Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 19 September 2019 at 10.00 am

Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor OwenSean Gaul

Councillors:	Mark Cherry	Hilary Hibbert-Biles	Laura Price
	Mike Fox-Davies	Jeannette Matelot	Alison Rooke
District Councillors:	Paul Barrow	David Bretherton	
	Nadine Bely-Summers	Neil Owen	
Co-optees:	Dr Alan Cohen	Anita Higham	Barbara Shaw

Notes: ***Date of next meeting:*** *21 November 2019*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Arash Fatemian Email: arash.fatemian@*oxfordshire.gov.uk*
Policy & Performance Officer	-	*Samantha Shepherd Tel: 07789 088173* *Email: Samantha.shepherd@oxfordshire.gov.uk*
Committee Officer	-	*Colm Ó Caomhánaigh, Tel 07393 001096* *Email: colm.ocaomhanaigh@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

September 2019

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Minutes (Pages 1 - 22)

To approve the minutes of the meeting held on 20 June 2019 and to receive information arising from them.

For ease of reference when considering the Matters Arising from the minutes a list of actions is attached at the end of the minutes.

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 23 - 26)

10.15

The Committee's Forward Plan is attached for consideration.

6. HOSC recommendation to the Board of Oxford Health FT (Pages 27 - 30)

10.20

The response from the Chairman of Oxford Health NHS Foundation Trust on the HOSC recommendation made on 31 May 2019.

7. Oxfordshire Clinical Commissioning Group Update (Pages 31 - 34)

10.50

This item will provide a report on the key issues for the CCG and outline current and upcoming areas of work including an update on gynaecological appointments and gynae-oncology services.

8. **PET CT scanning** (Verbal Report)

11.05

A verbal update for the committee on the developments with PET CT scanning services for Oxfordshire.

9. **Integrated Care System** (Verbal Report)

11.45

The will be a verbal update including

- An outline of the Integrated Care System which will include Oxfordshire
- Timescales for implementation of the ICS
- Implications for residents of Oxfordshire and plans to involve them in its roll out.

10. **Winter Plan 2018/19** (Pages 35 - 54)

12.15

To evaluate the Winter Plan 2018/19 and plan for Winter 2019/20.

11. **LUNCH**

13.00

12. **Transition of Learning Disability services** (Pages 55 - 62)

13.30

To receive a report on the benefits of the changes to LD services for patients.

13. **Dental Services and Dental Health in Oxfordshire** (Pages 63 - 78)

14.00

This paper will discuss the following

- Provision and capacity of NHS dentists in Oxfordshire
- Dental health of adults, older adults and children in the Oxfordshire population, including where inequalities exist
- Programmes of work to promote dental health
- Dental needs and health in nursing and residential homes

14. Musculoskeletal (MSK) Services (Pages 79 - 94)

14.30

This paper follows on from the update on actions to address recommendations made by the HOSC MSK Task & Finish Group presented in June 2019 to the Oxfordshire Joint Health Overview and Scrutiny Committee.

15. Healthwatch Oxfordshire (Pages 95 - 102)

15.00

A report on views of health care gathered by Health Watch.

16. Chairman's Report (Pages 103 - 164)

15.10

The Chairman’s report for September 2019 is attached.

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 20 June 2019 commencing at 10.00 am and finishing at 4.00 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	Councillor Mark Cherry Councillor Mike Fox-Davies Councillor Hilary Hibbert-Biles Councillor Jeannette Matelot Councillor Laura Price Councillor Alison Rooke District Councillor Paul Barrow Dr Alan Cohen Dr Keith Ruddle Barbara Shaw
Co-opted Members:	Dr Alan Cohen, Dr Keith Ruddle and Barbara Shaw
Officers:	
Whole of meeting	Colm OCaomhanaigh, Julie Dean and Sam Shepherd (Resources); Rob Winkfield (Adult Social Care)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

33/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

City Councillor Susanna Pressel attended for City Councillor Nadine Bely-Summers and apologies were received from District Councillors David Bretherton and Neil Owen.

34/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Doctor Alan Cohen declared a personal interest on account of him being a trustee of Oxfordshire MIND.

35/19 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 4 April 2019 were signed as a correct record, subject to some very minor corrections which would be rectified.

In relation to Minute 19/19 - 'Regional PET-CT Scanning Service' the Chairman referred the meeting to his letter (attached to his Chairman's Report) in response to Seema Kennedy MP's, Parliamentary Under Secretary of State for Health and Social Care, Department of Health. Discussion of which would be under Agenda Item 13 'Chairman's Report'.

The Minutes of the special meeting held on 31 May 2019 were approved and agreed as a correct record.

Matter Arising

With regard to Minute 31/19, recommendation (b), the Chairman invited David Walker, Chairman of the Board of Governors, Oxford Health NHS Foundation Trust (OH), to the table, at his request. He referred to the recent announcement of the creation of the Integrated Care System (ICS) for Oxfordshire stating that he hoped that in this climate of collaboration between Local Government and the National Health Service it would proceed successfully. He believed that this would make a real difference for residents. He pointed out that the Board's role was quite separate to that of this Committee, it being about executive decision making.

Mr Walker added that, as a newly appointed Chairman to the Board, he hoped that the Committee's future relationship with OH would be amicable, as well as functional, stating both his view that it was regrettable that the Committee had chosen not to acquire the opinion of the CEO prior to making the statement it had.

Councillor Fatemian echoed Mr Walker's wish that the relationship be amicable, adding that the Committee looked forward to hearing the Board's formal responses to the statement. He added that the Committee was looking forward to receiving evidence that OH was adhering to the agreed principles of working between HOSC and the NHS, as signed by the CEO himself. He concluded by thanking Mr Walker for his attendance that day. Mr Walker responded that OH would be considering its formal response.

36/19 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following requests to speak at this meeting – all addresses were to be made prior to consideration of the item itself:

- Agenda Item 7 - Local Health Needs Assessment: OX12

  Local Member Councillor Jenny Hannaby
  Maggie Swain – Save Wantage Hospital Campaign Group
  Terry Knight – Save Wantage Hospital Campaign Group

- Agenda Item 8 -Oxfordshire Health & Wellbeing Board Annual Report

  Councillor Jane Hanna

- Agenda Item 13 – Chairman's Report

  Liz Peretz – 'Keep our NHS Public' Campaign Group

37/19 FORWARD PLAN

(Agenda No. 5)

Following consideration of the Forward Plan (JHO5), the Committee **AGREED** to add the following items to the Plan:

- The work of the Health Inequalities Commission, to include having a strategy for addressing the outstanding recommendations;
- To revise the Forward Plan to include the 'Integrated Care Strategy – Oxfordshire, Buckinghamshire and West Berkshire' in both the September and November 2019 meetings;
- Optometry – to include waiting times for cataract operations;
- Recommendation from Education Scrutiny Committee – Chairman of CAMHS Special Needs Education Board to be invited to attend this Committee.

38/19 OXFORDSHIRE CLINICAL COMMISSIONING GROUP - UPDATE

(Agenda No. 6)

Diane Hedges, Deputy CEO, Oxfordshire Clinical Commissioning Group (OCCG), attended to present the report JHO6. She highlighted the following:

- The 'exciting' progress made that day in relation to the announcement of the Integrated Care Strategy (ICS) which was a testament to improved working between OCC and Oxfordshire NHS, together with the growing work with the other Oxfordshire authorities also;

- The large amount of learning which had taken place around primary care and the need to enlarge its capacity. An active piece of work had taken place in Bicester surgeries were being consolidated into one, in order to offer more services for patients. PML in Banbury were taking an active role in strengthening primary care into a more stable environment, supported by more back office structures. South Oxford Health Centre was another practice who had stepped forward to take on a pilot;

- The pilot work being undertaken by Sue Ryder around giving care and support to more people in their own homes; and

- The OCCG had realised a small financial surplus which would be used to improve care service.

The deputy Chairman, Councillor Sean Gaul, local member for Bicester, requested that Bicester councillors be involved in the work that was taking place in that area. In return, Councillors could offer the OCCG clarity on what would help in determining decision making. A member added that, as GPs were retiring from the service, it was vital that Councillors were involved in the decisions going forward. Diane Hedges responded that the Community Partnership Networks had been involved in the past, with which the OCCG had been very open. She reassured the Committee that talks were currently taking place with councillors and also within the public domain.

A member asked that, in light of the need to recruit more GPs, how robust was the CCG's forward planning processes? She also made a plea that, when considering sites for the new super-surgery in Bicester, that they be accessible for patients in terms of transport to the site, including cycling routes to it, and for parking availability. Diane Hedges gave her assurances that there would be a very clear set of criteria attached to these plans which would include the input of councillors.

In response to a question asking what contingencies were in place should Sue Ryder, or any other charity involved in the new structure, withdraw? Diane Hedges responded that the ICS was a form of contingency in itself. Thought was currently being given to how integration of the voluntary organisations would be achieved, given the pressures of the increasing workforce challenge. As an example of this, there was a collective group comprising end of life, palliative care workers from OUH who were supporting the consultation which included a proposal for the introduction of certain services. She added that these were different methods of working, and in a more joined - up fashion. She added also that the way organisations were now working, meant more of an understanding for each other's methods of working. The Sue Ryder pilot was a good example of how to facilitate ways of supporting people in new and creative ways.

A member asked that, in light of media reports of hospices not receiving the level of support from central government funding, what was the level of financial input from Sue Ryder and from the CCG; and how it would be balanced out should there be a significant drop in support for Sue Ryder. She also asked for more detail in relation to in-patient bed occupancy and bed numbers; on the scale of pressure on continuing health care and the spend; how much related to legal cases; and finally, how many self - funders there are?

Diane Hedges responded as follows:

- The Children's Hospital and Sue Ryder would always welcome more funding. The OCCG paid a proportion of it and donations were added. Favourable conversations were currently taking place with the Children's Hospital with regard to elements of care which had resulted in additional money flowing in their favour;
- The OCCG was not in a position to replace services provided by non-NHS providers. However, conversations were taking place with end of life

providers to ensure their financial positions. She gave the Committee her assurance that the OCCG wished to be very open and to share its understanding of what was the NHS spend;

- With regard to the number of beds provided, in September the OCCG planned to conduct conversations about the nature of care provision which did not include beds, intermediate care beds and those in the Hubs. She added that it was not about patients coming through the system, as care would be given at home; and
- In relation to the cost and volume of care packages provided, she pointed out that there were more older people needing support and this aspect was going to be looked at.

A committee member asked how the OCCG managed the pressures on payment by results, other than by lengthening waiting lists? Diane Hedges responded that it had now been agreed within the Oxfordshire system to pay by creative incentives. A fixed pot of money would be given and this would be used not as a means of managing spend, but via joined up working and by utilising the different skills which were available from within the community.

A member of the Committee asked for an update on the 3 months plan to address the waiting list for gynaecological services – and would Oxfordshire be providing all the services? Diane Hedges responded that OUH had diverted referrals to a quicker service, which had resulted in an improvement and the best performance for over a year. There was also nobody currently awaiting stage 2 treatment now. There had been 459 on the waiting list at the end of May, which was a reduction of 20-25%. Most referrals had been diverted to hospitals in Reading, Swindon and Buckinghamshire. However, there were still long waits for different aspects of the service. Further work was required with the clinicians on this to ensure the right options were considered. In response to a further question asking what the plans were to bring the services back to Oxfordshire. She reported that clinicians at OUH were being given the opportunity to operate on those waiting a long time. The OCCG would continue to review it and come back to HOSC with an update when the service was back in balance. She took this opportunity to thank patients for travelling that little way further to be seen in the meantime.

The Chairman thanked Diane Hedges for her attendance and for the report.

39/19 LOCAL HEALTH NEEDS ASSESSMENT: OX12

(Agenda No. 7)

Prior to consideration of this item the Committee was addressed and petitioned by the following members of the public:

Councillor Jane Hannaby welcomed the Task and Finish Group's report which she said provided an accurate record of the issue. She stated that Wantage Community Hospital will soon be closed to inpatients for 3 years. Given that it will be next spring before proposals can be brought forward it seems likely that it will be closed for 4 years in all.

Cllr Hannaby stated that the Save Wantage Community Hospital (SWCH) Group had worked hard to ensure that the OCCG's survey reached as many people as possible given the OCCG's limited resources. This was despite the SWCH Group's reservations about the survey, noting that only one question was about the hospital. She expressed hope that the two groups could work together to solve the problem.

Maggie Swain of the SWCH Group and the Stakeholder Reference Group expressed concern about reports that there would be an emphasis on care in the home rather than in hospital and stressed that both were needed. A Community Hospital is easy for people to visit patients, whereas people are often more reluctant to visit in the home and loneliness can result.

Volunteer drivers have problems accessing the JR Hospital in Oxford and many JR employees commute from Wantage and would much rather work closer to home. She also criticised the fact that physiotherapy services were supposed to be up and running but had not yet started.

Terry Knight of the SWCH Group stated that he had been born in the hospital and had received treatment there. He said that the lack of consultation on the survey was disappointing. There was talk that nursing homes could be used but it was not clear why they would be more efficient that the hospital.

He also criticised the survey for researching current use and stated that this is not a reliable guide to future need. There would be 5,000 new families in the area contributing £9 million towards the NHS in taxes. He asked what had happened to the idea of the money following the patients. He noted that the Health and Wellbeing Board advocated treatment closer to home but this is not what is happening in reality.

Councillor Mike Fox-Davies, Chairman of the Task & Finish Group, introduced the group's report and stated that it was an interim report as they had not fully discharged their duty. It had become clear around their second or third meeting that the original three-month timeframe was impossible. He anticipated that actions will be identified by December 2019.

Councillor Fox-Davies stated that he supported the Population Health and Care Needs Framework which was being used for the first time. There will need to be an evaluation process when completed. He welcomed the improved transparency and suggested that an extra HOSC meeting may be needed in December to discuss the proposals.

Jo Cogswell, Director of Transformation OCCG and Senior Responsible Officer (SRO) for the OX12 Project spoke to her report and responded to the points made. She accepted that the hospital had been closed for too long. She stated that the issue was not just about beds but about all services.

She regretted that there was dissatisfaction with the content of the survey and agreed that it could have been explained better how the "front-end" worked but said that the results gave a good picture of needs. The data will inform other pieces of work too. There were gaps remaining and different statistics on new homes which need to be settled as population growth is a key factor.

There will be a range of events to assist in the distillation process. The real pressure is in relation to Primary Care and the OCCG is talking with general practices regarding the next stages.

District Councillor Paul Barrow expressed frustration that decisions on the hospital had been held up because it was decided to do a broader review of all services.

Jo Cogswell responded to this and other timeline issues raised by Members of the Committee as follows:

- Initially work focussed on infrastructure but then the Health and Wellbeing Board agreed that there should be a needs-based assessment. There has also been an estates review.
- Regarding the timeline for decisions, it is expected that the options will be finalised by the end of November so that discussion can take place in December.
- The degree of consultation required on proposals will depend on the nature of the options. There will be some small-scale proposals but any changes to the use of the hospital will require consultation. A timetable will be agreed together as soon as possible.

The Chairman noted the commitment to have options developed by the end of November and reminded Members of the Committee of the possible need for an extra HOSC meeting in December as a result.

40/19 OXFORDSHIRE HEALTH & WELLBEING BOARD ANNUAL REPORT

(Agenda No. 8)

Prior to discussion on this item Julie Dean read out a statement produced by Councillor Jane Hanna. Her statement related to the Health and Well-being Board's recent establishment of wider stakeholder involvement through a new Stakeholder Network; and her points were as follows:

- The paper did not state what considerations under-pinned this recent development and did not give access to published information on any questions the public might have had in relation to the purpose, scope, remit and governance arrangements of the Stakeholder Network; and whether these issues had been scrutinised;
- There was also the question of whether the Network would be entirely separate from, or related in part, to the new approach to Planning for Population Health & Care Needs, as set out in the paper submitted to this Committee in November 2018. This approach was to be tried first with the population of Wantage and Grove. Indeed the OX12 Stakeholder Reference Group had recently contributed to the work being undertaken by the OX12 Task & Finish Group; and
- She called for clarity concerning any wider Stakeholder Network, on what it was and how it interfaced with a Population Health and Care Needs Approach, and most especially, any existing Stakeholder Reference Group.

Councillor Ian Hudspeth (Chairman, Oxfordshire Health & Wellbeing Board (HWB), Diane Hedges, Deputy CEO, OCCG, and Lucy Butler (Director for Children's Services and Interim Director for Adult Social Services) attended for this item. Councillor Hudspeth thanked the Committee for the opportunity to return to the Committee. He highlighted the following:

- There had been much change since the last time the Board had reported to Committee, and this had been for the better;
- The CQC had inspected in 2017 and its findings had given the Board the building blocks to work on, ensuring that the system was looked at as a whole, rather than its key parts;
- The CQC had paid a follow-up visit in November 2018 and had found that good progress had been made to deliver social care and health benefits to the residents of Oxfordshire;
- Healthwatch Oxfordshire (HWO) was playing its part in ensuring that the Board received as much information from the voluntary organisations as possible;
- He made reference to the shadow Integrated Care Board (ICB), which was due to be in place by April 2020 and which would have a complete, system-based approach for residents/patients, particularly in relation to prevention aspects;
- Success had been achieved in gaining additional funding, amounting to £215m across Oxfordshire in order to build affordable homes. The planning of these was also about the health agenda and £218m had been awarded for infrastructure and cycle facilities in Didcot to encourage a far greater health input, particularly in relation to air quality.

Lucy Butler added that the newly refurbished Board has spent a lot of time considering its priorities and building strong relationships with each other. Much more focus on all age-groups had also been considered to be very important.

Diane Hedges added that the inclusion of NHS providers was also considered to be very important to ensure integration. That way, benefits could be realised for commissioning, together with learning and knowledge. A whole new thinking had gone into how to get the best out of commissioning and providing – and this had strengthened the approach.

Questions and comments from the Committee were as follows:

A member of the committee enquired why there had been no performance information provided on what the HWB was doing about the areas with red flags against them. Lucy Butler informed the Committee that performance information was soon to be upgraded in relation to how it was monitored. Thought was to be given to the reasons behind what was driving it, and then, for it to be rigorously monitored as a system. She gave the example of concerns around the CAMHS (Children & Adolescent Mental Health Services) waiting list and the linkage behind the reasons why children were on a child protection plan. There were often a multitude of reasons behind why they were on the Plan – there could be mental health issues, domestic abuse, problems with parenting etc.

In response to a question regarding the lack of data on homelessness, Councillor Hudspeth undertook to bring this back to the Committee. He explained that all district councils and OCC did the account, but figures were somewhat skewed as homeless people tended to gravitate to the City where the facilities were. He added that the Board was working with all of the district councils on a Homelessness Strategy, and this was also being addressed by the Oxfordshire Councils Leaders' Group.

With regard to the matter of how the committee would be scrutinising the ICS, the Chairman reported that the committee had previously agreed to seek training on this and now that it was a post-election period, the officers were looking at dates to do so. There had been concerns aired previously at this committee about how much power that HOSC would have, realistically, to carry out scrutiny, given its bigger footprint. Diane Hedges explained that thought had been given to how the different scrutiny committees could work together; and out of this, a suggestion had been made. Each of the three scrutiny committees would work with a specialist commissioner on a particular range of scrutiny. She added that those working with ICS would be interested to hear from each committee on how it may work. Lucy Butler added that Integrated Care Partnerships would be specialised across all of the three areas (Oxfordshire, Buckinghamshire and West Berkshire) – and this HOSC needed to think about how it would like to interact with the wider work beyond Oxfordshire also. Councillor Hudspeth stated that he accepted HOSC's concerns and that training would be provided, adding that there would be a significant amount of hard work taking place, the vast majority of which would be on the actual structures in Oxfordshire. If one looked at the long-term plan it was about having accountability – previously democratic accountability had not been present.

In response to a comment from a member that it was important to think about the actual structures first before work took place on governance and accountability, to avoid HOSC's disempowerment; Councillor Hudspeth reassured the committee that local determination would feature in a part of it, and there would be a far better system approach. However, regionally, specialist areas needed thought and to be taken into consideration. The Chairman commented that it would be important to ensure that processes were put in place to tackle early challenges. That way, surprises could be avoided.

Rosalind Pearce, CEO, HWO was invited up to the table at this point for the consideration of the setting up of the Stakeholder Reference Network. A member asked where the information was on the move away from the Stakeholder Reference Group (SRG) to the Network? Councillor Hudspeth explained that he and Dr Kiren Collison (Deputy Chair, HWB) had approached all the voluntary organisations to discuss the matter of engagement and to explain that the HWB would have too many representatives on it if all representatives were to be present; and it would also serve to make decision making process too complex. He added that engagement with the voluntary organisations (which had been a CQC action point) would be taking place via a Stakeholder Reference Network (SRN) instead.

In response to a question asking if there was a difference between the SRG and the SRN, Rosalind Pearce explained that the proposal was to move away from having exclusive voluntary group around the table and to take a network approach. She added that HWO would be holding 3 or 4 events a year, all holding particular interest

to voluntary organisations, at which a themed discussion would take place. The outcomes of the themed discussion would then be reported back to HWB. She explained that it would also be about going out to people who did not necessarily have any involvement, to obtain their views, for example, the faith groups. This was a much broader approach than the SRG and would glean a great depth of knowledge about what happens within the population, and their views.

In response to a question asking what PCN's were, Rosalind Pearce reported that they were patient groups working together and being involved collectively. She added that HWO were very concerned that PPG's needed an effective group network, where they could be actively involved, rather than operating at individual GP level. Jo Cogswell stated that the CCG was leading on some of the work on PCN's around the county and this would be picked up at Agenda Item 11.

In response to a question about the sufficiency of provision for autism, Lucy Butler stated that she had already picked this up and was working on it.

Councillor Ian Hudspeth, responding to a question regarding affordable housing for social/health workers, explained that this would come under the recently successful £60m Growth Deal which been made, hopefully on a rolling basis. The money would be used to reinvest elsewhere, not just in Oxfordshire. He stated that it had to be used sensibly and good transport networks would be required, including the inclusion of walking and cycle routes.

Dr Ruddle commented that he had attended the last meeting of the revised HWB and it was his view that it had been a very good meeting, discussion being in an engaged, open and honest manner. It was his view also that the issues of joining up prevention, PCNs etc were nowhere near being real and needed to be made top priority. In relation to the performance report he commented on the following:

- the most significant CQC issue was to reduce admissions to hospital – and this needed to be included within the report. It was agreed that this would be included;
- the DToC measures had not been mentioned within the targets;
- the parking problem at the John Radcliffe Hospital should be a performance measure of whole system working. It was the most significant issue for all residents in accessing hospital services and was truly a cross-cutting issue.

Councillor Hudspeth commented that complacency was not wanted and challenge required. He agreed that the DToC figures, although they had improved considerably since the previous report, should still be reduced further.

Dr Ruddle added the following:

- targets with a green rating were more concerning that those with a red rating, in that the latter had an action plan behind them. One should ask 'is the target too low?';
- with regard to the parking problems at the John Radcliffe Hospital – he would have liked to see access to Headington via a better connectivity,

perhaps by bus lanes to the A40. He would like to see parking allocations linked to the appointment system. A solution for this had to be found with the devolving of services locally, adding that ICS could be a solution as clinics could be situated elsewhere rather than at the John Radcliffe Hospital.

In response to a question asking why some district councils were not represented on the Board – and why couldn't at least one local representative from each District Council be given a place, the Chairman stated that consideration had already been given to this issue – and it had been scrutinised by this Committee in November 2018. He added however that this Committee still had concerns with regard to the democratic responsibility on the Board and requested the Board to consider shifting the balance again to ensure that the majority of voting lay with democratic members (to at least 51%). Councillor Hudspeth **AGREED** to take this matter back to the Board.

Responses to various questions and comments from members of the Committee were as follows:

- The report that the prevention framework was coming to fruition was welcomed;
- In response to a question asking where the strategic aim was to tackle inequalities, Councillor Hudspeth responded that given there was a ten year difference in life expectancy across the county, an agreed aim was to reduce the gap by 2040 and to measure progress towards it;
- Could the performance targets be made more ambitious?

At the conclusion of this discussion, the Committee thanked Councillor Hudspeth, Diane Hedges and Lucy Butler for their attendance.

The Committee **AGREED** the following: to

(a) bring a report back to this Committee on work that was being undertaken by the county's leaders on homelessness;
(b) request the HWB to consider again increasing the district council representation on the Board to allow one representative from each to sit on the Board, to ensure that the majority of voting lay with democratic members;
(c) request the Board to consider making some of the targets a little more ambitious - and to include more detail on actions in relation to red targets; and
(d) request more information on the legal aspect of the Integrated Care Board/Strategy from the Director of Law & Govenrnance at OCC.

41/19 MUSCULOSKELETAL (MSK) SERVICES

(Agenda No. 9)

Diane Hedges, Chief Operating Officer and Deputy Chief Executive, OCCG, introduced the progress report which was requested at the February HOSC meeting when the Task and Finish Group presented a comprehensive list of recommendations. The Group was led by Councillor Monica Lovatt. MSK services receive over 5,000 referrals per month across Oxfordshire. Generally, the level of concern amongst patients has been reduced.

Members of the Committee raised the following issues:

- Dr Alan Cohen noted that several recommendations included the need to get a clinical review, for example - have long waits led to clinical harm? Also, three of the 8 KPIs have no data since September 2018. He also queried what the Clinical Governance Committee feedback was over the use of the EQ5D. He wished to see evidence that the Committee had considered this. The data should not just be about performance management. It should be about improving care. Diane Hedges stated that there was now clinical overview in the system with GP triaging. Diane Hedges **AGREED** to sharing the notes of the meetings where the recommendations on clinical governance had been considered. Diane Hedges also responded on the KPI's and stated that due to the provision of additional resources, the KPI's have been lengthened and adjusted. The CCG have looked at what is reasonable to measure and asked the provider to meet those adjusted KPI's. Diane Hedges **AGREED** to provide a full set of the revised KPI's.
- Councillor Laura Price noted that NHS physiotherapists have benefited from increased pay under Agenda for Change funded by central government and asked if InHealth staff were not receiving the same benefits. She noted the low number of complaints and wondered if it is clear to people how to complain. It had been reported to her that people in Witney had been told that they cannot have an appointment. Diane Hedges responded to say that she was not aware of any lag or issue with physiotherapists not receiving their uplifts in line with NHS rises, but she **AGREED** to look in to it and report back to the committee. Diane also **AGREED** to investigate to make sure patients were not being told they could not have an appointment in Witney.
- Barbara Shaw asked how the KPIs will be improved for those caught in the delay whose health has suffered as a result. She also queried the extent to which the CCG are tackling the trust of the service with GPs reporting that they are not referring to Healthshare. Diane Hedges recognised that the change-over to a new provider was difficult, but it was helpful to look forward now, which the CCG were doing with GP training events with Healthshare.
- Councillor Alison Rooke asked when the physiotherapist service in Wantage would be up and running. Diane Hedges reported that this would be by the end of July.

The Chairman stated that the committee still had some concerns around the performance of MSK services and would like a report back to its September meeting.

42/19 GP APPOINTMENTS

(Agenda No. 10)

Dr Ed Cao-Bianco, Locality Clinical Director, OCCG; Jo Cogswell, Director of Transformation, OCCG; and Julie Dandridge, Deputy Director and Head of Primary Care & Localities, OCCG attended for this item.

Dr Cao - Bianco introduced the report highlighting the following points:

- There were 70 appointments per 1,000 patients in a week;
- Difficulties experienced in the training of GPs;
- There was a variety of ways that patients could interact with GPs, including telephone and on-line appointments, where patients could complete medical questionnaires and receive a response the same day;
- E - consult – one of the online consultation platforms via a private provider. The first wave of 10 practices had signed up to this. There had been a slow uptake as Oxfordshire had one of the most aged populations in the country. However, the patients who had used it had found it both easy to use and speedy;
- A member commented that his surgery did not offer online appointments but offered a morning walk-in service. This had resulted in long waits for patients. It had given the impression that the surgery was managing its booking service rather than conducting a good customer service for its patients. Dr Cao-Bianco responded that there had been challenges with regard to what people needed, whether that was a health care assistant, a mental healthcare worker, or a clinical pharmacist etc. He added that a survey had recently been undertaken on all Oxfordshire GP practices, and it had been found that out of all of the practices in the county, 56 had operated a receptionist triage service. The vast majority operated appointment booking or telephone triage offering appointments afterwards. Not many offered a walk-in system where patients waited to see a doctor, adding a proviso that this could be due to workforce pressures.

  A member commented that it was her view that the data submitted masked what was actually taking place on the ground. There were long waits for same day appointments, following triage, for up to 3 hours. She added that this was not a good patient experience and proved very difficult for patients suffering from long-term conditions – adding also that a patient might have to wait 5 weeks to see a doctor who had an oversight of their condition. Julie Dandridge responded that data had been collected on a national basis, not at practice level. Moreover, data from patient surveys was used and detail collected allowed the OCCG to target where patient satisfaction was not ideal. She agreed that the problem with patient surveys was that many people had not experienced anything better than waiting for 3 hours. However, PCN's were already seeing patients coming together to exchange information – and PCN's should solve this with the sharing of practices. With regard to those patients waiting a long time with long-term conditions, Julie Dandridge added that, for those patients where continuity of care was not important was where single and group consultations with specialist nurses helped (for patient asthma and diabetes, for example). Jo

Cogswell added also that once the PCNs were rolled out, training would be offered to Committees on what they could offer patients.

Dr Cao-Bianco was asked for his perspective on the length of routine appointments? He reported that they were 15 minutes long in some practices in order to try to manage some of the complex problems experienced by some patients. Some practices gave 10 minutes but gave those patients who saw their named GP as much time they needed. These were then signposted to alternate appointments with other practitioners such as pharmacists and nurse specialists. He added that this would increasingly take place when the PCN's were introduced.

A Member reported that her GP practice was excellent, in that there was a Saturday morning walk-in service for emergencies, which worked very well. She advocated being seen by a different practitioner to the patient's named one, as often they highlighted different aspects of a condition which might not have been discussed previously. Also, many GPs nowadays worked part-time hours and patients may have to wait a long time to see them.

A Committee member pointed out that GP numbers varied in each surgery in his ward and it was his view therefore that the way doctors were trained needed to be looked at. Health Education England needed to train more GPs who were able to work week-ends and evenings and for all practices to have the ability to move patients to other practices in rotation to even out the numbers. Julie Dandridge added that often patients thought they needed to see a doctor when a telephone appointment would suffice. A member of the Committee who was a retired GP, differed from this view stating that a patient's pathology could be missed this way, which was mainly emotional.

The Chairman pointed out that the paper submitted had informed the Committee (page 88 on the Agenda) that the numbers of Oxfordshire patients seen by a GP was above the national average by 2.3%. At his request, the OCCG **AGREED** to circulate this trend data, particularly highlighting the points where they dipped to below the national average. He added that telephone appointments were 10% above the national average. Julie Dandridge pointed out that it would be the national data which would be circulated – when in the future individual practice data was produced, this would be monitored.

A member commented that it was difficult to see how the PCN clustering would work given that there might not be any transport facilities between practices in many rural practices, when sharing services. He asked if patients would have a choice about going to a practice in another PCN? Also would patients be consulted about the plans? Jo Cogswell responded that the long - term plan was published in January of this year – and detailed guidance was due on 29 March, to date it had yet to be delivered. Implementation would be at the end of July. There was a significant amount of work for Federations, Local Medical Councils and GPs to do in this regard. When PCN's arrived on the horizon, work with Oxford Health

was undertaken to think about how practices could be supported. There had been an uncertainty about what to advise one another, and it had been decided to run some workshops in which all were encouraged to work together to deliver a new and enhanced service.

Jo Cogswell added that stage 2 of PCN's implementation would involve a broad range of clinical practitioners. The PPGs were aware that there would be regulations for practitioners to engage in. During the previous week the CCG had run a wider workshop which had involved the locality forum chairs, HWO and third sector providers; the key outcomes for which were about how to engage patients, how to be coherent and consistent and what needed to be communicated.

Jo Cogswell, Julie Dandridge and Dr Cao-Bianco were thanked for their attendance.

43/19 GP FEDERATIONS

(Agenda No. 11)

The following representatives of the GP Federations attended the meeting to present their reports and respond to questions:

- Dr Ben Riley and Dr Louise Bradbury from OxFed
- Derek Sprague, CEO, Abingdon Federation
- Andrew Elphick, CEO, PML
- Dr Ed Capo-Bianco, SEOx

Andrew Ephick recognised that delivery of Integrated Care is critical. It acts as a glue between practices and facilitates more consistent provision. The Oxford Care Alliance are willing participants though not formally constituted yet. They deal with primary care and community services.

The federations have sought to engage where any practices were in crisis. Their policy is to support individual practices first, then look at working with neighbouring practices and to step in only if all that fails.

Asked about Patient Care Networks (PCNs), Dr Ben Riley said that they would be particularly beneficial for those with frailty or multiple issues. He said that it has been the federations' experience that practices at the scale of 30 to 50,000 patients work well. At that scale 19 PCNs would be needed in Oxfordshire. The networks could better share resources such as IT, communications, appointments, GDPR knowledge and facilitate team systems, career development, disease prevention and health promotion. They will be able to think more about the community needs.

An Oxfordshire training network has been set up to help improve failing practices and address workforce issues such as when a partner is retiring.

The federations have funding for a mentoring scheme to help improve efficiency in practices. There is a risk of greater access issues for PCNs in rural areas. Despite Oxfordshire being relatively attractive, the county has only 85% of the GPs it needs.

Dr Louise Bradbury described how networked practices can provide additional roles such as social prescribing, clinical pharmacists and paramedics. These have been well received by practices and patients. The whole team can learn from each other.

OxFed has seconded paramedics to offer home visits where they can assess and sometimes make decisions or discuss the next steps with the GP. They can make a big difference to GPs' lives but it is not clear yet if it will help with availability of appointments.

Derek Sprague warned that paramedics are a scarce resource as they are sought by the acute sector as well.

Councillor Hilary Hibbert-Biles expressed concern about competition for paramedics with the ambulance service. They are also used as first-aid units outside normal hours.

Andrew Elphick responded that they are training their own paramedics as well. Individual paramedics look for different work experiences.

Dr Louise Bradbury stated that all parties are talking to each other – they share the same set of patients – and ensure that resources are apportioned as appropriate. Being able to assess needs across networks enables better decision-making.

Dr Keith Ruddle expressed concern that a rush towards new arrangements will take over without any health improvement. There were pay-offs in scale but disadvantages at a local level too. He said that everyone needed to work with the communities on this.

