirement for newly qualified dentists to be required to do a minimum amount of NHS work before they could go into private practice would be helpful.

14.21 Charlotte Keeble responded that she would be very supportive of such a change, and that any way to recruit and retain more dentists locally was vital for implementing the workforce plan.

14.22 The Committee asked for clarification at Figure 1 of the report to whether the numbers shown were only providers that delivered NHS contracts, as there were currently no NHS providers accepting patients in Seaford.

14.23 Charlotte Keeble explained that the map on Figure 1 showed all NHS service contracts. There were five NHS dental contracts in Seaford, but this did not mean there were five separate providers. Some providers held more than one NHS dental contract for different services. NHS Sussex was widely advertising its market engagement event in November where it hoped to attract new providers to the area, recognising that there were some gaps in provision across the county.

14.24 The Committee asked what the proportion of NHS to private activity was for the average dental provider.

14.25 Charlotte Keeble said that this was not data that NHS Sussex had available and would only been known by individual providers themselves. There was no national data on this, but most providers delivering NHS activity would deliver a level of private activity as well.

14.26 The Committee asked how NHS Sussex ensure there was sufficient provision in more deprived areas of the county.

14.27 Charlotte Keeble explained that comparative data was considered as part of the allocation of dental provision across the county, including indices of deprivation. The number of currently commissioned UDA were RAG rated against the number that would be expected to meet the level of need in an area based on indices of deprivation to assess whether this was higher or lower than required. Commissioning on this basis then meant that activity could be targeted at the areas with the most need, such as the commissioning of temporary activity or overactivity on dental contracts in areas where there had been dental contract hand backs. Charlotte agreed to share the commissioning methodology with the Committee.

14.28 The Committee asked whether it was possible to pay dentists to overperform and deliver more NHS activity.

14.29 Charlotte Keeble explained that NHS Sussex commissioned for its allocated dental budget in a year. Where providers underperformed on their commissioned activity, funding was then clawed back and used to pay for overperformance on contracts by other providers. The way NHS Sussex commissioned its services were within the confines of the national contract which the new Government had committed to reform. Margaret Case explained that the funding allocated is based on the amount of work that was actually delivered, which meant if patients did not attend then dentists would not be paid for it. The UK did not train enough dentists to meet the level of demand which meant the country was reliant on dentists coming from abroad, which was a protracted process for those arriving. Often these dentists found working within the NHS system difficult and would more likely than not go private.

14.30 The Committee asked whether it was possible to require dentists arriving from abroad to work for the NHS for a longer period of time.

14.31 Margaret Case explained that she was a clinical dental advisor for the South East and worked to onboard foreign dentists into the area. Foreign dentists mostly funded their own training, including the required conversion courses to work in the UK, and they also faced long delays to entering the system and found working with the NHS difficult to navigate. These things created barriers for foreign dentists staying in the NHS for an extended period of time. Paying some of their costs upfront and treating them as salaried workers might help but that would require national change.

14.32 The Committee RESOLVED to:

1) Note the report and recognise greater levels of funding were required from national government to improve NHS dental services in East Sussex;

2) Receive a further report in March 2025.

15. ACCESS TO GENERAL PRACTICE IN EAST SUSSEX

15.1 The Committee considered a report on primary care services and access to General Practice across the county, following on from a report on Primary Care Networks (PCN) the Committee had considered in September 2023. The report covered a number of areas that the Committee had previously asked about when it had considered earlier reports.

15.2 The Committee asked what the average wait time was for patients to have a GP appointment.

15.3 Garry Money, Director of Primary Care Commissioning and Transformation, noted that at 5.3 in the paper there were average figures for waiting times. The NHS only monitored the number of appointments booked on the same day and the number of appointments given within two weeks. Currently just under 80% of patients in East Sussex who tried to book a GP appointment got one within 2 weeks, which was a couple of percentage points below the England average. Some GP practices' ways of working skewed these figures slightly, such as by booking recurring appointments for long term conditions in advance, which gave the impression that a patient was waiting much longer than the 2-week target. NHS Sussex was working to address issues of variation between individual practices, to identify where GPs had issues that they needed support to reduce waiting times.

