Notice of Meeting

Health Scrutiny Committee

Wednesday, 10th November, 2021 at 1.30 pm

in the Council Chamber Council Offices Market Street Newbury

This meeting can be streamed live here:
https://westberks.gov.uk/hsclive

Date of despatch of Agenda: Tuesday, 2 November 2021

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Gordon Oliver on 01635 519486
e-mail: gordon.oliver1@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Councillors Jeff Beck, Tony Linden, Alan Macro (Vice-Chairman), Andy Moore and Claire Rowles (Chairman)

Substitutes: Councillors Jeff Brooks, Gareth Hurley, Thomas Marino and Erik Pattenden

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Agenda

Part I

Page No.

1 **Apologies** — 1 - 2
To receive apologies for inability to attend the meeting (if any).

2 **Minutes** — 3 - 10
To approve as a correct record the Minutes of the meeting of the Committee held on 11 August 2021.

3 **Declarations of Interest** — 11 - 12
To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct.

4 **Petitions** — 13 - 14
Purpose: To consider any petitions requiring an Officer response.

5 **Health Scrutiny Committee Prioritisation Methodology** — 15 - 22
Purpose: This report presents a transparent and objective methodology which is designed to help prioritise which topics the Health Scrutiny Committee should be considering.

6 **Protocol between the West Berkshire Health Scrutiny Committee and local health bodies** — 23 - 48
Purpose: The report presents a draft protocol that sets out how the West Berkshire Health Scrutiny Committee will work together with bodies who commission or provide health and wellbeing services to residents of West Berkshire.

7 **NHS Dentistry** — 49 - 56
Purpose: To understand how NHS Dentistry services are performing, how they have been affected by the Covid-19 pandemic and how services will be developed in order to respond to patients' needs.

8 **Access to GPs and the Impact of Covid-19 on Primary Care** 57 - 66
Purpose: The Berkshire West Clinical Commissioning Group to provide a presentation on patient access to GPs and the impact of the Covid-19 pandemic on primary care.

9 **Berkshire West Clinical Commissioning Group Update** 67 - 68
Purpose: The Berkshire West Clinical Commissioning Group (CCG) to provide an update on activities and commissioning plans, including development of the Integrated Care System (ICS).

10 **Healthwatch Report** 69 - 80
Purpose: Healthwatch West Berkshire to report on views gathered on healthcare services in the district.

11 **Work Programme** 81 - 84
Purpose: To confirm the dates of future meetings, receive new items and agree and prioritise the work programme of the Health Scrutiny Committee.

Sarah Clarke
Service Director (Strategy and Governance)

If you require this information in a different format or translation, please contact Stephen Chard on telephone (01635) 519462.

West Berkshire
COUNCIL

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Agenda Item 1

Health Scrutiny Committee – 10 November 2021

Item 1 – Apologies

Verbal Item

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DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON WEDNESDAY, 11 AUGUST 2021

Councillors Present: Jeff Beck, Tony Linden, Alan Macro (Vice-Chairman), Andy Moore and Claire Rowles (Chairman)

Also Present: Graham Bridgman, Sarah Rayfield, Gordon Oliver (Principal Policy Officer) and Andrew Sharp (Chief Officer, Healthwatch)

PART I

3 Minutes

The minutes of the meeting on 4 May 2021 were accepted as a true and correct record.

4 Declarations of Interest

Councillor Andy Moore declared that he was an NHS volunteer, and asked that this be noted as a standing declaration for this Committee.

Andrew Sharp declared that he was Chair of Trustees of the West Berks Rapid Response Cars (WBRRC), and asked that this be noted as a standing declaration for this Committee.

5 Petitions

There were no petitions received.

6 Terms of Reference

Councillor Claire Rowles (Chairman) presented the current Terms of Reference (Agenda Item 5). She explained that these had been agreed when the Committee had been established by Council on 4 May 2021.

Councillor Graham Bridgman indicated that the Constitutional Task Group was reviewing the Council's Constitution and the Terms of Reference for this Committee would become an appendix of the Constitution. He noted that some aspects were already covered by the Constitution, such as the process for calling extraordinary meetings.

Councillor Tony Linden suggested that for a Committee of five Members, a quorum of three would be better than four, since some Members may not be able to attend all meetings or may need to attend remotely. He also suggested that the Committee should be increased to seven Members due to the volume of work involved. Councillor Bridgman explained that the Constitution was clear on the quorum, which was one third of the Committee or four Members, whichever the lesser in terms of membership.

Councillor Andy Moore noted that paragraph 1 of the Terms of Reference stated: "to ensure that services are safe and effective in improving health and wellbeing of local citizens and reducing health inequalities". He stated that a regulator or scrutiny Committee did not have the power to **ensure** something, but that its function was to **assure** as a result of its scrutinisation. As such, he suggested the Terms of Reference be

amended to reflect this. The Chairman advised that any amendment to the Terms of Reference would need to be agreed at Full Council.

Andrew Sharpe noted that scrutiny of Social Care services would remain with the Overview and Scrutiny Management Commission (OSMC) and asked how scrutiny of services jointly commission by the Clinical Commissioning Group (CCG) and Social Care would be considered (e.g. hospital discharges). Gordon Oliver advised that this issue had been raised in relation to the current review of Continuing Healthcare. He confirmed that where issues such as this arose, consideration would be given to who was taking the lead, and this would determine the most appropriate route for scrutiny. Councillor Bridgman added that the Health Scrutiny Committee and OSMC could appoint a joint committee to deal with such matters.

7 Joint Health and Wellbeing Strategy

Sarah Rayfield, Acting Consultant in Public Heath, gave a presentation on the Joint Health and Wellbeing Strategy (Agenda Item 6). The presentation went through the process of how the Strategy was developed.

In April 2019, the Health and Wellbeing Board Chairmen from West Berkshire, Reading and Wokingham had agreed to develop a Joint Health and Wellbeing Strategy. Work started in March 2020 by evaluating the current strategies and looking at their impacts. Identification of residents' needs was informed by data and discussion with stakeholders, partners and organisations working in the area. An initial long-list of 30 priorities had been developed, which was refined to a list of 11 through a series of workshops. In November 2020, a public engagement exercise was used to further refine the priorities to a total of five.

The presentation included a number of key Statistics relating to the population, demographics and health needs of West Berkshire residents.

It was explained that the Strategy had been co-produced and delivered through a Consultation and Engagement Task and Finish Group. An online survey had attracted 3,967 responses, 1,201 of which were from West Berkshire. In addition, 18 focus groups had been held with under-represented groups.

Comments from West Berkshire residents were around the following themes:

- Better communication and support for parents of children with mental health difficulties.
- Bring together the educational needs and long-term wellbeing of young people.
- More financial support for people and families who work but still struggle to pay household bills.
- Better coordination between Social Services and the NHS for elderly / vulnerable people.
- Minority groups were less likely to use and trust public services.
- The impact of dementia on people, and their families, required input from many agencies.

The final agreed priorities were:

1. Reduce the differences in health between different groups of people.
2. Support individuals at high risk of bad health outcomes to live healthy lives.
3. Help families and children in early years.
4. Promote good mental health and wellbeing for all children and young people.
5. Promote good mental health and wellbeing for all adults.

The Strategy was underpinned by the following eight principles:

1. Recovery from Covid-19
2. Engagement
3. Prevention and Early Intervention
4. Empowerment and Self Care
5. Digital Enablement
6. Social Cohesion
7. Integration
8. Continuous learning

It was confirmed that the Strategy would be in place for the next 10 years, but it would be adjusted as needed to reflect new learning and data.

An online public consultation on the draft strategy had taken place in West Berkshire and Reading from 24 June to 4 August 2021. Of the 162 responses received, 67% were from West Berkshire, 26% from Reading and 7% from other areas. 80% of responses were from individuals and 12% were on behalf of organisations. The responses showed strong support for each of the priorities and supporting strategic objectives.

Themes in the 'free text' comments included:

- A general acknowledgement that the priorities were sensible and important issues.
- Interlinking / overlapping nature of the priorities.
- Accessibility of the Strategy.
- The need for ongoing listening and engagement.
- The need for more emphasis on social determinants of health.
- Self-empowerment, self-management and people taking responsibility for their own health.
- The wording of the strategy needed to be more specific in parts.
- The need for funding.
- The need for a delivery plan and measurable targets.

Each of the three local authorities was developing their own delivery plan. West Berkshire Health and Wellbeing Board (HWB) held a workshop on 24 June to look at what needed to be done to achieve the strategy's objectives. Actions at both the West Berkshire and Berkshire West levels were being considered. The Integrated Care Partnership (ICP) was already using the priorities to help frame their future work, and work was progressing with the CCG on delivery of the priorities. It was confirmed that the delivery plan would be for the first three years of the strategy and would be regularly updated. Indicators would be developed to measure progress towards targets. A draft delivery plan would be taken to the HWB in September 2021 with the final version signed-off in December 2021.

Councillor Alan Macro asked how the long-list of 11 priorities had been arrived at and noted that there were no priorities for older people, particularly in relation to dementia. Sarah Rayfield explained that current strategies had been reviewed to identify where a difference had been made and where there were gaps. This was followed by engagement with community groups and stakeholders. Public Health data had been examined to understand local needs. A 'what's missing' exercise had also been carried out. Data for the three local authorities had been reviewed and if an indicator was red for at least one authorities or amber for all three, this was added to the list. This process gave an initial long list of 30 priorities. A series of stakeholder workshops were held, during which questions were asked in relation to each priority, such as: 'was this work being done elsewhere?'; 'would it be duplication if it was included within the strategy?'; and 'was there a way in which we could work together as a system to address this?'. This led to the reduced long-list of 11 priorities, which were put out to public consultation. The

consultation feedback was used to refine them down to the final five priorities. It was acknowledged that a significant number of people had felt there were things missing from the priorities, but these had mostly already been considered and some were included, but not explicitly. For example, dementia came under the second priority – 'support individuals at high risk of bad health outcomes to live healthy lives' – where those living with dementia were mentioned. She noted that over the course of the 10 year strategy, the groups who were at higher risk may change, but this would be kept under regular review.

Councillor Moore asked how contention between the plans of the three local authorities would be resolved. It was explained that although there was a shared vision, how each local authority chose to implement this would be different. Sarah Rayfield confirmed that she would lead that process for each of the three areas and was looking at which actions could better be delivered jointly. Councillor Bridgman commented that the delivery plan was the most important part of the Strategy. He agreed that there may be aspects that would be better delivered at 'place' rather than 'locality' level, which would need a separate delivery plan.

Andrew Sharp acknowledged the challenge of having to engage people remotely during the pandemic. He felt that all partners, especially Public Health, should be proud to have put together a good engagement programme and capture meaningful feedback to ensure that the public's concerns had been identified and addressed in this strategy. He felt it was incumbent on the Committee to ensure the strategy produced the desired outcomes in terms of delivering change and action in relation to health inequalities.

The Chairman thanked Sarah Rayfield for her role in developing the Strategy in difficult circumstances and indicated that she felt the voices of local residents had come across and she was pleased to see the level of feedback that had been received.

There was discussion around the Strategy's principle of 'digital enablement'. Councillor Moore noted that some people were unable to engage digitally, while Councillor Linden noted that would be circumstances where people wanted to engage with a health professional on the phone or face-to-face. Councillor Macro recalled a GP's testimony in a national newspaper in which he recounted that in about 30% of cases, he was able to determine a patient's status just from the way in which they presented themselves upon entering his surgery. Also, he suggested that in face-to-face consultations it was easier to establish whether information had been understood by the recipient. The Chairman questioned whether digital engagement took account of the needs of those who were hearing impaired and suggested ongoing training was implemented to enable people to become skilled and comfortable with digital engagement. Assurances were given that these issues were recognised and that the goal was to support people who are able to engage digitally, but not to exclude anyone either, and appropriate provisions would be made.

8 Healthwatch Report

Andrew Sharp presented the Heathwatch West Berkshire Annual Report 2020/21 (Agenda Item 7).

He began the presentation by providing an overview of the Healthwatch service and explained that Healthwatch came into existence in 2013 under the Health and Social Care Act with a Healthwatch in every local authority area to champion local communities and to take people's views and experiences back to those who commission and deliver services, with the aim that good practice would be recognised and repeated and to encourage reflection when things didn't go well.

Healthwatch had statutory powers to 'enter and view' healthcare facilities. Despite the pandemic, West Berkshire Healthwatch had been able to visit a number of care homes in December 2020 to talk to residents and their families. They also had a statutory power of response. Because it had not been possible to visit establishments during lockdown, they had focused on providing information to residents. They had produced 116 newsletters to disseminate the large amount of information related to the Covid pandemic. A key functions of HWWB was to let the public know what was happening with services and how they were changing, as well as letting the service providers know what the public were experiencing as a result of those changes.

Healthwatch England had shown that only one person in 100 formally complained about health services. As a result, service providers were often unaware when services failed to meet patient's needs and consequently they were not in a position to put things right.

A key function of Healthwatch within Health and Wellbeing Boards, Primary Commissioning Boards or Planned Care Boards, was to relay 'lived experiences'. An example was cited of people who had experienced problems getting emergency blood tests during the pandemic. When patients' experiences were communicated, it enabled providers to recognise problems and put in place solutions.

It was acknowledged that statutory bodies wanted to provide the best service they could for local residents, so it was important to get feedback from the public, both good and bad. It was stressed that even minor issues should be captured to avoid major problems from developing.

Another key function of Healthwatch was to capture feedback from West Berkshire's residents and deliver this to service commissioners and providers in a constructive, useful and helpful way.

