SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 10 February 2021

(NOTE: This meeting was held as a remote meeting in accordance with the provisions of The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020).

PRESENT: Councillors Cate McDonald (Chair), Steve Ayris (Deputy Chair), Sue Alston, Angela Argenzio, Vic Bowden, Lewis Dagnall, Mike Drabble, Jayne Dunn, Adam Hurst, Talib Hussain, Abdul Khayum, Martin Phipps, Jackie Satur, Garry Weatherall and Sue Auckland (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Lucy Davies

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Gail Smith. Councillor Sue Auckland attended as her substitute.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 13th January, 2021 were approved as a correct record. With regard to the recommendation at item 6(f) – to consider further scrutiny work on the relationship between disability and Covid - the Chair reported that she was in the process of setting up a meeting with Healthwatch Disability Sheffield to discuss this matter, which was to be held on 3rd March, 2021, between 10.00 a.m. and 11.30 a.m., and asked for any volunteers to attend this meeting. Councillors Angela Argenzio and Garry Weatherall volunteered to attend. The Chair added that she would report the outcome of that meeting to the next meeting of this Committee.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no questions raised or petitions submitted by members of the public.

6. ACCESS TO DENTAL SERVICES DURING COVID

6.1 The Committee received a report on how dental services in Sheffield had been impacted upon by the Covid- 19 pandemic and how access to those services had been affected.

6.2 Present for this item were Debbie Stovin (Dental Commissioning Manager NHS England), Deborah Pattinson (Dental Commissioning Lead, Yorkshire and Humber and NHS England) Margaret Naylor (South Yorkshire and Bassetlaw Local Dental Network), Sarah Robertson (Consultant in Dental Public Health, NHS England), Zoe Marshman (University of Sheffield), Jim Lafferty (Practising Dentist) and Emma Wilson (Head of Co-commissioning Yorkshire and Humber and NHS England).

6.3 The Chair, Councillor Cate McDonald, stated that the reason this item had been brought before the Committee, was due to several complaints/enquiries that had been received regarding dental services within the city.

6.4 Emma Wilson stated that the report set out details on how the impact Covid-19 had continued to have on NHS dental services in the city. She said that following advice from the Chief Dental Officer, dentists were asked to stop routine treatment and provide remote consultations and triage. An urgent dental care system had been established to ensure that patients, who were in pain or who had an urgent and immediate need, could access remote triage, and then be offered face to face treatment, where it was deemed clinically necessary and appropriate. She stated that, to ensure that both clinicians and patients were safe, all practices had to follow the stringent infection prevention and control measures published by the Chief Dental Officer and Public Health England. Emma Wilson further stated that all dental practices in the city were open, and patients would be offered appointments if deemed necessary. Unlike GP surgeries, there was no registration system in dental practices, with patients being able to have regular access to a dental treatment if they wished.

6.5 Jim Lafferty stated that offering appointments to patients has been quite challenging. He stated that the Personal Protective Equipment (PPE) worn by dental staff had proved to be quite onerous and that the aerosol spraying water, which was used to keep equipment cool, had the potential to spread the virus, thereby restricting access to dental services. Jim Lafferty stated that when surgeries re-opened last June, there had to be a one-hour turnaround time between patients to allow for the equipment to cool down and premises to be deep cleaned, which had a knock-on effect on the number of patients being given an appointment each day. However, the cool down time had since reduced to 10 minutes and a further 10 minutes to deep clean the premises. There was now a backlog of routine check-ups due to these restrictions.

6.6 Zoe Marshman referred to the work of the Oral Health Prevention Team which had been severely impacted by the pandemic. She stated that pre-Covid, there had been toothbrushing clubs attended by thousands of children in schools around the city, which ensured children cleaned their teeth every day, but these

had been temporarily closed. She stated that during the summer, she had been working with food banks, the Healthy Hamper Programme and other agencies to handout toothbrushes and toothpaste as part of food parcels.

6.7 Lucy Davies stated that there had been consistency throughout the country regarding issues linked to capacity, due to measures put in place for dental services, to keep everyone safe. Healthwatch Sheffield had received weekly feedback of the concerns expressed in the report, with the standout issue relating to equity, in that people who don't have a regular dentist were having problems accessing treatment, as well as the problems that arose through NHS versus private care. Lucy Davies stated that there had been a significant increase in the number of people seeking NHS dental care being told that they could be seen more quickly if they paid for their care. There were those who could afford to pay for private care and there was concern about this disparity, which could impact on existing health inequalities.

