Consultation on Oral Health Professional Advisory and Governance Structures Primary & Community Services Delivery Unit, ABMU Health Board

1. Introduction

The current oral health professional advisory structures in ABMU Health Board [ABMU] were established between 2010-2012. However, it has been recognised for some time that the roles and responsibilities of many of the groups in the structures have become less clear particularly as changes in national and local policies and associated architecture have developed. In addition, the number of committees/groups places a significant burden on the management teams and committee members.

This paper outlines, for consultation, two options for a revised structure for oral health professional advice to the Health Board. The aim is to establish structural cohesion, integration, a strengthening of clinical leadership and an alignment of local direction with national and Health Board priorities. Oral health services need to be responsive, equitable, effective and based on prevention. They need to be planned and managed, driven by population need.

2. Background

The aim of the reorganisation of the NHS in Wales in 2009 was to improve patient care through integration of NHS organisations with an emphasis on joined up working. It required a shift in the balance of care, looking at whole systems with a strong emphasis on public health and long-term planning. The intention was that service development should be based on co-operation, collaboration and partnership working in a system that was value driven.

To reflect this emphasis, ABMU established a Dental Advisory Group (DAG) in 2010. This group commissioned a review of a number of services by Dental Public Health Wales (DePHW), between 2010-12. This work subsequently led to the establishment of the following advisory groups and several associated work streams (Fig. 1):

i. Dental Services Strategy and Planning Group (DSSPG) to replace the DAG - Chair of the DSSPG was an ABMU executive director (Director of Planning).
ii. Orthodontics
iii. Operative Dentistry which included Paediatric (Paeds Dent), Restorative (RD) and Special Care Dentistry (SCD).
iv. Oral Surgery (OS).

The three speciality groups (ii-iv) agreed work plans based on the findings of the reviews and reported to the DSSPG. Orthodontics and Special Care Dentistry subsequently developed into managed clinical networks (MCNs) across ABMU HB and Hywel Dda HB and also linked into the respective Welsh Government's Strategic Advisory Fora (Orthodontic SAF and SCD SAF).

A Dental Clinical Governance Group was also established which reported to the Health Board's Quality and Safety Committee. A 'Designed to Smile' (D2S) steering group was also formed to reflect and deliver the national programme locally.

3. Current Position

It has been recognised that the roles and responsibilities of the DSSPG and associated advisory groups have become less clear in recent years as their initial terms of reference were achieved and/or changes in policies and structures have evolved. In particular, the DSSPG became a very large group, with much of its time spent on 'operational' issues. Furthermore, many of the groups worked in isolation to speciality-specific programmes with little integration with other services or reference to the Health Board's overall position and agreed priorities.

The number of committees also placed a significant burden on the management teams and committee members. This is reflected in the Review of Public Health Wales Dental Public Health Resources (2017) which highlighted the need to limit Consultants in DePHW input into Health Board's 'operational' activity. This will have a significant effect on the functionality of the Groups detailed in Figure 1 since DePHW played an active role in all the advisory structures. A similar pressure exists on the Local Dental Committee (LDC), the Department of Postgraduate Dental Education (DPGDE) as well as the administrative support.

In 2015, ABMU initiated an operational management restructuring and as consequence a number of the advisory groups were put into abeyance or their work limited. This included the DSSPG. This was on the basis that the relationships of the groups within the new structures, their terms of reference and the organisational requirements were unclear at that time. In addition, the senior clinical and management teams were not fully established.

In October 2016, the organisational structures of the Health Board became established at senior clinical and management levels and the lead responsibility for planning and delivering oral health services across the Health Board was placed within the Primary and Community Services Delivery Unit [PCSDU] . In January 2017, a dental stakeholder workshop took place in an attempt to understand and discuss the future requirements for oral health services in ABMU. Preliminary conclusions from this event highlighted the need to establish a relevant, robust and accountable architecture to support and underpin oral health services in the Health Board. It is therefore an appropriate time to establish an advisory structure which reflects the needs of the population and the Health Board as well as the current context for health services in Wales.

4. Context

The NHS in Wales has outlined its vision for the health services in several publications including:

- Primary Care Plan for Wales (2014);

- A Planned Primary Care Workforce for Wales (2015)
- Principles of Prudent Health Care
- Wellbeing of Future Generations Act (2015)
- Together for Health: A National Oral Health Plan for Wales (2013-2018).

