OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 19 September 2019 commencing at 10.00 am and finishing at 3.20 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen (Deputy Chairman) Councillor Mark Cherry Councillor Hilary Hibbert-Biles Councillor Laura Price District Councillor Paul Barrow City Councillor Nadine Bely-Summers Councillor Mrs Anda Fitzgerald-O'Connor (In place of Councillor Mike Fox-Davies) Councillor Jane Hanna OBE (In place of Councillor Alison Rooke) Councillor Kieron Mallon (In place of Councillor Jeannette Matelot)
Co-opted Members:	Dr Alan Cohen Anita Higham OBE Barbara Shaw
Officers:	
Whole of meeting	Sam Shepherd, Senior Policy Officer; Colm Ó Caomhánaigh, Committee Officer

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

46/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from:

District Councillor David Bretherton
Councillor Mike Fox-Davies (Councillor Anda Fitzgerald-O'Connor substituting)
District Councillor Sean Gaul
Councillor Jeannette Matelot (Councillor Kieron Mallon substituting)
Councillor Alison Rooke (Councillor Jane Hanna substituting).

The Chairman welcomed Anita Higham to her first meeting.

47/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Anita Higham declared a personal interest in that she will remain a Governor of Oxford University Hospitals until the end of September 2019.

Dr Alan Cohen declared a personal interest as a Trustee of Oxfordshire Mind.

Councillors Arash Fatemian and Kieron Mallon stated their local surgeries were involved in the Banbury merger referred to under Item 7.

48/19 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following requests to speak at this meeting:

Agenda Item 7 Oxfordshire Clinical Commissioning Group Update
Bill MacKeith - Oxfordshire Keep Our NHS Public

Agenda Item 8 PET CT Scanning
Bill MacKeith - Oxfordshire Keep Our NHS Public

Brexit Planning
Councillor Jane Hanna – Oxfordshire County Council

Councillor Hanna asked the Committee to consider planning for Brexit – in particular when discussing Agenda Item 10 Winter Plan. Operation Yellowhammer was only published in the last few days and too late for inclusion on the agenda for this meeting in the usual way.

There are risks across the whole system – long term and short term. A university study predicted that up to 12,000 extra deaths could occur between 2021 and 2030 as a result of increased food prices following a no-deal Brexit. The system for medicines is already creaking.

Councillor Hanna called for the publication of risk assessments for Oxfordshire. This Committee is the only democratic body in Oxfordshire where this issue can be discussed before 31 October 2019 – the proposed date for Brexit. Consideration should be given to having an extra meeting. Professionals on the frontline need support in this matter.

49/19 MINUTES

(Agenda No. 3)

The minutes of the meeting of 20 June 2019 were approved and signed with corrections to the list of Voting Members, correction of typos and, in item 38/19 on Agenda Page 4, first full paragraph, the insertion of “Banbury” before “Community Partnership Networks”.

50/19 FORWARD PLAN

(Agenda No. 5)

It was **AGREED** that the Integrated Care System will be a substantive item at the November meeting.

51/19 HOSC RECOMMENDATION TO THE BOARD OF OXFORD HEALTH FT

(Agenda No. 6)

David Walker, Chairman of Oxford Health, summarised the letter containing the OH Board's response to the Committee's resolution of 31 May 2019. He emphasised that OH and HOSC share the same common purpose to deliver excellent health services for the people of Oxfordshire.

At the Oxford Health AGM, later the same day, the main issues of work-related stress, inadequate staffing levels and heavy workloads will be discussed. These problems are experienced by all public bodies. He hoped that District Councils could particularly help in the provision of more social housing.

Councillor Laura Price asked if the emerging plans of the Integrated Care System (ICS) could help resolve these problems. She also asked if representations have been made to central government. City Councillor Nadine Bely-Summers noted that Oxford City Council had voted to support Oxford weighting in salaries and asked how that would be achieved. District Councillor Neil Owen stated that some people had expressed concern to him that increasing salaries would result in reduced resources for patients.

David Walker responded that the same problems of recruitment were seen across the Thames Valley area covered by the ICS. The first meeting of ICS addressed that and messages have been sent to central government. Oxford Health is a strong advocate of pay justice and wants to be able to pay competitively in order to recruit but the budget needs to be there to do that sustainably. His personal view was that the country needs to put more resource into the NHS especially given the aging population profile.

