Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 10 March 2022**

Time: **10.00am**

Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Jonathan Hall (contact details below) by **no later than 5.00pm on Monday 7 March 2022**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Cllr Daniel Candon	*Vacancy*	Great Yarmouth Borough Council
Cllr Penny Carpenter	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Barry Duffin	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Brenda Jones	Cllr Emma Corlett	Norfolk County Council
Cllr Alexandra Kemp	Cllr Michael de Whalley	Borough Council of King's Lynn and West Norfolk
Cllr Julian Kirk	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Robert Kybird	Cllr Fabian Eagle	Breckland District Council
Cllr Nigel Legg	Cllr David Bills	South Norfolk District Council
Cllr Ian Stutely	Cllr Adam Giles	Norwich City Council

Cllr Richard Price	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Sue Prutton	Cllr Peter Bulman	Broadland District Council
Cllr Robert Savage	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Lucy Shires	Cllr Tim Adams	Norfolk County Council
Cllr Emma Spagnola	Cllr Adam Varley	North Norfolk District Council
Cllr Alison Thomas	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
CO-OPTED MEMBER (non voting)	**CO-OPTED SUBSTITUTE MEMBER** (non voting)	**REPRESENTING**
Cllr Edward Back	Cllr Colin Hedgley / Cllr Jessica Fleming	Suffolk Health Scrutiny Committee
Cllr Keith Robinson	Cllr Jessica Fleming	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:
Jonathan Hall on 01603 679437
or email committees@norfolk.gov.uk

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This meeting will be held in public and in person.
It will be live streamed on YouTube and, in view of Covid-19 guidelines, we would encourage members of the public to watch remotely by clicking on the following link: https://www.youtube.com/channel/UCdyUrFjYNPfPq5psa-LFIJA/videos?view=2&live_view=502which

However, if you wish to attend in person it would be most helpful if, on this occasion, you could indicate in advance that it is your intention to do so. This can be done by emailing committees@norfolk.gov.uk where we will ask you to provide your name, address and details of how we can contact you (in the event of a Covid-19 outbreak). Please note that public seating will be limited.

Councillors and Officers attending the meeting will be taking a lateral flow test in advance. They will also be required to wear face masks when they are moving around the room but may remove them once seated. We would like to request that anyone attending the meeting does the same to help make the event safe for all those attending. Information about symptom-free testing is available here.

A g e n d a

1. To receive apologies and details of any substitute members attending

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 4 November 2021. (Page 5)

3. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);
      Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. To receive any items of business which the Chair decides should be considered as a matter of urgency

5. Chair's announcements

6. 10:10 – 10:40 Access to local NHS primary care services for patients who are British Sign Language (BSL) users (Page 12)

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 4th November 2021

Present:

Cllr Alison Thomas(Chair)	Norfolk County Council
Cllr Daniel Candon	Great Yarmouth Borough Council
Cllr Penny Carpenter	Norfolk County Council
Cllr Emma Corlett substitute for Cllr Brenda Jones	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Cllr Michael Dalby substitute for Cllr Julian Kirk	Norfolk County Council
Cllr Robert Kybird	Breckland District Council
Cllr David Bills substitute for Cllr Nigel Legg	South Norfolk District Council
Cllr Richard Price	Norfolk County Council
Cllr Sue Prutton	Broadland District council
Cllr Lana Hempsall substitute for Cllr Robert Savage	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Cllr Ian Stutley	Norwich City Council
Cllr Adam Varley substitute for Cllr Emma Spagnola	North Norfolk District Council

Co-Opted Members

Cllr Edward Back	Suffolk Health Scrutiny Committee
Cllr Keith Robinson	Suffolk Health Scrutiny Committee

Also Present in person:

Cath Byford	Chief Nurse, Norfolk and Waveney CCG (All items)
Rebecca Hulme	Associate Director – Children Young People & Maternity, Norfolk and Waveney CCG (All items)
Jo Yellon	Associate Director of Mental Health, Norfolk and Waveney CCG (items 6&7)
Diane Smith	Senior Programme Manager, Mental Health Strategic Commissioning Team, Norfolk and Waveney CCG (Item 6)
Rebecca Hulme	Associate Director – Children Young People & Maternity, Norfolk and Waveney CCG (Item 6)
Dan Dalton	Chief Medical Officer - Norfolk & Suffolk NHS Foundation Trust (item7)
Amy Eagle	Interim Chief Operating Officer - Norfolk & Suffolk NHS Foundation Trust (Item7)

Maureen Orr	Democratic Support and Scrutiny Team Manager
Jonathan Hall	Committee Officer

Present via video link

Rebecca Mann	Head of Integration and Alliance – Children's Mental Health Norfolk & Waveney CCG (Item 6)
Nikki Brown	Head of Finance - East of England Provider Collaborative(Item 6)
Kaeron Dodson	Head of Transformation - East of England Provider Collaborative (Item 6)
Dr Jaco Serfontain	Adult Eating Disorders lead consultant - East of England Provider Collaborative (Item 6)
Mike Bell	Senior Quality Improvement Manager, Adult Eating Disorders and Physical Health in Serious Mental Illness, Regional Mental Health Team – NHS England (Item 6)
Jane Poppitt	Matron for eating disorders-Cambridgeshire and Peterborough NHS Foundation Trust (Item 6)
Michelle Espley	Adult and Specialist General Manager - Cambridgeshire and Peterborough NHS Foundation Trust (Item 6)
Rob Mack	Service Director, Specialist Services - Norfolk and Suffolk NHS Foundation Trust (Item 6)
Yolande Russel	Chief Executive Officer – Eating Matters (Item 6)
Emma Willey	Head of Mental Health, Mental Health Strategic Commissioning team - Norfolk & Waveney CCG (item 7)
Heather Roach	Chair - Norfolk Safeguarding Adults Board (Item 8)

1. Apologies for Absence and details of substitutes

1.1 Apologies for absence were received from Cllr Barry Duffin, Cllr Robert Savage (substitute Cllr Lana Hempsall), Cllr Brenda Jones (substitute Cllr Emma Corlett) Cllr Julian Kirk (substitute Cllr Michael Dalby) Cllr Nigel Legg (substitute Cllr David Bills) and Cllr Emma Spagnola (substitute Cllr Adam Varley)

1.2 The Chair welcomed the newly appointed representative of Norwich City Council, Cllr Ian Stutley to the committee.

2. Minutes

The minutes of the previous meeting held on 2 September 2021 were confirmed by the Committee and signed by the Chair.

3. Declarations of Interest

3.1 Cllr Alison Thomas disclosed an other interest in that she was the Cabinet Member for Housing at South Norfolk District Council. Cllr Penny Carpenter disclosed an other interest as a board member of the Norfolk Safeguarding Board (Item 8). Cllr

Emma Corlett disclosed an other interest as an employee of Norfolk & Norwich University Hospital and also Norfolk Community Health & Care.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chair's Announcements

5.1 The Chair had no announcements.

6. Eating Disorders

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Manager, on how the Committee might like to examine the situation regarding the service for Eating Disorders which is commissioned by Norfolk & Waveney CCG. The In-patient specialised eating disorder beds are commissioned by NHS-led Provider Collaboratives, which took over this function from NHS England & NHS Improvement Specialised Commissioning in July 2021. Different approaches exist for services provided for children and young people and Adult services and national standards for care only exist for Children and Young People, at which services are expected to meet 95% of the standard.

The Committee received update reports (at appendix A to the suggested approach) which detailed the NHS Long Term Plan (2019) which set out the need to transform and invest further in eating disorders services. Since 2020 and the start of the Covid pandemic, the demand for eating disorder services has increased to around double that of pre-pandemic levels. Increased demand, and severity of presentation has had a knock-on impact on other areas of the health system such as increased acute hospital admissions.

Using the Long Term Plan as a key driver, and to respond to changing needs, the Norfolk and Waveney system has worked collaboratively to meet immediate needs and manage risk as well as developing the provision of high quality and sustainable services to all with an eating disorder need, through system-wide engagement and development of a strategy to focus improvement and innovation for the forthcoming years.

The committee has last considered the Eating Disorder service in April 2019.

6.2 The Committee received evidence in person from representatives of Norfolk and Waveney CCG: Cath Byford, Chief Nurse, Rebecca Hulme Associate Director – Children and Young People & Maternity, Jo Yellon Associate Director of Mental Health and Diane Smith Senior Programme Manager, Mental Health Strategic Commissioning Team and via video link from representatives of East of England Provider Collaborative: Nikki Brown, Head of Finance, Kaeron Dodson, Head of Transformation and Dr Jaco Serfontain, Adult Eating Disorders lead consultant. Rebecca Mann, Head of Integration & Alliance – Children's Mental Health Norfolk from Norfolk & Waveney CCG and Mike Bell Senior Quality Improvement Manager from NHS England. As well as representatives from Cambridgeshire & Peterborough NHS Foundation Trust: Jane Poppitt, Matron for eating disorders and Michelle Espley Adult & Specialist General Manager, representing Norfolk & Suffolk NHS Foundation Trust, Rob Mack, Service Director Specialist Services and Yolande Russel Chief Executive Officer from Eating Matters charity.

6.3 The reports submitted were taken as read and during the ensuing discussion the following points were noted:

- Patients (Children) are managed by the community teams and also by the voluntary sector whilst waiting to be seen. The majority of patients are seen within the target of 4 to 6 weeks.
- Outcomes for children are better if they are treated within the community rather than as an in patient.
- Voluntary support is both online and face to face, although virtual support is mainly for older children only. Covid has meant that virtual support has become predominant.
- The charity Eating Matters offers 20 one to one counselling sessions for children and adults.
- The business case for the proposed Intensive Treatment Pathway does present a danger that existing staff may be drawn away from other services but a more blended approach was required to tackle the relentless demand for services.
- Patients presenting for the first time often have more severe symptoms than previously seen and this matches the overall trend seen nationally.
- There is a known challenge regarding patients waiting to be seen and the possibility they may fall through the gaps on the pathway.
- Groups have been set up to receive feedback to gain knowledge of patient experience and how early intervention work has helped.
- Demand for current services is at an unprecedented level.
- Early intervention models are being developed to help reduce the demand before patients present with a greater need of treatment.
- Case loads averaged out at approximately 12 to 15 patients per staff member but detailed data would be provided within the next committee briefing.
- The service does work with NCC Children Services and Schools on preventative measures to combat increasing pressures from Social Media imagery. However, it was noted that disordered eating does not relate to body image and this symptom has meant a change of approach for the service, due to its complexities. A mixed picture of symptoms had been seen during the pandemic period.
- The number of in patient beds available is hampered by the lack of community services for those that could be discharged.
- Early targeting by use of preventative pathway services in the community would decrease numbers of in patients, although these services currently need improvement.
- The staffing levels required in the specialist units, particularly for children who are presenting with high levels of acuity is an enormous challenge. This has been exacerbated by the pandemic.
- Some beds have been closed due to Covid and to safeguard other patients due to the complex and demanding needs of patients putting pressures on staff. This has also increased lengths of stay in hospital as a result.
- Continued service development has taken place involving additional roles such as Clinical Associate Psychologists and allied health professionals to increase the mix of skills involved to help patients. Staffing numbers generally in adult services had also increased significantly in percentage terms.
- Children services adopted a bespoke approach whilst an infrastructure within health partners and the community was being built. This should help the service to become more robust in the future.
- The waiting list for admission to a specialist unit from acute hospital beds was very small, although the last 6 months had been a challenge.

The Chairman concluded the discussion by acknowledging:

- The service has seen an increase in demand as a result of the pandemic and that the level of demand has remained consistently high.
- Much work had been done but more is required, especially around early intervention to prevent the need for services when patients may present with greater acuity.
- An interim briefing would be provided in six months time after which the committee can schedule the item in the forward work programme if required.
- Members were encouraged to contact the Chair directly for requests for information and data to be included in the briefing report.

The Chairman thanked all those for attending both online and in person.

The committee took a short break and reconvened at 11.22am

7. Norfolk & Suffolk NHS Foundation Trust (NSFT) – use of out of area beds

7.1 The Committee received a briefing report by Maureen Orr, Democratic Support and Scrutiny Manager about the progress of the use of out of area beds for acute mental health patients and beds that are within the locality but are outside of the Trust's control i.e. private providers. The 2016 'Five Year Forward View for Mental Health' recommended reduction and elimination of inappropriate out of area placements for acute mental health care as quickly as possible, and the Government set a national ambition to eliminate them by 2020-21. Despite increased investment in mental health services this has not been met and the Covid 19 pandemic has increased the pressures on services.

Progress had been made from March 2019 to May 2020 where out of area bed days had reduced to 363 from 1974 and this was largely due to opening a 16 bedded admission ward, enhancing community teams, implementing a Patient Flow group and taking a more focused approach to improved bed management, inappropriate admissions and timely discharge. However, more recently numbers had risen again.

The Committee received evidence in person from representatives of Norfolk and Waveney CCG: Cath Byford, Chief Nurse, and Jo Yellon Associate Director of Mental Health, and representatives of Norfolk & Suffolk NHS Foundation Trust Dan Dalton, Chief Medical Officer and Amy Eagle Interim Chief Operating Officer and via video link from representative of Norfolk and Waveney CCG Emma Willey, Head of Mental Health, Mental health Strategic Commissioning Team.

7.2 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Manager, on how the Committee might like to examine the situation regarding the service at 2.3.4 of the report.

7.3 The following key points were noted during the discussion:

- The numbers of patients categorised as delayed transfer of care on hospital wards out numbers those number of beds commissioned out of area.
- Patients discharged to bed and breakfast accommodation do have a wrap around support package to help them following discharge.
- More suitable accommodation was required to be provided by districts so that bed and breakfast temporary accommodation did not need to be utilised. The central Norwich area was particularly challenging for suitable provision.

- Mental health is a whole system issue and includes demands for social work, housing needs and employment opportunities and not wholly reliant on the NHS.
- There is a national issue for provision of mental health beds and whilst commissioning out of area beds is undesirable this is only undertaken where the need of the patient demands it.
- There is an out of area matron placed to liaise with those patients placed out of area to ensure quality of service is monitored and connectivity remains with a view to repatriation as quickly as possible.
- Early intervention to ensure demand can be managed will be key moving forward. The service is working with partners to achieve these aims. Once patients reach the need for NHS services this is often too late and could have been prevented.
- Quick access to local specialist mental health beds is required to ensure more focused shorter stays in hospital take place. This pathway is critical to prevent some of the more complex, resource heavy cases from arising.
- Male and female patients sometimes have different pathways for treatment and some female patients have been sent out of area because they needed single gender provision. Specialist care provision can not always be provided locally.
- The crisis resolution and home treatment teams work with patients before being admitted to an in patient bed and then only when that need is acute.
- The service has worked with local private providers to ring fence local beds to prevent the need for out of area placements. Blickling Ward was opened in particular to prevent older residents having to travel out of area.
- New clinical models are key to help manage demand in the future, especially around early intervention.
- NSFT to provide information on waiting lists for NSFT community services and the level of service commissioned in the block contract compared to the level of demand for the service.

7.4 The Chairman concluded the discussion by acknowledging:

- Local provision and early intervention was key. There was a tension around using private provision locally, even though it would be preferable to use NHS provision, as without the private local beds NSFT would end up having to use more beds out of area and it would be private provision anyway, with the consequent difficulties for families and the increased challenges of monitoring quality of care at a distance.
- Out of area placements did place families under strain and the role of the out of area matron was welcome.
- Challenges exist with discharge to appropriate accommodation and these delays of discharge often cause pressure on the system often resulting in the need to have placements out of area. There was a challenge back to district, borough and city councillors to check the level of housing provision available for patients who are being discharged from the acute mental health hospital and whether the resources should be increased
- Mental health provision relates to the whole community in relation to housing, social work and suitable and meaningful work. All partners need to work together to overcome the challenges.

7.5 The Chairman thanked all those who had taken part in the discussion both online and in person.

8.0 Cawston Park Hospital – Safeguarding Adults Review – a briefing

8.1 The Chair welcomed Heather Roach, Chair of Norfolk Safeguarding Adults Board to the meeting via video link. The Chair of the committee explained that this was not a scrutiny item for this meeting but was a briefing.

8.2 Heather Roach gave a presentation (appendix A) to the committee after which she responded to questions and it was noted:

- A review of ethical commissioning had already started.
- More robust monitoring of service providers is required. A more inquisitive approach is needed to prevent issues that arose at Cawston Park, from happening again.
- The issues around the failures at Cawston Park were complex and were exacerbated by the pandemic.

The Chair thanked Heather Roach for attending and the committee **agreed** to add:

- Cawston Park Hospital Safeguarding Adults Review – Scrutiny of local health and social care partners' joint progress to implement recommendations to the forward work programme for 2022.

9. Forward Work Programme

9.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Manager which set out the current forward work programme and briefing details that was agreed subject to the following:

9.2 The Committee **agreed** additionally for their future work programme:

- Cawston Park Hospital Safeguarding Adults Review – Scrutiny of local health and social care partners' joint progress to implement recommendations to the forward work programme for 2022.

9.3 The Committee **agreed** additionally for the NHOSC Member Briefing:

- April 2022 – Eating Disorders update to include data on workforce, staffing levels, clinical & administration, as well as current vacancy levels.

Meeting concluded at 13:14

Cllr Alison Thomas, Chair

Access to local NHS primary care services for patients who are British Sign Language (BSL) users

Suggested approach from Maureen Orr
Democratic Support and Scrutiny Manager

The committee will follow up on progress with British Sign Language interpreting services for primary care since July 2021.

1.0 Purpose of today's meeting

1.1 Today's meeting is a follow-up to the Norfolk Health Overview and Scrutiny Committee (NHOSC) meeting on 15 July 2021 when the committee looked for the second time at the subject of 'Access to local NHS primary care services for patients with sensory impairments'.

In September 2021 NHOSC agreed that today's meeting would focus solely on the situation for Deaf[1] patients who are British Sign Language (BSL) users, which was of particular concern at the July 2021 meeting.

1.2 The BSL interpreting service for access to primary care in Norfolk and Waveney is commissioned by NHS England and NHS Improvement (NHSE&I). Primary care services include GP practices, dental practices, opticians and pharmacies. GP primary care is commissioned by Norfolk and Waveney Clinical Commissioning Group (CCG) and the rest by NHSE&I. Co-operation between the numerous independent business which provide NHS primary care and the interpreting service is essential for the service to work properly for patients.

NHSE&I and the CCG were therefore asked to provide a joint report for today's meeting covering:-

[1] **Deaf** - A person who identifies as being Deaf with an uppercase D is indicating that they are culturally Deaf and belong to the Deaf community. Most Deaf people are sign language users who have been deaf all of their lives. For most Deaf people, English is a second language and as such they may have a limited ability to read, write or speak English. A person who identifies as being deaf with a lowercase d is indicating that they have a significant hearing impairment. Many deaf people have lost their hearing later in life and as such may be able to speak and / or read English to the same extent as a hearing person.

- Changes to the service following the start of a new contract with a new provider, Language Empire, on 1 November 2021.

- Details of the new short-term contract (to March 2022) with Deaf Connexions (see paragraph 2.2 below) to enable them to offer to facilitate appointment bookings Deaf people and provide interpreters at short notice for urgent requests.

- Work done with GP practices, dental practices, pharmacies and opticians in Norfolk and Waveney on their responsibilities to ensure access for Deaf patients and how to use the BSL interpreting service to best effect.

- Work to specifically address the concerns of local Deaf people and make it easier for them to raise concerns.

NHSE&I and the CCG have provided the report attached at **Appendix A** and representatives will attend the meeting to answer councillors' questions.

2.0 Background information

2.1 NHOSC has examined the wider subject of 'Access to local NHS services for patients with sensory impairments' on two previous occasions. Reports and minutes of the meetings are available via the following links:-

NHOSC 26 Nov 2020 (agenda item 6)
NHOSC 15 July 2021 (agenda item 9)

Concerns about the difficulties BSL users faced in accessing primary care services since a change to the primary care interpreting contract in 2019 were raised on both occasions. The committee heard from BSL users and from family members and others speaking on their behalf. The committee was disappointed to hear in July 2021 that access for some was still extremely difficult. This was especially so for BSL users who did not use information technology and who did not read English.

NHSE&I and the CCG offered to meet with individuals who brought concerns to NHOSC in July 2021 and to work together to understand the root causes of the issues and make improvements.

The committee heard about a pilot Deaf Enhanced Support Service (DESS), which was to be put in place to allow Deaf patients who were unable to use technology to make their own appointments with primary care to access a BSL interpreter to make the appointments for them.

2.2 The CCG provided updates in the October & December 2021 and February 2022 NHOSC Briefings.

New contracts to provide interpreting and translation services for primary care across the region started on November 1, 2021. The contract for spoken

languages went to DA Languages, who had also been the provider of BSL interpreting since 2019, and the contract for non-spoken languages (including BSL) went to Language Empire.

On 11 January 2022 the CCG said that they had recognised the Deaf Enhanced Support Service (DESS) arrangements NHSE&I had put in place with DA Languages (see paragraph 2.1 above) were not meeting the needs of some patients in the Deaf community in Norfolk and Waveney. They were withdrawing from that contract and had agreed a contract to the end of March 2022 with Deaf Connexions to enable them to offer to facilitate appointment bookings between any of the four primary care services and Language Empire. Deaf Connexions was to confirm arrangements with patients and offer general follow up support as needed. Provision was also made for Language Empire to use Deaf Connexions' interpreters for urgent requests when available, if and when Language Empire were unable to source one at short notice.

The activity in this Deaf Connexions service, and how it is being used, was to be reviewed until the end of March 2022 and a longer-term solution agreed from April 2022.

3.0 Suggested approach

3.1 Members may wish to explore the following areas with the commissioner representatives:-

(a) Has access to primary care improved since July 2021 for BSL users who do not use information technology and do not read English?

(b) What is Language Empire doing differently from the previous contract holder?

(c) What is the initial feedback from service users since the new contract started?

(d) What steps has the CCG taken to encourage primary care providers to use the BSL interpreting service effectively to enable BSL users to access services, including for urgent care?

(e) What has NHSE&I, the CCG and Language Empire done to ensure that BSL users have easy access to raise concerns or complaints about the service?

(f) What arrangements will be put in place for Deaf people who need enhanced support to access primary care when the short term contract with Deaf Connexions expires at the end of March 2022?

4.0 Action

4.1 The committee is asked to consider whether to make comments or recommendations as a result of today's discussions.

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Title:	**Access to local NHS primary care services for patients who are British Sign Language (BSL) users**
Report author/s:	Jude Bowler Interim Head of Commissioning - Primary Care, NHSEI
	Fiona Theadom Interim Head of Primary Care Workforce and Training Norfolk and Waveney CCG
	Ola Sijuwade, Contract Manager, Primary Care, NHSEI
Date:	Date: 25 February 2022

Introduction

1. Interpreting and Translation (I&T) services (which included British Sign Language (BSL)), for patients attending NHS Primary Care services (GP, Dental, Community Pharmacy and Optician services) are commissioned by NHS England and Improvement (NHSEI) and Clinical Commissioning Groups in the East of England.

2. In March 2021 both NHSEI and Norfolk & Waveney CCG (N&W CCG) produced reports for the Norfolk Health Overview and Scrutiny Committee (HOSC) on the I&T services and access issues.

3. The HOSC has requested a joint update from NHSEI and the CCG focused on the service for British Sign Language (BSL) users accessing primary care. This report has been developed in partnership between the CCG and NHSEI and seeks to update the HOSC on the services and improvements being made in accessibility to primary care services for the Deaf community.

Newly Commissioned Services

(a) *Information on the new contract covering the BSL interpreting service for access to primary care and the new provider, Language Empire, who started on 1 Nov 2021 after the contract with the previous provider, DA Languages, ended. Particularly on what has changed from the point of view of a BSL user*.

Contract Award

4. On the 1st of November 2021, NHS England & NHS Improvement (NHSE&I) East of England Region awarded two contracts to provide interpreting and translation services across the region following an open competitive tender process by Call-Off from the Crown Commercial Services Framework 2020 (CCS). The contracts were awarded to DA Languages for spoken languages and to Language Empire for non-spoken languages (including BSL).

5. The new contracts include provision of services for all Primary Care contractor groups: Dentists, GPs, Optometrists and Pharmacies. With the exception of Luton, the contracts cover the whole of the East of England region. Face to Face

Services are available between 08:00hrs and 18:00hrs Monday to Friday of each week and on Bank Holidays and weekends. An additional out of hour's facility is available between 18:00hrs and 08:00hrs which includes access to GP Improved Access services and Extended Hours services, and other NHS commissioned primary care services outside of core services. Online consultation services are available 24/7 covering both core hours and out of hours.

6. NHSEI and the CCGs took the decision to commission a separate contract for non-spoken languages to bring in a specialised provider of this service. NHSEI and the CCG are working closely with Language Empire, to improve services for any patient who communicates using non-spoken languages to ensure they have access to primary care services when needed and suitably qualified interpreters are available and attend when required.

7. Examples of how services have improved are described below:

7.1. Continuity of Care

One concern raised by patients in the past was that they were unable to have the same interpreter when accessing different appointments. Both new contracts provide greater continuity of care as one of the stipulations in the contract is that the supplier captures this information as part of their booking system although this is also reliant on the primary care provider inputting a request for this as well. This means, that as far as reasonably practicable, patients should be able to have the same interpreter for example at a general practice or Dental appointment.

7.2. Preference for an interpreter

The primary care provider is able to request the gender of an interpreter and inform the supplier of any cultural sensitivities on behalf of their patient when booking an appointment which the supplier must try to accommodate as much as possible.

7.3. Real Time Feedback

Another requirement of the supplier contracts is to have a mechanism in place for patients to leave feedback on the service(s) received. This information is fed back on a monthly basis and allows NHSEI and the CCG to make improvements in real time.

(c)What has been the initial feedback from BSL user patients or their representatives regarding the service from Language Empire?

8. The decision to commission a separate contract for non-spoken languages has allowed NHSEI and the CCGs to commission a provider with specialist expertise in providing services for non-spoken languages.

9. Anecdotal feedback from representatives of the Deaf community in Norfolk and Waveney is that service provision offered by Language Empire has so far has

been more positive since November 2021. We are aware that Language Empire met with BSL interpreters across Norfolk and Waveney during the contract mobilisation period to better understand the issues and concerns being raised locally to enable them to mitigate these when delivering these services to primary care providers and patients.

(b)What was done by NHSE&I to ensure that all BSL interpreters provided by Language Empire met the required level of qualification, training and standards, and that interpreters can be available at short notice where needed

Training Levels of Staff

10. The contract stipulates that the provider must comply with all of the mandatory requirements set out in this section of the CCS Framework Agreement (RM6141) linked to the recruitment and appointment of Interpreters/Translators. These are set out in Appendix One.

11. The Contract states that for Non-Spoken bookings, Language Empire shall ensure that where a Trainee is utilised for an assignment by a primary care organisation that they are selected in accordance with the relevant nationally recognised codes of conduct i.e. recognising and working within the limits of their competence and undertaking those assignments for which they have the appropriate qualifications, competence, and experience. The Commissioner expects trainees to be used in exceptional circumstances only for non-spoken languages where all other options to source an interpreter have been exhausted.

12. Language Empire must identify an appropriately qualified and experienced interpreter who matches the requesting primary care organisation and patient's requirement. When they cannot fulfil the specific qualifications or necessary healthcare experience, they will notify the organisation that made the booking immediately and provide an alternative solution. It will then be at the discretion of the organisation requesting the booking to accept or decline the alternative solution.

13. Both suppliers must also be able to facilitate on demand video interpreters (within 60 seconds of receiving the call) when requested. It is recognised that online services will suit some patients but not all of them.

NHS Accessible Information Standard (AIS)

14. Training about Deaf awareness and the NHS Accessible Information Standard (AIS) is provided by Language Empire to primary care providers alongside training on how to use the booking system. This is helping to upskill primary care organisations on how they can support patients with the difficulties they face.

15. Norfolk and Waveney CCG has put in place additional training for GP practices in relation to the AIS following engagement with Norfolk Healthwatch and local Deaf and hearing organisations, this awareness training took place during January – March 2022 and will be followed up during 2022 with more focused education

sessions, for example, bitesize online videos that can be shared widely. The AIS awareness sessions have been recorded so they can be shared with practice staff and a wide range of resources from local and national organisation have also been made available to practices to use. To date, 87 members of staff from 36 GP practices have attended the training with additional sessions planned. Further training is being planned through practice manager meetings and the slides have been shared with the Local Pharmaceutical Committee. Training Hubs across the East of England region have also requested copies of the training pack and resources and a discussion is planned for early March.

16. HOSC members are asked to note that in a recent NHSEI Primary Care Bulletin dated 18 Feb 2022 for primary care providers and commissioning organisations, NHSEI took the opportunity to remind general practice about the importance of recording patient communication and accessibility requirements within GP records and as one of the requirements of NHS's AIS. Over the coming months, NHSEI will be reviewing the AIS and considering how the standard is implemented.

17. Healthwatch England has joined forces with a coalition of user-led national organisations to highlight how the NHS and social care fail to support people's accessible communication need for the launch of the Your Care, Your Way campaign, which calls for improved accountability and implementation of the Accessible Information Standard (AIS). An event has been organised on 2 March 2022 for all staff working in NHS and social care services, service providers, ICS leaders, voluntary sector and professionals, details of the webinar event can be found on their website at

Your Care, Your Way – improving delivery of the Accessible Information Standard | Healthwatch

(f)Details of the pilot Deaf Enhanced Support Service (DESS), which is service to allow Deaf patients who are unable to use technology to make their own appointments with primary care to access a BSL interpreter to make the appointments for them

Improving Access - Deaf Enhanced Support Service (DESS)

18. In July 2021, the NHSEI Deaf Enhanced Support Service (DESS) was commissioned as a pilot service across the region in recognition of the needs of Deaf people who needed support in booking appointments and to help us understand the needs across the region. The service is for Deaf patients reliant on British Sign Language (BSL) to communicate and who were unable to use technology to make their own primary care appointments. The service aimed to provide individuals with access to a BSL interpreter to make the appointments for them.

19. This service is provided by DA Languages across the region and, although there were some initial problems with providing face to face support, this has been rectified. This regional pilot ends in March 2022 and there will be an evaluation to understand the demand and how it can be commissioned locally via ICBs in future.

Local Commissioned Services

20. Representatives from both NHSEI and Norfolk and Waveney CCG have been listening to patients from the Deaf community and hearing about their concerns and barriers when trying to access healthcare services in Norfolk and Waveney. In response to this, Norfolk and Waveney CCG decided to withdraw from the NHSEI DESS pilot service and has entered into a new local interim arrangement with Language Empire and Deaf Connexions; this went live in mid January 2022.

21. Deaf Connexions shared information about the service arrangements with the Deaf community and the CCG informed general practice. Between now and the end of March 2022, the CCG will review the activity and how the service is being used and agree how a longer term local solution for Norfolk and Waveney will be commissioned from April 2022.

22. The Contract enables Deaf Connexions to offer to facilitate appointment bookings between any of the four primary care services and Language Empire. Deaf Connexions will confirm arrangements with patients and offer general follow up support as needed. The CCG has also made provision for Language Empire to use Deaf Connexions' interpreters for urgent requests when available, if and when Language Empire are unable to source one at short notice. For the period, 18 Jan – 17 Feb 2022, there were 23 contacts made with Deaf Connexions by individual patients.

(d)Details of the work has been done since July 2021 with GP practices, dental practices, pharmacies and opticians in Norfolk and Waveney on their responsibilities to ensure access for Deaf patients and how to use the BSL interpreting service to best effect.

Improving Response from Primary Care

23. The new provider Language Empire has offered training sessions to primary care organisations on how to use the booking system which also includes the consideration of using different forms of interpreting services.

24. In addition to the AIS awareness training referred to above, the CCG has also made available British Sign Language Training for any general practice staff member, although primarily aimed at reception staff. This will enable practice staff to communicate with patients and welcome them to the practice. To date, more than 80 members of general practice staff have enrolled on the training. This service will not replace the need for formally trained interpreters in clinical settings who can be booked with Language Empire.

25. In recognition that not all patients with hearing loss use non-spoken languages to communicate but may benefit from or need some support from primary care to enable them to communicate effectively with healthcare services, the CCG's Digital Team has been working closely with Healthwatch Norfolk and Hearing for Now to create a patient charter for practices and to make available a wide range of digital tools for patients and practices to use. This charter was rolled out in early 2022 as a pilot scheme with six practices across Norfolk and Waveney and a report on outcomes is due in March 2022.

