

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

15 APRIL 2025

PUBLIC MINUTES

- Present Solihull Metropolitan Borough Council: Councillors G Sleight (Chairman), A Mackenzie, K Jones, S Gethen, A Wilson (V)
Birmingham City Council: Councillors F Grindrod, D Harries, G Moore,
- Officers Paul Rogers: Democratic Services, Solihull Metropolitan Borough Council
Adewale Fashade, Interim Scrutiny Officer, Birmingham City Council (Virtual)
- Guests Paul Athey, Chief Financial Officer, BSOL ICS
Faith Button (Virtual), Chief Delivery Officer (CDO), BSOL ICB
Robbie Dedi, Chief Medical Officer, Birmingham Community Healthcare Foundation Trust
Phillipa Coleman, Associate Director, Primary Care & Commissioning
Helen Kelly, Chief Nursing Officer, ICB
Katy Hogan, Hospital Operations Director (Women & Children), UHB
Bhavna Gokani, Director of Nursing
Helen Reilly, Hospital Director for Allied Health Professionals & Professional Lead for Dietetics
Reva Stewart, Chief Operating Officer, BCHC

1. APOLOGIES FOR ABSENCE

No apologies for absence were received.

2. DECLARATIONS OF PECUNIARY OR CONFLICTS OF INTEREST

Councillor Moore declared that he was a Trustee of the Birmingham Citizens Advice Bureau and Birmingham LGBT, who hold contracts with the NHS, as non-pecuniary interests.

Councillor Jones declared that she was an employee of Birmingham Community Health Foundation Trust.

3. QUESTIONS AND DEPUTATIONS

No questions or deputations were received.

4. MINUTES

Councillor Jones raised that she was present at the JHOSC meeting held on 30 January 2025 and that her name was detailed as *Alison Jones*, which should read *Kate Jones*. Councillor Jones further advised that under agenda item 15 'Declarations of Interests', the Minutes detailed that she had declared an interest as being employed by Birmingham Community Health Partnership

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Unite the Union. Councillor Jones clarified that she was employed by Birmingham Community Health Foundation Trust.

Councillor Wilson advised the Chair that she had attempted to join the JHOSC meeting held on 30 January 2025 virtually, but was unable to do so and could not make contact with any Officers to send her apologies.

Subject to the above amendments, the Joint Health Overview and Scrutiny Committee:

RESOLVED:

- i. To agree the Joint Health Overview and Scrutiny Committee Minutes arising from the meeting held on 30th January 2025 as a true record.

5. BIRMINGHAM AND SOLIHULL ICS HEADLINE FINANCE REPORT (M11 2024/25) AND 2025/26 FINANCIAL PLAN

Paul Athey, Chief Finance Officer (CFO), NHS Birmingham and Solihull introduced the report to the Committee, highlighting key points of information detailed in the report. The report and presentation before the JHOSC provided a summary of the financial performance of the Birmingham and Solihull Integrated Care System (BSOL ICS) in the first eleven months of 2024/25 and the actions arising from this. Having received the presentation, Members of the Committee raised a number of questions pertinent to the report detail, which in summary included the following matters:

Councillor Gethen queried whether the JHOSC would receive a report detailing the impact on services of proposed budget reductions. Secondly, Councillor Gethen referenced the slide detailing the financial position for Birmingham and Solihull Mental Health Trust (BSMHT), running at a surplus of £4.2M, which was going towards covering the deficit of University Hospital Birmingham. Noting that with increased pressures being placed on mental health services how was it possible for BSMHT to be in a surplus position and which service areas in UHB were receiving BSMHT funding. The Chief Financial Officer advised that:

- Impact and savings information would be shared with the JHOSC once the process had been finalised. Secondly, statutory requirements were placed on ICB's to reach an overall financial system position, which led to resources being utilised across the entire system. UHB was facing more significant financial pressure than were any other organisations across the system largely attributable to being the last resort for patients to access emergency care. Resources were therefore used to support UHB as much as possible to reach a break even point. However, it remained the case that every effort was made to allocate available resources as equitably as possible.

