Health & Adult Social Care Select Committee agenda

Date: Thursday 4 March 2021

Time: 10.00 am

Venue: Via MS Teams

Membership:

K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins (Vice-Chairman), G Hollis, S Jenkins, J MacBean (Chairman), G Powell, B Roberts, A Turner, L Walsh, J Wassell, L Wood and Z McIntosh (Healthwatch Bucks)

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Agenda Item		Time	Page No
1	**Apologies for absence/Changes in Membership**	**10:00**	
2	**Declarations of interest**		
3	**Minutes** To confirm the minutes of the meeting held on Thursday 7th January 2021.		**5 - 16**

4 Public Questions

There were no public questions submitted for this meeting.

5 Chairman's update **10:05**

For the Chairman to update Members on health and social care scrutiny related activities since the last meeting.

6 Update from Healthwatch Bucks **10:10** **17 - 18**

The Committee will receive an update on the recent key projects for Healthwatch Bucks.

Presenter:
Ms Z McIntosh, Chief Executive, Healthwatch Bucks

Paper:
Update attached

7 Update from Buckinghamshire Healthcare NHS Trust **10:15** **19 - 30**

The Committee will receive a verbal update from Dr T Kenny, Medical Director on the current Covid situation at the Hospital and the recovery plans for bringing services back.

The Committee will then hear from Ms Heidi Beddall, Head of Midwifery at Buckinghamshire Healthcare NHS Trust following the publishing of the Ockenden Report in December 2020.

Background on the item:

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

Following the review of 250 cases, the emerging findings and recommendations from the independent review of maternity services at the Hospital were published in December 2020 and the report highlights the actions which the independent review believe need to be urgently

implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning that should be shared and acted on by maternity services across England.

Presenters:
Dr T Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust
Ms H Beddall, Head of Midwifery, Buckinghamshire Healthcare NHS Trust

Papers:

- Link to Ockenden report below

OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (donnaockenden.com)

- Buckinghamshire Healthcare NHS Trust's response to Immediate and Essential Actions – December 2020
- Buckinghamshire Healthcare NHS Trust's response – February 2021
- Assurance Assessment template – February 2021

8	**Dental services**	**10:45**	**31 - 50**

The Committee will hear from representatives from the NHS Dental Services Commissioning team and the Local Dental Committee on how dental services are currently commissioned in Buckinghamshire, how services have been accessed during the pandemic and some of the challenges faced by dentists over the last few months.

Presenters:
Mr H O'Keeffe, Senior Commissioning Manager Dental, NHS England and NHS Improvement – South East
Mr S Moonga, Clinical Director, Senior Dentist, Local Dental Committee

Papers:

- Cover report
- Profiles – information to health systems
- Dental profiles for Buckinghamshire, Oxfordshire and Berkshire West
- Delivery of Urgent Dental Care briefing paper – November 2020
- Delivery of Urgent Dental Care briefing paper – December 2020

9	**Adult Social Care** The Committee will review the key issues facing Adult Social Care, including the service area's response to Covid, pressures on the workforce, support to carers over the last few months, vaccinations in care homes, support to care providers and an update on the Better Lives Transformation programme. **Presenters:** Ms A Macpherson, Cabinet Member for Adult Social Care Ms G Quinton, Corporate Director, Adult Social Care and Housing **Papers:** Report attached	**11:45**	**51 - 56**
10	**Work programme** This item will provide Committee Members with an opportunity to reflect on the work of the Select Committee over the last few months and propose work programming ideas for the new Committee to consider after the Election. Attached is a "HASC highlights document" which has been produced to capture the work of the HASC over the last few months and to aid the HASC Select Committee in the new council. **Presenters:** All Committee Members **Papers:** HASC Highlights document	**12:45**	**57 - 62**
11	**Date of next meeting** Due to the Elections taking place on 6th May 2021, this is the last Select Committee meeting before the new Council. Dates of future meetings to be advised.	**13:00**	

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For further information please contact: Liz Wheaton on 01296 383856, email democracy@buckinghamshire.gov.uk.

Health & Adult Social Care Select Committee minutes

Minutes of the meeting of the Health & Adult Social Care Select Committee held on Thursday 7 January 2021 in via MS Teams, commencing at 10.05 am and concluding at 1.00 pm.

Members present

K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins, G Hollis, S Jenkins, J MacBean, G Powell, B Roberts, A Turner, L Walsh, J Wassell and Z McIntosh

Others in attendance

Mrs E Wheaton, A Macpherson, D Gibbs, Dr J Kent, N Macdonald, R Majilton, D Williams and S Taylor

Apologies

L Wood

Agenda Item

1 Apologies for absence/Changes in Membership

The chairman apologised for the delayed start of the webcast which was due to technical issues. Apologies had been received from Cllr Lawrence Wood but were not known until after the meeting.

2 Declarations of interest

Cllr Alan Turner declared a non-pecuniary interest as a trustee of an independent adult day care provider charity.

Cllr Guy Hollis declared that he worked as a Community First Responder for the South Central Ambulance Service.

3 Minutes

Cllr Patricia Birchley referred to the action under item 8, [Pharmacy Services] on page 17. Cllr Jane MacBean, the Chairman, confirmed she had contacted Cllr Gareth Williams, Chairman of the Health and Wellbeing Board (HWB), regarding pharmacy representatives being invited to attend the HWB meetings. Cllr Williams had advised it would be difficult as it would mean also inviting several other organisations. The Chairman stated she would continue to work with the HWB to ensure pharmacy representation at relevant HWB meetings as it was vital that they had an integral

part of any planning for key services.

RESOLVED: The minutes of the meeting held on 5 November 2020 were AGREED as an accurate record.

4 Public Questions

Councillor Jon Harvey from Buckingham Town Council read out the following question:

"Buckingham Town Council notes that "Two community hubs are being piloted in Marlow and Thame to help patients take greater control over their care and treatment and avoid hospital admissions" as part of plans to establish an ICS across Bucks.
https://www.england.nhs.uk/integratedcare/integratedcaresystems/buckinghamshire-ics/our-current-projects/
Please can the ICS Leads explain whether it will be one of the ICS priorities to establish something similar with the Buckingham Community Hospital within the next 5 years? And moreover, how will the introduction of the ICS across Bucks noticeably affect the lives of Buckingham people? And how will Buckingham people be able to have a say about all this?"

Neil Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust (BHT), advised that the community hub provision was a Place-based decision and BHT would publish a Strategy towards the end of this financial year which would include a roadmap for the establishment of community provision. N Macdonald added that it was slightly more complicated in Buckingham as the links to hospital services were with Milton Keynes.

Dr James Kent, Accountable Officer, Integrated Care System (ICS,) explained that the ICS consisted of three Places [Buckinghamshire, Oxfordshire and Berkshire West] and Dr Kent referred to paragraph 1.15 [page 35 of the agenda pack] which listed the aims of integrated care which would be achieved at Place through strong partnership working. Residents would notice greater joined up care, particularly in primary care. There would be less duplication, greater collaboration across providers and shared best practice. Patients and residents would have their say through the normal channels including Patient Participation Groups. If any service changes were planned the normal consultation process would be undertaken.

Cllr Harvey encouraged further public engagement on the issue of health care in Buckingham and advised he was interested in how the ICP would affect people across the whole county and hoped that residents would be involved in systematic changes. The Chairman assured that the Health and Adult Social Care (HASC) Select Committee would be reviewing and challenging the ongoing development plans of the ICP.

The Chairman read out the question below which had been submitted by Ozma, Save Wycombe Hospital Campaign:

How were the Marlow and Thame hospital buildings used during the first wave of the pandemic? Would it be sensible to prepare to use them as step down wards for Covid patients now that numbers in Bucks of Covid cases were on the increase again?

N Macdonald stated that the hospital buildings were used to support the physical location of the community teams, particularly for frail, older people. It would not be sensible or practical to re-establish them as wards as the ability to staff the wards would be more acute than before.

The Chairman advised that three further questions had been received from Ozma and written responses were included in the agenda pack for this meeting. Cllr Khalil Ahmed expressed concern over the substance and brevity of the responses provided. The Chairman suggested Cllr Ahmed speak to Ozma and request any further clarification needed.

The meeting was paused at this point and reconvened after 30 minutes due to technical issues.

5 Chairman's update

The Chairman advised that a draft response to the NHS consultation document was being prepared on behalf of the HASC Select Committee and would be finalised and circulated to the committee members after today's meeting. The deadline for submission was Friday 8 January 2021.

6 Update from Healthwatch Bucks

The Chairman welcomed Ms Zoe McIntosh, Chief Executive, Healthwatch Bucks, and advised that information had been supplied in the agenda pack for noting; any follow up questions could be provided to Ms McIntosh outside of the meeting. The Chairman added that she was pleased to have Ms McIntosh on the HASC Select Committee in order to gain a better understanding of residents' views of the healthcare services and ensure that the committee work dovetailed with the work carried out by Healthwatch Bucks.

Before moving on to the next item the Chairman stated she had made the decision, due to lack of time, to stand down Cllr Angela Macpherson, Cabinet Member for Adult Social Care; Cllr Gareth Williams, Cabinet Member for Communities and Public Health; Mrs Gillian Quinton, Corporate Director, Adults, Health and Housing and Dr Jane O'Grady, Director of Public Health, for Item 9, Winter Provision and Covid Update as other items needed to be considered in greater detail.

7 Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

The Chairman welcomed Dr James Kent, Accountable Officer, ICS. Dr Kent explained that the ICS was a system of three Places; Buckinghamshire, Oxfordshire and Berkshire West, and within each Place there were partnership arrangements which were called ICPs. The change had occurred approximately two years ago.

Dr Kent stated that the Integrated Care document, included in the agenda pack, was published by NHS England (NHSE) in November 2020; it outlined the way forward for the ICS and included two options on how to put each ICS onto a statutory footing. NHSE's preferred option was Option 2, whereby the Clinical Commissioning Groups (CCGs) would be subsumed into the statutory ICS. The purpose of the ICS was to drive forward all elements of the long term plan and Dr Kent emphasised that the Integrated Care document was a managerial and organisational document rather than a strategic document in terms of services and the majority of the paper was in line with the current direction of travel. Systems started from strong Places and the paper clarified the role of Place, which centred around local services and urgent care services and indicated the services which were likely to be commissioned at a system level; these tended to be some of the more specialised services. Several areas needed more detail, such the scrutiny process and the governance; these would be worked on between now and March 2022. If the second option was agreed it would also need to be decided how the voice of Primary Care was heard. The document provided clarity on the leadership roles to be recruited to in the ICS.

The following points were raised in discussion with Committee members

- The Chairman requested the timescale for when further information would be provided. Dr Kent advised that there was a large amount of work to be carried out before September 2021 but the ICS was currently working in the direction of travel and his personal view was that plans would need to be broadly configured by January 2022; however the timeline of March 2022 was dependent on the operational challenges of the pandemic being over by March/April 2021; if not, the date could slip.
- It was noted that there was little mention of social care within the report. In response, Dr Kent agreed that the document was overly health focussed; it started with the need for strong Places in order to ensure good integration between health and social care. The health and social care services would be commissioned at a local level and would build on work already underway in terms of joint commissioning and governance arrangements.
- A Member commented that social care was provided by Buckinghamshire Council (BC) and the report discussed pooled funding of resources. When asked if this would also apply to social care; Dr Kent stated that he had no information on social care funding flows but had not seen anything to suggest that it would change.
- A Member requested an update on how the establishment of the Primary Care Networks (PCNs) was progressing. Dr Kent advised that the PCNs had been formed and were expanding the number of resources e.g. pharmacists, physios and allied health professionals; some worked well, but others had teething issues. The Chairman added that the HASC Select Committee had increasing concerns over the development of the PCNs
- In response to being asked how patients knew which PCN their practice belonged to, Dr Kent explained that it was an organisational construct and the patient's front door remained their GP practice.
- The Chairman raised a concern about how PCNs would work once the CCGs

had merged into one. Dr Kent stated that there would a Lead for each Place who would liaise with the PCNs.

- A Member asked how budget decisions would be made as currently there were financial differences across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) area; Buckinghamshire traditionally received 12% less funding than the national average. The Member asked if Buckinghamshire residents would get their full share of funding, whether a scrutiny function would be set up and hoped that GPs would have more time for their patients. Dr Kent advised that the ICS had been operating under a different financial regime throughout the pandemic and he was unable to say what the financial position would be once the pandemic was over. The Integrated Care document was clear that funding resources should follow need; it was not known if that would be across the three counties or specific for each county. The ICS needed to be open and transparent and would welcome scrutiny on funding. Dr Kent shared the same hope for more GP time for patients.
- In response to a question on a change to the ownership of Continuing Health Care; Dr Kent stated that he was not expecting any changes; if option 2 was agreed, the CCG functions would be subsumed into the ICS.
- A member asked if the proposal would come to fruition by March 2022. Dr Kent advised he was confident the date would be met as the ICS was broadly operating as outlined in the document; it was a case of formalising what was currently carried out. There had been a huge amount of collaborative working throughout the pandemic and people had seen the benefits; however, getting the health legislation through parliament could be challenging.
- The Chairman commented that in previous presentations, it was stated that 30% of activity would be carried out at ICS level and 70% at ICP level but there was no clarity on what the ICS would be responsible for and what would be handled by the ICP. Dr Kent advised that he was unable to confirm the exact percentage split but confirmed that most urgent and emergency care pathways would be commissioned at Place, apart from the 999 and 111 services. Additional primary care services to the national contract would be commissioned at Place. Planned care would be at a system level along with specialised commissioning but there were some grey areas such as mental health services. The Chairman advised that the HASC Select Committee was concerned about the outcomes for residents if there was to be consolidation of services to Centres of Excellence which would attract more funding and greater expertise but would come at a cost if residents had to travel across three counties in order to access them.
- One of the Members asked for reassurance that Wycombe and South Bucks would not lose out financially; Dr Kent reiterated that the new financial regime had yet to be published. Within Buckinghamshire, over time, as the paper outlined, there was a view that there would be Place-based budgets for services, and it would be for the ICP to determine how the budget was spent. Dr Kent emphasised that the intent was to allocate funding to the areas of greatest need and that would be the goal at system level and Place

level. The Chairman added that she looked forward to seeing more detailed plans in the future.