15.4 The Committee noted that workforce absences in East Sussex due to mental health problems was double the national average and asked how access to the Emotional Wellbeing Service would be improved.

15.5 Garry Money explained that NHS Sussex was working closely with Sussex Partnership Foundation Trust (SPFT) and with High Weald and Seaford PCNs to provide the Emotional Wellbeing Support Service in all PCNs in the county. This included exploring how to fund it and simplify employment arrangements. Garry agreed to provide the Committee with an update on the service in these two PCNs, as well as data on current performance, activity and impact of the service broken down by other areas.

15.6 The Committee noted that in some cases GP appointments available to book online were much further in the future than those available to book on the phone, and asked if this was a common issue.

15.7 Garry Money accepted that there was variation between practices in this issue, and that often appointments offered online were with a nurse rather than GP. Different practices varied in how they used online consultation systems, sometimes turning them off in the morning once capacity had been reached. There were other known communication issues and NHS Sussex was working to reduce the level of variation between practices. There was a programme of unwarranted variation quality improvements that it would be possible to provide an update on the next time the issue was discussed by the Committee.

15.8 The Committee commented that patients had a right to choose when being referred to secondary care by GPs and asked how the NHS ensured this right was being upheld.

15.9 Garry Money commented that GPs worked according to clinical pathways, and that when they referred patients to specific specialist services, patients should be offered the right to choose which hospital they were referred to. Some services were intermediary, sitting between GP practices and hospitals, such as musculoskeletal, and were a triaging service. If intermediary services then offered a referral to secondary care, then they should also offer the patient choice about where they were referred to. He added monitoring of GPs offering patient choice was done by sample as there was no data monitoring of it. GPs had systems for

comparing waiting times for services at different hospitals and this should be part of the conversation with the patient. Richard Milner, ESHT Chief of Staff, commented that ESHT was not forcing patients to particular services, but agreed to discuss the issue with colleagues outside of the meeting.

15.10 Some members of the Committee commented that they did not believe patient choice was being routinely offered in GP consultations. Garry Money noted the Committee's concerns and agreed to follow up with any specific examples that members had outside of the meeting.

15.11 The Committee welcomed that Richmond Road car park in Seaford was being considered for estates developments, and asked what assessments were being undertaken and for a timeline update.

15.12 Garry Money explained that Value for Money assessments would be required as part of any development, and the NHS worked with local authorities on these assessments. He agreed to provide more detail on this specific development ahead of the next scheduled update.

15.13 The Committee commented that one GP (SDHC) operated across many PCN geographies asked why this practice was not able to provide the Emotional Wellbeing Service in all the PCNs it was part of.

15.14 Garry Money agreed to provide more information about the Emotional Wellbeing Service outside of the meeting. The first priority was provide an equivalent service as soon as possible in Seaford and High Weald that was available in the rest of the county. There were many more locations than the 50 GP practices listed, as some were collaborations of individual surgeries under a single provider. Where a provider was across many geographies then it would be providing in the PCN areas where the Emotional Wellbeing Service was currently in place.

15.15 The Committee asked what cloud-based telephony was.

15.16 Garry Money explained that cloud-based telephony was a means by which telephone calls could be securely answered without staff being present in a building. This reflected the pandemic where not all staff worked permanently in one place and meant that a GP could take a telephone consultation in a secure location that was not a surgery, increasing the number of phone lines available.

15.17 The Committee asked how it was possible to mitigate digital exclusion through training if people did not have digital devices.

15.18 Garry Money noted that digital inclusion included several different elements, so the report only covered a high-level update on some of the work involved in it. There was a general trend to have more of a 'digital front door' in general practice, so it would be more important to understand whether all patients trying to access healthcare were able to. He agreed to provide a more detailed update in a future report, as the ICB was doing a lot of work in the area of digital exclusion.

15.19 The Committee asked how many extended hours appointments were taken up at each individual practice.

15.20 Garry Money noted that for the whole of East Sussex 606 hours of enhanced access was provided per week, but did not have the did not attend (DNA) figure for the enhanced access sites. He agreed to explore whether that data was available and provide it to the

Committee if possible, as well as a breakdown of the number of enhanced hours appointments available at each practice.

15.21 The Committee noted a recent news piece where a patient had died due to symptoms being missed despite having repeatedly being seen a physician associate, and asked whether physician associates had sufficient training.