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- The surplus attributable to BSMHT was because of the actions the Trust had taken directly and therefore did not need to access to any across the system growth funding. Statutory and NHS constitutional standards applicable to partners across the system had been reviewed and BSOL ICS was confident that it was in a position to continue to support mental health services and for BSMHT to continue to hold a surplus position.
- BSMHT continued delivering their savings plan, which largely centred around repatriating a set of patients that currently were found in out of area beds, which was where the largest savings were to be found. BSMHT benchmarked relatively poorly for length of stay metrics i.e. relatively long durations, which led to significant attention in the savings plans being linked to introducing more effective patient discharge arrangements and to increase flow through NHS beds.
- BSMHT had savings targets in place for reducing high-cost agency and bank staff usage, some of which would be achieved through substantive recruitment to posts.

Councillor Wilson queried how flexible was the system exactly in meeting need and demands made of it. The Chief Financial Officer advised:

- Striking the balance was definitely a challenge. It was felt that there were a number of opportunities where both the financial challenge and improving systems flexibility around service access could be achieved, with emergency care being the obvious area to review in this sense. In the latter half of 2024/25 the NHS England had undertaken a review at what had been causing the financial challenges and the actions that could be taken to address them. As part of that review, a piece of work was undertaken reviewing how the urgent emergency care system had changed over recent years and the associated costs with those changes. It was consequently found that approximately £105M was being spent on urgent and emergency care than was being spent two years ago, but when looking at performance in the urgent and emergency care system the extra funding was not working as effectively as desired. It was further found that the system was not as flexible in responding to need in the local population as needed.
- Alternatives to urgent and emergency services located in hospitals as a point of access for patients were therefore being looked at, especially with regard to delivering the services in a more cost effective and flexible way for the local population.

Councillor McKenzie queried if cuts were being made to services was there the prospect of developing an unfair system, leading to timely access to services and treatment for private patients, whilst NHS patients may have to wait for up to seventy-two weeks before accessing treatment. The Chief Financial Officer advised:

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- Since the Covid pandemic waiting times had increased significantly. However, waiting times were now reducing and in 2025/26 more traditional methods were again being used to review elective waiting times i.e. the proportion of patients who were meeting the NHS constitutional standards of eighteen weeks. The established target was for sixty per cent of the population to meet the NHS constitutional target. Over the next two years, whilst financial challenges remained, additional funding was being put into elective funding. Certain funding received over recent years had also been used to address the elective waiting list. The Solihull Elective Hub also opened in autumn 2024 with an additional elective hub opening in Birmingham Children's Hospital for paediatric surgery in 2025, all of which was growing system capacity to reduce the gap between private and NHS waiting times.

Having considered the report, Members of the Joint Health Overview and Scrutiny Committee:

RESOLVED:

- i) To note the information in the slide pack presentation, particularly the forecast achievement of a breakeven financial position in 2024/25 and 2025/26;
- ii) To note the significant financial savings required to achieve financial balance in 2025/26; and,
- iii) To agree to receive a Birmingham and Solihull ICS Headline Financial Report at the Joint Health Overview and Scrutiny Committee meeting scheduled for 16 July 2025.

6. BIRMINGHAM AND SOLIHULL INTEGRATED CARE BOARD PERFORM AND DELIVERY PLAN

Faith Button, Chief Delivery Officer, presented report to Committee. The report and presentation slide pack provided a summary of the performance of Birmingham and Solihull Integrated Care System (BSOL ICS) to date in 2024/25. Having received the presentation, Members of the Committee raised a number of questions pertinent to the report detail, which in summary included the following matters:

Councillor Sleight questioned which areas were giving great cause for concern during the next twelve months. The Chief Delivery Officer advised that:

- Members were informed the biggest challenges that lay ahead were meeting the cancer sixty-two-day target, eighteen-week elective

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surgery target and meeting targets for Learning Disability, Autism and Dementia patients (LD&A).