The Chairman thanked Dr Kent for his contribution.

8 County-wide engagement exercise

The Chairman welcomed Mr David Williams, Director of Strategy, Buckinghamshire Healthcare Trust, and referred to the paper in the agenda pack. D Williams recapped that Mr Dan Leveson, Deputy Director of Strategy had presented a verbal update at the last meeting. The engagement exercise had been developed around the following four themes - reducing health inequalities, community services, keeping people safe and digital appointments. Phase two had been completed in order to obtain richer data, particularly from Black and Minority Ethnic (BAME) groups, carers and patients with disabilities and long-term conditions (LTCs). 83 members of the public were part of the second phase; 25% were from the BAME community, 27% were carers and 33% had a disability or LTC. D Williams highlighted the following points:

- Digital appointments were working well but residents were concerned that face to face appointments may not be available in the future. More communication was required to reassure residents that face to face appointments would continue where necessary.
- Keeping people safe - further communication was required regarding NHS 111 services to ensure efficient use of A & E resources.
- Residents were willing to travel further for a one-off appointment if it resulted in being seen earlier but not for regular appointments; particularly older people and if the journey was on public transport.
- BHT was committed as a partnership and needed to work harder with communities on how to change and deliver services. D Williams emphasised that BHT would work with the HASC Select Committee and the community if any changes were to be made which would impact on the residents.
- Community services – many people had experienced integrated care and the idea of community hubs and joined up care was well received. Recovering at home was preferable, if possible.
- Information on beds in the community hospitals would be provided in the report.
- Residents were receptive to information on lifestyle choices but did not like being preached to about what was good or bad. It was noted that work should be carried out with children and families to change habits.
- BHT acknowledged the need to improve communications regarding changes to services and the 'tone' of communications was important.

The following points were raised in discussion with Committee members

- A Member requested that the final report be written in 'plain' English; D Williams agreed and suggested that some of the committee members could help with the terminology for future reports.
- It was suggested that the focus groups be asked why they had not completed

the survey when it was first released.

- A Member referred to one of the public questions [question one on page 21 of the agenda pack]. D Williams acknowledged that the survey was carried out digitally which precluded some residents from taking part and this was the reason phase two of the survey was undertaken. The Community Boards were now established and would be an excellent way in which to engage with residents. The Chairman highlighted that 20,000 free text survey responses had been received and advised that the HASC Select Committee were keen to see these as part of the final report.
- It was noted that the report had been delayed; D Williams confirmed that the report would be completed within the next two weeks and would be discussed at the next Buckinghamshire ICP meeting. The Chairman stated that the HASC wanted to review the findings of the report and asked that this be factored into the project timeline.

The Chairman thanked David Williams for attending the meeting.

9 Winter provision and Covid update

Mr N Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust, advised that the infection rate was still very high in Buckinghamshire and the new variant of Covid was the driving cause of the pressure on the NHS.

During November, the new variant accounted for 5% of Covid cases; last week it had risen to 72%. Firstly, the critical care units were operating at 150-200% above normal capacity and there were other patients who were less unwell but still required hospital treatment and was almost double the number of the peak on 7 April 2020. There were currently 6-7 in-patient adult Covid wards at Stoke Mandeville Hospital. There had been a lower than expected demand for patients with flu, but the pressure far exceeded what was normally seen in the winter.

The second challenge was to safely manage people in hospitals which had implications in terms of the number of patients seen. The third challenge was the workforce as health care workers were 30% more likely to contract the virus and approximately 10% of nursing rosters were affected. There was significant pressure on the ability to maintain the level of activity. The medium and long-term mental health impact of working in such an environment would cause staff to become exhausted. The pressures were replicated in the ambulance service, community nursing, primary care and the care sector. The largest flu vaccination programme had been completed and the NHS was now being asked to establish the largest ever vaccine programme.

The Chairman asked N Macdonald to pass on the Committee's thanks to all the frontline workers and his team. The following points were raised and discussed by members of the HASC

- The Chairman asked what led to the major incident being declared by the Leader of the Council in December 2020, what assistance could be expected

and what were the ramifications. N Macdonald advised that the NHS had been working in national major incident mode since November/December 2020. The Council's decision followed triggers set out by the Council's own measures and would enable the Council to pull on further mutual aid support, redeploy staff, maximise safe capacity in the adult social care sector and reduce non-urgent pressures.

- In response to being asked whether a facility such as the Olympic Lodge would be set up to ease capacity in the hospitals; N Macdonald acknowledged that there was increasing pressure on the nursing and care home market and stressed that patients needed to be discharged safely. All available options were being considered.
- A Member requested the data on the number of Buckinghamshire residents who were in phase one of the vaccination programme and the timeframe of the delivery of the vaccine for the first two groups in phase one. Dr Kent stated that first vaccine was carried out in primary care in Buckinghamshire on 14 December 2020 and that the programme was now in week 4. There were approximately 65,000 residents in the initial two cohorts; and a further 50,000 in the other four cohorts making a total of approximately 115,000 residents to be vaccinated by the middle of February 2021.
- The Member also asked how many sites had been set up and how many more would be rolled out. Dr Kent explained that the vaccination programme consisted of hospital hubs, PCNs and mass vaccination sites; currently, the PCNs were the main source of delivery. As of this week, five sites had been set up and three more were due to open week commencing 11 January 2021. The level of GP uptake was good with almost all the practices having signed up or agreed to sign up. However, there were two variables; NHSE had to approve the site and allocated supplies; BHT was not able to order its own supplies. Confirmation was awaited of the amount of vaccinations to be delivered for week commencing 11 January. An additional hospital hub had been requested in Amersham but NHSE had not yet approved the site. Confirmation was also awaited on a mass vaccination site at Buckinghamshire New University. When asked why the sites had not been organised earlier; Dr Kent reiterated that sites had been put forward but were awaiting approval from NHSE. However, he anticipated that an additional three sites would be live next week. The mass vaccination sites were confirmed but timing and supply of the vaccine were being handled centrally. It was noted that Buckinghamshire only had 40% of GP sign up in December 2020 which was lower than the other authorities within the ICS. The Chairman asked why the GPs had been slow to sign up and Dr Kent stated that he had written to all the practices including offering to hold one to one discussions to better understand the challenges but now 46 out of 48 practices were either signed up or in collaborative agreements.

  He went on to explain that the GP contract for the vaccination programme was a national contract and GPs were independent contractors with choice about whether they chose to sign-up. It was agreed that there was a need to monitor the progress of the vaccination programme. One of the Members recommended holding a special HASC meeting with representatives from

Public Health England and NHS England to ensure Buckinghamshire residents were receiving the best service.

- In response to being asked how many residents had received the vaccine; Dr Kent advised that as of 4 January 2021 approximately 30,000 vaccinations across the system had been undertaken; 8,000 of those were Buckinghamshire residents. Around 115,000 residents in Buckinghamshire needed to be vaccinated by the middle of February 2021 in order to meet the Government target and Dr Kent was confident there was the capacity to deliver, provided the supply was maintained.
- The Chairman advised she had received a text message from her GP surgery saying not to contact the surgery as they did not know when the next delivery would arrive. The message was a concern and the Chairman asked what pressures were being used to ensure enough vaccine was received. Dr Kent reported that he had no visibility on how supplies were allocated; he was pushing daily, and the region was allocating supply. It was a fast-moving picture and Dr Kent confirmed he had been in touch with MPs to request them to contact the relevant minister. Concerns were raised around the clarity of the public communications around the vaccine programme. Dr Kent confirmed that this was handled regionally by the NHS who had embargoed certain information until launch date.
- Dr Kent confirmed that patients did not have a choice of which vaccine they would receive.
- In response to whether there was any data on reactions to the vaccine; Dr Kent advised that initially there were a couple of allergic reactions on the first day and there was a national reporting system for recording reactions.
- Dr Kent highlighted that there were many challenges in setting up the sites and explained that due to the volume of vaccinations and the need for waiting 15 minutes in a socially distant environment, most GP practices were not suitable sites. Buckinghamshire Council was aiding with the logistics of setting up new sites and volunteers were being used for example in front of house duties. Asking primary care to provide the vaccination service whilst maintaining core primary care services was a challenge.
- In response to being asked why pharmacies were not being used as vaccination sites; Dr Kent explained that pharmacies were commissioned by NHSE and four community pharmacies in south Buckinghamshire would provide the vaccine at the end of January/early February 2021.
- Further concern was expressed over the roll out of the vaccination programme in Buckinghamshire as it had been announced on the radio that the vaccinations were going well in Oxfordshire. It was thought that there were many other locations which would be suitable such as village halls or the Chess Medical Centre and could have been used since the start. The Chairman acknowledged that the programme was beholden to the NHS, but it was worrying as to why it was so slow in Buckinghamshire compared to neighbouring authorities. Dr Kent advised he was trying to understand why GPs had not signed up earlier and believed some of the GPs found the enhanced specification (the vaccination contract) challenging. Eight sites would be running by week five and all the PCNs would be on board; this was

an achievement due to the Christmas and New Year period and was a considerable amount of work for Primary Care to take on.

- A Member asked if the GPs administered the vaccines or could pharmacists be used to help at the centres. Dr Kent stated that the GPs would provide clinical leadership and a presence at the site, but most centres were using nursing and other trained staff to carry out the vaccinations, as well as GPs.
- In response to a question on whether private hospitals were still being used for non-covid patients and which services had closed; D Gibbs advised that there was minimal activity in the private sector but BHT was still looking to the private sector to support as much as was appropriate. BHT was continuing to treat priority one and two patients i.e. the most clinically urgent patients which included cancer treatment. A small number of operations had been cancelled but the patients had received new dates. Work was being undertaken with clinical teams to prioritise patients and some of the out-patient clinics had been reduced in order to release staff. BHT was endeavouring to keep as much activity open as possible but there could be further reductions as demand grew over the next few weeks. Referrals were still being received from GPs.
- Dr Kent confirmed that local clinical discretion could be used in deciding whether residents' second vaccinations were carried out as planned after that national policy changed on 30 December 2020. However, from 11 January 2020 all second doses would be deferred to twelve weeks after the first dose as it was better for two people to have the first dose than one.
- The Chairman requested that the vaccination updates be shared with the HASC Select Committee.
- One of the Members stated she expected GPs to follow the code of ethics not their contracts. The member also expressed concern over who was ensuring that elderly residents were able to get to the site and asked who was co-ordinating the transport. Dr Kent explained that the Corporate Director for Communities at Buckinghamshire Council was co-leading the co-ordination to ensure all the cohorts were covered. Once the care home residents' vaccinations were complete the roving model would carry out vaccinations for the housebound. It was the GP's discretion as to whether a couple would be vaccinated at the same time if they straddled two different cohorts.
- In response to whether the vaccination programme ran from 9.00 am to 5.00 pm; Dr Kent advised that the centres were open at 8.00 am and often did not close until late in the evening in order to ensure the vaccine was used up.

The Chairman summarised that she would follow up with Dr Kent and N Macdonald for regular updates and thanked them for everything that had been undertaken. Cllr Angela Macpherson's information would be circulated to the committee members.

ACTION: Liz Wheaton

10 Work programme

The Chairman advised that the next meeting on 4 March 2021 would be the final one. It was agreed that the following items would be included on the agenda:

- Access to Dentists and the impact of Covid-19 on dental services.
- Support for Carers and Staff wellbeing.

An update on the vaccination programme.

11 Date of next meeting

Thursday 4 March 2021 at 10.00 am.

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Healthwatch Bucks update (February 2021)

This paper summarises recent work we have undertaken in relation to health and social care services, as aligned with the priorities of Joint Health & Wellbeing strategy.

Live Well

Working in a Care Home during the coronavirus outbreak

Working in a care home during the coronavirus outbreak

We heard from staff about their experiences of working in a care home during the coronavirus outbreak. We asked for feedback for the period of 16th March and 31st May when care homes made the greatest changes. We worked with 3 staff members from Fremantle Trust care homes to co-design the survey questions.

We asked staff about:

1. Covid19 testing;
2. Hygiene, Personal Protective Equipment (PPE) and training;
3. Raising concerns, mental health support and staffing;
4. Movement around the care home, meaningful activities and visitors.

We heard from 152 members of staff; positive feedback was given in many areas that we looked at. Our recommendations focus on ways the current provision could be improved based on the more negative aspects reported to us. We've received a response to our recommendations from Bucks Council (Working in a care home during the coronavirus outbreak: Responses) and are awaiting one from the ICP.