Dr Ben Riley said that federations are trying to help PCNs by working on model frameworks, templates for governance and decision-making. Data protection is a difficult issue as practices do not have the expertise individually.

Derek Spraque added that they have begun conversations on improving district nursing and community services.

The federation representatives gave examples of how they work together:

- employing Data Protection Officers
- visiting each other's practices, sharing learning and replicating elsewhere
- networking clinical systems to enable consultation across practices.

Andrew Elphick stated that the PCNs all have federated practices. They will not disappear but will operate between PCNs. He clarified that Year 1 of the process starts from 1 July 2019.

The Chairman thanked the federation representatives for a very useful engagement.

44/19 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 12)

Rosalind Pearce, Executive Director, Healthwatch Oxfordshire invited questions on her report. Asked about the proposed series of network meetings for the Health and Wellbeing Board which include the voluntary sector she responded with the following points:

- It could be an unwieldy approach but as each meeting will be themed not all organisations will attend all meetings.
- The first one will be key – the Health and Wellbeing Board (HWB) must demonstrate that it is listening. The Board identified the themes.
- It had been said that the Board was closed to the voluntary sector and Healthwatch tried to be a voice for the sector, being close to it, but it can't really be.
- It will take about 18 months to know if it has been successful.
- Healthwatch has standing items on the HWB agenda.
- The HWB and HOSC do coordinate but their independence must be respected.

The Chairman stated that the HWB coordinates with the HOSC Forward Plan and suggested to come back and present on the progress with the voluntary sector forum for the HWB in three meetings time..

Rosalind Pearce reported that Healthwatch had carried out 24 reviews between November 2018 and May 2019. Problems included long wait times and difficulty in making a formal complaint.

Healthwatch is still calling for a community hospital strategy. They are observing developments in OX12 through the stakeholder group and have watched relationships become more collaborative, largely down to the approach taken by the Chair.

45/19 CHAIRMAN'S REPORT

(Agenda No. 13)

Prior to consideration of this item the Committee was addressed by Liz Peretz a representative of Keep our NHS Public Campaign Group (KONP).

She urged the Committee to continue the fight to insist that whilst the referral of the PET-CT scanner procurement process to the Secretary of State for Health was being processed, that NHS England do not sign the contract with InHealth. She thanked the Chairman for his clear reply on behalf of the Committee to the undersecretary Seema Kennedy's which was a clear refusal to accept her response.

She stated that it was helpful for the public to note the Committee's argument that NHSE's 'improper' process was a threat to all HOSC's, not just to Oxfordshire. Further, that in proposed service changes covering several authorities, NHSE should have requested a wider HOSC for all the relevant patient populations. She pointed out that the legal remit of HOSC covered not just the service changes but had

responsibility to ‘review or scrutinise any matter relating to the planning, provision and operation of health services in Oxfordshire’; adding that ‘the very strong clinical advice to HOSC was unequivocal that NHSE’s plans regarding the PET scanners at the Churchill Hospital would result in a qualitative reduction in the service offered to patients’.

She called for the original process, the route to preferred bidder status, to be re-run.

Finally, KONP felt that it had been very wrong of the Secretary of State to treat the only legal democratic voice for the people of Oxfordshire, ie. HOSC, with the contempt shown in the letters. She added that no HOSC took its responsibilities lightly, and the decision taken by Oxfordshire was on appropriate grounds. KONP wanted the retain the excellent clinicians at OUH.

The Chairman agreed that the Committee had set out the clear legal arguments in the letter, to which the DoH had committed to send out their latest response by the end of June. He added that there may be a need to call a special meeting in July to consider other potential actions.

On the conclusion of the discussion, the Committee **AGREED** to request the Chairman to:

(a) send out another letter to DoH asking them not to sign the contract until the process had run its course;
(b) write to OUH to request an update on the partnership talks which the Trust was engaged in; and
(c) to note the Chairman’s report JHO13.

..... in the Chair

Date of signing .....

HOSC Actions from 20th June 2019

Item no	Item	Action	Lead	Progress update
29/19	Forward Plan	Amend forward plan to include: • Health Inequalities. For the Director of Public Health to present a strategic plan in November 2019 on how the outstanding recommendations of the Health Inequalities commission report will be addressed. • Following the announcement of the Integrated Care System, to have time to scrutinise the ICS at the September and November meetings. • Following the consultation on the move of Moorlands Eye Hospital; the committee will add optometry to its forward plan. To include some specifics on the waits for cataract surgery (following reports of long waits for NHS treatment) • For the CAMH's item in November to have the Chairman of the Education Scrutiny Committee involved in that item. • For the CCG update item in September to include an update on the return of gynaecology appointments to OUH. • For MSK to be considered at the September HOSC meeting. • For Health Watch Oxfordshire to review and present back to HOSC how effective they feel the HWB voluntary sector network is at feeding in views to the board (to be presented in February 2020)	Sam Shepherd	Complete

HOSC Actions from 20th June 2019

Item no	Item	Action	Lead	Progress update
30/19	OX12 Local Health Needs Assessment Framework	• To provide a date for the return of physiotherapy services to Wantage • Provide a finalised set of options for Wantage and the surrounding area (for consultation as necessary) by midnight on the 30th of November. • An additional HOSC to be held in mid-December or early January to scrutinise the options for Wantage and the surrounding area.	Diane Hedges (CCG)	• Date for the return of physio services to Wantage was given through the meeting of the end of July. • Services confirmed as having returned to Wantage.
31/19	Health and Wellbeing Board Annual Report	Provide some data and information on: - child protection and child in need plans to demonstrate how much the model of early help is delivering results. - work that is being undertaken by the county's leaders on homelessness;	Lucy Butler (OCC)	Pending
31/19	Health and Wellbeing Board Annual Report	To include information on the progress against the CQC action plan in the performance reporting of the Health and Wellbeing Board. To include information on the actions being taken to address areas of poor performance in performance reports. To consider being more ambitious on some targets.	Jackie Wilderspin (OCC)	Noted for inclusion in next year's report

HOSC Actions from 20th June 2019

Item no	Item	Action	Lead	Progress update
31/19	Health and Wellbeing Annual Report	Register the concern HOSC still has about the democratic accountability of the HWB. To consider increasing the membership to have one representative from each district council and to shift the balance of the power so that at least 51% of the votes lie with democratically elected members.	Cllr Ian Hudspeth (OCC)	Noted
31/19	Health and Wellbeing Annual Report	Request more information on the legal aspect of the Integrated Care Board/strategy from Nick Graham	Nick Graham	On the agenda for HOSC on the 19th September and 21st of November
32/19	MSK	Investigate and report back to HOSC: • Whether Healthshare had benefitted from funding to support increased staffing costs related to changes in banding. • The low numbers of reported patient complaints for Healthshare and other providers. • How location of appointment is considered when offering appointments for patients by Healthshare. • Greater details on the KPI's being used to measure performance • Check whether people are being told they cannot have an appointment.	Diane Hedges (CCG)	On the agenda for the 19th of September

HOSC Actions from 20th June 2019

Item no	Item	Action	Lead	Progress update
33/19	GP appointments	To develop and deliver a workshop for HOSC members to attend on Primary Care Networks Provide trend data on the number of patients seen by a GP (not other clinicians)	Jo Cogeswell (CCG)	Training organised for the 13th of September
35/19	Chairman's report	Write to the Department of Health to understand the position to date, to request that NHSE do not sign a contract without scrutiny and to ask for more information on the 'partnership' approach.	Cllr Arash Fatemain	On the agenda for the 19th of September

HOSC Forward Plan – September 2019

The scrutiny work programming guide was shared in July 2017 and is designed to help assess the relative merits of topics brought forward in order to prioritise areas of focus for scrutiny through a transparent and objective process. The "PICK" methodology can help scrutiny committees consider which topics to select or reject. This is:

Public interest	➢ Is the topic of concern to the public? ➢ Is this a "high profile" topic for specific local communities? ➢ Is there or has there been a high level of user dissatisfaction with the service or bad press? ➢ Has the topic has been identified by members/officers as a key issue?
Impact	➢ Will scrutiny lead to improvements for the people of Oxfordshire? ➢ Will scrutiny lead to increased value for money? ➢ Could this make a big difference to the way services are delivered or resource used?
Council performance	➢ Does the topic support the achievement of corporate priorities? ➢ Are the Council and/or other organisations not performing well in this area? ➢ Do we understand why our performance is poor compared to others? ➢ Are we performing well, but spending too much resource on this?
Keep in context	➢ Has new government guidance or legislation been released that will require a significant change to services? ➢ Has the issue been raised by the external auditor/ regulator? ➢ Are any inspections planned in the near future?

Meeting Date	Item Title	Details and Purpose	Organisation
November 2019	Mental health	• To follow an item at November's Performance Scrutiny meeting which will scrutinise Oxfordshire County Council mental health activity and spend. Including: a) Section 75 partnership agreement between OHFT and OCC covering the delivery of social work - Acre Act compliant assessments, care planning, and reviews.	CCG/OH/OCC

Last updated: 16th July 2019

Meeting Date	Item Title	Details and Purpose	Organisation
		b) Mental Health Outcomes Based Contract between OHFT and OCCG (OCC contribute funding to this contract) covering the delivery of all mental health support to people with particular conditions, including inpatient care, community support, wellbeing and employment support, housing, and Care Act assessed social care needs. • How are mental contracts being fulfilled and delivered? • How is money being channelled to deliver on outcomes for the people of Oxfordshire?	
Nov 2019	CAMHS	• Following an Education Scrutiny Committee deep dive into educational attendance at secondary schools, one of the main reasons for persistent absence at schools has been a result of mental health difficulties being experienced by young people. Long waiting times at CAHMS was found to compound the issue. • This item looks to assess the progress on reducing waiting times, including progress made on an OH pilot to use £5.4m of funding from DoH to address waiting times in Oxford city centre. • This item will involve the Chairman of the Education Scrutiny Committee who conducted the review which resulted in a request to HOSC for scrutiny.	CCG/OH/ Education Scrutiny
Nov 2019	Health Inequalities	• Health Inequalities presentation on the progress of recommendations from the Health Inequalities Commission recommendation. • To include a strategic plan for health inequalities (to address the outstanding recommendations).	HWB/OCC

Meeting Date	Item Title	Details and Purpose	Organisation
Nov 2019	Integrated Care System	• To update HOSC on the progression of an ICS for Oxfordshire	System-wide
Future Items			
Dec 2019 or Jan 2020	Options for OX12	• To scrutinise options for health and care services in the OX12 locality, following the implementation of the Local Health Needs Assessment Framework	CCG
February 2020	HWB Voluntary Sector Network	• Healthwatch Oxfordshire to review and present to HOSC how effective they feel the HWB voluntary sector network is at feeding in views to the board	Healthwatch
	Adult Social Care Green Paper	• The potential implications of the ASC Green paper on the local health and social care system	System-wide
	Health in planning and infrastructure	• How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding • Learning from Healthy New Towns. • Impact on air quality and how partners are addressing this issue. • How can HOSC best support the planning function	CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure
	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
	Pharmacy	• Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities	
	Social prescribing	• The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell) • How District Councils and other partners link with and support social prescribing	

Last updated: 16th July 2019

Meeting Date	Item Title	Details and Purpose	Organisation
	Health support for children and young people with SEND	• How is Health contributing to improving outcomes for children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care? • Linked to outcomes of SEND Local Area Inspection	OH, OUH
	Priorities in Health – Lavender Statements	• How the CCG manages competing priorities – Thames Valley Priorities Forum	CCG
	Commissioning intentions	• Committee scrutinises the CCG Commissioning Intentions	CCG
	Optometry	• Provision of optometry in Oxfordshire. • Trends and issues in the provision of optometry services. • How best practice and innovation from elsewhere are used within the services in the county. • To include a summary of the pathway and waiting times for NHS cataract surgery.	CCG

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10 September 2019

Dear Cllr Arash Fatemian

Re: Resolution of Oxfordshire HOSC, 31st May 2019

I am writing in response to your letter of 11th June to the Oxford Health NHS Foundation Trust Board regarding the draft resolution of the Oxfordshire HOSC, 31st May 2019. The Trust Board discussed the matter at its meeting on 24th July. As you will recall, in the meanwhile I attended the HOSC meeting on 20th June to discuss this matter with you and your colleagues, and the Board was able to consider the resolution as you agreed at that meeting.

The Trust Board is absolutely clear that its decision temporarily to close the 12 inpatient beds at the City Community Hospital ward at the Fulbrook Centre from 31st May 2019 was taken on patient safety grounds and was timely and necessary on that basis. The Trust is responsible for the maintenance of safe care for its patients, and where there are insufficient staff of the appropriate level of qualification available, despite strenuous efforts to attract them on a permanent and/or temporary basis, then it is for the Trust to determine whether the correct course of action is to close services temporarily to protect patients from harm. The Trust is fully satisfied that this was a matter for it to decide, and that the decision was appropriate in the circumstances.

In this instance the Trust also took steps to mitigate the impact of the temporary closure on the availability of community hospital beds across Oxfordshire as a whole, by opening 8 beds at Witney and Abingdon, leaving a net reduction to the county of 4 beds, which is in line with the pattern of bed availability in previous years when bed numbers are increased over the winter months and reduced over the summer.

The Board will review the situation at its Board meeting on 25th September, and I am aware that HOSC has been receiving regular reports in the meanwhile about the steps being taken

by the Trust to recruit sufficient staff to enable the ward to be reopened safely. You will be receiving a further update at your meeting on 19th September.

The Board noted and endorses the shared goals and principles in the *Protocol between the Oxfordshire Joint Health Overview and Scrutiny Committee and health and wellbeing providers and commissioners serving the population of Oxfordshire*. Whilst it regrets that the Oxfordshire HOSC has come to the conclusion that the Trust disregarded established working pathways on this occasion, it believes the Protocol creates a mutual obligation on all parties to work together and to avoid 'surprises'; it reaffirms its commitment to that approach and its expectation that it will be upheld by all parties.

In relation to the process of communication on this matter the Board considered the sequence of events.

The risk of staffing levels prompting the need to consider closure of City Community Hospital was first raised as a possibility with the HOSC Senior Policy Officer in August 2018 by Dominic Hardisty, the Trust's Chief Operating Officer. Subsequently a conversation with yourself took place on 31st August. It was agreed (in a discussion shared with health and social care partner organisations across Oxfordshire) that the matter would not need to be discussed at the September 2018 HOSC, and as the risk of temporary closure was not immediate it would be appropriate to defer it until November, particularly as there was a concern about the impact of such a closure in the middle of the winter period when community hospital bed numbers are usually increased. Meanwhile Mr Hardisty undertook to use all reasonable endeavours to keep the ward open and to notify HOSC if that should not prove possible.

The HOSC Senior Policy Officer forwarded to Mr Hardisty the substantial change toolkit template which was to be completed and used for the purposes of that discussion. The template, as you will be aware, addresses circumstances where a closure or change is contemplated. In the event it proved possible to keep the ward open throughout the winter period, thanks to considerable efforts to bolster the staffing on the unit from other community hospitals. Because the anticipated risk of closure did not materialise there was no change to bring to HOSC's attention at that point.

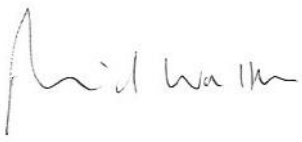
That situation changed only in April 2019, when it became apparent to senior clinicians that new information about the departure of a number of key nursing staff meant that it would prove impossible to keep the ward staffed safely beyond the end of May. Once it had been established that course of action was unavoidable, Mr Hardisty wrote to inform HOSC on 11th May 2019. The Senior Policy Officer wrote to Mr Hardisty on 14th May, setting out concerns that, as the matter had been under discussion beforehand, it could have been anticipated, and therefore ought to be subject to consultation before the closure took place. They also asked for the ward to be kept open, using temporary staff if necessary, until the next scheduled meeting of HOSC on 20th June.

Mr Bell, the Trust's Chief Executive, replied on 16th May. He apologised if the Trust had inadvertently prompted any concern, but confirmed that the proposed closure was temporary and to be undertaken specifically on patient safety grounds, pointing out that while the matter had indeed been raised earlier, the passage of time had only occurred because it had proved possible to defer the risk of temporary closure much longer than had originally been anticipated. He also confirmed that it was not possible to keep the ward open any longer than had previously been indicated, and that temporary staff had already been deployed to keep it open to that point. He offered to discuss the matter further if that would be helpful and asked for that message to be conveyed to yourself. It was at that point, without any further discussion, that the Trust was surprised to receive notice of HOSC's motion of no confidence. The emergency HOSC meeting of 31st May then took place, following which the Board received your letter.

The Board considered the question of whether other system partners were aware of the situation in relation to staffing levels at City Community Hospitals. It noted that information about the situation was shared at a number of points as it developed, including extensive discussions in August 2018, however, given the length of time that it eventually proved possible to keep the ward open over the winter, that communication might have been further reinforced. It is satisfied that the question of whether staff from other organisations could have been used to keep the ward open was addressed, and that it was established that was not feasible. That remains the case to date in relation to the potential to draw on staff from partners to assist in reopening the ward.

The Board also noted your observation about the temporary closure of Wantage Hospital. It is aware that the future arrangements for health services in the area surrounding Wantage (including the hospital) is subject to a consultation process led by Oxfordshire CCG which has been discussed separately at HOSC.

Yours sincerely



David Walker
Chairman

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 19 September 2019

Title of Paper: Oxfordshire Clinical Commissioning Group: Key & Current Issues

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

- Banbury Primary Care
- Gynaecology Outpatients
- Gynaecology Oncology

Senior Responsible Officer: Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group.

NHS
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Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. Banbury Primary Care

The sustainability of primary care in Banbury has been discussed with the HOSC previously (November 2017 and June 2019).

As you will be aware Horsefair Surgery in Banbury has faced significant pressure over the last three years in its efforts to ensure patients get good quality services with the loss of a number of partners and with difficulty in recruitment of new staff. In order to provide stability for Horsefair Surgery, OCCG's Primary Care Commissioning Committee agreed that PML take over the running of Horsefair surgery subject to due diligence exercise. This is in line with the longer term solution for Banbury and will ensure that stability of the practice is maintained. We are pleased to say that Horsefair Surgery has now moved to the management of PML. This is a contractual change for the practice and there will be no changes for patients.

At the beginning of August, of Banbury Health Centre and West Bar Surgery joined up to be one practice. Patients at both practices can expect business as usual, with no changes to either health services or opening hours. The move helps to develop a more sustainable service in the Banbury which can meet the challenges facing the health service in the years to come. Patients of West Bar Surgery and Banbury Health Centre will have the advantage of being able to use the more extensive range of services being provided across both practices.

Primary care in Oxfordshire, in line with the rest of the country remains under pressure from a shortage of GPs, more demand on services from an increasing population with fewer funding resources. To meet these challenges the CCG are commissioning health services that are run at scale. This allows clinicians like GPs and other health professionals such as nurses, pharmacists and social prescribers to provide a wider range of services to a bigger patient population to improve care.

2. Gynaecology

In March 2019, Oxford University Hospitals NHS Foundation Trust (OUH) proposed that GPs be asked to refer some gynaecology patients to out-of-county hospitals and independent providers during a period of three months (between 1 April and 30 June 2019) as a way of tackling long waits for outpatient appointments.

It was therefore agreed that women seeking referrals for general gynaecology, urogynaecology, endometriosis, menopause and pelvic pain would be offered appointments at the following Trusts (with their agreement):

- Buckinghamshire Healthcare NHS FT
- Great Western Hospitals NHS FT
- Royal Berkshire Hospital NHS FT
- South Warwickshire NHS FT
- Milton Keynes University Hospital
- Independent hospitals such as the Foscote in Oxfordshire

This did not affect referrals for:

- Suspected cancer two week waits
- Recurrent miscarriage
- Fertility

Oxfordshire GPs were asked to support these short term measures to allow their patients to get care more quickly and enable OUH clinicians to bring outpatient waits down as much as possible. It is important to note that if women preferred they could still be referred to OUH but were made aware of the long waiting times.

At the end of the three month period the total number of women referred to benign gynaecology clinics other than OUH was 1010.

As a result improvements in waiting times have been reported, although there is further work to do. There were no Oxfordshire patients waiting 52 weeks in April 2019 (the first time since February 2017). Performance on the 18 week referral to treatment time for benign gynaecology was 66% in June 2019 (target 92%).

At the end of August clinic waiting times are as follows; Menopause 8 weeks; Menstrual Disorders 6 weeks; General Gynaecology 12 weeks and Urogynaecology 8 weeks in Oxford, 10 weeks in Banbury.

The Endometriosis clinic will reopen by the end of December 2019. The current waiting time for these patients (referred prior to the pause) now stands at 16 weeks.

Women who need a referral to chronic pelvic pain clinic are continuing to be offered referrals to other providers as the OUH waiting time for these patients (referred prior to the pause) is currently 39 weeks. OUH is working to increase clinical capacity to reduce waiting times and subsequently take referrals at this clinic

3. Gynaecology Oncology (GO)

OUH commissioned an Invited Review by the Royal College of Obstetrics and Gynaecology (RCOG) in November 2018. This took place in January 2019; the final report was submitted to Trust on 1 July 2019 which detailed a number of options for consideration in relation to the future of the service.

A full options appraisal was developed and discussed by Trust Management Executive and Trust Board at end of July 2019.
Trust Board approved the following actions:

A short-to-medium term suspension of the Tertiary Surgical Service until such time that a new Leader is recruited to develop a strong, coherent, and effective team to deliver a world-class service and associated cutting-edge research, teaching and training.

Setting up collaboration with the Cancer Centres at Imperial and Southampton wherein they would accept referrals, in the short-medium term (8-12 months), from Oxford each month for tertiary level surgery in all Gynaecological Oncology tumour sites.

Gynaecological Oncology surgeons having blended contracts to enable them to operate with the teams at Imperial and Southampton. Surgical work would continue at the cancer unit level in Oxford. Medical Oncology provision for all GO cancers would continue in Oxford.

Staff facilitation and organisational development work to be commissioned from an external expert to enable Tertiary Service to recommence.

Once the organisational development work/mediation is completed and the new Leader has implemented the required changes to the service, the surgical work will return to Oxford in a staged manner. Discussions between the OUH, NHS England and CQC have affirmed that the OUH needs to be a centre for Tertiary Services and that as the service rebuilds there will be flexibility in the reintroduction of Tertiary Services.

Oxfordshire System Winter Plan 2019/20

Working in Partnership

"What's wrong?" to "What's strong?"
Using Strength-based approaches in Adult Social Care
OXFORDSHIRE COUNTY COUNCIL

#EndPJparalysis
GET UP, GET DRESSED, GET MOVING

Oxfordshire System Winter Plan Aim

To ensure the Oxfordshire health and care system:

- Is able to deliver **Care** for Patients/service user in the most appropriate setting to improve experience and outcomes
- Ensures **Safe and Effective** transfer of patients/service user across the system
- Ensure sufficient **Capacity** within our services to meet patient need
- Is **Resilient** throughout, whilst providing safe, effective and sustainable care for the local population
- Is able to **Achieve** national and local access targets and trajectories across the system

Oxfordshire Winter Plan On A Page

Our Approach :

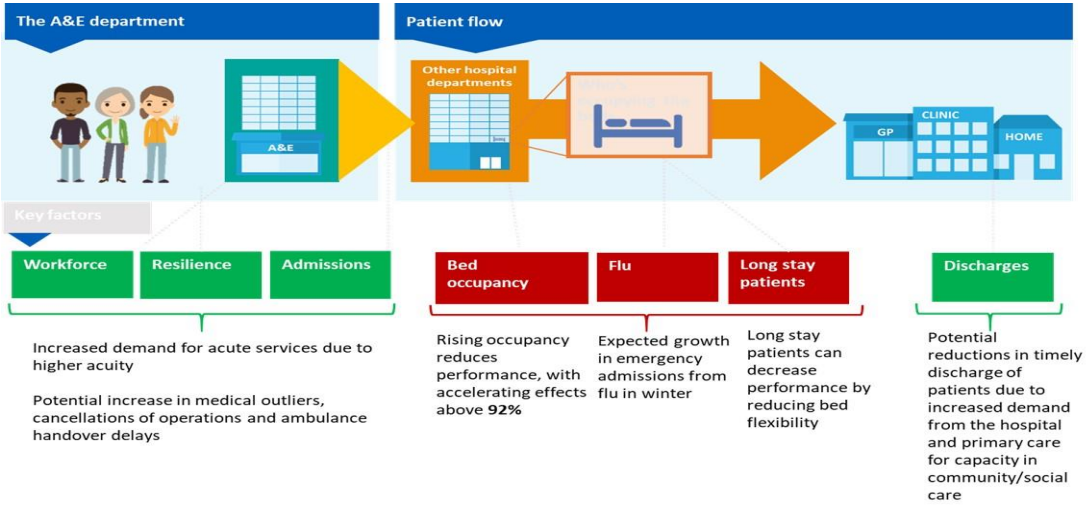
Alongside our system urgent care plan we are seeking specific assurances to manage the challenges of the winter period which include:

- Management of flu
- Increased demand and acuity

By

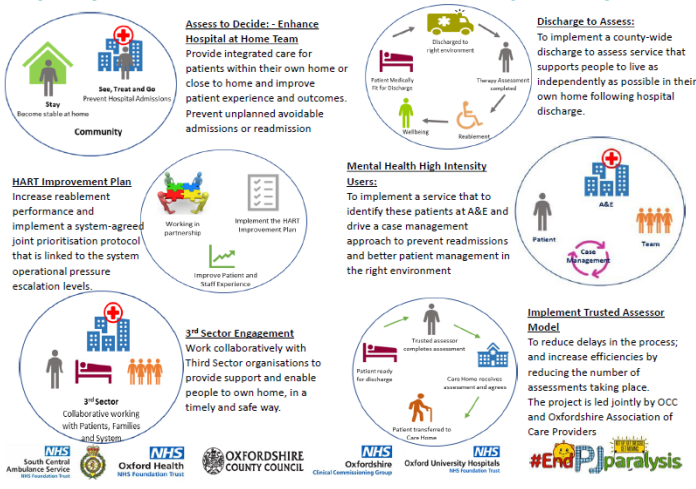
- Taking a whole system team with executive leadership
- Ensuring systems are in place to manage demand to minimise the impact of winter
- Staffing assurance to ensure that high quality care is maintained during winter

The Key Factors



Reducing Admissions and Hospital Stay

Key Projects for Winter 19/20 to Reduce Hospital Stays



Working In Partnership Putting Patients First

NHS Oxfordshire Clinical Commissioning Group

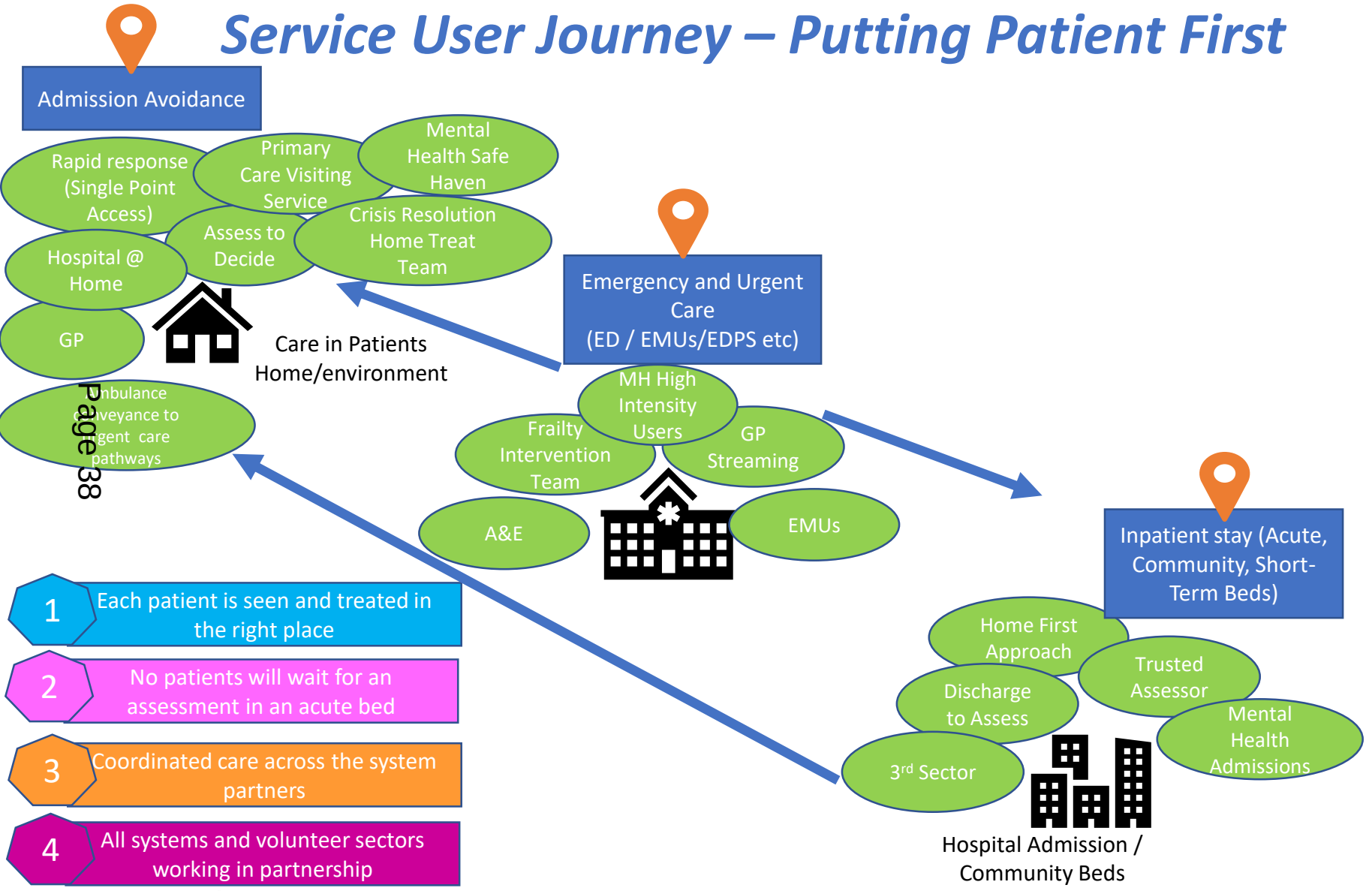
NHS Oxford Health NHS Foundation Trust

OXFORDSHIRE COUNTY COUNCIL

NHS South Central Ambulance Service NHS Foundation

NHS Oxford University Hospitals NHS Foundation Trust

Working In Partnership Throughout the Patients / Service User Journey – Putting Patient First



Urgent Care 2019-2020 Key Priorities

NORTH OXFORDSHIRE	HOME FIRST	ESCALATION
AIM Understanding our patient demand and ensuring that we have capacity and offer our patients / service user the right pathways at the right time	**AIM** Treating people at home and Helping people return safely home earlier once they no longer need medical support in hospital Improve our reablement pathway (HART)	**AIM** Better understanding our demand and capacity and working together to improve our response as a system to enable us to continue to provide high quality safe care to our patients at times of pressure

Key Successes from Winter 18/19 –

- Patients who had to wait more than 4 hours reduced by 4.2% compared to on 2017/18
- An average of 26 fewer patients incurred a length of stay greater than 21 days in December compared to the previous year
- We supported an additional 9% more timely discharges compared to previous winters
- Patients waited for less time in ED
- Despite increased demand less patients were conveyed by ambulance to ED over winter – 48.1% in 17/18 vs 46.5%
- Our winter schemes looked to reduce time spent in hospital by an average of 637 bed day equivalents and we achieved 511
- We improved communication across the system through transparency, integrated and multi-disciplinary working
- We improved our collaborative working across the patient pathway through our closer system working through the Winter Team and working with mental health services and Age UK.

What We Delivered Against Winter 18/19 Plan

To create flow through our system and minimise harm to our patients, we needed to make sure patients spent less days in hospital.

The table shows the number of bed days in hospital saved by the winter schemes

Performance	Target	Actual	% Delivered Against Plan
Increasing our medical acute capacity to support flow	350	287	82%
Increasing Community Hospital capacity to facilitate the flow through the system and reduce potential delays	1904	1190	63%
Providing a same day response service to our respiratory patients in the community (patients in their own home)	28	10	36%
Reduce the Length of Stay of respiratory patients in Community Hospitals	21	15	71%
Support Same Day Responses by the GPs for urgent patient calls	30	86	287%
Increase our Primary Care Visiting Services Capacity	336	294	88%
Provide a streamlined Single Hospital at Home service (8 beds per month)	32	57	178%
Pilot an Advanced Nurse Practitioner Outreach Service targeting acutely ill patients whilst keeping them at home	84	122	145%
Deploy additional flexible beds over 14 weeks	980	980	100%
Expansion of the Frail Intervention Team	315	849	270%
Provide Intensive Therapy in the community to enable patients to get home quicker safely	26	27	104%

What We Delivered Against Winter 18/19 Plan:

Other reported patient pathways improvement benefits

PERFORMANCE	Target	Actual	% Delivered Against Plan
Reduce waiting delays for home care packages (HART Contingency Hours) from 1124.5 per week	600 hours	447	**60.2%** (surpassed the target)
Collaborative working with Age UK to support discharges and patient experience ***(number of patent encounters)***	1560 (New)	1664	**106.7%**
	515 (Follow-Up)	1062	**206.2%**
Provide additional transport services to facilitate A&E and Emergency Admission Unit Discharges	Not applicable	153 patients used the service	Not applicable
Create additional urgent care response capacity to keep patients at home in emergencies	2 additional patients per week	84.6 hours	Not applicable
Reducing Mental Health Attendances at Emergency Services through the development of a Safehaven in Oxford City	Not applicable	Reduction of 168 visits to emergency services	Not applicable

Schemes Discontinued / Removed from Plan

Following a robust impact review process, it meant that some schemes were discontinued where they did not demonstrate any tangible benefits.

Winter communications evaluation 18/19

What went well?

- Campaigns, NHS Advice Care and Signposting App have been delivered for flu, staying well and personal winter plan, raising awareness of local services as alternative to A&E. Use of social media to support system winter messages.
- GP Toolkit developed with easy to use information to support winter communications
- Coordinated working with the local media with system spokespeople and proactive timetable to focus stories which gained considerable coverage.
- NHS and OCC worked well together with Age UK Oxfordshire to support initiatives and media activity.

What went less well?