Councillor Wilson queried what steps were being taken to future proof the exponential raising of targets across the system in order to support successful delivery of those targets and future target setting, taking account of such areas as staffing, ICT infrastructure etc . The Chief Delivery Officer advised that:

- It was a question of taking a whole service approach to ensure that no one domain dominated the others in order to deliver financial balance, and to deliver balance across services in terms of quality, safety and performance, for example.
- Furthermore, the Transformation Programme entailed how work was delivered across the system, how risks were managed across the board, entailing digital and community programmes. The Board, Committee and governance structure provided the whole overview and picture.
- Staffing was also recognised as a vital component, with a health and well-being component, as well as working to a backdrop of delivering system-wide efficiencies and driving out waste whilst simultaneously achieving more.

Councillor Moore referenced the RAG ratings detailed on page 30 of the report, noting that other than *for Urgent and Emergency Care* and *Primary and Community Services*, performance for all other areas appeared to be deteriorating rather than improving i.e. for the areas of *Elective Care, Cancer, Diagnostics*. Councillor Moore noted that performance was very concerning in light of the requirement to remove £300M from the ICS budget, as to how performance could be turned around and the downward trend reversed across the majority of areas reported. The Chief Delivery Officer advised that:

- The report before the Committee reflected the timing of the report which gave the position status coming out of the winter period. Regarding specifically the *Elective Care* performance indicator “*Eliminate waits of over 65 weeks for elective care by September 2024 (except where patients choose to wait longer or in specific specialities)*”, the current situation was that eighty patients were left waiting for sixty-five weeks, which was a significant improvement. The reason for the red RAG rating was that the plan detailed a zero target, which NHS England adjusted nationally throughout the year because the target could not be reached. Locally, the waiting list had reduced from over four hundred to eighty patients.
- Regarding *Cancer* “*improve performance against the headline 62-day standard to 70% by March 2025*” , there was a patient backlog over the

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winter period, with a performance of 60% for year end, which was an improvement on last year's performance which ended at 55%.

Councillor Gethen referenced the performance data for the *Psychiatric Decisions Unit Occupancy, PDU Referral and Acceptance Figures*, noting that a total of 113 patients were declined by service and 3 where no resources were available. Councillor Gethen questioned what for those patients was the criteria for them to be accepted, and if they were not accepted, what was the procedure for follow ups and to ensure that those patients concerned were safe. The Chief Nursing Officer, ICB advised that:

- If a patient had not been accepted by the Psychiatric Decisions Unit it may relate to how an individual was sectioned under the Mental Health Act, which depended upon what their section was which in turn would determine whether acceptance to the Psychiatric Decisions Unit would be appropriate or not. However, this did not equate to the individual not being able to access the appropriate mental health support to meet their needs.
- With reference to the three cases of no resources being available, this may be a case of the Psychiatric Decisions Unit being full to capacity, or a case of the individual/s concerned requiring a more stable mental health setting.
- Regarding keeping patients safe, the Committee was advised that if individuals had been in an Emergency Department they would be kept safe within that setting. Although not the most appropriate setting, UHB ensures that there is mental health support available via the Psychiatric Liaison Team and that the individual was kept safe whilst waiting for access to an appropriate mental health setting which would meet their needs.

Councillor Grindrod referenced the data presentation provided within the report and requested that a key/glossary of terms be provided for future reports detailing these data sets in order to provide greater clarity, context and understanding for Members of the Committee when reviewing future reports.