Healthwatch was one of the few services that covered both Social Care and Health and it went to great lengths to ensure there was a genuine issue before referring up to the statutory bodies. Recent examples had included issues with maternity, dentistry and phlebotomy services.

Where it had not been difficult to engage with the public during the Covid pandemic, Healthwatch had created vehicles in order to make it easier to do so, e.g. the West Berkshire Diversity Forum, the West Berkshire Maternity Forum and the forthcoming CAMHS survey.

The pandemic had highlighted health inequities, which had been made worse by the pandemic and it was stressed that the health system must be open to learning from the pandemic and other challenges so mistakes were not repeated.

Priorities for the coming year were highlighted as: the recovery of services to pre-Covid levels; working with ethnically diverse communities; maternity services; and children's mental health services.

With regards to digital exclusion, it was recognised by all partners that technology alone was not necessarily the solution. While some people would be able to use it or learn to do so, there were others that would never be able to engage with the technology and measures would be needed to support these individuals.

It was acknowledged that waiting lists must be managed as quickly, effectively and equitably as possible, and that new health inequalities should not be created by neglecting particular groups or conditions. It was noted that media coverage had focused on waiting lists for physical health conditions, but there had been little mention of mental health waiting lists. For example, the dementia diagnosis service ran through the memory

clinic, but from March to September this had been closed, thus creating a significant backlog in diagnosis.

The Chairman thanked Andrew Sharp for his presentation and invited questions from Members.

Councillor Linden acknowledged that services were still under pressure and asked what the Committee could do to help. Andrew Sharp hoped that the Committee would help capture learnings from the pandemic to help plan for future, similar challenges. He considered that NHS dentistry services were not fit for purpose. Members of the public did not understand the how to get NHS treatment and as a result 25% of the population did not see a dentist. He noted that NHS dentistry would be brought under Integrated Care System (ICS) management, which was a positive development. Also, NHS South East had met with HWWB and had made an offer to attend the Health Scrutiny Committee. He indicated that maternity was another key area and also stressed the need to consider services used by West Berkshire residents that were in neighbouring areas, such as North Hampshire and Great Western Hospitals.

The Chairman advised that the Overview and Scrutiny Management Commission (OSMC) was producing a piece on Covid learnings and that dentistry was already on the Health Scrutiny Committee's Work Programme.

Councillor Moore asked Andrew Sharp about GP Receptionists who he perceived to be under pressure and carried out a professional role in terms of triaging patients. Andrew Sharp acknowledged that the workforce was a major issue for all health and care services. He agreed that GP receptionists had a challenging role - they were often given conflicting targets in terms of being told to help patients, but without overloading GPs with appointments. He highlighted an anomaly in that NHS England advice was that anyone could register with a GP practice without ID, but in order to access NHS GP digital services a photo ID was required. This had led to people being refused registration. Andrew Sharp acknowledged the vital role that GP receptionists played and suggested that they needed support and training, and that better integration was needed between GPs and other services, such as the Citizens Advice Bureau (CAB).

Councillor Macro said he had been impressed with the Healthwatch report, in particular the stories about how Healthwatch had helped individuals to access health services. He asked whether enough was being done to promote this aspect of Healthwatch so people knew where to go if they had a problem with accessing services. Andrew Sharp indicated that a limiting factor was that HWWB only had 2.5 FTE staff and a very large portfolio. While Healthwatch, was often able to help due to their knowledge of local health services, he suggested that integration with other services would also help, and that it was important to make it as easy as possible for people to find answers themselves. He suggested that while the system worked for most people, it was important that it catered for everyone, and highlighted the recent success in securing vaccinations for people who were homeless. He stressed the importance of effective communication and the potential for HWWB to use the Council's communication package to promote their work and raise their profile. As the local authority representative for the CAB, the Chairman suggested that discussions should take place outside of the meeting about how the CAB and HWWB could work more effectively together.

The Chairman thanked Andrew Sharp for the report. She confirmed that Healthwatch reports would be a standing item on the agenda and stressed that the Committee was very keen to work closely with HWWB to ensure the public voice was heard. She invited Andrew Sharp to continue to highlight key issues for the Committee to consider.

9 Work Programme

The Chairman updated the Committee on the Work Programme (Agenda Item 8).

She highlighted that informal briefing sessions would be arranged with health bodies in between formal meetings to get the Committee up to speed. She asked if there were any further comments or suggestions around the Work Programme.

Councillor Linden noted that Royal Berkshire NHS Foundation Trust was included in the informal briefings item list and that they tended to deal with Reading Borough Council as that was where they were based, but he felt they should also deal with West Berkshire and Wokingham. Councillor Linden also advised the Committee that he had been accepted as a vaccine volunteer based at Calcot.

Councillor Moore asked how many protocols the Committee would be dealing with on the forward plan. Gordon Oliver confirmed that there would be one protocol, which would set out a way of working between the HSC and other health partners in terms of responsibilities and managing disagreements.

Councillor Macro suggested that Mental Health for Young People should be added to the Work Programme as highlighted in the Healthwatch report. He also suggested that Continuing Healthcare funding should be added to the Work Programme.

Andrew Sharp indicated that the Chief Executive of North Hampshire Hospital was keen to have a much closer relationship with West Berkshire, as well as Great Western Hospital and that representatives of both should be invited to talk to the Committee. In terms of the forward plan, he also suggested the Committee be mindful of the HIP2 projects for both Royal Berkshire and Basingstoke hospitals and the Ambulance Service and GP out of hours service.

Councillor Bridgman stated that the HIP2 projects did not lie with this Committee because they were cross-boundary, so should be considered by the relevant Joint Health Overview and Scrutiny Committees. Councillor Bridgman said there would be representation from the Royal Berkshire NHS Foundation Trust on the Health and Wellbeing Board and there would be a presentation by Dom Hardy on certain aspects of the ICP. Councillor Bridgman noted there was a standing item on the forward plan for updates from the CCG and strongly felt that Continuing Healthcare should form part of that regular update. Andrew Sharp advised that Berkshire West was at the bottom of the country in terms of awarding CHC funding with only 13 cases per 100,000 receiving funded, compared to 56 cases per 100,000 in Buckinghamshire and 108 cases per 100,000 in Cumbria.

Andrew Sharp referred to the closure of the Duchess of Kent Hospice and suggested hospice services should be added to the forward plan to recognise the closure’s likely impact and discuss how future demand could be met in West Berkshire.

(The meeting commenced at 3.30 pm and closed at 4.58 pm)

CHAIRMAN …………………………………………….

Date of Signature …………………………………………….

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Health Scrutiny Committee - 10 November 2021

Item 3 – Declarations of interest

Verbal Item

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Health Scrutiny Committee - 10 November 2021

Item 4 – Petitions

Verbal Item

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Agenda Item 5

Health Scrutiny Committee prioritisation methodology

Committee considering report:	Health Scrutiny Committee
Date of Committee:	10 November 2021
Portfolio Member:	Councillor Howard Woollaston
Date Portfolio Member agreed report:	19 October 2021
Report Author:	Gordon Oliver
Forward Plan Ref:	OSMC/HSC

1 Purpose of the Report

This report presents a transparent and objective methodology which is designed to help prioritise which topics the Health Scrutiny Committee should be considering.

2 Recommendation(s)

That the Health Scrutiny Committee adopt the PAPER criteria (Public interest, Area affected, Performance/Priority, Effectiveness, Resources) and associated scoring system to help prioritise its work programme.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	There are no financial implications arising from this report.
Human Resource:	There are no HR implications arising from this report.
Legal:	There are no legal implications arising from this report.
Risk Management:	There are no risks associated with this report. The PAPER methodology should ensure that the most appropriate topics are prioritised for health scrutiny.
Property:	There are no property implications arising from this report.

Policy:	There are no local policy implications arising from this report. The proposed methodology is broadly consistent with that set out in guidance from the Centre for Governance and Scrutiny.			
	Positive	**Neutral**	**Negative**	**Commentary**
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?		✓		There are no equalities impacts arising from this report.
B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		✓		
Environmental Impact:		✓		There are no environmental impacts arising from this report.
Health Impact:	✓			The PAPER methodology will help the Health Scrutiny Committee to prioritise its work and focus on where the greatest benefits can be delivered in terms of improving local health services.
ICT Impact:		✓		There are no ICT impacts associated with this report.
Digital Services Impact:		✓		There are no Digital Services impacts associated with this report.

Council Strategy Priorities:	✓			The PAPER methodology will help the Health Scrutiny Committee to prioritise its work and focus on where the greatest benefits can be delivered in terms of improving local health services. This in turn will support the Council Strategy priority to 'support everyone to reach their full potential'. In particular, it will help with the following areas: - improve the health and wellbeing of our residents - improve mental health and wellbeing
Core Business:		✓		There are no core business impacts arising from this report.
Data Impact:		✓		There are no data impacts arising from this report.
Consultation and Engagement:	None			

4 Executive Summary

4.1 This report sets out a proposed methodology for the Health Scrutiny Committee to use in prioritising topics for scrutiny.

4.2 Criteria have been based on those advocated by the Local Government Association and include:

- Public interest
- Area affected
- Performance / Priority
- Effectiveness
- Resources

4.3 A scoring system is also proposed, which should help with the prioritisation of competing proposals.

5 Supporting Information

Introduction

5.1 This report considers how the Health Scrutiny Committee can best prioritise its work programme and evaluate the merits of competing proposed scrutiny topics. This applies to discretionary scrutiny rather than formal consultations from health bodies.

Background

5.2 In May 2019, Government published statutory guidance for councils and combined authorities on overview and scrutiny. This indicates that prioritisation is necessary to ensure the scrutiny function concentrates on delivering work that is of genuine value.

5.3 The statutory guidance suggests that scrutiny committees should plan their work programmes by drawing up a long-term agenda, while making it sufficiently flexible to accommodate any urgent, short-term issues that might arise during the year.

5.4 The statutory guidance advocates that when local authorities are considering whether an item should be included in the work programme, the kind of questions Members should ask include:

- Do we understand the benefits scrutiny would bring to this issue?
- How could we best carry out work on this subject?
- What would be the best outcome of this work?
- How would this work engage with the activity of the executive and other decision-makers, including partners?

5.5 It highlights that some authorities use scoring systems to evaluate and rank work programme proposal. It goes on to suggest that if these scoring systems are used to provoke discussion and debate, based on evidence, about what priorities should be, they can be a useful tool. It notes that other local authorities take a looser approach with no scoring system, but whichever method is adopted, a committee should be able to justify how and why a decision has been taken to include certain issues and not others.

5.6 The West Berkshire Health Scrutiny Committee has previously agreed that it would be useful to develop a prioritisation methodology to help with planning its work programme.

Proposals

5.7 The Local Government Association (LGA) published 'A Councillor's Workbook on Scrutiny', which sets out a number of criteria that could be useful for selecting and prioritising topics for scrutiny.

5.8 The following PAPER criteria have been developed, based on the LGA criteria, and with a rudimentary scoring system attached.

Criteria	Aspects	Scoring
Public Interest	• Is the topic of concern to local residents? • What is the level of interest amongst particular communities / groups? • Has the topic been identified by Members / officers / Healthwatch? • Has there been negative press about the topic?	3 = high public interest 2 = medium public interest 1 = low public interest
Area Affected	• Does the topic affect all parts of the district or only selected areas / communities?	3 = entire district 2 = multiple wards 1 = single ward
Performance / Priority	• Is there / has there been a high level of dissatisfaction amongst service users? • Is there evidence of poor performance in this service? • Do we understand why performance is poor? • Is the service costly to run relative to other areas? • Does this relate to a priority in the Council Strategy and / or the Joint Health and Wellbeing Strategy?	3 = poor performance / high priority 2 = fair performance / medium priority 1 = good performance / low priority
Effectiveness	• Is the issue one where the committee can exert influence and add value? • Are changes to policy and / or legislation planned that will affect the service? • Is work already underway or planned to investigate the issue? • Are changes already planned for the service?	3 = good chance to deliver change 2 = fair chance to deliver change 1 = little chance to deliver change
Resources	• Can the review be delivered with existing resources and in a timely fashion?	3 = good availability of resources 2 = some resource constraints 1 = poor resource availability

5.9 The PAPER criteria can be used as reference guide for Members in selecting topics for scrutiny, or it can be rigidly applied as a scoring system.

5.10 How strictly the criteria are applied will depend of the number of competing topics proposed and the resources available to undertake reviews. However, it is likely that there will be more topics than the Committee has the capacity to consider.

5.11 There will inevitably be a degree of subjectivity to some of the scoring criteria, and so the Committees will need to use their best judgement in agreeing any scores and which items to take forward for scrutiny.

6 Other options considered

6.1 The Health Scrutiny Committee could choose not to adopt a prioritisation methodology, but in doing so, this could lead to a haphazard approach to work programming, with a focus on issues that are not necessarily where the Committee could be most effective.

6.2 An alternative option would be to have a methodology without a scoring mechanism. However, this approach is not considered to be as effective. Although scoring can be subjective, it does at least provide a rudimentary means of comparing competing scrutiny topics.

7 Conclusion

The proposed PAPER methodology and scoring system would support the Health Scrutiny Committee in effective work programming.