Other Improvements

26. To ensure that virtual meetings of the CCG and Integrated Care System are accessible to everyone, particularly those who are Deaf or hard of hearing, Norfolk and Waveney CCG is offering BSL interpretation for all of the public meetings, such as the Governing Body, Primary Care Commissioning Committee and ICS Partnership Board meetings. Once a virtual meeting has finished, the recording will be interpreted in BSL by local supplier Deaf Connexions and added onto the recording which will then be shared on the CCG's YouTube channel, website and social media channels. The recent meeting of the Primary Care Commissioning Committee in February 2022 can be viewed online at https://youtu.be/Ns4a2rCdVqs.

27. The CCG's complaints team has been liaising with local NHS advocacy services, PohWER in Norfolk and Voiceability in Suffolk, to explore arrangements and support to patients who only communicate using BSL (or other non-spoken languages) and wish to raise concerns or make a complaint about Norfolk and Waveney healthcare services. Initial conversations have indicated that the advocacy agencies will be able to offer interpreter services but means of initial contact needs to be explored further.

(e)The CCG met with a Deaf Community Engagement Group on 13 August 2021. What specifically has been done to address the concerns that they raised?

Engagement with the Deaf Community

28. As outlined above, representatives from the CCG's primary care and Communications & Engagement teams met with representatives from the Deaf community in August 2021 to listen to their concerns.

29. There was due to be a follow-up meeting in mid-December, however this was postponed in light of the increasing infection rates from the Omicron variant and deployment of staff to the accelerated Covid Vaccination programme. An invitation has been sent to members of the Deaf community and dates in early April are being explored with them.

30. A separate meeting took place in mid-January 2022 between the CCG/ NHSEI and a representative of the deaf community to follow up on the issues and concerns.

31. The CCG and NHSEI are very keen to hear from any members of the Deaf community about their experiences and concerns and how the changes that have been made are helping them to access primary care services and so any further issues can be resolved quickly with learning shared across the system.

32. The CCG recognises that there will need to be regular engagement with individuals from the Deaf community to ensure access to services is equitable for all patients.

Conclusions

33. NHSEI and the CCG wish to thank the HOSC for raising this important issue. Norfolk and Waveney CCG is committed to ensuring that all of its healthcare organisations are accessible to all patients on an equitable basis and that the patient's journey through the system is simple and easy. The CCG's Health Inequalities Oversight Group will be taking this responsibility and work forward in the future.

34. We also recognise that it is not only the Deaf community that the NHS's AIS applies to and that there are many individuals and patient groups who may also require support in accessing healthcare services, for example, individuals with Learning Disabilities or patients with dementia or their carers and that measures need to be taken to ensure that all services comply with the AIS. The CCG is committed to taking this work forward with system partners.

Appendix One - Qualifications

NON SPOKEN INTERPRETATION BANDINGS	
REGISTERED SIGN LANGUAGE INTERPRETER – RSLI	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in all Public Sector settings, dealing with complex requirements.
TRAINEE SIGN LANGUAGE INTERPRETER – TSLI	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in most Public Sector settings but cannot work in the Criminal Justice System or in Mental Health settings.
REGISTERED INTERPRETER FOR DEAFBLIND PEOPLE	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in all Public Sector settings, dealing with complex requirements.
REGISTERED TRAINEE INTERPRETER FOR DEAFBLIND PEOPLE	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in most Public Sector settings but cannot work in the Criminal Justice System or in Mental Health settings.
REGISTERED LIPSPEAKER	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or	• Can work in all Public Sector settings, dealing with complex requirements.

• Scottish Register of Language Professionals with the Deaf Community.	
TRAINEE LIPSPEAKER	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in most Public Sector settings but cannot work in the Criminal Justice System or in Mental Health settings.
REGISTERED ELECTRONIC OR MANUAL NOTETAKER	
	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in all Public Sector settings, dealing with complex requirements.
TRAINEE ELECTRONIC OR MANUAL NOTETAKER	
Registered:	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in most Public Sector settings but cannot work in the Criminal Justice System or in Mental Health settings.
REGISTERED SPEECH TO TEXT REPORTER	
	Tasks:
• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in all Public Sector settings, dealing with complex requirements.
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• Registered as a Registered Sign Language Interpreter (RSLI) with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) or • Scottish Register of Language Professionals with the Deaf Community.	• Can work in most Public Sector settings but cannot work in the Criminal Justice System or in Mental Health settings.

Access to GP primary care in Norfolk & Waveney

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

Examination of the situation regarding access to GP primary care across Norfolk & Waveney in light of the ongoing pandemic, the consequent Covid 19 vaccination campaign and the population's increasing need for primary care.

1. Purpose of today's meeting

1.1 NHOSC added this subject to its forward work programme in September 2021 due to the committee's interest in the model of GP primary care available during the pandemic, the NHS recovery period and into the future in comparison with public wants and needs.

For today's meeting Norfolk and Waveney CCG, the commissioners of GP primary care services, have been asked to provide detailed information on access to existing general practices and an update on provision of Primary Care Hubs across Norfolk and Waveney to address current and future capacity issues.

N&W CCG has provided all the requested information in the report at **Appendix A** and representatives will attend to answer councillors' questions

1.2 Norfolk and Waveney Local Medical Committee (LMC) was invited to provide its views on access to primary care to NHOSC and has submitted the paper at **Appendix B**. Dr Tim Morton, Chair of the LMC, will attend the meeting to answer any questions the committee may have.

2. Background information

2.1 In an update to the CCG Governing Body on General Practice on 23 November 2021 the N&W CCG Chief Officer pointed out:-

"*I think there is a real risk the situation will mean clinicians and other staff leave general practice, so we need to do all we can to support them. The demanding workload, coupled with the abuse staff are receiving from a small number of patients, is making general practice a less attractive place to work, risking making GPs and practice staff*

harder to recruit, and causing existing staff to retire early, choose to work elsewhere in the NHS or leave the health service completely."

2.2 **Previous reports to NHOSC on workforce shortage**

NHOSC has been aware of GP workforce pressures since 2014-15 when it scrutinised NHS workforce planning in Norfolk. It was clear that it would not be possible to attract or train up enough new GPs to fill the gap and that rising demand would not be met if primary care continued to operate in the way that it always had. NHOSC concluded that:-

"… primary care will have to change and change rapidly. Rising demand and the shortage of GPs make it inevitable. We are concerned that there has been very little information for the public on what this will mean for them."[1]

Since 2015 there have been initiatives to both increase GP numbers and improve the resilience of general practice by changing the model by which it offers care. Primary Care Networks (PCNs), established in 2019-20 were one of the most significant steps towards change. On 18 March 2021 NHOSC received a report on 'Local actions to address health and care workforce shortages' which included information about funding of new roles in PCNs to support primary care and distribute work across a range of clinical staff. The report is available on Norfolk County Council's website via the link NHOSC 18 March 2021 (agenda item 7).

Change to method of accessing GP primary care accelerated rapidly with the onset of the Covid 19 pandemic in 2020.

2.3 **Other local scrutiny**

2.3.1 On 13 October 2021 Suffolk Health Scrutiny Committee received a report on 'The Provision of GP Services in Suffolk'. The examination of the topic included the Waveney area and focused on:-

- The issues leading to additional demand pressures
- Why GPs are leaving general practice
- The extent to which processes within the wider health and care system impact on general practice
- Moving to a sustainable model for the future
- Patient experience and public awareness of the issues in general practice

[1] NHS Workforce planning in Norfolk - report to NHOSC 16 July 2015

The papers and minutes of the meeting are available on the Suffolk County Council website via the following link:- Suffolk HSC 13 Oct 2021 (agenda item 5)

The Suffolk councillors recommended to the CCGs that:-

- CCG campaigns to raise public awareness of the range of professionals now involved in providing health services at local GP practices should take a two pronged approach aimed at
    i) developing public trust in multi-disciplinary services and managing patient expectations of primary care across the CCG area, and
    ii) asking practices to undertake communications with their own practice population about "who's who" at the practice and what services they can deliver.
- A piece of work should be instigated with their relevant system leads to seek to identify some quick wins to improve referral pathways which would eliminate double handling, bureaucracy, delays and inefficiencies (for example, self-referral for some specific pathways where this was deemed appropriate).
- Consideration should be given to what support could be offered to practices currently experiencing extremely high / unmanageable telephone call volumes.

3. Suggested approach

3.1 Members may wish to examine the following areas with the commissioners and Norfolk and Waveney LMC:-

The service model

(a) What levels of video or telephone consultations, in person consultations at surgeries and home visits would the CCG expect to become the normal levels in general practice?

(b) What checks have or will be put in place to measure the effects of the new service model on patient outcomes?

Consistency across local areas

(c) It is understood that practices are currently under pressure but consistency of service across local areas could help people's understanding of the situation. What more can the CCG do to ensure a consistent service across primary care?

(d) Is the CCG aware of individual practices that are not consistent with others in meeting the currently expected standards of

access for patients and what is being done to support those practices in particular?

Communication with the public

(e) What more can be done to inform people of the kind of service they can and should currently expect from general practice?

(f) To what extent has there been consultation or engagement with the public about changes to the model of general practice for the longer term?

Primary care workforce

(g) The Chief Officer of the CCG expressed real concern for the wellbeing of the primary care workforce in the current situation and the risk of losing staff. What more can be done to help support the workforce?

(h) What further scope is there to broaden the range of practitioner roles in primary care to meet increasing demand and patient needs?

Future capacity

(i) To what extent do practices in Norfolk currently have capacity to register new patients?

(j) Will the CCG look to provide new facilities under the Wave 4b Primary Care Hubs programme firstly to the geographic areas with greatest need?

4. Action

4.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

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Norfolk and Waveney Clinical Commissioning Group

Agenda item: 7 Appendix A

Subject:	**Access to general practice in Norfolk and Waveney**
Presented by:	**Mark Burgis, Director for Primary and Community Care and Cath Byford, Chief Nurse**
Prepared by:	**Sadie Parker, Associate Director of Primary Care and Fiona Theadom, Interim Head of Primary Care Workforce and Training**
Submitted to:	**Norfolk Health Overview and Scrutiny Committee**
Date:	**10 March 2022**

Purpose of paper:

To provide Health Overview and Scrutiny Committee with an update of the situation regarding access to general practice across Norfolk & Waveney in light of the ongoing pandemic, the consequent Covid 19 vaccination campaign and the population's increasing need for primary medical care.

Executive Summary:

In the period April – November 2021, general practice delivered:

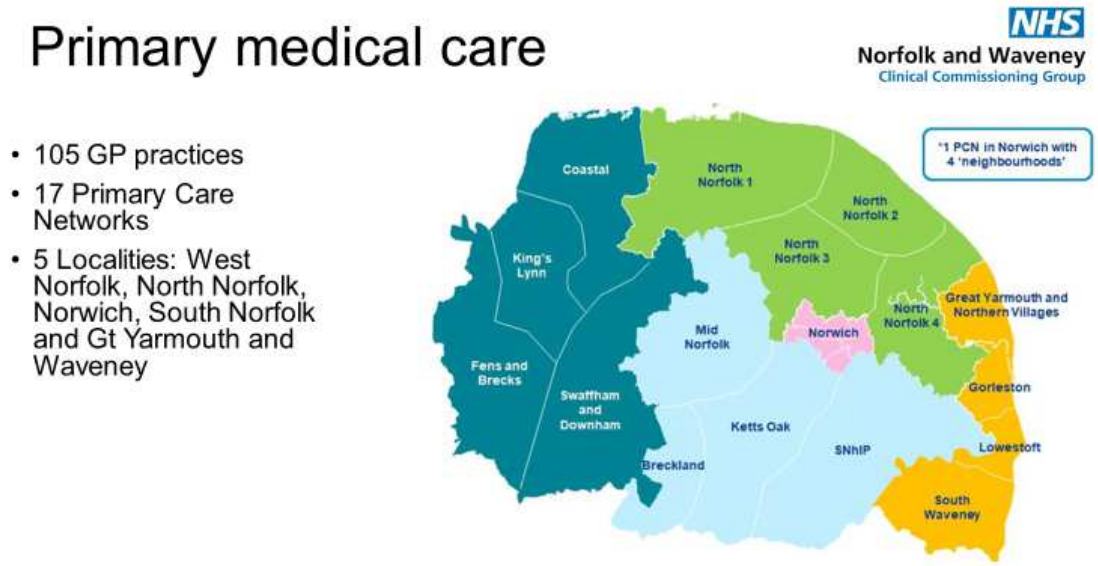
Activity	Total number	Comments
Appointments (face to face, telephone & online)	4,959,757	In Nov 2021, 695,179 appointments in general practice equivalent to 33,104 per day (Mon – Fri)
Covid vaccinations	580,685	A similar number delivered by general practice in period Dec – March 2021
Seasonal Flu vaccinations	271,502	58% of all flu vaccinations in general practice
Referrals to secondary care	165,307	

In Norfolk and Waveney, a higher proportion of appointments are face to face, 84.6% versus 70.7% nationally. Overall appointment activity was 12% higher in Nov 2021 than in Nov 2019.

1 Introduction

In the same way as all other providers of health and care, general practice has faced significant challenges in the past two years as a result of the response required to the Covid pandemic however they have continued to ensure that patients have access to primary medical care and clinical advice when needed whilst safeguarding their staff and other patients from Covid.

Within Norfolk and Waveney, primary medical care is made up of 105 GP practices operating across 150 sites and 17 Primary Care Networks (PCNs) delivering 81.9% of the system's same day, urgent care appointments.



The Primary Care Network (PCN) Directed Enhanced Service (DES) was introduced in 2019 and will be in place until end March 2024. It is designed to ensure general practice plays a leading role in every PCN and mean much closer working between networks and the Integrated Care System by enabling groups of practices to work together at local level to deliver services to patients. This is supported by a PCN development programme which is centrally funded and locally delivered and further investment linked to successful delivery of a wide range of indicators (known as the Impact and Investment Fund).

This paper sets out responses to the questions posed by Norfolk's Health Overview and Scrutiny Committee below.

(a) Information on the pressures on general practice in Norfolk and Waveney in terms of:

- **Increased demand for services;**
- **Additional tasks for practices;**
- **Current number of vacancies in the clinical and support staff workforce; and**
- **Other pressures**

Throughout the pandemic, all practices have remained open and accessible to patients through a clinical triage model of care and a mixed appointment model of face to face when clinically necessary, telephone and online consultations. It is however recognized that the way in which the delivery of primary medical care changed in 2020 and the speed with which this was achieved meant that there was little patient engagement and that new health inequalities may have appeared over the past two years.

From June 2021, practices began restoring general practice service provision and overall appointment numbers have been increasing month on month, including the number of face to face appointments which is generally preferred by both patients and clinicians. Some of the changes made in response to the pandemic have been beneficial and should be retained when restoring general practice services, for example using a clinical triage model and a mix of appointment types delivered by a clinical skill mix to offer patient choice and reduce waiting times for appointments. The increased reliance on digital technology to access services, in line with the national Digital First strategy, is of particular concern for some patients and is explored later in the paper.

In November 2021, 695,179 appointments were delivered in general practice equivalent to 33,104 per day (Mon – Friday) across Norfolk and Waveney, 65% of these were face to face appointments. Some of these appointments were delivered at weekends under Improved Access arrangements however much of that provision was repurposed for Covid vaccinations during 2021 although now being restored for core service provision and tackling the backlog of care.

The changes in the way in which general practice appointments were provided in response to the COVID-19 pandemic during 2019/2020 represented an unprecedented speed of change and a level of transformation not envisaged when the NHS Long Term Plan was developed and written. Changes were made to protect both patients and staff by implementing appropriate infection prevention measures to reduce the spread of Covid.

In Norfolk and Waveney our general practice response to the vaccination programme was impressive, we had seven sites which started vaccinating in the first week, rapidly followed by 14 more throughout the first weeks of 2021. This enabled our population to be vaccinated at pace and Norfolk and Waveney remains among the highest performing systems in the region and nationally for vaccination uptake. Vaccinating the population has been a key priority as one of the most important health interventions in health and social care.

As of 13 February 2022, more than 2m Covid Vaccinations (1st and 2nd doses and boosters) have been given across Norfolk and Waveney, with more than 50% being delivered in a primary medical care setting, either at a PCN designated site, GP practice or as part of a general practice roving model into Care Home settings for both older patients and non-older patients and individual housebound patients each time a dose was required.

For each dose, the work linked to the delivery of vaccinations has required a whole team approach and involved all general practice staff in some way, whether it's been planning and arranging clinics and care home visits, contacting patients or delivering the vaccinations each time.

In mid-December 2021, all systems were asked to accelerate the programme of Covid vaccinations in response to the Omicron variant; for Norfolk and Waveney, this meant trebling the number offered which was achieved within a few days. General practice was critical to the successful delivery of this programme and step up was immediate. 68,194 vaccinations were delivered by PCNs and GP practices during December, including 12,000 during Christmas week.

In late December, Norfolk and Waveney CCG declared Opel 4 Critical Incident level and within 24 hours, practices and PCNs immediately stepped up to support the system wide response over the New Year weekend and in the following weeks with some opening over the weekend and many enhancing the range of support to care homes to support patient discharge, 111/EEAST and proactive contact with homes to prevent avoidable admissions and emergency attendances. This took place at the same time as general practice was delivering the accelerated vaccination programme and continuing to provide patient care.

During 2021/2022, NHS England and NHS Improvement (NHSEI) made a number of contract changes to enable practices to deliver the key priorities for 2021 as set out below:

- rapidly administering the COVID vaccination programme to priority groups;
- responding to the pandemic, which called on all practices to adapt, remain fully and safely open, in order to offer accessible healthcare to all, with a particular focus on inequalities;
- facing a backlog of care, e.g. QOF reviews for people with chronic conditions, with the added burden of additional population ill-health, e.g. long COVID, the extent of which is not yet fully known; and
- needing to support the workforce who had worked incredibly hard for many months.

Recognising the continuing challenges still being faced by general practice, the most recent contract amendments published in January 2022 effective up to 31 March 2022, asked practices and PCNs to focus on the following three key priority areas while continuing to use their professional judgement to clinically prioritise care:

- continued delivery of general practice services, including timely ongoing access for urgent care with clinical prioritisation, the ongoing management of long-term conditions, suspected cancer, routine vaccination and screening, annual health checks for vulnerable patients, and tackling the backlog of deferred care events.

- management of symptomatic COVID-19 patients in the community, as part of the local system approach, including supporting monitoring and access to therapeutics where clinically appropriate

- ongoing delivery of the COVID-19 vaccination programme, including the vaccination of 5 – 11 year olds and 4th dose programmes recently announced.

General practice is being supported by some income protection arrangements for general practice and PCNs to enable them to focus on these priorities to end March 2022. From April 2022, all contract obligations are restored to normal.

Planned expansion of the PCN DES and the introduction of new services were also paused and will be implemented during 2022/2023, although PCNs are expected to do preparatory work this year to deliver the new services below in addition to those already provided, Enhanced Health in Care Homes, Early Cancer Diagnosis and Structured Medicines Reviews:

- Cardiovascular disease (CVD) prevention and diagnosis;
- Tackling neighbourhood health inequalities;
- Anticipatory care; and
- Personalised care.

General practice has seen the impact of longer waiting times in secondary care in managing patient expectations and in responding to concerns from patients. Some changes in secondary care pathways, for example, requests for phlebotomy to be done in primary care or requests from mental health or community for prescriptions and to arrange investigations have also increased the workload in general practice. The CCG has established a secondary care and primary care working group to review pathway changes and to develop a more collaborative working model.

Referrals

During the pandemic in 2020/2021, referrals fell as a consequence of the way in which general practice was operating although it should be highlighted that practices have been accessible to patients with urgent needs at all times. Referrals into secondary care and mental health services have been increasing steadily as services in general practice have been restored to pre-pandemic levels. The reduction in the number of referrals compared to pre-pandemic levels can be explained, in part, by the introduction of different pathways and these are highlighted below.

Comparing the period Apr – Dec 2019 with the same period Apr – Dec 2021, the following referrals were made by GP practices.

Secondary Care

Norfolk & Waveney			
2019	2021	Var	% Var
179,354	165,307	-14,047	-7.83%

General practice has been encouraged to use Advice and Guidance instead of making a referral when clinically safe to do so, this means a GP can manage more patients without referring them to secondary care. The dialogue can also be educational. Improvements to the Advice and Guidance pathway were introduced in

April 2021 enabling a specialist to convert an Advice and Guidance referral if they believe the patient needs to be seen.

The second reason for a reduced number of referrals is because some patients are sent straight for testing. Over the past year, there has been good collaboration between secondary care, primary care and radiology to support more efficient patient care.

Another example is where PCNs are sending dermatology images to a dermatologist directly which is enabling rapid diagnosis and support. This has reduced dermatology referrals to secondary care and improved the patient experience.

Although GP Non-Cancer Referrals reduced by -13.36%, GP Cancer referrals have Increased by 15.33% year to date as patients have been coming forward with their concerns, so the overall reduction in referrals is 7.83% year to date when taking into account cancer referrals.

Mental Health Wellbeing*

N&W GP Referrals reduced however self referrals increased by 10.42% and overall referrals increased by 3.42% year to date. One of the reasons that self referrals have increased is due to the First Response Mental Health 24/7 helpline which has helped to reduce pressure on general practice. It should however be highlighted that there has been an increase in stress and mental illness due to the pandemic which are largely being managed by general practice; these include anxiety, depression, stress, eating disorders, obsessive compulsive disorders, alcohol and substance misuse.

Norfolk & Waveney			
2019	2021	Var	% Var
20,341	21,037	696	3.42%

*Wellbeing referrals are not usually split by referral source due to data quality (field reliant on patients say-so). Self-referrals and all referrals included to give consistent overview.

Mental Health Secondary care - GP Referrals

GP Referrals into secondary care mental health show a small variance of -4.40%.

Norfolk & Waveney			
2019	2021	Var	% Var
17,324	16,561	-763	-4.40%

Seasonal flu vaccinations

The seasonal flu vaccination programme has been hugely successful this year, after a slow start it is now exceeding last year's performance. As of 28 February 2022, a total of 464,680 vaccinations have been delivered to the over 50’s and to those at risk under the age of 50 years; of these 271,502 (58%) have been delivered to date in general practice.

Practice and PCN stability and resilience

The recent challenges have provided practices and PCNs the opportunity to work closer together, building and developing relationships within their own PCN but also with other PCNs, thereby increasing PCN maturity and general practice resilience. PCNs received leadership and development funding in 2021/22 and funding to specifically support PCN clinical directors.

The CCG received £160k in 2021/2022 to support practice resilience. A process to enable practices to bid for funding has been completed in collaboration with key stakeholders, including the Local Medical Committee, and all of the funding has been committed for this financial year. A similar level of funding is available for 2022/23.

For practices facing specific challenges, e.g. workforce issues or an unfavourable rating from the Care Quality Commission, they will receive targeted support from different directorates within the CCG including the Quality, Medicines Optimisation, Delegated Commissioning and local PCN Development teams as appropriate.

The premise of supporting a resilient and stable primary medical care service to deliver high quality care for patients remains the same and this is the key aim within the Primary Care Strategy.

Increased demand for services

The increase in appointment activity demonstrates the increased demand for primary medical care services and is also reflected in the increase in referrals to secondary care. It is recognized that some patients may have had concerns about contacting general practice during the height of the pandemic for a variety of reasons however as primary care services are open and accessible, no patient should wait to contact their general practice if they have a health concern or are worried.

The way in which some practices manage their appointments, for example, to avoid mixing ill patients with those with long term conditions, can also create additional pressures particularly as practices have had to reduce the number of patients in waiting rooms for infection prevention reasons.

On the day demand from patients has increased leading to practices sometimes struggling to be as effective as they would like to be in chronic disease management, care of the elderly and vulnerable, and those with more clinical need. The CCG communications campaign aims to help alleviate some of this pressure by explaining to patients about how general practice operates and asking them to be kind to staff; this is covered in more detail later.

Longer waiting lists in secondary care often mean that the patient is being reviewed in primary care with further management needed. Early discharge may also create work

Current numbers of vacancies in the clinical and support staff workforce

This information is not available specifically for primary care however workforce absence due to sickness or isolation in acute trusts has risen from 4% normally to between 6-8% of staff in the past year and absence in primary care is likely to align with this. The CCG is aware of challenges in recruitment in particular areas, for example in West Norfolk, and in certain roles such as reception staff where turnover is higher than usual in some areas. Further details about workforce are described later in the paper.

Other pressures

Health Inequalities

Identification of health inequalities at practice and PCN level is also a critical factor to identify those unable or unwilling to access primary care services. It is apparent that some health inequalities worsened due to the pandemic response; patients who previously faced difficulties in accessing primary care services may face greater challenges and there are groups of patients and individuals where accessibility has worsened as a result of the pandemic and some for whom access may have improved. Examples of some patient groups who may face greater challenges are listed below:

- Patients with learning disabilities
- Patients with Severe Mental Illness and other mental health concerns
- Individuals with a sensory impairment, e.g. Deaf community and those who are hard of hearing, blind patients
- Homeless, health inclusion groups, migrant population
- non-English speakers
- those without access to digital technology, unable or unwilling to use technology or telephones to contact primary care
- Unseen backlog in cancer diagnosis and annual health checks
- There may be differences for patients living in rural areas to those living in urban areas
- Patients living in areas of greater deprivation.

The CCG used population health modelling working collaboratively with colleagues at Norfolk County Council, to help in its response to Covid and tackling vaccine hesitancy in specific communities across Norfolk and Waveney where health inequalities are higher or where cultural beliefs highlighted concerns with the vaccine. Examples of success initiatives include community door knocking that also resulted in individuals registering with a GP for the first time and supporting the deployment of the vaccination and “worry” buses visiting targeted areas to deliver vaccinations and respond to patient concerns about the vaccine. The CCG’s award winning Covid Protect initiative, a local NHS and social care initiative to protect Norfolk and Waveney’s most vulnerable patients at the onset of the pandemic, has also been instrumental in improving uptake in patients

The involvement of PCNs and general practice in this work in using population health modelling and working with local authorities and community teams to understand

areas where vaccine hesitancy is highest and can help them build upon these achievements and collaborative working at local level to better understand wider local health inequalities at practice and PCN level so that appropriate measures can be put in place to manage them.

As an integrated care system, we also need to better understand the reasons why individuals and certain patient groups remain unable or unwilling to access health and care services for early care and diagnosis. This work will be led by the CCG's Health Inequalities Oversight Group who will oversee and manage health inequality matters across Norfolk and Waveney and support services to use population health management tools and risk stratification more effectively.

(b) Data / graphs showing the number of GP appointments in each district (or appropriate local area, e.g. PCN areas) in Norfolk & Waveney broken down by type, i.e. face-to-face, online/video, telephone, home visits. Showing the trend over the past year and including comparison with the eastern region and England.

Despite the challenges outlined above, during the period April – November 2021, general practice successfully delivered the following activity, a more detailed breakdown is set out in the appendix 1 (information at PCN level is not available to extract by the CCG):

One of the PCN funding investments for 2021/2022 was directly linked to supporting PCNs and general practice to map their appointment activity by end of July 2021 against agreed national codes to identify the different types of appointment activity taking place in primary care.

Summary of general practice appointment data for April – November 2021

Month	PCN Total Covid 19 Vaccinations		Total No of Appointments		
	2021/22	2019/20	2021/22	2019/20	Var
Apr	180,876		681,309	498,491	182,818 ▲
May	161,888		651,140	516,802	134,338 ▲
Jun	63,579		607,428	482,819	249,217 ▲
Jul	32,648		556,855	543,616	203,177 ▲
Aug	20,599		503,592	478,160	170,858 ▲
Sep	6,002		565,937	526,196	173,061 ▲
Oct	49,516		698,317	625,037	222,176 ▲
Nov	65,577		695,179	562,411	244,063 ▲
Dec	68,194				
Total Appointments	580,685	0	4,959,757	4,233,532	1,579,708

Across Norfolk and Waveney, 84.6% of general practice appointments are provided face to face compared to 70.7% nationally according to the data up to Nov 2021.

Overall, 629,602 appointments were provided in November 2021, 12% higher (67.2k) than November 2019 and equivalent to 33,104 per day (Mon – Fri) in that month. 14% more appointments were available on same day of request and 28% more appointments within one day of request (compared to before the pandemic).

The overall picture is very good however we recognise that there may be local issues which are being addressed and patient choice is an important factor in driving the mix of appointments.

Many patients value a telephone or online consultation as it fits in with their lives whilst others continue to request face to face appointments and telephoning the surgery direct and speaking to a receptionist. Helping the public understand how general practice works with a multi-disciplinary team will help in being able to offer patients a choice and enable patients to see a GP if they need to do so. Continuity of care for some patients with long term conditions is also important in building a relationship with a clinician.

What levels of video or telephone consultations with general practice would the CCG expect to become the normal levels?

The activity level for 2020 and 2021 for the period April – Nov is shown below. It is anticipated that normal levels will be determined to a large extent by patient choice and general practice clinical determination.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
2020	884	478	3,248	3,887	3,500	7,084	8,931	5,351
2021	3,079	2,596	2,337	2,788	2,398	5,124	5,979	3,963

Increasing the number of face to face appointments whilst retaining appropriate infection prevention measures is challenging and managing a proportion of appointments remotely either by telephone or online reduces the number of patients in a waiting room, particularly when any Covid variant is increasing transmissions between patients and staff. It is important that general practice provides a safe environment for all patients to be seen, including older patients and those who are more vulnerable.

Workforce

Retention of workforce: age, resilience, exhaustion/burn out, health and wellbeing of all staff

Recruitment and retention of both a multi-disciplinary clinical and non-clinical workforce, including administrative teams is also a critical factor in supporting the recovery and accessibility of primary care services. A wide range of health and wellbeing services have been put in place both nationally and locally to support all primary care staff, links to the relevant websites can be found below:

#WeCareTogetherWe Care Landing Page - #WeCareTogether (wecaretogethernw.co.uk) – available to all staff working in any primary care service in Norfolk and Waveney

NHS England » Supporting our NHS people – available to all staff working in healthcare in England

In addition, all health and social care staff and volunteers working in Norfolk and Waveney have access to confidential advice via Mental Health Resilience Hubs hosted by Norfolk & Suffolk Foundation NHS Trust.

A range of initiatives led by the CCG's Training Hub and Primary Care Workforce team are in place or being developed to support increased recruitment and retention of both clinical and non-clinical workforce. We know that the proportion of the clinical workforce in primary care aged 55 years or over is 36% of GPs, 38% of Nursing roles and 30% of other clinical staff. The CCG is reviewing and refreshing its plans relating to GP and Nurse recruitment and retention working with the ICS Workforce team to develop a more integrated approach to workforce recruitment and retention planning, organisation development support for general practice and build upon existing plans to improve the stability and resilience of general practice and its whole workforce.

The CCG's new Flexible Pooling Scheme, previously only available to GP locums, has been expanded to include any clinician and also administrative staff. In some areas, estates may limit the ability of some practices to expand their staffing levels; a separate estates update is provided.

Workforce data

The workforce data below has been extracted from the National Workforce Reporting System and shows the whole time equivalent (WTE) clinical and non-clinical workforce in place as of December 2021.

The overall workforce has increased from 3259 WTE in April 2021 to 3314 WTE as of December 2021:

- GP workforce remains unchanged from April 2021;
- number of nurses has dropped slightly from 443 WTE in April 2021;
- workforce for direct patient care has increased from 502 WTE; and
- admin workforce has increased from 1540 WTE to 1672 WTE in the same period.

GPs		**Nurses**		**Patient Direct Care (this data excludes the Additional Roles Reimbursement Scheme)**		**Admin (non-clinical)**
656 WTE		**438 WTE**		**548 WTE**		**1672 WTE**
363	partners	115	Advance Nurse Practitioners	189	Health Care Assistants	
170	Salaried	42	Nurse Specialists	190	Dispensers	
115	In training	37	Extended Role Practice Nurses	25	Phlebotomists	
6	Locums	237	Practice Nurses	39	Pharmacists	

2	Others	2	Trainees	1	Physiotherapist	
		2	Nurse Partners	20	Physician Associates	
		1	Nurse Dispenser	6	Apprenticeships	
				30	Paramedics	
				1	Nursing Associate	
				13	Pharmacy Technicians	
				33	Other roles	

Supporting PCN development and maturity, the Additional Roles Reimbursement Scheme (ARRS) enables general practice to develop a clinical skill mix to increase the clinical workforce and therefore access in general practice to suit their local needs and patient demographic. The different roles include clinical pharmacists, social prescribers, mental health practitioners, physiotherapists, care coordinators, Physician Associates, trainee nurse associates, podiatrists, paramedics, health and wellbeing coaches and dieticians.

For the financial year 2021/2022, the CCG is forecasting an investment in ARRS of £14m by end of this year subject to successful recruitment. The number of individuals in the various roles has already increased this year from 150 WTE in April 2021 to 265 WTE at the end of January 2022.