Ask NHS

Ask NHS Survey — Healthwatch Bucks

Bucks CCG were keen to find out if the ASK NHS app was meeting the needs of Bucks residents. We worked with them (and Sensely, the App developer) to develop a survey on patient experience. The survey is now live (it can be accessed through the above link) and we are looking for participants who have used ASK NHS in the last 6 months.

Integrated care plans

Joint Healthwatch response to NHS England's integrating care plans

We worked with the 4 other Healthwatch in the BOB ICS (Oxon, Reading, Wokingham and West Berkshire) to submit a response to the NHSE public consultation on Integrated Care. The consultation was about the way NHS organisations and Local Authorities work together to design, provide and monitor NHS and Social Care Services. Our response can be accessed via the link above.

Keep on moving

Keep on Moving: Follow up

In October 2019, we ran an online survey asking people about their experience of the NHS Buckinghamshire Musculoskeletal Integrated Care Service. We wanted to know about the patient journey from their GP to an MSK professional. In December 2020, we requested a progress update on our recommendations.

Vaccination rollout

Have you had the COVID-19 vaccine? — Healthwatch Bucks

In response to the volume of feedback we were getting in relation to the Vaccination programme, we developed an online survey to gather people's feedback on the vaccination process with a focus on questions that could help improve the local rollout. We are looking for participants who have had their first injection of the vaccine in the last 6 weeks. We will be sharing our findings with the CCG.

Mental Health

As a result of findings in our 'Your experience of services during the coronavirus outbreak' report, we are developing a survey on people's experience of digital mental health appointments. We have worked with the Experience and Involvement Lead Mental Health at Oxford Health on the scope of the project and the design of our survey.

Community Engagement

Briefing for Patient Participation Group (PPG) Chairs

Briefing for PPG Chairs

On the 20th January, we hosted a webinar (on behalf of the CCG) for PPG Chairs about the Covid 19 vaccination programme. 51 people attended. Speakers included; Richard Barker (Corporate Director of Communities, Bucks Council), Dr Penny MacDonald and Dr Martin Thornton (clinical leads from 2 GP vaccination centres) and Kim Parfitt (Communications Lead for Bucks Council and the CCG). Please click on the link to view a recording of the event.

Digital Exclusion

In December, we started working on a project to engage with those who cannot access, or have difficulties with, remote GP appointments.

These groups are:

1. Over 65s,
2. Those with disabilities,
3. BAME/English language difficulties.

We are also surveying professionals working in GP practices about working with 'digitally excluded' patients.

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Neil Macdonald
Chief Executive

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Jenny Hughes
Regional Chief Midwife – South-East
NHS England / Improvement

18th December 2020

Dear Jenny,

Response to Ockenden Review – Buckinghamshire Healthcare NHS Trust

I am writing as requested to outline the position of the Trust in response to the Ockenden Review.

The report is a difficult read. We welcome this opportunity to work together with the national and regional teams to reflect and improve collectively on the quality of services we provide, but most importantly to do this along side our many stakeholders and the public we serve.

In response to the Immediate and Essential Actions (IEAs);

1) Enhanced Safety
a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

All perinatal deaths are currently reviewed using the perinatal mortality review tool from MBBRACE on a monthly basis. Quarterly maternity safety reports to the Trust Board include the perinatal maternity review tool summaries. We will implement the new Perinatal Clinical Quality Surveillance Model once made available, in partnership with our LMS, ICS and local stakeholders and MVP.

Serious incidents are reviewed at the Trust's monthly Serious Incident Group; these are then reported at the same frequency to the Trust Board. We will do more to strengthen the visibility of the maternity incidents, and the depth to which they are reviewed at our Quality Committee. I am aware that the LMS is also reviewing the BOB wide process. All HSIB reportable cases are reported and noted appropriately.

2) Listening to Women and their Families
a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named nonexecutive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

Buckinghamshire has an active and effective MVP that has regular meetings with both the maternity team and the CCG, as well as the LMS Board. In recent months we have co-produced user leaflets and other communication tools and we are currently working together designing an engagement project to reach out to women from our BAME community. Regular user surveys are conducted through the MVP social media pages, and they have been both constructively challenging and helpful over the events of the last year in shaping our response to the pandemic. We have a dedicated user experience midwife and a summary of feedback and actions is presented through a quarterly report.

Karen Bonner, our Chief Nurse, is our executive lead for maternity, supported by Dr. Dipti Amin, our nominated Non-Executive lead.

3) Staff Training and working together
a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place.
c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

We have scheduled and job planned consultant led ward rounds three times daily, seven days a week.

We established an MDT emergency skills training programme that has met all CNST requirements in years 1 & 2. All mandatory training is provided in house by an MDT faculty and all colleagues are allocated study time to attend. Compliance with training is tracked on our monthly maternity dashboard. Just before the pandemic, compliance for midwives was at 96.6% and doctors 97.9%. Currently this is 84% and 76.9% respectively, with plans in place to recover to pre-pandemic levels.

The department has an allocated training fund and non-recurrent transformation funding has been used in the last two years to provide supplementary training. CNST refund allocations will be protected for this use and other safety initiatives. Over the last two years the department has been an active member of the Oxford Academic Health Science Network maternity patient safety collaborative.

4) Managing complex pregnancy
a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

All antenatal clinics have an appropriate subspecialty named consultant lead and have done so since 2016. We are putting in place immediate actions to audit this.

BHT is part of the Thames Valley Maternal Medicine Network with Oxford University Hospitals as our specialist centre. There are agreed and followed network referral criteria and guidelines. Work is underway to formalise a regional specialist MDT.

5) Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

All women are risk assessed at booking, 28 weeks and if any change in pregnancy is reported. It is documented on the front of the woman's notes if she is on a midwife or consultant led pathway. If a pathway is changed, this is documented with a reason for the change. All women are risk assessed on admission to labour, with continuous risk assessments during labour and additionally hourly if in midwife led care. Personalised care plan usage is documented on our electronic record system, and compliance tracked and reported through to the BOB LMS Board. In September 2020, PCP recorded at booking was 68% compliant, with plans in place to improve.

6) Monitoring Fetal Wellbeing
a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

There is both a lead midwife and a lead consultant already in place for fetal monitoring. These leads run weekly fetal monitoring training sessions. Fetal monitoring training is included in the department's mandatory study days and compliance with this training is regularly tracked; compliance for midwives is currently 93% and doctors 88%.

We are on trajectory to complete the implementation of the Saving Babies Lives care bundle 2 in line with CNST requirements with the refresh of one outstanding guideline (to be formally signed off at our next guideline meeting) the only action outstanding.

7) Informed Consent
a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.

We have a dedicated section on our website for the Trust's maternity services, including care options, available support and detail of care pathways. Our whole website is currently undergoing a complete rebuild to make more user friendly.

We are therefore asking Trust Boards to confirm that they have a plan in place to implement the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

We will review this at Board alongside the workforce implications for the Continuity of Carer programme on the 27th January 2021.

We will complete the assurance assessment tool and report this through the LMS and the regional team by the 15th January 2021, with a review of the tool and the full report in our public Board meeting on the 27th January 2021.

I can confirm this response has been signed off by our LMS Chair.

We are very proud of our maternity services and look forward to learning more about how we can become even better for the women we serve.

If you have any further questions, please do not hesitate to contact me.

Yours sincerely

Neil Macdonald
Chief Executive
Buckinghamshire Healthcare NHS Trust

Cc: Hattie Llewelyn-Davies, Chair, BHT
Dipti Amin, NonExecutive Director and Maternity Champion Board Lead, BHT
Karen Bonner, Chief Nurse, BHT
Heidi Beddall, Head of Midwifery, BHT
Debbie Simmons, Chair BOB LMS
James Kent, Accountable Officer, BOB ICS
Sue Manthorpe, Director for Governance, BHT
David Williams, Deputy Director Quality, Bucks CCG
Fiona Dite, Co-Chair Bucks MVP
Helen Discombe, Co-Chair Bucks MVP
Aparna Reddy, SDU Lead, Obs and Gynae, BHT
Ian Currie, Divisional Chair, Women and Children, BHT
Ed MacFarlane, Divisional Director, BHT
Dan Gibbs, Chief Operating Officer, BHT
Tina Kenny, Medical Director, BHT
Lisa Cook, Care Quality Commission

Safe & compassionate care, every time

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Neil Macdonald
Chief Executive
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Jenny Hughes
Regional Chief Midwife South East
NHS England & Improvement
[redacted]

Monday 15 February 2021

Dear Jenny

Further to our letter of 18 December 2020 in response to the publication of the Ockenden Review, I am writing as requested to provide assurance regarding:

- the Trust Assurance Assessment Tool; and
- our plan for implementation of the Birthrate Plus (BR+) standard

Please find appended a copy of our Trust Assurance Assessment Tool which was reviewed by Trust Board in Public on Wednesday 27 January 2021. Through this exercise we have identified some gaps in assurance at national, local maternity system and organisational level; plans are in place to address these, several of which are due to be completed by 31 March 2021.

We can confirm that a midwifery acuity review using the Birthrate Plus standard has been undertaken and presented to the Executive Management Committee prior to 31 January 2021. The timescale for implementation is financial year 2021/22. Please find appended a copy of this review.

In your letter of 11 January 2021 you also provided additional guidance regarding Immediate and Essential Action 2 – Listening to Women and Families. We look forward to receiving further information and guidance on this including the package for standard JD, training and principles for establishing a network.

We confirm that this response has been reviewed and signed off by Dipti Amin, Trust Non-Executive Director and Maternity Champion Board Lead, and Debbie Simmons, Chair of the Buckinghamshire, Oxfordshire & Berkshire West LMS.

Your sincerely

Neil Macdonald
Chief Executive
Buckinghamshire Healthcare NHS Trust

Appendix 1: Assurance Assessment Tool
Appendix 2: Midwifery acuity dependency review against Birthrate Plus standard

CC: Hattie Llewelyn-Davies, Chair, BHT
Dipti Amin, Non-Executive Director and Maternity Champion Board Lead, BHT
Karen Bonner, Chief Nurse, BHT
Heidi Beddall, Head of Midwifery, BHT
Debbie Simmons, Chair BOB LMS
James Kent, Accountable Officer, BOB ICS
Sue Manthorpe, Director for Governance, BHT
David Williams, Deputy Director Quality, Buckinghamshire CCG
Fiona Dite, Co-Chair Bucks Maternity Voices Partnership
Helen Discombe, Co-Chair Bucks Maternity Voices Partnership
Aparna Reddy, SDU Lead, Obs and Gynae, BHT
Ian Currie, Divisional Chair, Women and Children, BHT
Ed MacFarlane, Divisional Director, BHT
Dan Gibbs, Chief Operating Officer, BHT
Tina Kenny, Medical Director, BHT
Lisa Cook, Care Quality Commission

BHT Maternity services assessment and assurance tool- Ockenden report

STANDARD	What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
IEA REQUIREMENT 1 (ENHANCED SAFETY): **Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.**							
Ockenden safety requirement Clinical change where required must be embedded across Trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	1) Quarterly regional (BOB) governance meeting includes presentation of SIs and concise reports / incidents at each meeting, including shared learning, analysis of the incident and recommendations. This is an MDT meeting that includes Governance Leads, Obstetricians, Neonatologists, and Anaesthetists from each organisation in the network. There is also a service user representative as part of the quoracy of the meeting, and the HSIB regional lead also attends. The maternity team at BHT have a good relationship with RBH Trust, where we have undertaken SI investigations on their behalf, and they have been part of the investigating team for some of our maternity incidents. All processes maintained during pandemic. 2) LMS highlight reports , local and regional dashboards, quarterly safety report to board includes dashboard, monthly CCG steering group includes dashboard review, mat neo safety improvement projects tracked on dashboard, term admissions to neonatal unit (ATAIN) tracked on local and regional dashboard with neonatal network oversight.	1) Regional: Shared learning from cases is presented at network shared learning events and in national publications. 2) Trust: learning from SIs and HSIB investigations incorporated in staff mandatory training programme, shared at academic half days, displayed on learning boards in clinical areas, published in maternity practice development newsletter and on closed practice developemnt facebook group.	1) National/Regional: HSIB themed reports . 2) Regional dashboard in final stages of development. 3) Trust: HSIB 6 monthly Trust level feedback. Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. trends monitored on maternity dashboard.	1) Regional: All SIs to be shared at regional governance group and minutes of meeting to be submitted quarterly for BOB LMS board agenda. 2) Trust: SI monthly report submitted to board includes maternity SIs - the maternity section to be seperate and lessons learned section strengthened.	1)Network patient safety lead 2) Patient safety team and lead midwife for clinical governance and quality by March 2021	No additional support needed.	The current approach is not a risk
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Are you submitting data to the Maternity Services Dataset to the required standard? Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	1) Compliant with PMRT standards. 2) Compliant with HSIB and NHSR reporting. 3) Currently non compliant with MSDS standards due to IT functionality.	1) PMRT enables MDT review of all perinatal deaths and essentially includes the involvement of parents in investigations. 2) HSIB and NHSR reporting enables publication of national reports of themes and trends/ recommendations for improvement see above approach to embedding the learning). 3) Data submission enables tracking of demography and clinical outcomes so that focused quality improvements are developed.	1) National PMRT annual report of themes and trends. 2) Quarterly reporting to Board of number of PMRT cases including when different care would have changed the outcome. 3) Rolling annual perinatal mortality rate.	Continue dialogue with System C who supply the maternity eletronic records to seek MMBI reporting solution. Currently weekly meetings between Head of Midwifery, digital midwife, head of IT and information team. If reporting solution not available from supplier in next week, risk to CNST will be escalated to Board. Risk added to divisional risk register.	Head of Midwifery by January 31st.	If the system supplier cannot provide a reporting solution, the Trust information team need additional resource to develop internal reporting workarounds.	Risk has been escalated to BOB LMS, NHS Digital and to be escalated to NHSE/I.
Link to urgent clinical priorities (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Perinatal quality surveillance model published December 19th 2020. Maternity SIs reported monthly in Trust SI report. Maternity section on lessons learned to be strengthened.	1) Regional: Shared learning from cases presented at network shared learning events and in national publications. 2) Trust: learning from SIs and HSIB investigations incorporated in staff mandatory training programme, shared at academic half days, displayed on learning boards in clinical areas, published in maternity practice development newsletter and on closed practice development facebook group.	2) Regional dashboard in final stages of development. 3) Trust: HSIB 6 monthly Trust level feedback. Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. Trends monitored on monthly maternity dashboard.	1) For review by board level safety champions with maternity and neonatal safety champions - to undertake gap analysis and develop implementation plan if required. Regional and national elements of the perinatal quality surveillance model to be reviewed and actioned byt regional and national teams. 2) Regional: All SIs to be shared at regional governance group and minutes of meeting to be submitted quarterly for BOB LMS board agenda. 3) Trust: SI monthly report submitted to board includes maternity SIs - the maternity section to be separate and lessons learned section strengthened.	1) Board and local level safety champions by April 1st 2021. Regional and national teams - no defined timeframe published yet. 2) Maternity and paediatric governance teams. 2) Network patient safety lead and BOB LMS chair.	Network patient safety lead to be appointed. LMS funding available.	Continue to follow SI sign off process with CCG. Continue to share SI reports and lessons learned in Trust monthly SI report and at regional governance meeting. Exception report to LMS via patient safety highlight reports.