8 Appendices

None

Background Papers:

MHCLG (May 2019) Overview and scrutiny: statutory guidance for councils and combined authorities,

LGA (May 2017) A Councillor's Workbook on Scrutiny,

Wards affected: All Wards

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Document Control

Document Ref:		Date Created:	
Version:		Date Modified:	
Author:			
Owning Service			

Change History

Version	Date	Description	Change ID
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Protocol between the West Berkshire Health Scrutiny Committee and local health bodies

Committee considering report:	Health Scrutiny Committee
Date of Committee:	10 November 2021
Portfolio Member:	Councillor Howard Woollaston
Date Portfolio Member agreed report:	19 October 2021
Report Author:	Gordon Oliver
Forward Plan Ref:	OSMC/HSC

1 Purpose of the Report

The report presents a draft protocol that sets out how the West Berkshire Health Scrutiny Committee will work together with bodies who commission or provide health and wellbeing services to residents of West Berkshire.

2 Recommendation(s)

The Committee is recommended to:

1. Endorse the draft protocol and the process for dealing with proposed substantial developments of variations to health services.
2. Authorise consultation with local health partners on the above, with a view to bringing a final version back to Health Scrutiny Committee for approval.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	There are no financial implications arising from this report.
Human Resource:	There are no HR implications arising from this report.

Legal:	There are not Legal implications arising from this report. The protocol sets out an approach to working with health partners, which is consistent with current legislation.
Risk Management:	There are no risks arising from the report. The protocol should actually reduce risks by providing clarity on what constitutes substantial variations or developments in delivery of health services and ensuring that proper scrutiny of such proposals takes place.
Property:	There are no property implications associated with the report.
Policy:	The report is consistent with national guidance on health scrutiny. The proposed protocol will help to achieve effective health scrutiny, which in turn will help to ensure that the priorities and objectives of the Berkshire West Joint Health and Wellbeing Strategy are delivered.

	Positive	**Neutral**	**Negative**	**Commentary**
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?		✓		The protocol will help to ensure that the needs of all service users are taken into account when variations or developments in health services are proposed.
B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		✓		
Environmental Impact:		✓		There are no environmental impacts arising from this report.

Health Impact:	✓			The protocol will help to ensure effective health scrutiny of proposed variations and developments in health services that are considered likely to have substantial impacts for residents of West Berkshire.
ICT Impact:		✓		There are no ICT impacts arising from this report.
Digital Services Impact:		✓		There are no digital services impacts arising from this report.
Council Strategy Priorities:	✓			The protocol will help to ensure effective health scrutiny of proposed variations and developments in health services that are considered likely to have substantial impacts for residents of West Berkshire. This in turn will support the Council Strategy priority to 'support everyone to reach their full potential'. In particular, it will help with the following areas: - improve the health and wellbeing of our residents - improve mental health and wellbeing
Core Business:		✓		There are no core business impacts arising from this report.
Data Impact:		✓		There are no data impacts arising from this report.
Consultation and Engagement:	It is proposed to consult health partners on the draft Health Scrutiny Protocol.			

4 Executive Summary

4.1 This report sets out the draft Protocol between the West Berkshire Health Scrutiny Committee and local health bodies responsible for the commissioning and provision of health and wellbeing services to the residents of West Berkshire.

4.2 The terms of reference for the Health Scrutiny Committee (as agreed at Full Council on 4 May 2021) require it to develop such a protocol.

4.3 The protocol is intended to improve engagement between the Committee and local health bodies and to guide the process for assessing whether proposes variations or developments in health services are considered to be 'substantial' and therefore require the Health Scrutiny Committee to be consulted.

4.4 The proposed document is based upon advice provided by the Centre for Governance and Scrutiny.

4.5 It is proposed to consult local health bodies on the draft Protocol prior to adoption. This is considered essential in order to secure their buy-in to and support for the approach set out in the Protocol.

5 Supporting Information

Introduction

5.1 This report sets out a draft Protocol relating to how the West Berkshire Health Scrutiny Committee (HSC) will work together with bodies who commission or provide health and wellbeing services to residents of West Berkshire.

5.2 The Protocol incorporates the working principles which guide and support the relationship between the scrutiny body and those commissioning or providing health and wellbeing services.

5.3 It also provides a process for assessing whether a proposed variation or development in health services is considered to be 'substantial' and therefore triggering formal consultation with HSC.

Background

5.4 The role of HSC is to undertake scrutiny of the planning, development and operation of Public Health and NHS services for citizens of West Berkshire, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

5.5 Its functions include considering and responding to consultations by relevant NHS bodies or health service providers, on proposals that both parties agree constitute a substantial development or substantial variation in the provision of health services for citizens of West Berkshire, using the powers set out in the relevant legislation and referring to any guidance issued by the Secretary of State for Health.

5.6 The Terms of Reference for HSC state that it will: *'develop and maintain a joint protocol about how the Health Scrutiny Committee and responsible NHS bodies and health service providers will reach a view as to whether or not a proposal constitutes a "substantial development" or "substantial variation"'*.

Proposals

5.7 A draft protocol has been prepared and is included in Appendix A. The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards which set out how all parties will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and communities across West Berkshire.

5.8 The Protocol is intended to represent an agreement between West Berkshire's HSC which represents the interests of West Berkshire Council and its residents, and those bodies who commission and provide health and wellbeing services for the population

5.9 The draft Protocol sets out the following as proposed shared goals:

- Deliver high quality, sustainable health and wellbeing services that meet the needs of the West Berkshire population.
- Improve the health and wellbeing outcomes for local people, including ensuring activity addresses health inequalities and aligns with the Berkshire West Health and Wellbeing Strategy.

5.10 It also proposed a number of working principles as follows:

1. There is a "no surprises" approach between the organisations concerned. This builds collaboration whilst also allowing scrutiny to constructively challenge strategic decisions.
2. There is a climate of mutual respect and courtesy, noting one another's independence and autonomy.
3. Proposals and recommendations are based on appropriately sourced, recognised and clearly presented evidence. This includes relevant clinical evidence.
4. The views and priorities of local people are gathered and considered in the development of proposals, in scrutiny and in decision making.
5. The overview and scrutiny approach is transparent, collaborative, constructive and non-confrontational. It is based on asking challenging questions and considering evidence.
6. There is recognition and respect for the difference which may arise around what constitutes 'best outcomes' for the local population.
7. Feedback from overview and scrutiny to health and wellbeing organisations is documented and well communicated.

5.11 A key element of the draft Protocol relates to determining whether or not a proposed variation or development in health services is 'substantial' and therefore requires the HSC to be consulted.

5.12 Whether a development or variation in health services is deemed 'substantial' is not precisely defined in legislation or Government guidance, and so a degree of judgement is required. The impact of the change on patients, carers and the public is the key concern.

5.13 The draft protocol sets out the factors that should be taken into account. It also defines a number of different 'levels' of change, with relevant examples of each level, as well as the actions that a health body would be expected to undertake in terms of engaging the HSC and the processes to be followed.

5.14 It should be noted that the proposed protocol would involve authorising the Chairman, in consultation with the Vice-Chairman and any relevant non-voting advisory members, forming an initial view as to whether a proposal change was considered 'substantial'. Such discussions would be supported by the Principal Policy Officer (and Legal Officer as appropriate) and would be reported to the next meeting of the Committee.

5.15 The draft Protocol also sets out what would happen in the event of disagreement between the HSC and the health body, as well as the circumstances in which the Committee would not need to be consulted.

5.16 The document largely follows the template adopted by the Oxfordshire Joint Health Overview and Scrutiny Committee. Given that both authorities fall within the same Integrated Care System (ICS), it makes sense to try to harmonise protocols and approaches wherever possible. Discussions with the Health Scrutiny Officer at Oxfordshire suggests that their protocol has been effective, and is well understood and observed by health partners.

5.17 It is proposed that local health bodes be consulted on the draft protocol, including the Berkshire West Clinical Commissioning Group, Berkshire Healthcare NHS Foundation Trust, Royal Berkshire NHS Foundation Trust.

6 Other options considered

6.1 The requirement to develop a Protocol is set out in the HSC Terms of Reference, so to 'do nothing' is not considered to be an option.

6.2 The Committee could choose to prepare a protocol in a different format and wording, but as mentioned in 5.14 above, there are clear advantages to having a consistent approach to other local authorities within the ICS, so this option is not preferred.

7 Conclusion

7.1 Creation of a Health Scrutiny Protocol would be a positive step in terms of improving communication between the HSC and local health bodies and agreeing the actions and processes to be followed whenever a change in local health services is proposed.

7.2 Consultation with local health bodies prior to adoption is considered essential in order to secure their buy-in to and support for the approach set out in the Protocol.

8 Appendices

Appendix A – Draft protocol between the West Berkshire Health Scrutiny Committee and commissioners and providers of health and wellbeing services to the population of West Berkshire.

Background Papers:

None

Wards affected: All wards

Officer details:

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Version	Date	Description	Change ID
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Protocol between the Health Scrutiny Committee and commissioners and providers of health and wellbeing services to citizens of West Berkshire

(November 2021)

1 Introduction

1.1 This Protocol describes how the Council's Health Scrutiny Committee (HSC) will work together with the bodies that commission or provide health and wellbeing services for citizens of West Berkshire.

1.2 The Protocol defines some working principles to guide and support the relationship between the HSC and local health bodies.

1.3 It sets out the processes that will be followed when substantial variations or developments to health and wellbeing services are proposed that require formal consultation and engagement, as required by legislation. The Protocol also specifies how smaller variations and developments to health and wellbeing services will be handled.

2 Purpose of the protocol

2.1 The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards about how all parties will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and citizens of West Berkshire.

3 Aims and responsibilities of health scrutiny

3.1 Guidance on health scrutiny, published by the Department of Health in June 2014, states that:

> *"the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe."*

3.2 West Berkshire Council has delegated responsibility for scrutiny of health matters to the Health Scrutiny Committee (HSC). Its terms of reference state that it will:

> *'undertake scrutiny of the planning, development and operation of Public Health and NHS services for citizens of West Berkshire, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'*

3.3 The HSC is responsible for reviewing or scrutinising services commissioned and provided by all relevant NHS bodies and health service providers. This includes GP practices and other primary care providers such as pharmacists, opticians and dentists, and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority, including Public Health services. References to

‘health and wellbeing commissioners or providers’ in the remainder of this document is used as a term to include all public, private or voluntary organisations.

4 Understanding of the role of the scrutiny relationship

4.1 All parties recognise the role of West Berkshire HSC in reviewing or scrutinising any issues relating to the commissioning and provision of health and wellbeing services to citizens of West Berkshire.

4.2 The bodies involved acknowledge the role of scrutiny in giving the public confidence of effective oversight of their health and wellbeing services. They also recognise the challenges facing the health and wellbeing system and that no single organisation can solve these alone.

4.3 HSC provides health and wellbeing commissioners and providers with a clear governance framework, transparency and a critical friend to help develop integrated solutions.

5 Application of the Protocol:

5.1 This Protocol is an agreement between West Berkshire’s HSC (which represents the interests of West Berkshire Council and its citizens), and those bodies who commission and provide health and wellbeing services for the local population.

5.2 It covers health and wellbeing commissioners and providers under the Care Quality Commission (CQC) regulation, including:

- Treatment, care and support provided by hospitals, GPs dentists, ambulances and mental health services; and
- Services for people whose rights are restricted under the Mental Health Act.

5.3 Scrutiny of activities relating to the treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care) is the responsibility of the Overview and Scrutiny Management Commission.

5.4 The Protocol is a living document so can include those commissioners or providers who may be involved, now or in the future, in the planning, provision, or operation of health and wellbeing services. It applies to the resident population of West Berkshire and therefore accordingly where commissioners and providers are serving West Berkshire residents across the district boundary.

5.5 Where necessary, joint health scrutiny committees may be formed across a different geography where a relevant body or service provider is required to consult more than one local authority’s health scrutiny function about substantial reconfiguration proposals. West Berkshire has delegated powers for the scrutiny of the Integrated Care System to the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee.

5.6 This Protocol applies specifically to West Berkshire HSC activities, but it could be used as a good practice example around ways of working for any other committees discharging the functions of health scrutiny.

6 Shared goals and working principles:

6.1 Table 6.1 describes the shared goals and working principles by which all organisations covered by this Protocol agree to work.

Table 6.1: Shared Goals and Principles

Shared Goals
• Deliver high quality, sustainable health and wellbeing services that meet the needs of the West Berkshire population. • Improve the health and wellbeing outcomes for local people, including ensuring activity addresses health inequalities and aligns with the Berkshire West Health and Wellbeing Strategy.
Working principles
1. There is a "no surprises" approach between the organisations concerned. This builds collaboration whilst also allowing HSC to constructively challenge strategic decisions. 2. There is a climate of mutual respect and courtesy, noting one another's independence and autonomy. 3. Proposals and recommendations are based on appropriately sourced, recognised and clearly presented evidence. This includes relevant clinical evidence. 4. The views and priorities of local people should be gathered and considered in the development of proposals, in scrutiny and in decision making. 5. The overview and scrutiny approach is transparent, collaborative, constructive and non-confrontational. It is based on asking challenging questions and considering evidence. 6. There is recognition and respect for the difference which may arise around what constitutes 'best outcomes' for the local population. 7. Feedback from HSC to health and wellbeing organisations is documented and well communicated.

7 The 'no surprises' approach

7.1 In support of the first working principle, to have a 'no surprises' approach. The HSC forward plan is informed by and developed through regular dialogue with

commissioners and providers. Involving HSC in discussions about proposed changes at an early stage will allow them to plan and scope their scrutiny reviews.

8 Service variations and assessing change

8.1 In circumstances where there are planned variations or developments to health and care services, relevant organisations will undertake to work in accordance with the working principles above to assess how significant the variation is.