6.8 Members of the Committee made various comments and asked a number of questions, to which responses were given as follows:-

- During the pandemic, several phases were put in place and dental practices were asked to prioritise patients to them going to Accident and Emergency in pain, which would increase pressure on the NHS. Patients were able to obtain prescriptions and triage services remotely. On 8th June, 2020, dental practices were permitted to re-open subject to the correct PPE equipment in place, and from 10th July, 2020 onwards, dentists had been dealing with urgent cases which, if not treated, would have resulted in patients having to go to hospital. Several factors were considered, such as the socio-economic status of inhabitants, the likelihood of them being able ???to attend the surgery, and the stability of practices. The commissioning of dental activity was based on courses of treatment and Units of Dental Activity (UDAs), which represent money paid by the Government to dentists, and some surgeries with smaller contracts might be unable to reach their pre-pandemic UDA targets.

- Regarding the issue of private dental care and services offered by the NHS, many practices were mixed, offering both private and NHS patients. It was often the case that when NHS sessions were full, patients would then be offered private care, which was the reason why people were being offered private sessions.

- If additional funding was made available to dental practices, more appointments would be offered. The Commissioners have done their best to address issues around access.

- Some patients who have been unable to attend for regular check-ups may require additional treatment, therefore the appointment time would be longer.

- NHS England were responsible for commissioning and contracting dental services across all 66 dental practices in the city. Occasionally, there was

clawback in resources and the Commissioners looked to see if that money was being used efficiently and how ? to make it work more effectively. There needs to be flexible commissioning to use money to work differently. When the pandemic was over, there would be increased challenges and support would be given to practices, but the level of funding available in next year's budget remained unclear. There was a need to improve the inequalities in dental care and make sure that there was access for all. NHS England had confirmed that all dental team members and their support staff in NHS and private settings would receive priority access to the Covid vaccine.

- It was felt that the current dental contract, which was implemented in England and Wales in 2006 and which remunerated dentists purely on activity, was not fit for purpose and there was a need for the Department of Health and Social Care, NHS England, and its local commissioners to drive forward meaningful contract reform.

- With regard oral health inequalities, the Council had a Health Promotion Team which was responsible for oral health improvement, and was working on a number of programmes to address this. Training was being offered to health professionals, and health visitors had been handing out oral hygiene packs, and it was hoped that toothbrushing clubs were able to re-open as soon as Public Health guidance allowed. One of the main factors was prevention, and the introduction of water fluoridation neededto be progressed.

- Communication over the past nine months had been given to patients, advising them of how to access emergency services if they were in pain. It was felt there was a need for patients understand that, unlike being registered with a GP, there was no obligation for dental practices to register patients as some people did not wish to attend regularly, just when they considered it necessary.

- It was a matter of managing patients' expectation, most NHS dentists will see people, but people were contacting them to plan for routine appointments and at present, dentists were not able to offer routine check-ups, as there was the need to prioritise those in pain or having problems.

- The current contract was based on services that had been provided between 2005/06, and hadn't changed over the years. Only 56% of the population had accessed dental services during that year, so current funding was based on that percentage, and it hadn't increased.

- Medical and dental services were not integrated. If a patient informed their dental practice that they were receiving treatment for cancer and a heart condition, they would be seen as a priority.

- With regard to inequalities, there was no structured guidance for practices coming out of Covid, but vulnerable groups would be prioritised. However, at present, no structure was in place as to how this would be achieved.

- NHS England had been posting messages on social media platforms on a weekly basis on how to access dental care, and what was considered to be urgent dental care during Covid. However, input from Healthwatch would be welcomed on what further information could be communicated.

- Each South Yorkshire Local Authority had its own oral health improvement action group, and had been charged with identifying groups within their communities that needed to focus on people being able to access dental care. In Rotherham and Barnsley, there had been links with safeguarding teams to identify vulnerable children to make sure they have access to dental care

- The guidance from the National Standard Operating Procedure was to deliver the safe and effective provision of the full range of care in all practices. The enduring priorities was for the protection of patients, the dental team, and the wider community. Practices had prioritised in certain ways, knowing their patients with high needs, those with gum disease and those with significant health issues. From a shielding perspective, many patients hadn't been out of the house since last March, and had still not sought the care and treatment they ought to get, as well as considering dental care and treatment to be an ongoing challenge. Practices had used their websites to show patients what to expect when visiting surgeries, how the patient journey has changed i.e., temperatures being taken, handwashing, screening, etc., in an attempt to alleviate these fears.