IEA REQUIREMENT 2 (LISTENING TO WOMEN & FAMILIES): **Maternity services must ensure that women and their families are listened to with their voices heard.**	What do we have in place currently to meet all requirements of IEA 2?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Ockenden Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	1) There is currently no independent senior advocate role in post as no national framework or job description. 2) NED appointed. First meeting re Ockenden actions held with Head of Midwifery and Lead midwife for clinical governance and quality. Invited to MVP and joint maternity neonatal safety champions meetings.	1) Awaiting national framework to determine measurment methodology. 2) Board level safety champion invited to MVP meetings and bi monthly safety champions meetings to review safety issues and provide check and challenge to improvement plans.	Not currently known as no post in place.	Await national role description. Seeking funding for post, recruit and train	Head of Midwifery	National framework.	Unable to determine risk as no clarity on the role description
CNST **Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** **Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**	1) Compliant with PMRT standards. 2) Compliant with MVP standards. 3) Two local maternity safety champions in place (1 obstetrician and 1 midwife) who meet bi monthly with Board level maternity safety champions.	1) PMRT enables MDT review of all perinatal deaths and essentially includes the involvement of parents in investigations. 2) User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report. Quality improvement plans derived from user feedback including complaints, surveys, birth reflections forms, friends and family test narrative - examples include triage and early pregnancy unit. 3) Board level safety champion review of safety issues provides check and challenge to improvement plans.	1) National PMRT annual report of themes and trends. Quarterly reporting to Board of PMRT cases including when different care would have changed the outcome. Rolling annual perinatal mortality rate. 2) Quality improvement plans have quarterly tracking and repeat audit of issues that led to improvement requirement. Ongoing gathering of feedback and analysis of themes and trends to identify and cyclical occurences. MVP meetings minuted. 3) Bi monthly safety champions meetings minuted and included in quarterly maternity safety Board report.	Confirm MVP terms of reference in date. Confirmatory letter from MVP chair re financial renumeration.	Head of Midwifery by March 31st 2021	No additional support needed.	The current approach is not a risk
Link to urgent clinical priorities (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	Established MVP, regular minuted meetings, MVP presence at maternity /CCG steering group meetings and BOB LMS board. Co produced patient information leaflets, communications. Currently codesigning engagement project to reach out to women from BAME communities to ensure services meet their specific needs. Regular service user surveys through MVP social media pages. Patient experience midwife in post who collates friends and family test, birth reflections feedback - quarterly patient feedback report produced demonstrating responsive changes. NED appointed. First meeting re Ockenden actions held with Head of Midwifery and Lead midwife for clinical governance and quality. Invited to MVP and joint maternity neonatal safety champions meetings	1) User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report. Quality improvement plans derived from user feedback including complaints, surveys, birth reflections forms, friends and family test narrative - examples include triage and early pregnancy unit. 2) Board level safety champion review of safety issues provides check and challenge to improvement plans.	1) Quality improvement plans have quarterly tracking and repeat audit of issues that led to improvement requirement. Ongoing gathering of feedback and analysis of themes and trends to identify any cyclical occurences. MVP meetings minuted. 2) Bi monthly safety champions meetings minuted and included in quarterly maternity safety Board report.	No further action needed	Head of Midwifery, lead midwife for clinical governance and quality, local and Board level safety champions.	No additional support needed.	The current approach is not a risk

IEA REQUIREMENT 3 (STAFF TRAINING & WORKING TOGETHER): Staff who work together must train together	What do we have in place currently to meet all requirements of IEA 3?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
OCKENDEN Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	1) Established annual MDT emergency skills training programme that has met CNST requirements year 1 and 2 . All mandatory training provided in house by MDT faculty and all staff allocated study time to attend. Attendance compliance tracked on maternity dashboard. 2) Consultant led ward rounds three times daily weekdays and twice weekends. 3) There is a small allocated training fund in the midwifery cost centres for supplementary training needs and non recurring maternity transformation funding has been used in last two years to support supplementary training. CEO confirmation that CNST (MIS) refund will be ring fenced for improving maternity safety to be agreed for financial year 21/22.	1) Monthly tracking of attendance via maternity dashboard to monitor and address compliance issues. 2) Currently no formal tracking of consultant ward round frequency. 3) External funding bids for maternity training documented and archived. Spend against allocated funds tracked with divisional accountant. Monthly budget statements track spend against internal training fund.	1) Reduction in incidents related to management of obstetric emergencies, non recurrence of lessons learned from previous incidents. 2) Documentation of ward rounds currently in patients notes. 3) Not applicable.	Implement ward round attendance monitoring process.	1) Maternity practice development team. 2) SDU Lead and labour ward lead by January 31st 2021. 3) Head of Midwifery and divisional accountant.	No additional support needed.	Audit of patient notes for consultant ward round compliance.
CNST Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	1) Compliant with workforce standards. 2) Currently non compliant with training standards due to pause on training due to COVID 19. Recovery plan developed.	1) Workforce planning influences establishment setting, consultant job planning, business cases for required clinical posts. 2) Monthly attendance tracking identifies areas for improvement and instigates any required additional study day requirements to acheive standard.	1) Meet national and regional standards such as ACSA, neonatal network recommendations, RCOG standards, neonatal nursing ratios. 2) Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. Trends on maternity dashboard.	Evidence to be embedded in CNST action plan. Training recovery plan monitoring via monthly maternity dashboard.	Head of Midwifery, maternity practice development team by March 31st 2021.	No additional support needed.	Ensure compliance with training within last 15 months. Increase to weekly simulations of obstetric emergencies in clinical settings.
Link to urgent clinical priorities (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	1) Consultant led ward rounds three times daily weekdays and twice weekends. Established annual MDT emergency skills training programme that has met CNST requirements year 1 and 2 . 2) All mandatory training provided in house by MDT faculty and all staff allocated study time to attend. Attendance compliance tracked on maternity dashboard.	1) Currently no formal tracking of consultant ward round frequency. 2) Monthly tracking of attendance via maternity dashboard to monitor and address compliance issues.	1) Documentation of ward rounds currently in patients notes. 2) Reduction in incidents related to management of obstetric emergencies, non recurrence of lessons learned from previous incidents.	Implement ward round attendance monitoring process.	SDU lead and labour ward lead by January 31st 2021.	No additional support needed.	Audit of patient notes for consultant ward round compliance.
IEA REQUIREMENT 4 (MANAGING COMPLEX PREGNANCY): There must be robust pathways in place for managing women with complex pregnancies	What do we have in place currently to meet all requirements of IEA 4?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
OCKENDEN Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	1) BHT are part of the Thames Valley maternal medicine network. BHT are associated with Oxford maternal medicine centre and follow Thames Valley network referral criteria and guidelines. 2) and 3) Sub specialty antenatal clinics with a named consultant lead have been in place since 2016.	1) Network clinical guidance monitored for pre term birth including pre term birth rates and administration of magnesium sulphate in preterm labour. Preterm births tracked on monthly maternity dashboard and reported quarterly to board in maternity safety report. Exception reporting for extreme preterm babies born in level 2 unit instead of tertiary centre and discussed at Trust maternity/paediatric forum. Magnesium sulphate compliance tracked at network level and discussed at Trust maternity/paediatric forum.	1) Preterm birth rates, preterm babies born in appropriate place of birth. 1) and 3) regional clinical guideline compliance audits including fetal monitoring, reduced fetal movements.	1) Thames Valley maternal medicine network to formalise regional MDT meetings (work in progresss) - this is not a BHT specific action . 2) and 3) Audit of appropriate triaging and referral to subspecialty clinics to be included on audit schedule.	1) Network maternal medicine centre. 2) Maternity audit team by March 2021.	No additional support needed.	Audit of triaging and referral to subspecialty clinic.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	On trajectory to fully implement Saving Babies' Lives care bundle 2 in accordance with CNST requirements. Quarterly submissions to NHSE/I.	Measurement of perinatal mortality rate both at Trust level and regionally following bundle implementation. Development of a regional dashboard in progress as an action within this care bundle implementation plan to enable system wide learning and sharing of good practice.	Rate of term stillbirths, neonatal deaths and brain injury being tracked via monthly maternity dashboard and LMS.	Complete outstanding actions for care bundle implementation.	SDU lead and LMS by March 31st 2021	No additional support needed.	Only two outstanding acctions, both work in progress but no current clinical risk
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	1) BHT are part of the Thames Valley maternal medicine network. BHT are associated with Oxford maternal medicine centre and follow Thames Valley network referral criteria and guidelines. 2) and 3) Sub specialty antenatal clinics with a named consultant lead have been in place since 2016.	1) Network clinical guidance monitored for pre term birth including pre term birth rates and administration of magnesium sulphate in preterm labour. Preterm births tracked on monthly maternity dashboard and reported quarterly to board in maternity safety report. Exception reporting for extreme preterm babies born in level 2 unit instead of tertiary centre and discussed at Trust maternity/paediatric forum. Magnesium sulphate compliance tracked at network level and discussed at Trust maternity/paediatric forum.	1) Preterm birth rates, preterm babies born in appropriate place of birth. 1) and 3) regional clinical guideline compliance audits including fetal monitoring, reduced fetal movements.	1) Thames Valley maternal medicine network to formalise regional MDT meetings (work in progresss) - this is not a BHT specific action. 2) and 3) Audit of appropriate triaging and referral to subspecialty clinics to be included on audit schedule.	1) Network maternal medicine centre. 2) Maternity audit team by March 2021.	No additional support needed.	Audit of triaging and referral to subspecialty clinic.
IEA REQUIREMENT 5 (RISK ASSESSMENT THROUGHOUT PREGNANCY): Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	What do we have in place currently to meet all requirements of IEA 5?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	All women are risk assessed at booking, at 28 weeks and if any change in pregnancy risk identified. Documented on front page of antenatal notes if the woman is midwifery or consultant led care pathway. If a woman changes pathway this is documented and dated wth reason for the change. Risk assessment in pregnancy guideline in place. All women are risk assessed on admission in labour, continuous risk assessment during labour and additionally hourly in midwifery led labour care. Personalised care plan use documented on electronic records system. Compliance tracked through personalised care highlight report to BOB LMS board. Consultant midwife and MDT care planning with women requesting care outside of guidelines.	This ensures that women are cared for on the correct clinical pathway by the correct lead professional.	1) Women on midwifery led care pathways appropriately referred to consultant led care if risk identified. 2) Births in appropriate care setting. 3) Improvement is monitored by rate of births in midwifery led settings both via monthly maternity dashbaord and LMS, audit of compliance with clinical risk assessment in labour guidelines, audit of midwifery unit transfers, audit of intermittent auscultation risk assessment. 4) Positive scores on annnual CQC survey of women's experiences re: place of birth, feeling involved in decisions about their care.	Ensure risk assessment is documented at each antenatal contact. Undertake record keeping audit to drive improvement in documentation.	Community and birth centres matron, Consultant midwife annually	No additional support needed.	Communication to all staff about risk assessment documentation
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	On trajectory to fully implement Saving Babies' Lives care bundle 2 in accordance with CNST requirements. Quarterly submissions to NHSE/I.	Measurement of perinatal mortality rate both at Trust level and regionally following bundle implementation. Development of a regional dashboard in progress as an action within this care bundle implementation plan to enable system wide learning and sharing of good practice.	Rate of term stillbirths, neonatal deaths and brain injury being tracked via monthly maternity dashboard and LMS.	Complete outstanding actions for care bundle implementation.	SDU lead and LMS by March 31st 2021	No additional support needed.	Only two outstanding acctions, both work in progress but no current clinical risk
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	All women are risk assessed at booking, at 28 weeks and if any change in pregnancy reported. Documented on front page of antenatal notes if the woman is midwifery or consultant led care pathway. If a woman changes pathway this is documented and dated wth reason for the change. Risk assessment in pregnancy guideline in place. All women are risk assessed on admission in labour, continuous risk assessment during labour and additionally hourly in midwifery led labour care. Personalised care plan use documented on electronic records system. Compliance tracked through personalised care highlight report to BOB LMS board. Consultant midwife and MDT care planning with women requesting care outside of guidelines.	This ensures that women are cared for on the correct clinical pathway by the correct lead professional.	1) Women on midwifery led care pathways appropriately referred to consultant led care if risk identified. 2) Births in appropriate care setting. 3) Improvement is monitored by rate of births in midwifery led settings both via monthly maternity dashbaord and LMS, audit of compliance with clinical risk assessment in labour guidelines, audit of midwifery unit transfers, audit of intermittent auscultation risk assessment. 4) Positive scores on annnual CQC survey of women's experiences re: place of birth, feeling involved in decisions about their care.	Ensure risk assessment is documented at each antenatal contact. Undertake record keeping audit to drive improvement in documentation.	Community and birth centres matron, Consultant midwife	No additional support needed.	Communication to all staff about risk assessment documentation