To what extent are the new roles already established in primary care across Norfolk and Waveney?

The Covid response created opportunities for Primary Care Networks (PCNs) to develop relationships and enhance collaborative working across the system and in localities, particularly with local authority and community care colleagues. PCNs are now able to build upon and develop these relationships in the future to deliver the right care to patients at local level and help identify and reduce health inequalities in GP access.

Expansion of the ARR Scheme came at a time when general practice was responding to the pandemic responding to very different, ever changing needs in an uncertain landscape all of which have created different challenges and pressures.

In most PCN areas, recruitment to the new ARRS roles has been very successful and are already integrated as part of PCNs and wider multidisciplinary practice teams and making an impact by directly seeing patients and supporting work in the background. ARRS role staff are welcomed into each practice and are given individual inductions for each practice they will be working in to ensure that they feel part of the team.

A number of examples of how they are working together across Norfolk and Waveney are described below.

Some of the most visible roles for clinicians working in general practice and patients include the First Contact Practitioners such as the pharmacy and social prescribing roles. For many of these roles, calculations may be made which equate to saved GP appointments/time although this is difficult to quantify accurately. In one PCN area, they have found that local discussions around referrals are necessary and

adjustments made to pathways in order to maximise the impact of these roles, for example, referrals for imaging or musculoskeletal pathways, and this has been a useful learning curve to everyone. For the majority of practices, these roles are embedded and felt to be useful not only in the patients they see and treat but also for the element of educational value they can bring.

Competition for paramedics (particularly ones who can prescribe), mental health and clinical pharmacy roles can make recruitment/retention challenging. It is important that the CCG and PCNs develop a mechanism for working in partnership with system partners which is essential to ensure that one part of the system does not unintentionally destabilise another. Community pharmacies are also facing significant workforce issues with approximately 70 vacancies across the CCG area. The Clinical Pharmacists and paramedics roles are however becoming well established in primary care. In one PCN area, joint post working with another provider has been established for a pharmacy role, which has worked well to mitigate destabilising existing providers by employing them directly full time and offers staff a richer portfolio of roles which helps with recruitment and retention.

As indicated above, mental health nurses have been a more challenging role to introduce due to differences in recruitment and HR management of the staff, as staff are employed and managed jointly between primary care and the Mental Health Trust. In one area, PCN-level workshops have been held to work through some of the main concerns, and they are in the midst of a fresh round of recruitment.

In another area, a PCN has appointed an Occupational Therapist linking in with wider community services which has been very successful in meeting the needs of the age profile of the patient group and they may appoint a second therapist.

To what extent have the initiatives to broaden the range of practitioners in primary care taken the pressures off GPs?

The ARRS roles have a different impact in each PCN depending on how the roles are utilised and embedded within the individual PCNs and practices. This includes increasing clinical capacity and non-clinical support to provide at scale solutions. There are however estates issues to be considered in expanding the workforce and also allowing general practice premises to be used by other services, such as community nursing and mental health; this is discussed in the Estates section of this paper.

Patients can be triaged based on the presenting medical condition and allocated accordingly to the most appropriate clinician to see them. Many of the roles have been involved in the Covid vaccination programme as well.

These roles are rapidly becoming embedded in general practice due to the commitment from PCNs and practices to build their wider teams which involves an investment in time to develop new ways or working, develop new protocols to support new roles, connecting with partners for onward referral, ensuring clinical supervision and finding staff a place to work. All clinicians working in practice need

to be aware of and adapt the way they work to support and accommodate these additional roles and input from some GPs in terms of clinical supervision is also required. Many of these new roles have been recruited this year and therefore PCNs are still in the early stages of this journey. For many of the roles then it may be that the GP's experience is one of different pressures rather than less pressure. As network teams become more established the aspiration is that general practice and their patients will feel the benefits of these roles.

Whilst PCNs are maturing, there will be a balance between additional appointment capacity being created by some roles (e.g. First Contact Practitioners) and somewhere for GPs and their teams to refer to for non-medical needs (e.g. social prescribers) and the support needed to embed these practice teams. Some of these roles are also about developing the workforce of the future, for example, Trainee Nursing Associates who will need more clinical supervision.

These roles tend to be far more outward facing than traditional practice roles. This is to be applauded and demonstrates a level of maturity in collaborative working previously not seen in general practice. In some PCNs, the First Contact Practitioner roles (such as physiotherapists, mental health staff or clinical pharmacists) enable receptionists to directly book patients to them without first seeing a GP for pre-approved conditions. This directly frees up GP time. Other roles have a more indirect benefit (such as medication reviews and repeat prescription queries) thus freeing up GP time for other tasks.

The role and pressures associated with being a GP partner are broader than the number of appointments they offer; they will be routinely reviewing large numbers of documents, checking laboratory results, carrying out clinical tasks on a daily basis as well as being responsible around the running of their business and employing staff. The development of wider practice teams does not necessarily relieve any of these pressures and much of it is unseen, for example, the multitude of ways in which patients and practices can communicate with each other and with other healthcare partners, e.g. email, Footfall, online referrals etc, has also created additional workload for general practice.

The ambition for more people to be cared for in the community, for example, fewer patients taken to Emergency departments and more patients wishing to die at home, will lead to additional pressures on general practice. The multi-disciplinary clinical workforce therefore needs to expand to meet the demands and additional workload, some of which is already being seen in community settings.

(c) Information on individual practices / areas that are outliers in terms of a lower proportion of face-to-face appointments.

When practices are identified as possible outliers in terms of face to face appointments, they are supported by the CCG to understand the reasons for this, review their appointment processes to ensure an accurate reflection of their appointment activity is being captured and to make adjustments to their appointment model if required following engagement with their Patient Participation Group. Other adjustments to the way in which the individual practice operates may also need to considered depending on the factors impacting access such as their workforce skill mix or looking at estates.

A number of practices (32) in Norfolk and Waveney have been actively engaged with the NHSEI's accelerated Access Improvement Programme since early 2021 and a small number were given the opportunity to engage with an accelerated programme supported by investment from the Winter Access Fund to support their participation in the programme and, where appropriate, to make changes to their appointment systems.

(d) To what extent are Covid 19 restrictions continuing to have an impact on availability of GP appointments, particularly face-to-face, following the update to guidance on 19 Oct 2021 allowing a more flexible approach to patient consultations?

All practices are fully open and accessible for their patients although a clinical triage model remains in place. Not all patients need to see a GP every time. All practices use a clinical and non-clinical skill mix and the clinical triage model ensures that individual patients can be seen by the right person at the right time for the right care freeing up GPs to seem patients with more complex needs.

In November 2021, 695,179 appointments were delivered in general practice equivalent to 33,104 per day (Mon – Friday) across Norfolk and Waveney, 65% of these were face to face appointments.

(e) How many temporary closures of surgeries or branches have there been in the past month and what are the reasons for them?

There have been a small number of days when an individual practice or a branch site has been closed due to short term staff shortages from staff isolating due to close contact or with Covid symptoms.

All Norwich GP practices had a planned temporary closure on 20th January 2022 from 1400 – 1830hrs for staff training. All calls were managed by IC24 as part of the planning process.

West - none
South – none
North – none
East - none

(f) How many GP practices across Norfolk and Waveney are dealing with only urgent / emergency contact from patients?

All practices are fully open and accessible for their patients with a clinical triage model to ensure patients are seen by the right clinician at the right time.

(g) Feedback from patients about GP primary care • Numbers of complaints / compliments • Recurring themes

In the period April 2021 – January 2022, the CCG received 259 concerns or complaints from patients of which 85 related to access and appointments. They are spread evenly across Norfolk and Waveney with no particular themes or outlier practices of concern.

Across healthcare, including across primary care, staff are witnessing an increase in challenging behaviour from patients against staff. The CCG continues to support practices faced with this type of behaviour and to endorse a zero tolerance policy whilst also encouraging practices to communicate and engage with their patients. The communications campaign (described later in this paper) seeks to address some of the reasons for this behaviour by explaining how practices operate and asking patients to treat staff with kindness, a message also rolled out nationally. Some of the concerns raised by patients relate to queries about waiting lists in secondary care resulting in additional workload for practices investigating for the patient concerned and relaying the message.

General Practice Access survey outcomes

The General Practice Access Survey (2021 pub) is a national survey; the most recent contains data collected January – March 2021. In Norfolk and Waveney, 30,328 questionnaires were sent out, and 14,020 were returned completed (more than any other CCG in the region). This represents a response rate of 46%.

In summary, practices overall scored above the national average in all areas where questions relating to positive experiences were asked, with the exception of Long Term Condition Management. An overall summary is set out below and further details are provided in Appendix 2.

☐

	Norfolk & Waveney	National
% who describe their overall experience as good	85%	83%
% who found it easy to get through by phone	71%	68%
% who describe their experience of making an appointment as good	75%	71%
% satisfied with appointment times	71%	67%

While overall, the level of satisfaction among patients is high, it is acknowledged there are a minority of practices where patient experience does not score as well. The CCG's Primary Care Commissioning Committee receives regular reports on actions taken by individual practices and PCNs in response to the Access Survey outcomes. These include actions such as improving the telephone system, changing the way appointments are scheduled and improving the use of digital technology.

(h) Information on the extent to which patients who do not have access to information technology are at a disadvantage when trying to make initial contact with a practice and in terms of the length of time they wait to see a healthcare professional.

As all practices are open and accessible to patients, individuals are able to access care when needed if they do not or cannot use technology. All practices are obligated to meet the NHS's Accessible Information Standard and make reasonable adjustments where necessary to ensure accessibility for individual patients.

The CCG recognises that some patients may not use or cannot use digital technology and therefore ensuring that practices are open and accessible to all patients is critical in reducing health inequalities.

As a result of the mixed model of care with many patients willing and able to use digital tools to communicate with practices, this frees up time and resources to see patients in general practice unable to use digital technology.

Waiting times overall for all appointments have significantly reduced as highlighted above. During November 2021, 238,132 (37.7%) appointments were for the same day, an increase of 14% on the same month in 2019. 44,194 appointments were for next day appointments, an increase of 28% on Nov 2019.

Digital technology is increasingly seen as beneficial in supporting patient care and staff health and wellbeing as well to ensure GP time and expertise is focused on caring for patients with more complex needs and those who need to see a GP. There is a wide range of digital tools available to support practices, their staff and communications with patients.

The majority of practices (86) use the Footfall online consultations system. This is being upgraded at the moment to a version which integrates with SystmOne (the practice clinical system) with positive feedback from practices that it helps improve communications with patients, works well with their clinical triage model and is quick and efficient; interaction with clinical systems saves time and reduces errors.

Patients of Footfall practices sent in **979,170** forms seeking help or advice in the 6 months from August 2021 to January 2022, and a total of **2,025,000** in the previous year. The new version of Footfall also has text messaging and a simplified website option.

A minority of practices in Norfolk & Waveney operate with the Emis clinical system. One of our Emis practices will soon be the first in the country to use Footfall with Emis integration and are helping to develop and test this now. For practices who do not want to use Footfall, other options have been made available for different systems, practices can select from 4.

Recognising the importance of being able to get through to a practice on the phone, we have completed a procurement exercise for a cloud telephony platform for Norfolk & Waveney practices. Wavenet were the successful bidder and have already built the underlying technology platform ready for testing. The solution can be entirely computer based, no need for handsets, and can work on any internet connected device which will support remote working for general practice staff
All practices on the platform will be able to transfer calls between each other free, giving lots of opportunity for the future in shared administration and digital front door initiatives at PCN level. There is connection with the clinical system so the caller's

clinical record can be automatically accessed and all set up costs can be paid for by the NHSX award.

All GP Practices in Norfolk & Waveney have had their data migrated to the Cloud and have adopted N365 enabling them to collaborate and access shared resources, using Teams for meetings and calls. This will enable practices to be an active part of the integrated care system, working flexibly from any internet connected location.

Support is also available to Care Homes to ensure that they and their residents are enabled to make better use of technology and provide support, resources and practical advice that Care Homes need to use Digital Technology. A SystmOne Care Home Module is available to be deployed in agreement with the practice. The module, developed for specific use within the Care Home environment, allows for easy communication with health service providers as well as enabling Care Homes to effectively manage residents, their information, care planning and connect patient records with other care providers in the area.

Remote monitoring in care homes was introduced in response to the pandemic in early 2020 to ensure that care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed). The *Covid Protect* initiative targeted outreach focussed on those most susceptible to serious illness and hospitalisation, including many who now found themselves cut off from traditional routes into health and care services. More than 100 redeployed NHS and Voluntary Sector staff were part of a team of contact callers who regularly telephoned those who were deemed most vulnerable. This allowed *Covid Protect* to prioritise and escalate individual health and social care needs to both clinical and non-clinical teams across Norfolk and Waveney.

The remote monitoring of health conditions, ongoing contact with those most at risk of harm and the provision of early care and support interventions enabled people to stay safe and well at home. This approach allowed the health and care system, working collaboratively as a whole, to proactively reduce demand on ambulance and A&E services and avoid further increases in hospital admissions during the early months of the pandemic.

The CCG's Training Hub has put in place training to raise awareness and remind practices of their obligations under the NHS's Accessible Information Standard and is working with local organisations and the voluntary sector to expand the training during 2022 to cover specific subjects, e.g. supporting patients who are hard of hearing or those with Learning Disabilities. This training has been shared with the Local Pharmaceutical Committee, with NHSEI and with other Training Hubs in the East of England region. Arrangements have been put in place locally to support Deaf patients as described in a separate agenda item at this HOSC meeting.

Communications and Engagement with patients

(i) What has been done to explain the pressures on GP primary care to the public and keep them informed about the nature of the service now and for the future (i.e. with online / telephone appointments forming an ongoing part of the service model)?

Norfolk and Waveney CCG continue to make strides in ensuring that its local population are informed of the services provided within general practice, starting with a new visual campaign to help support ways in which patients can access their local Primary Care services. The primary care campaign will target the below themes:

- **Choosing the right service**
- Highlighting the **vast range of health and care professionals** that exist in primary care, from pharmacists through to health care assistants.
- Focussing on the **importance of self-care**
- Improving access and **use of digital tools in primary care**
- **Support a Zero Tolerance of abuse to staff** which is currently experienced by staff in Primary Care which has been heighten by the ongoing pandemic

The campaign commenced in November highlighting the Self-Care and Zero Tolerance themes with the other themes being released in upcoming months.

Towards the end of 2021, a local primary care campaign began to raise awareness of the many different ways in which patients can access local primary care services (GP practices, pharmacy, optometry and dental services), as well as urging people to be kind to staff who continue to work tirelessly to care for patients. This has been important behaviour change campaign to signpost, raise awareness and educate patients, as well as to show our support for GP practices and their staff.

The overarching concept is that the NHS is adapting to the needs of its patients and the need to embrace this change by encouraging patients to support Primary Care services through our activities.

An asset toolkit was created: social media –Twitter and Facebook assets, Website content, leaflets / posters and T.V. screen adverts were shown in health centres and local practices.

The CCG's Communications team have also invested in funding the social media with pay-for advertising to ensure we target the right audiences and right age groups across Norfolk and Waveney. This helped to drive momentum of the campaign and remain in the public consciousness.

A joint press release, in partnership with the Norfolk and Waveney Local Medical Committee and Local Pharmaceutical Committee generated some positive media

attention. Our Chair, Dr Anoop Dhesi, featured on Greatest Hits Radio West Norfolk every hour during the news bulletin between 1pm and 7pm. (18 November, 2021).

The Winter Campaign was also unveiled - "Give Your NHS a Hand This Winter" aimed to help residents stay as well as possible during the cold months ahead. Launched during Self-Care Week (15-22 November), the campaign provides timely information and advice on practical ways that people can help to keep themselves well this winter.

GP services were one of the four main services listed in the "Help from your NHS section" of the Winter Wellbeing Guide, which was distributed to around 480,000 homes in Norfolk and Waveney in mid-December. The section outlines which services are available for different health needs, and that patients should arrange an appointment with their GP for concerns about recurring symptoms and if they're feeling unwell. It highlights that phone, video, and face to face appointments are available and that patients should contact surgeries by phone or online.

GP Services are also listed as one of the Health Services in the "Find the right health service" sub-page of the campaign portal. The listing in this section reminds people to contact their practice online or over the telephone rather than going in to see the GP as they might previously have done. GPs are also listed in the "Mental health support" sub-page, to remind patients that they can speak to their GP for mental health advice and referrals to appropriate services.

These webpages have been promoted throughout the winter campaign via organic and paid for social media posts, and signposted in articles and newspaper editorial, encouraging patients to identify what support they can get from different health services. Practices themselves also make good use of social media, messaging patients on their Facebook pages and publishing regular updates on their websites.

In addition, the CCG's Chair, Dr Anoop Dhesi has participated in regular interviews on local BBC radio throughout 2021 and continues to do so. The CCG's Chief Executive also provides regular briefings to MPs to keep them updated about a wide range of issues related to the Covid response and vaccination programme.

Expanding our social media channels

TikTok is the fastest-growing social media platform currently available. The video sharing platform allows users to create videos of any topic and share them with a wider audience than any of the other available social media platforms. Videos can range from 15 seconds to several minutes and can reach of hundreds or even thousands of people within minutes of posting – without the need for a large following.

The CCG has recently created a TikTok channel and have already seen high engagement on videos that cover information around COVID-19 vaccines and the availability of NHS 111. Creating and sharing short videos that inform people of the available services from general practice will help us to reach a wider audience, increase engagement, and help to share important health information to a large population of all ages and demographics. A recent example was a video of a young

vaccination centre steward from the Norwich site debunking the myths of the vaccination for those who are aged between 18-30 years.

There is also a range of national resources provided by Public Health England for practices to refer to at General Practice Access Routes | Campaign Resource Centre (phe.gov.uk)

(j) Data on the extent to which GP practices are delivering the routine checks required for specific patient groups to prevent more serious health problems from developing (e.g. the range of annual checks required for patients with diabetes) and information on whether those checks are delivered face-to-face, by online video or by telephone.

As indicated above, practices and PCNs have been asked to focus on the key priority areas while continuing to use their professional judgement to clinically prioritise patient care.

The NHSEI letter dated 7 December 2021, set out changes to the GP contract to support general practice to continue to deliver on the priorities outlined above. Within the Quality Outcomes Framework, practices were asked to focus on the four vaccination and immunisation indicators, the two cervical screening indicators, the register indicators (including Learning Disabilities and Severe Mental Illness) and the eight prescribing indicators, a copy is available to view on NHSEI's website at:

C1475_Letter-about-temporary-GP-contract-changes-to-support-COVID-19-vaccination-programme.pdf (england.nhs.uk)

In addition, an NHSEI letter published in January 2022, gave systems greater flexibility working with system partners to access additional funding or to use underspend to improve the uptake in annual health checks for patients with Learning Disabilities and Severe Mental Illness.

B1268-letter-delivery-of-annual-health-checks-for-people-with-severe-mental-illnesses-and-or-learning-disabili.pdf (england.nhs.uk)

All practices are working hard to catch up with the backlog of annual health checks for patients, the data for patients with a Severe Mental Illness (SMI) and for those with Learning Disabilities are shown below. Winter Access Funding is also being used to recruit targeted support for areas where practices may be facing specific challenges in encouraging patients to come forward for their checks by end of March 2022.

SMI health checks as at the end of Q3 (31st Dec 2021):

	No of Pts	%
Number of patients on the SMI register	9134	
1. Measurement of BMI	5793	63%
2. Blood pressure & pulse	6553	72%

3. Blood lipid including cholesterol	5120	56%
4. Blood glucose test	5782	63%
5. Assessment of alcohol consumption	4990	55%
6. Assessment of smoking status	6830	75%
All 6 health checks completed	2748	30%

Learning Disability health checks as at end of January 2022

	On LD QOF Register	On LD Register with HC	%
Great Yarmouth and Waveney	3530	1728	49%
North Norfolk	2408	1054	44%
Norwich	3004	1536	51%
South Norfolk	2688	1054	39%
West Norfolk	2076	748	36%
Grand Total	13706	6120	45%

Annual health checks should normally be carried out face to face although it is possible that earlier in the year, some with less severe learning disabilities may have been carried out by telephone or online where clinically appropriate; practices will be arranging to see these patients for a face to face consultation depending on their level of need. It is not possible to determine from the current data extracted if a health check has been carried out face to face or by telephone or online consultation.

Winter Access funds are also being used to support diabetes care. A support offer has been developed to help practices to recover performance across our system to pre-pandemic levels, including a targeted offer to practices who have the greatest improvement opportunity. The support offer will be tailored to the needs of practices and PCNs, which will be facilitated through conversations between the CCG's Diabetes Team and PCN Clinical Directors.

(k) Winter Funding of £250m for general practice to "increase the proportion of appointments face to face" was announced on 14 October 2021. How much was Norfolk and Waveney's share of that funding and how has it been used?

In October 2021, national Winter Access funding was made available to general practice with the specific aim to improve access, increase the proportion of appointments, in particular face to face appointments, and to support urgent same day care. Norfolk and Waveney CCG's allocation is £4.9m to be invested by end of March 2022; each CCG was required to submit a plan to NHS England and NHS Improvement East of England region for regional and national approval setting out how the funding would be invested to support the overall objectives; it is not a pass-through payment to general practice and there are strict criteria for practices to claim the funding and to evidence their spend. Practices are eligible to receive funding if they sign up to participate in the Community Pharmacist Consultation Service.

Through engaging with practices and our locality teams, the CCG identified, developed and agreed 22 schemes, the majority of which are directly accessible to individual practices. PCNs and practices claim funding on submission of the required evidence of spend together with a small number of system wide schemes aimed at benefitting general practice and urgent same day care more widely. Any changes to schemes or new initiatives require regional and national approval and the programme is closely monitored.

Ten practices were also nominated to receive accelerated support from the national Access Improvement Programme to help them to improve access in specific areas of need, e.g. telephone access; these practices were already receiving enhanced support from the CCG and actively engaged in trying to improve access and services. It should be noted that there is already active engagement with the national programme from 32 practices in Norfolk and Waveney and 6 practices have already successfully completed the programme.

To date, £2.26m has been claimed by practices or invested in CCG schemes.

The programme of initiatives in Norfolk and Waveney include the following:

- Recruitment of additional clinical workforce including reservists, locums and to pay overtime for clinical staff;
- Recruitment of administrative and receptionist staff to support increase in 111 referrals, referrals into the Community Pharmacist Consultation Service;
- Support expansion of @Home initiatives, including onboarding and offboarding both adults and children using Oximeters, Blood pressure monitoring and urine testing;
- Proactive support to practices to improve uptake in annual health checks and vaccinations for patients with Learning Disabilities, including the appointment of dedicated clinical resource to engage with individual practices and carry out health checks;
- Proof of Concept Primary Care Wellbeing Hubs Liaison Workers development;
- Home visiting services, including additional support for care home visiting;
- Online consultations for patients who wish to access primary care services thereby freeing up and increasing the number of face to face appointments for other patients;
- Continuation of AccurX contract to end March for those practices wishing to use it to send out fit notes or text individual patients about appointments or questionnaires;
- Population Health Management initiatives, including a targeted approach for practices with patients who may be struggling to engage with patients with diabetes and supporting practices to use Eclipse for risk stratification modelling;
- Pilot contract with a local organisation to enable and facilitate patients from the deaf community who are totally reliant on BSL to communicate and/or who are digitally challenged, to access all primary care services;
- Provision of additional oxygen cylinders in general practices in exceptional circumstances for respiratory patients at risk whilst waiting for transport to secondary care;

(l) What have the CCG / Primary Care Networks done to ensure consistency across GP practices in Norfolk and Waveney in terms of the service model offered (e.g. in the proportions of or criteria for face-to-face, online, telephone and home visits)?

Each of our 105 practices is an independent contractor and is responsible for determining their own appointment service model to meet their practice population needs. Practices are expected to regularly review their model to ensure it is meeting demand and responding to both practice and patient needs and discuss proposed changes with the practice's Patient Participation Group. We expect to see variation between practices, for example, a town centre practice may need a different model to that in a rural area, with a flexible mix of telephone, face to face and online appointments depending on their patient demographic.

All practices will have a policy in place for home visiting to ensure patients who are clinically housebound can receive a visit from an appropriate clinician according to their clinical need. Home visiting has a significant impact on clinical resource capacity and is therefore targeted and available to those who need it most.

In addition to normal opening hours, improved access and extended hours arrangements are also available in the evenings and at weekends and bank holidays to meet the local population needs. Improved Access arrangements have recently been extended to October 2022 to enable PCNs and other organisations time to agree how they will be provided in future.

(m) What is the CCG's plan for the model by which primary care will operate in the future?

The CCG's Primary Care Strategy 2019/20 – 2023/24 sets out general practice and Primary Care Networks (PCNs) as fundamental to delivering the NHS Long Term Plan and to addressing local health inequalities. While the Strategy is due to be refreshed following the rapid progress made during the pandemic and the emerging Integrated Care System (ICS), the premise of supporting a resilient and stable primary medical care service to deliver high quality care for patients remains the same.

For the medium to long term, our priorities are:

- To boost capability and capacity to support more people in the community breaking down the divide between primary and community health services.
- To reduce unwarranted clinical variation and pressure on emergency hospital services where possible.
- To increase the level of personalised care where appropriate.
- To increase the implementation of digitally enabled primary care.
- To increasingly adopt a population health management approach to patient care.

With these priorities in mind, our primary care service model is that of place-based care, where patients experience a seamless service between different professions

across different organisational settings. Access to services should be straightforward, with a combination of face to face and digitally enabled services where clinically appropriate.

Through collaboration and PCNs, practice management structures are supported in their day-to-day business, to help free up expertise (clinical and non-clinical) to transform services

We understand the current situational challenges that general practice is facing and believe that active engagement and involvement in the ICS and the alliances will support a pro-active population health management approach, which in turn will help to provide in-depth care for the clinically vulnerable and support the general population to improve their overall health and wellbeing.

(n) In terms of policy for the future, what is the CCG's reaction to the assertion that all diagnostic services should be delivered face-to-face?

In the majority of cases, patients in Norfolk and Waveney will be seen face to face for diagnostics. Where a patient is clinically triaged, the receiving clinician would make a clinical judgement on the next steps in treating the patient, whether that should be to bring them in for an appointment with the most appropriate clinician, undertake a test, or simply provide advice.

Practices are able to contact patients regarding a result and offer them telephone or face to face appointments; many patients choose a planned telephone call, others may choose to come into the practice. In many circumstances, most patients will have seen a GP or nurse before any diagnosis.

Examples of where a face to face appointment may not be needed include someone who has already had an MRI scan or X-ray showing an abnormality such as gallstones, fibroids or a torn ligament in the knee; the clinician would be able to discuss the result and diagnosis over the telephone. For skin lesions, some practices use dermoscopy images and remote specialists to diagnose. It may be possible to make a Mental Health diagnosis over the phone if they have filled in an appropriate questionnaire, such as those patients with ADHD or gender dysphoria. Coeliac disease is also an example where diagnosis is based on blood tests and patient history and therefore the patient could choose to discuss this by telephone or in a face to face appointment.

The key factors will be patient choice, clinical consideration or if a physical examination is required for diagnosis.

(o) Any other information the CCG wishes to bring to NHOSC's attention

In summary:

Appointment activity for all clinicians continues to increase across the area to meet patient need.

General practice across Norfolk and Waveney is open and accessible to patients however we recognize that there are areas for improvement with some patient groups and this will continue to be a priority for the CCG together with general practice and PCNs.

The national PCN and general practice priorities for 2022/23 have been identified and focus on five areas and will support the CCG in achieving this goal, these are:

- improving prevention and tackling health inequalities in the delivery of primary care;
- supporting better patient outcomes in the community through proactive primary care;
- supporting improved patient access to primary care services;
- delivering better outcomes for patients on medication; and
- helping create a more sustainable NHS.

PCNs, together with the practices in their grouping, across Norfolk and Waveney will be refreshing their PCN Development Plans to reflect these priorities and set out how they will be delivered at local level and continue to improve access to general practice for all patients.

Investment linked to the successful delivery of the PCN Impact and Investment Fund (IIF) indicators during 2022/23 will support PCNs in the delivery of these clinical objectives, as well as wider system-wide goals where PCNs have a central role alongside other NHS partners. The IIF scheme is aligned to the five areas of focus set out above.

We welcome questions and views from members of the Health Overview and Scrutiny Committee.

(p) An update on progress towards provision of Wave 4b Primary Care Hubs across Norfolk and Waveney in the following locations (since the previous update in the NHOSC Briefing August 2021):

St James Medical Practice

The planned relocation of St James' Medical Practice is subject to final NHS approval: the Full Business Case for the proposal is expected to be submitted to NHS England & NHS Improvement in April 2022. This submission includes an Equality Impact Assessment which makes reference to the need for the CCG and PCN to work together to ensure that mitigations are considered in the interim for demand and capacity in the south of the town, following the St James move (anticipated August 2023) and the opening of the Wave 4b Hub (anticipated Spring/Summer 2024). This work will commence following the expected approval of the St James' Medical Practice Full Business Case.

Wave 4b Primary Care Hubs

In 2019, the CCG were successful in obtaining £25.2m capital investment for 5 x primary care hubs across Norfolk & Waveney. As part of the award in order to

secure the investment to align with manifesto pledges all 5 hubs are required to be completed by March 2024. Appendix 3 shows the preferred locations of the hubs and further information about potential tenants and size of the buildings.

During 2020 with focus on the covid-19 pandemic progress on the Wave 4b Primary Care Hub programme was significantly delayed. In order to recover the programme the CCG was successful in obtaining (£0.7m) Estates Technology Transformation Fund (ETTF) funding to utilise on project management, architect fees and business case support. This support was subsequently procured from the CCGs local LIFT company NorLife Ltd who have been working with the CCG and other stakeholders throughout the programme.

Following dialogue with NHSE/I in January 2021 the CCG were issued with an approval process that instructed the CCG to submit a Programme Business Case (PBC) covering all 5 projects followed by 5 individual Full Business Cases (FBC). The PBC is now complete, was presented and approved at the November 2021 CCG governing body meeting and submitted to NHSE/I on the 1st December 2021.

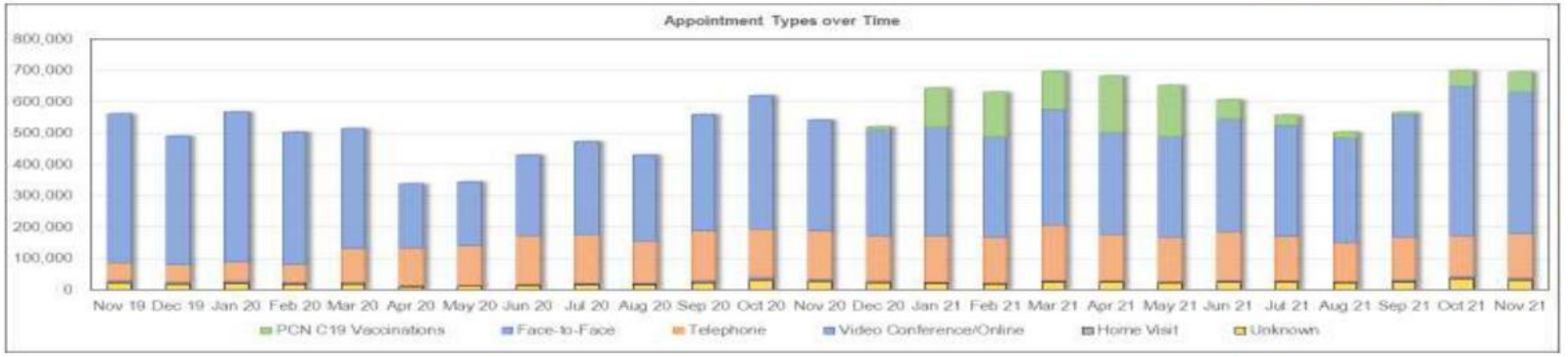
The PBC needs to be approved by NHSE/I before it can be assessed by the Department of Health and Social Care (DHSC). Subject to agenda scheduling the PBC is due to be reviewed at the May or June 2022 DHSC Joint Infrastructure Sub Committee (JISC). Initial feedback from NHSE/I was received on the 14th January 2022 which has highlighted 3 main areas to address before the document can be considered for JISC submission. These areas are: Procurement, Utilisation and Value for Money. The CCG has provided written responses to all queries raised to date but expect further queries to be received in the run up to the JISC committee date.

Elements of the FBC can be progressed while PBC approval is awaited, and the CCG intends to progress these tasks at risk utilising unspent ETTF funding during this period. The individual FBCs do not need to be submitted to NHSE/I at the same time which means there will be a phased approach to submission throughout 2022. FBC development and approval at scheme level is forecast to be completed between September 2022 and November 2022.