- The question regarding "registered" or "regular" patients was open to interpretation and was subjective. Patients who normally attend for "regular" six-monthly check-ups hadn't been able to be seen regularly, so this was becoming a problem.

- A number of projects for those "at risk" and vulnerable groups had commenced, one such project was to contact those of no fixed abode. It was hoped that the new contract would ensure more flexibility and be able to be more creative and responsive in doing things differently and getting it right for everyone.

- Practices had responded to urgent needs. The challenge post-Covid was to be reactive rather than proactive but there was a supportive regional team to focus on the wider recovery plan. Sheffield was one of the first cities to be up and running with its dental services throughout the pandemic, so whilst not being able to provide a full service, dental practices had coped reasonably well, and the focus now was on the wider recovery plan over the next few months.

- The Department for Health had acknowledged that the current contract for dental services was 13 years old and that dental services were restricted by that contract and its lack of flexibility and ability to target groups governed by that contract. The feeling was that there was a need to make local commissioning "local", which didn't exist in dentistry at the moment.

- The majority of dental practices were working at maximum capacity to see as many patients as possible, given the restrictions imposed. Extra resources were not the answer, many buildings would have to be redesigned, be subject to planning permission It would possibly take six months to carry out the works, and would cost a significant amount of money to achieve this, therefore was not considered feasible. Also, there was a shortage of dentists and dental nursing staff, so it would be impossible to supply personnel to work in extra buildings should they be made available.

- Dentists had been set a target to achieve 45% UDAs but it was impossible to reach 45% UDAs due to the pandemic. There were perverse – is this right? incentives not to exceed 45%. Many practices were achieving the target due to prioritising dental care, but it was known that some practices were just prioritising urgent care, as the Commissioners had made it more attractive to offer urgent care.

6.9 RESOLVED: That the Committee:-

(a) thanks Debbie Stovin, Deborah Pattinson, Margaret Naylor, Sarah Robertson, Zoe Marshman, Jim Lafferty and Emma Wilson for their contribution to the meeting;

(b) notes the contents of the report and responses to the questions raised;

(c) notes that greater local flexibility is required in the contracting arrangements for dental services, and requests the Chair of the Committee to write to the appropriate organisations to express the Committee's views on this, including concern over activity targets and perverse financial incentives;

(d) recognises the challenges facing commissioners in the context of Covid, and the importance of undertaking impact assessments and developing a recovery plan; and

(e) notes that the Committee has a track record of supporting consideration of whether fluoridation would be appropriate for Sheffield.

7. MAINTAINING A STABLE ADULT SOCIAL CARE MARKET

7.1 The Chair informed the Members that she had received a letter from lawyers on behalf of Sheffield Care Association expressing its concerns at the contents of the report. She said the Association thought that it was the Cabinet that was going to make a decision on this matter. She wanted to let people know the letter had been received, and that the Committee was not ignoring the issues raised.

7.2 The Committee received a report setting out the Council's approach to reviewing the adult social care market and setting the fees for contracted, independent sector care homes, home care, extra care, supported living and day activity providers in

Sheffield for the Financial Year 2021-22. The report also described the review of rates for Direct Payments for people who chose this means of arranging their own care and support.

7.2 Present for this item were John Doyle (Director of Strategy and Commissioning) and Joe Horobin (Head of Commissioning, Strategy and Commissioning, Adult Services).

7.3 Joe Horobin introduced the report and stated that it was always challenging to analyse the market, but it had been particularly challenging during the current climate. The report showed the process and methodology that was followed and asked for the Committee's input into the process. The Service was working through feedback from care providers which will form part of the final report to be submitted to Cabinet in March, 2021. She said the report was an annual process and this year there was additional input from some external consultants working on the strategic review of the adult care sector. John Doyle added that it was always a difficult process for the care sector, but there were more pressures around fee rates and occupancy, the changing marketplace and very uncertain pattern of demand.