IEA REQUIREMENT 6 (MONITORING FETAL WELLBEING): All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	What do we have in place currently to meet all requirements of IEA 6?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
OCKENDEN All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •	Fetal monitoring midwife in post - funded by maternity transformation funding for 20/21. Role included in workforce review paper submitted to Board. Lead obstetrician for fetal monitoring in place - lead weekly fetal monitoring training sessions, fetal monitoring training included in maternity madatory study days, staff annual competency assessment tracked on maternity dashboard.	Ensure high quality MDT education and up to date clinical guidance and pathways. Ensure lessons learned from fetal monitoring related incidents and adverse outcomes are embedded.	Reduction in adverse neonatal outcomes due to fetal monitoring interpretation or failure to follow guidance.	1) Approval of fetal monitoring midwife post in midwifery establishment from April 2021	Head of Midwifery by April 1st 2021	No additional support needed.	The current approach is not a risk.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	1) On trajectory to fully implement Saving Babies' Lives care bundle 2 in accordance with CNST requirements. Quarterly submissions to NHSE/I. 2) Currently non compliant with training standards due to pause on training due to COVID 19. Recovery plan developed.	1) Ensure high quality MDT education and up to date clinical guidance and pathways. Ensure lessons learned from fetal monitoring related incidents and adverse outcomes are embedded. 2) Monthly attendance tracking identifies areas for improvement and instigates any required additional study day requirements to acheive standard.	1) Rate of term stillbirths , neonatal deaths and brain injury being tracked via monthly maternity dashboard and LMS.2) Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. Trends monnitored on monthly maternity dashboard.	Evidence to be embedded in CNST action plan. Training recovery plan monitoring via monthly maternity dashboard.	Head of Midwifery, maternity practice development team by March 31st 2021.	No additional support needed.	1) Only two outstanding acctions, both work in progress but no current clinical risk 2) Ensure compliance with training within last 15 months. Increase to weekly simulations of obstetric emergencies in clinical settings.
Link to urgent clinical priorities a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Fetal monitoring midwife in post - funded by maternity transformation funding for 20/21. Lead obstetrician for fetal monitoring in place - leads weekly fetal monitoring training sessions, fetal monitoring training included in maternity madatory study days, staff annual competency assessment tracked on maternity dashboard. Saving Babies' Lives care bundle 2 implementation in progress - reported quarterly to NHSE/I.	Ensure high quality MDT education and up to date clinical guidance and pathways. Ensure lessons learned from fetal monitoring related incidents and adverse outcomes are embedded.	Reduction in adverse neonatal outcomes due to fetal monitoring interpretation or failure to follow guidance.	1) Approval of fetal monitoring midwife post in midwifery establishment from April 2021	Head of Midwifery by April 1st 2021	No additional support needed.	The current approach is not a risk.

IEA REQUIREMENT 7 (INFORMED CONSENT): All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	What do we have in place currently to meet all requirements of IEA 7?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
OCKENDEN All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	Trust maternity services have dedicated section on Trust website including care pathways, birth options, support available, including maternal choice ofr caesarean delivery . Trust consent policy, respect for women's preferences is included in clinical guidelines. Support maternal request Caesarean and care outside of guidelines via obstetric and consultant midwife pathways. Respect for women's preferences is included in clinical guidelines.	User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report.	Measured via annual CQC survey of women's experiences, patient feedback from birth reflections, surveys, compliments and complaints. CQC survey annnual action plan developed - including women's experiences of involvement in decision making, choices about their care.	Consider implementation of I decide framework once developed by Birthrights and NICE	Consultant midwife and Lead midwife for clinical governance and quality annually	No additional support needed.	The current approach is not a risk
CNST Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Established MVP, regular minuted meetings, MVP presence at maternity /CCG steering group meetings and BOB LMS board. Co produced patient information leaflets, communications. Currently codesigning engagement project to reach out to women from BAME communities to ensure services meet their specific needs. Regular servicer user surveys through MVP social media pages. Patient experience midwife in post who collates friends and family test, birth reflections feedback - quarterly patient feedback report produced demonstrating responsive changes.	1) User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report. Quality improvement plans derived from user feedback including complaints, surveys, birth reflections forms, friends and family test narrative - examples include triage and early pregnancy unit. 2) Board level safety champion review of safety issues provides check and challenge to improvement plans.	1) Quality improvement plans have quarterly tracking and repeat audit of issues that led to improvement requirement. Ongoing gathering of feedback and analysis of themes and trends to identify any cyclical occurences. MVP meetings minuted. 2) Bi monthly safety champions meetings minuted and included in quarterly maternity safety Board report.	Confirm MVP terms of reference in date. Confirmatory letter from MVP chair re financial renumeration.	Head of Midwifery by March 31st 2021	No additional support needed.	The current approach is not a risk
Link to urgent clinical priorities a) Every Trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website. An example of good practice is available on the Chelsea and Westminster website.	Trust maternity servcies have dedicated section on Trust website including care pathways, birth options, support available. All patient information leaflets on Trust website. All leaflets co produced with MVP.	User feedback and MVP is part of co production of leaflets and communcations shared on social media	Review and feedback from users via MVP	Clinical guidelines ? Open access online	Consultant Midwife	Trust communications team and guideline leads	The current approach is not a risk

NICE GUIDANCE RELATED TO MATERNITY	What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the Trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	Upon the issue of new NICE guidance, the Trust clinical audit and effectiveness department disseminate the new guidance to SDU leads/Quality and Safety leads for consideration. If the new guidance requires implementation, this is managed through the maternity department's guidelines committee for gap analysis in relation to existing Trust guidance and updates to Trust guidelines as required. The department does endorse the use of non-evidence based guidelines. The department has one guideline that is evidence based but not NICE, this is the fetal monitoring guideline which is based on FIGO international evidence based guidelines.	Upon identification that current practice is not in line with new guidance, local guidelines and SOPs are revised and reviewed via the maternity guidelines committee and new practice in embedded with support of the maternity practice development team where required.	The effectiveness of implementation of new guidance is audited. The audit process is monitored via the maternity clinical audit group. Any deviations from the guideline are identified via clinical audit or through exception reporting. This results in the idenitification of recommendations and subsequent development and implemenation of any required action plans. Action plans are monitored through the associated committee/forum for the relevant clinical area eg labour ward forum. Audit findings are presented at academic half days, and improvements are shared at regional learning events if system learning is identified from audits or incidents where guidelines have been a contributory factor.	1) Ensure that ongoing oversight of action plans is maintained to ensure timely completion of actions and therefore assurance that practice is in line with local and national guidance. 2) Ensure that guidelines have SDU ratification within 10 working days of approcal at the maternity guidelines meeting . 3) Ensure that guidelines are uploaded to the Trust intranet within 10 working days of SDU approval.	1)Maternity governance team, consultant midwife, SDU lead, Head of Midwifery 2)Maternity guidelines committee and SDU lead. 3) Trust clinical guidelines sub group and guidelines administrator.	Support from Trust clinical guidelines subgroup and adminstrtor to reduce time frame for approvals and upload.	Ensure updates and reviews of guidelines are undertaken in timely manner to allow for potential delays in the approvals and upload process. Undertake monthly guidelines risk assessment.

Report to Health & Adult Social Care Select Committee

Date: **Thursday 4th March 2021**

Title: **Access to NHS Dental services in Buckinghamshire**

Author: **Hugh O'Keeffe, Senior Dental Commissioning Manager, NHS England and NHS Improvement (South-East) and Satnam Moonga, Buckinghamshire Local Dental Committee**

Recommendations/Outcomes:

1. Background

NHS England and NHS Improvement commissions dental services from primary, community and secondary care providers. The primary and community services are commissioned via contracts which fall within the NHS (General/Personal) Dental Services Regulations 2005. Secondary care (hospital) providers deliver services under NHS standard contracts.

NHS Patient Charge Regulations apply to the contracts falling within the 2005 Regulations, but not services provided under NHS standard contracts.

Providers of NHS primary care services are independent contractors, which means they provide services via contracts with the NHS rather than employment. Some provide services to all groups of patients, but some are for children and charge exempt patients only. Patients can attend whichever practice they wish.

Patients are not registered with practices but are encouraged to attend at regular intervals with the regularity of attendance based upon their assessed oral health. In the Thames Valley area (Berkshire, Oxfordshire and Buckinghamshire) about 1.1m people (52% of the population) attend an NHS Dentist on a regular basis (attendance within a 2-year period).

Providers of Orthodontic services are 'primary care' providers but provide treatment on referral for children. The community and hospital services provide treatment on referral. The Community Dental Service is for patients who have additional needs which makes treatment in a primary care setting difficult. The hospital services are more specialist in nature delivering Oral

and Maxillofacial, Orthodontic and Restorative services. In addition to this there are primary care based (tier 2) Oral Surgery (more complex extractions) and Restorative (Root canal, treatment of gum disease and dentures) services in Buckinghamshire designed to provide less complex treatments in a non-hospital setting. The tier 2 service provider hold what is known as 'advanced mandatory' contracts.

The tables below detail NHS Dental services in Buckinghamshire

Primary Care:

GDS contracts	
Full NHS	43
Child/ exempts only	23
Child only	5
Sum	71
Orthodontic contracts	6

Other services:

Service	**Provider**
Community Dental Services	Central and North-West London NHS Foundation Trust
Hospital services	Buckinghamshire Healthcare NHS Foundation Trust Milton Keynes NHS Foundation Trust
Tier 2 Oral Surgery	Rodericks
Tier 2 Restorative	Dr A Rai

The attached information circulated to stakeholders in early February about the current situation re NHS access. These reports for the Integrated Care Systems (ICS) to provide an understanding of the current provision of dental services in each ICS. This includes information about provision in the Buckinghamshire. The reports are attached.

2. Main content of report

In the period between 25th March and 8th June 2020, dental practices (NHS and private) were required to close for face to face treatments. This was due to safety concerns for patients and staff due to the limited supply of Personal Protective Equipment (PPE) at the time, with the corresponding need that priority was given to hospital services. It was also recognised that changes that would be needed to the physical environment of practices to enable safe treatment. The PPE situation has since been addressed and the environmental arrangements remain in place.

Access to face to face care was provided via Urgent Dental Care (UDC) hubs. In the period March – June 2020 there were 2 hubs in Buckinghamshire – Eastgate Dental Centre and the Buckinghamshire Community Dental Service (provided by the Central and North-West London NHS Foundation Trust). The Community Dental Service was for more vulnerable and shielded patients. In the period between April and June 2020 there were 643 referrals to the Eastgate Dental Centre and 165 to the Buckinghamshire Community Dental Service. Further hubs were opened during the summer of 2020. There are now 4 UDC hubs in Buckinghamshire, but the number of referrals to them has fallen significantly in recent months. This is because General Dental Practices were allowed to open again, on a phased basis, from early June.

Due to the on-going safety requirements, the level of patient throughput that can be achieved is much reduced so, in line with the national Standard Operating Procedure, practices have focussed on patients with an urgent dental need, with on-going health needs and in courses of treatment.

There have been expressions of concern about access to NHS Dentistry over the period since the pandemic commenced. This has included reports from a number of Healthwatch organisations across the South-East. The Buckingham Healthwatch carried out a review of General Dental Practice websites.

Each concern has been followed up with the practices concerned and there have also been on-going communications with practices about wider concerns. Two newsletters issued to General Dental Practices are attached. In these issues, guidance was provided to GDPs about information to include on their practice websites and about key requirements as set out in the national dental Standard Operating Procedure.

In the period since 1st January 2021, primary care providers have been asked to achieve a targeted level of activity in the period to 31st March 2021. This is significantly below the targets required in normal years (for the safety reasons stated above) but has helped to open up the dental system in the period since then. The practices are still required to work within the national Standard

Operating Procedure. National discussions about the contract post April 2021 are on-going.