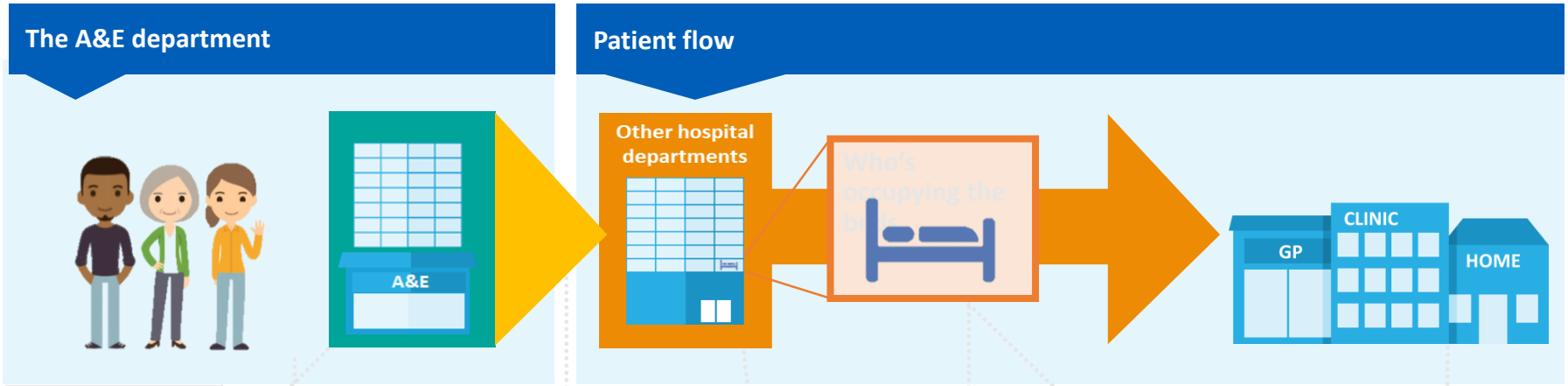
- Audit of GP practice websites showed 20 practices had no information about winter; of the 50 that had information only 10 of those had information on their homepage about sign-posting and using services appropriately.
- GP Access funding not made available from NHSE until mid to late November so campaign design and delivery was hampered.
- No significant change in Minor Injury Unit attendances for targeted postcode areas.

Winter Plan 18/19: Actions Going Forward

We need to:

- Grow the System Home First Approach including 3rd Sector to improve our patient pathways, reduce avoidable admissions and reduce delays including the risk of deconditioning
- Ensure our system capacity and workforce can meet anticipated demand.
- Respond better at times of pressure and strengthen our management processes to manage unpredicted surges in demand
- Strengthen our system oversight, collaboration and problem solving culture through our system team and partnership working.

Summary of key factors affecting system performance



Key factors

Workforce | **Resilience** | **Admissions**

Increased demand for acute services due to higher acuity

Potential increase in medical outliers, cancellations of operations and ambulance handover delays

Conveyance to urgent care pathways

Bed occupancy

Rising occupancy reduces performance, with accelerating effects above **92%**

Flu

Expected growth in emergency admissions from flu in winter

Long stay patients

Long stay patients can decrease performance by reducing bed flexibility

Discharges

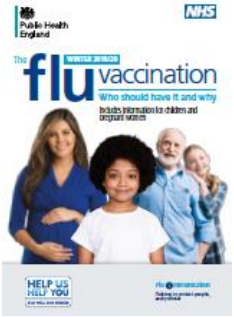
Potential reductions in timely discharge of patients due to increased demand from the hospital and primary care for capacity in community/social care

Winter Pressures 2019/20

FLU

Our local action plan includes:

- Targeted support to GP practices to increase uptake of vaccinations in high risk patients
- Sharing good practice and suggestions to increase uptake vaccination rates
- Media campaign to increase awareness for patients
- Working together on winter preparation in care homes and domiciliary care staff



Brief from OCCG EU Exit SRO

The Department of Health and Social Care issued Operational Guidance setting out local actions to be taken to prepare for EU exit without a deal;

- In line with this guidance we are working together with key stakeholders to ensure a coordinated approach
- We have carried out risk assessments and reported to Board no significant risks identified
- All relevant EU Exit SROs continue working with national/regional teams to address any outstanding issues.

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Understanding our Demand for Urgent Care Services

Predicted demand growth in 19/20 if it replicates Winter 18/19
(extract from 18/19 winter months CSU Urgent Care Reports October 18 to March19)

Performance	Actual Growth 18/19	Predicted Growth 19/20
OUH A&E Attendances (Type 1 & 2)	**7.3%**	**7%**
Out of Hours Services	**- 4.7%**	**1%**
South Central Ambulance Service (999)	**4.7%**	**7%**
South Central Ambulance Service (111)	**6.5%**	**3%**
Minor Injuries Unit	**10%**	**15%**
Emergency Medical Unit	**- 3.3%**	**TBC**
Urgent Adult Mental Health	**3.78%**	**1.99%**
Urgent Out of Area Mental Health	**-4.81%**	**2.14%**
Emergency Dept Psychological Service	**7.42%**	**6.02%**
Section 136	**17.49%**	**-3.44%**
Primary Care (GPs)	**8%***	**8%**

* NHS Digital July 18 vs July 19

Winter Plan 2019/20 Approach

Alongside our system urgent care plan we are seeking specific assurances to manage the challenges of the winter period which include:

- Management of flu
- Increased demand and acuity

By:

- Taking a whole system team with executive leadership
- Ensuring systems are in place to manage demand to minimise the impact of winter
- Staffing assurance to ensure that high quality care is maintained during winter, and especially over the holiday period. Including plans to minimise the number of ambulance handover delays.
- System communications planning

#EndPJparalysis by Reducing Length of Stay for our Patients

- Our proactive system approach to patient management - **"Why not home, why not today?"**
- **Coordinated multidisciplinary approach to discharge** to improve patient flow and reduce delays
- Increasing our **discharge to assess pathway** to help people home earlier
- Delivery of the **HART (Reablement Service) Improvement Plan**
- A **system approach to our bed base** to help us work better in managing our resources and get patients to the right place.

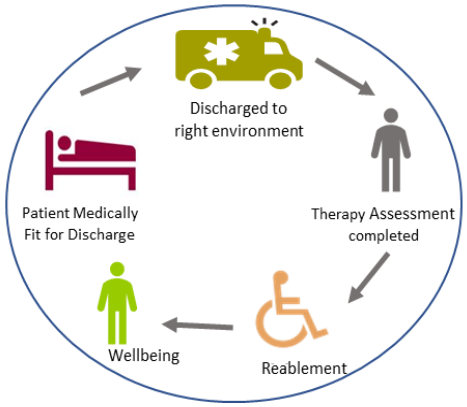
System-wide Communication Plan

- The system wide plan will aim to support Oxfordshire's System Winter Plan objectives and to ensure that people living in Oxfordshire are aware of and take action to keep physically and mentally well and help avoid an admission to hospital this winter.
- Building of the good work last year OCCG, OCC, OUH & OH will have named winter comms leads from their organisations that will make up the winter comms team to deliver the plan.
- A number of campaigns and initiatives will be delivered as part of the winter communications plan including flu, self-care, appropriate use of services and proactive media.
- The local campaigns will consist of two sets messages:
  - ***Stay well by looking after yourself***. The campaigns (incl. flu and self-care) aims to help those with long-term physical and mental health conditions, those over 65, pregnant women and parents of under-sevens stay well and keep their loved ones well this winter . The tone of the local message is to encourage and emphasise the importance of looking after yourself and others during the winter period.
  - ***What to expect if you do become unwell.*** The campaigns will help to manage expectations of staff and patients so that all understand the breadth of services available over winter that will aim at reducing the need for a stay in a hospital bed and if one is needed, reduce the length of stay.

Key Projects for Winter 19/20 to Reduce Hospital Stays

Assess to Decide: - Enhance Hospital at Home Team

Provide integrated care for patients within their own home or close to home and improve patient experience and outcomes. Prevent unplanned avoidable admissions or readmission



Discharge to Assess:

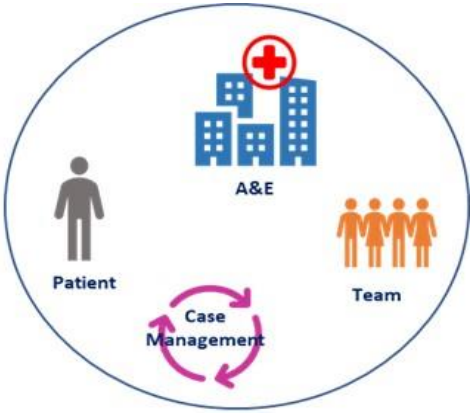
To implement a county-wide discharge to assess service that supports people to live as independently as possible in their own home following hospital discharge.

HART Improvement Plan

Increase reablement performance and implement a system-agreed joint prioritisation protocol that is linked to the system operational pressure escalation levels.

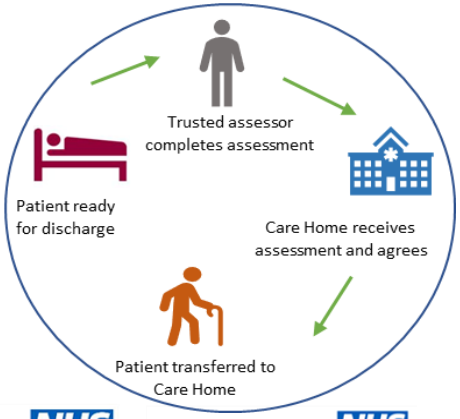
Mental Health High Intensity Users:

To implement a service that to identify these patients at A&E and drive a case management approach to prevent readmissions and better patient management in the right environment



3rd Sector Engagement

Work collaboratively with Third Sector organisations to provide support and enable people to own home, in a timely and safe way.



Implement Trusted Assessor Model

To reduce delays in the process; and increase efficiencies by reducing the number of assessments taking place.

The project is led jointly by OCC and Oxfordshire Association of Care Providers

#EndPJparalysis

NHS South Central Ambulance Service NHS Foundation Trust

NHS Oxford Health NHS Foundation Trust

OXFORDSHIRE COUNTY COUNCIL

NHS Oxfordshire Clinical Commissioning Group

NHS Oxford University Hospitals NHS Foundation Trust

Winter Investment for 2019/20

- Together we have identified £1.4million to further support winter within Oxfordshire County Council and CCG Pooled Budget. Additional investment has been prioritised to support delivery of key projects with impact for Winter 19/20

- Schemes approved so far for procurement for winter

Workstream	Cost
3rd Sector Support	£300,000
Trusted Assessor	£180,000
Flexible fund for mitigation	£920,000

- We have also secure further investment from the BOB STP Transformation Fund :
  - £112,788 to support better management of High Intensity Users of the Oxfordshire urgent care system
  - £50,000 for STP-wide implementation of MiDOS to increase knowledge and use of community alternatives to A&E where clinically appropriate.

- We are also working together on our investment in step down beds to improve our short term bed pathway for patients and improve productivity and use of our system resources

Working In Partnership Throughout the Patients Journey – Putting Patients First

Thank You

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 19 September 2019

Title of Paper: Update report on transition of LD services: benefits for patients

Purpose:
This paper provides HOSC with an update on developments in specialist learning disability health services since the transition to Oxford Health NHS Foundation Trust in July 2017. The paper describes the improvements this has delivered to patients.

Senior Responsible Officer: Sula Wiltshire, Director of Quality/Lead Nurse, Oxfordshire Clinical Commissioning Group

Update report on transition of LD services: benefits for clients

1. Introduction

Specialist health services for people with a learning disability have been provided by Oxford Health NHS Foundation Trust since 1 July 2017. Since then, there have been significant improvements to health services for people with a learning disability both within and outside of the Trust.

Prior to taking on provision, Oxford Health identified a number of areas within the specialist service which could be improved. Post transition, further opportunities have been identified. These include improvements in mental health and community services as well as in acute services and primary care.

The Trust continues to collaborate with colleagues in commissioning and providers in social care and healthcare to deliver joined up provision which delivers better outcomes and experiences for people using health and social care services.

There is a higher than average prevalence of autism amongst people with a learning disability and the work undertaken with services by the LD team has taken this into account. As a result improvements have been delivered for people with both a learning disability and / or autism, despite the latter cohort being outside the direct scope of the contract.

Following the service transition in 2017 Oxford Health and the Clinical Commissioning Group (CCG) began work on the development and implementation of a revised Trust-wide autism strategy. This aimed to improve the service offer for autistic people, with or without a learning disability. This has since been superseded by the Long Term Plan five year planning round, both for Oxfordshire and across the Berkshire Oxfordshire Buckinghamshire Integrated Care System (ICS).

2. Governance

The Oxfordshire Transforming Care Partnership Board has overseen the development of learning disability services across health and social care from April 2016.

The developments outlined below all fall within work streams which report to the Board.

The Board has equal voting numbers of service users, service user representatives and statutory sector representatives. It is currently co-chaired by a person with a learning disability and a service user representative.

3. Internal changes within Oxford Health NHS Foundation Trust

3.1 I**mprovements in mental health provision for people with learning disabilities and/or autism**

The Green Light Toolkit (GLT) is a national guide to auditing and improving mental health services to ensure that they are effective in supporting people with learning disabilities and / or autism.

A mental health liaison nurse role is being piloted. The liaison nurse is leading on implementation of the Green Light Toolkit.

The Green Light Toolkit assess 27 domains that review how well mental health services respond to the needs of people with learning disability and autistic people. Oxfordshire completed a baseline audit of its mental health services in January 2018 and reassessed this in January 2019.

In January 2019, 16 out of the 27 domains showed improved scores and a further 11 areas remained consistent with the baselines. Strengths highlighted in the review were; personalisation, physical health, service user involvement in governance of the service, psychological therapies and local plans. Improvement was noted in working together across mental health and learning disability services. However this is still inconsistent and is, at times, still a barrier to people with a learning disability in accessing mental health services. Further work to make access more consistent and to continue to improve relationships between services is a crucial next step in improving outcomes for people with a learning disability and a mental health condition

Prior to July 2017 people with a learning disability could not access local inpatient provision. Increasingly, people with a learning disability who require an admission under the Mental Health Act 1983 are accessing local Oxford Health inpatient services. This means that patients are receiving care closer to home and the need for out of area admissions has reduced. Lengths of stay have also reduced.

Since 1 July 2017, 18 people with a learning disability have received care in inpatient settings. Six of the 18 were inpatients at the point when Oxford Health took over service provision.

Of the 18, nearly half have accessed a local mental health bed for their entire treatment; provision that would not have been available prior to the start of the OHFT contract. Learning has been taken from each local admission into a mental health bed, with tailored support to mental health staff to help them make the reasonable adjustments required to ensure services are appropriate for people with a learning disability.

Currently there are fewer than five people with a learning disability in inpatient settings. All of those patients in out of area provision have discharge destinations and discharge dates where appropriate.

While OHFT's goal is to make mental health provision locally accessible there will be occasions where individuals have needs that require a specialist inpatient service. possible.

Oxford Health has participated in an NHS Improvement 'discharge collaborative'. This work, combined with closer working with Oxfordshire County Council and Oxfordshire Clinical Commissioning Group, has led to a reduction in the number of out of area inpatients. Lengths of stay have reduced from over 500 days to under 100 since the contract start date.

Oxford Health remains in discussion with NHS England regarding the provision of capital funding to develop two single person services for people with more complex and specialist needs and a two bedded 'crash pad' to mitigate the need to access mainstream mental health services. The design for these services has been developed in partnership with families of young people who have spent time in Assessment and Treatment Units (specialist hospitals for people with learning disabilities detained under the Mental Health Act 1983).

These discussions will be considered as a part of the ICS wide strategic plans which are intended to increase the opportunities for working at scale, and hence the potential to provide specialist services closer to home.

In 2018 the CCG commissioned Oxford Health to expand the remit of the Intensive Support Team (IST). The IST is the crisis support function within the specialist LD health services. It provides support to all ages, meaning children and young people can now access the specialist behavioural support. This service is this critical in preventing the need for an inpatient admission. The service has worked with nine young people to date to stabilise their circumstances and therefore prevent them from being at risk of admission and continues to work proactively with adults to prevent inappropriate admissions and support timely appropriate admissions. This includes working alongside the MH Liaison Nurse to ensure access to local mental health beds.

3.2 Training and Workforce Development

Oxford Health staff across the Trust can currently access training in communication, intensive interaction, epilepsy and learning disability awareness. Training is provided by the specialist service staff. This supports professionals across the Trust to deliver high quality care to patients with a learning disability and/or autism.

An online training resource is currently being developed in partnership with local user led organisations. The expectation is that this will be mandatory for all Oxford Health staff, and is in line with the requirements of the NHS Long Term Plan.

Oxford Health led on the development of a Berkshire West, Oxfordshire and Buckinghamshire (BOB) - wide Workforce Development Strategy covering learning disability and autism across health and social care services. The strategy was an NHS England requirement. It is expected that the final report will be incorporated into the BOB workforce development strategy and linked to the ICS five year plan.

4. System wide improvements

4.1 Health and social care

Several initiatives have improved the coordination and quality of health and social care provision to people with learning disabilities and/or autism.

Oxfordshire County Council has allocated three senior social work practitioners to provide links and expertise between the generic council offer and the specialist health service. A joint health and social care commissioning post, jointly funded by the County Council and the CCG and covering adult learning disability and autism, was created in March 2019.

There has been joint team building between operational team managers and leaders. This has enabled the development of a set of joint commitments to which teams now work when supporting people with learning disabilities.

The Oxfordshire Family Support Network (OxFSN) has delivered training to health and social care team members on working with families. This has further improved both the offer to people with learning disabilities and joint working across health and social care.

4.2 Primary Care

Oxford Health has developed a revised primary care liaison service, supported by GPs.A physical health strategy and implementation plan has been developed for primary care. These initiatives will be evaluated by the CCG in 2019-20.

4.3 Secondary Care

Joint work with Oxford University Hospitals NHS Foundation Trust (OUH) is underway to improve the co-ordination of health care for clients with complex physical health needs. There is now an agreed standard operating procedure in place for patients who are ‘stranded’ (this is a term used for patients who have been in a hospital bed for seven or more days) to support discharge and prevent further delays. The two trusts are also developing an improved system wide mechanism for seeking and receiving feedback from people with a learning disability.

A senior nurse from the Oxford Health specialist learning disability service is now in post within the OUH neurology department to develop a pathway for people with learning disabilities and neurological conditions.

System wide reviews into the deaths of all people with a learning disability through the LeDer programme are leading to learning and proactive work to address any factors which may have contributed to health inequalities and / or early mortality. A significant cause of premature mortality for people with a learning disability and complex health needs is aspiration pneumonia (commonly caused by food being inhaled into the lungs). Oxford Health has developed the Look@Me project with the

Oxford Patient Safety Academy which uses technology to help support people to be safe when they eat.

5. Contract Performance

Oxford Health is consistently delivering performance at or above required levels in the majority of key performance indicators. Detailed work is taking place between NHS Elect and Oxford Health around business process and demand and capacity to ensure contract performance remains good. Remedial actions are in place to address areas of underperformance which are detailed in the CCG's monthly integrated performance reports.

The performance of sub-contracted out of area inpatient beds is an area of concern for both Oxford Health and the CCG. The impact of the national Transforming Care Programme has been to reduce significantly the market for, and availability of, specialist inpatient services for people with complex needs which cannot be met in mainstream mental health settings.

The impact of the Oxford Health Intensive Support Team and close working with OCC social work has resulted in a very low number of people in out of area beds (three at the time of writing). Where out of area beds are needed, a quality monitoring process has been put in place. This process includes, as a minimum, fortnightly reports and monthly visits. The current recommendation from NHS England is for six to eight weekly visits. Oxford Health has developed a standard operating procedure to cover the whole pathway.

An out of area placement monitoring form has been developed by family carers for family carers. This enables information from families, including both concerns and compliments, to inform the quality monitoring process. This will make a major contribution to the intelligence commissioners hold about services and discussions are underway as to how this information will be used by commissioners and providers.

Where concerns are identified, particularly with regard to patient safety, enhanced monitoring is put in place. This includes increased frequency of visits, development and implementation of remedial action plans and liaison with CQC where appropriate.

The current quality monitoring process will be reviewed by a working group including family carers, Oxford Health, the CCG and the County Council in autumn 2019 to identify potential further improvements.

Despite the developments outlined above it remains the case that the lack of local specialist inpatient beds is a significant issue for service users, family carers and local services. Individuals are being placed at considerable distance from home, with implications for them and their families. While a range of quality assurance mechanisms have been put in place to ensure patient safety and the quality of third party services there are a number of inherent challenges in monitoring quality at distance.

The development of the four local specialist beds referenced in section 3.1 above is intended to remove, as far as possible, the need for out of area placements. As a health and social care system we need to work together across the BOB Integrated Care System to develop solutions to this.

6. Assurance

6.1 User feedback and involvement

Patient experience reports to OCCG's quality review meetings indicate that during the first year of the specialist learning disability health service there were 43 compliments and seven complaints received by PALS about the Oxford Health service, four of which were in regards to the community contract. Three were not upheld by Oxford Health but learning has been taken from these and one is currently being investigated.

Service user involvement in business as usual activities, for example interviewing for staff posts, development of accessible care planning and the mental health crisis pathway, was positively identified during the service's CQC inspection in 2018:

> *"The service promoted meaningful co-production and worked actively alongside patients to enable them to influence the running of the service"*

6.2 External assurance

The CQC visited the specialist learning disability health service in March 2018, seven months after the service transferred. The service received a rating of 'good' overall ('good' in all five domains). The report stated:

> *"All patients and carers we spoke with described ways in which they had been emotionally supported by the staff team. Patients talked about staff having an in-depth understanding of their individual situations, and the type of emotional support they found most helpful when they were finding things hard. We observed staff interacting sensitively with patients who were experiencing difficulties in coping with specific issues."*

The CQC:

> "*observed a culture across the service of treating people with learning disabilities as unique individuals with their own strengths and goals as well as needs, and of a strongly held belief in their right to access the same standard of care and treatment as the general population. We found staff and managers were committed to not pathologising learning disability, which means not treating the disability as an illness that requires treatment in itself*."

The CQC chose not to return to the service as part of the well-led review in 2019.

Oxford Health piloted the NHS Improvement 'Provider improvement standards' and, was involved nationally in reviewing these. The Trust completed the national bench marking exercise which included service user questionnaires. Provisional results

indicate that the 12 users that responded felt they were treated with respect 100% of the time and that the majority of respondents agreed or strongly agreed that they were happy with the care they received. The benchmarking report was received in August 2019 and is currently being analysed.

Following a visit from the Chief Executive of NHS Improvement in late 2018 the service was declared ‘a centre of excellence’.

The learning disability team have won and been runners up in consecutive years at the Oxford Health Staff Awards, including winning the patient nominated award following a carer stating that a staff member had “given her daughter a voice”.

A joint presentation between the Transition Programme Director who has since become the Service Director and a member of the Patient Experience Group at the Trust AGM indicated the positives and challenges of the transition and their joint hope for the future of the service.

6. Conclusion

The transition of specialist learning disability health services from Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust has delivered a number of benefits for people with learning disabilities in Oxfordshire, with some of the most significant changes outlined above.

Oxford Health has played a key role in the development of wider system changes which have enabled Oxfordshire to deliver against key Transforming Care targets. In particular adult inpatient numbers have been maintained at nine or fewer.

Oxfordshire is currently well placed to deliver against the NHS long term plan and its aims of reducing health inequalities for people learning disabilities and / or autism Many of the requirements are either in place or are in active development.

2019-20 is a transitional year for learning disability and autism in health services, which will move from the Transforming Care Programme to the NHS long term plan.

Work continues in a number of key work streams, in particular the development of specialist inpatient services in Oxfordshire and more specialist services for autistic people who do not have a learning disability. It is intended that these programmes of work will be incorporated into implementation plans for the forthcoming Adults Strategy and as part of the ICS led work on the Long Term Plan. This will ensure that health and social care provision is joined up and meets the needs of people with learning disabilities and autistic people.

Oxfordshire Joint Health Overview & Scrutiny Committee- 19th September 2019

Dental Services and Dental Health in Oxfordshire.

1. **Introduction**
   This paper will discuss the following
   - Provision and capacity of NHS dentists in Oxfordshire
   - Dental health of adults, older adults and children in the Oxfordshire population, including where inequalities exist
   - Programmes of work to promote dental health
   - Dental needs and health in nursing and residential homes

2. **Exempt Information**
   There is no exempt information contained within this report.

3. **Oral Health and the impact of poor oral health**
   Oral health is an integral part of overall health. A significant proportion of the population in England experience very good levels of oral health. Successive oral surveys have shown that child and adult oral health has been improving over the past 30 years. However, the vulnerable, disadvantaged and socially excluded groups are at a greater risk of oral diseases affecting their teeth, gums, supporting bone and soft tissues of their mouth, tongue and lips.

   Oral disease is largely preventable by addressing risk factors common to general health, such as smoking, alcohol misuse, poor diet and high sugar intake.

   Maintaining good oral health throughout life and into old age not only improves our general health and wellbeing but plays a part in helping us to stay independent for as long as possible. However vulnerable older people may require special care due to age, disability or risk of abuse or neglect

   Dental decay among young children remains an important public health issue. Poor oral health can affect a child's ability to eat, speak, play, sleep and socialise with other children. Poor oral health also causes pain, infections, and impaired nutrition and growth.

   When children have toothache or need treatment it can mean school absence and that families and parents must take time off work. Oral health is an integral part of overall health. When children are not healthy it affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness.

   Whilst more adults are keeping their teeth for life many still suffer from periodontal disease and tooth decay with the number of adults aged 56 with no teeth being higher than some EU countries. Evidence shows that poor oral health in older people can lead to pain and discomfort, which can lead to mood and behaviour changes, particularly in people who cannot communicate their experience. It can

also cause speech problems; reduced ability to smile and communicate freely; problems chewing and swallowing which limit food choices and can lead to impaired nutritional status; reduced self-confidence and increased social isolation; impaired well-being and mood; poor general health and premature mortality.

4. Oral health in children

Local data for Oxfordshire is based on national surveys whose sample size is at district level. Looking at the national data it is possible to see that tooth decay is linked with other measures of social disadvantage and so is a source of inequality in the County. The data available from the 2017 oral health survey of 5-year-old children showed that 80.2% of 5-year-old children in Oxfordshire are now free from any dental decay which is higher than the national average of 76.7% and an improvement from 67% in the 2012 survey. While the improvement is welcome there are still 19.8% of 5-year-old children who have experienced decay, which is an avoidable condition. There is an inequality in the number of children with decay between Districts. The number of children who experience decay is higher in Oxford City than the other districts at 23.5% as shown in Figure 1.

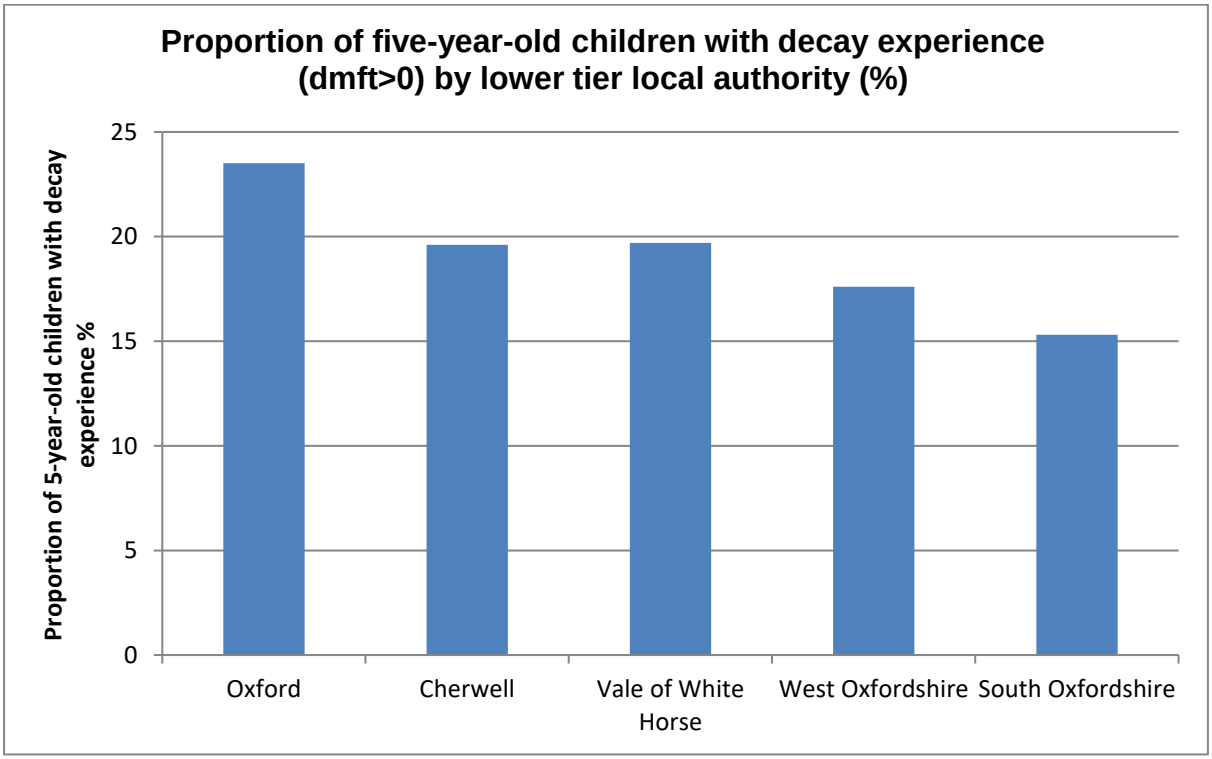


Figure 1 Proportion of 5-year-old children with decay by district in 2017

Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly to the health system. Extracting multiple teeth in children in hospitals in 2011-2012 cost £673 per child with a total NHS cost of nearly £23 million.

In 2017/18 six hundred and twenty children in Oxfordshire aged 0-19 years had teeth extracted under general anaesthetic. This number has remained relatively stable for the last five years, as shown in figure2.

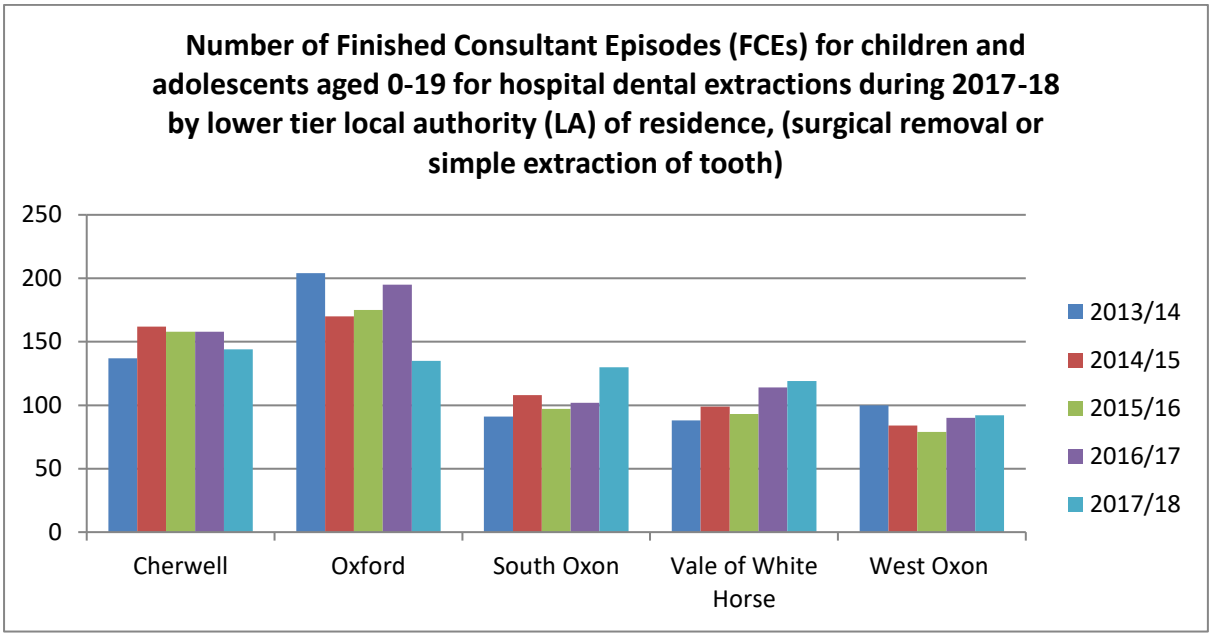


Figure 2. Number of Hospital Episodes for children 0-19 for dental extractions 2013/14 – 2017/18

5. Oral health in adults

Current local data on oral health in adults are not available. A report on a 2018 survey of the oral health of adults attending dental practices is due to be released shortly but for now the local needs must be estimated using South Central England estimates from the decennial national surveys: The Adult Dental Health Survey (ADHS). These surveys collect data on clinically defined ('normative') and patient defined ('perceived' or 'felt') oral health needs. It is an accepted convention to use Strategic Health Authority (as was) data as a proxy for local data with the caveat that it will not be a precise estimate and will not fully reflect local variations. South Central England comprises Thames Valley, Hampshire and the Isle of Wight. While the decennial survey can be used to determine some high-level estimates, they are likely to underestimate disease levels because of their survey methods.

During the post-war years, the nation's oral health was poor, dental disease was rife and there was little expectation that teeth would last a lifetime. This expectation has now changed, with the majority of adults having teeth for life. We have seen dramatic improvements in the last 50 years with the percentage of adults in England with no teeth falling from 37% in 1968 to 6% in 2009. In South Central England, only 2% of adults had no teeth in 2009.

Reasons for improvement in oral health in adults are thought to be:

1. Changes in social norms and behaviours, including body hygiene, smoking rates, use of fluoride toothpaste, increasing public engagement in oral health and rising expectations. Oral hygiene behaviours have substantially improved: 75% reported brushing twice daily in the most recent adult survey and levels of plaque and calculus have steadily improved over the last 40 years.

2. Changes in diagnosis and treatment of oral diseases mean that dentists are more likely to restore teeth than in the past where extraction of teeth and provision of dentures were commonplace.

While oral health has improved generally, it is not all good news. Population averages for adults hide oral health inequalities and a 'social gradient' exists whereby higher levels of disease can be seen at each lower level of the social hierarchy. Data shows that adults from the most deprived areas, in most age groups, are more likely to have:

- Decayed teeth
- No teeth
- Gum disease
- Oral cancer
- Suffer from urgent conditions

It is well established that absolute deprivation has a significant impact on health status, but the social gradient illustrates the importance of relative deprivation. This is significant for Thames Valley where there are pockets of deprivation in a broadly affluent area.