Councillor Grindrod referenced the performance/RAG ratings for the Mental Health area, specifically related to children and young people accessing mental health services (*'Increase the number of people accessing children and young people services - 35,000 additional CYP aged 0-25 compared to 2019'*), noting that there was a consistent red RAG rating against this performance measure. The Chief Delivery Officer advised that:

- Every effort was made to place patients in the community and not out of area. There were a number of competing priorities for allocation of beds, which at times led to an out of area bed being sought (for

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example, for a patient being held over in the Emergency Department whilst an appropriate setting was found). These decisions were made on a clinical basis. There was a bed strategy in place as part of the Mental Health Strategy, with the Crisis Teams and working on a range of initiatives in the community to keep people well in their own homes to prevent them reaching a crisis point and having to enter the Emergency Department seeking support.

- Psychiatric access is a red RAG rated performance measure, for which a Rapid Improvement Plan was put in place with the Children's Hospital and Mental Health Collaborative. Month on month numbers were increasing regarding access to mental health services, with the access target expected to be reached in 2025/26. Although service improvements and Constitutional standards continued to be improved throughout the year, the weight of continuing and expanding service demand meant that attaining the standards set at the beginning of the year were not quite being met. However, the areas recognised as requiring improvement were known and every effort was being made to improve performance in these areas to meet the patients need.

Councillor McKenzie questioned the Chief Nurse, ICB what the biggest challenges to her service were in keeping patients safe. The Chief Nursing Officer, ICB advised:

- In essence this amounted to addressing quality and safety of services. Focus was placed on patients not having significant waiting times to access services, that they were waiting safely with available support to hand. Secondly, it was recognised that with such high occupancy levels it was not always possible to provide the care desired owing to the demands placed on the service. This in turn had health and well-being implications for staff.

Regarding objectives for the LDA area (Learning Disability and Autism), Councillor Gethen queried the detailed objective for "*Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population*", asking whether this was an unrealistic target considering the plan was to decrease numbers whilst numbers had increased year on year for the service. The Chief Nurse, ICB advised that:

- This was a complex area relating to people who were in long-stay in-patients settings, some of which can equate to years in those settings. This stems from the strategic shift nationally moving from care in hospital settings towards care in the community. The target of 30 people was established nationally based against a population and what expectations were for having only 30 people in an in-patient setting for

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that cohort. Additionally, the identification of people with autism had increased patient cohorts in mental health settings, whose needs had to be met in the community. Work was being undertaken to identify people at the earliest opportunity to prevent admission and that joined up working was in place across partners such as social care, housing and care facilities in order to reach a position where a person could be discharged safely. The Chief Delivery Officer further clarified that this metric was the most challenging one to be achieved.

Having considered the report, the Joint Health Overview and Scrutiny Committee:

RESOLVED:

- i) To note the information outlined in the slide pack and performance position against the 2024/25 operational plan.

7. UPDATE ON NEURODEVELOPMENTAL ASSESSMENT PATHWAYS FOR CHILDREN AND YOUNG PEOPLE IN BIRMINGHAM AND SOLIHULL

The report before the Committee detailed the current status of the neurodevelopmental diagnostic pathways in Birmingham and Solihull. The report explained the current high demand, how services were responding to that demand and what actions were being taken to reduce the length of time it took to access support and diagnosis. The report was introduced by Helen Kelly, Chief Nursing Officer, ICB and Reva Stewart, Chief Operating Officer, BCHC.

Having received the presentation, Members of the Committee raised a number of questions pertinent to the report detail, which in summary included the following matters:

Councillor Mackenzie questioned whether colleagues were confident that children were receiving the right and adequate support within school settings. The Chief Operating Officer, BCHC advised that:

- Progress had been made, with substantial further progress to be made, which had led to seeking a systems solution. A commitment had been made to provide the right type of support to children and young people at the right time.