There is a requirement to spend the NHS capital on these schemes by March 2024 with a 3-month mobilisation plan expected to see all sites operational by June 2024.

GP Appointment Data - Summary as at Nov 2021

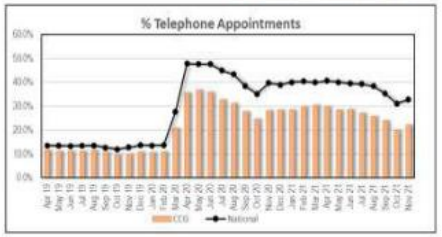
NHS
Norfolk and Waveney
Clinical Commissioning Group

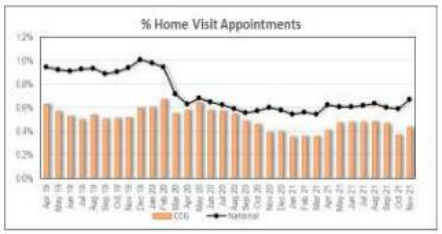


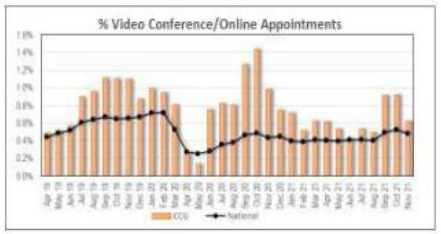
N&W f2f appointments 84.6% versus 70.7% nationally.
Overall, 629,602 appointments in Nov 2021, 12% higher (67.2k) than Nov 2019.
14% more appointments delivered on same day of request and 28% more appointments within one day of request (compared to before the pandemic)
65,577 Covid vaccinations delivered in Nov 2021 by primary care. In three weeks in December, 217,000 COVID-19 vaccinations delivered, majority by primary care.

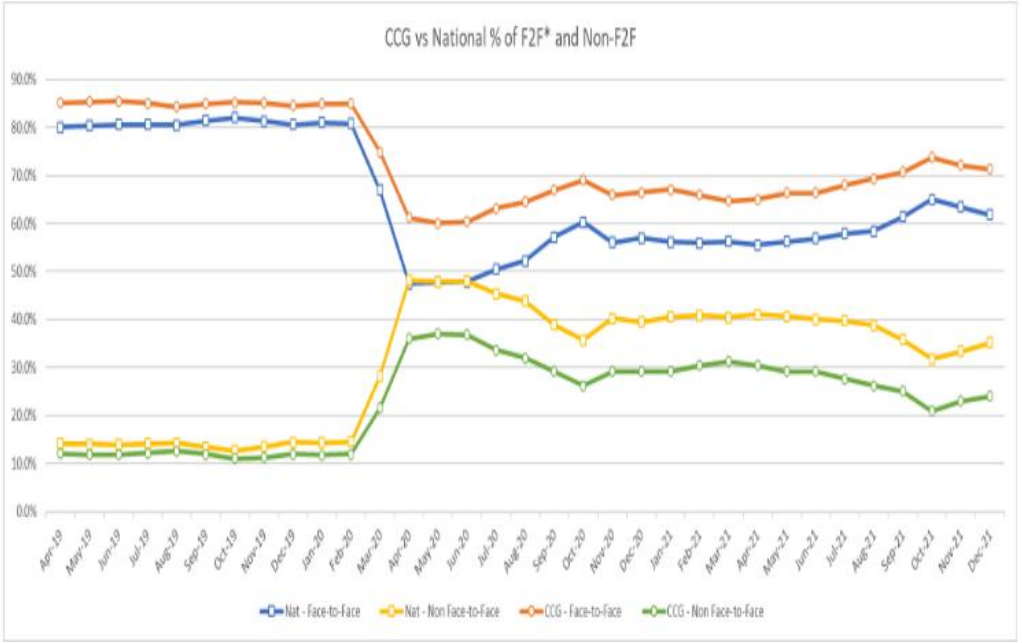
GP Appointment data - breakdown

NHS
Norfolk and Waveney
Clinical Commissioning Group









Time to Appointment - Last Three Months compared with the same period the in 2019/20

Actual Activity	2019/20			2021/22			Var (%)		
	Sep	Oct	Nov	Sep	Oct	Nov	Sep	Oct	Nov
Same Day	202,581	225,065	209,344	227,995	224,392	238,132	13% ▲	-0% ▼	14% ▲
1 Day	29,646	38,888	34,636	48,226	46,855	44,194	63% ▲	20% ▲	28% ▲
2 to 7 Days	100,397	115,102	105,200	119,222	146,640	133,982	19% ▲	27% ▲	27% ▲
8 to 14 Days	69,779	90,639	78,974	71,262	106,889	95,264	2% ▲	18% ▲	21% ▲
15 to 21 Days	44,512	56,195	49,467	39,681	51,380	59,123	-11% ▼	-9% ▼	20% ▲
22 to 28 Days	39,002	47,118	40,488	28,575	30,440	32,845	-27% ▼	-35% ▼	-19% ▼
More than 28 Days	40,210	51,971	44,258	24,892	42,051	25,921	-38% ▼	-19% ▼	-41% ▼
Unknown / Data Issue	69	59	44	82	154	141	19% ▲	161% ▲	220% ▲
Total	526,196	625,037	562,411	559,935	648,801	629,602	6%	4%	12%

Appointment Attendance - % by type compared to National figures

	CCG Breakdown						National					
% of Actual Activity	2019/20			2021/22			Current			Var CCG v National		
	Sep	Oct	Nov	Sep	Oct	Nov	Nov			Nov		
Same Day	38.5%	36.0%	37.2%	40.7%	34.6%	37.8%		42.3%			-4.5% ▼	
1 Day	5.6%	6.2%	6.2%	8.6%	7.2%	7.0%		8.2%			-1.2% ▼	
2 to 7 Days	19.1%	18.4%	18.7%	21.3%	22.6%	21.3%		20.8%			0.5% ▲	
8 to 14 Days	13.3%	14.5%	14.0%	12.7%	16.5%	15.1%		14.0%			1.1% ▲	
15 to 21 Days	8.5%	9.0%	8.8%	7.1%	7.9%	9.4%		7.4%			2.0% ▲	
22 to 28 Days	7.4%	7.5%	7.2%	5.1%	4.7%	5.2%		4.0%			1.2% ▲	
More than 28 Days	7.6%	8.3%	7.9%	4.4%	6.5%	4.1%		3.2%			0.9% ▲	

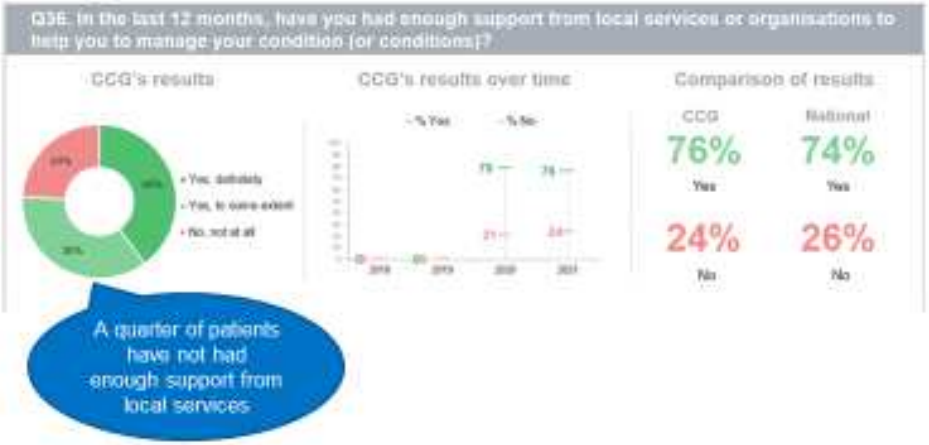
Primary Care – GP Patient Survey (1)

Norfolk and Waveney Clinical Commissioning Group

Headlines

- More than 14,000 surveys received (more than any other CCG in the East of England region)
- Scored above the national average in all areas where questions relating to positive experiences were asked except Long Term Condition Management

Long Term Conditions



- Q37. Have you had a conversation with a healthcare professional from your GP practice to discuss what is important to you when managing your condition (or conditions)?
  - National: Yes = 41%, No = 52.5%
  - CCG: Yes = 40%, No = 54%
- Q38. Have you agreed a plan with a healthcare professional from your GP Practice to manage your condition (or conditions)?
  - National: Yes = 59.5%, No = 32.1%
  - CCG: Yes = 57%, No = 34%

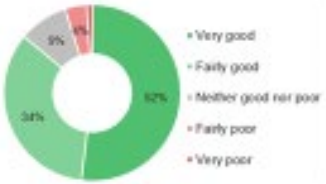
Of those that have one 94% of CCG respondents find their plan helpful, but a third of people with LTCs don't have one

Source: NHSD – GP patient survey
http://gp-patient.co.uk/

Primary Care – GP Patient Survey (2)

Q30. Overall, how would you describe your experience of your GP practice?

CCG's results



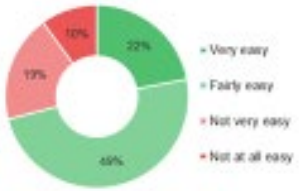
CCG's results over time

Comparison of results

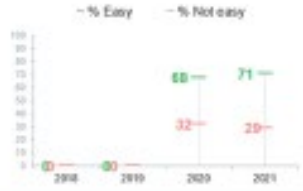
	CCG	National
	85%	83%
	Good	Good
	5%	7%
	Poor	Poor

Q1. Generally, how easy is it to get through to someone at your GP practice on the phone?

CCG's results



CCG's results over time

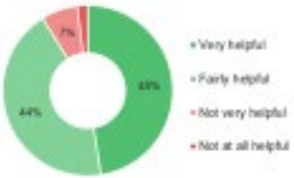


Comparison of results

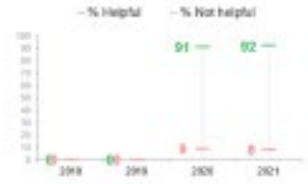
	CCG	National
	71%	68%
	Easy	Easy
	29%	32%
	Not easy	Not easy

Q2. How helpful do you find the receptionists at your GP practice?

CCG's results



CCG's results over time



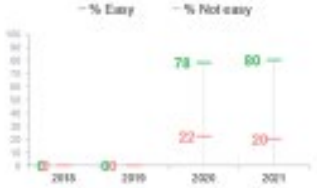
Comparison of results

	CCG	National
	92%	89%
	Helpful	Helpful
	8%	11%
	Not helpful	Not helpful

Q4. How easy is it to use your GP practice's website to look for information or access services? [1]

CCG's results

CCG's results over time



Comparison of results

	CCG	National
	80%	75%
	Easy	Easy
	20%	25%
	Not easy	Not easy

Q14. On this occasion (when you last tried to make a general practice appointment), were you offered any of the following choices of appointment?

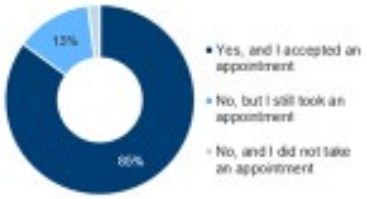
CCG's results

Comparison of results

	CCG	National
	71%	69%
	Yes	Yes
	29%	31%
	None of these	None of these

Q15. Were you satisfied with the appointment (or appointments) you were offered? [1]

CCG's results



Comparison of results

	CCG	National
	85%	82%
	Yes, took appt	Yes, took appt
	13%	16%
	No, took appt	No, took appt
	2%	2%
	No, didn't take appt	No, didn't take appt

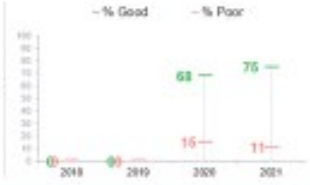
Source: NHSD – GP patient survey
http://gp-patient.co.uk/

Primary Care – GP Patient Survey (3)

Q20. Overall, how would you describe your experience of making an appointment?

CCG's results

CCG's results over time

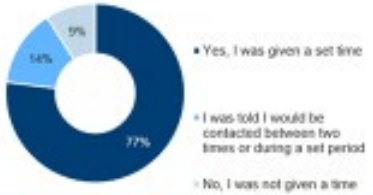


Comparison of results

	CCG	National
Good	75%	71%
Poor	11%	14%

Q23. Were you given a time for the appointment?

CCG's results

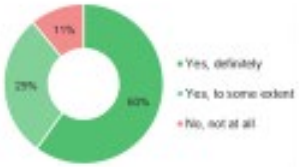


Comparison of results

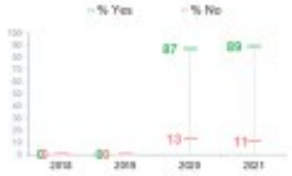
	CCG	National
Yes	91%	91%
No	9%	9%

Q26. During your last general practice appointment, did you feel that the healthcare professional recognised and/or understood any mental health needs that you might have had?

CCG's results



CCG's results over time

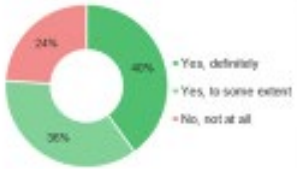


Comparison of results

	CCG	National
Yes	89%	86%
No	11%	14%

Q36. In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition (or conditions)?

CCG's results



CCG's results over time

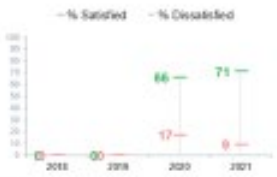
Comparison of results

	CCG	National
Yes	76%	74%
No	24%	26%

Q6. How satisfied are you with the general practice appointment times that are available to you?

CCG's results

CCG's results over time

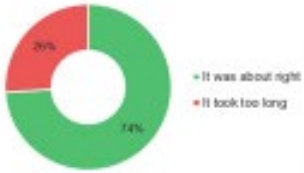


Comparison of results

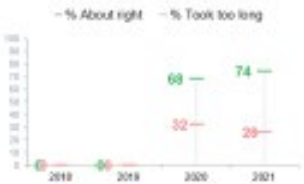
	CCG	National
Satisfied	71%	67%
Dissatisfied	9%	13%

Q42. How do you feel about how quickly you received care or advice on that occasion?

CCG's results



CCG's results over time



Comparison of results

	CCG	National
About right	74%	70%
Took too long	26%	30%

Source: NHSD – GP patient survey
http://gp-patient.co.uk/

Locations And Services

NHS
Norfolk and Waveney
Clinical Commissioning Group

Presentation last modified: 11/11/2021

GYW Locality	North Locality	Norwich Locality	South Locality	West Locality
Shrublands	Rackheath	Aslake Close	Attleborough	Kings Lynn (South)
New build replacement on Magdalen Way, Gorleston	New build: Preferred site identified on Broad Lane	Extension to existing East Norwich Medical Practice premises	New build replacement on Station Road.	New build: Preferred site identified on Nar Ouse Way.
Indicative size 2,932m² Approx. 800m² increase in primary care estate capacity	Indicative size 1,586m² Approx. 1,000m² increase in primary care estate capacity	Indicative size 145m² (plus refurb)	Indicative size 2,432m² Approx. 900m² increase in primary care estate capacity	Indicative size 1,574m² Approx. 700m² increase in primary care estate capacity
Providers: The Beaches Medical Centre Millwood Surgery ECCH Community Services JPUH – to be confirmed	Providers: Hoveton and Wroxham Surgery NCH&C NNUH (maternity/neonatal)	Providers: East Norwich Medical Practice Others tbc	Providers: Attleborough Surgeries NCH&C NNUH (maternity/neonatal)	Providers: Primary care provider tbc QEH (maternity/neonatal and diabetes)

- Designs for each scheme are included within the scheme appendices to the main Programme Business Case (PBC).
- The hub designs will have to demonstrate compliance with the latest standards and guidance for healthcare buildings, including functional design issues around accessibility and wayfinding. As modern, purpose built health buildings they should also demonstrate efficiency and innovation.
- The initial designs include access considerations for people with Learning Disabilities. These requirements will be reviewed as each design is taken forward. Equality Impact Assessments (EIAs) have been drafted for each of the five hubs and reviewed by clinical colleagues. The actions identified will help to shape the hubs and will act as a point of reference throughout the design and development. However, the issues and actions identified via the EIAs are not static but will be reviewed and expanded as needed.
- Choice of sites is partly driven by the original bid, but also by known existing and upcoming capacity constraints due to housing demand/population growth and areas of deprivation. The following slide explores this further.

Norfolk and Waveney LMC Report for HOSC on Access to Primary Care

General Practice is and remains the gateway to many health and social care services and like A+E waiting times is seen as a barometer of pressures building up within the system.

Access is not so much the problem but it is the capacity to deal with the problems presented. The pandemic coincided with the beginning of the introduction of online consultation methods in practices in Norfolk. This enables patients to contact practices via an online portal in addition to the telephone access. It enables practice staff to direct patients to the most appropriate clinician and administrative staff to deal with their queries. However this has opened up a Pandora's box of demand which many practices have found challenging in responding to with their current resources.

While it is true that face-to-face primary care appointments are not back to pre-pandemic levels – in October 2021, 64% of English general practice appointments were face-to-face, compared with 80% in January 2020. GPs are demonstrably working harder than ever. The number of appointments provided by English general practice increased from 27.2m in January 2020 to 30.2m in October 2021. General practice appointment bookings reached record highs over the winter of 2021 with GPs seeing more patients than ever. In Norfolk we have higher than average face to face appointments being delivered.

This is despite the fact that England has lost 1,307 GPs since 2015, nearly 5% of the former total number. For those still working in the general practice, the slow but steady haemorrhaging of GPs means that current pressures become even more acute. As the number of GPs goes down and patient numbers go up, each remaining GP takes on significantly more responsibility for more and more patients, this is unsafe - the average number of patients each GP is responsible for has gone up by around 300 – or 15% - since 2015.We are also seeing a noticeable shift from GPs wanting partner roles to salaried roles where doctors can control the hours and workload, however this puts increasing stress on remaining partners carrying unlimited workload pressures and financial liabilities.

Shift of work from hospitals to general practice has increased since the start of pandemic, coupled with the added workload of dealing with patients remaining on longer waiting lists. The Covid Recovery plan anticipates that hospitals will stop inviting many patients for at least some of the checks and follow-up appointments that have been standard for years, in an attempt to free up doctors and nurses. There will be increasing reliance on Advice and Guidance dialogue between GPs and Hospital colleagues and also giving patients the right to have their operation at a hospital many miles from their home, if it has spare capacity. The NHS will also be expected to help patients overcome the challenges involved, such as transport. This will see a seismic shift of more work into General Practice without sufficient resource to support an already beleaguered workforce.

Primary Care Networks (PCNs) which are groupings of practices via an additional voluntary contract to the 'core' GP contract, are employing additional clinical staff such as physios, social prescribers, pharmacists, physician associates and nursing associates to augment current staff, but this is taking time to train, develop and assimilate within general practice

Recruitment and retention of staff is a major issue, and although there are reportedly more doctors undertaking GP specialist training many don't stay in the area and prefer to take up portfolio careers mixing general practice work with other medical roles, or choose to work part-time. The future problem is that there are greater numbers of GPs retiring earlier than the full time equivalent numbers are replacing them. This is even more acute in respect to GP partners compared to salaried GPs.

Staff sickness rates have posed huge logistical challenges in General Practice and the wider NHS. Total triage methods were brought in earlier in the pandemic to protect patients from cross-infection but also to protect staff and keep practices functioning even if they had small outbreaks. Total Triage has helped General Practice to assess more patients and enabled clinicians to work remotely from home whilst isolating or recovering, when appropriate. Despite this, it is disheartening when politicians and the media focus on, and are pre-occupied, with face to face rates rather than the numbers accessing general practice and having their problems dealt with by the most appropriate appointment type.

Morale has been particularly hit by ill-founded comments by certain parts of NHS England, politicians at all levels and sections of the media suggesting that GPs have shied away from work just because they have followed Government orders to triage first all those patients contacting general practice, before a face to face appointment is offered. Increased levels of unacceptable abuse both verbal and sometimes physical, fuelled by ill-judged comments on social media has also been seen in General Practice. Reception staff are often at the forefront of this behaviour and vexatious complaints do nothing but reduce the morale of staff working in a service which is being stretched in all directions.

General practice have been at the forefront of both the Covid and Influenza vaccination programmes in addition to maintaining core services. Norfolk can be rightly proud that the system has worked well to deliver some of the highest Covid vaccination rates in the country. This has proved a huge logistical exercise and taken many frontline health professionals away from normal roles, however many have sacrificed spare time and weekends to support this programme.

As a result of the Covid pandemic a huge backlog in non-Covid care has built up. Nationally between April 2020 and November 2021, there were 4.2m fewer elective procedures, and 29.1m fewer outpatient attendances. In October 2021, 312,665 patients had been waiting more than a year for treatment; in October 2019, this figure was 1,321. This has implications for GPs as well as hospitals. Many patients who have been on long waiting lists need frequent reassessment, require letters expediating appointments were necessary but also require ongoing symptom support whilst waiting not least psychologically. We have seen huge increases in mental health presentations most noticeably in children and young people with local mental health services unable to cope with these numbers.

Increasing housing is also placing even greater challenges on General Practice access and capacity going forwards. We are seeing huge housing developments spring up all over the county which are not being matched by sufficient expansions of practice premises or staff to manage this potential population increase.

In summary the patients of Norfolk can be rightly proud of their general practices who have risen to the challenges posed by the pandemic. They have been swift to innovate, coped with an ever changing medical/social care availabilities and vast numbers of policy changes, delivered on the largest vaccination programme in the NHS's history and still provided core services.

The recently announced Covid Recovery Plan to deal with waiting lists has exposed the huge workforce deficit both in hospitals and general practice.

What can HOSC do?

- Understand the workplace pressures in general practice
- Understand longstanding workforce issues are not likely to improve in the near future, so it is essential to support the NHS staff currently in post
- Be circumspect in comments made that may negatively impact on the working lives of NHS staff

- To support General Practice in Norfolk otherwise we may be faced with a situation similar to NHS Dentistry where patients cannot access NHS dentists in large areas of the county.
- Ensure when new housing plans are agreed that there is a more robust infrastructure in the locality to support essential services

Yours sincerely

Dr Tim Morton
Co-Chair

Access to NHS Dentistry in Norfolk & Waveney

Suggested approach from Maureen Orr
Democratic Support and Scrutiny Manager

A report on progress regarding access to NHS dentistry across Norfolk & Waveney since September 2020.

1. Purpose of today's meeting

1.1 NHOSC added this subject to its forward work programme in July 2021 because of ongoing concerns about access to NHS dentistry since the committee's last examined the subject in September 2020.

For today's meeting the commissioners, NHS England and NHS Improvement East of England (NHSE&I), were asked to provide information on:-

- Oral health needs assessment
- Current capacity of local NHS dental services
- Recent changes to capacity and services
- Workforce
- Help for members of the public to find an NHS dentist
- And any other matters they wished to bring to the committee's attention

The NHSE&I commissioners provided the report at **Appendix A** and will attend the meeting along with a representative from the Local Dental Network, East of England, to answer the committee's questions.

The Local Dental Network (LDN) is chaired by a dentist and includes local clinicians, managers from the NHSE&I local team, patient representatives, secondary care clinicians, local dental committee representatives and educational supervisors.

1.2 NHSE&I's report is supplemented at **Appendix B** by data from an access review carried out by an NHSE&I Consultant in Dental Public Health. The information covers:-

- Rates of access in Norfolk and Waveney
- Location of General Dental Services practices mapped against areas of deprivation
- Dental health of 5-year-olds

Norfolk County Council Public Health colleagues sourced further information, which is attached at **Appendix C.** This provided additional data on:-

- Norfolk's ranking for access to NHS dental services
- Reduction in number of dentists with NHS activity
- Trend in the percentage of children seen by a dentist
- Trend in A&E attendances for dental related conditions.

1.3 **Healthwatch Norfolk** (HWN) has provided the paper at **Appendix D** to update the committee with its information on local people's experience of accessing dentistry and to spotlight progress of the new NHS dental practice at Marham in the wider context of pressures on NHS dentistry.

At the time of the last report to NHOSC in September 2020 this dental practice was the only one that HWN could find in Norfolk that was taking on new NHS patients.

A representative of HWN will attend the meeting to answer any questions on the information provided and to give the results of their latest telephone survey of dental practices in Norfolk to determine:-

- Which dental practices are taking on new patients
- When can dental practices offer an appointment for urgent treatment.

1.4 **Norfolk Local Dental Committee** (LDC) has provided a paper for information at **Appendix E**.

The Local Dental Committee is an independent body which represents dental practitioners and has a statutory right to be consulted by NHS England on issues relating to the dental profession.

1.5 Other information that could help to complete an understanding of the gap between the level of NHS dental service available in Norfolk and

Waveney, the level that is needed and the extent of unmet need is not comprehensively collected or collated, e.g.:-

- The numbers of people accessing private dentistry.
- The numbers of people accessing private dentistry because of lack of an available NHS dentist rather than as a positive choice.
- Average waiting time between asking for a routine appointment and getting to see an NHS dentist.
- Clinical staff vacancy rates (dentists and others) in practices providing NHS dentistry.

1.6 Members should note that it is the general and specialist dental services commissioned by NHSE&I that are the subject of today's meeting, not the preventative services commissioned by Norfolk County Council Public Health, i.e. the Norfolk Healthy Child Programme and oral health promotion services in Children's Centres and schools.

2. Background information

2.1 Previous reports to NHOSC

NHOSC last received a report from the dentistry commissioners on 3 September 2020. Links to the agenda papers and minutes of that meeting and earlier reports to NHOSC are available at 5.1 below.

On that occasion the committee also received a paper from Family Voice on the difficulties that the families of children and young people with special educational needs and/or disability (SEND) experienced when accessing NHS dental services.

In Sept 2020 NHOSC expressed frustration at the lack of dentists to treat NHS patients in Norfolk and Waveney and pointed out that the issue, although made worse by the pandemic, pre-dated Covid 19 by a long way. The committee acknowledged the regional commissioners' and local dentists' ongoing efforts to improve the situation but felt that progress was too slow and hindered by issues that needed to be resolved at national level.

The committee agreed to write to the Department of Health and Social Care (DHSC) about the national issues, particularly the dental contract and workforce shortage. NHOSC's letter of 29 September 2020 and the DHSC's response of 21 March 2021 are attached at **Appendix F**.

2.2 Additional local democratic scrutiny and other action

2.2.1 East Suffolk Council Scrutiny Committee carried out a review of access to dentistry in its local area, which includes Waveney, on 21 October 2021. Minutes of the meeting are available on the East Suffolk Council

website via the following link:- East Suffolk Council Scrutiny Committee 21 Oct 2021

Much of the discussion focused on the shortcomings of the current national dental services contract and the workforce shortage. The Committee resolved to report its findings to Suffolk Health Scrutiny Committee and:-

- That a letter be sent to the Minister emphasising the importance of creating a new national contract as soon as possible.
- That a letter be sent to the Universities of East Anglia and Suffolk regarding the creation of a dental school in the region which could be attached to the universities.
- That the Cabinet Member and Head of Communities discuss potential interventions the Council could make, possibly through the Community Partnerships, including an early years programme to improve oral health and contacting practices regarding better communication.

Suffolk Health Scrutiny Committee received East Suffolk's information on 26 January 2022 along with a paper from Healthwatch Suffolk summarising enquiries it had received from people struggling to access NHS dentistry in Suffolk. The papers are available on Suffolk County Council's website via the following link: - Suffolk Health Scrutiny Committee 26 January 2022 (agenda item 5).

2.2.2 Local MPs from across political parties have raised concerns about access to NHS dentistry in Parliament. On 10 February 2022 there was a debate in Westminster Hall in which numerous MPs, including four from Norfolk and Waveney, brought concerns to the attention of Maria Caulfield MP Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care).

2.2.3 The Chair of Healthwatch England Sir Robert Francis QC and the Chair of the British Dental Association Eddie Crouch sent an open letter to the Chancellor of the Exchequer on 21 October 2021 calling for a recovery plan for NHS dentistry. The letter is available on Healthwatch England's website via the following link:- Healthwatch England website

2.2.4 In November 2021 there was national media coverage for the 'Toothless in England' group which started as 'Toothless in Suffolk' group during the pandemic. The group has organised petitions, marches and local meetings on the issue of access to NHS dentistry.

3. Suggested approach

3.1 Members may wish to examine the following areas with the commissioners and the Local Dental Network:-

The information on which the commissioner bases its decisions

(a) Does NHSE&I have sufficient information on levels of unmet needs, and needs served by private practice due to lack of an NHS alternative, on which to base its commissioning of a universal NHS dental service?

(b) Commissioning of dental services is due to transfer from NHSE&I to local Integrated Care Systems in April 2023. Will the information needed for commissioning and the funding situation improve before the handover happens?

(c) NHSE&I was unable to procure 3 of the 7 new practices for Norfolk and Suffolk in 2022. What can be changed to attract more bidders?
(Note that the LDC, Appendix E, is concerned that the limited length of the contracts and the requirement to provide services from 8am – 8pm 365 days per year could be off-putting).

Communication with the public

(d) What is NHSE&I doing to communicate the situation regarding access to routine and preventative NHS dentistry to the public?

Current and future capacity

(e) On 25 January 2022 the government announced additional funding for dentistry to increase the number of available appointments. The East of England's share was £5.7million and the funding was to be used by the end of March. Do the commissioners expect to use all of the additional funds in the time available?

(f) To what extent does NHSE&I expect the four new dental services being commissioned in Norfolk and Waveney from 1 July 2022 to bridge the gap between capacity and demand?

(g) Is NHSE&I confident that the contract holders will be able to staff the four new practices opening in July 2022 from 8am – 8pm, 365 days a year?

(h) When does NHSE&I expect a new NHS dental contract to be in place that will help to attract and retain dentists to work in the NHS?

Special care dentistry and specialist treatments

(i) The LDC's paper (Appendix E) mentions lack of options for dentists to refer patients requiring complex restorative work, endodontics (root fillings), crown and bridge and periodontal (gum) treatments. NHOSC was aware in 2014 that a specialist referral service used to be available at the Norfolk and Norwich hospital but that there was difficulty in recruiting to it. Is it still the commissioners' intention that there should be a specialist referral service available in Norfolk and Waveney?

4. Action

4.1 The committee may wish to consider whether to:-

(a) Make comments or recommendations as a result of today's discussion.
(b) Ask for an update at a future committee meeting in advance of the transfer of commissioning responsibility from NHSE&I to the local Integrated Care Board.

5. Background documents

5.1 Reports to Norfolk Health Overview and Scrutiny Committee and minutes of meetings
NHOSC 3 Sept 2020 (agenda item 7)
NHOSC 19 March 2020 (agenda item 8) This meeting did not go ahead due to the pandemic but the papers were published in advance of the decision to 'lock down'.
NHOSC 11 April 2019 (agenda item 6)
NHOSC 24 May 2018 (agenda item 8)

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NHS England and NHS Improvement Report for General Dental Services (Norfolk and Waveney)

Norfolk Health Overview and Scrutiny Committee

February 2022

Progress report regarding access to dentistry across Norfolk and Waveney

1. Oral Health Needs Assessment

An integral part of the commissioning cycle is to undertake an assessment of need. This is ordinarily undertaken when a new tender exercise is to be embarked upon, to understand current delivery against need and where there are gaps in provision. This is then used to develop new services or re-design current services to ensure that they are meeting the needs of population that require these services.

The most recent and relevant assessment of need that has been undertaken is in relation to the oral health needs of patients in Norfolk and Suffolk. This assessment of need was embarked upon prior to undertaking the procurement process to commission the 8-8 services in Norfolk which are due to commence in July 2022.

The outcome of the need's assessment is detailed in the extracts 1 and 2 below:

8-8 East Anglia Procurement Extract 1:

"Part 3 Information about the Norfolk and Suffolk areas of East Anglia

3.1 Sociodemographic information about East Anglia

The following sociodemographic information about the Norfolk and Suffolk areas of East Anglia has implications for the provision of health services including unscheduled dental care services.

3.1.1 Norfolk's sociodemographic information

Norfolk is a predominantly rural area with a population of 917,736 residents (ONS, 2020). More people are living in King's Lynn and West Norfolk and fewer people are living in Great Yarmouth and North Norfolk. Since 2014 the population grew by 3.5%. Population trends anticipate numbers to grow to a population of over a million by 2036 (Norfolk's Story, 2021), with Breckland and Broadland projected to be the fastest growing districts in the county.