As the population ages and people are increasingly retaining their teeth into later life, the restorative problems experienced by adults have become more complex. In addition, the prevalence of periodontal disease and root caries increases with age, as does the medical complexity of patients. The most recent ADHS found that almost 1/5 adults were found to have complex oral health needs with multiple management issues, particularly in those over 45 years old.

6. Oral health in older adults

At the moment local data on oral health in older adults are not available. A 2016 survey of the oral health of adults in supported living settings is due to be released shortly but for now the local needs must be estimated using South Central England estimates from the decennial national surveys: The Adult Dental Health Survey (ADHS) and from surveys conducted in other areas. The national surveys collect data on clinically assessed ('normative') and subjective (public view) oral health needs.

The most recent (2009) decennial national survey (Adult Dental Health Survey, ADHS) collected data at a Strategic Health Authority (as was) level. These data can be used as a proxy for local data with the caveat that it will not be a precise estimate and will not fully reflect local variations. The SHA, when the survey was carried out, which relates most closely to Thames Valley, was South Central. South Central comprises Thames Valley, Hampshire and the Isle of Wight. While the decennial surveys can be used to determine some high-level estimates, they are likely to underestimate disease levels because of their survey methods, for example, adults living in care homes are excluded from the survey population.

Good health is central to improving outcomes for older adults and good oral health is a key part of that. The consequences of oral diseases in older adults can be considerable. Pain, discomfort and sleepless nights are all common impacts of oral diseases.

The number and position of a person's natural teeth affects their ability to chew. Difficulty with chewing affects the nutrient intakes of older people. There is evidence

that people who cannot chew or bite comfortably are less likely to consume high fibre foods such as bread, fruit and vegetables, thereby risking reducing their intake of essential nutrients such as fibre, iron and vitamin C. In older adults, this can lead to dehydration and malnutrition. Age UK report that it is estimated that 1.3 million people over 65 suffer from malnutrition, the vast majority of whom (93%) live in the community.

Poor oral health can have a negative impact on a person's ability to socialise and can reduce a person's self-esteem. This can increase the problems of loneliness and isolation. Poor oral health therefore can impact on a person's quality of life and their ability to live independently. A survey carried out with residents of care homes found that 40% of the residents reported that poor oral health affected their daily life.

Good oral health is therefore important for an older person to be able to lead an independent life with good general health and quality of life.

In general, the oral health of older people has improved in recent decades. For example, more older people are now keeping their teeth into old age. In 2009 the ADHS found that in England the proportion of the population aged between 65 and 75 with some natural teeth was 84% with over half of the people aged over 85 having some natural teeth. This compares with 26% of adults aged 65 to 75 with some natural teeth in 1978.

The number of teeth a person has an impact on their general health. For example, older people with a need for dentures are more likely to be frail than those without a need and older people with 20 or more natural teeth are less likely to be frail than those with no teeth. This would suggest that improving the oral health of older people can have an impact on their ability to live independently.

The 2009 ADHS found that the number of natural teeth is related to age. 86%of all adults with some natural teeth (dentate) had 21 or more teeth. This proportion fell significantly as age increased. For example, 100% of dentate adults aged 16 to 24 had 21 or more natural teeth compared with 40% of dentate adults aged 75 to 84. Among adults aged 85 and above only 26% had 21 or more natural teeth. These older dentate adults with enough natural teeth remaining to enable functional dentition represents 14% of all adults aged 85 and over.

The number of teeth a person has an impact on their general health. For example, older people with a need for dentures are more likely to be frail than those without a need and older people with 20 or more natural teeth are less likely to be frail than those with no teeth. This would suggest that improving the oral health of older people can have an impact on their ability to live independently.

Tooth decay is not distributed evenly throughout the population; inequalities exist. Older adults, for example, are more likely to experience tooth decay than younger adults. Studies carried out in other parts of the country have found that older adults

living in care homes are more likely to experience tooth decay than the general older adult population (Figure 3). The 2009 ADHS found that those older people with tooth decay had a considerable number of teeth affected by decay with an average of 2.5 teeth affected.

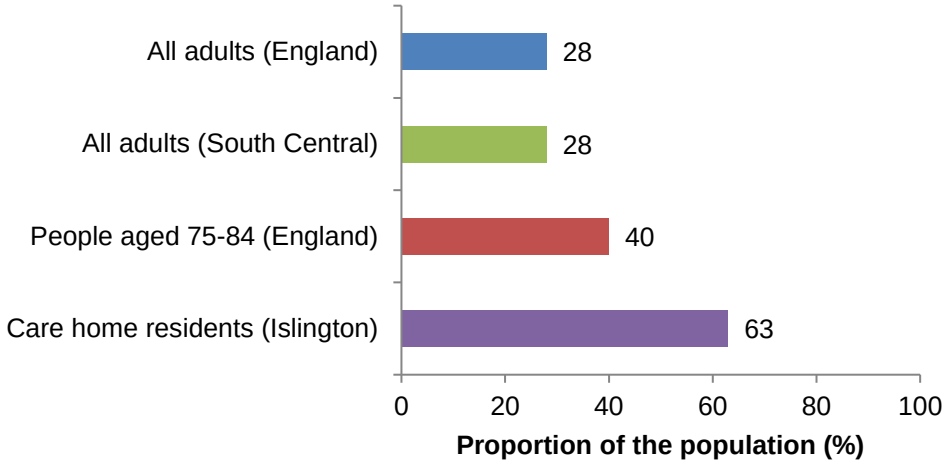


Figure 3. Proportion of the population with tooth decay. Source: ADHS 2009, UCL

7. NHS dental care in Oxfordshire

NHS England commissions all dental services including primary, community and hospital services and urgent and emergency care.

NHS England has a legal duty to commission dental services to meet the needs of a local population. It commissions local oral health needs assessments in partnership with local authorities and other organisations and decides subsequently how best to use its resources to meet this need. NHS dental services are commissioned through contract with independent providers which take account of the access to local dental services and the dental health of the local population.

Everyone is entitled to NHS dental services. Patients are not 'registered' with dental practices and can attend whichever practice they choose. Some practices treat adults and children and others only see children and patient charge exempt adults on the NHS. The NHS Choices website advises only to visit A&E in serious circumstances:

- Severe pain
- Heavy Bleeding
- Injuries to the face, mouth or teeth.

NHS dental services provide care and treatment for adults and children alike, but dental care for children under the age of 18, or young people under the age of 19 and in full time education, is free of charge.

8. NHS Dental services in Oxfordshire

i. Primary Care

Services are provided by 'High Street' Dentists under the NHS (General Dental Services/Personal Dental Services) Regulations 2005. Treatments are delivered within NHS treatment bands which include check-ups, fillings, dentures and crown and bridge work. Dentists also monitor patient oral health with health promotion advice and early intervention to maintain oral health. Patient Charges apply to these services.

Practices see patients on a planned and urgent basis. In 2015, the local office has established arrangements with NHS 111 and a number of dental practices for patients to be seen urgently on the day if they do not regularly attend a Dentist or cannot get an urgent appointment at the practice they normally attend. These are normally patients who do not attend the Dentist on a regular basis. Many of these patients then form an on-going relationship with the dental practices concerned.

Services are provided via cash limited non-time limited General Dental Services (GDS) contracts with 'Unit of Dental Activity' targets. Providers paid on monthly basis based on planned activity. If they fail to deliver at least 96% of this activity in a financial year, monies are recovered.

For more complex cases Dentists refer to the following:

- Secondary care (hospitals) – oral and maxillofacial surgery, restorative and orthodontics (includes 2 week waits for potential cancer cases)
- Level 2 oral surgery and restorative dentistry – specialist but does not require treatment in hospital
- Community Dental Services – special care and paediatrics for patients with more complex management needs
- Orthodontic services

Table 1 below details primary care provision in the county 2018-19:

Local area	Population	Practices	UDAs commissioned	UOAs per head	'Full' NHS practices	Numbers over 96% 17-18	% over 96%	Referrals from NHS 111
Cherwell	145,600	16	261,048	1.79	12	5	31.25%	3
Oxford	154,600	20	283,434	1.83	14	9	45%	4
South Oxon	137,400	21	143,731	1.05	10	8	38.1%	3
Vale of the White Horse	126,700	15	137,693	1.09	10	8	53.33%	1
West Oxon	108,600	18	159,638	1.47	14	13	77.78%	1
Oxfordshire	**672,900**	**90**	**985,544**	**1.46**	**60**	**43**	**71.67%**	**12**
Thames Valley	**2,124,175**	**282**	**2,775,796**	**1.31**	**191**	**202**	**71.63%**	**40**

Table 1. Primary dental care provision for Oxfordshire 2018/19

ii. Access to primary care services

In 2009 the government commenced a programme of improving access to NHS Dental Services (as measured by the number of patients attending an NHS Dentist in the previous 24 months). Since April 2009 the number of patients attending an NHS Dentist in the Thames Valley has increased by 248,050 from 852,516 to 1,100,566

(July 2019); a growth of 29.1%. The local office is set a target for the % of patients attending an NHS Dentist. The target is that 51.50% of the population attend an NHS Dentist; the position at the end of July 2019 is that 51.81% of the population had attended an NHS Dentist in the previous 2 years. This compares to 43.64% of the population in 2009. The current access rate in Oxfordshire is about 54% of the population attending in the last two years.

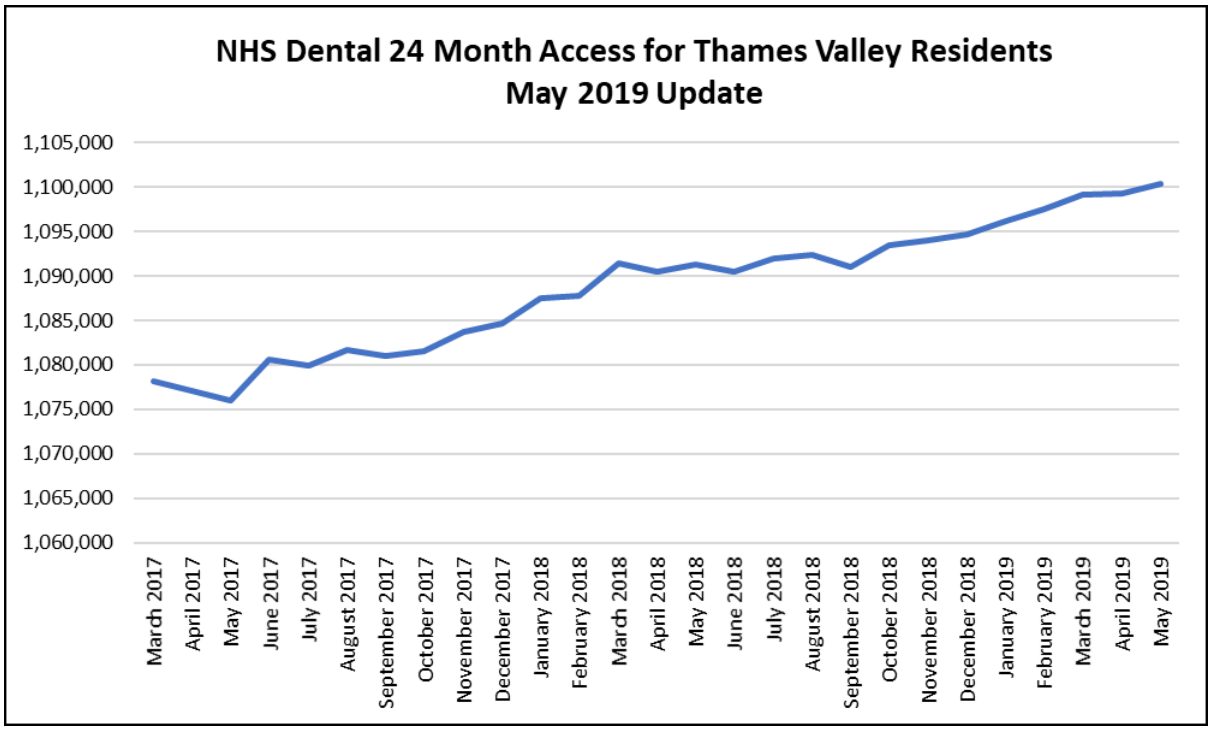


Figure 4. NHS Dental 24 month access for Thames Valley residents March 2017 to May 2019

In Oxfordshire the information about attendance by District is available about patients attending over one-year period. The latest available information is for October 2018; detailed below. This does show some variation between the Districts, from 37.1% in the Vale of the White Horse to 64.6% in Oxford.

Local Authority	Population	Patients attending Oct 17	Patients attending oct 18	Change	% attending Oct 18
Cherwell	145,600	90,511	92,807	2,296	63.7%
Oxford	154,600	99,069	99,917	848	64.6%
South Oxon	137,400	58,248	59,240	992	43.1%
Vale of the White Horse	126,700	48,918	46,955	-1,963	37.1%
West Oxon	108,600	59,881	61,229	1,348	56.4%
Oxfordshire	**672,900**	**356,727**	**360,518**	**3,791**	**53.6%**
Thames Valley	**2,124,175**	**1,029.400**	**1,040,150**	**10,750**	**49.0%**

Table 2. Oxfordshire patients accessing primary dental services over a one-year period Oct 2017- Oct 2018

iii. Orthodontics

One of the peak ages for people to attend High Street Dental services is between the ages of about 10 and 14. This is due to possible Orthodontic (braces) treatment under the NHS. If patients are identified as having an Index of Treatment Need (IOTN) of 3.6 and above, they are eligible for NHS treatment. Patients are in

treatment for an average of 21 months with a year retention period to monitor the outcome of treatments. In the Thames Valley there are usually about 24,000 patients either starting treatment; mid-treatment and in-retention. Patient charges apply to these services, but it is rare for them to be collected as most patients are children aged under 16 and are in full time education and so exempt from dental charges.

Services provided via Orthodontic specialist led cash limited time limited Personal Dental Services (PDS) agreements with 'Unit of Orthodontic Activity' targets. Providers are paid on monthly basis based on planned activity. If they fail to deliver at least 96% of this activity in a financial year, monies are recovered.

For more complex cases Orthodontists refer to the following:

- Secondary care (hospitals) – oral and maxillofacial surgery, restorative and orthodontics
- Dental Services – special care and paediatrics for patients with more complex management needs

These services have recently been subject to a procurement exercise across the south of England with new arrangements to be implemented from April 2019. New contracts for 7 years have been awarded. The level of activity to be commissioned in Oxfordshire will be very similar to levels commissioned prior to April 2019 (49,925 UOAs post April 2019 v 50,310 pre-April 2019). But there will be some redistribution of the activity, in line with need, with reduction in the Cherwell area, but increases in South Oxfordshire, the Vale of the White Horse and West Oxfordshire. This will provide more local access for patients.

Some providers will be those who had contracts pre-April 2019, and some will be new to the area. For providers who submitted unsuccessful bids or who did not bid there are arrangements in place for them to complete treatments over a 2-year period. For patients who have been assessed as eligible for NHS treatment but who have not yet started treatment or who have yet to be assessed and their current provider cannot start treatment before their contract expires, arrangements are in place to transfer these patients to new providers from April.

The local office has also written to all dental stakeholders about referral arrangements post April 2019.

iv. Community Dental Services

For patients whose management needs cannot be met in primary care (possibly due to learning disabilities or mental health issues) there is the Community Dental Service. This Special Care and Paediatric service is provided by the Oxford Health NHS Foundation Trust via a cash limited time limited PDS contract. The service has a number of clinics across the county and is led by Dentists who have training in Special Care Dentistry. Patient charges apply for these services, but many of the patients attending fall within the charge exempt categories.

In addition to routine care, the service provides urgent care and treatment under Sedation and General Anaesthetic.

These services are currently subject to review with a planned procurement to be implemented in April 2021.

v. Secondary care (hospital) services

If patients have more complex treatment needs that cannot be met in primary care then referrals are made to the hospital services, as described above. The hospital services are provided by the Oxford University Hospitals NHS Foundation Trust from various sites across the county. Services are commissioned via NHS standard contracts and patient charges do not apply.

vi. Tier 2 services

Over the last few years across the country, the NHS has commissioned services that are deemed to be outside the expertise of primary care but do not need hospital treatment. An example is Orthodontics, but in addition to this there are Oral Surgery (extraction) and Restorative (complex root canal fittings and crown and bridge work) services. These have been subject to review over the last few years with recently updated clinical pathways (in line with NHS England Commissioning guides). The local office is now procuring tier 2 Oral Surgery and Restorative services with the aim of ensuring that the same pathways are in place in each of the 4 health systems in the Thames Valley.

9. Challenges facing NHS Dental services in Oxfordshire

i. Improving oral health

Dental access and oral health have improved substantially in recent years. However, for more deprived communities the rate of improvement has been more challenging. These groups are less likely to attend the Dentist regularly but more likely to attend urgently when they have dental pain. There is also national growth in the number of children having teeth extracted. There are arrangements in place to ensure children can access dental services both in or out of hours, but a focus on access alone will not lead to oral health improvement.

In order to try to address this, the NHS England Chief Dental Officer has led a national programme called ‘Starting Well’ with a focus on improving the oral health of young children. The scheme is designed to support dental practices in identifying children more at risk of poor oral health with early interventions and also for them to engage with local communities to encourage regular attendance at the Dentist.

The scheme led by the NHS England Chief Dental Officer has identified the 13 local authorities with the poorest oral health in the country with Starting Well to be implemented in these areas. Slough has been identified as one of the areas and the scheme has been running there since early 2018. The project is being carried out in partnership between the Dental practices taking part in the scheme, NHS England and the local authority. The local office agreed to roll out this scheme to other areas where oral health has been identified as challenging. From April 2019 the Starting Well scheme was implemented in Oxford and High Wycombe. One practice in Oxford is taking part in the scheme and the local office is working with the council to ensure the success of this scheme.

ii. Access for hard to reach groups

Recent Healthwatch reports in Oxfordshire and Reading have highlighted the challenges of access to dental care for residents of care homes. If residents of care homes are unable to visit dental practices and have an urgent dental need, they can be referred to the Community Dental Service who carries out domiciliary visits.

Since the current NHS contract was introduced in 2006 very few dental practices now visit care homes, as it is not included as part of the standard national contract. Their contracts relate to the sites from which they provide services; the dental practice. Legislative changes since 2006 in terms of issues such as infection control have also made it more difficult for dental services to be taken to care homes.

A number of local offices have carried out pilots into providing dental care in care homes. These reports tend to highlight some of the challenges of providing services; such as legislative constraints, facilities in care homes to enable dental care to be delivered and turnover of staff in the homes.

The local office is investigating whether some of the identified barriers to care home provision can be addressed in practical ways to enable provision in care home settings.

iii. Population growth

When the Dental Access Programme began in 2009, the population of the Thames Valley was 1,953,500. It is now estimated to be 2,124,175; a growth of 170,675 people (8.7%). Much of the growth relates to new housing with Oxfordshire facing significant pressures in the Banbury, Bicester, Didcot and Wantage areas.

In order to address these pressures, the local office does offer dental practices non-recurrent uplifts to their contracts (in each of the last 3 years) to enable them to deliver more activity. A new practice was opened in Bicester in January 2019 to help address pressures in this area.

The local office is working on the development of a 5-year plan with the aim of achieved a planned increase in provision in that time, with a focus on areas with housing growth.

10. Resources

When the Dental Access Programme was established in 2009 ringfenced monies were identified to support delivery. This has proved to be very successful and access to NHS Dentistry continues to improve. However, the ringfence was removed in 2012 and the use of monies for dental services has to be considered alongside other services.

If dental practices fail to deliver their contracted activity targets, then monies are recovered by NHS England; for that year only. These monies are then used on a non-recurrent basis to commission additional activity from practices with a history of contract delivery. In developing the 5-year plan, the local office aims to develop an investment plan to ensure resources are maximised both to support on-going

improvements to dental access and the oral health of the people of the Thames Valley.

11. Oral Health Promotion and Dental Epidemiology

On 1st April 2013 the statutory responsibility for the commissioning of dental public health functions transferred to local government (oral health promotion and dental surveys). The dental public health functions of local authorities are described in regulations and include a statutory requirement to provide or secure provision of oral surveys.

The statutory instrument states that:

A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area-

I. The assessment and monitoring of oral health needs
II. The planning and evaluation of oral health promotion programmes.
III. The planning and evaluation of the arrangements for the provision of dental services as part of the health service, and
IV. Where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.
V. The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.) so far as that survey is conducted within the authority's area.

Oxfordshire has had longstanding dental epidemiology and oral health promotion services delivered in the county. The current contract for these services commenced 1st April 2019 and ends on 31st July 2025 with a break point in 2023. This contract is delivered by Community Dental Services (CDS), a community interest company based in Bedfordshire who have been providing the service since 2014. They have an office based in Upper Heyford as base of their operations for Oxfordshire.

i. Dental Epidemiology Services

The dental epidemiology service is a mandated function of the County Council. It involves the collection of oral health data through conducting dental surveys. The information that is obtained from the service will contribute to the wider intelligence on the oral health of the population and help inform the future commissioning of dental services which are commissioned.

The service conducts surveys in accordance with the national Dental Public Health Intelligence Programme (DPHIP). The DPHIP is a national programme of dental surveys and are co-ordinated by Public Health England (PHE). The DPHIP surveys are conducted annually, usually over academic years and are carried out on randomised stratified samples or commissioning organisations can opt to conduct wider surveys e.g. census surveys. The surveys are conducted according to a national standard protocol and examiners are trained and calibrated to a national standard. The sampling procedure conforms to the national standard and is agreed

with the DPHIP survey co-ordinator before fieldwork is carried out. DPHIP epidemiology co-ordinators are employed by PHE. They work on a regional basis and are responsible for the quality assurance of the fieldwork carried out in their area. This quality assurance and standardisation allows local, regional and national comparisons of the data. Participation in DPHIP enables commissioners to collect meaningful, comparable data which has been collected, analysed and validated to the highest standards.

The current survey being conducted is of 3-year-old children in Oxfordshire.

ii. Oral Health Promotion Services

The Oral Health Promotion Service aims to coordinate, facilitate, support and provide a range of evidence-based interventions to improve oral health and reduce oral health inequalities in Oxfordshire by:

- Improving oral health promotion
- Improving diet choices
- Reducing consumption of sugary food and drinks, alcohol and tobacco
- Improving oral hygiene
- Collaborating with NHS England, dental practices, other healthcare professionals, early years settings, schools, community groups and other organisations to increase access to and improve patient awareness of NHS dental services
- Identifying and targeting vulnerable groups
- Providing training to frontline professionals

The service delivers information and advice on oral health in line with Commissioning Better Oral Health and Delivering Better Oral Health (two key guidance documents published by PHE), whilst being flexible to the varying needs of the population.

The model is based around providing a range of services for children and adults in a range of locations.

The health promotion activities provided by the service include:

Oral health promotion interventions aimed at children;
This includes:

- Direct oral health education and outreach oral health promotional work in high risk, vulnerable child groups.
- Training the trainers about oral health strategies (including hygiene, primary prevention, and first aid response to dental trauma or emergencies) amongst health and non-health professionals working with children.
- Accreditation in oral health of settings for early years and primary school age children, prioritising setting based on need and deprivation.

Oral health promotion interventions aimed at vulnerable adults with additional needs.
This includes:

- Direct oral health education and outreach oral health promotional work for identified adult priority groups.

- Training the trainers about oral health strategies amongst health and non-health professionals working with adults with additional needs.
- Accreditation in oral health of residential care homes with the development and use of an oral health care assessment tool as recommended by NICE

The ethos of the service is to train and develop the wider workforce to become knowledgeable in oral health issues and how to use this knowledge to improve oral health in the service users they regularly engage with – public health commissioners are trying to make every contact count for oral health.

In 2018/19 CDS working to the agreed work plan delivered the following:

- Training of health and non-health professionals who work with children and adults.
- Direct oral health sessions and outreach oral health promotion aimed at children and adults. The service trained 348 local staff in oral health, how to maintain good oral hygiene and how to access dental services.
- Supervised toothbrushing programme in primary schools. Five-year-old children brush their teeth under supervision of their teacher. The team worked with 5 schools who signed up to take part in this programme. Overall 160 children took part in this pilot scheme.
- Training for carers in 16 care homes. CDS trained 136 members of staff who work in care homes in older adult oral health.
- CDS attended, in total, 198 different groups, sessions and events throughout the year. They made contacts with 2604 people.
    - Adults
      Some of the groups the team worked with; Age UK, RVS, Macmillan, Healthy Hospital Days, Here4Health, Solutions4Health, OSJCT, Day centres, CSS centres and Maggie's Oxford.
    - Children
      Some of the groups the team worked with; JR and Horton outpatients, Toddler/baby groups, primary schools, libraries, Play Bus, OCC stay and Learn sessions and OPA days.
- Promotion of oral health related national campaigns.
- CDS Took part in events for National Smile Month (May) and Mouth Cancer Action Month (November)
- Involvement in public health groups, events and workplace health fairs.

Health Education England is also focussing on oral health improvement for care home residents and currently F1 dentists (post-registration training year) in Oxfordshire are carrying out training to care home staff as part of their training year.

12. Older adults and CQC report on Oral Health

In June 2019 the CQC released a report, Smiling matters, Oral health in care homes. This report described the findings of dental inspectors who attended 100 routine planned inspections of care homes alongside inspectors from the CQC adult social care team. The inspectors found that staff awareness of NICE guideline recommendations on oral health was low and not everyone was supported to keep

their teeth or dentures clean. There were some examples of good joined up practice between care homes and dentists. The report made the following conclusions and recommendations

- People who use services, their families and cares need to be made aware of the importance of oral care
- Care home services need to make awareness and implementation of the NICE guideline 'Oral health for adults in care homes' a priority
- Care home staff need better training in oral care
- The dental profession needs improved guidance on how to treat people in care homes
- Dental provision and commissioning need to improve to meet the needs of people in care homes
- NICE guideline NG48 needs to be used in more regulatory and commissioning assessments

A Healthwatch report last autumn highlighted the issues and concerns regarding oral health of residents of care homes in the County. This is an issue that colleagues in adult social care and public health have been aware of and had been working to address prior to publication of the report.

In Oxfordshire the work on addressing the issues had already begun, the findings of the CQC report are timely and give clear direction on issues to be addressed. Local commissioners are committed working collaboratively with local services to improve in the local oral health system for older people.

Since 2016 CDS have been working with care home providers to pilot an oral health accreditation programme. This pilot programme enabled care home providers:

- To be accredited as an oral health promoting environment
- Support elderly care home to oral health friendly practices
- Help improve the oral health of residents in their care

Five care home took part in the pilot and CDS has maintained contact with these homes to continue supporting the training need for staff in these homes.

The public health team are currently developing an oral health assessment tool and training which will help care home staff assess the oral health of residents in line with NICE guidelines. Using the learning from the pilot programme, commissioners will be working with the new provider, Adult Social Care colleagues and care home providers in developing a programme to introduce use of the assessment tool as a standard practice and create healthier oral health promoting environments in care homes.

The expectation is that a multilevel training offer will be available for local care home staff. This will be

- Level 1
  Online training programme to learn how to use the oral health assessment tool for care home residents. This will be for all staff to train at a time to suit them and provide resources on oral health.
- Level 2

Face to face training for all care staff to further develop their understanding of oral health, the causes of poor oral health, how to help service users in their care to maintain good oral health and how to access dental services.

- Level 3
  Building on level 1& 2 care home providers can be accredited as oral health promoting environments. This will include having a champion for oral health, training staff who can in turn train internal staff on oral health and the development of policies which will promote good oral health for residents.

The NHS plans to:

Work with the local authority to improve knowledge in care homes about local NHS Dental services
Review access to domiciliary care as part of the review of Community Dental Services with the aim of the strengthening the partnership with High Street Dentists to provide this support when required

Test an 'enhanced' service for High Street Dentists to support identified care homes. This is also being looked at nationally in terms of closer partnership working between GPs, Pharmacists and Dentists

Investigate whether the Starting Well model for young children can be applied to other patient groups, such as older patients

13. Recommendation

The Oxfordshire Joint Health Overview & Scrutiny Committee is recommended to note the oral health of the local population, the current dental services provided to address oral health issues in Oxfordshire.

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September 2019

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health Overview and Scrutiny Committee

Date of Meeting: 19 September 2019

Title of Paper: Update on MSK Task and Finish Group Recommendations

Purpose: The following paper follows on from the update on actions to address recommendations made by the HOSC MSK Task & Finish Group presented in June 2019 to the Oxfordshire Joint Health Overview and Scrutiny Committee.

Items specifically to investigate and feedback to HOSC raised in June were:

1. Whether Healthshare has benefitted from funding to support increased staffing costs related to changes in in banding?
2. The low number of reported patient complaints for Healthshare and other providers?
3. How location of appointments is considered when offering appointments for patients by Healthshare
4. Greater detail on the KPIs being used to measure performance?
5. Whether people are being told they cannot have an appointment.

6. When MSK Services will return to Wantage Hospital?

Senior Responsible Officer: Diane Hedges, Chief Operating Officer, Oxfordshire Clinical Commissioning Group

1. OCCG to investigate and report back to HOSC whether Healthshare had benefitted from funding to support increased staffing costs related to changes in banding.

The dialogue on uplift to cover the recent changes to agenda for change pay scales is still ongoing with a meeting scheduled for September 16th, during which we hope a resolution can be found. Healthshare have upheld all TUPE staff members' terms and conditions from their original contract and in addition have increased their salary in April by 1% as stated within the original Healthshare bid for services.

2. OCCG to investigate and report back to HOSC low numbers of reported patient complaints for Healthshare and other providers.

2.1 Complaints assurance: All NHS contracts contain the requirement to follow NHS complaints regulations.

Within these regulations, the complainant has the right to complain directly to the provider or to raise their complaint with the commissioner who will take it to the provider on their behalf.

It is not possible to assess the quality of a service by the crude number of complaints. There are many factors which influence complaints and, such is the variation between services, it is not possible to make comparisons. We can, however, look at complaints over time. A sudden spike or upward trend are indicators of a decline in quality.

As a part of quality monitoring of contracts, OCCG requires providers to share with us details of complaints which they have received. They are required to report on numbers of complaints, whether or not they met required timescales for response and investigation and what has happened as a result. Complaints which go via the CCG provide an additional level of insight into patients' experiences.

It should be noted that overall satisfaction rates with NHS commissioned services is very high. This is repeatedly demonstrated by patient surveys and the Friends and Family test. A summary of Healthshare reported patient satisfaction response is provided in appendix 1.

Complaints performance data forms a part of regular reporting from all commissioned services.

Healthshare has a link to its complaints policy and 'how to complain' on the front page of their website. There are posters up in each of their clinics that advise patients how to complain to them. Healthshare has a dedicated complaints officer, and are in the middle of training two more staff members, one specifically to support Datix and issues raised by GPs and one for patient complaints in order to make the process more robust and improve the timescales in which they are able to respond to complaints.

Healthshare are now required to provide quarterly reporting of the in-house complaints they receive; providing information on the nature of these complaints and numbers of complaints received during the reporting period. This requirement has yet to be met and is currently under review. OCCG expect a full reporting set for August 19. OCCG undertakes regular quality visits to commissioned services. As a part of a quality visit to Healthshare OCCG looked at their complaints process and spoke to patients about their experiences of Healthshare.

In terms of overall complaints received by OCCG a summary is provided below regarding Patient and GP feedback between 01/05/19 – 23/08/19:

2.2 Patient experience: During this time there were 16,742 referrals to Healthshare MSK services, and 22 patient experience complaints were received (0.1%).