Due to the way in which demand has presented differently to different practices, some practices have been able to more quickly to opening for routine appointments than others. Patients can receive more information about this from their dental practice

One of the patient groups that has faced particular access challenges since last March is patients who have not attended a dentist on a regular basis. The Region has recently approved a number of practice applications to provide additional sessions to enable access for these patients. There are 6 practices delivering these services in Buckinghamshire.

Another key challenge has been access to referral services. The increase in hospital waiting times has been reported nationally. This is impacting on hospital dental services in this area and the Berkshire West, Oxfordshire and Buckinghamshire Integrated Care System (ICS) is running on several workstreams to address the backlog, including use Independent Sector hospitals. As with primary care services priority is for the more clinically urgent cases to be seen more quickly. All hospital services are using the Royal College of Surgeons' prioritisation guidance to inform this process

Non-hospital dental services do not fall within this programme so NHSE/I (South-East) is leading a Restoration and Recovery programme to attempt, over time, to address this issue. At the moment services such Community Dental Services and tier 2 Oral Surgery and Restorative services are having to focus on the most urgent patients. The improved situation re PPE and recent guidance about infection control arrangements have helped to improve the situation, but patient throughput remains significantly below normal levels.

The Local Dental Committee perspective is described below:

As dentists we have always wanted to provide services to our patients and continued to do this throughout the pandemic. Even after we were required to close in March 2020, we continued to provide telephone and video consultations and have been seeing patients at the practices since June when we reopened. As PPE has become more readily available, we have performed more and more treatments safely with the highest level of PPE being used, as well as slots for vulnerable patients. We have also historically prioritised emergencies of all sorts, whether regular attenders or not.

However, the challenges we face are that it has been a long time since we have been able to see children and routine adults. This needs to be done to ensure we are screening for cancer and that there isn't a serious deterioration in children's oral health now they are at home, not having their usual routine.

As such, with a backlog of patients and longer appointments required to ensure safe practice, we are trying our hardest to see as many patients as

possible. Whilst most practices are now offering routine appointments for patients for examinations, this results in it being harder to book in emergencies. Many practices in Buckinghamshire have responded by offering increased hours during which urgent appointments for patients who do not attend the Dentist regularly can be seen, and most importantly, stabilised medium term until they can find a regular dentist. It's not ideal but we are doing whatever we can to keep the service running fully and comprehensively, albeit more slowly due to increased ventilation requirements following aerosol generating procedures.

The hardest group to reach however are older patients, especially in care homes. With the high levels of PPE that dentists are used to wearing now, there may be an opportunity to help this group of patients who have little access historically, and with flexible commissioning available there is a framework to explore this further to address patients in pain who are unable to attend the dental surgery through any of the other options available.

Long term, we are hoping that with the comprehensive vaccination programme, we will be able to return to normal appointment times and expect to clear our backlog over the year.

3. Next steps and review

3.1 Access to services:

Ensure access can be achieved for patients who attend the Dentist on regular basis and those who do not via:

- Service provision in line with the national Standard Operating Procedure
- Increased face to face provision in the period January – March 2021 (national decision to be made re provision from April 2021)
- Maintain Urgent Dental Care hubs
- Maintain access sessions for irregular attenders
- NHS Restoration and Recovery programme to address backlog of patients awaiting treatment following referral

3.2. Information about services

- Continue stakeholder communications vis NHS England and NHS Improvement and Dental services
- Receive and follow up on feedback re access to treatment

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Update on NHS dental services in the South East

Access to dental services – Berkshire West, Oxfordshire and Buckinghamshire

February 2021

Background

All dental practices were required to close for face to face care on 25 March 2020 at the beginning of the first national lockdown due to the COVID-19 pandemic. They continued to provide telephone advice to patients with an urgent need, including advice on pain relief and prescribing antibiotics where clinically appropriate.

Urgent Dental Care Hubs were set up during April with strict infection prevention control (IPC) measures in place to protect patients and staff in order to provide a referral service for those patients with the greatest urgent need. In Berkshire West, Oxfordshire and Buckinghamshire there were three hubs located in Reading, Oxford and Aylesbury.

Dental services recommenced from 8 June and have remained open for face-to-face care during the current lockdown period. By 20 July all practices were required to be open for face to face treatment whether or not they carried out aerosol generating procedures (AGPs; for example fillings, root canals, crown preparations).

A second phase of urgent dental care hubs was introduced following the reopening of practices in June with further hubs opening in Carterton in Oxfordshire, High Wycombe and Chesham in Buckinghamshire

In the national Standard Operating Procedure published in June the Office of the Chief Dental Officer detailed the priority order in which practices should see patients, with routine care to be provided only when urgent need had returned to pre-COVID levels.

Current situation

Whilst dental services are operational, the priority remains focussed on:

- patients who require access to urgent care
- patients at higher risk of oral disease
- patients with outstanding treatment needs that cannot be delayed.

All dental practices are continuing to provide remote consultations with triage and advice as necessary options.

Dental practices are also prioritising the health and safety of both patients and staff. The nature of the treatments involved means adhering to strict infection prevention control procedures between appointments, which reduces the number of patients who can be treated on a daily basis.

This has had a significant impact on those patients wishing to resume their routine dental check-ups and treatments. Patients requiring routine dental care such as check-ups and scale and polish will inevitably experience longer waiting times.

The Standard Operating Procedure (SOP) and letters from the Chief Dental Officer outlining a phased transition to the resumption of the full range of dental services are subject to regular updates.

At this stage, the patient pathway for dental care now consists of two broad stages:

- remote management and
- face-to-face management – for both urgent and routine care.

It is important to retain the initial remote stage, particularly to identify possible/confirmed COVID-19 cases (and household/bubble contacts), patients who are/were shielding, and patients at increased risk, to ensure safe care in an appropriate setting. This stage also helps to prevent inappropriate attendance, support appointment planning and maintain social distancing and patient separation.

During this phase, the baseline expectation is:

- Practices should be open for face-to-face care unless there are specific circumstances which prevent this, which should be agreed with NHS England and NHS Improvement
- Practices should prioritise urgent dental care provision, with flexibility for practices to do what is best for their patients.

Access to NHS dental services

NHS England and NHS Improvement South-East has received reports that NHS dentistry is difficult to access at the moment. This is partly due to the still prevalent belief that patients register with a practice. This has not been the case since the current contractual arrangements were introduced in 2006. Under the current contract, practices' obligations extend only as far as the patient's current course of treatment; once it ends, practices do not have to see the patient again if they do not have the capacity to do so. However, most practices operate a list of patients that they consider to be theirs, and because practices can self-determine whether they accept new patients for NHS treatment this leads many to say that they are not accepting new patients.

All practices have varying sizes of NHS contract which will affect how many hours per week they are funded to provide NHS treatment. This means they have varying levels of capacity to see patients on the NHS on a face to face basis. In order to assist practices to determine the amount of time that should be allocated to NHS treatment, NHS England and NHS Improvement has advised that the same amount of time should continue to be allocated now as would have been the case during a typical week pre-COVID.

If patients have concerns about this they can follow up with NHS England and NHS Improvement on england.contactus@nhs.net who can provide further advice or investigate the matter with the practice concerned.

Action being taken by NHS England and NHS Improvement South-East

We continue to stress that all practices should deal with any patient who calls them within their NHS capacity, whether or not they have seen that patient in the past. This means that if a patient enquires to whether the practice is 'taking on' NHS patients, the practice should assess whether the patient has an urgent need, is at high risk of oral disease or has outstanding treatment that cannot be delayed. Practices should not be utilising capacity for routine care if they are unable to meet the urgent need presenting to them. This does not necessarily mean that patients with an urgent need will automatically be offered a face to face appointment but if a need to be seen is identified, the practice can arrange for this happen.

In December, NHS England and NHS Improvement implemented arrangements for the NHS dental contract for the period 1st January – 31st March 2021. This re-introduced activity targets for this period. Whilst this means that practices should continue to support patient access as described above, it also means that many will be able to open for routine appointments. All the safety considerations remain in place and priority should be given to patients identified as having the highest need, but the arrangements from 1st January will increase capacity in the system.

NHS England and NHS Improvement (South-East) also recently approved 14 practices in the area to provide additional hours in support of patients who do not attend the Dentist regularly and are in need of urgent treatment. They will commence service provision this month.

Urgent Dental Care hubs are still in place to see patients referred to them where practices cannot provide certain dental procedures due to safety considerations for members of the dental team or they have service continuity issues due to local outbreaks. Referrals to these hubs have fallen by 98% since resumption of services in June when general dental practices started to reopen, but they remain vital to the local dental systems.

As per other referral services there are on-going challenges with waiting times for dental referral services. This includes referrals to hospital Oral and Maxillofacial, Restorative and Orthodontic services; General Anaesthetic services for children and special care adults and tier 2 community based Oral Surgery, Restorative and Orthodontic services. NHSE/I (South-East) is working with a range of stakeholders on Restoration and Recovery plans with a focus on patients in the most urgent need of treatment. But all these services face the same challenges as others in terms of access to facilities in the NHS at this stage of the pandemic and the requirements to provide services safely.

Information for patients

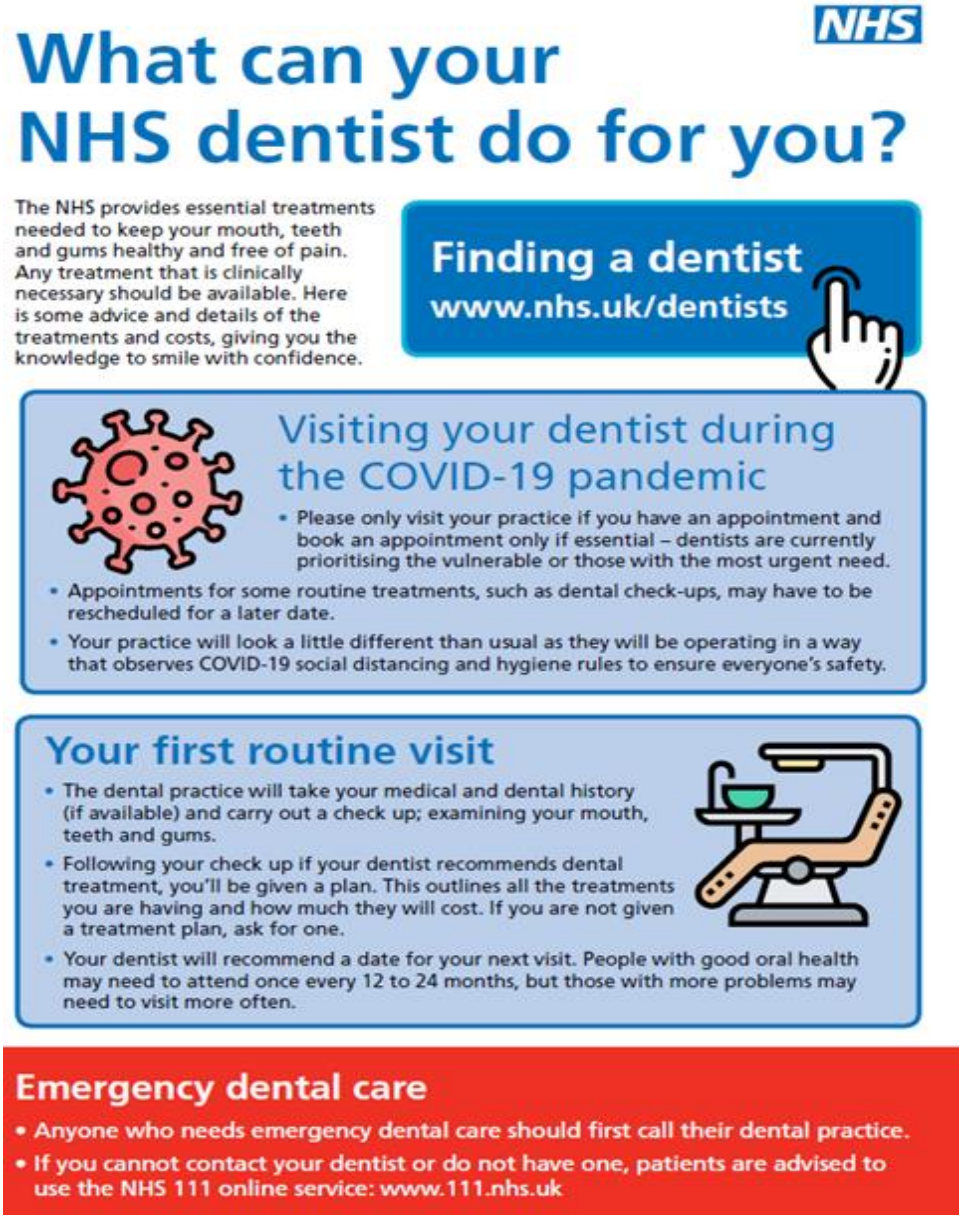
We understand that this is a confusing time for members of the public trying to access NHS dental care. Practices are communicating with their regular patients to keep them informed of services available from their practice and what they need to do to access these. Practices are also responsible for ensuring their information is up-to-date on the NHS website so that members of the public without a regular dentist can search for services local to them.