Anita Higham asked if Brexit was leading to a loss of staff. David Walker responded that it remains a threat rather than a measurable reality. Some staff fear that they will not be able to stay in the UK and this creates a debilitating insecurity.

Dr Alan Cohen asked how the type of misunderstanding that led to the Committee's resolution in May could be avoided in future. David Walker stated that he was very happy to attend meetings of the Committee and suggested that there should be a mutual attendance at Oxford Health's public meetings. He saw the Winter Plan as an opportunity to recalibrate.

The Chairman welcomed the suggestion and stated that attendance at partner meetings was being arranged. He asked for a commitment to flag issues earlier to the Committee.

David Walker **AGREED** to a "no surprises" approach but noted that OH would have to be trusted when it needed to make decisions in the interest of safety and practicability.

52/19 OXFORDSHIRE CLINICAL COMMISSIONING GROUP UPDATE

(Agenda No. 7)

Prior to consideration of this item, the Committee was addressed by the following member of the public:

Bill MacKeith of Oxfordshire Keep Our NHS Public expressed his group's concern at the proposal to merge the Clinical Commissioning Groups of Oxfordshire, Buckinghamshire and Berkshire West. He asked how the larger CCG could be effectively scrutinised. He urged the Committee to seek a full public consultation before any application to merge is made.

Louise Patten, Chief Executive Officer, summarised the CCG's update report. General Practices in Banbury continue to merge with the running of Horsefair surgery taken over by PML. It is not anticipated that there will be any change to services for patients.

On Gynaecology services, as a temporary measure to alleviate the waiting times for Oxford University Hospital (OUH), patients were given a list of alternative hospitals if they wished to be seen sooner. However, if they wanted OUH then they could still go there. There were no patients waiting 52 weeks in April 2019 and by June 2019, 66% were referred within 18 weeks for benign gynaecology. There is still more work to do. Patients with chronic pelvic pain are continuing to be offered referrals elsewhere due to the 39-week waiting time.

Professor Meghana Pandit, Chief Medical Officer OUH, updated the Committee on Gynaecology Oncology. The Royal College of Obstetricians and Gynaecologists were invited to review the service in January and delivered a final report in July.

All are agreed that Oxford needs to be a centre for tertiary services and that time was needed to reorganise. Diversions to Imperial Health will continue until a new clinical leader has developed a new team to deliver the service. That position has been filled to start this week.

Barbara Shaw asked if patients are still being referred out-of-county for gynaecology services, how long they have to wait and if Oxfordshire patients are receiving a poorer service. Louise Patten responded that hospitals work well together anyway. Other hospitals have shorter waits but people tend to prefer their local hospital if they are given a choice. Chronic pain is where they are asking GPs to encourage patients to go elsewhere but now for other services people are just informed of the longer wait in local services.

Councillor Hilary Hibbert-Biles asked that the Committee be kept involved in any possible changes to pathways. Louise Patten **AGREED** to do this.

Dr Alan Cohen welcomed the reports showing that everything was being done to reopen the City Community Hospital but asked if there was any progress on a wider county-wide strategy for community hospitals.

Louise Patten said that all providers are reporting workforce challenges. It needs to be tackled along with social care and she has already had discussions with the new Director for Public Health about it. It will need to start with workforce modelling. Louise Patten **AGREED** to scope the work to look at how the workforce challenges in health and social care locally limit the provision of community services.

The Chairman asked if it would not have made more sense in Banbury to merge Horsefair and West Bar surgeries as they operated in the same building. Louise Patten responded that the previous provider for Horsefair had a number of practices outside Oxfordshire and did not have much interest but the solution arrived at keeps the providers local.

With regard to Brexit, there are seven key areas for regional and national preparations and they are working to provide a readiness plan for the potential impacts. This is all part of emergency preparedness which the CCG does all the time. Each organisation has to have a Senior Responsible Officer. They work with the Local Resilience Forum. The A&E Delivery Board is cited on plans. Mitigation plans are being worked through. The CCG says no significant risks have been identified.

It will all depend on behaviours which may change as we get closer. There are regular regional and national events to share information. The three main areas are continuity of supply, reciprocal care (charging those not eligible for free services from 1 November) and communications.

Anita Higham asked if the departure of the Director of OUH would have any implication for continuity. Meghana Pandit responded that the Chief Operating Officer, Sarah Randall, was the officer with responsibility.