Recent themes for patient complaints in order of greatest number of complaints:

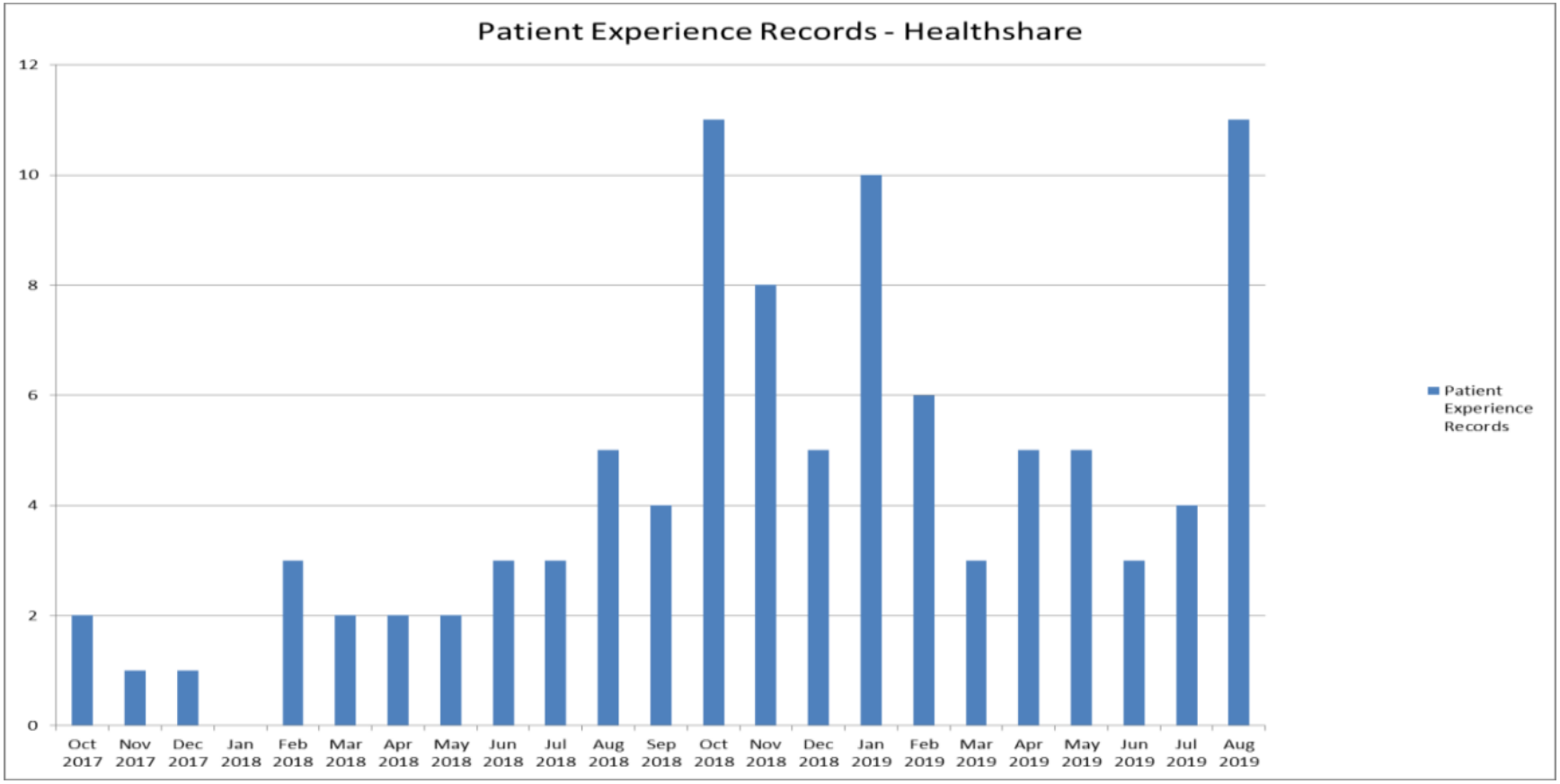
- No answer to calls to make appointments, waiting times, rescheduled appointments, appointment locations moved
- No response when complaining to Healthshare direct
- Treatment given but not working (physio), no follow up or follow up delay to treatment
- Results not available at appointments
- Made to do exercises she told physio she could not do resulting in more pain

2.3 GP Feedback: During this period there were also 29 items of GP feedback, which raised a range of matters, with concerns around the time frames and journey for patients, a summary of themes raised are shown below with the areas generating greatest feedback listed first:

- Lack of routine appointment availability
- Poor appointment process, lack of communication
- Failure of referral process, requiring re referral
- Long wait times to first appointment
- Failure to follow up
- Poor communication with GP
- Delay in diagnosis
- Inappropriate onward referral delaying pathway to treatment (including referring to secondary care via GP)

Graph of trends in Patient experience complaints and GP Feedback for Healthshare MSK services are shown below:

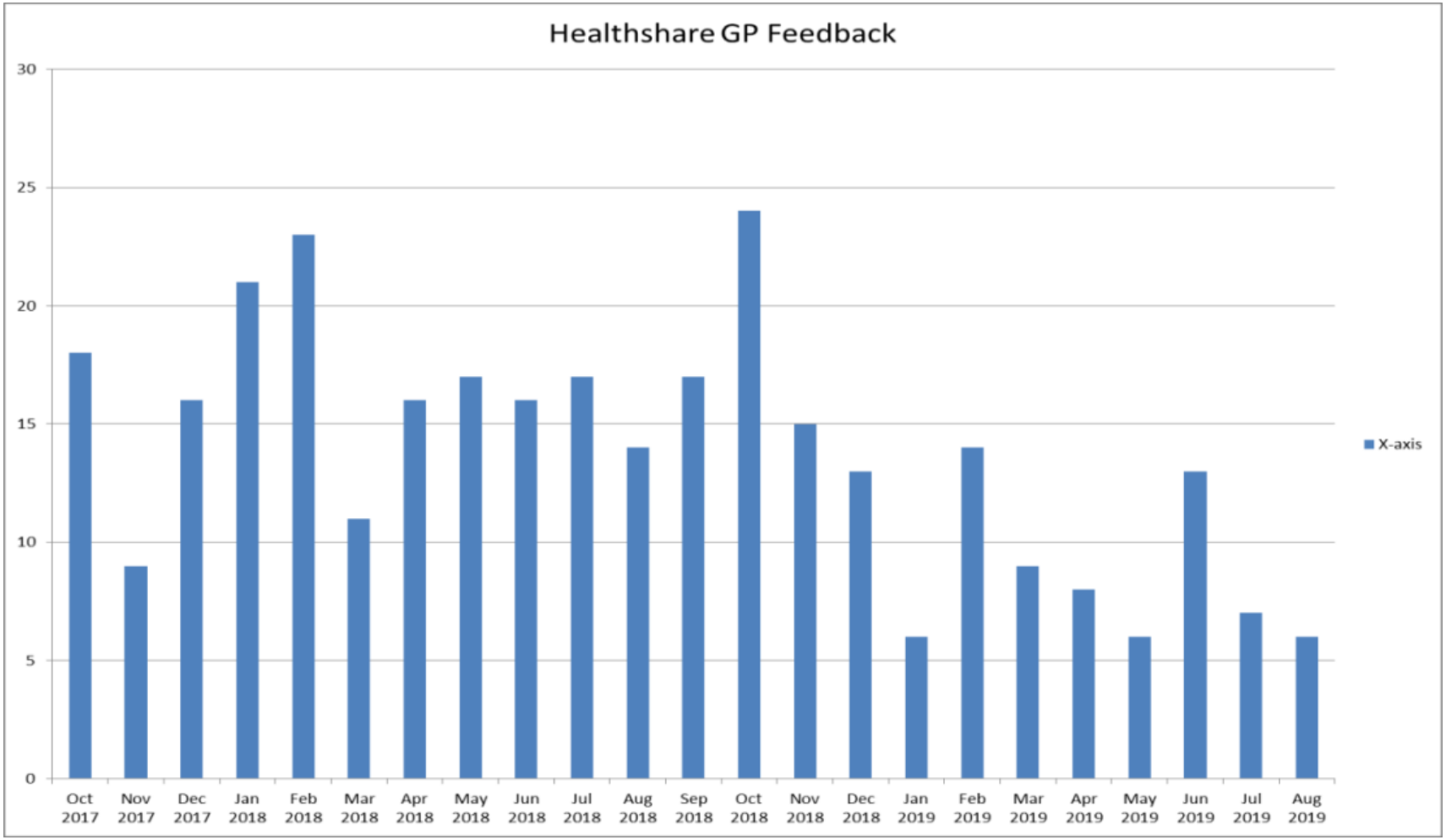
(Figure 1: MSK MATT (Healthshare) patient experience complaints Oct 2017 – Aug 2019**)**



Since October 2018 there has been a downward trend in patient experience complaints, however this did increase in August, with relevant matters being addressed with Healthshare. Ongoing monitoring of complaints and use of learnings from complaints for service improvement continues.

There has been a general downward trend in GP feedback during 2019, however this was above trend in June with 13 items received.

(Figure 2: MSK MATT (Healthshare) GP Feedback Oct 2017 – Aug 2019**)**



2.4 Patient Survey

At the end of 2018, OCCG undertook a survey to understand the patient experience of the new musculoskeletal (MSK) service being provided by Healthshare. The survey was carried out as part of the work of the HOSC Task and Finish Group on MSK services. The report was been shared with the HOSC Task and Finish Group. OCCG's planned care team responsible for commissioning MSK services and Healthshare to help support improvements in the MSK services. The survey was re-run in June this year and ran until the end of August. A report will be available at the beginning of October 2019. However headline data includes:

- 98 people responded to the survey; this is similar to the number who previously responded (93)
- 57% of those who responded rated their experience as average or above average; this is down 13% from the previous survey
- 69% of respondents waited less than six weeks for their first appointment after being contacted by Healthshare (previously 44%); 29% of respondents waited more than six weeks.(36% previously)
- 47% of respondents were satisfied or very satisfied with information, treatment and follow up they received; 36% were not satisfied – this is down by 8% from the previous survey

To note: Any interpretation on this smaller sample size needs to be done with care given that the service feedback reported an average of 91% as shown in appendix 1.1.

3. OCCG to investigate and report back to HOSC how location of appointment is considered when offering appointments for patients by Healthshare.

When speaking with a Healthshare operative the patient will be given both the soonest available appointment at any site and the soonest available appointment at their closest site, to allow for choice. However, in order to streamline the booking process Healthshare have started to move to using the e-Referral System (e-RS) for the booking of our own clinics. What this means is that the patient gets a letter asking them to book their appointment on line or on the phone and when they do so they will have all of the clinics available to book in to, along with the individual wait times for each of those clinics. This enables 100% transparency and patient choice.

3.1 Scheduled Service locations and times

- East Oxford Health Centre: Mon – Fri 8:00 until 6:00 with Saturdays as required

- Bicester Community Hospital: Mon to Fri 8:00 until 5:30
- Chipping Norton Health Centre: Mon to Fri 7:30 until 5:00
- Wallingford Community Hospital: Mon to Fri 8:00 until 5:30
- Deer Park Medical Centre, Witney: Mon to Fri 8:00 until 5:30
- Woodlands Medical Centre, Didcot: Wed & Thu 7:30 until 6:00
- Townlands Hospital, Henley on Thames: Mon to Thur 8:00 until 5:00
- White Horse Medical Practice, Faringdon: Mon, Wed, Thu & Fri 8:00 until 5:00
- Horton Treatment Centre, Banbury (Ramsay Hospital): Mon to Fri 8:00 until 5:30
- Wantage commenced 3 September 2019 planned clinic times Tuesday, Wednesday and Thursday 8am until 5pm.

4. Greater details on the KPI's being used to measure performance

Having achieved significant improvement in time to first appointment for Urgent referrals, the current focus for Healthshare MSK services is on achievement of core KPI's including time frame to first appointment for routine referrals, which is targeted to be within 30 working day.

The chart below provided current levels:

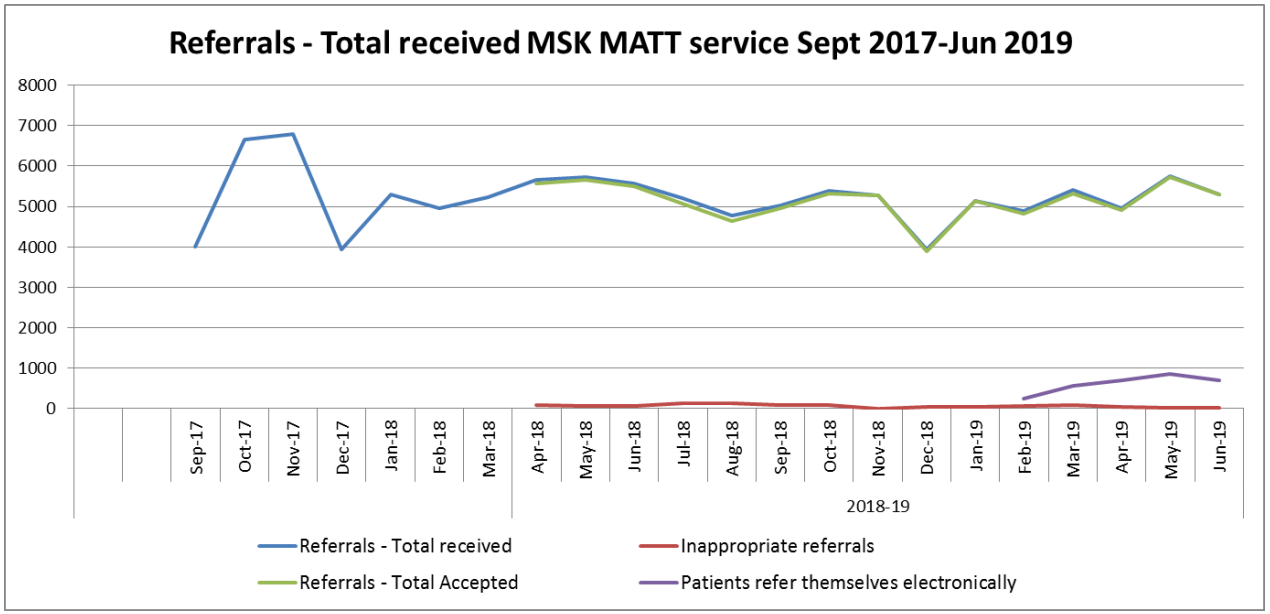
July 2019 MSK MATT KPI performance		
KPI	**Target range**	**July 2019 Healthshare MSK**
Urgent referrals (%) seen in 7 working days	**80-95%**	**86.4%**
Routine referrals (%) seen in 30 working days	**75-95%**	**41.8%**
Referrals triaged within 48 hours	**>65%**	**89.3%**
EQ5D % Improvement in 1 or more areas measured by EQ5D	**50-85%**	**86.8%** **(n 566 responses)**
Patients satisfaction questionnaire	**64-90%**	**90.5%**

% of people rating their care as good or excellent		**(n 1,486 responses)**
Self referral - # of referrals /month	**20-35%**	**842 (37.7%)**

To add additional detail to KPI information, the series of graphs below, drawn from Healthshare reported, commission support unit reviewed data, shows MSK MATT activity since commencement of the Healthshare provided service. This is represented for referrals, and performance in terms of progressing referrals through from triage to the first appointment, non-attended appointments, those cancelled by the service and patients discharged.

Onward referral patterns to secondary care, both direct and those referred following patient appointment with Healthshare are shown.

(Figure 2: MSK MATT (Healthshare) referrals September 2017 – Jun 2019**)**

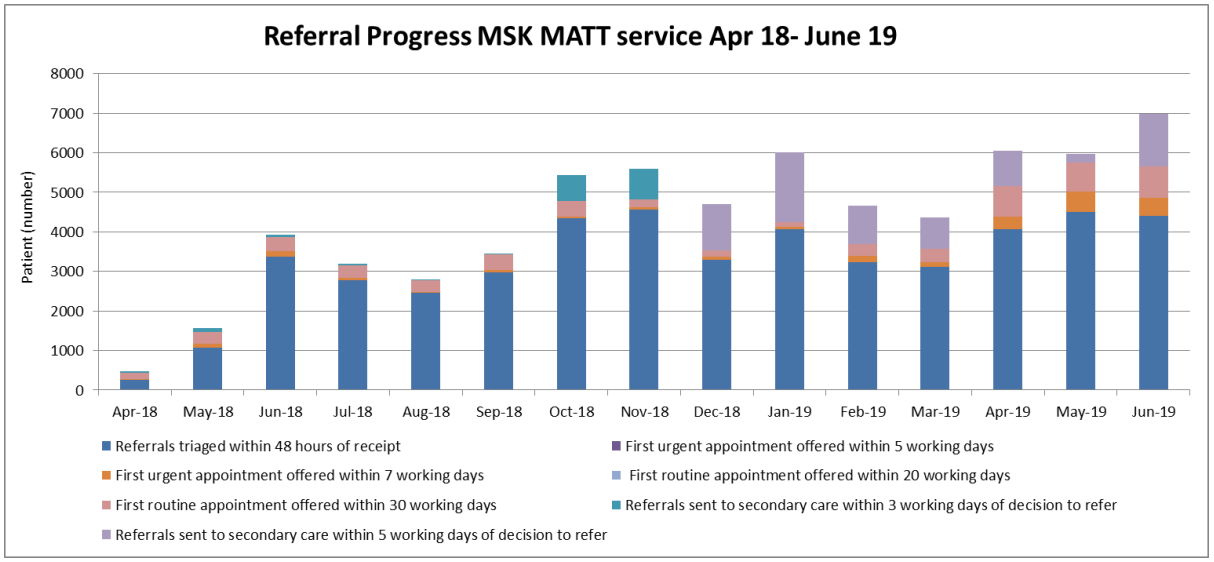


Referral activity has maintained a consistent level over the last 12 months, once the initial backlog of referrals was processed.

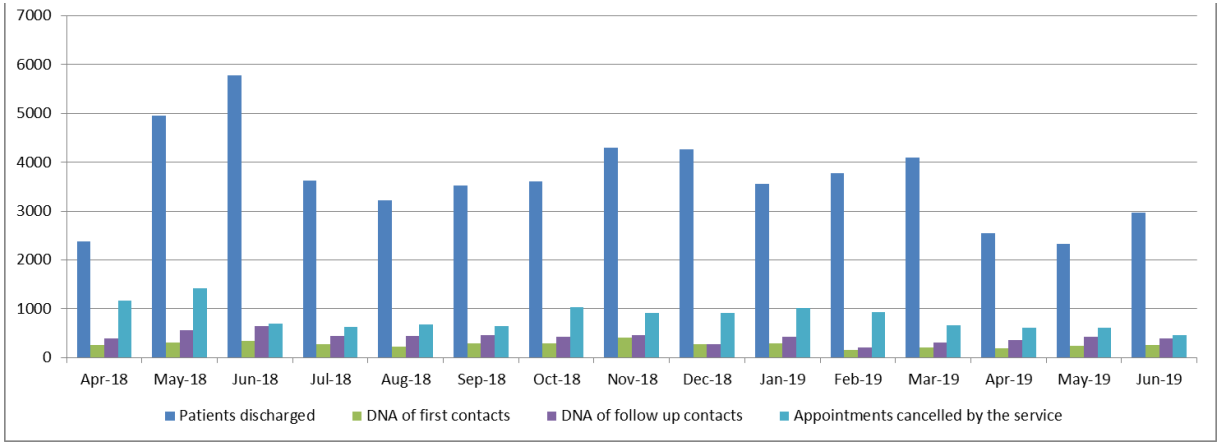
4.1 Performance

Overall service performance in terms of triage and processing of referrals has seen improvement in timeframes to first appointment for urgent referrals and consistency in terms of onward referrals to secondary care. A recent decline in patients discharged from the service has been seen, which Healthshare have explained relates to patients being left on open access at the end of their active appointment/treatment phase.

(Figure 3: MSK MATT (Healthshare) referral triage and timeframes to first appointment Apr 18 – Jun 2019)

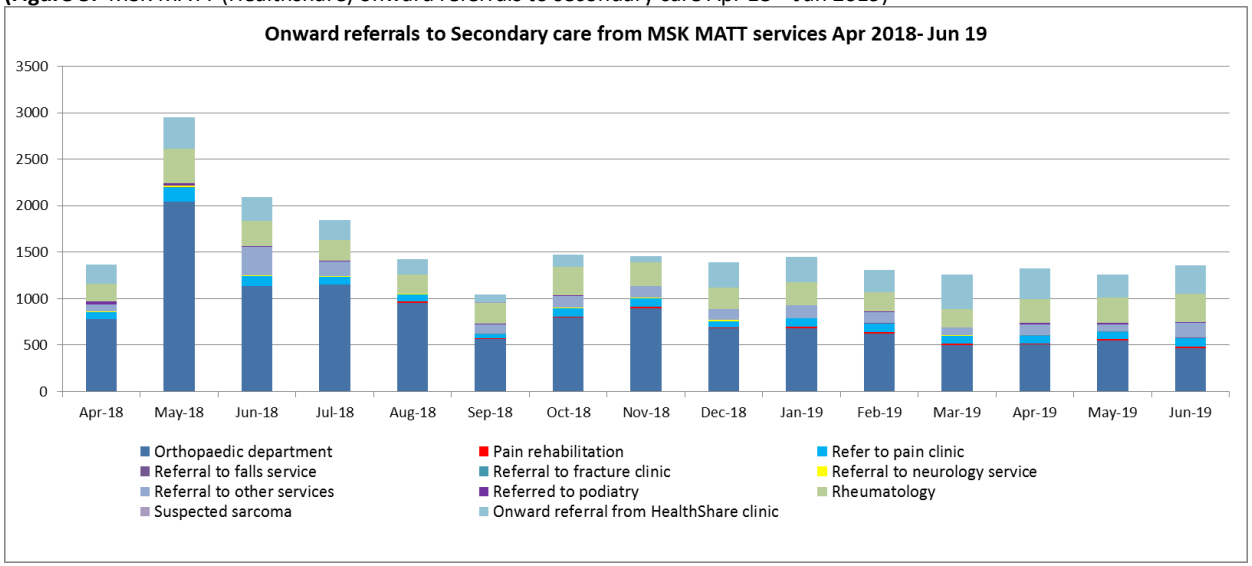


(Figure 4: MSK MATT (Healthshare) Patients discharged, non attendance and cancellations by the service Apr 18 – Jun 2019)



Non attendance of appointments remains relatively low, however, whilst improved, appointments cancelled by the service at around 400-500 appointments per month, while reduced still appear high and of concern.

(Figure 5: MSK MATT (Healthshare) onward referrals to secondary care Apr 18 – Jun 2019)



Onward referrals to secondary care show a consistent pattern in 2019.

5. Check whether people are being told they cannot have an appointment

As with all NHS funded services some people, once assessed either via their referral or in face to face assessment appointment, may prove to be outside the scope of the service.

Beyond that there is no brief currently from the CCG for patients with existing MSK issues to be excluded from the service. The timeframe in which the patient's referral is progressed through the queue will depend on a range of variables, working within target time frames.

Although poor response and timeframes in relation to referrals and first appointment are evident in recent patient experience feedback, there were no cases raised of patients being told that they cannot have an appointment.

6. When MSK Services will return to Wantage Hospital?

Musculoskeletal services at Wantage Hospital re-opened on 3 September. There was a short delay in the start of the service due to mobilisation issues but they are now up and running. The planned clinic times are Tuesday, Wednesday and Thursday 8am until 5pm.

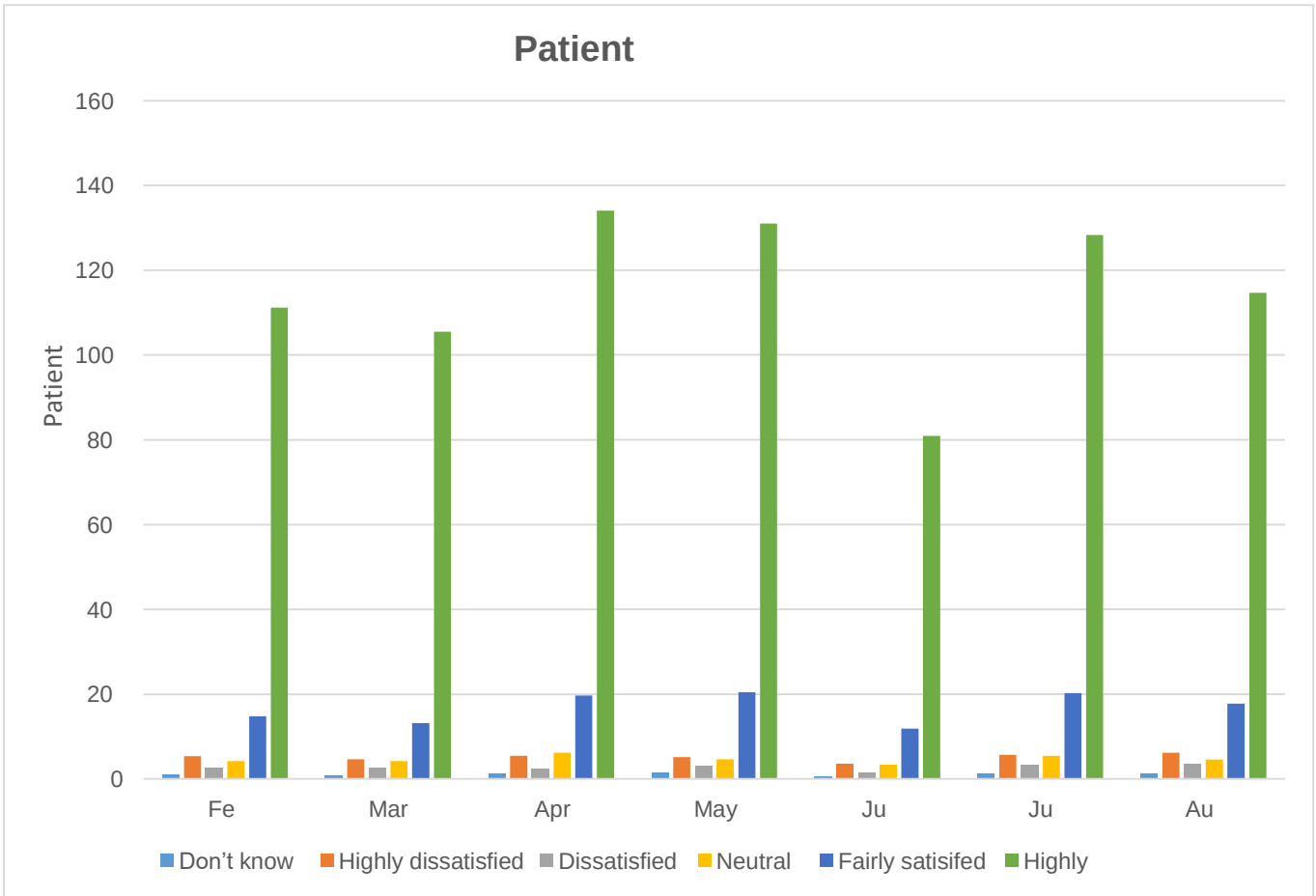
Appendix 1: Update from Healthshare on Patient Satisfaction, Outcome Measures, Wait Times, Call Data and Self- Referral

1.1 Patient Satisfaction

As the below table demonstrates Healthshare have an average of 91% patient satisfaction, with 5% of those responding not satisfied with the service. For comparison the data released by NHS England for June 2019 for the friends and family test shows that on average across the NHS 89% of GP's patients and 94% of outpatients would recommend the service they received, with 6% and 3% respectively not recommending the service.

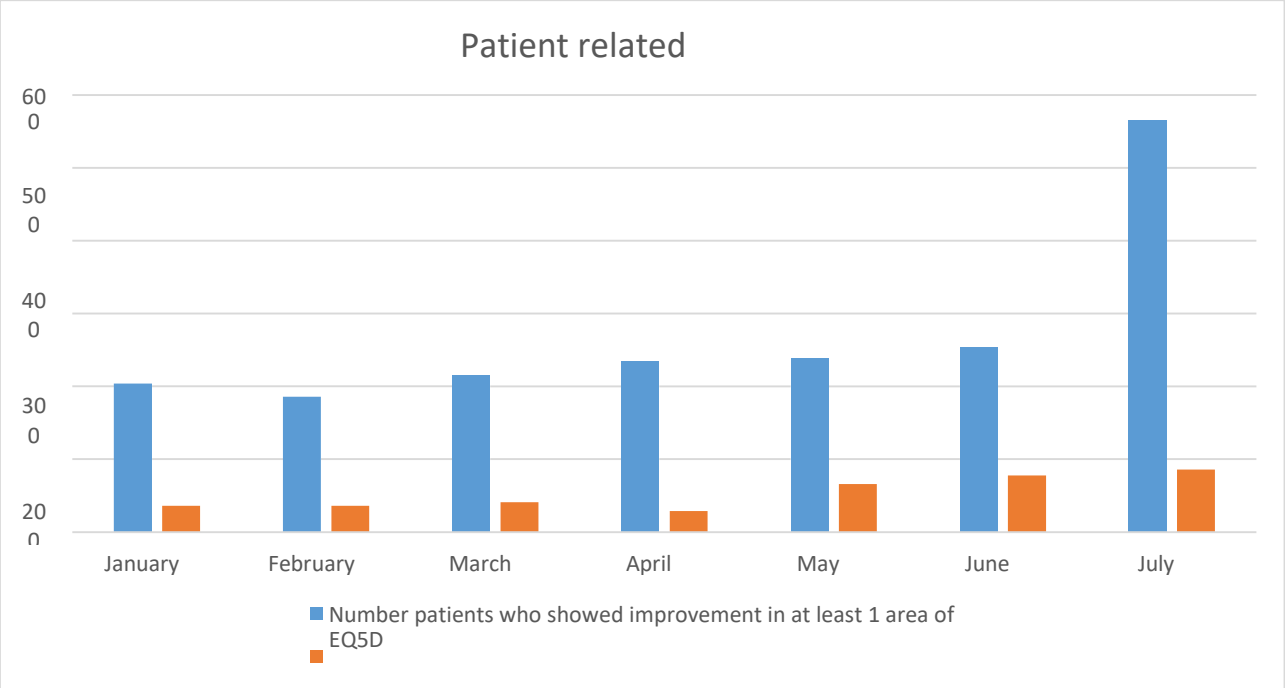
For an even closer patient group comparison the 2019 data from the NHS GP survey for patients only with joint and muscles issues and living in Oxfordshire the satisfaction rating is 87%, with 6% unhappy with their treatment. Demonstrating that the service that Healthshare delivers is comparable or better than the national averages.

It is also worth noting that for the period below Healthshare have collected over 10,000 patient responses with a response rate of 25% compared to a response rate of c.1% of GP appointments and c.4% of outpatient appointments, allowing for a much truer reflection of the service Healthshare deliver.



1.2 Patient related outcome measures

On average 85% of Healthshare patients report an increase in their general health. We record this data using the EQ5D outcome tool. This gives a more holistic insight that ties in to the approach Healthshare uses in signposting patients to various other local resources for things like; weight loss, smoking cessation and mental health. It also allows benchmarking against other health services that use the EQ5D measure. For example in 2017/18 NHS digital reports that 82% of patients that had a knee replacement self-reported an increase in their general health. Healthshare have also been working hard to improve our collection data and have recently seen a significant increase in patients returning a questionnaire at both their initial and final appointments.

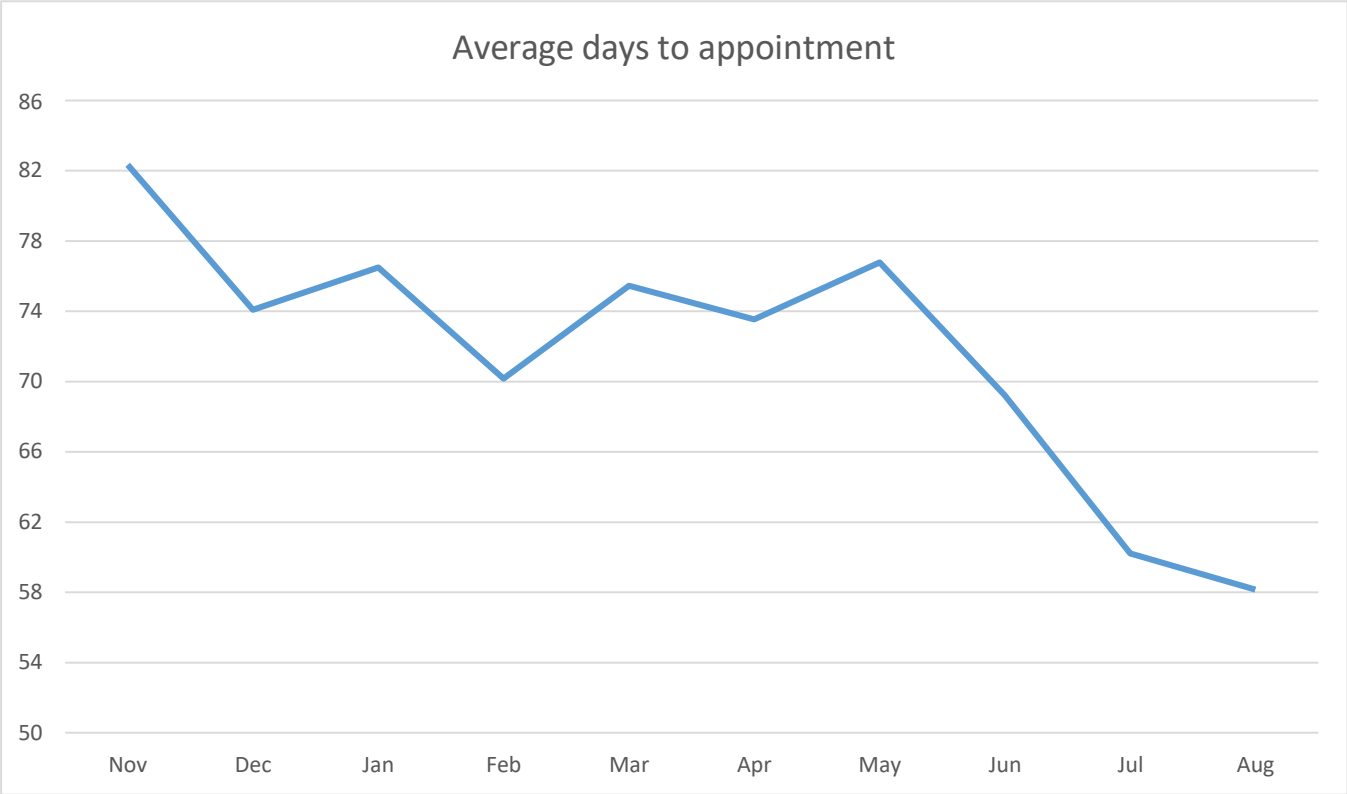


1.3 Wait times

Wait times for the service have been consistently dropping since Healthshare began the contract. As of mid- August 2019 the average wait for appointments is 58 days, and we expect to see that decrease further to within the CCG designated KPI by the start of September. Along with additional estate in Wantage Healthshare have invested in both new permanent staff to ensure the long term sustainability of the improvement and temporary clinical staff to drive wait times down as quickly as possible.

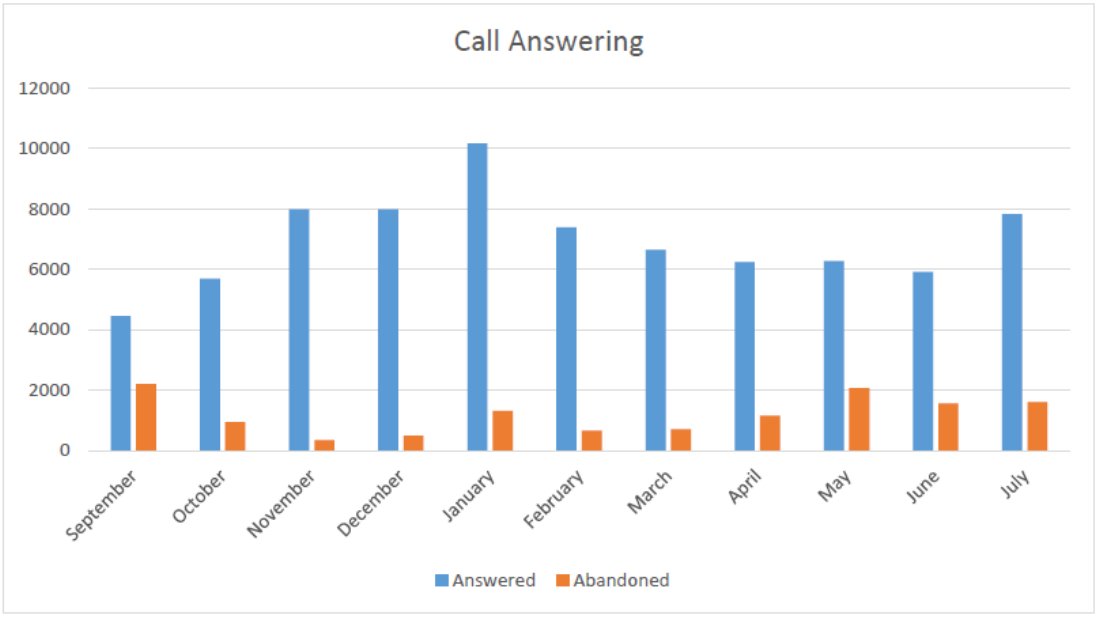
Alongside this there has been an evolution of the clinical model, whereby patients that have low level degenerative changes, such as osteoarthritis of the knee, are seen as a group by a multi-disciplinary team of clinicians. This allows more time

with the patients to provide education, advice and treatment than a one to one appointment, whilst also allowing the service to see more patients in a shorter time.