8.2 The threshold at which a proposed variation or development is deemed 'substantial' is not precisely defined and an element of judgement is required. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

- Changes in accessibility of services.
- Changes to methods of service delivery.
- Impacts on service users and their families / carers.
- Impacts on health and social inequalities.
- Implications for service quality, deliverability and risk.
- The effects on other health services and the wider community

8.3 Table 8.1 describes and gives examples of the levels of change, variation or development which may occur in in health and wellbeing service for West Berkshire:

Table 8.1: Levels of change

Level	Category	Description	Example(s)	Action Required
1	Minor	When the proposed change would have a **minor** impact	A minor change in clinic times, the skill mix of particular teams, or small changes in operational policies.	The Committee would not routinely be notified or become involved.
2	Moderate	Where the proposed change would have a **moderate** impact, or where consultation has already taken place on a national basis	Rationalising or reconfiguring Community Health Teams. Policies that will have a direct impact on service users and carers. Changes that include the following may be considered substantial rather than moderate: • A reduction in service • A change to local access to service • Large numbers of patients being affected	The responsible commissioner notifies the Principal Policy Officer at an early stage. The Principal Policy Officer will liaise with the HSC Chairman and Vice Chairman to determine whether a fuller briefing is required in accordance with the Committee's stage one assessment process described below. The Committee will wish to ensure that the Healthwatch and other appropriate organisations are notified by the responsible commissioner or service provider concerned.
3	Substantial	Where the proposal has **substantial** impact and is likely to lead to: • A reduction or cessation of service • Relocation of service	Reconfiguration of GP Practices leading to practice closures. Centralisation of services, leading to closure of local clinics / treatment centres. Redevelopment / relocation of acute hospitals as part of HIP2 programme.	• The responsible commissioner(s) notify the Committee and formally consult the Committee. The Committee will expect to see formal consultation plans. The Local Ward Councillors concerned will be informed of the proposal. • The responsible commissioner(s) notify and discuss with the appropriate local authorities on service developments.

		• Changes in accessibility criteria • Local debate and concern		• The Committee consider the proposal formally at one of their meetings. • Officers of the responsible commissioners and service providers work closely with the Committee during the formal consultation period. • The Committee responds within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

Stage One

At the earliest possible stage, the health organisation responsible for the proposed change initiates dialogue with the HSC through the Principal Policy Officer.

The HSC Chairman and Vice Chairman are briefed on the proposed change.

The Chairman and Vice Chairman assess and determine the level of change using information gathered at the briefing and advice from officers. A recommendation and rationale is reported alongside the content of the briefing at the next formal HSC meeting for decision.

Stage Two

The organisation responsible completes the substantial variation assessment **(see Appendix A)**, gathering and presenting the relevant evidence.

The organisation responsible contacts the Principal Policy Officer to arrange an informal briefing with the HSC.

All HSC members should be sent detailed information regarding the proposals, including the completed 'substantial variation assessment'.

The organisation responsible should go through the assessment with HSC at the meeting and discuss whether they believe the proposed service variation or development is 'substantial'. A recommendation and rationale will be reported alongside the content of the briefing at the next HSC meeting for decision.

All HSC members and the health organisation responsible should be informed of the outcome of the meeting and given a record of the meeting.

Final Say

8.6 Should there still be disagreement over whether a service change or variation is substantial at the end of a stage two assessment; it is the view of HSC which prevails. The HSC view therefore determines whether a service variation is substantial and requires commissioners to consult.

Exemptions

8.7 The following are circumstances where the HSC will not need to be consulted:

- Proposals to establish or dissolve an NHS trust or CCG if this does not represent a substantial development or variation to the provision of health services.

- Proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997, as these are the subject of separate legislation.

- Where a decision has to be taken immediately because of a risk to the safety or welfare of patients or staff. These circumstances should be anticipated and reported in advance, making unanticipated situations the absolute exception. The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how patients and carers have been informed about the change and what alternative arrangements have been put in place to meet the needs of patients and carers.

9. Consulting with the Committee

9.1 As identified in the table above, where a 'Level 3' or substantial service variation is identified, the responsible commissioner(s) will notify the Committee and formally consult the HSC. This is in addition to discussions between the responsible commissioner(s) and the appropriate local authorities or Health and Wellbeing Boards on service developments. It is also additional to the NHS duty to consult patients and the public.

9.2 The HSC has the responsibility to consider and comment on:

- Whether as a statutory body the HSC has been properly consulted (in addition to the public consultation process).

- The adequacy of the consultation undertaken with patients and the public.

- Whether the proposal is in the interests of health services in the area.

9.3 The HSC may refer proposals for substantial service developments or variations to the Secretary of State where it is not satisfied that:

- Consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed.

- The proposal would be in the interests of the health service in West Berkshire.

- A decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate.

Appendix A:
Substantial Change Assessment Form

NAME OF RESPONSIBLE BODY:	
CONTACT INFORMATION:	
Name: **Job Title:** **Address:** **Email:** **Telephone**:	

SECTION A: BACKGROUND INFORMATION
Proposed service change: Brief description of the proposal, including whether it involves: an increase / decrease / introduction / withdrawal of service; changes to hours of operation; relocation; changes to methods of service delivery. Also indicate if the proposed change will be permanent or temporary.
Rationale for the proposed change: All key drivers for the proposal.
Strategic fit of proposal: Consider this at national, system and place level.
Date by which final decision is expected to be taken:

SECTION B: CONSULTATION / STAKEHOLDER ENGAGEMENT
Legal Obligations: Have the legal obligations set out under Section 242 of the consolidated NHS Act 2006 to 'involve and consult' been fully complied with?
Yes / No (delete as applicable) **Commentary:**
Stakeholder Engagement: Have initial responses from service users, their carers / families / advocates, and from Healthwatch indicated whether the impact of the proposed change is substantial?
Yes / No (delete as applicable) **Commentary:**
Stakeholder Support: Is there any aspect of the proposal that is contested by key stakeholders? If so what action has been taken to resolve this?
Yes / No (delete as applicable) **Commentary:**
Staff Engagement: Have staff delivering the service been fully involved and consulted during preparations of the proposals? If so how?
Yes / No (delete as applicable) **Commentary:**
Staff Support: Is there any aspect of the proposal that is contested by the clinicians / other staff? If so what action has been taken to resolve this?
Yes / No (delete as applicable) **Commentary:**

SECTION C: PATIENT IMPACT
Improvement: How will the proposed change deliver improved clinical and social outcomes for patients and improved patient experiences?
Commentary:
Service Users: How many people are likely to be affected by the proposal and which areas are the affected people from?
Commentary:
Inequalities: Does the proposed change of service have a differential impact that could create new / widen existing inequalities (geographical, health, social, etc)?
Yes / No (delete as applicable) **Commentary:**
Patient Access: Will the proposed change affect patient access in terms of location, transport access (public and private), travel time, etc?
Yes / No (delete as applicable) **Commentary:**
Incremental Impact: Does the proposal appear as one of a series of small, incremental changes that when viewed cumulatively could be regarded as substantial?
Yes / No (delete as applicable) **Commentary:**

SECTION D: SERVICE QUALITY, DELIVERABILITY AND RISK
Proven Practice: What is the strength of evidence about the clinical performance of the proposed change?
Commentary:
Service Capacity: Will the proposal result in sufficient capacity to meet demand, taking account of aspects such as demographic changes, changes in morbidity / incidence of relevant conditions, or reductions in care needs due to improved screening?
Yes / No (delete as applicable) **Commentary:**
Workforce implications: Have the workforce implications associated with the proposal been assessed?
Yes / No (delete as applicable) **Commentary:**
Financial Implications: Have the financial implications of the change been assessed in terms of capital and revenue and overall financial sustainability?
Yes / No (delete as applicable) **Commentary:**
Risk: What are the key risks associated with the proposal and how will these be managed?
Commentary:

SECTION E: WIDER IMPACTS
Community Impacts: What are the wider impacts on affected communities (e.g. environmental, transport, housing, employment, etc)?
Commentary:
Service Impacts: Will the proposed changes affect: a) services elsewhere in the NHS; b) services provided by local authorities; c) services provided by the voluntary sector?
Yes / No (delete as applicable) **Commentary:**

OUTCOME / DECISION
Is this considered to be a substantial service change or development by the commissioner / provider?
Yes / No (delete as applicable) **Commentary:**
Is this considered to be a substantial service change or development by the Health Scrutiny Committee?
Yes / No (delete as applicable) **Commentary:**

Possible Outcomes

Consultation is required

- If the health organisation and the Health Scrutiny Committee representatives agree that the proposal does represent a substantial service change or development, the formal consultation with the Health Scrutiny Committee will commence.
- The Health Scrutiny Committee must be provided with:
  - The date by which the responsible organisation intends to decide whether to take the proposal forward.
  - The date by which the responsible organisation requires the Health Scrutiny Committee to provide any comments. (It is expected that any formal consultation would be undertaken by the commissioner of the service.)

Consultation is not required:

- If the health organisation and the Health Scrutiny Committee representatives agree that the proposal does not represent a substantial service change or development, then formal consultation with the Health Scrutiny Committee is not required.
- Best practice is that the health organisation should continue to engage scrutiny and the public in the development of the proposal and onwards to public consultation in accordance with Section 242 requirements.

Agreement cannot be reached:

- If agreement cannot be reached between the health organisation and the Health Scrutiny Committee representatives, then all reasonable, practicable steps should be taken towards local resolution.
- Further meetings may be conducted with the wider Health Scrutiny Committee members and other stakeholders such as Healthwatch, carer/user groups, and the voluntary sector.
- If it continues to be impossible to reach agreement, both sides may jointly or independently pursue the options open to them under their respective statutory instruments, such as escalation to the Secretary of State or to the provider's Board.

NB: Health Scrutiny Committee representatives may prefer not to make a final decision about whether formal consultation is required at the meeting and choose to notify the organisations involved once a decision is made.

Note on Consultation Processes

The Department of Health's (DH) Local Authority Scrutiny Guidance (2014) states the following in relation to consultation processes:

> *"The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS*

should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed."

It is therefore understood that the process of assessing substantial change should take place as part of broader meaningful engagement with local communities.

The relevant health organisation is responsible for engaging and consulting all relevant local people. It is expected that this will include locally elected representatives where the service change will have an impact (parish / town council, district council and MPs).

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NHS

Report to the West Berkshire Health Scrutiny Committee

Date: **Wednesday 10th November 2021**

Title: **Access to NHS Dental services in West Berkshire**

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

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 through direct NHS 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. The currency of payment to dental practices is Units of Dental Activity (UDAs) and Units of Orthodontic Activity (UOAs) for Orthodontic practices. They are paid in twelve monthly instalments against an activity target each year. The practices must deliver at least 96% of that activity each year to retain all monies paid to them. Contract performance of between 96% - 100% will result in additional activity that has to be delivered in the following year. Performance below 96% will result in financial recoveries for the year in question. If practices overperform by up to 2% they can either be paid or have activity target reduction for the following year.

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) normally attend an NHS Dentist on a regular basis (attendance within a 2-year period). This has fallen recently due to the impact of the pandemic.

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 service is more specialist in nature delivering Oral and

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

The tables below detail NHS Dental services in West Berkshire.

Primary Care:

Primary Care Services	Number of contracts	UDAs/UOAs*	UDAs delivered 19-20**	%
GDS contracts	19	173,706	167,271	96.3%
Full NHS	10	163,483		
Child and exempt	5	3,884		
Child only	4	5,135		
Orthodontic contracts	1	10,046		

*Units of Dental/Orthodontic Activity

**Last full pre-Covid year

New NHS practices were opened in Newbury in 2009 and Pangbourne in 2012.

Other services:

Service	Provider
Community Dental Services	Berkshire Healthcare NHS Foundation Trust
Hospital services	Royal Berkshire NHS Foundation Trust
Tier 2 Oral Surgery	Rodericks
Tier 2 Restorative	Dr A Rai

2. Main content of report

The Impact of COVID-19 on Access to Dental Services

COVID-19 has had a greater impact on dentistry than some services due to the close proximity of dental teams members to the patients they are treating with an open mouth in a confined space. Since the pandemic all dental services have been delivered within the framework of a national Standard Operating Procedure (SOP). This outlines the requirements for ensuring patient and staff safety and arrangements for prioritising patients to receive treatment.

NHS

Additional infection, prevention, control measures (IPC) must be followed in order to reduce the risk to dental teams, patients and the wider population. IPC guidelines include specific requirements when undertaking Aerosol Generated Procedures (AGPs) which are used for treatment including fillings, scale and polish, root treatment and crown preparation. This requires a fallow time after treatment to allow aerosols to settle before an enhanced clean can be carried out. Fallow time was initially 1 hour but reduced to 30 minutes in many cases by the end of 2020. As most dental procedures involve the use of AGPs this has had a significant impact on capacity and the number of patients that can safely be seen. It is unlikely that these restrictions will be lifted until the pandemic is deemed to be over which means that capacity will continue to be reduced for some considerable time.

While access to dental care is limited across the country due to COVID-19, practices are concentrating on the provision of urgent care and treatment for patients with the greatest clinical need.

Background

During the first wave of the pandemic all dental practices were required to close for face-to-face care from 25 March 2020 until at least 8 June 2020. This was in the interests of patient and dental team safety. Although closed, practices provided remote advice, analgesia (to help to relieve pain) and anti-microbials (to treat infection) where appropriate (AAA). Following clinical assessment where this did not address a patient's needs dental practices were then able to refer patients to the Urgent Dental Care (UDC) Hubs that were set up to treat patients with the most urgent need.