Councillor Jane Hanna asked if the risk assessments that support the statement of no significant risk can be published. Louise Patten responded that the risk assessments are subject to Freedom of Information requests anyway so she was happy to **AGREE** to publish them. She also **AGREED** to find out if they include issues raised in Operation Yellowhammer.

Members of the Committee asked about

- reported shortages of anti-depressants and HRT drugs;
- potential difficulties relating to drugs for epilepsy which cannot be stockpiled;
- who will have to pay for their care?;
- the number of staff who are EU nationals;

Louise Patten responded as follows:

- It is difficult to know if medicine shortages are due to stockpiling in advance of Brexit or not. She will raise the issue of epilepsy at the next regional meeting. Drug issues are handled at a national level.

- Who will have to pay for services will depend on the outcome of the Brexit negotiations.

Matt Akid, Head of Communications at OUH, added that they had 1500 EU staff and they were working hard to retain them.

It was **AGREED** that national and local risk assessments be shared with the Committee who can then collate a set of questions for the CCG to be answered in their next report.

53/19 PET CT SCANNING

(Agenda No. 8)

Prior to consideration of this item, the Committee was addressed by the following member of the public:

Bill MacKeith of Oxfordshire Keep Our NHS Public stated that his group was concerned that the provision of mobile scanners in the other areas of the Thames Valley region could have knock-on effects for Oxfordshire. He understood that many clinicians believed that the mobile scanners were inferior and that scans would have to be redone at the Churchill Hospital in Oxford.

He asked the Committee to contact other local authorities in the region to coordinate support for public provision of services and to require a six-month report from NHS England to measure performance of the services in the different centres.

Janet Meek, Director of Commissioning South East, NHSE, described the collaborative approach that has been agreed. The OUH service based at Churchill Hospital will be retained on a separate contract directly with NHSE. New services in Milton Keynes, Reading and Swindon will be run by InHealth. The agreement increases access and will reduce waiting lists.

Dr Bruno Holthof, Chief Executive OUH, stated that the new contract met their requirements and would allow them to invest in new scanners. They were keen that pathways be maintained especially those involving multi-disciplinary teams. Any changes will be clinically-led.

Nicola McCulloch, Head of the Cancer Programme of Care, Specialised Commissioning NHSE, confirmed that this was NHSE's view. Clinical consensus would include cancer groups.

Louise Patten, Chief Executive OCCG, added that there was a lot to be learned from the process in terms of how to engage locally in national procurement. This will set a precedent for others. There will be a local specialist commissioning board for the Oxfordshire services moving forward.

Councillor Laura Price asked what NHSE had learned from this. The feeling was that they presented a blank wall to those expressing concerns. She also asked if there was a danger of duplication if mobile scanners produced inferior quality scans, that

then had to be redone at Oxford. She was also concerned that waiting times might be used to nudge Oxfordshire residents towards the services outside the county.

Janet Meek and Nicola McCulloch confirmed that there would be much earlier and greater engagement. All parties recognise their responsibilities. Changes suggested by clinicians were taken on board. They would have to make sure that they heard directly from HOSC.

Dr Bruno Holthof stated that the feedback on their original bid was that it focussed mostly on clinical quality whereas access was a key issue too, which the trust had not prioritised in its bid. Increased capacity in Thames Valley will help cope with expected increases in demand. If scans need to be redone this will be registered as a serious incident as it increases the patient's exposure to radiation.

Janet Meek confirmed that the contract is for seven years with an option for three more. The Long Term Plan envisages earlier diagnosis and the increase in capacity will help deal with this.

City Councillor Nadine Bely-Summers asked if there would be more investment in the Churchill Hospital or if this was really about privatisation.

Janet Meek responded that only the new services were being supplied by InHealth. Investment in OUH will continue. All providers go through a rigorous process and must work closely with the NHS and clinicians. Nicola McCullough added that there had been a procurement process for the extra services and InHealth was the only bid offering services on the wider geography.

Dr Alan Cohen asked if the situation had not been inflamed by threats of legal action by NHSE. The Chairman stated that he understood there were threats made from lawyers to lawyers regarding staff speaking out. He asked for assurances that this would not happen again.

Janet Meek stated that she would not support that, never instructed it and would not ever do so.