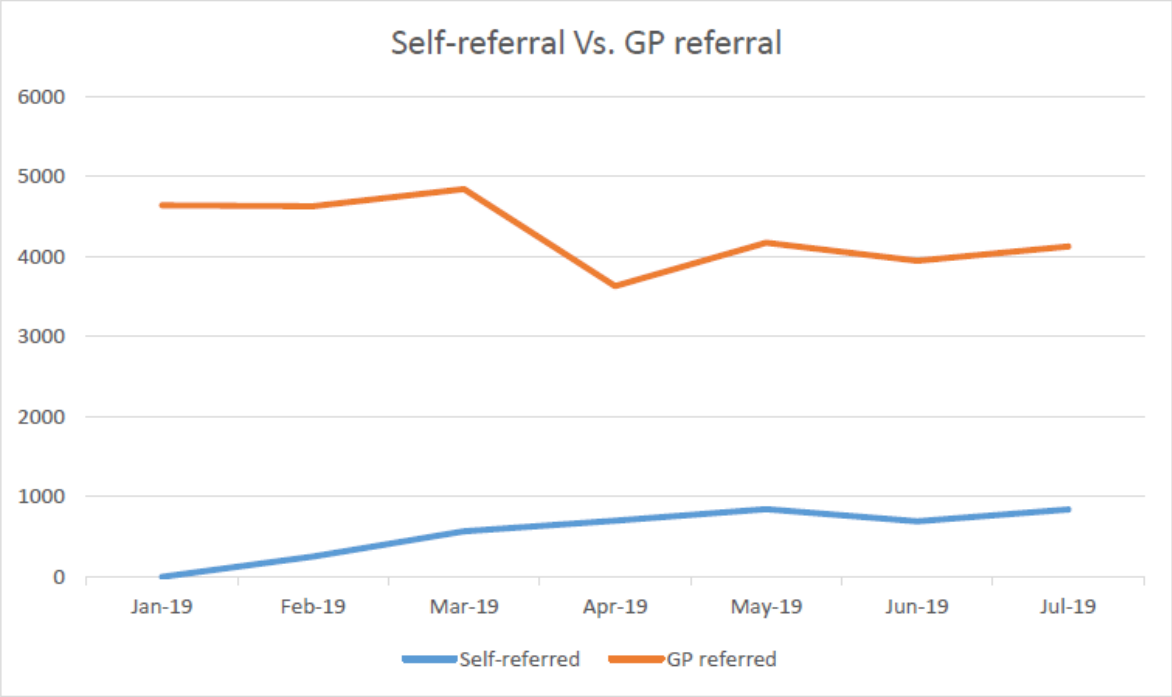
1.4 Call Data

On average between September ’18 and July ’19 Healthshare answered over 85% of the 90,000 calls that came in to our phone system to be answered. As a comparison the NHS GP survey for 2019 advises that 81% of Oxfordshire patients and 68% of patients nationally advise it is easy to get through to someone at their GP practice.



1.5 Self-referral

Self-referral continues to be a success, having seen a drop in the number of patients referred by GP and a commensurate rise in self-referrals, but with no increase in overall referrals. With referral numbers now starting to plateau Healthshare will engage on a new round of publicity for the self- referral service, concentrating on advertising on the screens within GP surgeries and looking at publicising it more directly to patients.



Healthwatch Oxfordshire Report to Health Overview Scrutiny Committee September 2019.

1 DENTISTRY

Healthwatch Oxfordshire carried out two pieces of research in 2018 focusing on NHS Dentistry. This focus was as a result of hearing concerns about access to NHS dentistry in Bicester in 2017. This led to Healthwatch Oxfordshire highlighting the problem to NHS England Commissioners, who have since commissioned more NHS dentists in the area.

Our subsequent reports 'Filling the Gaps; Access to NHS Dentistry in Oxfordshire' and 'Treatment only when needed- dental services for care home residents', included conversations with more than 400 people across the county, 172 questionnaire responses, and 26 care home responses.

Reports can be found here - https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/

Overall, we found:

- Concerns expressed about access to NHS dentistry in some areas of the county experiencing population growth- with services not keeping up with demand in Thame, Faringdon, Bicester Wantage. This was also highlighted in Healthwatch Oxfordshire Wantage town study.
- Gap in awareness of importance of oral health among some adults and children.
- Room for improved information on what is available on the NHS including clear communication about pricing

Our main findings highlighted by the **care home** study were:

1. A significant number of residents in care homes did not use dental services at all.
2. Healthwatch Oxfordshire found that there were significant gaps in provision of dentistry services to residents of care homes.
3. Some care homes struggle to obtain NHS dental services for their residents.

Barriers faced meant that many residents at care homes received no dental treatment at all, or only in an emergency. Barriers included:

- Lack of NHS dentists to visit a home.
- Poor physical access at dentists' surgeries.
- Lack of transport and staff time to take residents for appointments
- Some homes felt that dentists were unwilling or unhappy to treat patients with dementia or learning disability.

We asked care homes what could be done to improve access to dental services for their residents and the following were suggested:

1. Better access to dentists at the care home for residents who cannot easily visit dental surgeries.
2. Dementia training for dentist treating residents with dementia. This would also improve the experience of people living with dementia in the community.
3. More information available to care homes about dental services that can be accessed by their residents.

1.1 Stakeholder meeting

Healthwatch Oxfordshire convened a stakeholder meeting to discuss the findings of the report in September 2018. This enabled discussion and support for a collaborative approach to tackling some of the issues.

Whilst NHS England South was unable to attend the meeting, it gave a written response to our reports saying that:

'We recognise there are growing challenges around oral health for older patients, particularly as a much higher proportion of older people still retain their own teeth nowadays.

In terms of key issues raised in the report:

Access to High Street Dental practices

NHS Dental practices provide access to a full range of services for patients of all ages. Their contracts are site specific which means they can only provide services from sites identified in their contracts. Their services have to meet all the necessary requirements for Care Quality Commission registration and with regard a number of other legal requirements, such as Infection Control.

There are challenges for dentists in terms of going into care homes in terms of the limitations it places on treatment that can be provided if the necessary equipment and facilities are not available. Dentists also have to ensure compliance with Infection Control regulations and CQC registration for any site from which they provide services.

If patients are unable to attend High Street services on medical grounds, they can attend or be referred to Community Dental Service clinics with staff and facilities more adapted to their needs. In Oxfordshire, this service is provided by Oxford Health NHS Foundation Trust and they have a number of clinics from which they provide services. The Trust has three domiciliary teams (North, Oxford City and South and West). The Trust has provided a domiciliary service for many years and is happy to see patients with a range of needs, both routine an urgent. The service has experienced staff willing to provide support to the care homes. Access to High Street Dentistry is under review at the moment with the aim of ensuring there are no gaps in provision. This is both in terms of High Street access and access to more specialist services.

The Oxfordshire Community Dental services has advised us that they have been unusually quiet recently in terms of contact with care homes and that they are looking to do work to ensure the care homes are aware of this service. We are aware that some care homes experience high turn-over of staff and this may impact on the local awareness of available services. We would also like to share that guidelines were recently published about maintaining good oral health in care home settings (i.e. helping residents brush their teeth twice a day). This is the responsibility of the home, but the Community Dental Services could advise and support staff if needed'.

Healthwatch Oxfordshire followed up the report recommendations with partners both on publication and again in August 2019. Full written responses to Healthwatch Oxfordshire recommendations were received from stakeholders (Local Dentistry Committee (LDC) and NHS England can be seen on Healthwatch Oxfordshire website here and show some positive progress and development, and increased joint working

1.2 Summary of feedback on progress August 2019

Feedback from partners show some positive progress has been made:

- Timely publication of the 'Smiling Matters: Oral Health in Care Homes' (Care Quality Commission. June 2019) supported Healthwatch Oxfordshire findings and recommended multidisciplinary approach and mandatory training and oral health checks for care home residents along with improved access. It has raised awareness of the issue both nationally and in Oxfordshire, with accompanying policy development taking place
- Community Dental Service (CDS) in Oxon currently developing and piloting online oral health training for care homes with Oxfordshire County Council (OCC), and has experienced increased demand since the report, with commissioners aiming to develop more training to care home staff
- Health Education England (HEE) providing online training in dementia awareness for dentists.
- Positive moves to refocus commissioning for dental support to care homes, both nationally and locally, with local NHS exploring how to increase joint working and improve information and awareness of support, and use flexibility in contract reallocation and use to support improvements in access at dental practices and increased provision to keep up with population growth.
- Emerging Primary Care Networks provide a much-needed opportunity to highlight population oral health and improve joint working.

However:

- Healthwatch Oxfordshire has also received update from one care home identified as proactive but still struggling to access NHS dentistry for residents, with comments that although progress has been made, they "have constantly prompted to move forward. It appears problem after problem…very difficult in this area to manage without the service being

readily available" adding that concerns about payment and obtaining consent seemed to be also acting as barriers along with availability of support.
- Family members who cannot take a loved one to the dentist from the care home end up funding transport (taxi) and the cost of a carer. This is an issue of equity as this can be very costly.
- Dentistry support in care homes, via domiciliary support or Community Dental Service is still a limited resource.
- Dentist groups in Oxon state that adequate funding is needed to ensure support is available to more vulnerable patients with flexibility in commissioning packages and training.

1.3 Rose Hill Primary School - Healthy Eating Consultation.

This Healthwatch Oxfordshire Project Fund report carried out by researchers associated with Rose Hill Primary School focused on engaging parents, children and teachers in exploring development of healthy eating guidelines for the school. It highlighted some issues around oral health including:

- Many felt that information about dental care is scarcer, that knowledge about keeping teeth healthy is low and so many children have dental caries (tooth decay).
- Challenges of the wider food environment to healthy eating related to oral health, including access to foods high in sugar, higher cost of fresh fruit and vegetables, food poverty and confusing labelling systems on foods.
- Some parents spoke of their efforts to find a 'child friendly dentist'.
- Schools can be a powerful vehicle in efforts to improve public health. They can create a healthy environment by encouraging and modelling healthy behaviour, educating children about healthy options, harnessing the power of positive peer influence, and reaching out to families, carers and the wider community.

As a result of the report, Rose Hill school has had ongoing conversations with the Community Dental Service (CDS) and is now working closely with the school to deliver oral health training, support future healthy food events and attend the youth club.

1.4 Wider 'service review' comments on dentist services from our Feedback Centre

78 reviews from April 2018-March 2019 about individual dentists on Informatics, part of the Healthwatch Oxfordshire Feedback Centre. Overall positive about treatment, but include comments on access to NHS dentists, waiting times, and communication/ information given by dentists about treatment, costs and care, pressure to go private, high staff turnover.

2 HEALTHWATCH OXFORDSHIRE ACTIVITY UPDATE

2.1 Healthwatch Oxfordshire Annual Report 2018-19

Healthwatch Oxfordshire's Annual Report for 2018/19 was launched at a public meeting on June 25 at The King's Centre. Report available at: https://healthwatchoxfordshire.co.uk/our-reports/annual-reports/

2.2 Mental health

Healthwatch Oxfordshire continues to focus on mental health services throughout 2019 (community and other).

To date we have undertaken five 'Enter and View' visits to acute mental health inpatient wards in Littlemore and Warneford, with support from Oxford Health NHS Foundation Trust.

Future visits will include Enter and View voluntary sector services provided by Oxfordshire Mental Health Partnership and Community Mental Health Teams.

Related Enter and View Reports will be on Healthwatch Oxfordshire's website on an ongoing basis and a final report pulling together mental health themes in March 2020.

2.3 Oxfordshire Adult Safeguarding Board

Healthwatch Oxfordshire carried out a secret shopper exercise for the Oxfordshire Adult Safeguarding Board (OSAB) to find out 'how easy is it for a member of the public to raise a concern?'. The resulting experience was reported back to the Board and it is not at all easy! 'We have a lot of work to do' was the comment from the new OSAB Chair after hearing our experience. We will repeat this exercise in six months' time to see if changes have been made to make the entire process for members of the public easier.

2.4 Healthwatch Oxfordshire Health and Wellbeing Board Network

There is a planning group with representatives from all partners on the Board working together to deliver three Network events per year. We will be reporting to the Health and Wellbeing Board in September and further updates will be available on the Healthwatch Oxfordshire web site.

2.5 Hospital visits

Healthwatch Oxfordshire continues its monthly 'pop up' visits to hospitals across the Oxford University Hospitals NHS Foundation Trust's sites and has visited Churchill and Horton during this quarter. Patients continue to leave reviews on Healthwatch Oxfordshire 'Tell us' link. Generally, the reviews about care are very positive, however administration and parking continue to have a negative impact on the overall patient experience. We have sent a summary of the reviews to OUH for comment.

Comments from reviews:

"All staff are committed to delivering a good service. Reception staff are helpful/caring and professional. Nursing staff are excellent. The Oncology/Haematology staff are a real team. They are obviously experts in their field and are positive in their deliberations. Never rush you - so you feel you are listened to and have their total support." (Churchill)

"Difficult to get to phone in time… automated hospital appointment reminder except it does not give you the actual reminder info. You get these calls at all times day and night and can be very anxiety provoking getting calls from the JR as you worry it is something urgent." (John Radcliffe)

"Excellent service, we were treated with care and compassion" (JR-Maternity)

"I cannot speak more highly of all the staff I came into contact with" (JR-Cardiology)

"My sincere thanks to you all for the fantastic service and help I received" (Horton)

2.5.1 Other feedback received:
Between June and Sept 2019 Healthwatch Oxfordshire has received 96 reviews via its Feedback service.

- Reviews on a total of 11 service types
- Including Hospitals (29) GPs (27)
- Physiotherapy (13) (MSK) with continued concern about appointments system, communication.
- GP reviews focused on positives of care, and negatives of waiting times
- Pharmacy 5 reviews (Av star rating 3) comments include admin process, prescription mistakes and communication between pharmacy and GP

2.6 General updates

- **Healthshare MSK support**: Continued patient concern picked up by Healthwatch Oxfordshire about waiting times, communication and administrative process. Healthwatch Oxfordshire continues to monitor comments about this. We have sent an update report to HOSC Task & Finish Group, OCCG and Healthshare.
- Healthwatch Oxfordshire carried out a piece of work with BOB Healthwatch organisations, funded by NHS England through Healthwatch England to look at patient views on the **NHS Long Term Plan**, culminating in a report to BOB STP from the Healthwatch groups in the BOB footprint. A separate report with views of 155 Oxfordshire residents has also been produced. Two focus groups were also run as part of this: with an Asian Women's group and mental health service users. All reports are available on HWO website https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/
- In June 2019 Healthwatch Oxfordshire contributed to a report on, **'Delivering Better Births'**, on Personalised Care Plans featuring voices of women and families across BOB STP. This was carried out jointly with the five Healthwatch groups across BOB. Available on Healthwatch Oxfordshire's

website: https://healthwatchoxfordshire.co.uk/wp-content/uploads/2019/06/Maternity-survey-Full-report.pdf

- Healthwatch Oxfordshire continues to support the development of **Patient Participation Groups** (PPGs) across the county. June saw a networking event for PPGs with the theme of 'Working Together' attended by 34 PPG members. The next PPG Forum is in early October focusing on how the patient voice can be heard in the developing Primary Care Networks. Healthwatch Oxfordshire is supporting Oxford's PPG forum event on Winter Planning in the Primary Care Network on 17 September. See website for details.

2.7 Healthwatch Oxfordshire Projects 2019-20

These are now under way with a focus on experiences of health and social care for families of military personnel, access to healthcare in the boating and bargee community, early year's and family experiences of mental health support as well as outreach and response to upcoming issues. Healthwatch Oxfordshire is also undertaking a separate piece of work exploring the process of Financial Assessment Review undertaken by Oxfordshire County Council during changes that took place in 2018-19.

We continue to try actively to support seldom heard groups to voice their concerns and ideas, and carry out outreach through groups and market stalls, and specific projects.

We are currently recruiting to the Children's Trust Board a Healthwatch parent representative.

2.7.1 Community outreach

Healthwatch Oxfordshire attended Mela, Eid Extravaganza and Cowley Road carnival in this period, and has linked with groups in areas of health inequality. We continue to develop our activity in the south of the County and have visited groups in Henley and Didcot. Work with East Oxford United on Men's Health culminated in launch of a short social media clip encouraging men to take up NHS Checks that was Launched at Eid Extravaganza in Oxford.
https://www.youtube.com/watch?v=44wYqRWknHM&feature=youtu.be

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Oxfordshire Joint Overview and Scrutiny Committee.
19 September 2019

Chairman's Report

1. HOSC Referral to the Secretary of State on PET Scanning

1.0 *Progress with the referral*

1.1 At the HOSC meeting of the 4th of April 2019, the committee unanimously decided to refer the refer NHS England's (NHSE) proposal to make In-Health the preferred bidder of Cancer PET-CT scanning in Oxfordshire to the Secretary of State of Health and Social Care. The letter sent by the Chairman (with enclosed documents) and the reply the Chairman received from the Secretary of State's office, rejecting the referral and the Chairman's subsequent reply were all published in the HOSC papers for June 2019. They can be found under the Chairman's report (item 13), here: https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=148&MId=5618&Ver=4

1.2 Further to the above communication, the Secretary of State's office replied to the Chairman on the 1st of July 2019, upholding the rejection of the referral. This letter is contained in Appendix 1 of this report.

1.3 On the 3rd of September, the following statement was jointly released between NHSE, Oxford University Hospital Hospitals and InHealth:

> *The NHS is committed to detecting more cancers earlier to save more lives. That means a major increase in scanning and diagnostics, so patients can easily access services like PET-CT scanning.*
>
> *To that end, NHS England and Improvement, Oxford University Hospitals (OUH) NHS Foundation Trust, and InHealth are pleased to announce we have now signed a formal partnership agreement.*
>
> *It creates new and additional services for patients who need these important services across the Thames Valley provided by InHealth while sustaining the PET-CT scanning service on the Churchill site provided by the OUH.*
>
> *These brand-new scanning facilities will be based in Milton Keynes (Milton Keynes University Hospital NHS Foundation Trust), Swindon (Great Western Hospitals NHS Foundation Trust) and Reading (Royal Berkshire NHS Foundation Trust) provided by InHealth using highly skilled clinical staff.*
>
> *The new sites will use modern mobile scanners, with the aim of putting in place permanent facilities in the longer term.*
>
> *This new arrangement will help reduce waiting times, as well as ensuring the easy transfer of scans and scan reports between different doctors and sites in more convenient locations for patients across the region.*

In time, there may also be an opportunity to develop additional local scanning services across the Thames Valley.

1.4 NHSE and Oxford University Hospitals will attend the HOSC meeting on the 19th of September to update the committee on the development announced in their joint statement and on services moving forward.

2. Committee briefings and communication

2.0 The committee received two written briefings since its meeting in June 2019. These are in the Appendix of this report and are on:

Appendix	Name	From	Received
2a and b	Special Care Paediatric and Dentistry. Letter and Draft Service Specification	NHSE	2/7/19
3	Oxford City Community Hospital Update (June)	OCCG	2/7/19
4	Oxford City Community Hospital Update (July)	OCCG	9/8/19
5	Oxford City Community Hospital Update (Aug/Sept)	OCCG	3/9/19
6	Gynae-oncology briefing	OUH/OCCG	21/8/19

3. Horton HOSC

3.0 The Horton HOSC met on the 4th of July to consider reports on the following workstreams:

- Workforce
- Financial analysis
- Option appraisals
- Research on small Consultant Led Units

3.1 The Horton HOSC will next meet on the 19th of September where it will consider the recommendation on the future of obstetric services at the Horton General Hospital. The paper for this meeting will be published on the 16th of September as an addenda. The recommendation will be simultaneously published for the OCCG Board meeting (26th September) and decision on the matter.

4. Health and HOSC liaison

4.0 A meeting between the HOSC Chairman and the Chief Executive and Director of Governance of Oxfordshire Clinical Commissioning Group (CCG) with a Policy Officer from Oxfordshire County Council and the Head of Communications from the CCG, took place on the 8th of August, to discuss upcoming items for HOSC's Forward Plan.

4.1 The main points covered during the meeting were the following:

- Winter Planning. The System has learned the lessons from the last winter, including having a Winter Director in post. They have revamped the team as a

result of the learning and this will be included in the update to HOSC on the 19th of September. HOSC want to see that there is clarity on what worked, what we did, what we learnt and what will change going forward.

- There is exploration of bringing together three CCGs across the Buckinghamshire, Oxfordshire and Berkshire West geography. This is likely to occur in 2021 and communication will be coming out over the next few months over this. This is still in its early stages and the CCG undertook to keep HOSC updated regularly.
- Specialist Commissioning. The CCG will initiate some work to align specialist commissioning with ways of working locally, using PET CT scanning commissioning as an initial case study. With the ICS, the area which includes Oxfordshire will be big enough to have its own specialist commissioning board and therefore it is likely that there will be greater oversight and influence at a more local level of specialist commissioning services. OCCG and HOSC will take the lead on developing agreement on involving HOSCs on national commissioning which will then be applied nationally.

4.0 In addition to the above from the CCG, Oxford University Hospitals (OUH) Foundation Trust agreed to provide a briefing to the committee on temporary arrangements for Gynae- Oncology services with other hospitals. This is to respond to an invited Royal College review of the service and to allow new leadership to map out services moving forward. The briefing will inform an update at HOSC on the 19th of September (Under the CCG update item). The briefing is referenced in section 3 of this report and included in the appendices.

4.1 Oxford City Community Hospital. Monthly updates on this issue will continue to come to HOSC as agreed on the 31st of May 2019. The committee briefings for July, August and September are referenced in section 3 of this report and included in the appendices.

5. Task and Finish Group: OX12

5.0 The HOSC OX12 Task and Finish Group has met two more times since the last HOSC meeting; 22nd July and 6th August. Summaries of each meeting are loaded onto the OX12 project area of the CCG website, they can be reached at the following link:

https://www.oxfordshireccg.nhs.uk/about-us/planning-for-future-health-and-care-needs-in-wantage-and-grove-ox12.htm

5.1 Members of the Task and Finish Group will be observing a planned Listening Event 12th September and a Solution Building workshop on 18th September. A further Task and Finish Group meeting is planned for 8th October. Members will also observe a second workshop scheduled for later in October.

5.2 The Task Group are planning to meet a final time in early November after which the draft recommendations will be finalised, and a final report will be produced. This will be shared with the Project Group and responses to the recommendations agreed before being shared with HOSC at the next meeting.

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Seema Kennedy MP
Parliamentary Under Secretary of State for Public Health and Primary Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Department of Health & Social Care

Cllr Arash Fatemian
Chair, Oxfordshire JHOSC
County Hall
New Road
Oxford
OX1 1ND

1st July 2019

Dear Arash,

Referral of the decision to name a preferred bidder and award the contract for PET CT scanning services in Oxfordshire

I am writing in response to your letter of 10th June regarding your concerns about PET CT scanning services in Oxfordshire.

As stated in my previous letter of 5th June, I do not consider this to be a valid referral under the Regulations, partly because discussions are ongoing regarding partnership arrangements between Oxford University Hospitals (OUH), NHS England and InHealth.

I have urged all parties to pursue an agreement on this matter at pace. I have been informed that discussions continue between OUH, NHS England and InHealth. I have continued to discuss this issue with Parliamentary colleagues and NHS England, and have reiterated my encouragement for all parties to work for a resolution.

I understand that OUH, NHS England and InHealth will be providing a formal update on their discussions shortly.

Your sincerely,

Seema Kennedy

SEEMA KENNEDY

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NHS England South East (Hampshire & Thames Valley)

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Councillor Arash Fatemian
Chairman of the Oxfordshire Joint HOSC
Oxfordshire County Council
County Hall
New Road
Oxford
OX1 1ND

2 July 2019

Dear Councillor Fatemian

Re-commissioning of Special Care Adult and Paediatric Dental Services

NHS England South East is currently in the planning stages of re-commissioning of Special Care Adult and Paediatric Dentistry services, sometimes known as Community Dental Services, as the current contracts to provide these services in the South East and Dorset are due to come to an end on 31st March 2021.

As part of this process we are gaining feedback on the services currently provided to assess if this is the best way of providing them or if they could be delivered in a different way which would be better for patients. We are developing a service specification for the new contracts and will be considering feedback from the profession, stakeholders, patients and the public when doing this.

About the services

Special Care Adult and Paediatric Dental Services (often known as Community Dental Services) include a wide range of services provided for both children and adults unable to attend general dental services due to additional needs, for example, those relating to physical or learning disabilities, or where they have a need for enhanced support to receive treatment.

Services are provided to patient groups with a variety of needs, some of the key groups are: adults and children with learning disabilities; those with physical or sensory disabilities; with complex medical problems: where patients need dentistry in their homes; where patients need general anaesthetic or sedation; obese adults requiring a bariatric chair for treatment and children in the care of social services or with complex social problems.

Service needs assessment

Public Health England has carried out a service needs assessment to identify existing need for the services, as well as gaining feedback on potential enablers and barriers to accessing care from organisations advocating for and supporting groups of people with additional needs. We will be using this information along with patient and stakeholder feedback to influence design of future services.

Your feedback

We would be grateful for any feedback you have on these services which will then be considered alongside views from patients, the public and the dental profession to help to inform the new contracts. Please find attached a copy of the draft service specification for information.

Please can you send your feedback to england.southeastdentalfeedback@nhs.net **by 1 August 2019.**

Thank you in advance for your feedback.

Yours sincerely

Sarah Macdonald

Director of Primary Care and Public Health Commissioning

NHS England and NHS Improvement South East

NHS England South East
Personal Dental Services
Specialist-led Special Care and Paediatric Dentistry
Draft Service Specification

Service Specification Number	
Service	Special Care and Paediatric Dentistry
Commissioner Lead	NHS England South-East
Period	April 2021 Anticipated contract term -10 years with option for further 2 years (to be confirmed)
Date of Issue	12th June 2019
Version	V6, final draft for engagement

Table of Contents

1. Introduction

When developing this specification, the working group considered a number of information sources. These included:

- The findings from the patient and public engagement which was conducted as part of the needs assessment
- The findings from the stocktake exercise of current special care/paediatric services
- The draft commissioning standards for vulnerable adults developed by the Office of the Chief Dental Office, published in June 2019
- Feedback from the South East Special Care Managed Clinical Networks on a draft specification
- Feedback form other stakeholders on a draft specification

The purpose of this draft specification is to outline the services to be commissioned for specialist-led special care and paediatric dental services. Stakeholders will be invited to comment on this draft specification as part of the stakeholder engagement process prior to procurement. Findings from the engagement will be considered in the development of the final specification.

2. Background

2.1 Description of the Speciality

Special Care Dentistry
The speciality of Special Care Dentistry is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors. The specialty focuses on adolescents and adults only and includes the important period of transition as the adolescent moves into adulthood. The speciality was formally recognised by the General Dental Council (GDC) in 2008.

It is important to recognise that Special Care Dentistry is not synonymous with the Community Dental Service (CDS). It is a specialty related largely to adults, whereas most CDS provide some Special Care Dentistry, but also provide other services such as Paediatric dentistry.

Paediatric Dentistry
The specialty of Paediatric Dentistry provides specialist oral healthcare for infants and children whose needs cannot be adequately managed by their General Dental Practitioner. This includes care for children with extensive oral disease, those whose

oral health care is complicated by intellectual, medical, physical, social, psychological and/or emotional disability, children with developmental disorders of the teeth and mouth, and children who are either too anxious or too young to accept routine dental treatment if required. The age range covered by the specialty is normally regarded as 0 -16 years, at which stage children transition to adult oral health services.

Transition from Paediatric to Special Care Dentistry
It is important that local transitional arrangements and age implications are understood and communicated to both service users and all dental clinicians. There can be some local variation in this transition stage due to local arrangements in the delivery of care for certain conditions and age limits for access to certain components of the service, such as in-patient Paediatric services.

For those with comorbidity, significant disability and/or complex health needs specialist care beyond 16 will be most appropriately met by the adult specialty, Special Care Dentistry. Transition to other adult specialties, such as restorative dentistry, oral surgery, oral and maxillofacial surgery and orthodontics may also occur during adolescence. Transition should have a carefully planned, co-ordinated and systematic approach which is prepared well in advance of the transition phase.

2.2 Service Delivery - National Picture

Special Care and Paediatric Dentistry are provided by General Dental Practitioners (GDPs), by Community Dental Services (CDS) and by Hospital Dental Services, including Dental Hospitals.

These services operate under various contractual arrangements and have different methods of data collection. Therefore, identification of the volume of Special Care and Paediatric Dentistry provided by each sector or by each provider is difficult.

A survey of NHS Area Teams was undertaken in September 2014 by NHS England in an attempt to describe how much Special Care and Paediatric Dentistry was being commissioned. Responses were received from 12 out of 27 Area Teams and covered 36 CDS. However, very little useful data was obtained to inform the national picture of current service provision and demand for special care dental services.

The services were very disparate in terms of size of population served (135,700 to 1,963,500 people) and the reported size of the adult special care population they served (0.33% to 27% of the population). All of the services operated under a Personal Dental Service agreement except one, which was provided under a standard NHS contract. The majority of contracts were due to finish in 2015 or 2016.

The main contracting currency used was UDAs and almost half had key performance indicators attached to the contract.

Special Care and Paediatric Dentistry provided under a GDS contract cannot be quantified; data collection (via the FP17 form) submitted to the BSA limits the ability to easily capture and identify this group of patients. Special Care Dentistry provided in the hospital sector does have a separate specialty code 451 that is not widely used. There are no separate or specific treatment function codes for Special Care Dentistry. Treatment is often recorded utilising restorative and/or oral surgery codes, which may not reflect the true cost of providing this service.

Development of Special Care Dentistry provision has usually been provider led and based on historical CDS provision and the clinical interests of committed clinicians. The introduction of the specialty in 2008, with transitional arrangements for admission to the specialist list has reinforced historical provision in existing areas.

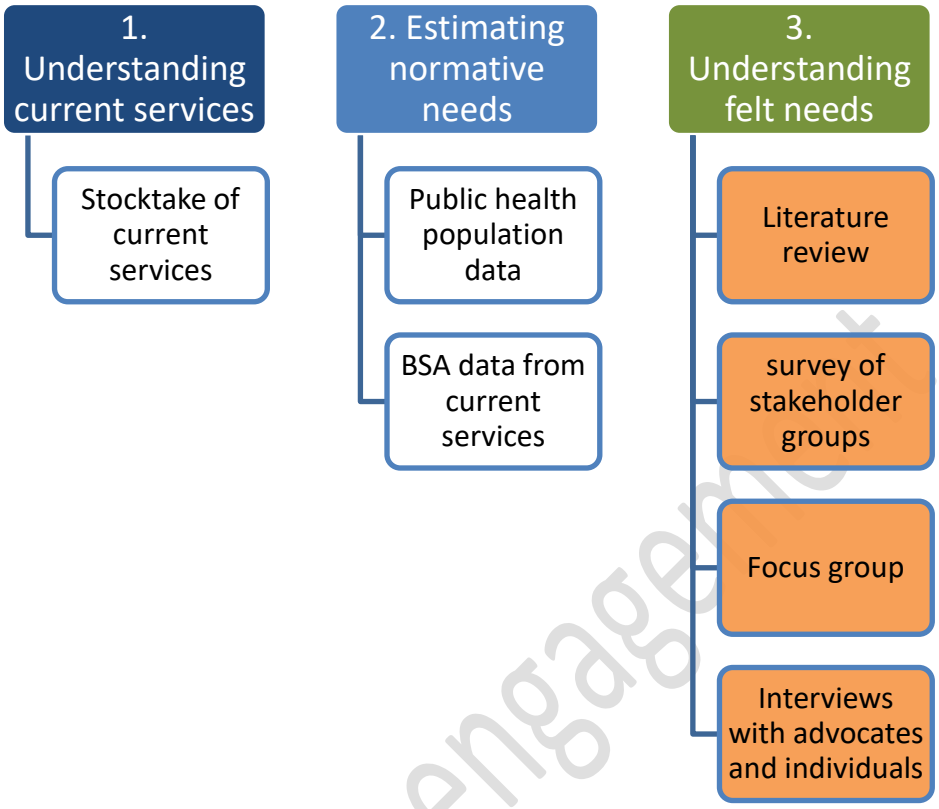
Referral protocols and acceptance criteria have developed locally, again often provider driven to manage demand. This has resulted in variability in provision between services.

Current contracting arrangements have led to variability in activity targets, contract monitoring and quality measurement. IT systems are different in each sector and there is no standard software system for recording and reporting Special Care Dentistry. The British Dental Association's CaseMix tool is used by many CDS's to measure patient complexity, but clinicians using the tool are not usually calibrated and this does contain a subjective element which makes comparison challenging.

2.3 Population Need in the south of England

As part of the preparation for procurement of special care and paediatric services Public Health England have been leading on an assessment of need. The Needs Assessment consists of three linked workstreams figure 1.

Figure 1. Oral Health Needs Assessment workstreams



The needs assessment has included a public engagement exercise. This exercise gathered the views of people likely to require special care dental services. This findings from the engagement have informed the development of this specification.

A summary of the findings is contained in the embedded presentation below

PPE special care summary findings Ju

2.4 Workforce – National Picture

Special Care and Paediatric Dentistry, in common with other dental specialties, are provided by dentists and Dental Care Professionals (DCPs).

Special Care and Paediatric Dentistry can and does form part of routine care provided by primary care dentists on an 'informal' basis. Most Special Care and Paediatric Dentistry at a specialist level is delivered by Community Dental Services, Foundation Trusts, District General Hospitals and dental hospitals under a variety of contractual arrangements. There are 10 dental hospitals in England providing under graduate and post graduate training and delivery of NHS dental services. Traditional dental hospitals are usually hosted by secondary care trusts.

Care provided by secondary care providers is largely outpatient based. Much of this care could be delivered in primary care. However due to historic hosting arrangements, with the acute trusts, care is currently paid for at secondary care tariff.

Ideally Special Care and Paediatric services should have Consultant leadership, but this may not be possible in all cases and services may be led by a Specialist. Ideally the specialist would have links to a teaching hospital. Services usually deliver care using specialists and dentists with a specialist interest.

Services also utilise Dental Care Professionals (DCP). This group includes dental hygienists and dental therapists, as well as dental nurses many of whom will have completed post-basic qualifications in both sedation and Special Care Dentistry. Many Special Care and Paediatric providers employ dental therapists as they can provide the less complex dentistry as part of their overall treatment plan. Dental therapists and hygienists can provide treatment under inhalation sedation, following suitable training and competency assessment.