In the second phase of the pandemic as infection rates dropped, there was a phased reopening of practices for face-to-face care, with all open by 20 July 2020 at the latest. In order for dentists and their teams to see as many patients as safely possible, NHS England and NHS Improvement worked closely with Ministers and determined for the period 20 July to 31 December 2020. It was agreed this would be a minimum of 20% of historic levels of NHS activity in recognition of the 1 hour fallow time and enhanced cleaning requirements. For the period 1 January to 31 March 2021 practices were required to deliver 45% of their contracted activity (70% for orthodontics) which reflected fallow time reducing to 30 minutes in many practices followed by the enhanced cleaning. Between April and September 2021 practices were required to deliver 60% of their contracted activity (80% for orthodontics). The reduced capacity applied both to primary care and referral services.

Practices may have to temporarily close if members of the dental team or their household are required to self-isolate. Practices may also have to temporarily stop provision of treatment involving AGPs where they have been unable to obtain their usual make of respirator mask and need to be fit tested to a new model. In both instances, where patients require face-to-face urgent care, the

practice can refer patients to UDC Hubs which remained open when practices resumed face-to-face care for this reason.

Current situation

Although this gradual increase in activity has improved access to urgent dental care and is starting to deliver routine care for those with the greatest clinical need, it is still some considerable way from 100% of usual activity. Provision is currently at 65% (85% for Orthodontics). This is subject to further national review at the end of December. The resulting backlog is going to take some considerable time to address.

The ongoing reduction in activity and backlog means that many patients, including those with a regular dentist, are unable to access routine care at the current time. Although many patients have historically had a dental check-up on a 6 monthly basis, NICE guidance states this is not clinically necessary in many instances and clinically appropriate recall intervals may be between 3 to 24 months dependent upon a patient's oral health, dietary and lifestyle choices. Therefore, many patients who are attempting to have a dental check-up may not clinically need this at the current time.

While practices continue to prioritise patients with an urgent need, if they have the capacity to provide more than urgent care, they will prioritise patients who fall within the following categories:

- require dental treatment before they undergo medical or surgical procedures,
- part way through a course of treatment when practices closed,
- have received temporary urgent treatment and require completion of this
- children
- identified as being in a high-risk category and so have been advised they should have more frequent recall intervals.

Although practices have been asked to prioritise patients with an urgent need, it may be necessary for patients with an urgent need to contact more than one practice as each practice's capacity will change on a daily basis dependent upon the number of patients seeking care and staffing levels. Where a practice has the capacity to do so, they will assess patients over the telephone to establish whether the patient requires AAA. If it is established a patient requires a face-to-face appointment, the practice can arrange for them to attend an urgent appointment at the practice or in some instances refer the patient to a UDC Hub.

NHS and private dental care

Whilst most practices provide both NHS and private care, practices have been advised that they must spend an equal amount of time on NHS care now as they have historically, albeit much of their surgery time will not be spent on face-to-face care due to the fallow time between patients. A common

misconception is that practices are attempting to convince patients to be seen privately rather than on the NHS, this is because practices are contracted to provide a set amount of NHS dentistry per year and so are unable to increase the number of NHS appointments they can offer. However, some can increase their private hours and number of private appointments available. In some instances, practices may have filled their NHS appointments but still have private appointments available and therefore sometimes patients may only be offered a private appointment when they contact practices.

Finding a dentist

Patients are not registered with a dentist in the same way as they are with a GP. A practice is only responsible for a patient's care while in treatment, but many will maintain a list of regular patients and will only take on new patients where they have capacity to do so, such as when patients do not return for scheduled check-ups or advise they are moving from the area. The ongoing reduction in activity and backlog means that many patients, including those with a regular dentist, are unable to access routine care at the current time. Details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist or by ringing 111 who will provide details of local dental practices providing NHS care. However, for the reasons outlined above, at the current time it is unlikely that they will be able to accept patients for non-urgent care or those people not considered as having greater clinical need.

Improving access

Funding has been offered to all practices across the South East Region to increase access by providing additional sessions outside of their normal contracted hours, for example in the evening or at weekends. These sessions are for patients who do not have a regular dentist and have an urgent need but have experienced difficulty accessing this or have only been able to receive temporary care (such as AAA, a temporary filling or first stage root treatment) and require further treatment. There are 12 practices in Buckinghamshire, Oxfordshire and Berkshire currently undertaking additional sessions, specifically for patients that would be new to those practices. The offer of additional sessions remains open so that should other practices subsequently determine they have the staffing levels to safely deliver additional sessions, these will be established.

Should any patient need urgent dental care and the practice that provides this is only able to provide temporary care, they will be able to contact one of the following practices to obtain longer term treatment. This is only for urgent care and these practices will unfortunately not be able to provide routine care.

- Smile Dental Care, Twyford, Berkshire, 01189 321803
- Loddon Bridge Road Dental Practice, Reading, Berkshire, 01189 692935
- Gentle Dental Care, Reading, Berkshire, 0118 945 2900 / 0118 945 5555
- Moonlight Dental Surgery, Slough, Berkshire, 01753 526301
- SC Dental Studio, Slough, Berkshire, 01753 550888

- Smile Dental Care Cippenham, Slough, Berkshire, 01753 577017
- Busby House Dental Centre, Didcot, Oxfordshire, 01235 816486
- Bourbon Street Dental Surgery, Aylesbury, Buckinghamshire, 01296 331100
- Haddenham Dental, Haddenham, Buckinghamshire, 01844 292118
- Risborough Dental Practice, Princess Risborough, Buckinghamshire, 01844 345192
- The Chesham Dentist, Chesham, Buckinghamshire, 01494 776 550
- Beaconsfield House Dental, Beaconsfield, Buckinghamshire, 01494 730 940

Access to referral services

The dental referral services must address the same safety issues as the primary care services, which has had impact on patient throughput. As dental practices have increased their capacity, they have prioritised patients with greater oral health needs. This impacts on the time required for treatment in primary care and means a proportionately high number of patients being referred for specialist treatment.

In line with other hospital services, the specialty of Oral and Maxillofacial Surgery saw a significant increase in the number of patients waiting more than 18 and 52 weeks for treatment as a result of the pandemic. The Integrated Care Systems are leading on the recovery of hospital waiting times. At the Royal Berkshire the number of patients waiting for more than 18 weeks within this specialty fell from 303 in January 2021 to 249 in August. The number of patients wating more than 52 weeks fell from 35 to 4 in the same period.

NHSE/I South-East has recently approved Restoration and Re-set investment funding for community-based providers of Special Care and Paediatric (Community) Dental Services and tier 2 Oral Surgery services for the period 1st November 2021 – 31st March 2023. The commissioner is working with the service providers to mobilise this additional capacity which will include increased provision of General Anaesthetic services for Special Care adults and children.

3. Next steps and review

3.1 Access to services:

Ensure access can be achieved both 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

- National review of contractual arrangements from 1st January 2022
- Urgent Dental Care hubs to support the wider system if needed
- Maintain access sessions for irregular attenders
- Implement NHS Restoration and Re-set programme to address backlog of patients awaiting treatment following referral

Hugh O'Keeffe,
Senior Commissioning Manager,
NHS England and NHS Improvement
November 2022

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Berkshire West

Clinical Commissioning Group

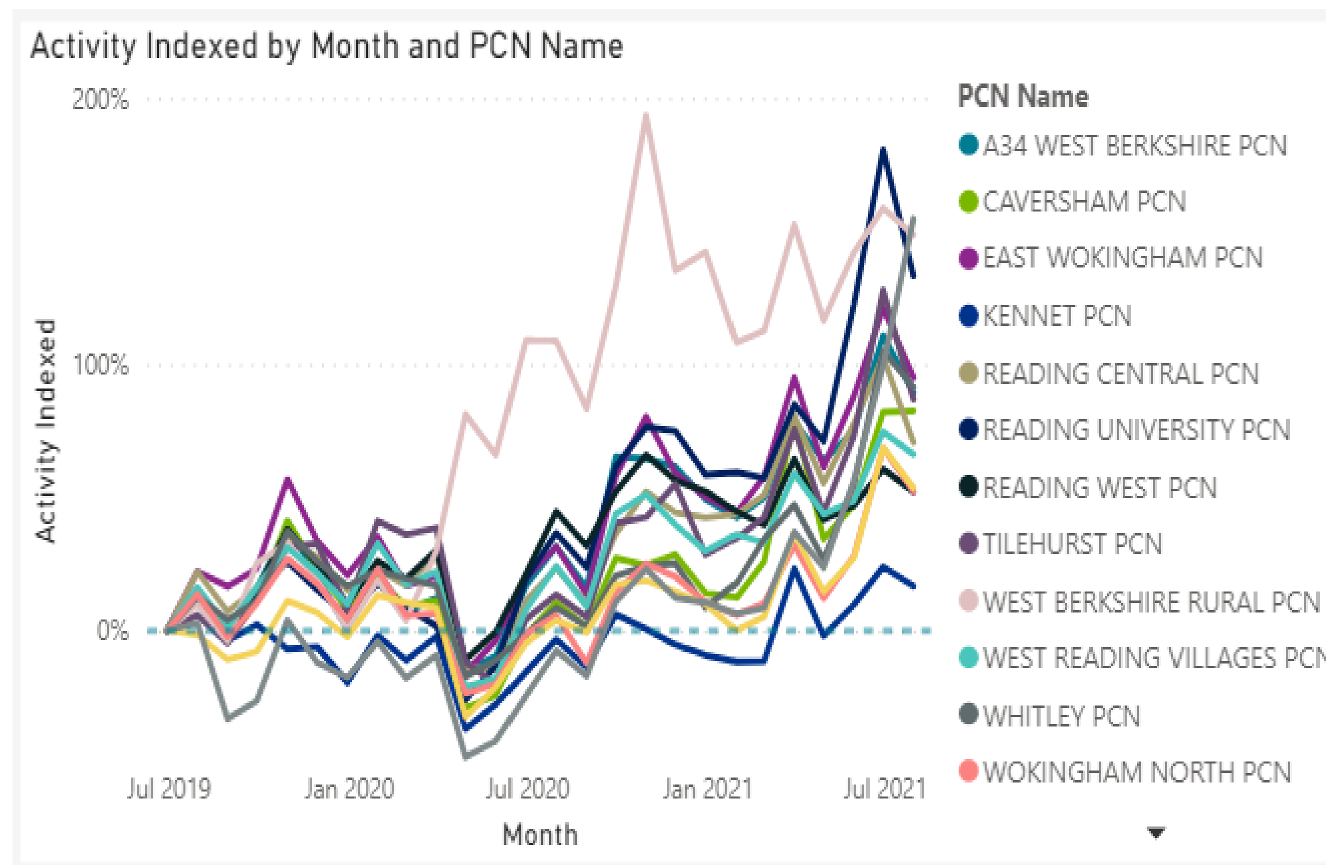
Impact of Covid-19 on Primary Care

West Berkshire Health and Wellbeing Board

Thursday 30 September 2021

Impact of Covid-19 on Primary Care

- Demand has increased with the easing of restrictions across the health system, including primary care.
- Pressure linked to backlog in demand and extra secondary care work, i.e. blood tests, starting medications, follow up of problems
- The chart below shows the change in appointment activity overtime from July 2019 (pre-pandemic) to July 2021



Impact of Covid-19 on Primary Care

% Change in Activity per month now versus month 0

PCN Name	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+	Total
WOKINGHAM WEST PCN	79%	106%	263%	181%	220%	218%	167%	60%	52%	40%	**155%**
WEST BERKSHIRE RURAL PCN	59%	132%	90%	98%	115%	187%	202%	203%	157%	92%	**149%**
READING UNIVERSITY PCN	98%	118%	127%	160%	159%	152%	126%	110%	86%	40%	**133%**
EAST WOKINGHAM PCN	57%	77%	112%	96%	106%	124%	111%	89%	75%	71%	**95%**
WHITLEY PCN	57%	60%	126%	100%	97%	91%	109%	75%	59%	129%	**92%**
A34 WEST BERKSHIRE PCN	73%	113%	81%	80%	95%	121%	117%	74%	57%	39%	**89%**
TILEHURST PCN	55%	92%	75%	91%	100%	88%	88%	108%	78%	77%	**87%**
CAVERSHAM PCN	82%	102%	117%	88%	88%	92%	86%	72%	56%	18%	**83%**
READING CENTRAL PCN	84%	72%	131%	79%	48%	64%	65%	48%	39%	-8%	**71%**
WEST READING VILLAGES PCN	53%	62%	71%	91%	65%	75%	63%	72%	43%	47%	**66%**
WOKINGHAM SOUTH PCN	50%	33%	51%	62%	63%	53%	68%	56%	34%	19%	**54%**
WOKINGHAM NORTH PCN	40%	34%	81%	61%	65%	58%	49%	49%	38%	17%	**52%**
READING WEST PCN	59%	60%	71%	52%	59%	44%	58%	47%	32%	31%	**52%**
KENNET PCN	36%	-28%	25%	28%	21%	22%	24%	16%	6%	-0%	**17%**
Total	**60%**	**57%**	**99%**	**87%**	**86%**	**85%**	**81%**	**65%**	**48%**	**39%**	**76%**

- Percentage increase in consultation activity across PCNs varied during Jul19 –Jul21 - ranging from 17% - 155% increase.
- Across Berkshire West there has been a 76% increase in consultations in their various forms

Impact of Covid-19 on Primary Care

- Face2face / telephone consultation data shows a decline in these types of contacts in some PCNs, although a 5% increase overall.
- Decline likely consequence of national SOP changes at start of pandemic introducing total triage model that ensued GP services were sustainable and safe.