7.4 Members of the Committee made various comments and asked a number of questions, to which responses were given as follows:-

- It was acknowledged that fundamentally, the Council needed to be commissioning services that were co-produced and co-designed with those who used them.

- Relating to direct payments, it was hoped that annual market analysis and fee review would reflect more on customer experience, and that the customer and carer voice would come through in that analysis. The Service was keen to hear the views of Members of what they think could be factored into the analysis. The Council had a duty under the Care Act to meet the needs and wellbeing of the people of the city.

- The focus of the report formed part of a bigger discussion. The wider strategy was about how do we support families sooner.

- The Council was looking into a review of the services it provided and it was important to look at this year on year to keep going forward, because it was essential that the Council didn't stand still on these issues.

- In terms of the contribution that an individuals made towards the cost of their care, there was a difference between the calculation for home care and residential care in that if someone was receiving home care, the value of their home wasn't taken into account.

- The Consumer Price Index (CPI) was determined every year in September, in line with the level of pensions determined by the Department for Work and Pensions and was used to determine the CPI for the next financial year.

- Consultants had been engaged to carry out the strategic review into Older Adult Care Homes, and initial feedback has been very useful A final report of the review was expected by the end of February 2021, before submission to Cabinet in March 2021. The review would show the medium and long- term recommendations for the future demand for, and shape of, the care home market and support for older people. The pandemic has had a catastrophic impact on care, and had shown that providers needed to shift to a different footing and work closely with the older care sector. One area was to ensure the level of capital expenditure to support the aging housing ?? stock and ensure ?? sure the Council had a 10-15 year strategy for older peoples care homes, ensuring they are well designed and fit for purpose.

- The Council needed to understand what the effect the current low occupancy in care homes would have on the long-term funding strategy. At present, there was 78%-79% occupancy of beds in the city, and it was not known what support would come from the Government.

- The draft White Paper did not suggest anything about more funding for the care sector, and there hadn't been any investment over many years. At present, there was a two-tier system, with those who could pay for care and those who could not, but it was considered there was a need to offer good quality of care for everyone.

- One concern for care home providers was the non-staffing element and whether it was sufficient to cover their costs. In Sheffield, there were fewer homes with a mixed economy of self-funders and Council-funded placements, so cross-subsidy was far less than it used to be. The Council's duty, when understanding the cost of care, was to ensure the rates it paid was sufficient to ensure quality of care that assumed no third-party contribution. However, this does not mean cross-subsidy does not exist.

- The Council could anticipate that there would be less demand for care homes in that people would want to receive more care in their own homes. The pandemic had been damaging to the reputation of care homes, and it was anticipated that there would be shorter lengths of stay and higher turnover of residents in care homes, resulting in a need for the costs of these changes to be assessed.

- Care homes had the lowest turnover of staff as they tended to work as a team and supported living teams have a more stable cohort., Staff delivering home care tended to have the highest turnover, and the aim was to ensure that staff were properly renumerated, supported and respected, with the aim of reducing the level of stress and build in a more resilient workforce.

- Strategic Review means as much about staff and it does about buildings.

- It was acknowledged that this was an annual process which has historically been fixed on fees and providers, and that the Council must be able to account for that. The stakeholders were largely health and social care professionals, and the invitation to be involved could be extended to include

Healthwatch, the Carers Centres and the next step was to consider what the people of Sheffield want, which should be highlighted in the Strategic Review.

- The trade unions had not been part of the Review but there was no reason why not to engage with them. The Council holds regular meetings regarding changes to home care.

7.5 RESOLVED That the Committee:-

(a) thanks John Doyle, Joe Horobin and Councillor Jackie Drayton for their contribution to the meeting;

(b) notes the proposal set out in the paper;

(c) calls on Government to urgently respond to the national funding crisis in adult social care;

(d) recognises the difficulties that care providers in the city are facing;

(e) will schedule a future look at the full strategic framework for Adult Social Care as soon as is appropriate; and

(f) would like to see a wider range of stakeholders involved in the consultation process including trade unions and service users.

8. WORK PROGRAMME

8.1 The Committee received a report of the Policy and Improvement Officer on the Work Programme for the Committee.

8.2 RESOLVED: That the Committee approves the contents of the Work Programme.

9. DATE OF NEXT MEETING

9.1 It was agreed that the next meeting of the Committee will be held on Wednesday, 10th March, 2021, at 4.00 p.m.

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