Norfolk has a child population (aged 0-17) of 173,356 residents. The adult population (aged 18-64) comprises of 518,254 residents (ONS, 2020). With respect to older people (aged 65 and above), Norfolk has an ageing population with 226,125 older residents (ONS, 2020; Norfolk's Story, 2021). It is expected that around 27% of the

population will be aged 65 and over by 2028. The 85+ population of Norfolk is projected to grow significantly with a 24% increase by 2028 (Norfolk's Story, 2021). Norfolk has a very low proportion of people from ethnic minorities (4%) compared to England. It has the fourth highest score of the Index of Multiple Deprivation 2019 amongst local authorities in East of England.

3.1.2 Suffolk's sociodemographic information

Suffolk is a predominantly rural area with a population of 765,899 residents (ONS, 2020). It has a child population (aged 0-17) of 154,403 residents. The adult population (aged 18-64) comprises of 429,074 residents (ONS, 2020). With respect to older people (aged 65 and above), Suffolk hosts 182,422 older residents (ONS, 2020). Compared to England, Suffolk has a higher proportion of people aged 65 and over and a lower proportion of working age people. Population growth since 2011 has been exclusively in older age groups and this is expected to continue, with the number of people aged 65 and over increasing while the proportion aged under 65 falls (The State of Suffolk Report, 2019). The number of people aged under 18 is projected to decrease slightly over the next twenty years (The State of Suffolk Report, 2019). Suffolk has a very low proportion of people from ethnic minorities (5%) compared to England. It has the seventh highest score of the Index of Multiple Deprivation 2019 amongst local authorities in East of England.

3.2 Normative and felt oral health needs in East Anglia

In terms of normative and felt urgent dental needs, Peterborough and Norfolk are amongst the areas that have the highest estimates of urgent dental conditions in East of England. Data suggests that 24.1% and 23.1% of the population in Peterborough and Norfolk are estimated to have one or more urgent dental conditions respectively (Table 1). The latter include having dental pain and/or having one or more PUFA/pufa (pulp, ulceration, fistula and/or abscess) symptoms. With respect to Cambridgeshire and Suffolk, data suggests that 13.4% and 12.2% of the population in these two areas are estimated to have one or more urgent dental conditions respectively (Table 1).

Table 1. Estimated prevalence of urgent dental conditions in East of England by upper tier local authorities.

Local Authority	Total population	One or more urgent dental conditions	
		%	Number
Bedford	174,720	24.4	42,632
Central Bedforshire	290,053	12.1	35,096
Luton	213,099	26.7	56,897
Milton Keynes	271,238	13.3	36,075
Cambridgeshire	657,833	13.4	88,150
Peterborough	205,764	24.1	49,589
Norfolk	917,736	23.1	211,997
Suffolk	765,899	12.2	93,440
Essex	1,498,181	12.5	187,273
Southend-on-sea	184,882	23.3	43,078
Thurrock	176,624	23.7	41,860
Hertfordshire	1,192,465	11.7	139,518

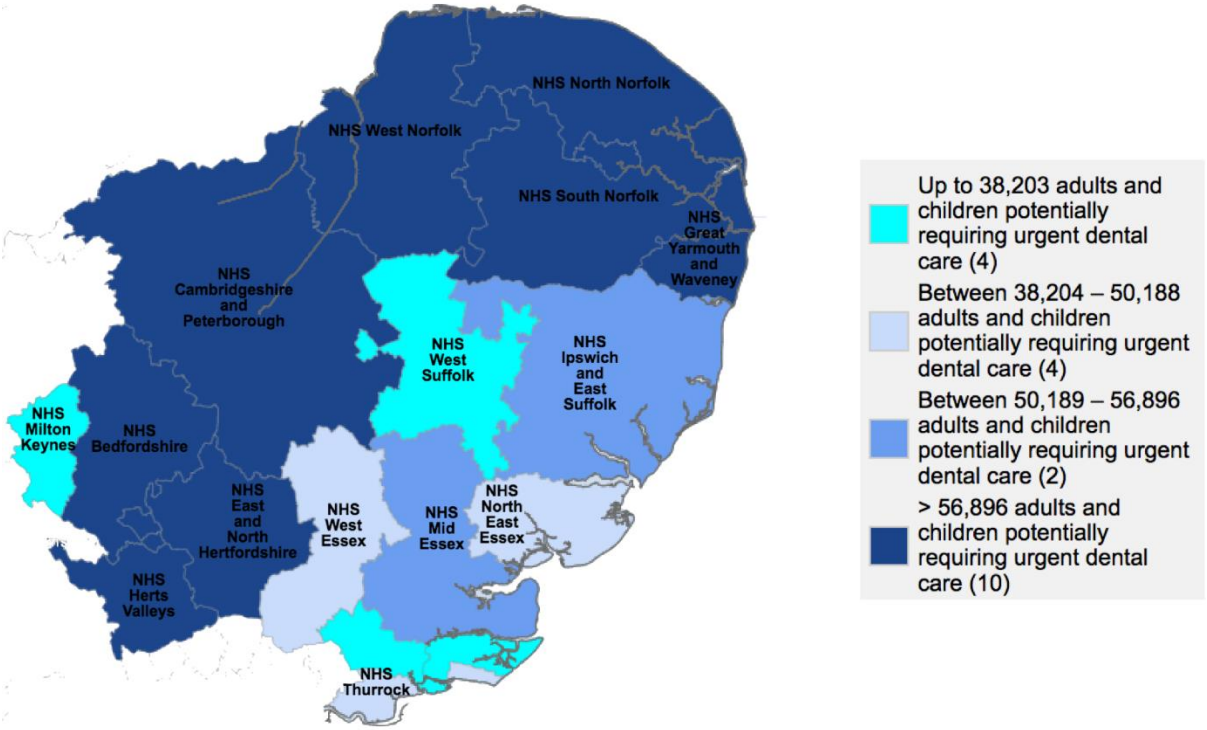
Source: Urgent Dental Needs Assessment across the East of England region (2021, unpublished); data analyses undertaken using data from ADHS, 2009; CDHS 2013; Census 2011; NOS 2020 population estimates and Joury et al., 2018.

At a CCG level, data suggests that the number of people with one or more urgent dental conditions is 227,508 in Norfolk & Waveney CCG; 137,739 in Cambridgeshire and Peterborough CCG; 50,458 in Ipswich & East Suffolk CCG; and 27,565 in West Suffolk CCG (Figure 1).

The abovementioned normative and felt urgent dental needs' estimates were produced by the East of England Urgent Dental Needs Assessment through analysing data from the Adult Dental Health Survey (2009), Child Dental Health Survey (2013), Census (2011), National Office for Statistics (2020) population estimates and Joury *et al.* (2018) paper. These calculated estimates might be slightly higher than the actual estimates given the improvement seen in child's oral health in East of England over the past decade.

Children's oral health has deteriorated in Peterborough in the past few years, with decay levels increasing amongst 5-year-olds from 30% in 2015 to 32.4% in 2017 and 37.7% in 2019. These decay levels are significantly higher than the East of England average (19%) and England average (23.4%) (Dental Health Profile: Peterborough local authority, 2020).

Figure 1. Needs map showing number of adults & children potentially requiring urgent dental care in East of England by population quartiles.



Source: Urgent Dental Needs Assessment across the East of England region (2021, unpublished); data analyses undertaken using data from ADHS, 2009; CDHS 2013; Census 2011; NOS 2020 population estimates and Joury et al., 2018.

Similarly, decay levels amongst 5-year-olds have increased in Norfolk from 15.4% in 2017 to 17.3% in 2019, and in Cambridgeshire from 12.9% in 2017 to 16.7% in 2019. These decay levels are lower than the East of England average (19%) and England average (23.4%) (Dental Health Profile: Norfolk local authority, 2020; Dental Health Profile: Cambridgeshire local authority, 2020). However, within Norfolk and Cambridgeshire there are inequalities in oral health, with certain lower tier localities having higher levels of tooth decays than the East of England average (19%) and/or England average (23.4%). In Norfolk, at lower-tier local authority level, children living in Great Yarmouth have the highest levels of experience of dental decay (38.3%). Within Norfolk, the highest levels of experience of dental decay are clustered around the Norwich wards of Mancroft (38.9%) and Bowthorpe (34.6%). In Cambridgeshire, at lower-tier local authority level, children living in Fenland (25.8%) and Cambridge (22.2%) have the highest levels of experience of dental decay (Dental Health Profile: Cambridgeshire local authority, 2020).

On the contrary, in Suffolk decay levels amongst 5-year-olds have decreased from 20.8% in 2015 to 17% in 2017 and 15.7% in 2019. The current decay levels are lower than the East of England average (19%) and England average (23.4%) (Dental Health Profile: Suffolk local authority, 2020). However, within Suffolk there are inequalities in oral health with some areas having higher than average levels of experience of dental decay. At lower-tier local authority level, children living in West Suffolk (18.1%) and East Suffolk (19.2%) have the highest levels of experience of dental decay (Dental

Health Profile: Suffolk local authority, 2020). Within Suffolk, the highest levels of experience of dental decay are clustered around Mid-Suffolk middle super output area 007 (19.4%) and the Forest Heath (27.1%), Lowestoft (29%) and South Waveney (23.5%) Primary Care Networks (Dental Health Profile: Suffolk local authority, 2020).

Amongst 3-year-old children in East Anglia in 2020, 7.2% had tooth decay in Peterborough, which is higher than the East of England average (6.7%) (PHE, 2021). With respect to Norfolk, Suffolk and Cambridgeshire, 6.2%, 4.8%, and 1.7% of 3-year-olds had tooth decay respectively. These figures are lower than the East of England average (6.7%) (PHE, 2021).

With regard to adults, the most recent Adult Dental Health Survey (2009) reports nationally and regionally on levels of adult dental diseases. In East of England, 23% of adults had tooth decay, 32% had periodontal pocketing (4+ mm), 4% had tooth loss, and only 20% reported having excellent oral health.

3.3 Expressed oral health needs in the Norfolk and Suffolk areas of East Anglia

In the Norfolk and Suffolk areas of East Anglia the number of adult and child patients seen by an NHS dentist has been decreasing year on year.

In Suffolk, the number of adult patients seen by an NHS dentist in the last 24 months has been reducing year on year from 55% in 2018 to 52.5% in 2019 and 47.8% in 2020 (NHS digital, 2018/2019/2020). Similar trends are found with respect to the number of child patients seen by an NHS dentist in the last 12 months, decreasing from 59.9% in 2018 to 58.5% in 2019 and 30.6% in 2020.

In Norfolk, the number of adult patients seen by an NHS dentist in the last 24 months has also been reducing year on year from 54.9% in 2018 to 52.9% in 2019 and 47% in 2020 (NHS digital, 2018/2019/2020). Similar trends are found with respect to the number of child patients seen by an NHS dentist in the last 12 months, decreasing from 55.6% in 2018 to 54.2% in 2019 and 24.7% in 2020.

Compared to regional and national estimates, West Suffolk (86%); Ipswich & East Suffolk CCGs (89%); and Norfolk & Waveney CCGs (90%) have lower proportions of people who tried to get an NHS dental appointment in the last 2 years and were successful in getting their appointment (NHS statistics, 2020).

Appendix 1 shows the number of units of dental activity (UDA) by treatment band delivered in East Anglia's CCGs as well as other CCGs in East of England by December 2020 (excluding orthodontic treatment).

In terms of expressed urgent dental needs, between September 2019 and August 2020, there were 23,111 from Norfolk and Waveney ICS/STP and 13,962 from West Suffolk & North East Essex ICS/STP (Table 3).

Table 3 Number of NHS 111 urgent dental calls in East of England by ICSs/STPs.

ICSs/STPs	Number of NHS 111 dental calls					
	Sep 2019-Feb 2020	Mar 2020-Aug 2020	Total	Dental nurse	Health advisor	Other clinical advisor
Bedfordshire, Luton & Milton Keynes[1]	7,547	11,298	18,845	6,840	6,414	2,417
Cambridgeshire & Peterborough[2]	10,367	16,324	26,691	11,673	11,627	3,391
Norfolk & Waveney[3]	9,607	13,504	23,111	None^	-^^	-^^
West Suffolk & North East Essex[4]	10,010	13,962	23,972	5,391^	12,445	3,969
Mid & South Essex[5]	5,725	11,018	16,743	None^	-^^	-^^
Hertfordshire & West Essex[6]	11,989	19,878	31,867	12,549^	15,111	4,207
Total	55,245	85,984	141,229	36,453	45,597	13,984

[1] Served by Herts Urgent Care and DHU Health Care
[2] Served by Herts Urgent Care
[3] Served by IC24
[4] Served by Care UK and IC24
[5] Served by IC24
[6] Served by Herts Urgent Care and IC24
^ IC24 do not have dental nurse triage
^^ Data was not obtained from the provider

Source: Urgent Dental Needs Assessment across the East of England region (2021, unpublished); data from NHS 111.

3.4 Oral health inequalities in East Anglia

Besides the abovementioned inequalities in oral health between and within counties in East Anglia, evidence suggests that in East of England children from deprived backgrounds and those from particular ethnic groups, such as Asian, Mixed or other ethnic backgrounds, have higher levels of tooth decay (PHE, 2020). Further evidence from decennial and annual oral health surveys, cancer registers and from NHS service activity showed that there are marked socioeconomic inequalities in oral health in England across all stages of the life course and over different clinical indicators such as dental decay and related quality of life measures (PHE, 2021). The relative inequalities in the prevalence of dental caries in 5-year-old children in England increased from 2008 to 2019 (PHE, 2021). There are also inequalities in the availability and utilisation of dental services across ages, sex and different social groups (PHE, 2021). Vulnerable groups including homeless people, prisoners, people with different types of disabilities (including mental illness), travellers, looked after children, refugees and immigrants have considerably poorer oral health and face substantial difficulties accessing dental care (PHE, 2021).

3.5 Existing Providers in East Anglia

There are 265 NHS contract holders in Norfolk & Waveney and Suffolk & North East Essex ICSs/STPs providing mandatory and/or orthodontic services either via a

General Dental Service (GDS) or Personal Dental Service (PDS) contract and 13 Oral Surgery providers in a primary care setting and 2 Community Dental Service (CDS) providing special care dentistry and an out of hour's urgent care dental service.

NHS England also commissions primary care services from 200 medical practices and 359 pharmacies:

	Dental NHS Contract holders	Pharmacies	GP Practices
Norfolk & Waveney	116	184	105
Suffolk & North East Essex	149	175	95

8-8 East Anglia Procurement Extract 2:

Appendix 1: Dental activity measured by Units of Dental Activity (UDA) within each treatment band in East of England, by December 2020.

NHS CCGs	Units of Dental Activity (UDA)				
	Band 1	Band 2	Band 3	Urgent / occasional	Total
Bedfordshire	9,435	11,757	7,896	10,532	39,620
Luton	1,370	3,657	2,928	5,852	13,807
Milton Keynes	4,652	8,451	4,992	5,300	23,395
Cambridgeshire & Peterborough	21,415	22,989	13,056	16,580	74,040
Norfolk & Waveney	14,424	19,905	15,768	26,568	76,665
West Suffolk	7,109	7,494	5,472	5,303	25,378
North East Essex	6,450	10,830	7,452	7,754	32,486
Ipswich & East Suffolk	11,035	12,843	7,116	6,712	37,706
Basildon & Brentwood	6,357	11,079	7,404	6,642	31,482
Castle Point and Rochford	2,232	5,787	3,924	4,154	16,097
Mid Essex	10,456	14,175	9,816	11,009	45,456
Southend-on-sea	2,764	5,826	4,512	5,131	18,233
Thurrock	2,187	5,154	4,128	3,691	15,160
Herts Valleys	16,310	21,852	11,208	13,476	62,846
East & North Hertfordshire	16,471	20,478	11,160	15,793	63,902
West Essex	6,481	6,381	3,636	5,436	21,934
East of England	139,148	188,658	120,468	149,935	598,209
England	960,847	1,593,315	1,114,896	1,415,298	5,084,356

Source: NHS Digital, 2020.

Patients accessing Accident and Emergency for dental care

In response to the pandemic additional work was undertaken by NHS England and NHS Improvement – East of England to ensure that a robust pathway was in place to support patients to access urgent dental care provision through 111:

- For patients that arrive at A+E, for those who have already contacted NHS 111 and been sent to A+E by NHS 111, the Nurse Triage at A+E will take place as normal.

- For patients that arrive at A+E and have not yet been in contact with NHS 111, the Nurse Triage will undertake a few basic checks and if the condition is not life threatening, the patient will be advised to contact NHS 111 for referral to an appropriate service.

The number of patients that accessed and continue to access care through this route will be included in the figures displayed in table 3 above.

This work has continued to be taken forward, beyond the initial response to the pandemic, as it is considered invaluable, to ensure that the pathways are continually reviewed and strengthened.

2. Dentists per 100,000 population data

This date is published on a yearly basis. The current available data is from the financial year 2020 / 21 in comparison to 2019 / 20:

Population per dentist and the number of dentists providing NHS dentistry
Table 1. Number of dentists with NHS activity, for years ending 31 March, England – NHS England region geography and CCG

				2020/21				2019/20		
	Dentists difference 2019/20 to 2020/21	Percentage difference 2019/20 to 2020/21	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]		Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]	
East of England	**-174**	***-5.6***	**2,955**	**2,209**	**45**		**3,129**	**2,087**	**48**	
NHS Norfolk & Waveney CCG	**-29**	***-6.9***	391	2,625	38		420	2,443	41	

Source: NHS Dental Statistics for England - 2020-21 Annual Report

There are fewer dentists per 100,000 of population in the Norfolk and Waveney CCG than East of England.

Please note that the information published within the report has been provided by CCG area only, therefore it has not been possible to compare this to the data published previous reports.

3. Recovery and restoration of NHS Dental Services

COVID-19 restrictions continue with dentists having been asked to prioritise patients with an urgent need of dental care, for example those patients who are in pain. Initially, at the start of the pandemic all routine dental worked stopped and although this has restarted the number of patients that can be seen by dentists has significantly reduced.

This is due to the increased infection prevention measures needed, such as social distancing and the need to ventilate the rooms between patients. Those procedures which involve drilling and scaling create an increased risk of spreading Covid by generating aerosols (a water vapour) so procedures such as fillings, root fillings, crowns, scaling present particular difficulties for dental practices to operate safely.

This combined with a lack of dentists has led to increased waiting lists to access NHS dentists, which combined with the particular difficulties Covid presents to dental practices has resulted in reduced access for non-urgent NHS dental services.

Primary care dental services continue to restore from the pandemic the minimum threshold of delivery has increased in increments, being 85% from January 2022 allowing more routine patients to be seen.

Additionally, you will be aware that extra funding has been made available to NHS England and NHS Improvement to help increase the number of appointments made available in February and March 2022. We are currently working with providers across the region to increase evening and weekend appointments during this period.

3.1 Urgent Dental Care Centres in Norfolk and Waveney

Across East of England, all Dental Practices providing NHS services are open for face-to-face appointments. Within Norfolk and Waveney there are 10 Urgent Dental Care practice, providing in-hours care, which continues to be utilised to meet the urgent needs of patients.

NHS England and NHS Improvement have provided additional funding to every region, to offer to all Dental Practices holding an NHS contract across the region, the option to deliver additional urgent dental care and stabilisation sessions (outside of contracted hours) between 1 February - 31 March 2022.

To date, 18 practices in Norfolk and Waveney area have expressed an interest in delivering this additional activity.

All practices that undertake this activity, will be added to the Directory of Services to support patients that contact NHS 111 in urgent dental need, to be appropriately sign-posted to one of these practices to access dental care.

The offer to deliver additional sessions has been left open to allow further dental practices to apply for this funding.

3.2 Current capacity, clinical staff rates, waiting times and accepting new patients; general dental services in Norfolk and Waveney

Dental practices are independent providers who hold a contract to provide NHS dental services. Dental providers manage their own practice including capacity and determine whether they are able to accept additional/new patients and therefore their lists can open and close on a frequent basis. This is not information that NHS England and NHS Improvement holds for each contract.

3.3 Updating NHS UK profiles

As detailed in the *Key steps in 2022 to deliver for patients in NHS dentistry letter from the Chief Dental Officer dated the 22 December 2021*, in addition to the pre-existing conditions of income protection, in Q4 *"Contractors are also required to update their dental profiles within NHS UK and work with their regional commissioner to ensure*

that the Directory of Services is up to date during Q4. This is needed to make it easier for people seeking care to find a dentist."

3.4 Access to Level 2 Minor Oral Surgery and Orthodontic Services

If a patient requires Level 2 Minor Oral Surgery, the Dentist that has clinically assessed this need will make a referral to a Level 2 Minor Oral Surgery service. This is a referral only service.

A patient is able to seek urgent orthodontic assistance from any orthodontic provider who holds a contract to provide NHS orthodontic care and treatment subject to their capacity to assist. In the first instance patients will contact the practice who undertaking their care and treatment as advised by the practice when commencing treatment.

3.5 Dental Transformational Strategy

NHS England and NHS Improvement – East of England has developed a Transformational Dental Strategy. The aim of which is to support a model that delivers universal access to urgent dental care and patient-focused preventative care to improve oral health and quality of life and reduced health inequalities across the life course and in all communities including our more vulnerable populations. This is underpinned by building a resilient and effective dental workforce better suited to meeting our patient needs, in line with Health Education England's, programme of Advancing Dental Care which develops a wider skill mix of dental professionals.

By aligning general dental services to Primary Care Networks (PCNs) this will build resilience and capacity and the treatment of co-morbidities (such as periodontal disease and diabetic health) as we emerge from the pandemic and align to the NHS Long Term Plan.

The eight dental strategy transformation workstreams shown below will be rolled out in phases:

1a. Urgent Care in normal contracted hours
1b. Prevention and stabilisation in normal contracted hours
2. Urgent care and stabilisation weekday outside of normal contracted hours
3. Prevention and Oral Care in Early Years
4. Oral Health in Care Homes
5. Advanced Restorative Care
6. Advanced Paediatric and Orthodontic Care
7. Diabetes Prevention in Primary Dental Care
8. Prevention and Treatment for Oral Cancer Patients

The programmes are being rolled out in phases. Programme 1a was rolled out

initially with Urgent Dental Care practices. A phased roll-out plan is currently being devised with the wider Dental Practices across the region.

3.6 Of all the general dental care available in Norfolk and Waveney, what percentage is private care and what percentage is NHS?

NHS England and NHS Improvement contracts with dental providers to deliver NHS Services, therefore we are not able to comment or provide information regarding private dental care and do not hold this information.

4. Commissioning additional NHS dental practices in Norfolk & Waveney.

NHS England and NHS Improvement – East of England, has completed a procurement process aimed at providing access to 8am-8pm dental services across Norfolk and Suffolk, 365 days a year, including all Bank Holidays.

Through an open procurement process, seven contracts (Lots) were advertised for potential providers to apply for. As a result, the following contracts have been awarded to the named providers below:

Lot 1, King's Lynn, Norfolk – Smile Care Norfolk Limited
Lot 2, King's Lynn, Norfolk – Smile Care Norfolk Limited
Lot 3, Norwich, Norfolk – Smile Care Norfolk Limited
Lot 6, Lowestoft, Suffolk – Apps Smiles Limited

These contracts will commence by 1 July 2022 which will significantly increase access to local dentist provision across a number of communities.

These '8-8' dental services will provide new services for adults and children, operating from 8am-8pm, 7 days a week for routine treatment, as well as urgent appointments. They will also provide dental care services to vulnerable people in their local area, including the homeless, asylum seekers and those that do not have access to financial support.

Unfortunately, it was not possible to offer contracts for Lots 4, 5 and 7 at this point covering Fakenham (Norfolk), Thetford (Norfolk) and Leiston (Suffolk), respectively.

NHS England and NHS Improvement – East of England certainly recognises the existing dentistry services challenges in these specific areas. We continue to work towards re-commissioning services in these geographical areas with the aim to have services available commencing - summer of 2022.

In the interim period, existing NHS contract holders have been invited to take on additional activity to potentially support communities affected in these areas.

For any urgent patients, or those in pain, the NHS 111 service will direct them to Urgent Dental Care providers. It is important to recognise that urgent dental care continues to be available for anyone who needs it - as it has been throughout the pandemic. There are 50 Urgent Dental Care hubs across the East of England, providing care for people with urgent and emergency dental needs.

The procurement process for these '8-8' dental services took into account a review held with clinicians, the general public and current patients, to approach a service model that delivers high quality, affordable dental care to meet the future needs of the population of Norfolk and Suffolk.

Commissioners are working with the providers of the awarded contracts to mobilise services by 1 July 2022 to ensure patients can access new services as soon as possible.

5. Primary Care Orthodontic service provision

The Dental Contract Team has approval through the NHS England and NHS Improvement governance process, to extend the current PDS contracts to ensure continuity of care for patients (children) already undergoing a course of treatment and to maintain access to services for new patients. this will also provide flexibility to undertake a phased procurement and avoid all contracts expiring on the same date.

6. Special Care Dental Services

The Special Care Dental Service is fully operational across Norfolk and Waveney at all 9 sites. COVID-19 restrictions continue with dentists having been asked to prioritise patients with an urgent need of dental care, for example those patients who are in pain, therefore the service is prioritising these patients in-line with National guidance.

7. Progress on the primary care pilots to improving oral health care for residents of care homes

The Pilot is a Dental Care Professional-led intervention linking primary care dental practices with geographically co-located care homes at place-based level. It utilises transformational commissioning models to deliver training to care homes, support the delivery of mouthcare assessments by the care home and facilitate access to appropriate care through a care pathway.

There is at least one provider in each ICS area, including one in Norfolk and Waveney, assigned to 3 – 5 care homes or the equivalent of 150 residents, providing support as outlined above.

8. Clinical Workforce

Recruitment and retention of dentists onto the Performers List remains a limiting factor in large parts of East Anglia, including Norfolk and Waveney. NHS England and NHS Improvement – East of England alongside the Local Dental Network are working closely with Health Education England to improve the retention of Foundation Dentists in this region.

The Dental Therapist Trainee programme is in its second year. There are currently 4 students working in 2 Norfolk and Waveney practices.

Dental Access for Norfolk & Waveney ICS

Feema Francis, Consultant in Dental Public Health

NHS England and NHS Improvement

Rates of access per 1000 pop by age breakdown in Norfolk & Waveney ICS 2021 extrapolated data

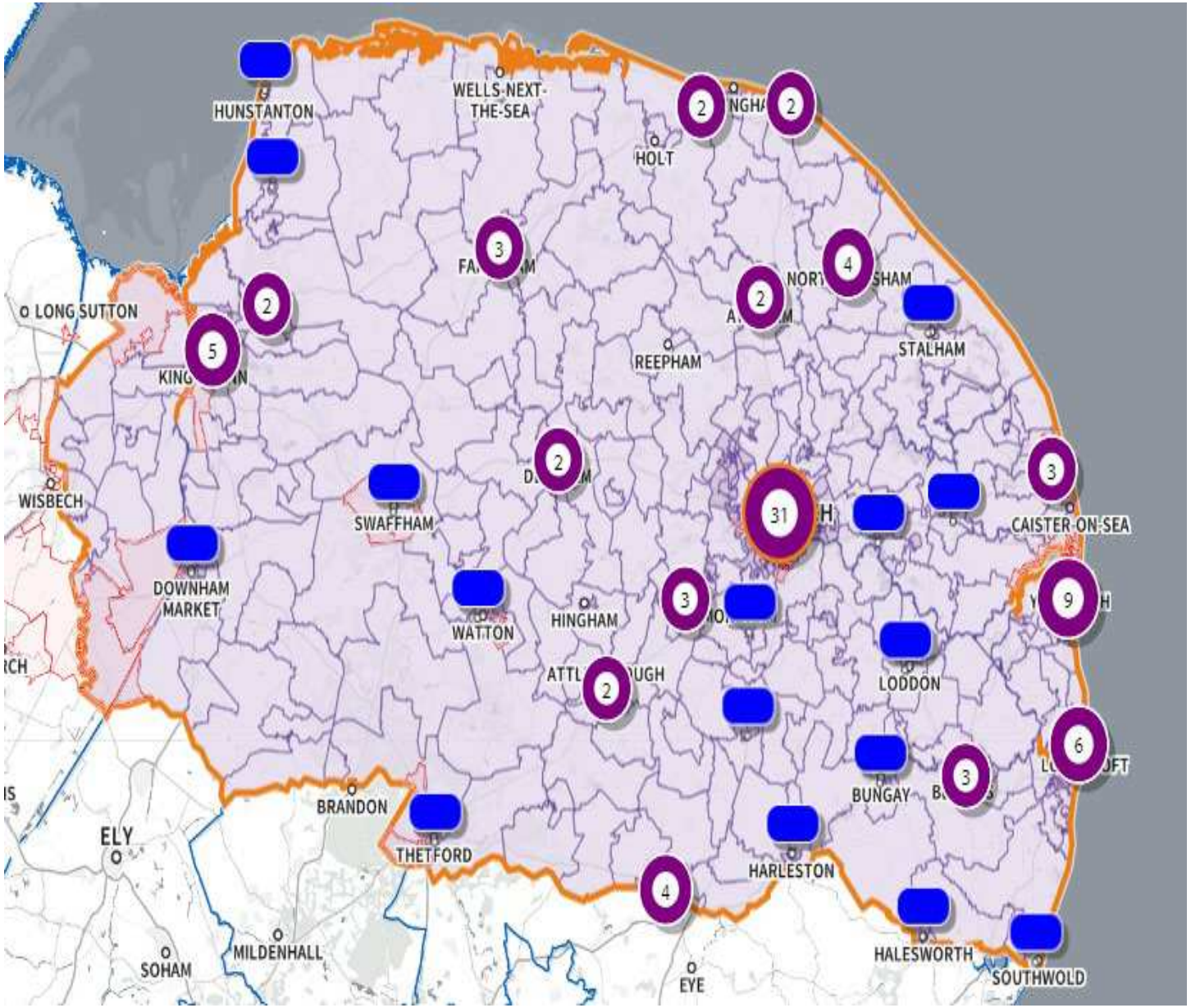
Access in Norfolk has reduced during COVID 19 (please ref slide 7), using extrapolated data for 2021 using (Dec 2020-Mar 2021) Breckland and Kings's Lynn and West Norfolk shows statistically significant reductions across all age groups from the EoE mean and all LAs in the EoE in 2021 (please ref slide 6)

Year 2021 (Dec 2020-Mar 2021 *extrapolated*)	**Age groups**									
	0-17 yrs	18-24 yrs	25-34 yrs	35-44 yrs	45-54 yrs	55-64 yrs	65-74 yrs	75+	All ages	Significance of all ages for each year
Breckland	241.20	159.39	168.39	204.89	233.58	264.89	279.33	194.80	225.55	0.0349
Broadland	350.54	235.00	232.71	281.24	313.68	328.36	333.35	240.03	299.29	0.4604
Great Yarmouth	301.84	234.18	265.69	294.36	298.28	317.40	306.29	217.41	284.76	0.3310
King's Lynn and West Norfolk	345.68	196.88	159.86	191.59	198.79	210.51	234.24	183.53	227.31	0.0382
North Norfolk	320.84	213.57	227.05	246.50	276.52	286.07	290.95	249.59	272.79	0.2373
Norwich	291.47	83.86	180.54	282.75	299.04	310.97	335.64	229.85	237.87	0.0634
South Norfolk	340.04	239.93	243.51	268.54	283.91	330.15	319.36	246.13	293.05	0.4034
EoE	-	-	-	-	-	-	-	-	303.57	-
England	-	-	-	-	-	-	-	-	300.94	-

Note: the map shows practices operating under General Dental Services contracts, which is the majority in Norfolk & Waveney. Practices operating under other NHS contracts are not shown.