15.22 Garry Money commented that he was not aware of the level of training required or what the clinical governance around the physician associate role were specifically, but was aware of the national news. NHS Sussex was positive about the role of physician associates and other ARRS roles and agreed to provide further detail on training outside of the meeting.

15.23 The Committee asked for further detail on the distribution of specific roles between PCNs under the Additional Roles Reimbursement Scheme (ARRS), and how PCNs were able to access funding for those roles.

15.24 Garry Money explained that all the ARRS roles were available to PCNs to choose from. Every PCN had a notional allocation of the national funding it would receive for the recruitment of ARRS roles, and there was then a bidding process to receive the funding. The role of NHS Sussex was to maximise the number of roles employed in the area based on its notional allocation, which it had to draw down from to receive. It engaged PCNs throughout the year to encourage and support the uptake of ARRS roles. Garry agreed to provide a breakdown of which PCNs recruited to which roles.

15.25 The Committee noted that some GP practices no longer offered online appointments which they did during the pandemic, and asked which surgeries offered online appointments currently, and whether NHS Sussex could encourage an increase in the number offering it.

15.26 Gary Money explained that GPs were contractually required to offer a live online consultation tool, and NHS Sussex followed up with surgeries where there were reports that this was not available. However, the GP contract did not specify at what hours these tools needed to be available, and there was a potential safety issue associated with online tools where the level of need being presented was not able to actively be met. NHS Sussex was actively exploring how to improve access to online consultation and reduce the level of variation seen across the county

15.27 The Committee asked where Pharmacy First services were available.

15.28 Gary Money explained that there was a paper on Pharmacy First going to a future meeting of the Integrated Care Board, and agreed to come back on the detail of which pharmacies were offering Pharmacy First services. There were seven specific pathways that allowed patients to avoid having to go through general practice for certain common issues. Where it was in place it was working well and NHS Sussex was supporting pharmacies with it, as well as communicating to GPs how it operated.

15.29 The Committee commented that the availability of COVID-19 vaccinations in Eastbourne had been limited when people were trying to book online and asked how this was being addressed.

15.30 Gary Money confirmed there were vaccination sites available in Eastbourne and agreed to quickly investigate this issue.

15.31 The Committed commented that there were often delays in GPs signing off repeat prescriptions sent by pharmacies, which presented issues for patients and prevented pharmacies from offering the service.

15.32 Garry Money commented that a focus of the development of Integrated Community Teams was to improve join up between GPs and pharmacies. Pharmacists were not contracted to provide a repeat prescription ordering service, but it was a very valuable one for patients. NHS Sussex was able to facilitate discussions between GPs and pharmacies to improve working relationships and address this issue. There was communication activity on Pharmacy First and more targeted work to explain to the public what the offer was would be explored ahead of winter.

15.33 The Committee commented that there was not a GP surgery in Baird ward in Hastings despite previous site allocations, and asked for an update.

15.34 Gary Money agreed to provide an update outside of the meeting.

15.35 The Committee RESOLVED to:

1) Note the report; and

2) schedule an update report on primary care for its meeting in June 2025.

16. NHS MISSED APPOINTMENTS

16.1 The Committee considered a report from NHS Sussex on work being undertaken to minimise missed appointments in secondary care (hospitals) across East Sussex. An update on missed appointments in primary care was included in the report on agenda item 6, Access to General Practice in East Sussex.

16.2 The Committee raised a concern that often people would call East Sussex Healthcare NHS Trust (ESHT) and their calls would not be answered, which was a barrier for some people cancelling appointments they could not attend.

16.3 David Garrett, ESHT Divisional Director for Core Services accepted that at certain times of day it was difficult to get through on the phone lines. He added that very few members of the booking team worked remotely, with call handlers based at both Eastbourne and Conquest hospitals. Teams had information on how many people were waiting and how long they had been waiting for, so it was possible to get more staff to answer phones as required. There were periods of high traffic and ESHT was considering implementing a semi-automated switchboard for the booking team which would allow people to cancel appointments without needing to have someone answer the phone.

16.4 The Committee commented that sometimes patients were unable to attend appointments as hospital transport required advanced booking which could not always be arranged in time.