If patients do attend a dental practice on a regular basis then they should contact that practice if they believe they have an urgent need. If not, they can search for a dentist in their local area on the NHS website or they can call NHS 111 who will direct them to the NHS practice closest to their home address.

We ask patients to be understanding of the current situation with regards to the prioritisation of those with urgent needs and be respectful of the clinical decision. The dentist is best placed to clinically assess their dental issue. If they are deemed non-urgent, we would ask that they don't then call NHS 111 for a second opinion leaving the service free to deal with other patients with urgent health issues.

Communicating with the public

Please find below a tweet/Facebook message and a digital asset for sharing on your own social media accounts:



Name of Health system	**Berkshire West, Oxfordshire and Buckinghamshire**
Population (2018)	1,704,635
% of patients accessing NHS dental services in the 2 years to 30th April 2020	50.59%
Number of dental practices	193
Number of Units of Dental Activity (UDAs) commissioned	2,194,856
Number of UDAs per head (health system)	1.29
Number of UDAs per head (South-East)	1.33
Number of Orthodontic practices	17
Number of Units of Orthodontic Activity (UOAs) commissioned	139,583
Number of Sedation practices	1
Number of Urgent Dental Care Centres (UDCs)	9
Location of UDCs	Reading, Slough, Bracknell, Oxford*2, Carterton, Aylesbury, Amerham, Chesham, High Wycombe
Locations of Out of Hours services	Reading, Newbury, Slough, Oxford, Aylesbury
Out of Hours – hours of availability	West Berkshire - 18.30 - 22.00 evenings, 12.30 - 15.30 Saturdays and 10.00 - 14.00 Sundays and bank holidays. Oxfordshire - 18.30 - 21.30 evenings, 09.00 - 17.00 weekends and bank holidays. Bucks - 18.30 - 21.30 evenings, 09.00 - 17.00 weekends and bank holidays
Name of Community Dental Services providers	Berkshire Healthcare NHS Foundation Trust; Oxford Health NHS Foundation Trust and Central and North-West London NHS Foundation Trust (Bucks)
Local hospitals for secondary care dental	Royal Berkshire Hospital, Reading; West Community Hospital, Newbury (Roysl Berkshire NHS Foundation Trust). John Radcliffe Hospital, Oxford; Horton Hospital, Banbury (Oxford University Hospitals NHS Foundation Trust). Stoke Mandeville Hospital, Aylesbury and Wycombe General Hospital, High Wycombe (Buckinghamshire Healthcare NHS Foundation Trust)

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NHS England and NHS Improvement South-East

Covid-19: Delivery of Urgent Dental Care

GDP and Urgent Dental Care hub briefing

Issue No. 11 **27th November 2020**

Issue	
Communications re access to dental services	We have recently issued updated communications to a range of stakeholders about access to NHS dental services during the Coronavirus pandemic.
Dental practice capacity to see urgent patients	Practices should have the same number of performers/staff working the same number of hours as pre-Covid to provide the same level of NHS capacity with the expectation that all patients who contact them with urgent need are seen. If practices do not have the capacity to do this then they should not have resumed non-urgent care.
Information for patients on dental practice websites and in response to phone calls	A number of Healthwatches have recently completed reviews of information on GP and dental practice websites and made the following recommendations for dental practice websites. Practice websites should describe: • *how the practice is handling routine appointments (eg if patients will be contacted with a rescheduled appointment)* • *what to do in an emergency or if urgent treatment is needed* • *how patients will be protected and what to expect when visiting the surgery as well as any actions a patient is expected to take on arrival* • *a prominent date when the website is updated to reassure patients that it's up to date* We ask that all practices review their websites to ensure this information is included as a minimum. *When patients ring dental practices and say they've been advised they're taking on new patients the practices must clarify with the patient if they have an urgent or emergency dental need.*
Christmas and New Year Opening Arrangements	On 28 October 2020, NHS England and NHS Improvement South East Dental team emailed all providers to seek their Christmas and New Year opening hours. This return covered the period from 21 December 2020 – 1 January 2021 inclusive. The email was sent from england.southeastwinter@nhs.net

	The communication made it clear that hours were needed from all services with the exception of Restorative, IMOS, prisons and Sedation. Where a provider has multiple contracts then a survey would be completed for each of them, with the exception of Community Dental Services which we can identify more easily from the data received. We would like to thank the majority of practices which have replied. We have received 1004 completed surveys. However, we are still waiting for a significant number, for 185 contract numbers, which are outstanding. We have targeted our reminders to those practices which still have yet to submit a survey, sending out two reminders already. Please can you review whether you have completed this survey or been in contact with us to confirm your Christmas and New Year arrangements. If you have still not done this then do get in touch as soon as possible, by early December at the very latest. The survey link is shown here https://forms.office.com/Pages/ResponsePage.aspx?id=kp4VA8ZyI0umSq9Q55Ctv1ze_yYHqqxBhOuDt1izxeRUOEdLM0hERFZDM1pJN0k3NEVJTFlKNk4xUC4u We will be sharing the opening hour arrangements with 111 and Helpdesks. We would like to add that if as a provider you are contracted to open on Saturdays then we would expect you to do so given that the Monday 28 December is the bank holiday this year. As stated in our original email: “When it is clinically indicated practices must still see patients face to face. If your practice chooses to close you must have in place a buddy arrangement with a neighbouring practice. This "buddy" practice must have the capacity to carry out AAA for your patients and when necessary see them for a face to face appointment. It is acceptable for you to carry out AAA remotely with your buddy arrangement in place to see a patient face to face should this be required. Where you are closed altogether with a buddy arrangement for all urgent care your practice answer phone and website must be updated to detail your buddy arrangements for normal working hours and Out of Hours service details for those periods. *Please be aware that it is not acceptable to refer patients needing face to face appointments either to Urgent Dental Care Hubs or to Out of Hours services. The Hubs’ remit will not change and referrals should be made only in cases where you cannot carry out an aerosol generating procedure; Out of Hours*

	services should be used by patients only where their dental pain starts outside of your normal practice opening hours."
Launch: Reducing the health inequality gap; new framework for NHS trusts	A new resource from NHS Providers and the Provider Public Health Network (with support from Public Health England) sets out a plan of action for trusts to combat growing health inequalities in the next stage of the COVID-19 pandemic. *Reducing health inequalities associated with COVID 19: a framework for healthcare providers* presents a set of principles, stepped actions and examples from practice from NHS and integrated care settings, to help trusts and partner organisations understand and tackle health inequalities amongst their populations. Comments or feedback on the framework are welcomed – please contact leanora.volpe@nhsproviders.org.

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NHS England and NHS Improvement South-East

Covid-19: Delivery of Urgent Dental Care

GDP and Urgent Dental Care hub briefing

Issue No. 12 **23rd December 2020**

Issue	
Dental Transition to Recovery	It is now over six months since the arrangements for restarting face to face dental services were published – Standard Operating Procedure (SOP) – Transition to Recovery version 1. We are now working to version 4 published on 27th October 2020. In the intervening time providers of primary dental care have commendably taken heed of the various versions of the guidelines to ensure a safe working environment for dental teams to move from: • initial provision of urgent dental care to • prioritisation of patients with interrupted care or at risk of deterioration, • provision of routine preventative care to • eventually progress to a full range of routine dental care and full operating capacity gradually over time. There is now however much concern about the access for patients to dental care regarded as non-urgent. The care that dental teams are currently offering will depend on their own situation. Whilst the request of NHS England is for all dental practices to offer AAA via remote triage or by a face-to-face appointment if considered necessary, with the reduction in fallow time that the majority of dental practices can implement as a result of SDCEP document - Mitigation of Aerosol Generating Procedures in Dentistry A Rapid Review Version 1.0 ~ 25 September 2020, the times available for appointments should increase. Providers should be familiar with the documents suggestions for fallow times summarised in the table on page 23 The current version 4 of the SOP recommends on page 11: ….. recommencing deferred courses of treatment, recall and re-assessments will need to prioritise groups with the greatest need. Practices should consider prioritising patients: • Who have contacted the COVID-19 UDC system and already been triaged for urgent dental care and/or require follow-up care. • With incomplete care plans. • With frequent recall according to NICE recall guidelines eg children, high oral disease risk, those patients whose oral health impacts on systemic health and those who have been through stabilisation and need review.

	• With routine dental care needs, not applicable to any of the above cohorts. • In sequencing and scheduling of patients the aim will continue to be the need to minimise the risk of transmission of COVID-19 between staff, patients, patients and staff. Page 12 of version 4 gives further guidance on treatment planning: Treatment planning with a focus on stabilisation should be delivered in line with the principles outlined in the Avoidance of Doubt: Provision of Phased Treatments and complemented with a strong focus on prevention of disease progression, including periodontal management, oral health prevention including fluoride applications (ie Delivering Better Oral Health). The document Avoidance of Doubt: Provision of Phased Treatments refers to urgent treatment initially, but then to a second phase course of treatment which may include: Other appropriate treatment, such as: • definitive restorations • periodontal therapy • endodontic therapy • extractions Decision regarding further courses and timescale The document also has a note to acknowledge that for some patients, there will be cases where an immediate prostheses may be provided in the initial CoTs. This will be Band 3 treatment. Thus, for those patients who seek care who have terminal teeth and need to move on to dentures, these treatments should still be going ahead. Useful guidance is also included in the SOP in Appendix 7 which shows a clear pathway for: 1. Teeth with reversible pulpitis to proceed in primary dental care to be permanently restored and 2. Teeth which have symptomatic irreversible pulpitis, symptomatic apical periodontitis or have acute apical abscess after any urgent dental care e.g. extirpation should progress in primary dental care to RCT, obturation of root canals and initial restoration. Where obturation of root canals has occurred, the flowchart recommends remove obturation material at orifice level and restore with permanent core restoration – prior to future definitive cuspal coverage restoration if indicated The prolonged use of temporary restorations frequently results in eventual loss of these, further caries and pulpal symptoms. There is much evidence to suggest that a prolonged interval between pulp extirpation and dressing and root canal preparation and obturation lowers

	the RCT success rate. We are now hearing of patients having pain as the initial extirpation and temporisation was performed many weeks ago. There are also reported cases of patients receiving repeat courses of antibiotics where straightforward (tier one) dental care would have avoided that need. The dental team are hearing that most providers are adopting the phased treatment approach as above and where urgent dental care has been given to progress to definitive care – in fact most are now at the point in their transition to recovery to be able to offer a comprehensive service to patients as indicated by the SOP. This is clearly necessary to avoid a second course of urgent care being provided for the same patients. As you may be already aware, from 1 December 2020, you'll no longer need to submit a COVID-19 triage form if a face-to-face appointment is made for the patient and an FP17 form is submitted. However, a COVID-19 triage form is required if the patient fails to attend their appointment and has previously received remote advice from a dentist, dental care professional or orthodontic therapist. This new change in recognised activity is a shift towards the assumption that more and more practices should now be offering more f2f appointments. This return to the ability of most providers to offer comprehensive care by following the guidance in the SOP is in line with clause 261 of the GDS contract which requires providers to comply with all relevant legislation and have regard to all relevant guidance issued by NHS England & NHS Improvement. It is worthwhile also to remember that the fallow time for an AGP commences from the point of ceasing to create any aerosol e.g from the point a clinician stops using high-speed dental drills or ultrasonic devices. Currently whilst practices strive to offer urgent and comprehensive care, we are aware that prioritisation is occurring. The dental team has received requests that in their protocols for prioritisation, providers should consider those patients who need specific attention as their care will be affected by being seen in a timely manner. Two less obvious examples where we would hope that providers will prioritise patients accordingly are: 1. Patients about to receive treatments for cancer where a dental examination and any necessary treatment is required prior to treatment to assure that their oral health will not later impact on their general health and cancer care and 2. Patients about to receive orthodontic care where timely conservation and possibly extractions are required to enable the orthodontic care to proceed at the appropriate time. In all of this, the NHS England South East dental team are aware of the significant efforts that providers and their dental teams have gone to in order to offer safe patient care. We will be conducting a survey of all providers to ensure they are at the stage of being able to offer

	comprehensive care and if not when this will be or what the barriers to this are.
Information for patients	Please find attached a recently released NHS leaflet providing information to patients about access to NHS Dental services: Adobe Acrobat Document
Covid tiers and Christmas bubbles	Please see links to information Covid tiers and advice for making a Christmas bubble with family and friends: https://www.gov.uk/government/publications/tier-posters-medium-high-and-very-high?utm_source=795b3ace-84b4-4724-b2df-e79ac54d3316&utm_medium=email&utm_campaign=govuk-notifications&utm_content=daily https://www.gov.uk/government/publications/making-a-christmas-bubble-with-friends-and-family?utm_source=d2e022c4-5b52-4bd5-ba32-faf8790d3d6c&utm_medium=email&utm_campaign=govuk-notifications&utm_content=daily

Report to Health & Adult Social Care Select Committee

Date: 4th March 2021

Title: **Adult Social Care Update**

Author: **Gillian Quinton, Corporate Director**

Officer support:

Recommendations/Outcomes: The Committee is asked to note the report.

1. Background

Following its last meeting, the HASC asked for an update on key issues facing adult social care. This report focuses on the adult social care response to Covid, the social care workforce, support to carers, vaccinations in care homes, support to care providers, and the Better Lives Transformation programme.