Location of GDS practices in Norfolk and Waveney ICS in February 2021

ICS Name	No. LSOAs making up 20% most deprived LSOAs IMD	Key areas (lower tier local authorities)
Norfolk &Waveney	99	1 Beccles (Waveney) 17 Lowestoft (Waveney) 1 Caister-on sea (Great Yarmouth) 1 Hemsby (Great Yarmouth) 23 Great Yarmouth 3 Thetford (Breckland) 2 Watton (Breckland) 1 Swaffham (Breckland) 1 Dereham (Breckland) 1 Hunstanton (Kings Lynn) 11 Kings Lynn 2 Downham Market (Kings Lynn) 1 North Walsham (North Norfolk) 1 Tuckswood (Norwich) 1 Lakenham (Norwich) 17 Norwich 3 Heartsease (Norwich) 9 Earlham (Norwich)
Total N&W ICS	99/611	



The colours represent the quintiles:
- 6,509.01 to 106,716 pop/km²: 38 areas
- 4,332.01 to 6,509 pop/km²: 65 areas
- 2,571.61 to 4,332 pop/km²: 101 areas
- 744.01 to 2,571.6 pop/km²: 137 areas
- 2 to 744 pop/km²: 270 areas

Shape Atlas, PHE HCPH Sept 2021

Note: A map showing areas of deprivation is also included in Appendix C (Map of Indices of Multiple Deprivation 2019 for Norfolk & Waveney)

Dental health data across EoE

Area	PHE oral health survey of 5-year-old children 2019							PHE oral health survey of 3-year-old children 2020						
	%pop examined	d3mft Mean	0<d3mft Mean	Mean 0<d3t	% d3mft>0	%mt>0	% with incisor caries	% pop examined	d3mft Mean	0<d3mft Mean	0<d3t Mean	% d3mft>0	%mt>0	% with incisor caries
England	11	0.8	3.4	3.1	23.4	2.2	5.2	3	0.3	2.9	2.9	10.7	0.8	3.4
EoE	10	0.6	3.3	0.5	19.0	1.8	3.5	4	0.2	3	2.7	6.6	0.5	2.2
Bedford	10	1.0	4.2	3.5	24.7	4.4	7.3	5	0.3	*2.5	*2.5	12.2	0.0	4.1
Cambridgeshire	14	0.5	3.2	3.0	16.7	2.0	3.9	4	0.1	*3.4	*3.4	1.7	0.0	0.5
Central Bedfordshire	7	0.4	2.8	*2.5	14.5	0.7	3.0	3	0.2	*3.0	*2.7	6.4	0.0	3.9
Essex	14	0.6	2.9	2.7	20.4	1.4	2.2	6	0.3	3.1	2.7	8.3	10.8	2.8
Hertfordshire	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2	0.1	*2.2	*2.2	3.9	0.0	1.8
Luton	7	1.5	4.1	3.5	36.8	5.5	13.3	2	0.8	*4.1	*4.0	20.8	0.0	7.6
Norfolk	17	0.7	4.0	3.8	17.3	1.8	3.3	7	0.2	3.6	3.2	6.2	7.7	2.4
Milton Keynes	7	0.7	3.9	3.2	18.1	1.7	7.9	1	0.1	**	**	7.6	**	0.0
Peterborough	7	1.4	3.7	*3.5	37.7	2.7	11.0	6	0.2	*3.2	*2.5	7.2	8.2	3.8
Southend on Sea	7	0.6	2.8	2.6	20.3	2.6	4.0	3	0.3	*2.1	*2.1	12.6	0.0	3.4
Suffolk	19	0.5	3.2	2.7	15.7	1.7	2.5	6	0.1	*1.9	*1.7	4.8	12.7	0.8
Thurrock	8	0.8	3.3	3.2	23.6	2.6	4.1	***	***	***	***	***	***	***

PHE/OHID, National Dental Epidemiology Programme

Top 3 worst dental health for that indicator across the EoE

- Five-year-old children in Norfolk experience large inequalities in oral health. In 2019, the average 5-year-old child (2019 PHE NDEP) living in Norfolk had 0.7 teeth affected by decay experience. However children with dental decay experience have about 4 teeth affected. Therefore oral health inequalities exist amongst 5-year-olds.
- Norfolk 5-year old children (2019) experience on average the most number of teeth affected by dental disease across the whole of the EoE.
- Dental disease of the average 3- year- old child (2020) in Norfolk is amongst the worst in the EoE (jointly third worst with 2 other Local Authorities). At the age of 3 years- the average child in Norfolk already has some teeth affected by dental decay (0.3 teeth affected).
- The average 3-year-old child (2020 PHE data NDEP) in Norfolk with dental decay experience has just under 4 teeth affected with dental decay experience. These results indicate that oral health inequalities start from an early age and continues to be present in later childhood.

Dental Activity Summary

Date: 24/02/2022

Contact: tim.winters@norfolk.gov.uk

Sources:

- https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics
- https://app.shapeatlas.net/
- NHS Norfolk and Waveney CCG BI team for A&E ECDS data

Norfolk County Council

Summary

- Access to NHS dental services - in 2018/19 Norfolk was ranked 133 out of 147 local authorities for successfully obtaining a dental appointment, the bottom 10%
- The number of dentists with NHS activity has reduced since 2018/19 and the relative reduction is greater for Norfolk and Waveney than East of England or England. This accelerated between 2019/20 and 2020/21
- A similar decline is seen in dentists with NHS activity per 100,000 population
- Across Norfolk and Waveney the % of children seen by a dentist declined over the period of the pandemic in line with England but has started to increase since a low in March 2021
- The trend in A&E attendances for dental related conditions indicates that peaks over the last two years may be associated with introduction of national lockdown
- Looking at three year trends by deprivation quintile shows that rates of A&E attendances for dental conditions is higher in more deprived communities and rate increased faster in the more deprived communities across all age bands.

Fingertips profile - in 2018/19 Norfolk was ranked 133 out of 147 local authorities for successfully obtaining a dental appointment, the bottom 10%

Quintiles: Best | Worst | Not applicable

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

Access to NHS dental services - successfully obtained a dental appointment 2018/19

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	389,663	94.2	94.1	94.3
East of England region	–	44,059	94.3	94.0	94.5
Southend-on-Sea	–	1,375	97.3	95.9	98.2
Essex	–	11,064	96.4	95.9	96.8
Bedford	–	1,120	96.1	94.4	97.4
Central Bedfordshire	–	2,083	95.6	94.3	96.6
Hertfordshire	–	8,144	95.5	94.8	96.1
Thurrock	–	1,024	95.3	93.8	96.5
Luton	–	1,503	94.7	93.0	96.0
Suffolk	–	5,516	93.5	92.6	94.3
Cambridgeshire	–	4,530	92.3	91.1	93.3
Norfolk	–	6,872	91.5	90.6	92.3
Peterborough	–	828	82.5	78.3	86.0

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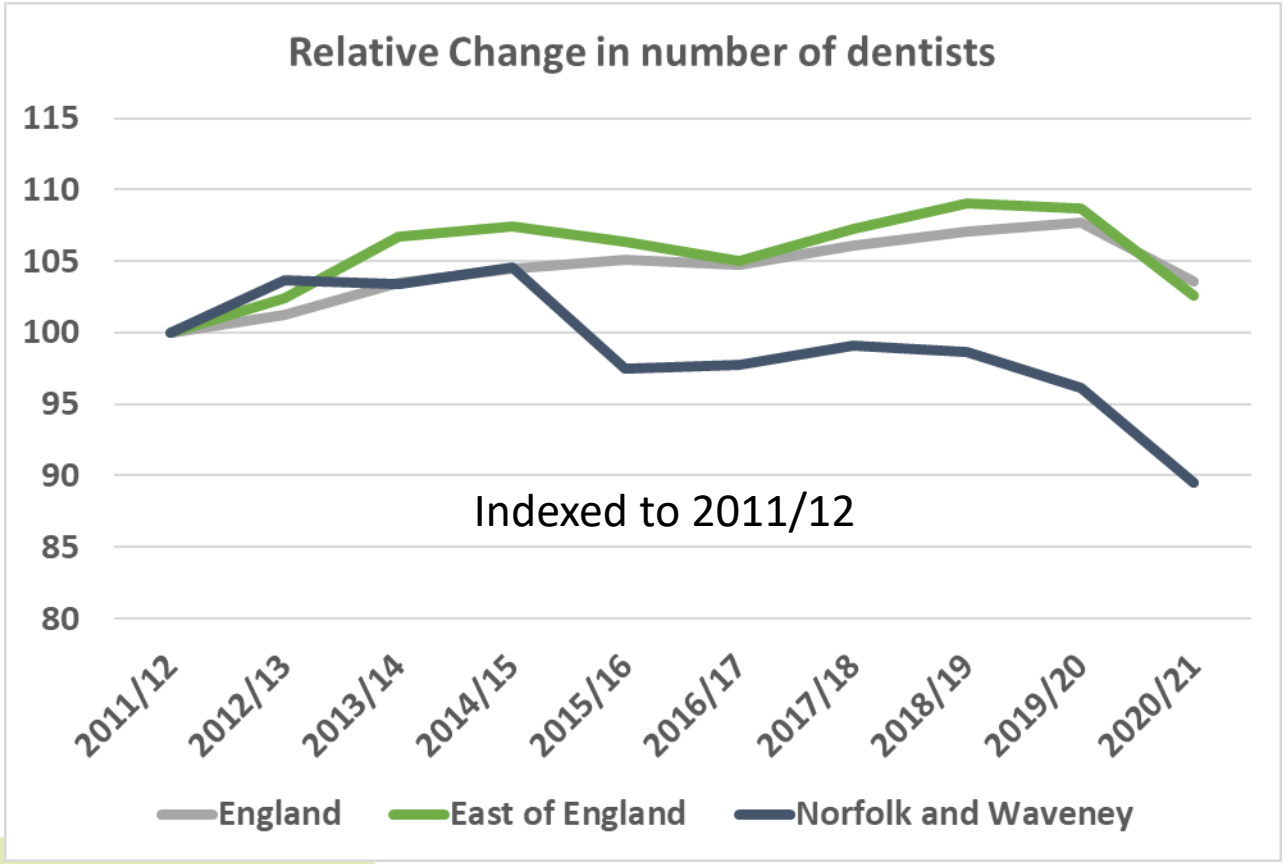
https://fingertips.phe.org.uk/search/dental#page/3/gid/1938133251/pat/6/par/E12000006/ati/402/are/E10000020/iid/92785/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0_car-ao-1

The number of dentists with NHS activity has reduced since 2018/19 and the relative reduction is greater for Norfolk and Waveney than East of England or England. This accelerated between 2019/20 and 2020/21

Year	England	East of England	Norfolk and Waveney
2011/12	22,920	2,880	437
2012/13	23,201	2,949	453
2013/14	23,723	3,073	452
2014/15	23,947	3,094	457
2015/16	24,089	3,063	426
2016/17	24,007	3,024	427
2017/18	24,308	3,088	433
2018/19	24,545	3,141	431
2019/20	24,684	3,129	420
2020/21	23,733	2,955	391



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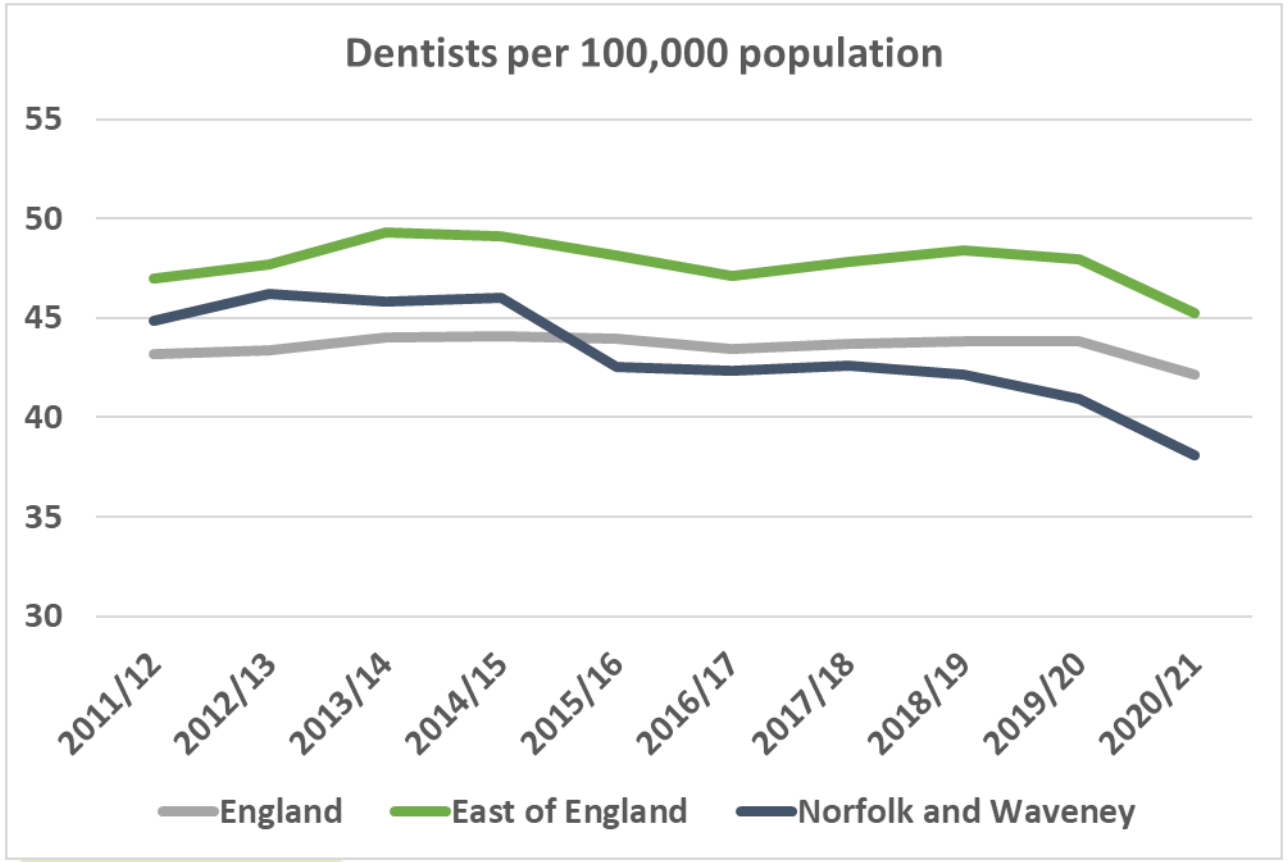
Source: Table 2a: Number of dentists with NHS activity, for years ending 31 March, England - NHS England region geography and CCG https://files.digital.nhs.uk/9B/6B58B0/nhs-dent-stat-eng-20-21-anx2.xlsx

Decline in dentists per 100,000 population with NHS activity is larger for Norfolk and Waveney and accelerated between 2019/20 and 2020/21

Year	England	East of England	Norfolk and Waveney
2011/12	43.2	47.0	44.8
2012/13	43.4	47.7	46.2
2013/14	44.0	49.3	45.8
2014/15	44.1	49.1	46.0
2015/16	44.0	48.1	42.5
2016/17	43.4	47.1	42.3
2017/18	43.7	47.8	42.6
2018/19	43.8	48.4	42.2
2019/20	43.9	47.9	40.9
2020/21	42.2	45.3	38.1



Source: Table 2a: Number of dentists with NHS activity, for years ending 31 March, England - NHS England region geography and CCG https://files.digital.nhs.uk/9B/6B58B0/nhs-dent-stat-eng-20-21-anx2.xlsx

Across Norfolk and Waveney the % of children seen by a dentist declined over the period of the pandemic in line with England but has started to increase since a low in March 2021

Patients Seen in Clinical Commissioning Groups

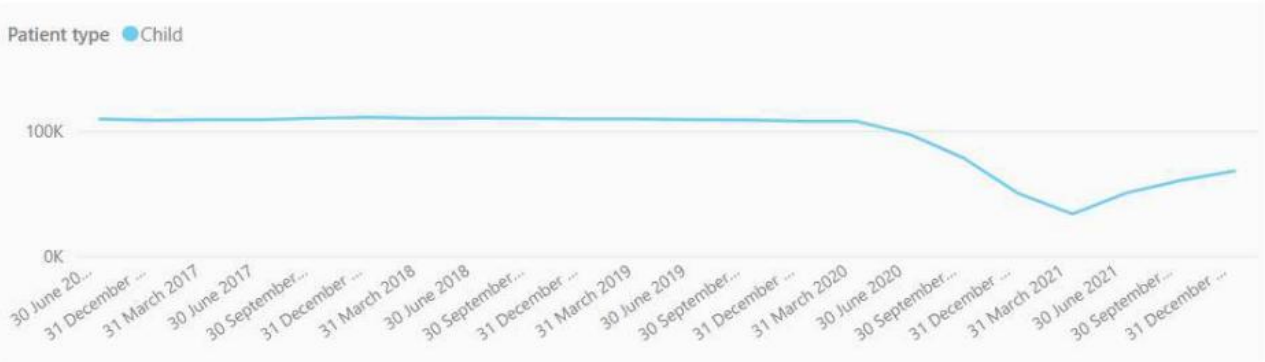
Patients seen data are published a quarter ahead of activity data. To coincide with NICE guidelines on intervals between oral health reviews.

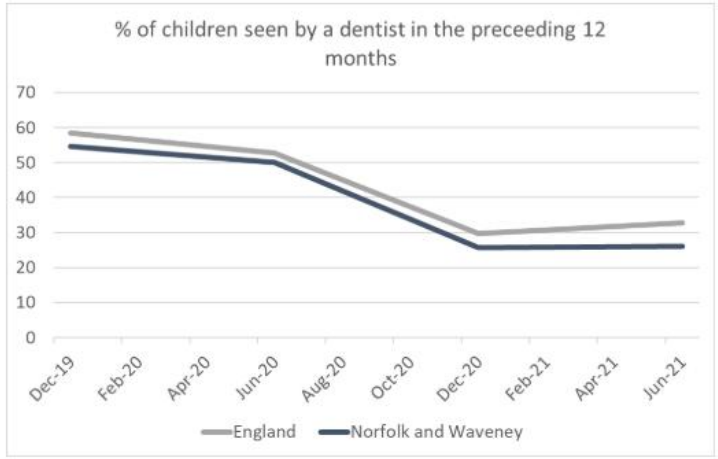
NHS Digital

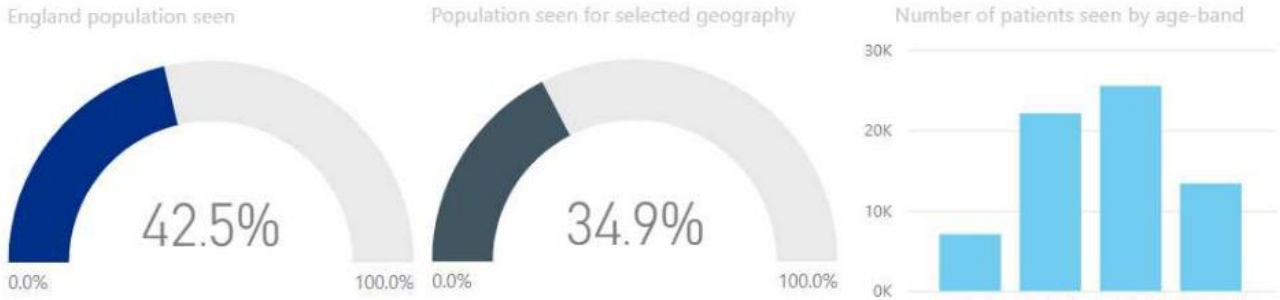
Patient type: Adult, Child (Child selected)
Quarter end date: 31 December 2021
Region name: All
CCG name: NHS Norfolk and Waveney CCG

Adults refers to the number who received NHS dental care in the preceding 24 months of the quarters end date.
Child relates to the preceding 12 months.

Data are mapped to CCGs although practices are not being contractually associated to them. Unmapped practices are shown as 'Unallocated'.







Adult breakdown available from 30 September 2019

https://app.powerbi.com/view?r=eyJrIjoiYTRlMzJiYTEtMTgwMi00ZTdiLTgzMWUtZGM5Y2NmMTI5MGE4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

To access the publication, including the underlying data in csv format, click here

Lack of access to dentists might result in increased A&E attendances for dental related conditions. Dental abscess is the most common diagnosis.

This might be thought of as a proxy for understanding variation in unmet demand for dental services
Time period is from April 2019 through to December 2021
Only includes A&E attendances for NHS Norfolk and Waveney residents at the following:

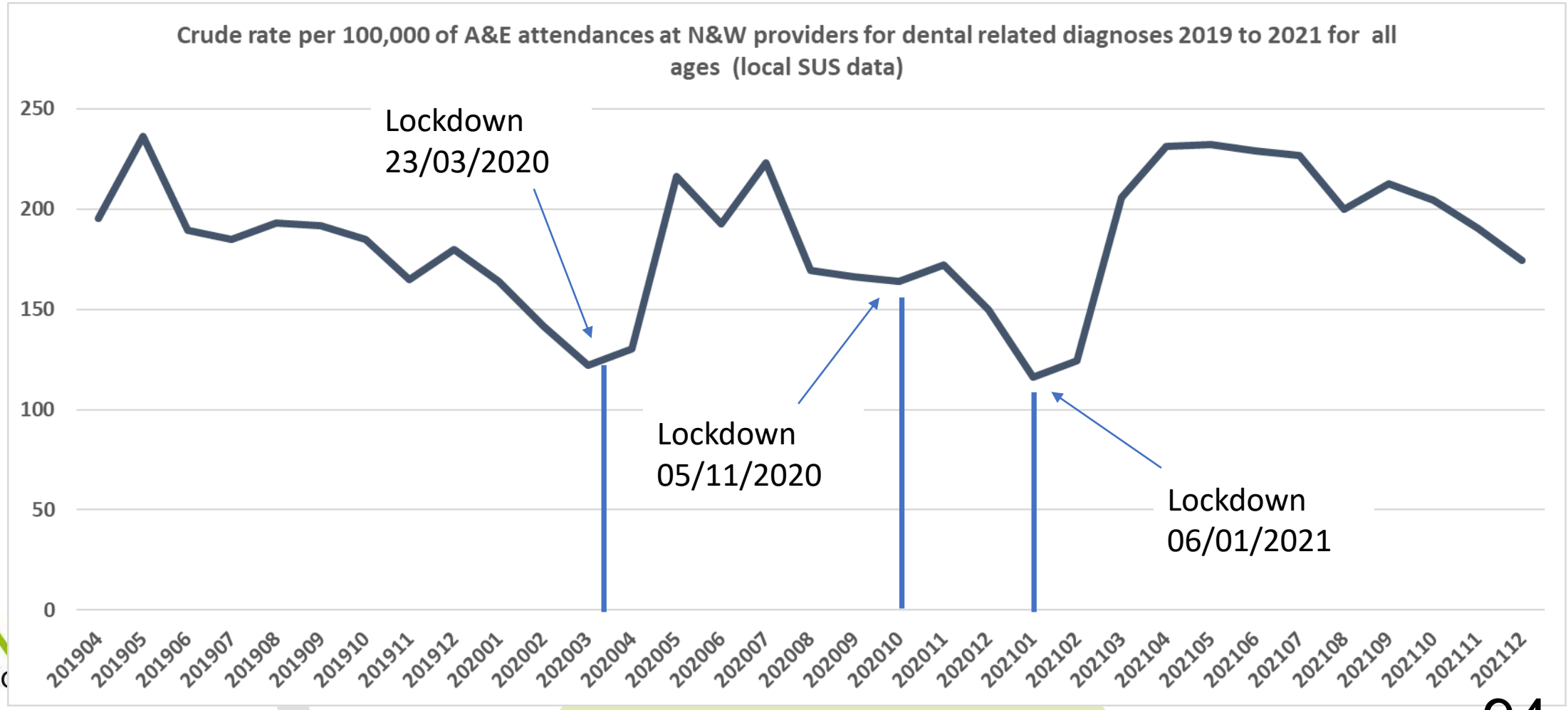
- Cromer Hospital
- James Paget University Hospital
- Norfolk and Norwich University Hospital
- The Queen Elizabeth Hospital King's Lynn

This may mean that some A&E attendances from South West Norfolk e.g. Thetford is missing as some of these attendances would go to the West Suffolk Hospital in Bury St. Edmunds

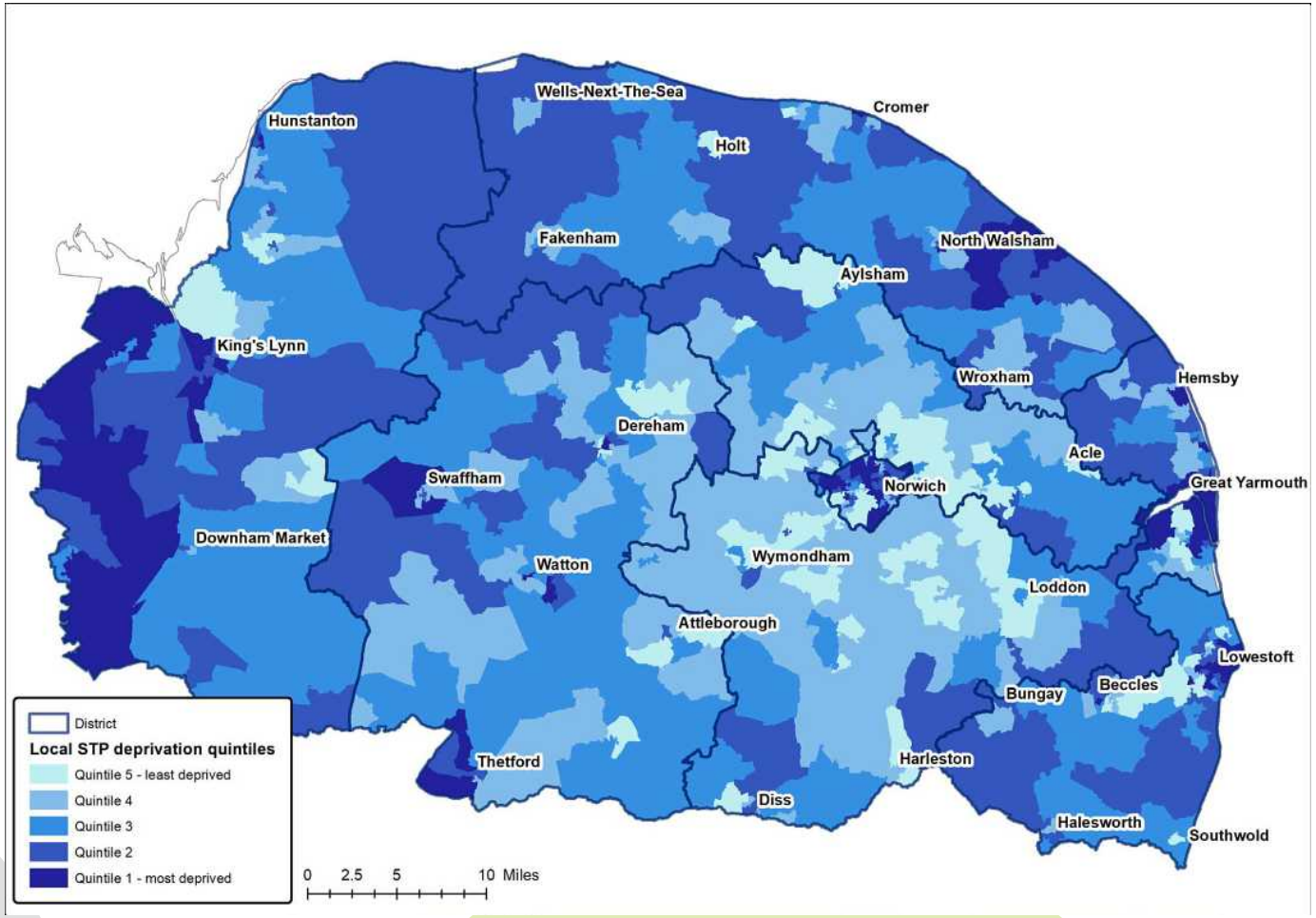
Average cost of A&E dental related attendance 2019/20 = £96
https://www.england.nhs.uk/wp-content/uploads/2021/06/National_Schedule_of_NHS_Costs_FY1920.xlsx

SNOMED primary diagnosis code	Primary diagnosis description	Average Attendances Per Year	Estimated average cost per year
299709002	Dental abscess (disorder)	1,196	£115,009
80967001	Dental caries (disorder)	465	£44,745
109678002	Extrusive luxation of tooth (disorder)	84	£8,075
109671008	Complete avulsion of tooth (disorder)	68	£6,537
42744004	Broken tooth without complication (disorder)	68	£6,502
58411009	Broken tooth with complication (disorder)	17	£1,678
Grand Total		**1,899**	£182,546

The trend in A&E attendances for dental related conditions indicates introduction of national lockdowns may be associated with subsequent increases in A&E dental related diagnoses

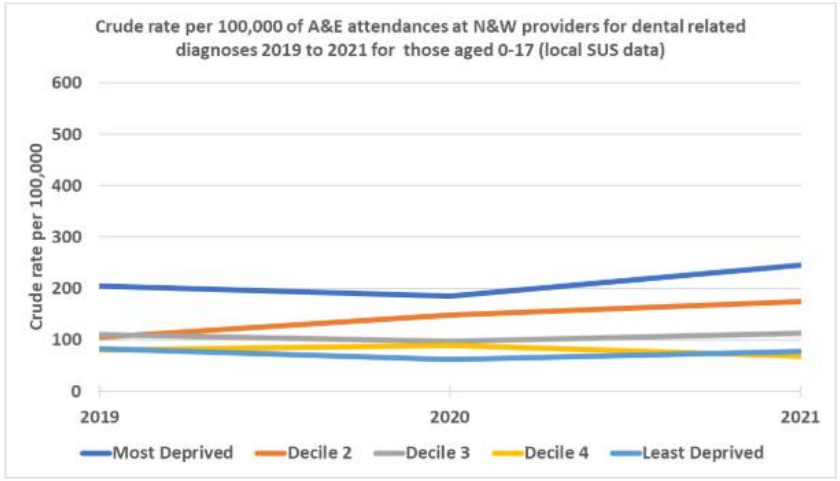


Map of IMD 2019 (showing Deprivation) – the darkest areas show the most deprived 20% and the lightest areas the least deprived 20% for Norfolk and Waveney.

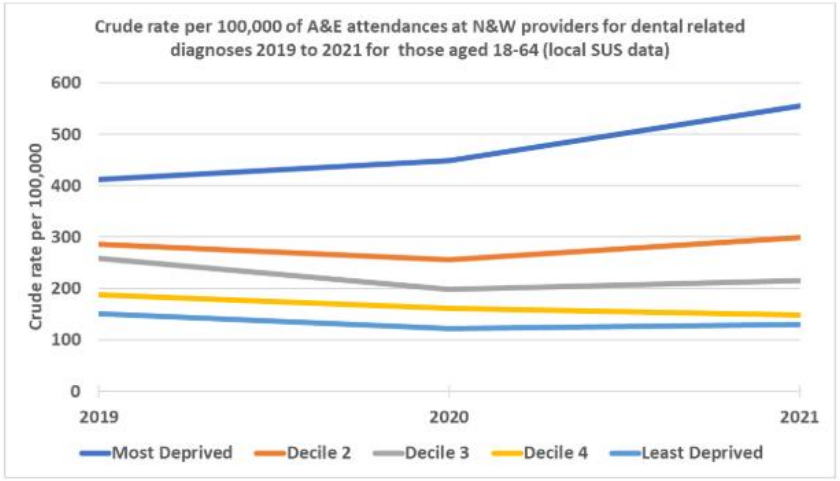


Norfolk County Council

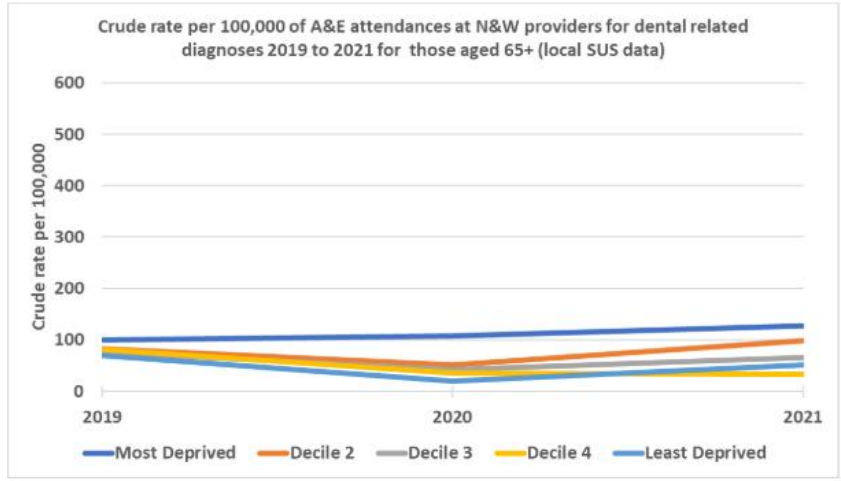
Looking at three year trends by deprivation quintile shows that rates of A&E attendances for dental conditions is higher in more deprived communities and increased faster in the more deprived communities across all age bands.



Aged under 18



Aged 18-64



Aged 65+

Highest rates of A&E dental activity are seen in the working age (18-64) population.

Norfolk County Council

Report: **Access to Dentistry Update 2022**

Author: Alex Stewart

Item No.