Councillor Jane Hanna asked if the procurement arrangements took account of research networks and if there was any difference in terms of accountability and grievance processes between public and private contracts.

Janet Meek responded that all contracts are managed and evaluated the same way with the same grievance procedures including the Ombudsman. Research is outside of core NHSE services. A question about this is included in the bidding process. In this case, both providers are able to do research.

The Chairman thanked Members of the Committee for their robust scrutiny and welcomed the outcome as being in the best interests of the residents of Oxfordshire. He asked for confirmation that no consultation was needed since there was no change of service. He also asked when would be the best time to receive a follow-up report – including pathways, number of patients and patient flows – and if the contracts had actually been signed at this stage.

Nicola McCulloch said that the contracts were still being finalised and confirmed that no consultation would be required. She **AGREED** to provide a follow-up report as requested. It would need to be a joint report and will include notifications of any serious incidents. She suggested early in the new year.

54/19 INTEGRATED CARE SYSTEM

(Agenda No. 9)

Louise Patten, CEO OCCG, gave a presentation on progress and plans with the Integrated Care System. This is a way of working regionally. It is not creating new organisations. For planning and commissioning the level of population makes sense. The counties share the characteristics of additional population growth and an aging population.

Integrated Care Partnerships, involving health and social care, are certainly at the best level of population for commissioning and provision. For example, with discharge from hospital we need to look at the cost of everything and then see is there a way of working differently to change the provision at a cost that works. A budget would be delegated to Oxfordshire and local accountability would remain.

With ICS the partnership at this scale makes sense for dealing with workforce, digital and prevention issues. It is all a bit empirical at this stage but she can provide examples of how it is working elsewhere.

There is a certain inevitability of the CCGs merging. It will free up money for services. The process includes consultation – an engagement document has been drawn up with the initial thoughts. The timescale is being worked on.

From April 2020 it will shadow the ICS but will have more form at that stage and it will be clearer how it relates to HOSCs and the Health and Wellbeing Boards.

At the request of the Chairman, Louise Patten **AGREED** to share the maturity assessments.

Anita Higham asked where the patient voice would be in this. Louise Patten responded that Patient Participation Groups are the patient voice in primary care. They can vary greatly in how they operate. There will be a contracting group for a PCN rather than for individual practices. The commissioning process will set expectations for PCNs and will need to state that they are expected to have the patient voice represented.

Councillor Laura Price asked to what extent the ICS is a Sustainability and Transformation Partnership (STP) rebranded. The language is the same: it's a way of working not a body. She also asked how the different financial positions are being managed and what the relationship will be with Adult Social Care.

Louise Patten said that the STP is a difficult concept to communicate. They will only work together where it adds value and makes efficient use of NHS resources. There

are many overlaps and much learning that can be shared. At this higher level the scale is enough to have our own Special Commissioning Board. People locally can sit on that and influence it. There is more form on ICS than before, but the statutory organisations still exist. Different providers such as OUH and Royal Berkshire Hospital are starting to work together on common issues to support choice and outcomes for people. With regard to different financial positions, all have got challenges and they can be better tackled by working together. There is an aspiration to bring together health and social care. This will be developed further with outcomes-based work.

The Chairman suggested and it was **AGREED** that ICS be a more substantive item on the Committee's agenda for the November meeting with adult social care represented.

Dr Alan Cohen said that the difference between purchaser and commissioner was not clear. There appeared to be more movement towards commissioning. He asked, if there is going to be closer working between health and social care, what the role of the CCG will be and could it be a case of getting rid of the CCGs?

Louise Patten responded that what CCGs did was to engage clinicians and that engagement must not be lost. Historically commissioning described what we want and they bid. Now it works on describing the outcomes, setting up frameworks so patients get a better experience as they go through the system. Some commissioning functions are not needed anymore. What is needed is analysis, planning and making sure the outcomes are being achieved. Some commissioning needs to happen at scale, in particular special commissioning such as Mental Health. It's not about CCGs getting bigger. The role is changing.

District Councillor Paul Barrow asked what the estimated savings would be over five years and how they will be distributed. Louise Patten stated that each CCG has to achieve a 20% reduction in running costs - including the cost of clinicians and services bought from Commissioning Service Units. The money is expected to be recycled into clinical services. There may be a single management team with more money put back into the front line.