16.5 Ashley Scarff, NHS Sussex Director of Joint Commissioning and ICT Development (East Sussex) commented that communication between patient transport and hospital trusts should be improved to avoid missed appointments. If there were issues with providing patient transport for a patient to get to their appointment, then a link back to the hospital or service should be

made so that the appointment can be rearranged for a time when the patient would be able to attend.

16.6 Cllr Turner commented that if a patient missed an appointment because of a lack of available transport, then there was a risk they could go to the back of a waiting list through no fault of their own.

16.7 The Committee asked what the cost to the NHS was of missed appointments.

16.8 David Garrett explained that it was difficult to quantify the cost of missed appointments, as all clinics were booked based on a model of likely attendance to that particular clinic. This meant that if everyone booked in attended their appointment, then the clinic would likely overrun. Where clinics regularly underran then the model would be reviewed, and additional appointment slots would be added. Did not attends (DNAs) added some unpredictability to the running of a clinic that meant while every effort was made to try and adjust for them, it could only be determined on the day whether a clinic would over or under subscribed. Ashley Scarff added that the key cost would be the opportunity cost of having staff present at a clinic without anyone to attend to.

16.9 The Committee asked whether patients were able to request specific times for appointments to avoid having to pay for peak travel fares.

16.10 David Garrett explained that there would have to be a dialogue with patients to understand their travel needs, and they should be given two reasonable time offers for an appointment. Patients had to inform whoever was booking appointments of times at which they could not attend, and there was a function on the patients' notes system where important patient information could be logged that would support discussions with patients on these issues.

16.11 The Committee asked what was meant by stricter policies in reference to repeat non-attendees of appointments.

16.12 David Garrett responded that ESHT had a Patient Access Policy which stated that if a patient did not attend an appointment twice then consideration would be given to discharging them back to their GP, subject to the advice of clinicians. There were a very small number of difficult to engage patients where a disproportionate amount of time was spent trying to contact and arrange suitable appointments, and so a process was required for dealing with patients that did not respond to any communication.

16.13 The Committee asked for more information on how short notice appointments were taken up.

16.14 David Garrett explained that short notice appointments lists had been introduced across a number of specialities to avoid clinical time not being utilised. Staff in the booking team had short notice lists of patients by speciality which allowed them to fill appointment slots that became available with less than 24 hours notice. Appointments that became available with more than 24 hours would be filled according to clinical need as usual.

16.15 The Committee asked if there was a link between DNAs and the number of times appointments were rearranged.

16.16 David Garrett commented that there can be a correlation between a DNA and a patient having their appointment rearranged. ESHT tried to set clinics six weeks ahead of time in order to give patients 4-6 weeks' notice of their appointments. The exception to this was for urgent

suspected cancer patients who were given appointments within seven days, which meant that it was not uncommon for patients to agree to an appointment without realising that they cannot actually attend and then have to have their appointment rearranged. ESHT was aware that sending patients different appointment letters could be confusing and tried to avoid it where possible.

16.17 The Committee commented that some communications to patients on long waiting lists suggested that they should consider being seen privately.

16.18 David Garrett explained the appointment validation process, whereby patients on long waiting lists were contacted to confirm whether they still needed an appointment. ESHT had found that a significant proportion (around 10-15%) of patients would respond that they no longer needed the appointment. The wording of communication may ask whether the patient has had their issue resolved privately, which was helpful information for understanding why a patient no longer needed their appointment. However, communications from the hospital should not be suggesting people be seen privately and if there were examples of that taking place David agreed to investigate.

16.19 The Committee RESOLVED to note the report.

17. HOSC FUTURE WORK PROGRAMME

17.1 The Committee discussed the items on the future work programme.

17.2 The Committee discussed the development of Integrated Community Teams (ICTs) and asked whether this was something it should receive a report on. Ashley Scarff commented that there was a standing item on the development of ICTs at the Health and Wellbeing Board and agreed to suggest an appropriate time in the future that HOSC may wish to discuss this topic.

17.3 The Committee RESOLVED to amend its work programme in line with paragraphs 14.32 and 15.35.

18. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

18.1 None.

The meeting ended at 12.27 pm.

Councillor Colin Belsey

Chair