% Change in Activity per month now versus month 0

PCN Name	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+	**Total**
WEST BERKSHIRE RURAL PCN	17%	35%	10%	7%	5%	29%	36%	51%	67%	61%	**31%**
WEST READING VILLAGES PCN	15%	24%	22%	29%	15%	26%	15%	31%	23%	37%	**23%**
CAVERSHAM PCN	27%	20%	35%	24%	17%	23%	20%	16%	25%	4%	**21%**
READING UNIVERSITY PCN	20%	31%	14%	15%	22%	29%	22%	32%	35%	26%	**21%**
TILEHURST PCN	14%	28%	10%	17%	21%	12%	9%	28%	18%	40%	**17%**
EAST WOKINGHAM PCN	10%	5%	17%	8%	11%	15%	17%	15%	36%	33%	**16%**
READING CENTRAL PCN	42%	22%	46%	16%	0%	11%	9%	6%	12%	-14%	**16%**
A34 WEST BERKSHIRE PCN	8%	22%	6%	5%	5%	16%	31%	17%	27%	25%	**15%**
READING WEST PCN	17%	2%	14%	2%	3%	-10%	4%	5%	7%	7%	**4%**
WOKINGHAM NORTH PCN	-6%	-11%	9%	-7%	1%	0%	-6%	1%	7%	1%	**-1%**
WOKINGHAM SOUTH PCN	1%	-6%	-10%	-5%	-7%	-8%	1%	6%	7%	6%	**-2%**
WHITLEY PCN	-15%	-8%	-3%	-1%	-8%	-9%	1%	-8%	3%	83%	**-4%**
WOKINGHAM WEST PCN	-12%	-21%	-2%	-16%	-18%	-23%	-18%	-21%	-6%	0%	**-16%**
KENNET PCN	-13%	-54%	-26%	-27%	-29%	-30%	-26%	-20%	-14%	-15%	**-27%**
Total	**7%**	**-3%**	**9%**	**4%**	**1%**	**2%**	**4%**	**8%**	**14%**	**18%**	**5%**

Impact of Covid-19 on Primary Care cont.

- Activity may not reflect true demand/activity, i.e. online requests (emails, practice website requests, text consultations) which have become vital tools in communication / consulting with patients although there has been a national drive to map all appointment types and improved data is expected

- Face2face consultations taking longer due to Covid infection control measures (donning / doffing PPE, social distancing, cleaning processes)

- Despite some patients wishing to return to face2face consultations the new, flexible ways of consulting have been appreciated / taken up by many including those who prefer not to attend the surgery for work or health reasons unless it is necessary for them to do so

- Housebound patients and those with transport difficulties have more access than before

- Likely to see continued mixed model going forward but with greater emphasis on offering face2face in response to patient preference as well as clinical need

Recovery

Recovery plans:

- Step down of Respiratory Hub arrangements with all patients now managed within practices - Hub closed end of Mar21. Suspected Covid pts. now seen by practice, safe hot / cold streaming arrangements established.

- Further work to embed new models of access to primary care and support patients to engage with these - Being addressed through digital inclusion programme and comms campaign, including introduction of digital champions to support all groups in accessing care.

- Planning for next phase of covid vaccination programme

Recovery cont.

- Backlog of routine appointments addressed and focus on ensuring chronic diseases are appropriately managed - Funding made available to increase GP capacity, oximetry @home arrangements, long COVID management, clinically extremely vulnerable patient management, chronic disease management, routine vaccinations and immunisations and health checks for learning disability patients

- Improvements seen in routine vaccinations and immunisations / screening rates – improvements rates seen, continuing to be monitored /supported

- Focussed work to support vulnerable patients / address inequalities e.g. increase in learning disability health checks and physical health checks for patients with severe mental illness – Funding detailed above has supported, 67% Learning Disabilities Health Check target achieved

Continued work addressing Primary Care Demand

- System-wide workshop held in May to agree remedial actions

- Key Primary Care remedial actions:
  - Building intelligence about activity in primary care, including predictive modelling
  - 111 call handlers now able to book into primary care
  - Standardised telephone message for GP Practices
  - Maximising GP call handling / workflow management capabilities
  - Additional 170 appointments per day being commissioned to increase capacity until end of March 2022
  - Piloting how RBFT's Emergency Department can book patients into GP appointments
  - Practices now have 'front doors' open so patients can book in person
  - Establishing a Community Pharmacy Consultation Service as an alternative to the GP practice
  - Exploring the potential to enhance the telephony systems used by GP Practices
  - Taking part in the Additional Roles Reimbursement Scheme to create bespoke multi-disciplinary teams

NHS
Berkshire West
Clinical Commissioning Group

Why are GP Practices still working differently?

If the Pandemic is over why aren't GP practices open?

The pandemic is not over. GP practices worked hard to provide a service throughout lockdown and continue to do so. To protect everyone, we must maintain safe infection control and minimise unnecessary physical contact.

How are practices working now?

Most appointments are being triaged. This helps keep you safe and makes sure the people with the greatest need are contacted first. We will see everyone in person who needs to be seen that way.

Where else can I get help?

Visit **www.nhs.uk** for advice on common symptoms and a list of local services or speak to your community pharmacist first for advice on minor illnesses.
Find your nearest:
nhs.uk/service-search/find-a-pharmacy/

Why do receptionists ask personal questions?

GP reception staff are a vital part of the health care team and ask questions to direct you to the best support. They are supported by the highly trained clinical teams and are skilled in assisting with triage. They also work to strict codes of patient confidentiality.

I wanted to see my GP, so why am I seeing someone else?

Many GP practices now include a range of professionals (e.g. physician associates, pharmacists, paramedics, advanced nurse practitioners) who can diagnose and treat health conditions. This ensures that you see the right person at the right time more quickly.

What is triage?

You will be assessed to decide who needs:

- to be seen in person
- a phone consultation
- a video consultation
- help from a community pharmacy.

What about emergencies

Always dial 999 in a life-threatening emergency. If you need help with minor injuries at any time or urgent care when your GP practice or community pharmacy is closed visit **111.nhs.uk** or **dial 111** if you do not have internet access.

Please be patient

Our health services are under enormous pressure- local GP's are seeing 30% rise in demand-but we are open and here if needed. Our GP's still run an out of hours service for emergencies. You can help us and help yourself by making sure you get the right care, in the right place, at the right time appropriate for your needs. Staff should be treated with respect and consideration at all times, so please continue to be kind to our staff, socially distance where possible and wear a face mask in healthcare settings.

Together we can choose well

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Health Scrutiny Committee - 10 November 2021

Item 9 – CCG Update

Verbal Item

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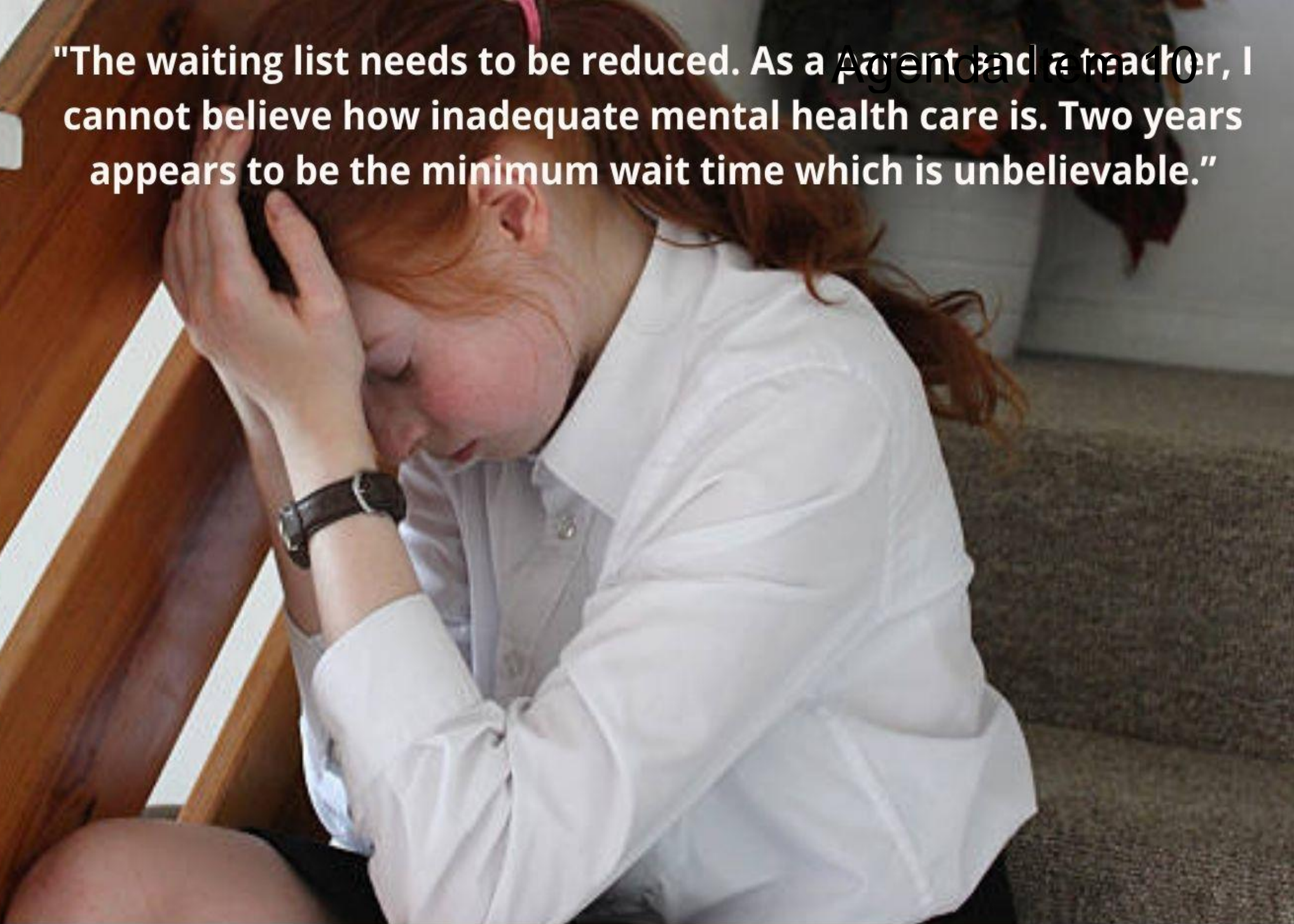

Child and Adolescent Mental Health Services (CAMHS) Survey Feedback Report February 2021

healthwatch
West Berkshire

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DRAFT

"these are the adults of the future and you are letting them down"

Introduction

According to the BMJ report 10th March 2021, *Mental health of children and young people during pandemic*

"The mental health of the UK's children and young people was deteriorating before the pandemic, while health, educational, and social outcomes for children with mental health conditions are worse than for previous cohorts.[456] Between 2004 and 2017 anxiety, depression, and self-harm increased, particularly among teenage girls.[7]"

In February 2021 Healthwatch West Berkshire undertook an online survey exploring the views and perceptions of the parents/guardians of children who were currently using the local Child and Adolescent Mental Health Service (CAMHS). The survey was a follow-up to a focus group run by Healthwatch in July 2019. Due to covid the survey was available only online and was shared on the West Berkshire Healthwatch website and on social media. The survey ran from February to the middle of March 2021. This preliminary report explores the responses and presents some early recommendations for the way forward.

The key finding on extensive waiting times is of great concern especially given Berkshire West was found to be one the 10 CCGs nationwide with the largest increases in average waiting time from 2017/18 to 2019/20 in The Children's Commissioner's fourth annual report on the state of children's mental health services in England 2020/21

It is evident from the 128 respondents who took part in the survey that changes are urgently needed, however the recommendations are by no means exhaustive at this stage and involve far more than just the CAMHS service. Only a totally integrated approach will succeed in improving outcomes for the burgeoning numbers of post pandemic young people with Mental Health and other emotional issues.

We hope this report will be a springboard for root and branch transformations that will improve the mental health and emotional wellbeing of our children and young people in West Berkshire.

DRAFT

Sadler K, Vizard T, Ford T, Goodman A, Goodman R, McManus S. The mental health of children and young people in England 2017: trends and characteristics. Health and Social Care Information Centre, 2018. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-s
2020-21-tech-report.pdf

Executive Summary

The online survey undertaken by Healthwatch West Berkshire of views and perceptions of CAMHS users locally in February/March 2021 had 128 responses. The responders were the parents and guardians of young people who were seeking help for their children or had sought help in the past. 93% of the children and young people concerned were of school age (11-18 years).

Many of the responses within the survey highlighted the issue of very long waiting times for help, with 50% of the responders waiting between one to three years to be given a diagnosis for their child. In addition, over half had waited between one to three years to access CAMHS for any reason. Some parents and guardians said that their child's condition worsened due to long waiting times, others believed their child's education had suffered and that the mental health and wellbeing of other family members had been adversely affected. A considerable number resorted to paying for private treatment and diagnoses. Three quarters believed that earlier access to CAMHS would have made a difference to their child.

In response to questions about the effectiveness of CAMHS, there was an overall feeling that the service was not satisfactory. 61% of respondents said the service had not made a real difference to their child. 70% were unhappy with the information received on discharge with 8 out of 10 stating they would have liked more information about where to get help.

Additional comments/requests supported the urgent need to decrease CAMHS waiting times and support parents/guardians and the children and young people at all stages including waiting to be seen and after discharge. Many responders felt there needed to be better communication between the CAMHS team and the families and there was a general plea for more staff and more experienced staff, better able to help the children and young people with complex and challenging mental health problems.