Councillor Sleight questioned how it could be ensured to prioritise those children and young people with the most complex clinical needs. The Hospital Director for Allied Health Professionals advised that:

- A whole systems approach working in partnership across systems, rather than solely a healthcare approach, was the correct strategy to

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follow. The Special Assessment Service in Solihull is an assessments and diagnostics service providing support for children with a diagnosis provide by other services. Those services do not require a diagnosis to provide support, as they are needs based services rather than diagnosis-based services, such as the Specialist Inclusion Support Services (providing workshops and support for schools and parents), West Midlands Autism Services, Parent/Carer Forum, Speech and Language Therapy Services. These services provide a raft of support for children with needs that can be delivered whilst waiting for a diagnosis. Information for all services is available on the Specialist Assessment Service website, with signposting for parents and schools to other resources that can help children before receiving a diagnosis.

- Regarding prioritisation of those children and young people with the most complex clinical needs, stratification across two groups occurred via early years support and a clinical harms assessment process ahead of other children (for example, for looked after children and potential NEETS due to a need for a diagnosis).

Councillor Jones queried about instances of people waiting on a waiting list for a substantial period of time (e.g. years) who were ultimately considered to be inappropriate for referral to the service and/or required an alternative pathway or access to another service, and whether this was a common scenario. The Hospital Director for Allied Health Professionals advised that:

- In Solihull, a very high proportion coming to the service were diagnosed with autism or a similar neurodevelopmental condition. A lot of information is requested on referral which tended to result in the right referrals being received, leading to appropriate and correct signposting to the correct services for support. Satisfaction with the service was reported to be very high, with only a 2% DNA rate (Did Not Attend).

The Chief Medical Officer, Birmingham Community Healthcare Foundation Trust stated that from a Birmingham perspective children referred to their service were risk assessed and stratified in a slightly different way to those in Solihull, which involved prioritising children with higher needs. It was found that of that group approximately 95% had a positive diagnosis. Of those with lower needs and showing lesser behavioural disturbance, the figure was closer to 60% and would have a lower diagnosis rate. The reason for the high diagnosis rate of children seen was attributable to being triaged in the first instance. This led to higher dependency children being seen which automatically skewed the diagnosis rate to those individuals with higher needs. In terms of the support offer, the Committee was advised that attempts were being made to provide and develop a support offer using the information received pre-assessment whilst prospective patients were waiting for a diagnosis.

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Regarding adaptations for children in schools whilst on the waiting list, Councillor Gethen questioned what sort of adaptations were entailed and how were they funded whilst the child was on the waiting list. The Chief Nursing Officer, ICB advised that:

- Adaptations covered a number of different arrangements in the school setting , such as specialist chairs, provision of key support worker and other arrangements to support the child and family while waiting for a diagnosis. If the arrangements involved substantive additional cost implications, the school was likely to require an Educational, Health and Care Plan (EHP) to be in place for that child to enable the additional resources to be passported through to the school.

Councillor Gethen reference paragraph 3.5 of the report , specifically “*Both providers are actively engaging with parent carer forums, commissioners, mental health providers and education and local authority colleagues*”, questioning what was the feedback that had been received from schools and local authorities regarding the support initiatives being delivered. The Chief Nursing Officer, ICB advised that:

- SEN partnerships were being used to deliver support initiatives and pathways. Partners had prioritised delivery of assessments to time and were now collectively addressing how to best meet children’s needs safely within the resources available to enable children to reach their potential.
- Positive support had been received from schools and local authorities for the proposed support initiatives. The assessment process adhered to NICE (National Institute for Health and Care Excellence) guidelines and the ICB had contacted NHS England seeking how to best get support from the region for a prospective different delivery model that could be applied, incorporating areas of best practice.

Councillor Gethen queried what feedback was being received back from Government regarding the current waiting list for ASD/ADHD. The Chief Nursing Officer, ICB advised that:

- The waiting list for this cohort of children does not fall within an eighteen-week pathway target. The significant waiting list had been highlighted and was subject to any external inspections that may be required. The waiting period for those on the waiting list had been raised across the partnership to be addressed and potential solutions to it found.