Dental Nurses with suitable training and competency assessment can provide a range of additional extended skills. These include taking radiographs, impression taking and application of fluoride varnish and provision of oral health advice. Prevention is vital for people requiring Special Care and Paediatric Dentistry.

Health Education England (HEE) and the deaneries are responsible for providing an adequate number of Special Care and Paediatric Dentistry specialist training posts nationally. Local Trusts and providers will work in conjunction with HEE to host and deliver training to dentists and DCP's. Training Programme Directors in Special Care and Paediatric Dentistry will oversee training locally. Funding for some trainee posts is available from deaneries.

2.5 Levels of Care

NHS England has published commissioning guides/standards for paediatric[1] and special dentistry[2]. The Department of Health advanced care pathway working group defined procedures and modifying patient factors that describe the complexity of a case. The levels of complexity do not describe contracts, or practitioners or settings. Levels 1, 2 and 3 care descriptors reflect the competence required of a clinician to deliver care of that complexity.

Level 1 outlines what a dentist on completion of undergraduate and dental foundation training (or its equivalence) would be expected to deliver. Therefore,

[1] https://www.england.nhs.uk/wp-content/uploads/2018/04/commissioning-standard-for-dental-specialties-paediatric-dentristry.pdf

[2] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-specl-care-Fdentstry.pdf

Commissioners expect that level of competence as a minimum competency standard for performers on the NHS performer list.

The levels of care are described as:

Level 1 –needs that require a skill set and competence as covered by dental undergraduate training and dental foundation training, or its equivalent

Level 2 –procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care. Level 2 complexity maybe delivered as part of the continuing care of a patient or may require onward referral

Level 3a - needs that require management by a dentist recognised as a specialist as per the GDC-defined criteria

Level 3b – needs can only be managed by a dentist recognised as a specialist as per the GDC defined criteria and holding consultant status

Further detail on the treatment/patient types which fall into the different levels of care can be found in section 3.

3. Transforming Services

The points below set out NHS England South East's approach to commissioning services from 1 April 2020:

- Services will be commissioned in line with the NHS Long Term Plan[3]. Services will need to deliver NHS care in a more joined up and coordinated way using health professionals from different disciplines working together, in networks focused on local communities and reducing reliance on hospital care
- Managed Clinical Networks (MCNs) will enable clinicians to shape and influence service redesign through working with commissioners and patients. In developing, redesigning, procuring and monitoring services, arrangements will be made to involve patients, carers and the public, and the organisations that advocate for them including Health Watch;
- Contracts will include key performance indicators (KPIs) and/or quality indicators which will incentivise quality;

[3] https://www.england.nhs.uk/long-term-plan/

- GDPs will require appropriate training to support valid referrals
- A single point of entry for referral to services underpinned by a referral management system;
- Referral management will be via electronic referrals
- Referrals will include an agreed minimum data set
- Agreed definitions and standards for waiting times both for review of referral, assessment, advice and treatment 'starts' from optimum treatment time.
- Patients and referring dentists will have access to waiting time data and will use this information when considering where to refer for treatment;
- Services will be specialist led and will use skill mix in care delivery;
- Maintenance of core skills and enhanced continuing professional development (CPD) for all members of the team

4. Service Definition

4.1 Aims and Objectives of Service

Aims

The service will:

- Ensure access to dental care for children and patients with additional needs unable to receive care or treatment in a primary care setting due to their enhanced management needs

- Provide care and treatment to children and those with additional needs in line with the evidence base and best practice to achieve clinically effective outcomes for patients

- Contribute to the improvement of oral and general health and reduction in health inequalities of the local population with a focus on prevention both via service delivery and partnership working with a range of health care providers and other key stakeholders.

- Work in partnership with the wider dental system to facilitate access to early intervention for treatment to prevent the need for treatment at more advanced stage of disease

Objectives

The service will achieve its aims by providing:

- A leadership role within local networks focusing on prevention, early intervention and access to Special Care and Paediatric services
- Specialist-led Special Care and Paediatric dental services to the required standards meeting the identified needs of the population
- Mandatory and additional (sedation, domiciliary care) dental services for patients who are unable to access care from general dental practice as described in the service specification
- Treatment under general anaesthesia for those patients who meet the criteria for referral to the service and who have a clinical need for treatment under GA, linking with secondary care services to achieve access to general anaesthetic services
- Care which complies with national commissioning guides
- Joint working arrangements with other specialised services to provide multi-disciplinary care for patients as appropriate
- Services that have suitably trained and skilled workforce to deliver the services and needed to provide Special Care and Paediatric dentistry in the local area, including Level 2 and Level 3 care
- Services from premises which meet the relevant legislative requirements and comply with the access requirements outlined in this specification
- Services which are fully integrated with the dental electronic referral service and are compliant with relevant IT and IG legislation and guidelines
- A contribution to the building of skills across the local dental workforce by participating in teaching and training and workforce development

4.2 Contract Type and Length

The contract is offered under the terms of the NHS (Personal Dental Services Agreements) Regulations 2005 effective from 1 April 2006 and any subsequent revisions.

It is anticipated that the agreement will be for 10 years in the first instance with the option available to both parties to extend for up to a further 2 years by mutual agreement. This is an indicative contract length and is subject to confirmation by NHS England.

4.3 Service Description

Population covered

The specialist-led special care and paediatric dental services described in this specification will cover people resident in the lot area or registered with a General Medical Practitioner in the specified area. It will also provide immediately necessary care and clinically-appropriate treatment to any individual temporarily residing in the area and meeting the eligibility criteria to access the service.

The final version of the specification will include, in this section, a description of the lots. The lots have yet to be determined but the development of them will consider the shared care and leadership role this service will provide. It is anticipated that the commissioned service will cover a population of 750,000 to 2 million. The size of the population covered will be influenced by local systems and geography and the estimated level of need in the population.

4.4 Service description/care pathway

Special Care Dentistry

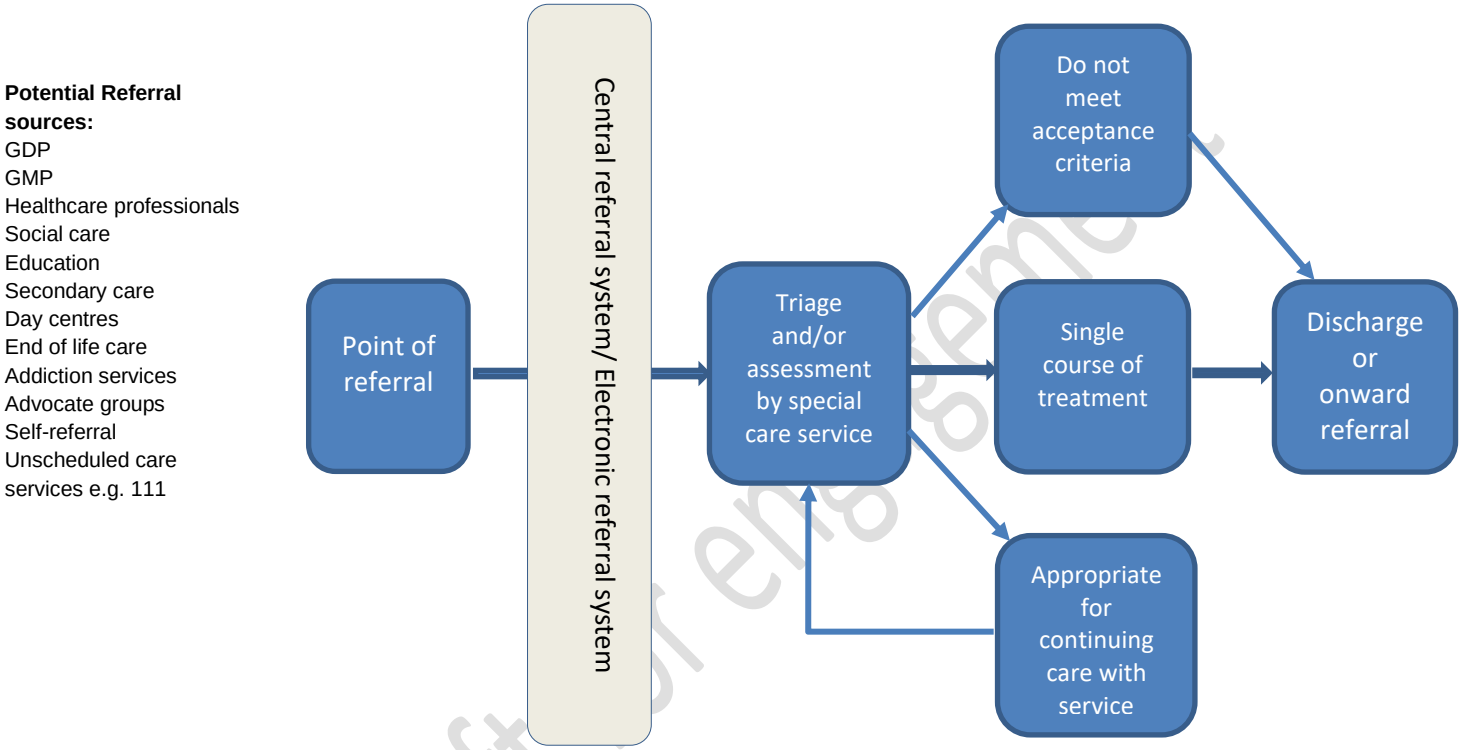
Adult patients (aged 16+ years) who meet the description of level 2/3 care (section 7) will be accepted for care with the special care services. Care may be provided completely by the specialised service or care may be shared with other services, including the referring dentist and the specialised provider.

The provider will be required to deliver an advice and treatment planning service to local clinicians as part of the service.

There will be a cohort of special care patients who need to be seen in special care services for continuing care as their needs are too complex to be managed in the GDS.

The proposed adult referral pathway is shown in figure 2.

Figure 2. Proposed care pathway for adults



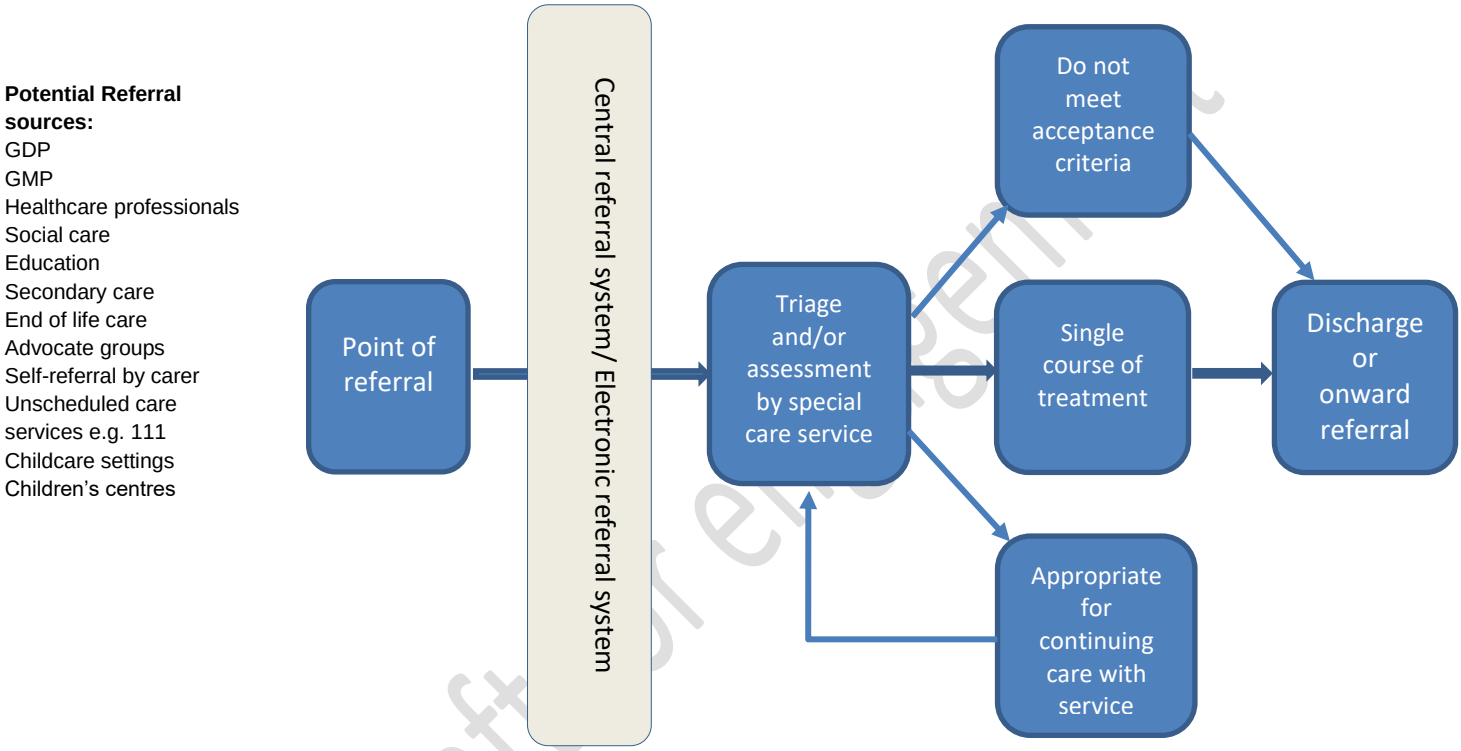
Paediatric Dentistry

Child patients (aged <16 years) who meet the description of level 2/3 care (section 7) will be accepted for care with the paediatric service. Care may be provided completely by the specialised service or care may be shared with other services, including the referring dentist and the specialised provider.

There will be a cohort of paediatric patients who need to be seen in the specialist-led service for continuing care as their needs are too complex to be managed in the GDS.

The proposed referral pathway for children is shown in figure 3.

Figure 3. proposed care pathway for children



General Anaesthetic (GA) services

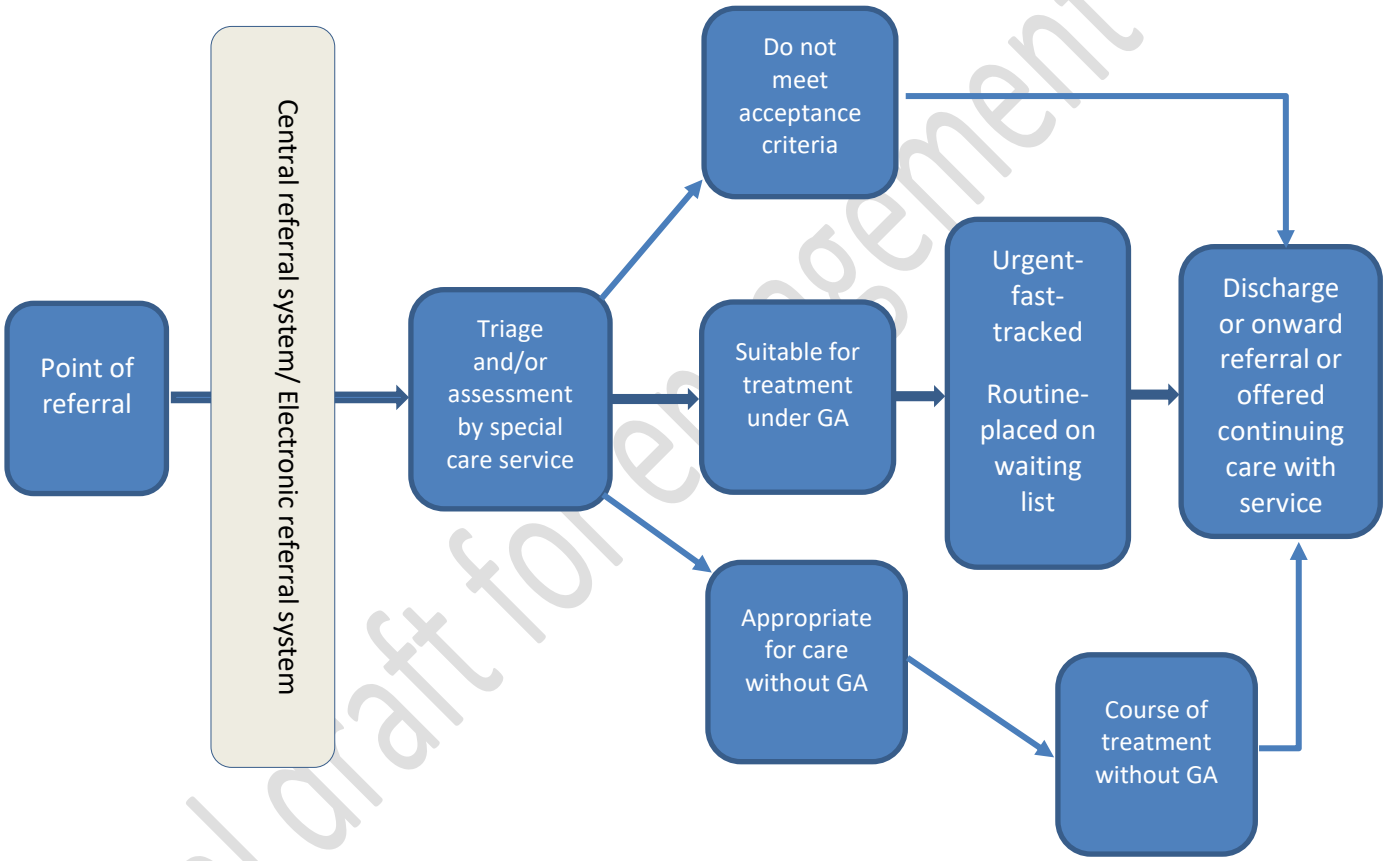
Adult special care and Paediatric patients who are unable to be treated by any other treatment modality such as local anaesthetic +/- sedation may require dental treatment under general anaesthetic. The service must ensure that it secures access to general anaesthetic facilities which comply with the relevant legislation and guidance. The service should provide exodontia and clinically relevant restorative treatment under general anaesthetic. Restorative treatment would normally only be available for patients with special needs.

All other treatment options should have been considered by the service where appropriate prior to accepting these individuals for dental treatment under general anaesthetic,

The service must ensure that any activity carried out under a general anaesthetic is reported under the Hospital Episodes Statistics (HES) reporting system, so that it is included in national reporting of GS data.

The local pathway for care under general anaesthetic is shown in figure 4.

Figure 4. Care pathway for treatment under general anaesthetic



As part of the GA pathway the services must ensure that it has access to timely orthodontic assessments for patients being considered for extractions of first permanent molars.

Sedation

Due to the complex needs of Special Care and Paediatric patients it is necessary for the service to provide dental treatment using a range of treatment modalities, including both psychological such as behaviour management and pharmacological such as sedation (inhalation, intra-nasal, intra-venous). Sedation is used as an adjunct to behaviour management and local anaesthetic. The service must offer care

under inhalation, intra-venous and intra-nasal sedation, where it is clinically appropriate to do so.

For Adult Special Care and Paediatric patients to receive care under sedation their needs must meet the criteria for level 2/3 special care or paediatric care as described in section 7. The criteria take into the account both demand and the limitations of being able to provide certain dental treatments to a high standard under sedation such as molar endodontics.

The main reason for the use of sedation is because of limited co-operation, this may be due to anxiety, learning disability, young age etc.

Sedation services must be delivered in line with service standards outlined in 'Commissioning Dental Services: service standards for Conscious Sedation in a Primary Care setting' (NHS England, June 2017)

Domiciliary care

Adult Special Care and Paediatric patients who are unable to access dental clinics due to, for example, mobility issues, dementia must be offered access to domiciliary care. This service must provide care for patients with urgent and routine dental problems.

Domiciliary care must be provided for patients for whom it is clinically appropriate and where it is unrealistic for the patient to travel to the clinic. It is recognised that for clinical and logistical reasons it may not be possible for a full range of mandatory treatments to be provided in a domiciliary setting. Treatment plans may have to be modified to take account of this. Treatment under sedation and general anaesthetic are excluded from being provided in a domiciliary setting.

Feedback from the public engagement exercise has shown a need for clarity about when domiciliary care may be offered and appropriate. The aim is to eliminate the geographic variation that currently exists about who can access domiciliary care and the treatment offered. The intention is to develop an agreed set of criteria for domiciliary care which will be used across the South Easy of England. These will be developed by the MCNs and the service will be expected to abide by them.

Case Mix Index

The service should use the case mix index for all patients. The latest version of the tool should be used. The 2019 version of the tool is available from https://bda.org/casemix

Case Mix Index for adults

The Case Mix Index is a tool to assess the degree of difficulty in carrying out dental treatment, based on the individual's impairment or disability and the impact this has

on providing a responsive service. It assesses Communication, Cooperation, Medical problems, Oral risk factors, Access to Oral care and Legal and ethical barriers to care. It does not assess the degree of dental complexity. It is completed at the end of each course of treatment as it is impossible to assess these factors prior to or at the beginning of a course of treatment.

Case Mix Index for children

The Case Mix Index has been adapted for paediatric patients to reflect the fact that the parents and/or guardians play a large role in the dental care of their child. So, if the parent's communication skills are poor this reflects on the difficulty in treating the child. Similarly, if the parent does not bring the child to appointments, the child is subject to a care order or is on a child protection plan this can impact on the ability to provide care and the additional time needed.

The case mix tool is intended to be one of several indicators which can be used to monitor and ensure adequate provision of dental services for disabled children and adults.

Referral forms

Referral forms for the service will be developed with the provider and appropriate MCN to ensure that they capture the essential information required for accurate triaging and assessment. Where an electronic referrals system is in place the referral algorithm will be developed with the provider and the appropriate MCN.

4.5 Service Requirements (Provider)

Clinical services

The provider will:

- Ensure that service provision conforms to all relevant guidance and standards;
- Provide a clinical service in line with 'Level 2 and 3' provision as described in the Guides for Commissioning Specialist Services
- Ensure that where referrals are deemed inappropriate, or where additional information is required to establish appropriateness, they respond to the referring dentist within 10 working days, to request clarification, confirm reason for rejection or arrange onward referral to appropriate providers;
- Liaise with the referring practitioner and provide a written report containing the treatment plan; reports to be sent within 2 weeks of the completion of the assessment – for referrals triaged as routine,
- Provide high-quality, timely and appropriate care;
- Maintain good working relationships with colleagues in and outside the NHS who contribute to the overall care of any patients to ensure that this is conducted in the most appropriate, efficient and effective manner;

- Follow the local referral pathways;
- Deliver care within a defined timescale recognising the provider's contracted activity level; patients assessed as eligible for treatment should be scheduled for treatment in a timely manner based on clinical need/age; 95% of patients should start treatment within 18 weeks of referral being received.
- Where possible the patient should receive care from the same clinical team so that they are able to build a trusting relationship with them.
- Where appropriate patients should be offered an introductory visit so that they are able to familiarise themselves with the service in advance of any dental care being provided
- Ensure that they have good links to secondary care and other clinical services so that care can be provided in a co-ordinated way for the benefit of the patient e.g. out-patients under the care of the secondary care multi-disciplinary team.

Strategic leadership

The provider will:

- Have a key role in providing clinical strategic leadership to the wider dental system within the area. The service (through the strategic lead) will be responsible for bringing together local stakeholders, both dental and non-dental, to improve and develop local pathways and care for children and patients with additional needs. This will involve working with established and emerging local networks
- Ensure that a senior representative (or deputy) from the service attends the appropriate MCN. 100% of MCN meetings must be attended.
- Ensure that the service is able to cascade information from MCNs, commissioners, other networks etc. to staff within the service
- Ensure that the service has processes in place which ensure that it adopts practise and service developments agreed by the MCN
- Facilitate patients to access care from other services including other level 2/3 dental services

Governance

The provider will:

- Monitor and seek to improve service satisfaction rates
- Implement a programme to ensure that feedback from service users is sought and acted upon;
- Implement a feedback exercise which asks patients *"have your needs been met by the service? If not, what could we do differently".* The service must

demonstrate that it reflects on this feedback and implements changes as a result, as part of a robust audit cycle.

- Ensure that robust procedures are in place to address issues arising from the patient pathway e.g. validation of patient data, management of patient complaints and incidents, management of clinical information/data security
- Provide a person who has the responsibility for overall clinical leadership of the service. This person should be a Consultant or specialist in special care or paediatric dentistry.
- Provide service leads for the following areas:
    - Special care dentistry
    - Paediatric dentistry
    - Training and workforce development
    - Governance
    - Strategic leadership (with an external focus)
    - Domiciliary care
    - Sedation
    - GA
- The service leads and overall clinical lead must have protected time to carry out their leadership duties. All the leads should have up to date level 3 safeguarding training.

The role of the service leads will not be as clinical experts but as strategic leaders. They will have a role in building relationships with other parts of the healthcare system e.g. emerging healthcare networks (ICS, PCN) with the aim of ensuring that patients across the system are able to access appropriate care.

Communication

The provider will:

- Ensure the service provides information to patients/carers/public about the services including waiting time
- Ask all patients at their first assessment appointment
    - Whether they have any additional needs e.g. ground floor surgery, hearing loop, quiet waiting space. These needs should be clearly recorded on the patient notes so that any member of staff is made aware of these needs.
    - For their preferred method of communication. This method should then be used by the service. To meet the varied needs of the patients the service must offer a variety of communication methods including text, e-mail, letter.
- Ensure that the patient's additional needs and communication preferences are updated at each assessment appointment.

- Ensure that each member of staff uses the patient's additional needs and preferred method of communication to customise the care and approach for the individual patient. This includes non-clinical staff such as receptionists who have a crucial role in ensuring that the patient's needs are met.
- Ensure that they provide a service website which contains information which can help patients and carers prepare for their visit. An example which patients have found useful in the past has been a video or downloadable document summarising the patient journey in simple language appropriate to people with a variety of with additional needs. Ideally any document could be customised by carers for individual patients. photographs and information on staff in the service should also be available.
- The website should also include information on how the service is delivering against the quality framework with the aim that the public is able to see how the service is performing against the quality measures
- Ensure that interpreting services (including British Sign Language) are available for patient who need them
- Provide information on who is eligible and exempt from dental charges and facilitate patients in accessing support for completion of forms for claiming exemptions

Access

The provider will:

- Ensure that the service provides good access to care. When addressing access the service must demonstrate that it has addressed all five aspects of access:
    - Acceptability
    - Affordability
    - Availability
    - Accommodation
    - Accessibility

The provider must take steps to ensure that relevant stakeholders (e.g. care home mangers, social workers, day centre staff) are aware of the service, what it provides and how to access it. The provider must us a variety of communication methods to disseminate this information e.g. website, social media, written information.

4.6 Excluded from the Service

The service is limited to Special Care and Paediatric mandatory services and specified additional services within complexity level 2 and 3 and therefore excludes all advanced mandatory services. The service will not provide care to patient groups such as in-patients as part of this contract, although the provider may contract directly with other providers e.g. secondary care, haemophilia centres to provide care for patient groups excluded from this specification if it wishes.

The following services are excluded from this service:

- Care to secondary care in-patients
- Unscheduled care for patients who are not under a course of treatment with the service OR who are not appropriate for care with the service (do not meet criteria)
- Sedation and domiciliary care for patients who do not meet the level 2/3 criteria in section 7 e.g. patients with dental anxiety alone
- Care to other in-patients e.g. forensic mental health units, health and justice secure units

4.7 Service Requirements (Performer)

Performers will ensure that for each new course of treatment:

- The patient and/or carer understands that the patient will need to attend the appointments on time and on the correct day. If the patient is late, the performer may be unable to see the patient since his/her treatment session might subsequently run late and thus inconvenience all other patients scheduled to attend after the failed appointment. If the patient misses their appointment or cancels without giving 24 hours' notice, the patient will be offered the next available appointment (usually maximum of six weeks after the date of the failed/late cancelled appointment). The service should have a process in place for managing patients who repeatedly fail to attend appointments. This may include referring to safeguarding policies and liaison with carers and other agencies.
- they deliver safe and appropriate care
- offer a choice of appointment times including evening and weekend appointments
- where patient's needs are outside the scope of the service they are referred to a more appropriate provider of care.

4.8 Referral Acceptance and Data Collection/Submission

Providers must comply with the requirements listed below:

- the service will only use the referral management process as identified by the relevant Local Office and the service must have systems which are compatible with the current and future local referral management services, including web-based electronic referrals
- the service will only use electronic data interchange (EDI) to submit claims to the Business Services Authority
- providers will review the referral for appropriateness within 10 working days of the referral being received, returning any that are incomplete or inappropriate

- all referrals will not automatically warrant an assessment appointment to be offered.
- Where the referral suggests that a routine assessment is appropriate this should be offered within 12 weeks from date of receipt of the referral
- If a referral is clinically triaged as being urgent then the appointment should be offered within 2 weeks from date of receipt of the referral. Until the patient is assessed by the service pain management remains the responsibility of the GDP. Where the patient does not have a GDP, the service will need to ensure the patient's pain is managed.
- following assessment where a patient meets NHS criteria and is ready to commence treatment they should be placed on a treatment waiting list if it is not possible to start treatment immediately. The placement on the waiting list is to be prioritised in date order of referrals being received recognising some patients need to be treated more quickly due to clinical need;
- providers will communicate the outcome of the assessment with the referring practice either confirming acceptance of the patient for treatment and outlining the treatment plan or provide an explanation why treatment has not been offered.
- Any correspondence about the patient must be copied (via their preferred method of communication) to the patient or, where appropriate, their representative
- 95% of patients should be treated within 18 weeks of the referral being received
- the submission of FP17s for completed courses of treatment is required within 62 days

4.9 Service Delivery

The model of service delivery is that of a specialist led service. The service must employ sufficient special care and paediatric specialists (on GDC specialist list) to provide clinical leadership and governance of the service. Clinicians, dental care professionals and other staff working for the service must be adequately trained, skilled and experienced to deliver a high quality and safe service. It is up to the service to determine the correct level of skill mix.

It is not proposed that the commissioners undertake a process of level 2 accreditation for non-specialist clinicians working in the service. The service will hold the responsibility for ensuring that all dentists providing level 2 care have the appropriate skills, knowledge, training and experience to provide the care. The provider can choose to follow an assurance model similar to that of accreditation or they can opt for an alternative method. If, during the course of the contract the commissioners implement an accreditations process then the service must comply with that process.

All staff must have annual appraisals and personal development plans and there must be a system for clinical supervision within the service.

4.10 Training

Training must be supported and encouraged within the service for clinicians, DCPs and other staff.

Suggested topics for staff (including non-clinicians) training include:

- Disability equality training
- Equality and diversity training
- Excellent customer service/communication
- Equality Act
- Mental Capacity Act
- Informed consent
- Dementia
- Brief advice for alcohol, tobacco, diet

The service must be part of the system to develop the skills of the wider workforce within the geography they are working. This will include supporting the skills and development of the primary care workforce. The plan for this will be developed by the Managed Clinical Network.

Health Education England (HEE) and the deaneries are responsible for providing an adequate number of Special Care and Paediatric Dentistry training posts nationally. Service providers will work in conjunction with the HEE to host and deliver training to dentists and DCP's.

5. Outcomes

5.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

Quality and outcome measures

Definitions

Key performance indicators include a mix of Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs) and Clinical Outcome Measures.
The service must report against the quality framework described in section 5.2 but can also collect and report other PROMs and PREMs if it wishes.

Any measures used need to be clear and meaningful with regard to these different audiences using the data; for example, it should be possible for non-clinical audiences to understand clinical outcome measures. Measures should also take account of what a good service looks like for these different groups and should be patient centred. There is a need to reduce inequalities between patients with respect to both their ability to access services and the outcomes achieved for them. The quality measures used need to reflect this and the care should be as seamless as possible.

Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMs)

PROMS

Generic PROMs can include simple patient reported clinical outcome measures used elsewhere in dentistry.

Examples of PROMS -
Were you given appointments at a time that was convenient to you?
Was your appointment at a convenient location?
Did the clinic facilities meet your needs?

It must be emphasised that given the nature of some special care and paediatric service users' disabilities, the functions of eating and speaking comfortably, should be presented as separate questions, rather than as the single generic question that may be appropriate elsewhere. In addition, the responses to such questions may not be truly indicative of the quality of care received.

PREMS

With regard to additional specialty specific PREMs, these could include disabled access, having adequate time to understand the proposed treatment and what it will entail for delivery of their care, feeling valued as a service user and the particular attitude and approach of staff members.

Examples of PREMS -
Were you treated with dignity and respect?
Was your dental treatment explained to you in a way that you could understand?
Would you recommend the service to your friends and family?
Were you satisfied with the treatment you received?

As a more qualitative measure it may also be helpful for services to show how they have evaluated, reflected upon, responded to, and acted upon feedback and how services are being developed to improve patient experience as a result of the feedback received.

Clinical Outcome Measures
The National Commissioning Guide outlines the following as examples of evidence which could be used to demonstrate that appropriate processes and protocols are in place:

- Key performance indicators e.g. actual waiting times, DNA rates, CaseMix, Repeat GAs, band 2 to urgent courses treatment
- SIRIs and Never events.
- Formal complaints
- Accolades
- Reference to CQC inspection reports and CQC Outcomes
- Audits

5.2 Locally defined outcomes

It is proposed that the service will be measured using a quality framework which will focus on five key areas:

• Access
• Communication
• Value for Money
• Clinical Care
• Patient Experience

The draft quality framework is shown in the table below. The final quality framework will be co-developed with the provider.

Draft Quality Framework

Category	Description	
Effective Care	Proportion of all patients who receive care who are categorised as case mix level 2 or above	
	Proportion of patients where application of fluoride is recorded as part of the treatment provided	Adults (over 16 years)
		Children (under 16 years)
	Proportion of appointments which are not attended by patients	
Waiting times	Proportion of discharge letters sent within 2 weeks Proportion of patients accepted for care who are seen for an assessment within 12 weeks Proportion of patients who start treatment within 18 weeks	
Patient experience	Proportion of patients reporting satisfaction with care provided - using question *"have your needs been met by the service?"* Patients' additional needs are recorded at assessment	
Governance	Service leads have received level 3 safeguarding training	

6. Premises

6.1 Premises and Equipment Requirements

The provider is expected to secure facilities suitable for service delivery the location of which are detailed in the lot specifications. The premises must meet the needs of the patients and their carers. The nature of the patient group means that the service should have facilities and equipment to treat patients with additional needs. The service does not have to offer services from a mobile unit but can choose to use mobile units. If a mobile unit is used it must comply with the relevant guidelines and legislation e.g. HTM0105.