It is important to note that there has been a recognition by Commissioners of the need to improve CAMHS provision locally and a Local Transformation Plan was developed to this end in 2015. The *Future In Mind Local Transformation Plan (LTP) For Children and Young People's Mental Health and Wellbeing* has been regularly refreshed and in January 2020 a report was taken to West Berkshire Health and Wellbeing Board of the refreshed version of October 2019. The LTP provided an update on service development and improvement across the comprehensive CAMHS system.

The refreshed LTP can be found here:

https://www.berkshirewestccg.nhs.uk/media/3378/311019-final-ltp-bw-ccg.pdf

The backdrop driving activity and improvement in this area included a continued increase in demand for children's mental health services and thus increased waiting times; difficulty recruiting the CAMHS workforce, despite additional resources for specialist CAMHS teams across Berkshire West; concerns about the self-harm rates in all three Local

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Authorities for people aged 10–24 and self-harm rates for 15- to 19-year-olds across all three areas that were higher than the national average.

The LTP listed 7 priorities for action, the majority of which relate strongly to the Healthwatch West Berkshire CAMHS survey, in particular priorities 1,3,5,6 and 7:

Priority 1 – Ensure that we embed and expand the Mental Health Support Teams in Berkshire West

Priority 3: Continue to build a 24/7 Urgent care/Crisis support offer for Children and Young People (CYP)

Priority 5: Improve the Waiting times & Access to support, with particular this year on access to Autistic Spectrum Disorder (ASD) and Attention-deficit/hyperactivity disorder (ADHD) assessments and support.

Priority 6: To improve the Equalities, Diversity and Inclusion offer and access for Children and Young People in Berkshire West

Priority 7: Building a Berkshire West 0 – 25-year-old comprehensive mental health offer.

The foreword to the LTP was signed by the Directors of Children's Services for the Berkshire West 3 Local Authorities plus the Director of Joint Commissioning for Berkshire West Clinical Commissioning Group. The following statement was made:

'We must and we will work together to find creative solutions to get the right help, at the right time, in the right place for our children and young people, and their parents or carers. We are committed to listening and responding to what children and families tell us they need. We will review and learn from what's working well and agree together what we need to do to continue to improve.'

Since January 2020, we have suffered a Coronavirus pandemic which has taken the lives of over 127,000 people nationwide. Many NHS service developments have had to be put on hold in order to deal with this pandemic. It is evident that there has been commitment at the highest levels locally in Berkshire West CCG and the 3 Local Authorities to improve CAMHS and address the mental and emotional health and wellbeing needs of children and young people. However, this survey demonstrates that the CAMHS in West Berkshire is still not meeting these needs and the service users are unhappy with many aspects of the service.

The recommendations listed in this report undoubtedly will dovetail with the action plans that have been developed as part of the LTP to improve the mental and emotional wellbeing services for our children and young people. Healthwatch West Berkshire believes that these recommendations should be urgently addressed.

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Recommendations

1. Decrease the waiting times for children and young people to receive a diagnosis, having been referred to CAMHS, to a level that is acceptable and reasonable.

2. Decrease the amount of time taken for a child/young person and their parents/guardians to be seen by CAMHS for any reason following referral.

3. Initiate an internal review as to why parents and guardians of young people who have been seen by CAMHS do not believe that it made any difference to their child. Develop an action plan to improve outcomes of the service.

4. Improve the quality of information and advice that all children and young people and their families receive from CAMHS when they are discharged from the service.

5. Ensure that all children and young people and their parents and guardians are signposted to other mental and emotional health and wellbeing services as appropriate.

6. Increase the support given to children and young people and their parents/guardians throughout the whole CAMHS journey from referral, diagnosis and treatment through to discharge or referral to another service.

7. Improve communication between the CAMHS team and parents/guardians and children and young people being referred to the service at every stage of their CAMHS experience.

8. Increase the number and quality of staff working within the CAMHS team to meet the needs of the children and young people and their families.

9. Ensure the most up to date Local Transformation Plan for Children and Young People's Mental Health in Berkshire West is fully implemented and all aims and objectives in any accompanying plans are fulfilled and reported to the Health and Wellbeing Board.

10. Ensure that all Public Health data relating to the ongoing mental health and wellbeing of children and young people in West Berkshire is regularly reported to the West Berkshire Health and Wellbeing Board and local service commissioners.

11. Improve the preventative and early intervention services available to all children in West Berkshire in order to improve and maintain their mental health and wellbeing and help to prevent the number of referrals to CAMHS.

12. Improve communication and liaison between mental health services in schools and CAMHS to help ensure that children and young peoples' needs are met and there is clear and logical continuity of care across settings.

DRAFT

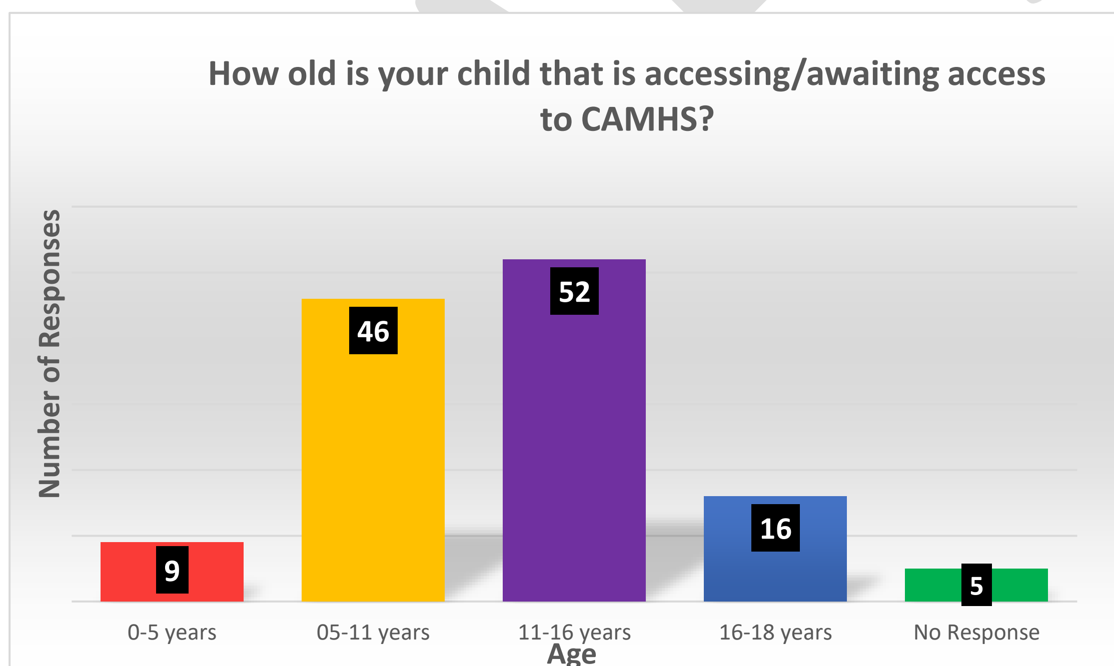
"Post diagnosis my child's mental health has not been good, and she has been self-harming. I contacted CAMHS and was told she didn't meet their criteria for referral, and they closed the case. They told me to wait for the Emotional Health Academy to get back to me, even though the EHA's triage form says if your child is high risk of self-harm, you should contact CAMHS."

"Triage kids earlier! By the time we get seen, it may be too late to effectively help."

"Impossible to access because of the ever-changing goal posts Remember these are the adults of the future and you are letting them down. They are thus starting adulthood on the back foot. Constantly changing staff who never read the notes means that the whole story has to be retold every time."

Survey Findings

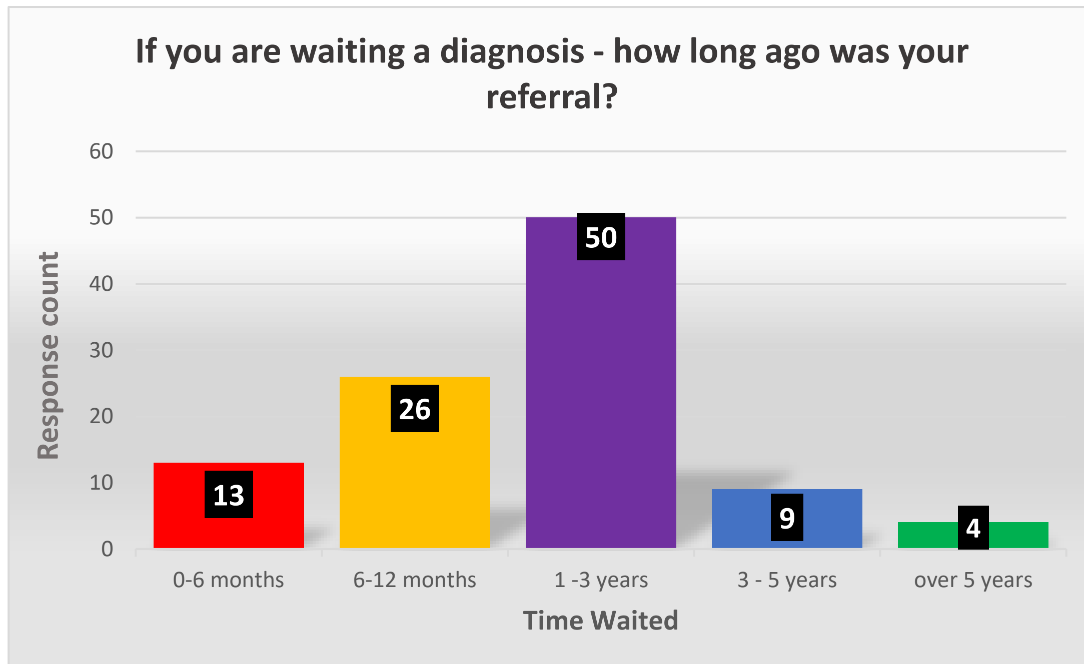
Question 1 - Parents/guardians were asked the age of their child who accessing/awaiting access to CAMHS was.



Out of 123 responses, 43% of children were 11-16 years old and 37% were 5-11 years old. Thus 80% (98 out of 123) were from ages 5 to 16 years. 13% were 16-18 years old, and 7% were in the 0-5-year age group. (5 non responders). For future reference 93% of the children and young people who were accessing CAMHS were of school age.

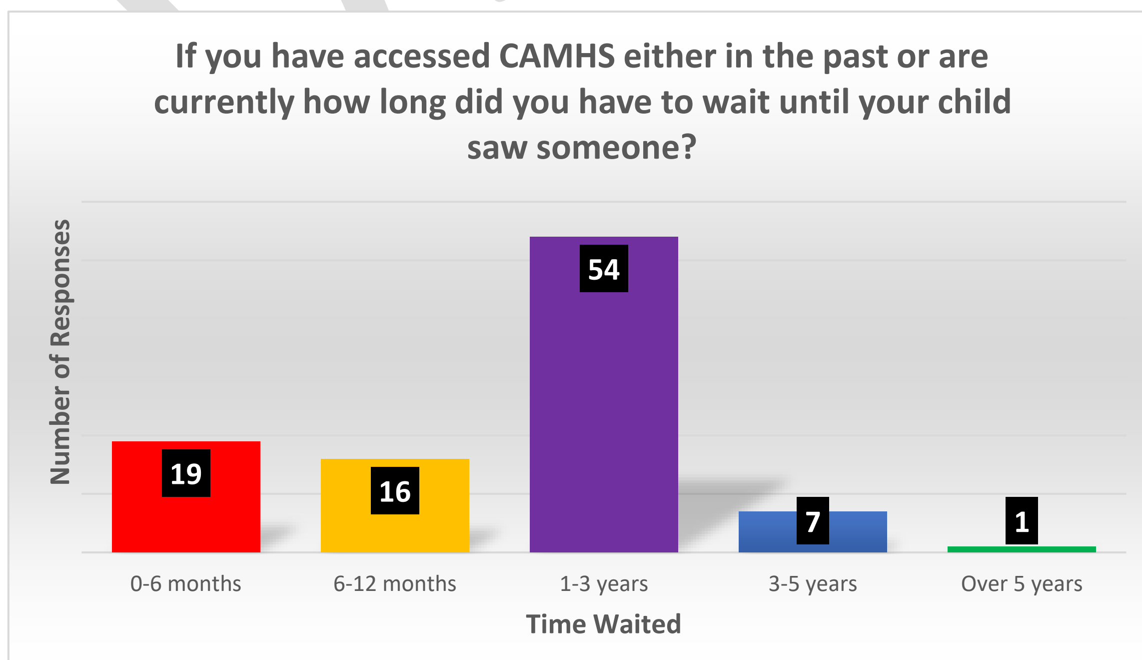
"More funding and more staff. Their waiting times are awful and to offer no help for a self-harming primary school aged child is negligent".

Question 2 - This question examined the length of time a parent/guardian had to wait for a diagnosis if their child was referred for a diagnosis.