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The Hospital Operations Director (Women & Children), UHB further advised that:

- The eighteen-week pathway was managed at UHB, and the cohort of patients were assessed there. Meetings were held with the ICB on a monthly basis, and local therapy teams fortnightly. This provided a clear picture of the status for each patient, including high-risk patients.

Councillor Moore questioned how realistic the timeframe for the roll was out of the new pathway arrangements by 26 January 2026 and secondly, what steps were being taken to address the problem through taking examples of best practice in place elsewhere in the country to replicate in Birmingham and Solihull to drive down the waiting lists. The Chief Nursing Officer, ICB advised that:

- The timetable was indeed ambitious. All partners were attempting to identify what could be done better and smarter and wished to accelerate that process. This ambition had led to reviewing other systems, contacting the national team seeking to initiate a pilot scheme in Birmingham and Solihull, all of which was reflected in the ambitious and challenging timescale for implementing the new pathway arrangements.

The Chief Medical Officer, Birmingham Community Healthcare Foundation Trust advised that:

- Examples of best practice by other providers had been sought out and reviewed. It was found that all regions were struggling with waiting lists. The Government had established a task force to address this issue. The national lead was keen for a need led service, moving away from a diagnosis led system. It was further found that some providers were attempting to 'turn the tap off', in effect rationing assessments (in respect of lower needs children). Secondly, other providers were addressing the issue facing Birmingham and Solihull which was how to best support the children was facing a very significant capacity demand mismatch. Whatever resource may be directed towards assessment and diagnosis services, the Committee was informed there were not sufficient numbers of qualified staff available, such as community paediatricians and qualified psychologists to deliver the demand.

Councillor Jones queried how transparent the process for prioritisation of patients was and whether it would be beneficial to breakdown waiting times according to the prioritisation process to show the range and median for waiting times. The Chief Medical Officer, Birmingham Community Healthcare Foundation Trust advised that in relation to Birmingham:

- There was no hard science applied to the prioritisation process or a validation system for it. The system being proposed for prioritisation

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entailed categories of no need, low need, moderate need, high need, which was based on a provider located on the south coast who had implemented this model. A number of elective pathways with peak prioritisation categories existed, depending on need. The prioritisation process was largely a subjective clinical decision at the time of triage as there were no hard and fast rules around how categories of assessment were arrived at, transparency around the process and decision making itself was quite hard to fulfil. For the same reasons, monitoring against these categories would be quite difficult.

The Hospital Director for Allied Health Professionals advised Solihull did not have the same prioritisation categories in place as for Birmingham, as it was in the process of introducing a harms assessment process, in consultation with parents and carers.

Having considered the report, the Joint Health Overview and Scrutiny Committee:

RESOLVED:

- i. To note the report and support the proposed approach of developing a new model of care for neurodevelopmental needs, with phased testing and implementation.

8. DENTAL SERVICES UPDATE

The report before the Committee provided an update on the commissioning and delivery of NHS dental services in Birmingham and Solihull. The report was presented by Phillipa Coleman, Associate Director Primary Care Commissioning and Performance, BSOL ICB.

Having received the introduction to the report, Members of the Committee raised a number of questions pertinent to the report detail, which in summary included the following matters:

Councillor Gethen queried whether any figures were available for those Solihull residents calling 111 for urgent care or attending A&E who were not on the register of a dental practice, and whether in such scenarios unregistered patients would be allocated an NHS dentist. Secondly, Councillor Gethen queried whether there was any prospect of community dental services, such as school dental services, ever returning. Associate Director Primary Care Commissioning and Performance, BSOL ICB advised that:

- It was difficult to secure data from 111 calls and A&E contacts because they tended to have broader categories than was desired. However, dental services were focussed on liaising with those partners. Information provision and signposting patients to appropriate commissioned services was a priority. Anecdotally, it was known

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however that both the 111-telephone service and A&E services were being used by residents to access emergency dental care.