2. Main content of report

Adult social care continues to operate at the forefront of the Covid pandemic response, as it has done since the start of the crisis in early 2020. At the same time, statutory services have been maintained as a result of careful planning, joint work with health and social care partners, and a highly flexible and adaptable workforce.

Unfortunately, we were unable to secure additional support from neighbouring authorities although by reallocating our resources we were able meet the demands of the pandemic without resorting to enacting any of the Care Act Easements.

Covid Response: Since early January 2021, adult social care has particularly focussed on hospital discharges and on ensuring the safety of our most vulnerable clients:

<u>Vulnerable clients</u>

- A consortium of providers are delivering a 'keep in touch' service to those users of social care services who need and have requested support
- The consortium includes Connections Support, Bucks Mind & Age UK, and Community Impact Bucks is seeking engagement from other VCS organisations
- Approximately 170 people have signed up for the service and are receiving weekly calls from the providers.
- Six library staff have been reassigned through the Council's mutual aid programme, providing addition capacity to ensure that support is provided to everyone who requests it.

Hospital discharges

- A joint ASC and NHS hospital discharge cell was set up in early January, initially meeting daily, to monitor, address issues and plan for people to leave hospital appropriately
- A Covid-positive designated setting, Chartridge Ward, has been consistently used to capacity (14 beds)
- An additional 4 Covid-positive beds have been secured at a designated setting in Berkshire
- Seeleys was repurposed for several weeks as a facility to take people with low level care needs whilst their home care arrangements were sorted
- 139 short-term placements (Discharge to Assess) in care homes were commissioned to ensure people could recover and be assessed for care needs out of the hospital setting
- A new operational process was introduced for the hospital RRIC and local authority Reablement teams which meant that patients were more quickly helped to return home
- Capacity was developed so that 70 people could be supported home through Home First and home care Discharge to Assess arrangements
- A reporting process was developed to ensure issues on discharge were logged and lessons quickly learned
- Improvements were made to the information available on patients who were or about to be medically fit within Bucks Hospital Trust (BHT) to enable better system planning
- Issues faced during this period included significant pressures on hospital capacity, and community hospital and care home outbreaks (which reduced discharge pathway capacity)
- Pressure on hospitals, as at 16 February, appears to be easing.
- D2A beds in care homes have high occupancy and each one will require assessment and consequent arrangement of care packages, as necessary, during the 6-week stay.
- Staffing capacity to support the D2A care home pathway is challenging. Therapists and reablement staff are needed to support recovery, and social care staff to make assessments

Workforce:

Vacancies

The table below shows the vacancy rate as at 12 February 2021. The data relates to all regulated adult social care posts and excludes social work assistants and agency posts. The data does include social worker posts covered by agency workers (shown as vacancies for the purpose of the vacancy rate calculation).

Table 1: Social Work Vacancies, 12 Feb 2021

HR Metric	Posts	Comments
Total social worker posts	118	78 posts covered by BC/BCC employees
Total vacant social worker posts	37	15 posts covered by agency workers 22 vacant posts
Vacancy rate (including posts covered by agency staff)	31%	Calculation: 37/118 x 100 = % rate
Vacancy rate (excluding posts covered by agency staff)	19%	Calculation: 22/118 x 100 = % rate

In addition, adult social care has a further 18 agency/interim staff, 15 of whom are funded by the CCG/Covid-19 funding.

Support for Staff

The past year has been a challenge for those working in adult social care. As part of the Council's commitment to supporting health and wellbeing of staff, employees have been encouraged to take advantage of a range of support and advice including:

- Information, advice and support available through the Council's corporate functions including the employee assistance programme, access to counselling, Mental Health First Aiders and learning hub resources
- Use of the MIND Wellness Plan, which has been actively promoted throughout adult social care
- Specialist support for adult social care staff such as Cruse bereavement webinars, team reflective sessions, and webinars for managing anxiety and for managers in supporting the mental health of their teams
- You Matter, a new staff mental health and wellbeing hub, which was launched in early February across the Buckinghamshire, Oxfordshire and Berkshire West footprint

3. Carers:

Adult social care commissions Carers Bucks to deliver support to Buckinghamshire's carers. At the end of Quarter 3, 2020-21, there were 12,786 registered with the service. During Covid, Carers Bucks has:

- Secured infection control grant monies of £150,000 to enable carers to access PPE and pay additional support so carers can attend vaccinations or testing. This has been promoted across Buckinghamshire and approx. 400 people to date have applied for funds
- Continued to provide prompt information, advice, guidance and emotional support to carers through its Adult Carer Service including the core team, hospital team and Caring for Older Carers team, both by responding to calls and by making wellbeing calls to some of the most vulnerable carers. Calls received have related in the main to carers in crisis, seeking practical support or seeking support over the loss of family members who had passed away in hospital.
- Reorganised delivery from April to June 2020, arranging telephone monitoring to check on wellbeing, and prioritising people caring for someone with dementia and young carers no longer able to access support through school
- In July 2020, started delivering monthly virtual support groups for adult carers via Zoom, as well as continuing offering support services to newly referred carers
- Used the carers discretionary budget to fund therapies to help carers with their own health and wellbeing needs

Young Carers

- Carers Bucks contacted all 1043 young carers several times during the initial lockdown
- Support offered included free meals through the Masons and delivery of activity packs
- Assessments and one-to-ones were held in schools and colleges in a safe environment with Zoom used where that was not possible

- Zoom has also been used for targeted support, and fun sessions such as fitness, Zumba and arts and crafts
- Two activity days were held during the summer for young carers most socially isolated with over 40 attendees at each
- A 'Reaching Out' project was started using additional funding from the Carers Trust to support young carers to overcome anxiety about returning to society
- In the autumn, face-to-face sessions resumed, and young carers were able to take part in Halloween events in Chesham, Wycombe and Aylesbury
- Covid safe walks with support workers were instigated
- Presents and hampers were arranged for all carers over the Christmas period

4. **Vaccination programme:** All care home settings have been contacted regularly to offer residents and staff vaccines. Staff have additionally been repeatedly encouraged to be vaccinated, which they can access through care homes, the national portal, or from hospital hubs.

Data is only available through the Capacity Tracker and therefore is unlikely to be an accurate record. However, as at 16 February, of the 122 care homes listed on the tracker:

- 2403 residents had been vaccinated, with 308 not vaccinated
- 2779 staff had been vaccinated, with 1440 staff not vaccinated

Communications to care homes and social care staff continues to encourage vaccinations.

5. **Care Home Provider market**:

Support to Care Providers

The Covid pandemic has created a number of pressures on care providers including increased operational costs and a reduction in self funder clients. During the Covid pandemic the Council has supported providers in a number of ways:

- Ensuring care providers have had prompt access to additional funding made available by the Government:
  - Infection Control Fund – 1st Allocation - £6,252,586
  - Infection Control Fund – 2nd Allocation - £5,335,317
  - Rapid Testing Grant - £1,524,454
  - Covid claims - £5,895,013
  - Workforce Capacity Grant - £836K

- Supporting provider operations, for example by enabling access to key Government schemes such as access to free PPE and testing, and working with providers who are experiencing staffing difficulties
- Using the National Capacity Tracker and intelligence from other agencies to identify providers facing particular challenges and making proactive contact to offer assistance
- Holding regular forums to meet with the senior leaders from the largest providers, to get feedback on the care environment.

Financial Viability

A key activity in the commissioning of social care services is identifying, understanding and managing supplier risk and the ongoing monitoring of the financial viability. Providers at risk of financial difficulties are identified through contract monitoring or by making direct contact. The Council seeks to mitigate the financial risks as far as possible by working with providers and providing appropriate support. A provider support tool has been developed to assess approaches from providers who are experiencing financial difficulties.

However, the Council has limited control over financial risks, as many providers have a high number of self-funders and are businesses which are independent of the Council. There are also limits to the level of intervention the Council can provide to a business which finds it is no longer financially viable. In this event, the Council has a duty to safeguard and support the affected clients and ensure continuity of their care. The form this will take is dependent on the specific circumstances.

6. **Better Lives Strategy:** Despite the pandemic work has continued on key transformation projects where it has been possible to do so:

Better Lives Strategy Shift

- *Living Independently* aim: The majority of people will help themselves to stay well and live independent, fulfilled lives
- *Regaining Independence* aim: Services provide short-term support to help people maintain or regain control over their lives
- *Living with Support* aim: Personalised social care support will be created with people and their families

Project Updates

- Short term intervention: This project is about transforming health and Council reablement services into a single, therapy led service, integrated with the community OT. Work has been delayed as the system responds to the pandemic. However, as a result of the need to relieve hospital pressures a joint triage system is being piloted and is showing encouraging results. This will be taken into consideration in shaping the future design of the service
- Preparation for adulthood: Development of an holistic service across ASC and Children's Services is being progressed, although implementation has been delayed by Covid
- Mental health services: Work is taking place to review the Section 75 arrangement and to review and implement improvements to social care practice. Timeframes have again slipped due to the pandemic.

Transformation Phase 2

- The Directorate is starting work to consider what the next phase of the Transformation programme should include. One area will be on services and support for carers.

7. Next steps and review

The Adults and Health Directorate is still responding to the Covid pandemic and supporting partners in the wider health and social care system in their response. However, statutory

services continue to be delivered and the Directorate remains focussed on doing all it can to ensure our most vulnerable residents are supported to stay safe and well.

2020-2021

Health & Adult Social Care Select Committee Highlights

Prepared by Liz Wheaton
Principal Scrutiny Officer
February 2021

Health and Adult Social Care Select Committee – Chairman's statement from 2020-21

"I was elected as Chairman of the Health and Adult Social Care Select Committee (HASC) in June 2020 at one of the most challenging times for our health and social care colleagues. Understandably, the Covid-19 pandemic has dominated our work programme over the last few months but we have, as a Committee, also been involved in challenging the proposed closure of a local GP surgery, responding to a number of consultations and working towards a joint health scrutiny committee for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

On behalf of the Committee Members, I would like to thank the Cabinet Members, officers and health partners who have attended the Select Committee over the past year."

Jane MacBean, Chairman of the HASC Select Committee 2020-21

Members of the HASC Committee between May 2020-March 2021


Khalil Ahmed


Zia Ahmed


Alan Bacon


Patricia Birchley


Malcolm Bradford


Michael Collins


Guy Hollis


Sandra Jenkins


Gary Powell


Brian Roberts


Alan Turner


Liz Walsh


Julia Wassell


Lawrence Wood

Co-opted Members
Ms Z McIntosh, Healthwatch Bucks

Committee Support
The HASC Select Committee is supported by Liz Wheaton, Principal Scrutiny Officer who is part of Democratic Services. Email – ewheaton@buckscc.gov.uk

The Role of the HASC

The Council's Health and Adult Social Care (HASC) Select Committee holds decision-makers to account for improving outcomes and services for the residents of Buckinghamshire. The Committee works cross party and for the good of all Buckinghamshire residents.

Committee meetings

The Select Committee has held 5 formal Committee meetings this year (June to March) and has reviewed and challenged a number of key issues as outlined below.

Key issues looked at during 2020-21

The Committee has reviewed and challenged a number of key areas including:

- Mental Health services;
- Pharmacists;
- Winter Planning – system resilience;
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System;
- Buckinghamshire Integrated Care Partnership – response to Covid-19 and recovery plans, including the vaccination programme;
- Adult Social Care, including support to care home providers;
- Development of Primary Care Networks;
- Proposed closure of New Chapel Surgery, Long Crendon;
- Dental services;
- Maternity services in light of the Ockenden Report (published December 2020).

Key Achievements between June 2020-March 2021

- A group of HASC Members prepared a statement for inclusion in the Buckinghamshire Healthcare NHS Trust's annual quality account (September 2020);
- Committee Members responded to the consultation around the proposed closure of New Chapel Surgery, Long Crendon;
- Buckinghamshire organised an informal meeting with key health scrutiny colleagues from BOB ICS to discuss the arrangements for setting up a joint health scrutiny committee;
- Committee Members prepared a response to the NHS Integrated Care – next steps consultation which could see Integrated Care System's given more of a legal footing.

Possible future agenda items

- Primary Care Networks – progress with developing these;
- Primary Care healthcare planning;
- Tackling Health inequalities;
- Obesity – build on the 2018 Child Obesity HASC Inquiry;
- Review Diabetes patient pathway;
- Ongoing review and challenge of the decisions coming out of the recent County-wide engagement project;
- Development of Community hubs – progress on moving care closer to home for elderly patients – linked to the above;
- Impact of drugs and alcohol on the health system;
- Adult Social Care – delivery of Better Lives Strategy;
- Maternity services – ongoing review in conjunction with the Ockenden report;
- Support for Carers;
- Care Homes – market position and plans for future;
- Director for Public Health Annual report;
- Commissioning intentions – pre-decision scrutiny;
- Workforce wellbeing;
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System;
- Covid-19 – lessons learnt;
- Performance of BHT and the CCGs – review their performance against national indicators;
- SCAS performance.

Possible topics for in-depth reviews

- Oxford Health – mental health services – joint piece of work with the Children's Select Committee;
- Dementia Services – following on from the Dementia Inquiry report in 2013;
- Future plans for GP surgeries – with the inception of Primary Care Networks in June 2019, what has the impact been on patients on this new way of working and what are the plans for renovating existing GP surgeries and building new surgeries to meet future demand.

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