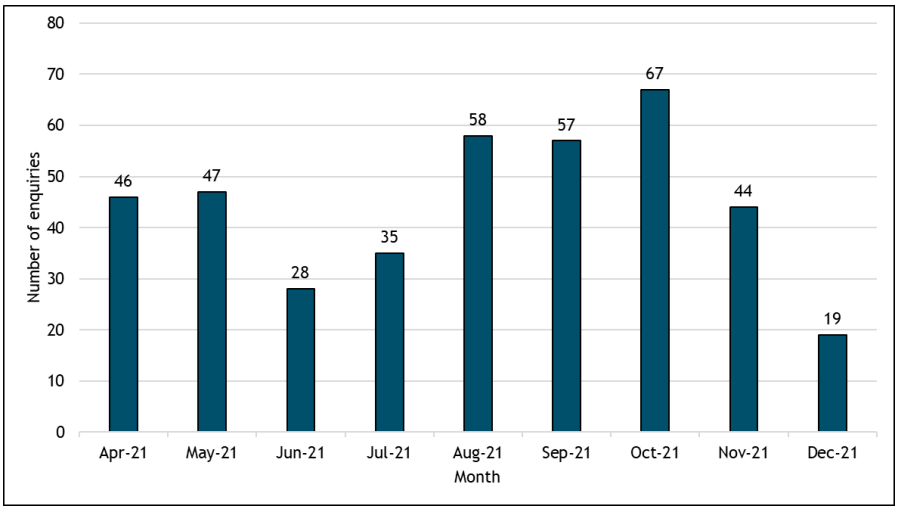
Date: March 2022

1. Introduction

1.1. The purpose of this report is to provide members of the Health Overview and Scrutiny Committee (HOSC) with a general update in relation to dentistry provision along with a specific insight into the progress of a pilot dental practice based at RAF Marham.

2. General Overview

2.1. Healthwatch received 401 enquiries relating to dental services between April 2021 and the end of December 2021. The graph below illustrates the average monthly totals.



2.2. In terms of where in Norfolk enquiries are received from, over half (213) did not state a specific location. However, based upon experience and information provided, we are able to assume that there will be a similar pattern to those that have provided Healthwatch with the first 4 digits of their postcode (shown below).

Great Yarmouth & Waveney	North	Norwich	South	West
18	43	50	47	30

2.3. From these are contacts, the top issues relayed to Healthwatch are:

- access to NHS dental care
- patients being told they can't be seen as an NHS patient but they can at the same practice if they were to go private – some practices will se children if the parents opt to go private
- confusion as to what constitutes an emergency

3. Accessing NHS Dental Care in Norfolk

3.1. Healthwatch try to contact every NHS Dental Practice across Norfolk on a fortnightly basis to ascertain their waiting list status and whether they are currently taking NHS patients. This enables us to provide relatively "live" information to anyone making an enquiry.

3.2. As reported to HOSC in 2018, the issue of dental practices not keeping their website as well as information on the NHS search facility up to date, remain. This is despite repeated requests from both Healthwatch and colleagues at NHSEI. This not only undermines the NHS advice to use their locator facility but also increases the pressure on dental practice reception staff who will take the brunt of frustrations of individuals calling to ascertain if they can receive treatment or not.

3.3. When coupled with reports from members of the public being offered treatment on a private basis when calling, whilst being refused treatment under the NHS at the same practice it is understandable that there is concern as to the accessibility of NHS dental care from many Norfolk residents. This is further exacerbated by some practices choosing to become exclusively open to private patients.

3.4. In a circular (dated 13/01/22) from Sara Hurley – Chief Dental Officer for England; she wrote: -

> The NHS has stood shoulder to shoulder with dental practices throughout this pandemic. The NHS's generous income protection represented a substantial financial investment in the stability of NHS dentistry - safeguarding provision for our patients, protecting valued dental practices and preserving livelihoods. In addition to the recent pay increase announced by the Government, in our last letter we confirmed to you further financial support.
>
> Alongside ongoing income protection, this includes that the variable cost reduction is being retained at the lower level of 12.75%, applied to nondelivered activity, and that delivery over the performance threshold required for NHS income protection may be used to offset performance under the threshold in an earlier time period, offering contractors the greatest financial value. The government has also confirmed that free PPE provision will be extended beyond March 2022.
>
> The 85% threshold for income protection during quarter 4 reflects our belief that, as practices have a proven ability to deliver more, it's only right this capacity is used to the maximum benefit of NHS patients.
>
> But we understand there may be circumstances where reaching 85% isn't possible, particularly as practices navigate the current workforce pressures relating to

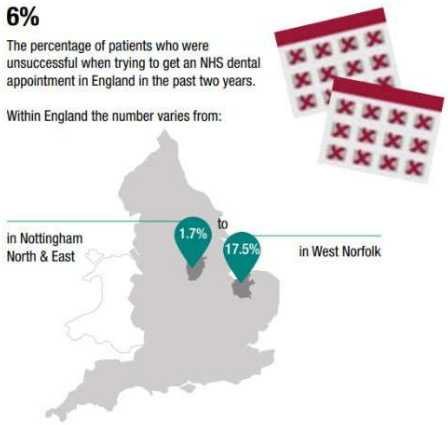
Omicron. We continue to stand by our hard-working dental teams, today expanding on the exceptional circumstances guidance that has been in place throughout Covid-19.

We are also repeating our ask of those of you who are nearing (or already above) 100% UDA delivery that you go further where you can. In our last letter, we created an additional opportunity for practices in year by raising the upper tolerance threshold from 104% to 110% UDA delivery. We did this because we want NHS dentistry to see as many patients as possible. This opportunity is both for practices delivering over 100% UDAs in Q4 (after offsetting as necessary into earlier periods), or for the full year 2021/22.

Dentistry is an important part of the NHS. This year, by working with you and continuing to stand by you, we're determined to see NHS dental services recover and improve.

3.5. Despite the assurances, the situation doesn't appear to reflect the state of play across Norfolk.

3.6. In February 2020, the National Audit Office released Dentistry in England - National Audit Office (NAO) Report. This reported that within England, the number of NHS primary care dentists varied from 12.6 dentists per 10,000 in Bradford City to 3.4 per 10,000 in West Norfolk, equating to almost a fifth of people unable to access an NHS dentist in this area of Norfolk.



3.7. The same report showed that pre-pandemic, between 2018 and 2019, 17.5% of patients in West Norfolk had been unsuccessful in getting an NHS dental appointment in West Norfolk, compared to 1.7% in Nottingham North and East. Out of the NAO comparator data, this meant that patients in West Norfolk were the highest in the UK at unsuccessful contacts.

3.8. In August 2021, the EDP reported on an agreement to open six new dental practices across Norfolk and Waveney as NHS England was inviting tenders for two new surgeries in King's Lynn, one in Norwich and one in Fakenham, Thetford and Lowestoft. At time of writing, there is a planning application for a new dental practice in Norwich.

3.9. The article also said that procurement papers state the new services are expected to start on July 1, 2022, and contracts will last for four years and nine months with extensions of up to a further three years and that, "Premises are to be accessible to serve the main population densities and located near good public transport links and road networks. The service is to be open from 8am to 8pm, 365 days per year."

3.10 Members of HOSC will be aware of the latest Government initiative to provide monies to secure up to 350,000 additional dental appointments across England. The monies are expected to alleviate people suffering from oral pain, disease and infection to get the care they need, as services attempt to get back to pre-pandemic levels of activity. Children with learning disabilities, autism, or severe mental health problems, will be prioritised over the coming months, with the one off funding available until the end of **March 2022.** It is envisaged that locally, NHS teams will use the funding to secure increased care capacity amongst local dentists.

3.11 Whilst Healthwatch welcome these additional monies, there still remains a deeper and more systemic challenge in the dental sector that has been laid bare over the last few years in order to address some of the deep-rooted issues faced by dentists across Norfolk.

4. Spotlight on Marham Dental Practice

4.1. In April 2018, Healthwatch Norfolk reported on access to dental care in West Norfolk, particularly focusing on children and young people. The report included the results of a survey carried out with members of the armed forces community living and working at RAF Marham. Appendix One sets out "How Healthcare is delivered to the Armed Forces".

4.2. The project, which was the culmination of four years of work by Healthwatch Norfolk, RAF Marham and Norfolk's Armed Forces Covenant, gained agreement from the Defence Infrastructure Organisation (DIO) to facilitate the reappropriation of a house on the RAF Marham estate in which NHSE could contract a NHS dental provider to operate.

4.3. In March 2020, just ahead of the pandemic, Marham Dental Practice, run by Dentistry for You, opened its doors to NHS Patients, the first NHS dental practice to operate out of an MOD owned property.

4.4. Although, one of the fundamental reasons for the project was a recognition of the challenges faced nationally by armed forces families accessing NHS dental care, the practice serves not only families of those serving at RAF Marham and Robertson Barracks but also the wider civilian community in line with NHS standards.

4.5. Two years on, the pilot practice has proved extremely successful. The state-of the-art facilities, combined with the enthusiasm of the practice operator has seen the practice grow from a single to three dentist operation within the space of just over a year.

4.6. However, there is no escaping the fact that the practice is experiencing some significant operational issues. The following series of questions were asked to provide HOSC with the experiences of this new practice:

Question	Response
Average time from joining patient list to receiving treatment	This varies on patient need. If a patient has a dental emergency then we prioritise them being seen ASAP. This is done by including emergency treatment slots within each dentists appointment diary. For patients requiring routine examinations, the current wait time is now nearly 1 year.
Patient to Dentist ratio – i.e. how many patients is a Dentist able to see during a 'normal' day	Approximately 12-15 allowing for 'Post Aerosol Generating Procedure Fallow' times. New NHS standard operating procedures have been released and we expect this to increase to 15-20 due to the reduction in fallow time
Number of people on the patient list waiting for treatment (including check-ups)	Approximately 2000. Due to COVID restrictions, we are facing a massive backlog as a result of the reduced capacity to see patients. Also, patients have told us that neighbouring practices have either closed, reduced capacity or gone private.
How busy the practice generally is	The practice is generally extremely busy especially from Monday to Thursday.
How difficult it can be to manage patients when you are so busy	We have experience at managing busy NHS dental practices. The new norm has added to our administrative duties as each patient needs to be screened using an NHS template questionnaire before attending the practice. The call volumes in Marham have escalated due to needing to reassure patients that it is safe to have treatment during the pandemic and also explaining some of the new protocols. We have tried to make the practice more efficient by employing an additional receptionist and also by installing a VOIP system allowing for calls to be attended to remotely if the reception cannot manage the volume of calls while attending to patients. This has proved very useful in cases of self-isolation.
How helpful it would be if you had more surgery availability and patient capacity	Increased surgery availability and NHS capacity will allow us to employ additional dentists and staff to attend to the significant backlog of patients. This will in turn reduce waiting times for new patient appointments and ongoing treatment appointments. We do include emergency slots with each dentists appointment diary so that any patient suffering from a dental emergency can be attended to however these are booked very quickly every morning making it difficult to attend to emergency patients calling later in the day. Increased capacity will allow for us to increase the number of emergency slots available every day to manage such patients.

4.7. Although it has not been possible to do a full survey, we asked families from RAF Marham about their experiences of accessing dental care in Norfolk since the practice opened, these are just a few of the responses we received:

'Me and my two children have used it – no problems so far'

‘We are unable to get registered there as they say their waiting list is too long’

‘Was put on a list when it opened and heard nothing. We have tried a lot of dentists and none of them are taking on NHS patients. I couldn’t even get an emergency appointment for my eldest. We ended up taking her to a dentist in Edinburgh when visiting family when she needed a tooth removed.’

‘I manager to get myself registered just before the first lockdown I believe however I have since had a baby who is now 19 months, I’ve been unable to register him, I’ve been told there is a waiting list of over 1000. I’ve tried various other NHS dentists but no luck. I’d rather him be seen than me as he’s never seen a dentist.’

4.8. The heat map in Appendix Two illustrates that some patients are travelling a significant distance to access the practice. It also shows that some people are accessing from out of County which inevitably increases pressures on our local system.

5. Accessing dental care by armed forces families

5.1. In recognition of the ongoing challenge of accessing dental care for armed forces families nationally, the RAF, Navy and Army Family Federations are in the process of producing a report detailing some of the issues and experiences of those affected.

5.2. Norfolk is already leading the way with the dental practice at Marham. However, some areas of exploration remain in order to fully improve access for members of the community in Norfolk. Many of the partners who would need to be part of this work have already signed the Armed Forces Covenant, thereby demonstrating support for the community and a desire to address areas of disadvantage such as those detailed in the report.

5.3. To this end HOSC are asked to agree the following recommendations:

- That, when appropriate, an update report be provided by NHSEI in conjunction with the ICB as to how concerns and issues relating to dentistry are being dealt with
- To support ongoing work by Healthwatch, Armed Forces Covenant, NHSE and DIO to determine ways in which the issues highlighted in the report can be addressed in Norfolk, using the Marham Dental practice as a starting point.
- To seek assurance that the ICB will be adopting and recognising the importance of the armed forces covenant.

Appendix 1

How Healthcare is delivered to the Armed Forces

Primary healthcare, including community mental health of Serving personnel is taken care of by Defence Medical Services (DMS) who provide an all-inclusive, comprehensive package of health services.

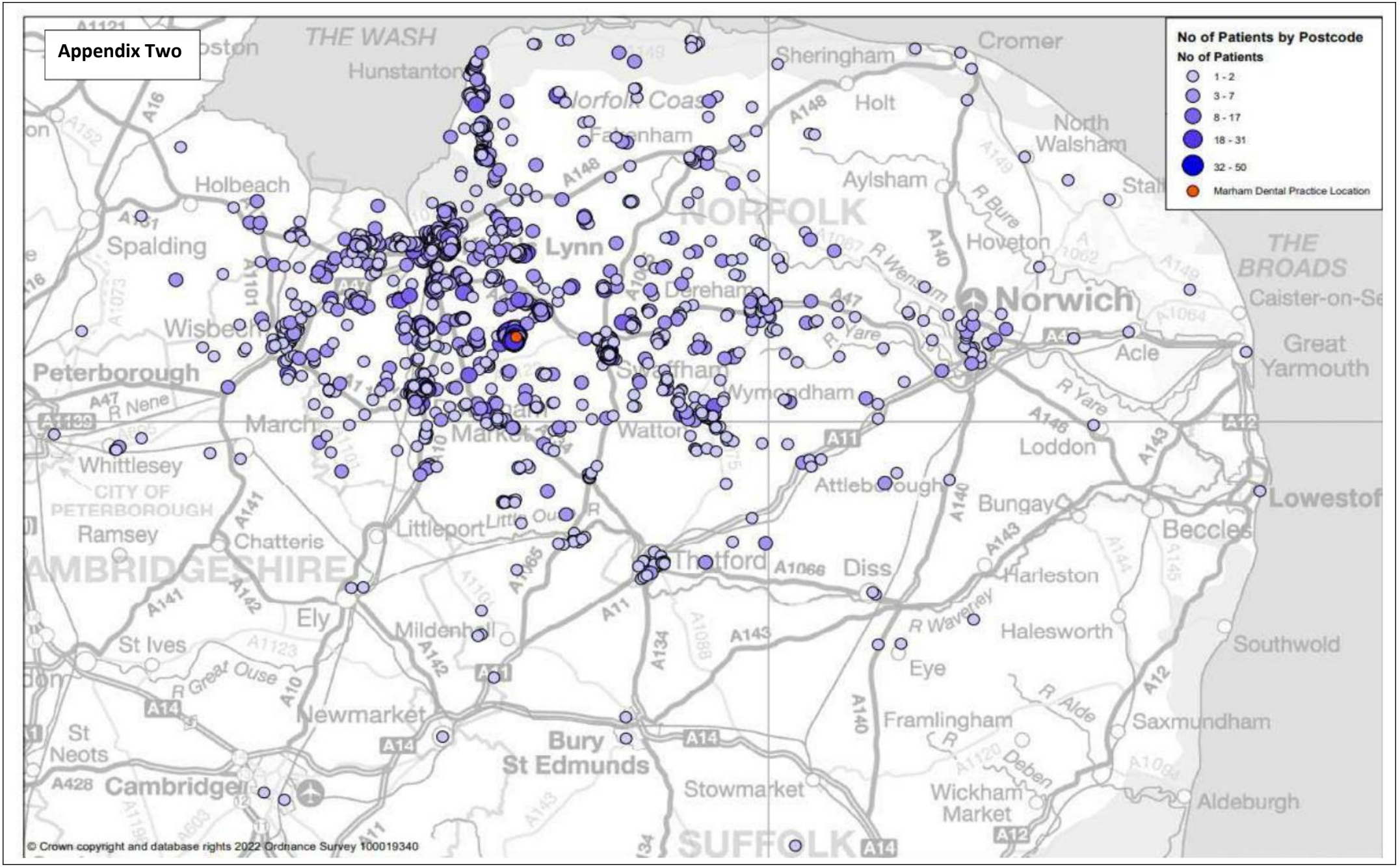
The health of their family members, however, is a different story and reflects a mixed economy of provision. For families accompanying the Serving person overseas, primary healthcare for the whole family is delivered through DMS facilities or in combination with host nation health facilities and local contracts where appropriate. Overseas, DMS medical and dental staff are responsible for providing a comprehensive healthcare service broadly equivalent to that provided in England by the National Health Service. While the DMS provide healthcare for Serving personnel across the whole of the UK, their families experience healthcare delivered variously in the different nations

In England, the National Health Service England and Improvement (NHSEI), has the lead responsibility for military families and DMS facilities are used only on the small number of bases where there is a training value for the DMS healthcare staff and spare capacity exists.

In England, healthcare is provided mainly by NHS England which has now combined with NHS Improvement (NHSEI). Primary care is delivered by independent contractors including GPs, dentists, pharmacists and optometrists. The majority of secondary care is delivered in NHS facilities. Clinical Commissioning groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible. The CCGs are overseen by NHSEI.

It is usual for all members of a civilian family to be registered at the same General Practice (GP) surgery and to use the same dental practice.

Appendix Two



Report to Norfolk County Council Health Overview and Scrutiny Committee.

This report has been compiled to provide an update to the HOS committee on changes to NHS dentistry in Norfolk since the last examination by HOSC (September 2020). I am sorry I cannot deliver this report in person, I am on my first annual leave for many months. I mean no disrespect to the Committee.

Fundamentally it must be understood that all NHS primary care dental provision is decided by NHS England and NHS Improvement (NHSEI). NHSEI decides on the level of spending on dental services, has the ability to expand current services and commission new services. NHSEI monitor the current delivery of dental services and the needs of the local population. It is important to understand this fact when scrutinizing the level and quality of dental services in Norfolk. The choice to reduce expenditure per head of capita on primary care dental services over the last decade has been an active decision by NHSEI. Workforce retention in the NHS has been historically challenging in rural and coastal areas. Offering more generous contracts to encourage a more stable workforce in Norfolk is a measure NHSEI could adopt but has chosen not to.

From a national perspective the plans to introduce a reform of the current dental contract for primary care NHS dentistry in England has changed fundamentally. The original strategy was to learn from Prototype Practices and use this learning to create a new national primary care dental contract for England. The prototype practices will cease to operate from April 2022 as HMG were unwilling to extend the legislation that allows their operation. Currently there are likely to be a range of changes to the existing NHS dental contract rather than a new way for dental teams to work. This is disappointing news as the political consensus for some time has been that the contract is “not fit for purpose”. The move away from a new contract will further damage the extremely low levels of morale suffered by NHS dental teams.

NHSEI is offering flexible commissioning of dental contracts. This means that 10% of activity can be delivered outside of the current contract. This opportunity for change may entice some practices, but the limited proportion is unlikely to steer practices away from leaving the NHS if the current contract does not allow the long-term viability of their business.

Covid 19 Update.

Since March 2020 the pandemic has overshadowed all elements of dentistry in the county.

Although the Government has announced the removal of almost all Covid 19 restrictions. This does not apply to healthcare facilities currently.

The suspension of routine care, and the pandemic restrictions we are still working to mean that across in England over 30 million appointments have been lost. In Norfolk

that amounts to around ¾ million courses of treatment that we would have delivered in normal times, that did not take place. As Infection Prevention and Control protocols continue to limit the throughput in dental practices, this backlog continues to grow.

Each missed appointment is an opportunity lost to pick up on the early signs of disease, whether it's decay, gum problems, or even oral cancer. So not only are we now facing a genuinely unprecedented backlog, but the level of need among those patients who have had to bottle up problems will be higher. NHS dentistry faces a double impact, of both supply problems, and a surge in demand.

Since the reopening of practices on June 8th, 2020, the Office of the Chief Dental Officer (OCDO) has insisted that priority is given to those who had experienced toothache during that period, were under a course of treatment which was postponed and those new patients with developing problems. This means a reduced number of practices are seeing patients for what would be classed as routine dentistry. This is due to the OCDO guidance and because of the reduced numbers that can be safely treated in a practice under the pandemic guidelines. There is also a significant reduction caused by short term patient cancellations and increased staff absence due to sickness and self-isolation. NHS practices are treating around 85% of patient numbers face to face compared with those seen prior to the pandemic. New Standard Operating Procedures for treating patients were published 25th November 2021. These allow more patients to be seen, but as any patient with respiratory symptoms should be re-scheduled, there will still be a reduction in patient through-put. Several practices in Norfolk are unable to reach the 85% target. This may lead to financial penalties that could pressure these patients to leave the NHS. Practices may be able to demonstrate special circumstances that may prevent financial "claw-back". Unfortunately, the concerned practices that have tried to discuss their precarious financial position with NHSEI have been unable to enter into dialogue due to the pressures on the team at NHSEI in our area. This lack of reassurance and financial pressures will be heightened after 31st March 2022. From 1st April 2022 dental practices will need to deliver 100% of their pre-pandemic targets. This may not be possible for some Norfolk practices. These practices may have to consider a move to the private sector to ensure the continued delivery of any predictable future service.

Issues that are specific to Norfolk include.

1. **Access**.
   The difficulties for patients to access an NHS dentist in the Norfolk have been challenging for several years. This is particularly severe in the North and West of the county. To be clear NHS dentistry was in crisis here long before Covid struck. Recruitment and retention problems were endemic, and it not unusual for practices to have vacancies unfilled for 2 years or more. Practices have been handing back NHS contracts, or simply shutting up shop for some time.

The current NHS contract has had a damaging impact on the delivery of care across this region, pushing talent out the NHS, and in some cases out of dentistry altogether. The harm caused by the NHS contract is acknowledged across all political parties at Westminster.

For context, since 2006 the profession has no longer had the ability to set up dental services in response to local need. The funding would be based on the level of NHS dental work completed. Before 2006 any NHS dentist could set up an NHS practice where there was need and a business case could be made for the viability of the practice to whoever was providing funding. The opportunity and risk were borne by the dental team setting up the service. This sharpened the mind of those involved. Under the old contract (prior to 2006) it was unusual for practices to close completely.

Since 2006 the NHS has directly controlled the placement and size of dental contracts. Commissioning of NHS dental contracts do not directly involve the dental profession. The amount of money spent on NHS dental provision and the location of those services is a commissioning choice made currently by NHSEI. NHSEI has a duty to conduct needs assessments to determine the service required. NHS dental funds are not ring-fenced. NHSEI can choose to spend more or less money depending on the overall dental health needs of the population. If Norfolk County Council Health Overview and Scrutiny Committee comes to the decision that more NHS dental services are required, this can only be achieved by NHSEI directing more resource to the delivery of these services. As the planning, monitoring and delivery of dental services has been the role of NHSEI (and its predecessors) since 2006 some of the committees' questions about the current quality of provision can only be answered by NHSEI.

In all areas each year some NHS dental practices underperform. This is usually completely unrelated to the demand for dental services in the area and is often caused by a practice's inability to recruit, which is particularly common in coastal/rural areas like ours. The money that would have been spent on these undelivered services is returned to NHSE in a process called **claw-back**, with NHSEI then able to choose to spend it elsewhere. East Anglia has seen extremely high levels of claw-back in recent years; in 2019/20 almost £11.5m were returned by dental practices to NHSEI, over 9% of the total value of NHS dentistry commissioned in the area. That is almost double the average rate of claw-back across England. Practices currently able to deliver more care could take up the slack in this situation, but this requires NHSEI to agree to re-direct this funding during that financial year. NHS dental practices cannot over-perform significantly, no matter what the level of local shortages, without the express permission of NHSEI. If a practice has extra capacity to treat patients and NHSEI cannot or will not agree to use underspend (also known as claw-back) then the practice can only provide extra care to patients privately. It can be challenging for claw-back monies to be used within a financial year. However, it is not impossible. One of the reasons this does not occur is the pressure upon the staff at NHSEI.

Over time many practices have found it increasingly difficult to meet their NHS targets. The initial targets were set in 2006. Since that point, contracts have generally failed to keep pace with both inflation and population growth. Some practices have had a permanent reduction in their NHS contract (a **rebasing**) as they cannot consistently hit the original target. Other practices have withdrawn from providing NHS activity completely. The money released by these changes to NHS contracts mean that there is less commissioned dental activity being delivered to patients. This money can be re-directed to patient care if NHSEI wished to use the money in this way.

In East Anglia the commissioning of new dental activity, using money from claw-back in the short-term or rebasing money, or new money for more long-term contracts is uncommon. However, in the Autumn of 2021 a process to procure 7 new lots of General Dental Services for the East of England Region started. The aim was for these extra services to be available to patients in the early Summer of 2022. Any new commissioning of NHS activity must be welcomed. However, the quality of the procurement process will inevitably impact on the quality of the service commissioned and delivered to patients. The contracts that will be offered are time limited. The timescale for the contracts is 4 years and 9 months with the Commissioner allowing extensions of up to a further 3 years (total contract duration 7 years and 9 months). This means that any provider of services that requires funding via a business loan will struggle to gain finance at competitive rates due to the short length of the contract. Business loans under 10 years for large sums of money can be very difficult to source. This will reduce the number of bidders to those with corporate funding or existing practices that can be expanded. Less bidders will reduce competition and will also exclude smaller business ventures who may be more committed to an area in the long term. Also, these short-term contracts could lead to a service meeting the population need, but then being withdrawn after less than 8 years. Patients need a more long-term commitment by the NHS to their oral health. It is possible that these initial time limited PDS (Personal Dental Services) could be converted to long-standing GDS (General Dental Services) contracts, but the impact of the NHS choosing to initially commission PDS contracts will not be mitigated by this change.

The contract will require service delivery from 8am to 8pm, 365 days per year. This sounds like a boon for patients but is irrelevant if this type of provision is impossible to deliver. NHS dental teams work under stressful and challenging circumstances. Insisting on this level of provision will make recruiting and retaining staff difficult. This draconian requirement could increase the risk of these new practices failing. Again, this does not signal a long-term commitment by the NHS to the oral health of our local population.

Recently the outcome of the commissioning of new dentistry services in Norfolk and Suffolk was announced.

Through an open procurement process, seven contracts (Lots) were advertised for potential providers to apply for. As a result, the following contracts have been awarded to the named providers below:

Lot 1, King's Lynn, Norfolk – Smile Care Norfolk Limited
Lot 2, King's Lynn, Norfolk – Smile Care Norfolk Limited
Lot 3, Norwich, Norfolk – Smile Care Norfolk Limited
Lot 6, Lowestoft, Suffolk – Apps Smiles Limited

Unfortunately, it was not possible to offer contracts for Lots 4, 5 and 7 at this point covering Fakenham (Norfolk), Thetford (Norfolk) and Leiston (Suffolk), respectively. The committee may take a view that the lack of interest in the 3 Lots above may provide some evidence that the procurement process was not conducted in a manner that will lead to good quality, long-term extra dental provision in Norfolk.

In previous procurement exercises outside of Norfolk, a company being awarded a contract following procurement does not always lead to a service being delivered for patients. Poor quality procurement processes have awarded contracts to companies that have entered the process speculatively. The committee may wish to discuss with NHSEI how they ensured that this will not occur and that the successful providers have secured premises and are on target to deliver services by the 1st July 2022 deadline.

2. **Procurement of services.**
Orthodontic procurement has not been progressing smoothly either. The procurement of NHS orthodontics has been a nationwide exercise with the south of England and London regions having already completed the process.

The Midlands and East were about to embark on their own procurement but in early December 2019 it was announced that the process was to be abandoned across the entire region. The reason given was that 'Issues were identified in the scoring of the bids and how the process dealt with multiple bids from the same/similar providers' and as a result 'NHS England has decided that it is unable to make an assured, unequivocal award'.

Current contracts have been rolled on until April 2022, but this has created great uncertainty for those current contract holders. There has now been a contract extension for 18 months granted by NHSEI that will provide temporary service delivery after April 2022.

When the contract termination date is regularly changed or is uncertain it is difficult to plan the through flow of patients. The impact to patients has probably not been felt as severely as it might have been due to the professionalism of the current providers of orthodontic activity in the county who have been continuing to provide a high-quality service under very difficult circumstances.

NHSE was tasked with conducting a “lessons learned” exercise concerning the failed orthodontic procurement activities. To date the LDC and Orthodontic providers have had no sight of any official report or conclusions.

3. **Out of Hours Care**
   The OOH contract currently in place in Norfolk offers an extremely limited service. This has been further compromised by the pandemic and issues around the physical facilities rented by this provider. The LDC has raised professional and patient concerns with NHSE over the quality and scope of this service. NHSE does not wish to develop and improve the OOH service. Their current strategy is to enhance the provision of urgent care within normal working hours. This focus will not aid patients with problems over the weekend period, also any shift of practices towards increased urgent/emergency provision will reduce access to standard dental care. The current provider of services is now developing a new practice on Queens Road, Norwich. This may improve the level of service delivered to patients in this area.

4. **Transformation**
   NHSE is using flexible commissioning to change the delivery of dental care. There is a plan to provide a range of enhanced services to patients. The first two parts of this transformation project are 1a Urgent care and 1b Stabilization & Prevention. Practices involved in this initiative will be able to use up to 10% of their capacity to focus on these new priorities. Any imaginative changes to the NHS dental contract should be applauded. The current contract is seen as unattractive by many dental teams. It is often cited as the reason why practices move their business partially of completely private. Whether a 10% shift in activity will be seen as attractive to practices is not clear. It may take a more fundamental shift in the NHS terms and conditions for dental teams to improve recruitment and retention.

5. **Prototype Practices**
   There are several NHS dental practices in Norfolk that have been involved in a prototype for a new NHS dental contract. They have worked for many years providing a more preventative form of dentistry. Most practice teams have enjoyed this new way of working. Unfortunately, NHSEI has stated that it will end the prototypes in April 2022. There will be a huge impact on the prototype practices (this is evidenced by the experiences of other practices that have had to withdraw from the prototype arrangements). There is currently no concrete information about how these practices will be supported in this transition. The whole situation could result in many practices moving into a private business model when the prototype contract ends.

6. **Recruitment/retention.**
   The long running issues around retention and recruitment are deteriorating. These long-term chronic problems have been exacerbated by the pandemic and Brexit. Rural and coastal communities have traditionally relied on a larger proportion of foreign dentists. With Brexit a number of these practitioners have returned to their

country of origin or have moved to areas where freedom of movement and professional recognition are more straight-forward. This situation will deteriorate after 2022. Until the end of this year the General Dental Council continues to recognize dental qualifications from European dentists. From 2023 onwards European dentists will need to take an entrance exam (ORE) to be considered for inclusion on the dental register. Hopefully there will still be some colleagues willing to work in the UK, but this extra barrier may deter some of the workforce we have traditionally relied upon. There has been discussion about increasing the numbers of dentists that we source from countries outside of Europe. These individuals also have to pass the ORE examination which reduces interest and increases costs and delays.

Recruitment & retention of clinical staff is seriously contributing to the difficulty of NHS dentists in the county to deliver treatment. This is now being amplified by a difficulty in recruiting support staff. Practice owners can't recruit sufficient staff to provide the quantity of dentistry required. The LDC recognized this situation some years ago and whilst limited in what it can do to contribute to addressing this crisis, they have set up a project to highlight dentistry as a career to school students who are considering career options. This project includes the commissioning of a video for dissemination to Careers teachers in secondary schools with supporting brochures and attendance at Careers Fairs. The link is https://vimeo.com/352695716 . It is well recognized that many dental students once graduating will return to their place of upbringing. If the number of dental students from Norfolk can be increased, then there is likely to be a higher proportion returning to Norfolk to work long term in the county.

Health Education England (HEE) is working to diversify the dental team. This will bring some of the changes in general medical practice. This may result in patients having less access to dentists, but more access to other dental team members. This evolution of the workforce is likely to take years rather than months. Also, unless dental team members are recruited from our locality, we may find that the advantages of this change are limited in our county. It has recently been announced that HEE is to be closed, and its functions taken over by NHSEI. Hopefully this development won't delay the moves to adapt the dental workforce.

7. **Other services.**
A previous report to this committee highlighted the problems of dentists accessing specialist referral services for patients requiring complex restorative work, endodontics (root fillings), crown and bridge and periodontal (gum) treatments. In many cases patients still must travel to London and then there is no guarantee that they will be accepted for treatment. This was reported to HOSC in 2014 and the situation has not moved on significantly since then.