- Regarding the return of community dental services to schools, Members of the Committee were advised that such a service was highly unlikely to return. However, resources were being targeted at those areas of greatest need in locations where residents were least accessing dental services. Services such as the supervised tooth-brushing would be aimed at such areas of low dental take-up. Dental services information was also distributed via leafleting via schools and general practices.

Councillor Sleigh sought clarity as to how many dental practices were located across the BSOL geographic area. The Associate Director Primary Care Commissioning and Performance, BSOL ICB advised that:

- There were currently approximately 150 dental practices across BSOL.

Councillor Sleigh sought clarity as to how many dental practices were no longer taking new patients. The Associate Director Primary Care Commissioning and Performance, BSOL ICB advised that:

- The figures were dynamic, with dental practice patient lists changing frequently and that it was not known at any point how many dental practices were no longer open to new patients. A number of practices, however, were not at capacity and BSOL was not experiencing issues as elsewhere nationally where most dental practices were closed to new patients.

Councillor Jones questioned whether the funding received for the delivery of dental services was sufficient to enact meaningful interventions. The Chief Financial Officer, BSOL ICS advised that:

- Dental funding was ring-fenced, with the current dental allocation fully spent for the current financial year. Dental funding was one of the few areas where allocations were not set on a needs basis, but rather on a historic spend basis. Compared to other West Midlands dental systems, BSOL was much closer to delivering to its full contractual level, which is the pre-pandemic level of service. Reviewing the data for the percentage of BSOL residents accessing dental services, the area is reportedly below the average nationally. To reach the national figures, BSOL would be required to commission additional capacity than was currently commissioned for with the 150 dental practices across the BSOL region, whilst the BSOL funding allocation was still being fully spent. Moving to a needs-based system, as advocated for by the Department for Health and Social Care, would effectively increase the funding allocation for the provision of dental services across the BSOL geography at some future point.

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Councillor Sleigh queried which body controls private practice dental service charges, if any such control existed. The Associate Director Primary Care Commissioning and Performance, BSOL ICB advised that there were no controls over private practice charges.

Councillor Moore questioned whether the UDA (Unit of Dental Activity) would remain at its current rate, or fall back to its previous rate, and if that were the case would it likely have an impact on access to dentistry services moving forward. The Associate Director Primary Care Commissioning and Performance, BSOL ICB advised that:

- There would be a need to closely follow the UDA arrangement. The new patient premium being on top of the UDA rate attracted some interest within BSOL areas, whereas elsewhere nationally it was felt to make very little difference. Nationally the arrangement was viewed as not achieving what it set out to deliver, subject to some national variation. The additional urgent care activity presently being commissioned will be in receipt of new funding to take it forward, which may be of help. Most of the funding was tied to the UDA and contracts, but there were also some limited opportunities around flexible commissioning locally.

Councillor Wilson questioned how patients were prioritised with complex health needs, who may present with a relatively minor dental issue at the point of contact, but which had potential to lead to a significant health crisis at a later date if not addressed with relative urgency. The Associate Director Primary Care Commissioning and Performance, BSOL ICB advised that:

- For the additional urgent care activity being commissioned, the payment rate would be above what a standard UDA rate might be. For anyone presenting in crisis there is a recognition that it may need some more time and care. It was frequently vulnerable people and people with high needs that present in crisis rather than accessing a dentist through routine, which raised the question of whether an alternative service offer could be made for such patients. Statistics for those attending A&E and Urgent Treatment Centres (UTC's) would also be a source of data and information in such cases.

Having considered the report, the Joint Health Overview and Scrutiny Committee:

RESOLVED:

- i. To note the detail presented in the report; and,

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- ii. To AGREE for the JHOSC to receive a further Update Report following completion of the Urgent Care Review at the JHOSC meeting scheduled for July or October 2025.

The Joint Health Overview and Scrutiny Committee (JHOSC) meeting concluded at 8:33 p.m.