Anita Higham asked what the governance arrangements will be in a CCG merger. Louise Patten noted that no decision has been made to merge but where they have, there is a single board with the same representation as currently. There will be an engagement exercise to go through.

55/19 WINTER PLAN 2018/19

(Agenda No. 10)

Diane Hedges, CEO OCCG, gave a presentation. She described the learning from last winter. A number of aspects showed improvement: shortened hospital stays and reduced waiting. Schemes that need new staff struggle. The 'home first' approach is important - avoiding someone going into hospital in the first place. They are integrating mental health into the planning.

Sam Foster, Chief Nursing Officer OUH, said that a key aim is to reable more quickly and release capacity. She emphasised that health was not just about hospital beds and that there was no “Winter Ward”.

The Chairman noted that last year a commitment was made to send weekly updates but none were received. He asked for a commitment again and that it be followed through. He also asked for clarification on the target for the Home Assessment Reablement Team (HART).

Benedict Leigh, Deputy Director Commissioning OCC, responded that the target for HART Contingency Hours was 600 and the actual outcome was 447. These are hours that HART can use to support people to leave hospital quickly while a longer term solution is found. So a reduction in the hours needed is a positive indicator.

Diane Hedges apologised for the absence of weekly briefings last year and **AGREED** to provide them this year. They will need to discuss what is most useful to include.

Councillor Mark Cherry asked how they were set up to cope with any heavy snow fall, for example how will patients be transferred?

Ross Cornett, Head of Operations Oxfordshire, South Central Ambulance Service, responded that they have a 4x4 but could not have a whole fleet of them based on the need for a few days of the year. They would get assistance from the local resilience forums and through the County Council prioritising roads around hospitals for gritting.

Councillor Laura Price asked with the trusted assessor model if private providers are being asked to do an assessment and if their assessments can be believed? She also asked if the £1.4m fund included the Better Care Fund and Improved Better Care Fund.

Benedict Leigh said that short-term beds would be sourced from private and voluntary sectors. They have brought together the various schemes to create a more coherent offer. It was a much clearer way of buying short-term beds and being supported by multi-disciplinary teams. They are asking all to trust the assessments of other people and developing relationships between those in the system. He **AGREED** to circulate more detail through a briefing around this next week. He confirmed that the BCF and iBCF are not included in the £1.4m.

Dr Alan Cohen said that the Section 136 figures looked extraordinary. He asked if the planning on beds was with or without the Fulbrook Centre and if there would be an impact on the strategy for community beds.

Diane Hedges **AGREED** to come back on the section 136 numbers to explain them. On Community Hospital beds, they have made the same assumptions as last year. With short term beds, throughput will be different to acute beds.

Pete McGrane, Clinical Director OH, said that there would be recommendations next week on the City Community Hospital. They gave a commitment to reopen it through

recruitment. Winter planning excluding CCH is for 140 beds and he thought they will open more beds than that.

Barbara Shaw noted that families often underestimate the amount of unpaid care needed. She asked what they are doing to ensure right levels of care and not over-reliance on unpaid care and for the number of readmissions.

Sara Randall, Chief Operating Officer OUH **AGREED** to provide readmissions numbers. Sam Foster added that they use a clinical assessment in the home with the family to determine how much support people need. Readmissions are not always a bad thing.

Councillor Jane Hanna raised a number of issues:

- She asked to see a list of all the acuities to see where the pressures are coming from.
- Does the £1.4 million include Brexit?
- When will the Emergency Medical Unit will be live?
- What is the latest on the temporary closure of Wantage Community Hospital?

Diane Hedges **AGREED** to provide a list of acuities and an update on the EMU. It has been agreed to have an Urgent Care Leader. Sam Foster is writing the scope to ensure there are structures in place.

With regard to Wantage CH, patients are moved to where the bed is most appropriate, irrespective of where they live, in order to get the best outcome. They are looking at the blend of services and beds needed. Workforce problems make it difficult to keep beds open.

The Chairman noted the commitments to provide information on trusted advisors, winter weekly updates, section 136 growth, readmissions data, EMU and risk assessments. He asked for them all to be circulated within two weeks of the meeting.