Examples of non-standard equipment which must be provided are:

- Hoist
- Wheelchair tipper
- Dental chair and equipment for people weighing over 23 stone

The provider must indicate potential premises and number of surgeries planned for the provision of the service, this may include the development of outreach clinics (as a hub and spoke arrangement), plans to work with other practices or other innovations. Services should not be provided from single surgery sites (with the exception of mobile units). The provider should ensure that performers work with other performers for the majority of their clinical time i.e. lone working should be avoided. Where it is not possible to avoid lone working e.g. domiciliary care this should not represent more than 20% of the clinical time of the performer.

The provider will be responsible for the funding of all premises and service delivery costs including but not limited to consumables, equipment, laboratory services, appliances and IT operational infrastructure (including Electronic Data Interchange [EDI]).

The provider shall ensure that the premises used for the provision of Special Care and Paediatric Dentistry:

- Are suitable for the delivery of these services
- Are equipped to meet the reasonable needs of the patients
- Are EDA compliant
- Are registered with the Care Quality Commission (CQC)
- Has appropriate and with sufficient waiting-room accommodation for patients and carers
- Has equipment and facilities that conform to relevant standards / regulations and are maintained regularly in line with guidelines and manufacturers protocols

- Is responsible for the funding of all consumables, equipment, laboratory services and appliances
- That any laboratory services are registered with the Medical Devices Agency and these work within the relevant legislation
- Has robust governance and quality assurance programmes in place to ensure a safe environment for all service users.
- Have in contract access to appropriate radiographic facilities and the arrangements for the facilities covers all the legal requirements relating to the use of radiographic equipment
- That the telephone number to be used by patients and or professionals in connection with the delivery of the Special Care and Paediatric service is a local personal number, unless the service is provided free to the caller.
- Meets HTM01-05 best practice
- Uses agreed local checklists highlighting aspects of the service and facilities of relevance such as signage and accessible information

6.2 Location of Services

Providers will need to demonstrate that the premises proposed for the delivery of the service are in a convenient location (e.g. close to schools, places of work, good transport links or homes) within the defined location(s) advised as part of the procurement process. The locations should be easily accessible to patients arriving by foot, public transport or car.

6.3 Additional Requirements

In addition to the requirements detailed in 5.1, the provider must ensure that:

- they have robust governance and quality assurance programmes in place to ensure a safe environment for all service users;
- they have safe processes and working environment in place, that will include ensuring that there are up to date policies and processes, that staff are familiar with these and have the relevant training;
- legal requirements relating to radiological legislation and guidance are met;
- dental laboratory services used meet with GDC guidance, EU legislation, are registered with the Medical Devices Agency and work within the relevant legislation;
- dental services are in accordance with best practice as set out in the following guidance
  - High Quality Care for All – next stage review 2008
  - NHS Constitution, 2009
  - Implementing Care Closer to Home, 2007
  - Modernising Medical Careers
  - NHS Personal Services Agreements
  - Ionising Radiation (Medical Exposure) Regulations
  - AIDS/HIC infected Healthcare worker Guidelines

- Equalities Act, 2010
- Human rights Act, 1998
- Dental Practitioners' Formulary
- GDC Standards for the Dental Team
- GDC Standards
- Caldicott Principles
- The Hazardous Waste Regulations, 2005
- The Health and Safety at Work Act (1974) Statement of Policy with Respect to the Health and Safety at Work of All Employees
- Disability Discrimination Act (1995) and Disability Equality Duty (DED) 2005
- Decontamination of Dental Instruments: Health Technical Memorandum (HTM) 01-05, Parts 1 and 2, 2013
- Health Protection Agency Guidance on Infection Control, Communicable Diseases for Primary and Community Care within the Local Area
- Securing Excellence in Dental Commissioning, NHS Commissioning Board 2013
- Guide for Commissioning Dental Specialities – Special Care, 2015
- Guide for Commissioning Dental Specialities – Paediatrics, 2018
- Royal College of Surgeons of England, National Clinical Guideline for the Extraction of First Permanent Molars in Children (2014)
- Five Year Forward View, NHS England 2014 (aspects relevant to dentistry)
- BSDH Guidelines and Policy Documents for Oral Care of People with Disabilities (https://www.bsdh.org/index.php/bsdh-guidelines)
- BSPD guidelines (https://www.bspd.co.uk/Resources/BSPD-Guidelines)
- Draft Commissioning Standard for Dental Services for Vulnerable Adults

7. Clinical Competencies

7.1 Description of the Complexity Levels

The table below describes the different levels of care and where it should be provided. This service will provide level 2 and 3 care only.

Adults (aged 16+ years)

	Tier		
Special care (adults)	**Level 1 Primary care**	**Level 2 Shared care (joint specialist-led and primary care)**	**Level 3 Specialist-led special care service**
Adults with moderate to severe learning disabilities	Patient with LD and able to accept all forms of treatment in GDS. Able to have a full mouth exam including charting, radiographs, BPE. Pt co-operative enough to have treatment. May need to be referred to for more complex care.	Patient with LD. Able to have full mouth exam, BPE, simple scaling, simple fills but will not tolerate radiographs. The patient is able to accept some elements of care in primary care but may need treatment planning or specific types of treatment carried out in a specialist-led service	Patient is unable to accept care in primary care e.g severe/profound LD. 24/7 support - residential, full time care at home. Best interest. Lack capacity. Inability to have a straightforward examination (not able to have full mouth exam, BPE, radiographs). Severe behavioural issues. Combined with complex medical conditions that make them too complex to manage in GDS. Domiciliary care. Sedation or general anaesthetic required for treatment. Mental health issues/personality disorders. Risk of harm to healthcare workers.
Adults with physical disability and/or communication impairment	Patient disability does not significantly impact on the ability to transfer to the dental chair. Being in a wheelchair does not preclude them being treated in primary care. Interpreter services are available. Those with language difficulties in isolation should be seen in primary care.	Patient able to have full examination in primary care dental surgery. If require treatment may require access to hoist or wheelchair tipper. .	Patient requiring assisted transfer. Pts who cannot have treatment delivered safely in dental chair. May require domiciliary care or specialist equipment e.g. hoist, wheelchair tipper. Sedation or general anaesthetic required for treatment.

Adults with progressive degenerative diseases resulting in neurological conditions such as MS, MND, Huntington's Disease	Patient able to have a full examination, BPE, radiographs, scaling, simple fillings. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Second opinions or joint treatment planning. Able to co-operate for full mouth exams, BPE but unable to tolerate radiographs and treatment. Pts may have capacity issues or fluctuating capacity.	Patient is not able to access regular dental care. Lack of capacity. Best interest decisions. Unable to co-operative for dental treatment safely. May require dental treatment with sedation or general anaesthesia. May require domiciliary care.
Adults with mental health issues	Patient able to have a full examination, BPE, radiographs, scaling, simple fillings. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Able to have full examination in primary care dental surgery. Limited co-operation for certain treatments such as fillings, extractions etc. If patient is supported by CPN or support worker. Pts may have capacity issues or fluctuating capacity. Pts with fluctuating periods of uncontrolled mental health and behavioural issues.	Patient who are unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.
Adults with dementia	Patient able to have a full examination, BPE, radiographs, scaling, simple fillings. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Second opinions or joint treatment planning required. . Able to co-operate for full mouth exams, BPE but unable to tolerate radiographs and treatment. Pts may have capacity issues or fluctuating capacity.	Patient is not able to access regular dental care. Lack of capacity. Best interest decisions. Unable to co-operative for dental treatment safely. May require dental treatment with sedation or general anaesthesia. May require domiciliary care.
Adults with complex medical conditions	ASA 1 and 2	ASA 3.	ASA 4 and above Sedation or general anaesthetic required for treatment.
Adults with severe dental anxiety	Care should be provided in primary care for patient with anxiety who is able to accept an examination including radiographs, BPE, simple scaling. ASA I/ASA II patients requiring treatment under IHS/IV sedation.	Medically compromised patient able to have examinations/continuing care in primary care but require IHS/IV sedation or GA for treatment.	Medically compromised patient who is unable to have examinations/continuing care in GDP and require IHS/IV sedation or GA for treatment. These patients are ASA III/ASA IV and their medical problems/complex needs fulfil the acceptance criteria of the service in addition to their anxiety.
Patients requiring specialist equipment e.g. specialist dental chairs for people weighing over 23 stone.	Patient who is mobile and have no co-morbidities. If exceeding the weight of the chair examination and simple treatment may be provided without reclining the chair.	Patient who is usually cared for in primary care but need treatment using a bariatric chair or wheelchair tipper.	Patient who is severely obese and have medical problems which are too complex to manage in primary care. Patient who is unable to access general dental services due to limited mobility, large wheelchairs, transfer to dental chairs. Housebound patients who may need, due to their problem, treatment using a bariatric chair or

			wheelchair tipper, wider door access, accessible toilets. Patient who may require specialised transport to get to a clinic. Patient who is unable to leave home and need domiciliary care.
- Homeless people and rough sleepers	Can be treated in primary care where there are no issues of capacity or complex medical needs	Limited co-operation for certain treatments such as fillings, extractions etc. Pts may have capacity issues or fluctuating capacity. Pts with fluctuating periods of uncontrolled mental health and behavioural issues. Pt with medical problems or complex needs that require more specialised management/treatment.	Patient who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings required, case conferences etc. Sedation or general anaesthetic required for treatment.
- Migrants, asylum seekers, refugees and sex workers (excludes people detained/housed within the health and justice system) **People with substance misuse**	Can be treated in primary care if there are no problems which mean more specialist care is required Language barriers in isolation are not a reason for referral to specialist services	Able to have full examination in GDS dental surgery. Limited co-operation for certain treatments such as fillings, extractions etc. Patient may have capacity issues or fluctuating capacity. Patient with fluctuating periods of uncontrolled mental health and behavioural issues. Patient with medical problems or complex needs that require more specialised management and treatment.	Patient with medical problems or complex needs that require more specialised management and treatment. Patient who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.
People in secure forensic psychiatric units			Treatment may be provided in the clinics or on a domiciliary basis. Patient with medical problems or complex needs that require more specialised management and treatment. Patient who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.

Paediatric care (children aged 16 years and under)

	Tier		
Paediatric care	**Level 1 Primary care**	**Level 2 Shared care (joint specialist-led and primary care)**	**Level 3 Specialist-led paediatric service**
Children with moderate/severe and profound multiple learning disabilities	Patient with LD and able to accept all forms of treatment in GDS. Able to have a full mouth exam including charting, radiographs, BPE. Pt co-operative enough to have treatment. May need to be referred to for more complex care.	Patient with LD. Able to have full mouth exam, BPE, simple scaling, simple fills but will not tolerate radiographs. The patient is able to accept some elements of care in primary care but may need treatment planning or specific types of treatment carried out in a specialist-led service	Patient is unable to accept care care in primary care e.g. severe/profound LD. 24/7 support - residential, full time care at home. Best interest. Lack capacity. Inability to have a straightforward examination (not able to have full mouth exam, BPE, radiographs). Severe behavioural issues. Combined with complex medical conditions that make them too complex to manage in GDS. Domiciliary care. Sedation or general anaesthetic required for treatment. Mental health issues/personality disorders. Risk of harm to healthcare workers.
Children with physical and/or communication impairment	Patient disability does not significantly impact on the ability to transfer to the dental chair. Being in a wheelchair does not preclude them being treated in primary care. Interpreter services are available. those with language difficulties in isolation should be seen in primary care.	Able to have full examination in primary care dental surgery. If require treatment may require access to hoist or wheelchair tipper. .	Patient requiring assisted transfer. Patient who cannot have treatment delivered safely in dental chair. May require domiciliary care or specialist equipment e.g. hoist, wheelchair tipper. Sedation or general anaesthetic required for treatment.
Children with moderate/severe chronic mental health conditions including ADHD, Eating disorders and substance abuse or Under the care of PCAMHS	Child able to have a full examination, or and straightforward treatment i.e. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Able to have full examination in primary care dental surgery. Limited co-operation for certain treatments such as fillings, extractions etc. Pts may have capacity issues Pts with fluctuating periods of uncontrolled mental	Child who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.

		health and behavioural issues.	
Children with complex medical conditions as classified by The American Society of Anaesthesiologists	ASA 1 and 2	ASA 3	ASA 4 and above Sedation or general anaesthetic required for treatment.
Children with dental anxiety	ASA I or II where HIS only is required	Sedation required for more complex treatment e.g. multiple extractions	Child under PCAMHS Acclimatisation for severe anxiety requiring multiple appointments Treatment under GA or sedation other than HIS required
Children with behavioural problems	Child is able to co-operate with treatment in primary care	Some treatment is possible in primary care. Joint treatment planning required	Child with severe Learning disabilities and behavioural issues who are unable to accept care in primary care or where involvement with multiple agencies is required
Children with cleft lip or palate or dental abnormalities including genetic diseases or dental trauma	Treatment required is routine and within the scope of primary care	Dental Trauma where the patient requires support for ongoing treatment after initial injury or joint care for initial injury	Specialist care required e.g. endodontics in complex trauma cases where there is open apex and /or displacement, Dental abnormalities and cleft palate patients. MDT care
Children under the care of social services or with complex social problems	Social issues do not impact on ability of child to receive care in primary care	Social issues may require joint treatment planning or liaison with external agencies	Complex social issues requiring contact with multiple external issues e.g. safeguarding

7.2 Governance and Information

The provider will have an Information Governance (IG) policy in place in accordance with the NHS Information Governance Toolkit. The following must be included in the policy:

- the provider must assign responsibility for IG to an appropriate member of staff;
- the policy must address the overall requirements of information quality, security and confidentiality;
- all contracts, staff, contractor, third party, contain clauses that clearly identify responsibilities for confidentiality, data protection and security;
- all staff members are provided with awareness and training across the IG agenda;
- the provider must implement IG Information Security management. arrangements to ensure the NHS CFH Statement of Compliance is satisfied;
- the provider must ensure that all staff and all those working for or on behalf of the provider where applicable comply with the terms and conditions set out in the RA01 form;
- the provider must ensure that all correspondence, fax, email, telephone messages, transfer of patient records and other communications are conducted in a secure and confidential manner;
- the provider must ensure patients/carers are asked before using their personal information that is not directly contributing to their care and that patients'/carers' decisions to restrict the disclosure of their personal information is appropriately respected;
- the provider must be fully computerised, for examples, but not limited to, electronic patient records, ability to submit electronic FP17 claims by EDI transfer, access Compass to update contractual information including annual superannuation reconciliation returns and access schedules, submit Friends and Family Test data, submit annual complaints returns, work with any electronic referral management system in place (or be able to work with future systems);
- the provider must only use nhs.net email account/s when transferring patient identifiable information and other confidential or sensitive information.

7.3 General Principles

- Treatment should only be undertaken in situations where it is believed to be in the patient's best interests in terms of their oral health and/or psychosocial wellbeing.
- In all situations the clinical advantages and long-term benefits of treatment must justify such treatment and outweigh any detrimental effects

7.4 General Patient Factors

The clinician should ensure that the cooperation, motivation, aspirations and general health of the patient are consistent with the provision of treatment.

7.5 General Dental Practitioners

Providers will return any incomplete or inappropriate referrals.

Any referrals that require additional clinical information to explain the need for advice or where there is no indicator that the patient would warrant an assessment should be returned to the referring GDP with an explanation as to why the patient has not been offered an assessment.

Providers will work with GDPs to improve their referrals with the aim of ensuring that referrals are appropriate.

Providers will communicate the outcome of the assessment with the referring practice either accepting the patient for treatment or provide an explanation why treatment has not been offered.

Providers will inform the referring practice when treatment is complete or has been discontinued or abandoned.

7.6 Interdependencies

All providers are required to ensure their performers become pro-active members of the Special Care and Paediatric Managed Clinical Network (MCN). Service providers and performers will work closely with the MCN to implement and improve the patient pathways and ensure that patients receive a high-quality service.

The provider will need to demonstrate effective working relationships with secondary care colleagues to ensure appropriate management of complex cases and appropriate management of complications outside the scope of the service in accordance with the agreed pathways.

Relevant networks include, but are not limited to:

- NHS England;
- Oral Surgery MCN;
- Local Dental Network (LDN);
- Clinical Commissioning Groups (CCGs);
- Sustainability and Transformation Partnerships (STPs);
- British Dental Association (BDA);
- Local Dental Committees (LDC);
- Other relevant clinical networks;
- Local Authority Health and Wellbeing Boards and Scrutiny Committees;
- Health Education England (HEE) and Postgraduate Deanery;
- Healthwatch
- Local system networks e.g. ICS, PCN

8. Accessibility and Opening Hours

The service will be flexible and responsive to individual patient need in accordance with the Equality Act 2010 and the Health and Social Care Act 2008.

The service must offer a choice of appointments, e.g. evenings and weekends as well as weekday daytime access. The range of appointments offered should recognise that carers maybe unable to take time off work. It is not essential for the service to offer extended opening hours at every clinic, but extended hours must be available at a range of sites to maximise access.

The service must provide unscheduled care for patients in a course of treatment with the service where this is assessed as being clinically appropriate. The service must also provide unscheduled care for patients not currently undergoing a course of treatment with the service but who meet the level 2/3 criteria in section 7. This will include patients referred from other services such as 111.

Unscheduled access must be available during working hours (including weekends and evenings). The service should ensure that patients can access unscheduled care in a timely way. To deliver this the service may have to set aside specific time each day to manage this care.

The provider must ensure that patients are able to book and cancel appointments using a variety of methods e.g. website, text, telephone, recognising that due to their additional needs patients may not be able to give a long notice period if they are not able to attend an appointment.

The service will monitor patient satisfaction to include accessibility and implement change where reasonable and appropriate following discussion and agreement with the Commissioner.

8.1 Management of Failed Appointments

Providers are expected to demonstrate effective methods of monitoring and reducing failures to attend to improve service utilisation and improve treatment outcomes.

8.2 Patient Information

The service must ensure that patients are provided with relevant verbal and written information in a variety of formats, where necessary utilising a translator service.

The service must also provide information concerning the outcome of any assessment, a written treatment plan and an explanation of the different treatment options.

Prior to the start of treatment, the patient and/ or carer should be provided with the following information verbally and in writing

- treatment plan including length of treatment and frequency of visits;
- what to expect during treatment;
- what is expected of them and under what circumstances treatment will be terminated e.gg poor attendance, poor oral hygiene, abusive behaviour;
- the information should be given in such a way that it supports the patient's ability to give informed consent to initiate treatment.

Providers will be required to:

- ensure the patient and/or carer has a clear understanding in advance of what will happen to them during the treatment, who will be responsible for delivering each element of care
- ensure informed consent is gained for all patients prior to initiating assessment and / or treatment;
- have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults.
- have in place a policy that meets the commissioner's and CQC requirements for safeguarding children/young persons. The provider should evidence that all patient information and consent processes have involved patients/carers in its development and that it is regularly reviewed and updated.

8.3 Safeguarding

Providers must ensure that:

- valid consent is gained from all patients prior to initiating assessment and/ or treatment;
- they have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults. All staff must receive regular safeguarding training;
- they have in place a policy that meets the commissioner's and CQC requirements for safeguarding children/young persons.

8.4 Waiting Times

The definition of a treatment waiting list is the period of time when the patient is assessed and judged to meet NHS criteria, accepts the offer of NHS treatment and is ready to commence treatment.

There will be separate waiting lists for assessment and treatment that are to be managed as follows: NB times are maximum times

- Review/triage of referral – 10 working days (from date of receipt of referral)

- Information back to referrer – 2 weeks (from completion of triage/assessment/completion of treatment)
- Referral to assessment appointment – 12 weeks (from receipt of referral)
- Assessment to treatment start– 18 weeks

8.5 Discharge Criteria and Planning

A patient will be discharged only when the treatment for which they were appropriately referred is complete or when the patient's treatment is not appropriate for this service. Discharge will be via an agreed method. Discharge information to patients and doctors may need to be sent via standard mail.

8.6 Discharge Information Standards

Discharge information will:

- include the unique reference number (URN) (where referral management arrangements are in operation) and the NHS Number (where known)
- contain clear instructions for the patient's GDP for any on-going care
- contain a summary of the treatment provided and/or the reasons for discharge
- contain details of the continued treatment to be given by the service
- be sent to the referring GDP, patient and GMP within 2 weeks of treatment completion date

Standards for discharge letters:

- the referring GDP and patient will receive a discharge summary including the URN and/or NHS number within 2 weeks of completion of treatment
- the patient's General Medical Practitioner (GMP) should also receive the discharge summary. The GMP copy should include all relevant medical information including, but not limited to:
    - smoking status
    - alcohol consumption
    - blood pressure (if known e.g. for sedation/GA patients)
    - details of any brief advice, signposting or referrals e.g. to smoking cessation services
- where appropriate, other agencies will be informed;
- an FP17 completion form must be submitted within 62 days of the completion of active treatment

Patients whose treatment is not complete:

- patients who do not attend for appointments (DNA) will be discharged according to the provider's DNA protocol following suitable efforts to contact the patient/carer to complete treatment. The provider must be able to demonstrate they have made reasonable efforts to contact the patient/carer and inform them what will happen if they DNA
- where appropriate, other agencies will be informed
- an FP17 completion form must be submitted within 62 days of the decision to discontinue treatment
- discharge letters must follow the above standards

9. Currency and Pricing

TBC

10. Baseline Performance Targets – Quality, Performance and Productivity

Performance	Indicator	Threshold	Method of

Indicator			Measurement
Control of Infection	Premises to confirm to HTM01-05 best practice and other relevant standards	100%	CQC report/other national quality assurance reports IPS 6 monthly audit tool
Premises and Equipment Compliance	Premises to conform to relevant national standards	100%	CQC report/other national quality assurance reports

Appendix A: Provider Specification

	Requirement
Clinical skills and competencies: performer(s)	1. Registered with General Dental Council. 2. Currently on, or eligible for inclusion, on Performer List. 3. Specialist in Special Care Dentistry and Paediatric Dentistry on the register held by the General Dental Council Service must be specialist led by dentists who are specialists in Special Care and Paediatric Dentistry or by one or more dentists who have completed additional training and hold Consultant in Special Care and Paediatric Dentistry or are on the GDC specialist list for Special Care and Paediatric Dentistry. Other performers delivering the service do not need to be on a specialist list but must have required skills to provide level 2 care as assessed and verified by the provider.
Clinical skills and competencies: Chairside Dental Care Professionals	*GDC Registered Therapist* Current skills outlined in the GDC Scope of Practice 2013 and work under the supervision of GDC registered dental practitioner as outlined in the …. *GDC Registered dental nurse* Current skills in chairside dental nursing for Special Care and Paediatric procedures (where provided) and expanded duties subject to suitable training.
Facilities **Record keeping**	Accessible, appropriately equipped and CQC registered clinical setting for the provision of Special Care and Paediatric services. In-contract access to: • appropriate radiographic facilities and equipment. Evidence of adequate clinical records keeping and a document management/data governance as well as compliance with relevant legislation/standards. Use of contemporary and secure practice/records management software.

Medical emergencies	Evidence of training within last 12 months for all clinical staff.
Management of service: (interface with other clinical service providers and RMS)	Appropriate IT to receive patient referrals safely and compliance with information governance standards. All providers will have an nhs.net email account. Able to communicate effectively (written and verbal) with primary and secondary care clinicians with primary and secondary care clinicians.
Management of service: interface with patients	Systems in place for receiving patient feedback and management of complaints/incidents. Robust appointment and reminder systems. Appropriate verbal and written information for patients in a variety of formats/media. Policy for minimising wasted appointment times due to failed appointments and cancellations. Flexible and responsive service able to adapt to patients' needs including those with physical or learning disabilities and different cultural needs, ethnicity, language.
Management of service: interface with commissioners	Able to demonstrate systems in place for reporting on performance, activity and quality of service.

Appendix B: Location of Services

TBC

Appendix C: Units of Dental Activity (UDAs) to be commissioned

TBC

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NHS
Oxfordshire
Clinical Commissioning Group

Update for Oxfordshire HOSC: Temporary Closure of City Community Ward

June 2019

At the end of May 2019 Oxford Health temporarily closed City Community Ward due to it not being possible to roster 24x7 shifts in accordance with Safer Staffing Guidance. The Trust and Oxfordshire Clinical Commissioning Group have suggested to HOSC that a range of options be developed over the summer and presented to HOSC at the end of September.

This paper provides background to the temporary closure decision and an update on progress.

City Community Ward, located at the Fulbrook Centre on the Churchill Hospital site in Headington, is one of eight[1] community hospitals with inpatient beds[2] run by Oxford Health NHS Foundation Trust serving the people of Oxfordshire. The purpose of the ward has been to provide general rehabilitation typically following a stay in an acute hospital. Each community hospital tends to share facilities with other services from a variety of providers. Other community hospitals provide a broader range of services including Minor Injury Units, Emergency Multidisciplinary Units/Rapid Access Clinical Units, First Aid Units, stroke rehabilitation, diagnostics and therapy services. The City site is co-located with two Older Adults Mental Health Wards (one for males, one for females) run by Oxford Health.

The rehabilitation contract held between Oxfordshire CCG and Oxford Health is designed to be based on episodes of care rather than the number of beds. However, there is a commitment in principle to maintain an agreed capacity: this was c.148 beds in 2017/18 and c.142 in 2018/19 and 2019/20. The number of beds is flexed seasonally to respond to changing needs. The number of beds will fall to 130-135 over the summer and increase back up to 145 or more for winter.

In June 2018 the Trust became concerned about its ongoing ability to staff the City Community Ward over the summer period. In actuality the Trust was able to maintain safe staffing at that point but reduced the number of beds from 18 to 12. This situation was maintained throughout winter and the Trust's ability to keep the

[1] Wantage Community Hospital is currently temporarily closed. The other community hospitals are: Abingdon, Bicester, Didcot, Henley, Wallingford, Wantage and Witney.
[2] Chipping Norton War Memorial Community Hospital does not have inpatient beds run by Oxford Health NHS Foundation Trust.

hospital open was based largely on the extraordinary efforts of staff on the ward and the support of staff from the other community hospital sites.

Whilst adverts for registered nursing staff have run more or less continually during the period there were no applicants. In addition, at the end of April three registered staff members gave notice, each for different (and personal) reasons. This was escalated to the Trust Board and the decision made to close the ward on a temporary basis for safety reasons. This was discussed with system partners then formally communicated to HOSC on 8th May.

HOSC held an emergency meeting at the end of May to scrutinise the matter. At the meeting, Oxford Health and the CCG informed members that the system would review the options for City Community Ward over the summer and return with a view on preferred options at the end of September. OCCG agreed to provide a monthly update to the committee on progress.

City Community Ward was temporarily closed to patients on 31st May 2019. Of the 12 inpatients, 6 were from outside the City and repatriated to a community hospital closer to home. Of the remaining six who were local to the City, three were discharged home, one was moved to a local intermediate care bed, and one moved to Didcot Community Hospital.

Currently the Trust has 126 beds open across its community hospitals which is a slightly lower number than at the same time last year. Two additional stroke beds are scheduled to open on 1st July with a further two opening 1-2 weeks thereafter, taking the number of beds back to 130, in line with summer 2018.

This is the first update since the emergency meeting of HOSC and progress to update:

- A recruitment working group has been established by Oxford Health, in partnership with Oxford University Hospitals NHS Foundation Trust, to explore all avenues to encourage recruitment locally and nationally.
- A lead has been identified by Oxford Health and agreed at Oxfordshire A&E Delivery Board to work for the system in developing an options appraisal, drawing on input from system partners as necessary, with the objective of reaching consensus about a way forward.

An engagement plan is being developed that will ensure local stakeholders are involved as options are developed and considered for the future.

NHS
Oxfordshire
Clinical Commissioning Group

Update for Oxfordshire HOSC: Temporary Closure of City Community Ward

July 2019

Current position

- The ward was temporarily closed to patients on 31st May 2019.
- Staff Consultation was completed on 7th June 2019. All staff members have been redeployed across Community Hospital wards and are settling well.
- Oxford Health NHS Foundation Trust (OH) Patient Liaison Advice Service (PALS) are asking all community hospital inpatients if they experience issues with being visited by family members or being placed further away from home for their rehabilitation. This will enable them to look at the home location to see if there is a negative impact on patients displaced from City postcodes. To date no negative responses as a result of this work have been received.

Recruitment

- OH continues to actively recruit to the registered nurse vacancies for City Community Hospital, with a dedicated recruitment team supporting this work. NHS Creatives have been engaged to assist us with a social media campaign focussing on Community Hospital recruitment.
- To date the following posts for City Community Hospital have been recruited:
    - Band 7 Ward Manager (external appointment)
    - Band 6 Deputy Ward Manager (external appointment)
    - Band 6 Clinical Development Nurse (external appointment)
- Eight Band 5 vacancies remain and are currently advertised – four applicants are being interviewed in August. There are also plans to move at least one Registered Band 5 nurse from another site to City Comm.
- External candidates recruited are going through employment check processes with a view to start dates in September/ October.
- Once staff commence employment, they will be inducted on other community hospital wards in readiness for reopening City Community Hospital. All candidates are fully aware of the temporary closure of City Community Hospital.
- OH anticipate being in a position to make a decision about the re-opening of City Community Hospital by the end September 2019.

Maintaining Bed Provision

- Currently OH have 130 beds open across all community hospitals, the same number of beds as this time for the last two Summers.

- OH have successfully opened the additional four Stroke beds, bringing us to the full 20 stroke beds.

System Wide Planning

A system wide group has been set up to consider the following-

- The conditions required for safely reopening City community beds in the Fulbrook centre; or,
    - If not there, where else could beds be re-provided; or,
    - If not beds, then what other tangible offer could we make to the residents of Oxford City.

The group is meeting fortnightly and includes good representation from the whole Oxfordshire system.

NHS
Oxfordshire
Clinical Commissioning Group

Update for Oxfordshire HOSC: Temporary Closure of City Community Ward

September 2019

Current position

- The ward was temporarily closed to patients on 31st May 2019.
- Staff Consultation was completed on 7th June 2019. All staff members have been redeployed across Community Hospital wards and have settled well.
- Oxford Health NHS Foundation Trust (OH) Patient Liaison Advice Service (PALS) continue to ask all community hospital inpatients if they experience issues with being visited by family members or being placed further away from home for their rehabilitation. This will enable them to look at the home location to see if there is a negative impact on patients displaced from City postcodes. There continue to have been no issues raised.

Recruitment

- To date OH have recruited the following posts for City Community Hospital
    - Band 7 Ward Manager
    - Band 6 Deputy Ward Manager
    - Band 6 Clinical Development Nurse
- OH have 8 Band 5 vacancies (registered nurses) out of an establishment of 13.9 WTE B5 staff and are in the process of interviewing candidates. Four new B5 members of staff have been recruited, and further interviews are taking place during the remainder of August and September.
- Partners have confirmed that their own band 5 staffing vacancies would not allow them to consider there being any staff surplus to their own needs who could be offered to OH.
- This is the hardest staff group to recruit. Therefore, OH are assessing whether the ward could employ different types of staff for example Nurse Associates (trainee nurses).
- External candidates recruited are going through employment check processes with a view to start dates September/ October.
- Once staff commence employment with OH they will be inducted on other community hospital wards in readiness for reopening City Community Hospital. All candidates are fully aware of the temporary closure of City Community Hospital.

Maintaining Bed Provision

- Currently OH have 130 beds open across all community hospitals, the same number of beds as this time for the last two Summers.
- Stroke beds remain at the full 20.

System Wide Planning

A system-wide group comprising representatives from Oxford Health, Oxford University Hospitals, Oxford Clinical Commissioning Group, Oxfordshire County Council and OxFed has been meeting on a fortnightly basis to consider three options (see below). Healthwatch and Age UK have provided stakeholder challenge to this work.

1. *The conditions required for reopening City community beds in the Fulbrook Centre*

OH is actively working towards reopening beds in City Community Hospital. This is dependent upon recruiting and retaining sufficient staff at all levels to ensure the unit remains safe. Recruitment in recent weeks has been encouraging and this remains the primary option.

2. *If not at City community hospital, where else could beds be re-provided*

It has been possible to reprovide beds across the other community hospital sites since the temporary closure of City community hospital, and these will remain in place until the City site reopens. This includes increasing the number of beds across the winter months to support the system at a time of high demand and pressure.

3. *If not beds, then what other tangible offer could we make to the residents of Oxford City?*

Oxford City, in common with other areas, has an ageing population. Between 158 patients with an OX1-4 postcode were admitted to a community hospital bed, of whom 59 were admitted to City Community Hospital during this time period. In other areas of the county, notably Henley, Abingdon and Witney, Oxford Health has set up “ambulatory” units where unwell patients can be assessed, diagnosed, treated and discharged home or admitted for a very short stay, without needing to go to the John Radcliffe or Horton Hospital. These units also offer “community outreach” where highly trained staff support people in their own home. All partners, including Oxford City GPs and OxFed and OUH have been reviewing what sort of service could be provided in this type of unit in Oxford City in the future. This type of unit is able to provide care for 1800-1900 patients a year.

Next steps

Oxford Health NHSFT Trust Board will consider whether it is safe to reopen City Community Hospital beds at the next Board meeting on September 25th, 2019.

OUH Gynaecology Oncology

OUH commissioned Invited Review by Royal College of Obstetrics and Gynaecology (RCOG) in November 2018.

RCOG Invited Review took place in January 2019. RCOG final report submitted to Trust on 1 July 2019 which detailed a number of options for consideration in relation to the future of the service.

A full options appraisal was developed and discussed by Trust Management Executive and Trust Board at end of July 2019.

Trust Board approved following option:

A short-to-medium term suspension of the Tertiary Surgical Service until such time that a new Leader is recruited to develop a strong, coherent, and effective team to deliver a world-class service and associated cutting-edge research, teaching and training.

Setting up collaboration with the Cancer Centres at Imperial and Southampton wherein they would accept referrals, in the short-medium term (8-12 months), from Oxford each month for tertiary level surgery in all Gynaecological Oncology tumour sites. This would also involve Gynaecological Oncology surgeons having blended contracts to enable them to operate with the teams at Imperial and Southampton. Surgical work would continue at cancer unit level in Oxford. Medical Oncology provision for all GO cancers would continue in Oxford.

Staff facilitation and organisational development work to be commissioned from an external expert to enable Tertiary Service to recommence.

Once the organisational development work/mediation is completed and the new Leader has implemented the required changes to the service, the surgical work will return to Oxford in a staged manner. Discussions between the OUH, NHS England and CQC have affirmed that the OUH needs to be a centre for Tertiary Services and that as the service rebuilds there will be flexibility in the reintroduction of Tertiary Services.

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