The commissioners have undertaken an accreditation exercise to which the LDC have contributed and have now a list of "Level 2 dentists" with enhanced skills in periodontics and endodontics. The services that these dentists can provide are not

located in Norfolk. The LDC is encouraging NHSEI to expand these Level 2 services to provide more suitable care for the population of Norfolk.

The poor level of oral health care of residents in care homes has been highlighted in a CQC report - Smiling Matters (2019). The commissioners have acknowledged the issues faced by care home residents in accessing dentists and dental support for care homes. There is a pilot to improve dental care in care homes. Care home staff are provided with sessions of training (Public health England). This is to train oral health champions within each care home. The pilot has encountered issues with staff shortages within care homes, and the time for someone within the care home to be an oral health champion. There are attempts to address this by putting oral health on par with other medical issues such as diabetes within the protocols of the care homes.

8. **NHS reorganization.**
   The NHS is likely to undergo a significant reorganization in 2022. It was originally expected that these changes would come in to effect in April 2022. However, this target date has now been changed to 1 July 2022 to allow more time for the remaining parliamentary stages and to enable organisations to manage their more immediate pandemic response priorities. Once the Health and Care Bill: Integrated Care Boards and local health and care systems complete its journey through parliament commissioning of local dental services will be the responsibility of our local Integrated Care System. How this will work in practice, and the impact of dental provision and budgets is unknown. At a time when some dental practices are considering a move away from NHS care, this type of uncertainty is unhelpful.

We have seen some horrendous reports about the impact of poor planning and resourcing of dental care in this region over the last few years. A rally was held in Bury St Edmonds, Suffolk, by an organization called “Toothless in Suffolk”. The organization was keen to highlight the lack of NHS care in Bury St Edmonds, but has now expanded to highlight these issues nationally: https://www.bbc.co.uk/news/uk-england-suffolk-59206782

None of these problems are inevitable. With imagination and an acknowledgement that reducing dental funding per head of capita for the last decade destroys our services, a way forward could be forged. As a local authority, I am heartened that you are exploring what you can do to improve this situation. The facts remain that these stories are the direct result of choices made by successive administrations at Westminster and their interpretation by the local commissioners, and you need to make your concerns and demands heard at that level.

Jason Stokes (Norfolk Local Dental Committee Secretary) 22nd February 2022

Norfolk County Council

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The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
Department of Health and Social Care

Letter sent by email

29 September 2020

Dear Mr Hancock

Norfolk Health Overview and Scrutiny Committee – access to NHS dentistry

Norfolk Health Overview and Scrutiny Committee (NHOSC) asked me to write to your department following a meeting on 3 September 2020 when we examined 'Access to NHS dentistry in Norfolk and Waveney' with representatives from NHS England and NHS Improvement (NHSE&I), the Local Dental Network and the Local Dental Committee.

We started our examination back in 2018 with the King's Lynn and West Norfolk area where we knew access was and had been particularly bad. At that time only around 39% of children in the area had seen an NHS dentist in the last 12 months and only 40% of adults had seen one in the past 24 months. This was far below the England average at the time. In subsequent years we broadened the examination out to the whole of Norfolk and Waveney as we realised there were widespread problems. Frustration at the lack of access to NHS dentistry has now risen to the point where the committee felt we needed to take it beyond NHSE&I and raise it with you and your department.

The situation in Norfolk and Waveney is simply unacceptable and has been for years. We know that Covid 19 has made things worse because the necessary measures to reduce the spread of infection drastically reduce the numbers of patients that dentists can see. However, the difficulties in accessing NHS dentistry in our area pre date Covid 19 by a very long way.

For years residents have been telling us that they can't find NHS dentists. The latest figures we have for local areas, from 2018/19, show that particularly West Norfolk and also North Norfolk were below the England average for number of NHS dentists per 100,000 of population but even in areas with above the average number people are telling us they cannot find an NHS dentist who will take them on.

People try to use the NHS 'Find a dentist' website but find it is constantly out of date. Healthwatch Norfolk has confirmed for us on several occasions that practices which the website says are taking on new NHS patients are in fact not taking them on. In their most recent telephone survey, in July 2020, they could only find one practice in in Norfolk that was taking on new NHS patients. We appreciate this was during the

period of Covid restrictions but the situation prior to March 2020 was also totally unacceptable.

The latest figures that we have from 2018/19 show a rising trend in the numbers of adults and children attending local A&Es because of dental problems and a rising trend in the number of subsequent admissions.

We have also heard from Family Voice, which represents parents and carers of children with special educational needs and disabilities, of waiting times of more than a year for special care dentistry. There has also been a long-standing lack of provision of restorative dentistry in the area because the Norfolk and Norwich Hospital has been unable to recruit specialists for this service, which has meant that people have had to travel to London for a service that should be available much closer to home. Access to NHS dentistry for care home residents and other vulnerable groups is another of our concerns and I could go on.

Regional NHSE&I and local dentists have been working very hard to improve matters over the years and the way they have pulled together during the Covid 19 crisis has been extraordinary. We really appreciate the work they have done to establish Urgent Dental Care centres across Norfolk and Waveney and to get general dental practice up and running again to some extent. Before Covid they had delivered a new dental practice at Marham in West Norfolk and we know they try to redistribute Units of Dental Activity unused by some practices to other practices in-year so that the maximum number of patients can be seen. They have also got a group of dentists and funding in place to provide specialist treatments locally and we understand that this very welcome service should be starting soon. We also know they are doing their best to improve recruitment and retention of dentists locally and to train up dental therapists and other clinical professionals to support the service.

The relationship between NHSE&I and our local dentists appears to be good and they are clearly working as hard as they can towards better access and better services but the progress is very slow. We know there are wider fundamental issues that cannot be solved locally or regionally and we think these have been holding back NHS dentistry in our area.

The dental contract

The contract introduced in 2006 is not fit for purpose. This has been clear for years and we know that that NHS England and NHS Improvement and its predecessors have been working on a new contract since at least 2015. It is time that we had a new contract in place as a foundation for more and better NHS dental services.

Recruitment and retention

This has become an urgent problem in recent years. We know there is no easy solution but national level action is required to do everything that can be done in every arena to mitigate the situation. This includes supporting the training of more dentists and other dental clinical professionals and doing everything possible to remove barriers to dentists from overseas coming to this country, particularly in light of Brexit. In 2018 NHOSC made a submission to a Public Accounts Committee inquiry into ‘Supporting primary care services: NHS England’s contract with Capita’. We hope that the situation has improved since 2018 when application waiting times for the NHS performers list were around 8 – 12 months, which meant that dentists

recruited from overseas were waiting to start work in Norfolk but couldn't and in the meantime patients were being turned away.

We have also been told that there has been no uplift in the level of funding for NHS dentistry in 10 years. NHOSC has not looked at the financial situation in detail but clearly this would be a concern.

I would be pleased to hear from the Department of Health and Social Care on what is being done to address all of the underlying issues that cannot be resolved locally.

Yours sincerely

Penny Carpenter
Chairman of Norfolk Health Overview and Scrutiny Committee

Department of Health & Social Care

PO-1313581

Councillor Penny Carpenter
By email to: maureen.orr@norfolk.gov.uk

26 March 2021

Dear Councillor Carpenter,

Thank you for your further correspondence of 11 March on behalf of your constituent, Councillor Penny Carpenter, about access to NHS dentistry in Norfolk and Waveney.

I was sorry to read of the continuing difficulties experienced by residents in finding available NHS dental practices.

As you are aware, all dental practices providing NHS services across Norfolk and Waveney are open for face-to-face care, including a new NHS dental practice in Marham. NHS dentists are following the advice of the Chief Dental Officer, which is to prioritise urgent care, particularly for vulnerable groups, followed by any routine care which is overdue. Therefore, it may be the case that very few dental practices have the capacity to carry out routine examinations at present. Due to COVID-19 restrictions and the difficulties it presents for dental care, the day-to-day capacity of dental practices is significantly reduced.

In the east of England, 100 Urgent Dental Care Centres (UDC's) are currently being utilised to meet the urgent needs of patients, ten of which are based in Norfolk and Waveney and there are plans to increase this number. Many of the UDC's in operation are open on weekends to support dental out of hours services. Additional funding is in place in parts of Norfolk, in particular, West Norfolk and North Norfolk until 31 March. In addition, the regional dental commissioning team have engaged some of these practices to provide urgent oral surgery and urgent orthodontic procedures.

NHS England and NHS Improvement (NHSE&I) is responsible for commissioning domiciliary services for care home residents and community dental services for people with special needs. I was saddened to hear of difficulties these vulnerable groups are experiencing in access to NHS dental care. As you are aware, the Special Care Dentistry service is available in clinics across Norfolk and Waveney. The NHSE&I commissioning team will continue to monitor and review these provisions.

Norfolk was one of the first counties in the east of England to work to amend the Directory of Service to improve pathways to UDCs and dental practices. This work is being extended to support wider stakeholders, by promoting a web-based programme called 'Service Finder' that has recently been launched and provides up-to-date information on services that are available locally to a potential patient. Plans are also being developed for urgent access to be widened out to link emergency departments to UDCs, dental practices and

Clusters for those patients who attend with dental pain. If a patient is struggling to get an urgent appointment at a dental practice, they can seek help through NHS 111.

We take concerns about the recruitment and retention of dentists seriously and I agree that NHSE&I is working hard to improve recruitment and retention. NHSE&I is working with the University of Essex to ensure training practices across East Anglia, including in Norfolk and Waveney engage with a BSc programme due to start in September 2021. Furthermore, an oral surgery upskilling project is scheduled to resume in September, and I am pleased to report that a large number of applications have been received for a voluntary mentorship programme being developed by NHSE&I. In addition, Health Education England (HEE) plans to further develop the pilot involving the Eastman Dental Hospital, which aims to offer further training to dentists to support workforce and skills development.

On a national level, NHSE&I's Interim NHS People Plan commits to addressing shortages within the dental workforce. In addition, HEE is exploring opportunities for flexible dental training pathways through their Advancing Dental Care programme, the aim of which is to improve dental workforce retention. More widely, we want to support dentists and the wider dental team to make NHS dentistry more attractive and we are currently testing a new NHS Dental Contract model which we hope will provide more scope and prospects for all dental care professionals within the dental team.

NHSE&I has been working with the profession and the British Dental Association to assess how the whole dental team may be better utilised to enable dentists to free up capacity and increase access. They are continuing to develop the commissioning framework to allow flexibility to existing contractual arrangements that incorporates the full skill mix of all disciplines within the dental team, thus creating a capable and motivated multidisciplinary dental workforce.

I can assure you that EU staff who are currently practicing in the UK can continue to do so, and that professionals qualified in the European Economic Area and Switzerland can continue to apply for registration.

Regarding your concerns about the NHS dental contract, the department is working with NHSE&I and the Office of the Chief Dental Officer on arrangements for 2021/22 onwards. An announcement will be made in the coming weeks regarding these arrangements.

I hope this reply is helpful.

JO CHURCHILL

Forward work programme and scoping for scrutiny

Report by Maureen Orr, Democratic Support and Scrutiny Manager

The Committee is asked to:-

(a) Approve the scope for scrutiny of 'Health and care for adults with learning disabilities / autism - local health and social care partners' joint action following the recommendations of the **Cawston Park Hospital Safeguarding Adults Review**'.
(b) Consider the current forward work programme and suggest issues for future scrutiny.

1. Scoping for scrutiny

1.1 On 4 November 2021 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a briefing from the Chair of Norfolk Safeguarding Adults Board on the recommendations in the report of the Cawston Park Hospital Safeguarding Adults Review (SAR), which was published on 9 September 2021, and the plans of the NSAB and local partners around implementation of the recommendations.

NHOSC agreed that scrutiny of local health and social care partners' joint progress to implement the recommendations of the SAR should be scoped and scheduled on its forward work programme.

1.2 A scoping document for scrutiny of 'Health and care for adults with learning disabilities / autism – local health and social care partners' joint action following the recommendations of the Cawston Park Hospital Safeguarding Adults Review' was circulated to members with the February 2022 NHOSC Briefing. Comments have been taken into account and a final draft version is presented at **Appendix A** for the committee's approval.

2. Forward work programme

2.1 The current NHOSC forward work programme is attached at **Appendix B**.

3. Action

3.1 NHOSC is asked to:-

(a) Approve the scope for scrutiny of 'Health and care for adults with learning disabilities / autism - local health and social care partners' joint action following the recommendations of the Cawston Park Hospital Safeguarding Adults Review' (Appendix A)

(b) Consider the current forward work programme (Appendix B):-

- Whether there are topics to be added, deleted, postponed or brought forward
- To agree the briefings, scrutiny topics and dates.

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Norfolk Health Overview and Scrutiny Committee (NHOSC)

Health and care for adults with learning disabilities / autism

Local action following the recommendations of the Cawston Park Hospital Safeguarding Adults Review (SAR), published on 9 September 2021 (the recommendations are set out at Appendix 1)

The roles of NHOSC, the Scrutiny Committee and Norfolk Safeguarding Adults Board are set out at Appendix 2.

Scoping for NHOSC scrutiny

Purpose

To contribute to improving services for people with learning disabilities by examining the effectiveness of local action following the recommendations of the SAR to meet the needs of those people with mental health needs alongside either learning disability or autism support needs.

Context

Norfolk Safeguarding Adults Board (NSAB) will oversee and seek assurance around the implementation of the action plan from the SAR. It will hold partners to account for its delivery at local level and influence national agendas which are linked to the relevant recommendations.

> National level - the Chair of NSAB has had meetings with the Law Commission, Department for Health and Social Care, NHS England and Care Quality Commission who have made commitments to make necessary changes to national systems.
>
> Local level - the NSAB is working with Norfolk and Waveney Clinical Commissioning Group (CCG) and Norfolk County Council Adult Social Services (ASS) to set up a Coalition for Change which will produce a strategy for people with challenging behaviours. People with learning disabilities / autism and their families will be involved. The strategy will address SAR recommendations for local action by the CCG and ASS. In relation to the SAR recommendation about addressing the racism of people with cognitive impairments NSAB has started work with the Norfolk Safeguarding Childrens Partnership and obtained assistance via NCCs Equality and Diversity officer.

NHOSC will scrutinise the local health and care system for additional assurance that there is effective change.

NHOSC members will receive written updates from NSAB via the NHOSC Briefing on its wide-ranging overseeing and assurance work.

NHOSC will scrutinise local health and social care commissioners on the effectiveness of specific areas of action, which may relate to the SAR recommendations to Norfolk or to the recommendations at national level as they impact on Norfolk.

Timing

9 Sept 2021 - SAR published

Progress updates from NSAB for NHOSC members

4 Nov 2021 – at NHOSC meeting
Feb 2022 –in NHOSC Briefing
Apr 2022 – in NHOSC Briefing
Jun 2022 – in NHOSC Briefing
Aug 2022 – in NHOSC Briefing

Scrutiny by NHOSC

The Coalition for Change agreed a project initiation document on 7 Feb 2022. It is now in the process of establishing a Steering Group and recruiting an independent Co-ordinator. The Steering Group will produce a detailed timeline for the project.

8 Sep 2022 – first scrutiny – at NHOSC meeting
Date tbc – second scrutiny – at NHOSC meeting

SCRUTINY - Issues to be addressed and questions to be asked

First scrutiny meeting to examine:-

1. **What has changed in the way that commissioners check the quality of the services they are commissioning for Norfolk and Waveney patients**

    - The CCG's process for ongoing checking of quality of service in the hospitals in which Norfolk and Waveney residents with learning disabilities / autism and mental health needs are placed, including checking daily activities, physical healthcare, sleep (including support for use of CPAP), and medication. What processes are in place to escalate concerns where necessary? Evidence of what is done differently since the Cawston Park Hospital review.

    - How does the CCG check that the hospitals in which it places patients are taking a family-centred approach to their care and engaging the expertise of their relatives as appropriate?

    - How does the CCG liaise with families to check their impression of the quality of care the patient is receiving?

- As the pandemic continues, with potential restrictions on access for infection control, what arrangements have been put in place by the CCG to make sure it can effectively check the quality of service during these periods?

- What action does the CCG take if the Care Quality Commission lowers the rating of a facility in which Norfolk and Waveney residents are placed, e.g. from 'Good' to 'Requires Improvement' or 'Inadequate'?

- What is Adult Social Care's process for making quality checks in the separate area of longer-term residential care for adults with learning disabilities. How does it draw on lessons from the CCG's experience in the mental healthcare area? What changes has Adult Social Care made to its quality check process since the Cawston Park Hospital review?

2. What has been done towards reducing hospitalisation, distance from home and length of stay

- How many Norfolk and Waveney residents are currently placed in hospitals for adults with learning disabilities / autism and mental health needs? What are the geographic locations; are the hospitals NHS or private; what are their current CQC ratings?

- What is the trend in hospital placement of patients from Norfolk & Waveney in terms of numbers, length of stay and placement close to home?

- The CCG's progress towards more community-based services to help avoid hospitalisation for adults with learning disabilities and mental health needs.

- To what extent are patients from Norfolk and Waveney in the position of 'delayed discharge' from the hospitals in which they are placed?

- How do the CCG and Adult Social Care facilitate timely discharge of patients from hospital? What additional steps have they taken to ensure timely discharges since the Cawston Park Hospital review?

3. What is now done differently when issues around specific facilities / providers become known to the CCG and Adult Social Care commissioners

- When the CCG and / or Adult Social Care have concerns about a facility or a provider in Norfolk and Waveney, or in different parts of the country in which any of our residents are placed, do they proactively liaise with CCGs, Adult Social Care departments and other agencies across the country who also place people with that facility / provider to alert them to concerns?

- Do the CCG and Adult Social Care alert the CQC to issues which they pick up during their monitoring of facilities and are they satisfied with the way the CQC has handled any such reports since the Cawston Park Hospital SAR?

How do the CCG and Adult Social Care monitor the CQC's response to their reports and what action can they take if they are not satisfied with the CQC's response?

- Is there a system to keep track of where managers, clinical staff and support staff from a facility that has been rated 'inadequate' and found to have an unacceptable culture towards patient care go on to work when that facility is closed down? Is there a system to ensure appropriate re-training and support for staff coming from such a facility?

- Is Adult Social Care up-to-date with keeping other local authorities from across the country who place residents in Jeesal Group residential care homes in Norfolk informed about the issues around the overall stability of the provider.

Second / subsequent scrutiny meetings to examine:-

4. **How are the CCG and Adult Social Care changing their approach to commissioning to promote better quality care in the sector?**

5. **What steps have the CCG and Adult Social Care taken to support providers to challenge the racism of people with cognitive impairments and how are the results evaluated?**

6. **All other issues …**

People to speak to

Representatives of:-

- Norfolk and Waveney CCG (to be replaced by the Integrated Care Board from 1 July 2022)
- Norfolk County Council Adult Social Services
- Norfolk Learning Disabilities Partnership
- Norfolk Autism Partnership

APPENDIX 1

Conclusions and Recommendations of the Cawston Park Hospital SAR report (summary version)

a) Norfolk's SAB should write to the Law Commission proposing a review of the current legal position of private companies, their corporate governance and conduct in relation to services for adults with learning disabilities and autism. Given the clear public interest in ensuring the well-being and safety of patients, and the public sponsorship involved, the Law Commission may wish to consider whether corporate responsibility should be based on corporate conduct, in addition to that of individuals, for example.

b) Norfolk and Waveney CCG and Norfolk ASSD should review their commissioning arrangements to embrace "ethical commissioning." This should attend to:

"**Ethical employment:** Commissioners must be able to distinguish between the workforce practices of different providers and prioritise those acting as ethical employers. This might include prioritising those companies that are accredited by the Living Wage Foundation; have effective training, development and supervision; sign up to an ethical care charter; outlaw false self-employment and zero-hours contracts; and encourage staff to participate in collective bargaining.

Tax compliance: The ownership of all companies contracted to deliver public services should be available on public record. At the same time, a taxation test could require contracted private companies to demonstrate that they are based in the UK and subject to UK taxation law.

Transparency: A transparency test could stipulate that where a public body has a legal contract with a private provider, that contract must ensure full openness and transparency with no recourse to the cover of "commercial confidentiality…"

Localism: A focus on smaller and more local commissioning is needed – a challenge for public services commissioners who generally favour dealing with a small number of large organisations with established contracting infrastructures. Smaller organisations hold vast expertise about the precise issues affecting people in their area and can serve very small or isolated communities or specific communities of interest.

Ethical vision: To create change in adult social care, we need a guiding vision, rooted in ethical considerations of promoting good lives well lived, and protecting the wider economic, social and environmental wellbeing of a local area. Procurement legislation in Scotland seeks to promote just such a vision but has no real equivalent in England."

In addition, a **Community Benefit** test to nurture connectedness to communities would ask potential providers what they will gift to a locality. For example, apprenticeships for local school leavers; opportunities for local businesses and farms to provide goods; the provision of studio spaces for artists; and growing plots for gardeners. This would allow local credit for initiatives to be dispersed and to take root. The test should require the provider to exemplify the community benefit every year, in believable human terms, using people's own words, for example.

c) Evidence of changing commissioning arrangements should be shared with Norfolk's SAB.

d) NHS – England should ensure that (i) all placing CCGs are proactive in ensuring that they have up-to-date knowledge about the services they commission and how these are experienced. The "four eyes principle" may be useful, most particularly if the additional "eyes" are those of a parent whose relative has current or recent experience of the assessment and treatment services being commissioned;5 and (ii) that when transfers take place between in-patient settings, these cease to be recorded as "continuous inpatient stay …treatment for the purposes of the one year CTR" [Care and Treatment Review].

e) Norfolk and Waveney CCG and Norfolk County Council should transfer all its remaining patients from this Hospital.

f) Norfolk's SAB should make representation to the Department of Health and Social Care to ask what additional rights and protections will be afforded to adults with learning disabilities and autism who become vulnerable to detention in the same clinical settings under the Mental Capacity Act (2005).

g) Norfolk's SAB should share this review with NHS – England since it was responsible for Jon's placement. NHS – England and the CCGs responsible for placing people at Cawston Park Hospital should visit services, host reviews and ask questions such as:

- how many patients have returned to Cawston Park Hospital for further assessment and treatment?
- does Cawston Park Hospital have admission criteria concerning patients who have had previous episodes of assessment and treatment?
- are there periods when the patient we fund is super-busy or are their days characterised by naps, snacking and sitting for hours? - are routines such as cleaning teeth, bathing, showering, changing clothes, hair washing and nail cutting, for example, expected and actively supported?
- does the patient we fund sleep deeply during the night because they are physically tired?
- how is the patient we fund, who is malnourished and/ or obese, encouraged and supported to make dietary and lifestyle changes? - what happens if the physical health of the patient we fund deteriorates because they are resisting essential, prescribed treatment such as CPAP?
- what happens if the patient we fund refuses to participate in activities?

- what examples are there of Cawston Park Hospital maintaining and developing the ability of patients to perform daily tasks and promoting their participation in purposeful and valued occupations?
- on how many occasions have acute hospital security staff assisted Cawston Park Hospital's support workers to subdue an inpatient during acute hospital admission or attending clinic appointments?
- where are the service destinations of all former Cawston Park Hospital inpatients?

h) NHS-England should be invited to provide evidence to Norfolk SAB that these questions have been circulated and incorporated into its own processes.

i) Placing/funding Clinical Commissioning Groups are keepers of the public purse. **NHS England is invited to bring forward evidence of strengthened mechanisms for: discharge dates; the stability of accommodation within a service; close attention to an inpatient's physical health needs and experiences, their mental health needs and experiences, and the service's track record in addressing these.**

j) Norfolk's SAB should propose to the CQC that the legal process of registration cancellation should proceed irrespective of a service's improvements if these are attributable to the ongoing efforts of the NHS, local authority social care employees and Inspectors.

k) Norfolk's SAB should set out for CQC's Chief Executive the consequences of Cawston Park Hospital's failure to enable family-centred approaches and engage with the expertise of patients' relatives. This is paralleled in CQC inspections. The inspectors would benefit from including parent "experts by experience" with recent experience of seeking to work with assessment and treatment services and units (see, for example, families' contributions to this Review). **To maintain public confidence, CQC may wish to confirm (i) that it has no remit to determine whether patients should remain in such services, not least since this conflicts with national policy; and (ii) what specific actions it proposes to take in relation to locked wards in specialist hospitals and units.**

l) Norfolk and Waveney CCG and the County Council should rebalance responsibility for Norfolk citizens away from "medical led admissions and social care discharges." The reform of the Mental Health Act (1983) should anchor discussions and agreements between these public authorities concerning ethical commissioning.

m) The taboo of addressing the racism of people with cognitive impairments remains to be explicit and made visible in all services. Norfolk's SAB should begin a process of (i) gathering the efforts and experiences of the county's service providers in challenging racism and racist stereotyping and (ii) convening "world café" conversations with providers and other interested people, including those at the sharp end of injustice.

APPENDIX 2

The roles of NHOSC, the Scrutiny Committee and NSAB

NHOSC

The County Council holds statutory powers for democratic scrutiny of the local health service, which is carried out by Norfolk Health Overview and Scrutiny Committee (NHOSC). The committee includes non-Cabinet members of Norfolk County Council and a non-Cabinet member from each of the district councils in the county. NHOSC focuses primarily on health services and can also pick up scrutiny of integrated health and social care services. Its meetings are held in public.

NHOSC is picking up the scrutiny in relation to the health and care system as outlined in scoping document above.

The Scrutiny Committee

Norfolk County Council has a Cabinet and Scrutiny model of governance. The Cabinet is the decision-making body in the County Council and the Scrutiny Committee holds it to account. The Scrutiny Committee is made up of non-Cabinet members in line with the political balance of the council. It focuses primarily on the functions of the County Council, including social care. The Scrutiny Committee holds its meetings in public.

The Scrutiny Committee intends to pick up the subject of 'Social Value in Procurement' across the County Council, including social care, at a later stage following the NHOSC review. NHOSC's findings in relation to the SAR report's recommendation on 'Ethical Commissioning' will feed into the Scrutiny Committee review.

Norfolk Safeguarding Adults Board (NSAB)

NSAB was established under the Care Act 2014 as the mechanism for agreeing how the relevant partner agencies within the Norfolk County Council area co-operate to safeguard adults at risk of harm. Part of the purpose of the Board is to draw out and disseminate the learning from reviews and to ensure that the lessons arising from review are promulgated and acted upon by the agencies.

In relation to the recommendations in the Cawston Park Hospital SAR report NSAB has described its role as to 'oversee and seek assurance around the implementation of the action plan and hold partners to account for its delivery'.

NSAB is independently chaired. Norfolk and Waveney CCG and Norfolk County Council are statutory members of the Board. It is not a democratic scrutiny body and its meetings are not held in public.

NHOSC recognised during discussions on 4 November 2021 following a briefing by the Chair of NSAB that it would be important for NHOSC's scrutiny to proceed in a way that is complementary to NSAB's work.

Proposed Forward Work Programme 2022

ACTION REQUIRED

Members are asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the agenda items, briefing items and dates below.

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Meeting dates	*Main agenda items*	*Notes*
12 May 2022	Prison healthcare – access to physical and mental health services Queen Elizabeth Hospital NHS Foundation Trust – progress report	
14 July 2022	Children's neurodevelopmental disorders -waiting times for assessment & diagnosis – follow up to 15 July 2021 NHOSC Annual physical health checks for people with learning disabilities – to examine progress.	
8 Sept 2022	Health and care for adults with learning disabilities / autism - local health and social care partners' joint action following the recommendations of the Cawston Park Hospital Safeguarding Adults Review.	

Information to be provided in the NHOSC Briefing 2021-22

Apr 2022 - **Eating disorders** - an update on the data that was included in the report to NHOSC on 4/11/21 and in addition (for adults' and children's services):-

- Workforce data- staffing levels, clinical & admin, including current vacancy level
- Information on management of the workforce to staff the expanding Eating Disorders services without taking away from other local mental health services.

- Waiting list sizes
- Feedback from service users and their families about their experience of the service.
- Management of Really Sick People with Anorexia Nervosa – has a current policy been put in place at the Queen Elizabeth Hospital in respect of children and young people?

- **Health and care workforce shortages** – update on local action to address shortages (follow-up from NHOSC 18/3/21 meeting)

- **Cawston Park Hospital Safeguarding Adults Review** – update from Norfolk Safeguarding Adults Board on action underway to address the recommendations.
(See also 'Health and care for adults with learning disabilities' scrutiny item scheduled for Sept 2022 agenda – scrutiny of health & social care action)

Jun 2022 - **Cawston Park Hospital Safeguarding Adults Review** – update from Norfolk Safeguarding Adults Board on action underway to address the recommendations.

Aug 2022 - **Cawston Park Hospital Safeguarding Adults Review** – update from Norfolk Safeguarding Adults Board on action underway to address the recommendations.

NHOSC Committee Members have a formal link with the following local healthcare commissioners and providers:-

Norfolk and Waveney CCG	-	Chair of NHOSC (substitute Vice Chair of NHOSC)
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Julian Kirk (substitute Alexandra Kemp)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	Brenda Jones (substitute Daniel Candon)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr Nigel Legg
James Paget University Hospitals NHS Foundation Trust	-	Penny Carpenter (substitute Daniel Candon)
Norfolk Community Health and Care NHS Trust	-	Emma Spagnola

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Glossary of Terms and Abbreviations

ACP	Advanced Clinical Practitioner
AIS	Accessible Information Standard
ARRS	Additional Roles Reimbursement Scheme
BDA	British Dental Association
British Sign Language (BSL)	BSL is a visual-gestural language that is the first or preferred language of many d/Deaf people and some deafblind people; it has its own grammar and principles, which differ from English.
CCG	Clinical Commissioning Group
CCS	Crown Commercial Services
d/Deaf	A person who identifies as being deaf with a lowercase d is indicating that they have a significant hearing impairment. Many deaf people have lost their hearing later in life and as such may be able to speak and / or read English to the same extent as a hearing person. A person who identifies as being Deaf with an uppercase D is indicating that they are culturally Deaf and belong to the Deaf community. Most Deaf people are sign language users who have been deaf all of their lives. For most Deaf people, English is a second language and as such they may have a limited ability to read, write or speak English
DESS	Deaf Enhanced Support Service – a pilot service in 2021-22 to enable Deaf patients who are unable to use technology for making their own appointments to access a BSL interpreter to make the appointments for them
DIO	Defence Infrastructure Organisation
DMS	Defence Medical Services
EEAST	East of England Ambulance Service NHS Trust
EoE	East of England
HCPH	Healthcare Public Health
HE	Higher education
HEE	Health Education England
HIV	Human Immunodeficiency Virus
HMG	Her Majesty's Government
HWN	Healthwatch Norfolk
ICB	Integrated Care Board
ICS	Integrated Care System
I&T	Interpreting and translation
LA	Local Authority
LDC	Local Dental Committee - an independent body which represents dental practitioners and has a statutory right to be

	consulted by NHS England on issues relating to the dental profession
LMC	Local Medical Committee
LSOA	Lower super output area – a geographic area; part of a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales
MOD	Ministry of Defence
MSK	Musculoskeletal
NDEP	National Dental Epidemiology Programme for England: oral health survey of 5 year olds 2019
Needs – normative, felt and expressed	Normative need – a need which is identified according to a norm or set standard; such norms are generally set by experts. Felt need – the need which people feel; that is, need from the perspective of the people who have it. Expressed need – the need which people say they have; people can feel need which they do not express and express needs they do not feel.
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE&I EoE (NHSE)	NHS England and NHS Improvement, East of England. One of seven regional teams that support the commissioning services and directly commission some primary care services and specialised services. Formerly two separate organisations, NHS E and NHS I merged in April 2019 with the NHS England Chief Executive taking the helm for both organisations.
OCDO	Office of the Chief Dental Officer
OOH	Out of hours
ONS	Office of National Statistics
ORE	Overseas Registration Exam
OSC	Overview and Scrutiny Committee
PA	Physician Associate - support doctors in the diagnosis and management of patients. Often PAs are graduates who have undertaken post-graduate training and are working under the supervision of a GP
PCN	Primary Care Network
PHE	Public Health England
PPE	Personal protective equipment
PUFA	Pulp, ulceration, fistula and/or abscess
QOF	Quality Outcomes Framework – the annual reward and incentive programme for GP practices. It rewards practices for provision of quality care and helps standardise improvement in the delivery of primary medical services

STP	Sustainability Transformation Partnership (became Integrated Care Partnerships)
UDA	Unit of dental activity
UDC	Urgent Dental Care Centre
VOIP	Voice over internet protocol
WTE	Whole time equivalent