56/19 TRANSITION OF LEARNING DISABILITY SERVICES

(Agenda No. 12)

Helen Ward, Deputy Director of Quality, OCCG, introduced the report. There have been significant improvements since Oxford Health NHSFT took over provision of services. Mainstream services have become more accessible for those with Learning Disabilities and autism. There is a self-assessment toolkit available. Before 2017 there was no local inpatient provision but now nearly half are being treated within Oxfordshire. They are reliant on independent providers for specialised services. The Oxford Health contract is monitored through a range of information including serious incidents and complaints.

The LeDer programme involves reviewing the deaths of people with a learning disability and helps identify proactive work to address any factors that may have contributed.

Kirsten Prance, Associate Clinical Director of Learning Disability Services at OH, added that the aim is to support all those with LD where there is ability to have life expectancy the same as the rest of the population. They work in partnership with Adult Social Care and provide supported living placements where there are changes to family support.

Benedict Leigh stated that Oxfordshire Family Support Network have targeted support specifically for parents supporting an older adult to ensure they have a sustainable home available.

Dr Alan Cohen asked if health outcomes are being measured. Helen Ward responded that people with LD have an annual health check. The LeDer programme nationally has data on this. People with LD have the same issues as the general population but do not access health care services as much. For example, annual health checks found two previously undiagnosed conditions when first rolled out.

Kirsten Prance added that the priorities in terms of physical health are diabetes, respiratory health and bowel management.

Councillor Jane Hanna asked about epilepsy given that, in some areas, 25% of people with LD have epilepsy.

Kirsten Prance responded that the LD team have a comprehensive toolkit. There are usually a range of other health needs associated with epilepsy. There is a special clinic for complicated cases. Every death is reviewed but none has been found to be directly from epilepsy.

The Chairman noted that it was rare for a service to receive 43 compliments and seven complaints, but it was clear that they were not resting on their laurels.

57/19 DENTAL SERVICES AND DENTAL HEALTH IN OXFORDSHIRE

(Agenda No. 13)

Anna Ireland, Consultant in Dental Public Health (Thames Valley), Public Health England South East, stated that dental health in Oxfordshire is good compared to the national average but, as with general health, there are more problems in some groups, especially the young, the old and the poor.

Hugh O'Keefe, Contract Manager for Dental Services, NHS England South Central, added that in the Thames Valley there has been a 30% increase in people accessing NHS dentists in the last ten years which is a higher rate of growth than for other areas.

There are about 280 NHS practices in the Thames Valley and 150 private providers. Work focuses on deprived areas with "Starting Well" pilots. They are also looking at how to provide dental services in care homes.

Dr Eunan O'Neill, Consultant in Public Health OCC, described the oral health promotion service which is trying to improve knowledge and behaviours. They have trained people to work with children and adults as well training care home workers in

older adult oral care. A report by the Care Quality Commission helped in shaping the response. Care plans should include oral health.

The Chairman noted that he had seen nursery school children being encouraged to brush their teeth after lunch and asked if this was common.

Anna Ireland said that it was becoming more commonplace but was not universal. Eunan O'Neill added that they had piloted toothbrushing in primary schools but it was difficult to get schools to keep it up.

Barbara Shaw noted a couple of references in the report to data to be released shortly but one of these referred to data from 2016. She also asked about variations in the numbers of UDAs Commissioned.

Anna Ireland described two types of survey. A national survey was delayed due to confusion over who should pay. A survey commissioned locally in 2016 on 'mildly dependent' was carried out locally but the data is "cleaned" nationally. Both are due but there are no timelines.

Hugh O'Keefe said that the number of UDAs is dependent upon the new contracts and how much NHS dentistry is involved. Cash limiting was introduced in 2006 in areas where there is pressure on contracts and so reflects where demand is and explains the variation.

Councillor Kieron Mallon asked if there was a connection between bad oral health and heart disease. Anna Ireland said that there were links with aspiration problems and pneumonia but any association with heart disease was not understood.

Anita Higham asked if there were differences between ethnic groups and if more attention should be paid to 11 to 14-year-olds. Anna Ireland responded that there were different decay rates in different ethnicities but there was no data on brushing. 11 to 14-year-olds in the UK had quite good oral hygiene. They are most likely to attend a dentist and so would not be a group they would target.

District Councillor Paul Barrow asked what were the high risk groups. Dr Eunan O'Neill said that they target high levels of deprivation where they provide an offer with schools. They are moving towards an accreditation programme with primary schools with policies on sugary food, water etc. Some look to use the pupil premium to invest.