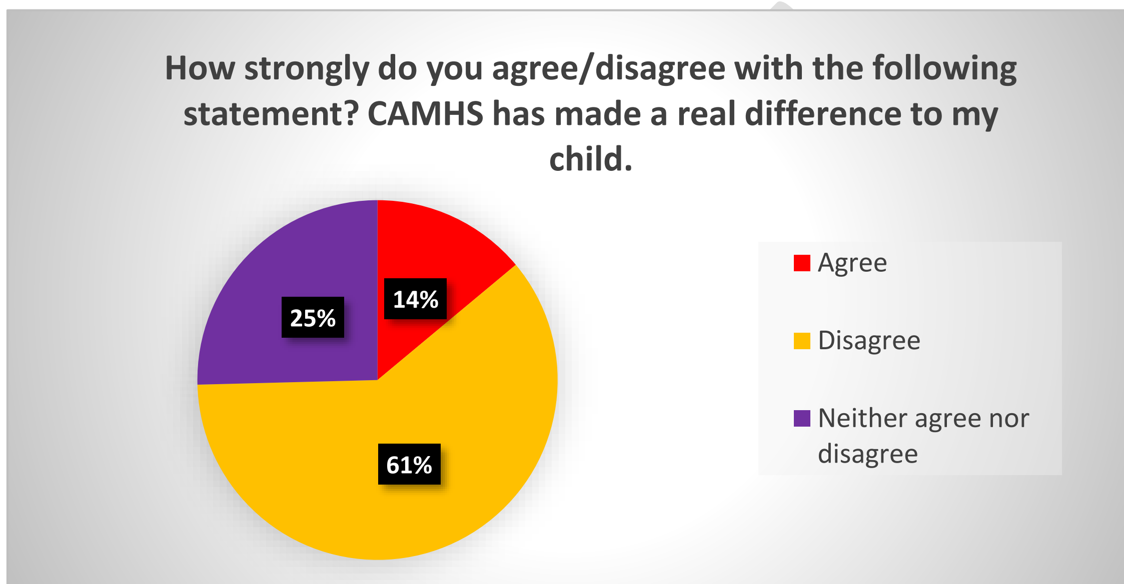
Out of 102 responses, almost half (49%) reported waiting between 1 and 3 years from their referral to CAMHS for a diagnosis. Only 13% said their referral to CAMHS was 0-6 months ago whole another 25% waited 6-12 months. A disturbing 9% said their referral was 3-5 years ago, with a further 4% reporting a gap of over 5 years. (26 non responders).

Question 3 - This question referred to waiting times in particular to be seen for any reason: 'If you have accessed CAMHS either in the past or are currently, how long did you have to wait until your child saw someone?'



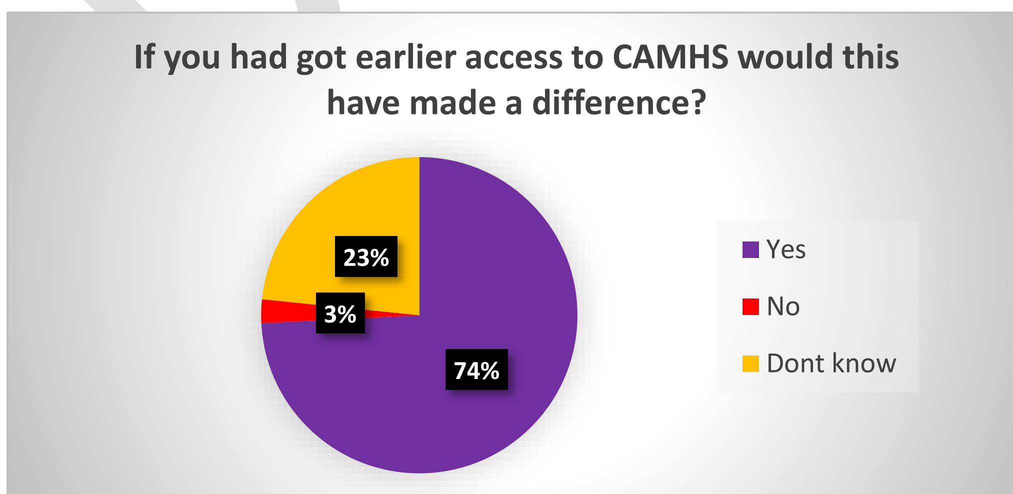
Out of 97 responses, over half (56%) said the wait for CAMHS to see their child was between 1-3 years. Only 20% said the wait for their child to be seen was between 0-6 months while a further 16% waited between 6 to 12 months. 7% of respondents said they waited 3-5 years for CAMHS to see their child with 1% reporting a wait of over 5 years. (31 non responders)

Question 4 - Parents/guardians were asked to agree or disagree with the statement 'CAMHS has made a real difference to my child'.



Of 122 who responded (6 non responders), a majority of 61% disagreed or strongly disagreed that CAMHS had made a real difference to their child. Only 14% agreed that CAMHS had made a difference, and 25% of respondents neither agreed nor disagreed.

Question 5 - Parents/guardians were asked the following question: 'If you had got earlier access to CAMHS would this have made a difference?

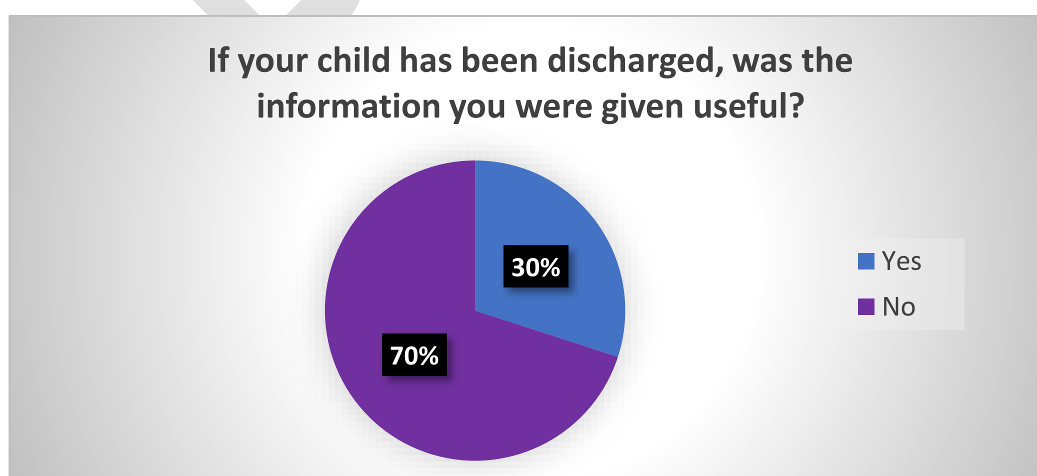


Out of 124 responses, around three quarters (**74%**) believed that if they had got earlier access to CAMHS this would have made a difference to their child's mental health. **23%** reported they did not know whether earlier access would have made a difference while a small percentage (3%) did not believe earlier access would have made a difference. (4 non responders)

Question 6 - Respondents were asked to elaborate on this question and 84 shared their views which have been thematically analysed below. This is not an all-inclusive list but some of the more frequent answers have been grouped and included.

- 62% of responders (52/84) were dissatisfied with the time it took for their child to be seen by CAMHS. This included time taken to be seen, be assessed, be given a diagnosis or to receive treatment
- 20% or 1 in 5 (17/84) were unhappy with the treatment their child did receive from CAMHS
- 17% (14/84) believed the condition of their child worsened due to the delay in being seen by CAMHS
- 13% (11/84) believed that their child's education had suffered significantly because they had not received the help they needed from CAMHS in a timely fashion.
- 9 respondents stated that they were forced to pay privately for their child to receive help.
- 7 respondents reported that as a result of their child having to wait to receive the help they needed from CAMHS it had affected other family members.

Question 7 - Parents/guardians were asked the following question: 'If your child has been discharged, was the information you were given useful?'



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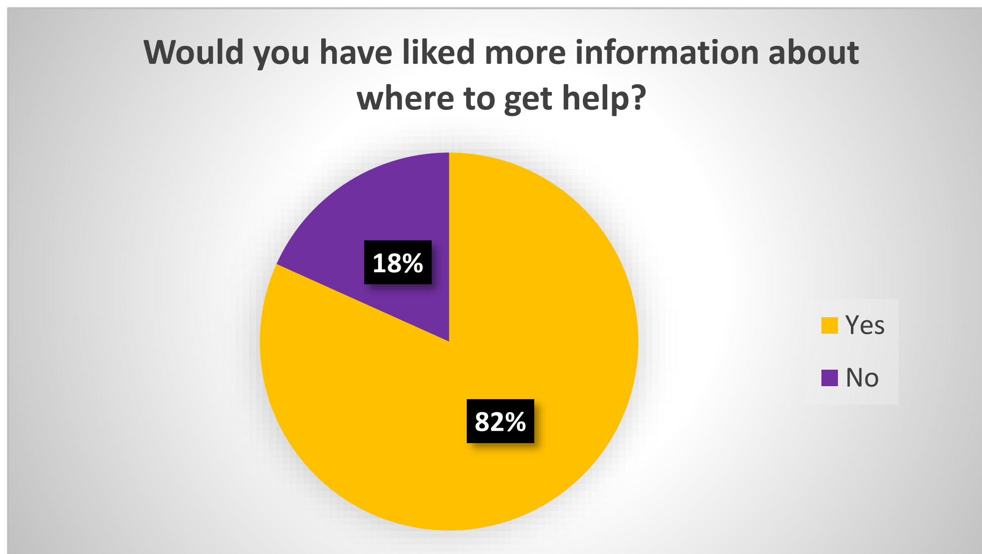
70% (49/70) did not believe the information given to them when discharged was useful, and only 30% (21/70) felt the information given was useful. 58 respondents did not answer this question

Question 8 - Parents/guardians were asked if they would have liked more information about where to get help?



Of 104 responses, around 4 out of 5, or 82% (85 respondents), said would have liked more information about where to get help from CAMHS. 18% (19 respondents) said they would not have liked more information. 24 people did not respond to this question.

Question 9 - In this question parents/guardians were given the opportunity to elaborate on what recommendations they would make to improve CAMHS locally.

94 people shared their thoughts with 34 non responders. Again, these comments, many of which were emotional, and heartfelt have been clustered to demonstrate the most common recommendations. Further analysis could be undertaken to identify more suggestions.

- 55% (52/94) of respondents urged that waiting times be significantly reduced.
- 20% (19/94) recommended more support be made available for both children and families while the child was waiting to be seen, from referral, during diagnosis and treatment, and after treatment.
- 22% (21/94) recommended that there was better communication between the CAMHS team, the child/young person and the families at every stage of the process.
- 23% (22/94) wanted to see more staff and more experienced staff within CAMHS.
- 9 responders suggested increased funding was needed to bring down the waiting times and increase the number of staff.

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Question 10 - A final section asked parents/guardians to share any other ideas and thoughts they had.

79 parents/guardians shared additional thoughts. Many showed a high level of frustration and dissatisfaction.

- Just over a quarter (21/79) of the comments were critical and negative. Typical phrases included 'appalling service', 'disappointed with the service', 'feel let down', 'awful experience', 'an absolute disgrace'.
- Only 8 respondents, or around 10%, made any positive comments. Some of these comments mentioned 'practical advice', 'excellent clinician who got to the bottom of our problem', 'amazing course of therapy' and 'very thorough and diligent professionals'.
- Waiting times again featured with 18 respondents, or 22%, mentioning this was a problem in their child's diagnosis and treatment.

THANK YOU

Healthwatch West Berkshire would like to thank all the members of the public who took the time to fill out the survey and everyone who has been in touch to give feedback around the CAMHS services in West Berkshire.

Thanks to Board Member Lesley Wyman for co-authoring the report, placement student Abbie Rickard and all of our amazing volunteers and board members for their help.

Acronym Buster

CAMHS – Child and Adolescent Mental Health Services

BMJ – British Medical Journal

LTP – Local Transformation Plan

CYP – Children and Young People

ASD – Autism Spectrum Disorder

ADHD – Attention Deficit Hyperactivity Disorder

CCG – Clinical Commissioning Group

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Health Scrutiny Committee – Forward Plan Items

Meeting Date	Item Title	Purpose	Organisation
All meetings	Berkshire West Clinical Commissioning Group Update	To receive an update from the Berkshire West Clinical Commissioning Group on their activities. (Standing item for information and discussion.)	Berkshire West CCG
All meetings	Healthwatch West Berkshire Report	To receive an update from Healthwatch West Berkshire on patient feedback received, reports prepared and other activities. (Standing item for information and discussion.)	Healthwatch West Berkshire
February 2021	Director of Public Health Report	To receive the annual report from the Berkshire West Director of Public Health.	Berkshire West Shared Public Health Team

Informal Briefings

Formal public meetings will be supplemented by private briefing sessions to allow HSC Members to develop knowledge of various health topics. Suggested topics are provided below.

Date	Item Title	Purpose	Organisation
TBC	Public Health Services	To have a presentation from West Berkshire Council's Public Health Team covering: their roles and responsibilities; the services they commission and the procurement plans; and the relationship with the Berkshire Shared Public Health Team.	Public Health Team
TBC	Integrated Care System	To have a presentation on the Oxfordshire, Buckinghamshire and Berkshire West ICS covering: its functions; structure; timescales; and the levels at which future decisions on health services and their funding will be made.	BOB ICS
TBC	Royal Berkshire NHS Foundation Trust	To have a presentation on the RBFT covering: services provided; locations; patient flows; operational and financial performance; key Covid impacts and recovery plans.	RBFT
TBC	Berkshire Healthcare NHS Foundation Trust	To have a presentation on the BHFT covering: services provided; locations; patient flows; operational and financial performance; key Covid impacts and recovery plans.	BHFT
TBC	Mental Health Services	To have a presentation on the different mental health services provided for adults and children in West Berkshire, from preventative work to voluntary sector programmes to primary care and specialist support.	Public Health Team, BHFT, Mental Health Academy, Time to Talk, 8 Bells

TBC	Social Prescribing	To have a presentation on social prescribing – what it is, who is involved and the benefits for patients.	Berkshire West CCG

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