Barbara Shaw asked how they are linking with community dental services and care homes. Dr Eunan O'Neill responded that they went to a workshop with Healthwatch Oxfordshire and looked at aspects of the care plan. They want to establish an accreditation where staff can do online training that will be free and quick. Face-to-face training is also available.

58/19 MUSCULOSKELETAL (MSK) SERVICES

(Agenda No. 14)

Diane Hedges, CEO OCCG introduced Rob Walker, Senior Operations Manager, Healthshare and invited questions on the report.

Dr Alan Cohen noted that the last meeting of the Committee asked for EQ5D data but has not received any. There is debate about which measure and then how you measure. He asked for a demonstration on how patient feedback is being used to improve care.

Rob Walker stated that EQ5D is used to benchmark for the CCG. The information is independently gathered. He **AGREED** they can share the data and members are welcome to visit and see for themselves. Dr Cohen asked for one example of a PDSA cycle.

The Chairman asked if physiotherapists employed by Healthshare are getting their uplift according to Agenda for Change. Robert Walker responded that all staff "tupe'd" across came with their terms and conditions. There are band increases every year and Healthshare gave a 1% rise. The Agenda for Change uplift is unprecedented so they are discussing with the CCG what they can do. It was **AGREED** to receive a report back on this when discussions are complete.

Anita Higham gave the example of where a patient is referred to a physiotherapist, all of their notes are given to them. How are patients' GDPR rights managed in such a situation.

Rob Walker said that referrals us a pro forma. He was only aware of two incidents where extra information was given. It is incumbent on GPs to do this correctly. Diane Hedges added that clear advice has been given to GPs following investigations into the cases and they were particularly advised to be aware of the issues around auto-population of data.

Councillor Hilary Hibbert-Biles asked why provision in Chipping Norton is not in Chipping Norton Hospital. Rob Walker said that they engaged with the hospital at the time but there was no space so they took space in the health centre that is just next door.

Barbara Shaw asked if they identify and support patients who have suffered from delay in referral. City Councillor Nadine Bely-Summer said that she had been told there is a six month wait. Rob Walker stated that times are always within the KPI. They need to engage with GPs more.

The Chairman commented that 56 days was still not great. Rob Walker responded that 8% of the population is referred every year. They have new staff coming in.

The Chairman stated that if the EQ5D data, up to date data on waiting times and an update on Agenda for Change are delivered in good time, then this does not need to be on the agenda next time.

59/19 HEALTHWATCH OXFORDSHIRE

(Agenda No. 15)

Rosalind Pearce presented the update report and will share it with the Task and Finish Group.

Healthwatch meets with the Chief Executives on the Buckingham, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) - formerly the Sustainability Transformation Partnership (STP). They are concerned that there is no stakeholder involvement at BOB level but only at county level and
that strategies and decisions are taken without local involvement.

She wished to make it clear that Healthwatch is a patient voice and is not signing things off. They have been asked to do more at BOB level but that is outside of their remit and they are negotiating for resources to deliver this.

Healthwatch has no input into the Integrated Care Partnerships either. There is a reporting process to the Health and Wellbeing Board. Healthwatch wants Patient Participation Groups to be strong in their Primary Care Networks.

A problem Healthwatch has identified is with access to dentistry in care homes. A visit can cost £150 for patients to access (with taxis and paid time for carers to accompany care home residents) and clinics are often upstairs. They stressed the need for commissioners not to commission dentists who have not addressed access issues.

BOB does not meet in public. Their argument is that this happens at county level where the decisions are made.

Dr Alan Cohen asked if it is difficult for Healthwatch to represent all of the voices on HWB and BOB - voluntary sector, patients – while looking to them for finance.

Rosalind Pearce responded that Healthwatch will not compromise its independence and she is happy to be challenged on that point. They get funding from the County Council but that does not stop them being critical.

60/19 CHAIRMAN'S REPORT

(Agenda No. 16)

Councillor Hilary Hibbert-Biles noted that the Health and Wellbeing Board (HWB) and the Integrated Care System (ICS) are supporting each other and asked who will be scrutinising their decisions. The Chairman stated that this Committee scrutinises the HWB regularly. Where scrutiny of ICS sits will need to come out at the November meeting.

..... in the Chair

Date of signing .....