These have been reflected locally by ABMU in policies such as Changing for the Better, its Aims, and Values as well as its Quality Strategy. These have been further reinforced and reflected in the Health Board's Local Oral Health Plan (2013) and the Primary and Community Services Strategy which is currently under development within the PCSDU with partners

In particular, the Health Board's six strategic aims offer an opportunity to establish a framework for the development of Oral Health Services:

i. **Services are accessible and sustainable with a system shift to primary care-**
   - Services planned for the long-term
   - Primary care driven
   - Prevention as a priority
   - Seamless pathways across primary and secondary care

ii. **Services should deliver excellent outcomes and experiences-**
   - Do only what is needed, no more, no less; and do no harm.
   - Reduce inappropriate variation using evidence based practices consistently and transparently.

iii. **Services should aim to support healthier communities-**
   - Reduce inequalities and services prevention driven
   - Care for those with the greatest health need first

iv. **Effective governance should underpin all activity-**
   - Robust indicators of performance and standards
   - Effective systems of monitoring and reporting
   - Effective and efficient use of resources
   - Accountable structures with clear roles and responsibilities.

v. **There should be strong partnerships-**
   - Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
   - Generalists working seamlessly with specialists

vi. **Establish a fully engaged and skilled local workforce-**
   - Making the most effective use of all skills and resources
   - Only do what only you can do
   - Develop new and extended roles.

5. Objective

The objective of this proposal is to put forward two alternative options for an effective and efficient professional advisory structure to develop strategy and policies as well as planning, delivery and quality assurance of oral health services within ABMU whilst reflecting the national and local context and the Health Boards six strategic objectives.

The proposals advocate a commissioning-service delivery structure underpinned by robust governance, integration and sound professional advice. Although all elements are linked the proposals make a clear distinction between how roles and responsibilities are discharged and lines of reporting. The proposals also reflect the outcome from the stakeholder event in January 2017 as well encouraging better integration between services. One option, in particular, has the potential to make a significant impact on improved efficiency and integration.

6. Proposal: Option 1 (Figure 2).

This proposal advocates the establishment of the following:

a. Oral Health Strategy Group (OHSG).

This group replaces the previous DSSPG and will have terms of reference to develop and oversee the delivery of strategies and supporting policies, including service standards and models of care for improving the oral health of the population through the provision of quality, sustainable, integrated services which reduce inequalities and improve access. It will report to the PCSDU's Board through its Primary Care Forum (PCF) and engage with equivalent Committee in the Morriston Hospital Service Unit (MHSU).

b. Sustainability and Transformational Advisory Group

The OHSG will be informed and supported in its work by a Sustainability and Transformational Advisory Group which will, with relevant stakeholders, consider new models of working based on integrated, primary care driven services and a modern workforce.

The Group's work-plan and priorities will be established by the OHSG and it will take a Task and Finish and innovative approach to its responsibilities. It will seek best practice both locally and nationally and develop robust key performance indicators when necessary. An initial priority will be to spread learning and good practice from the Health Board's Dental Contract Prototype Practices to support contract innovation in line with current Welsh Government initiatives more widely in the organisation.

c. Oral Health Operational Group (OHOG)

This Group will plan and oversee the delivery of services within the parameters developed by the OHSG and will liaise closely with the OHSG to ensure that strategic objectives are met. The Group will coordinate and support the clinical activity of the service delivery units and the work of the Integrated Oral Health Service Networks and will prioritise its work to demonstrate continued service improvement and integration.

OHOG will also be responsible for collecting, monitoring and reporting data on clinical and service performance as well as indicators of patient safety and experience and outcomes to the Oral Health Quality and Safety Committee (OHQ&SC).

d. Integrated Oral Health Service Networks

- **(i) Children's and Vulnerable Young Adults Network**
  Special Care Dentistry, Paediatric Dentistry and Designed to Smile
- **(ii) Specialist Dental Services Network**
  Orthodontics, Oral Surgery and Restorative Dentistry
  (including Mono-Specialties)

These network groups will bring together services and specialties that have common operational elements to function whenever possible in an integrated and coordinated manner and to share best practice. The two networks will replace the five previous groups and work to an agreed work-plan and common objectives. They will focus on delivering quality integrated care based on the agreed strategy, policies and priorities developed by the OHSG. It would be anticipated that engagement between both networks would also occur whenever possible.

Specialty MCNs will continue and be a critical and vital component to service delivery and development. However, it is expected that speciality MCNs will function in a 'virtual' manner linking through a lead representative. They will also continue, through the relevant Service Network and OHOG, to act as a conduit between the Health Board and any National Strategic Advisory Fora.

e. Oral Health Quality and Safety Committee (OHQ&SC)

This Committee replaces the previous Dental Clinical Governance Committee. It will oversee the governance of all oral health services across the Health Board.

The Committee will take full account of the contracting and commissioning responsibilities of PCCSU Board and work in partnership on the quality and safety agenda with primary care contractors as well as salaried services. It will ensure that there is a robust system and architecture for monitoring and reporting of clinical risks/incidents as well as key performance indicators.

It will engage with other bodies such as HIW, Department of Post-Graduate Dental Education and General Dental Council to ensure that the organisation learns from as well as resolves any quality and safety issues identified.

7. Proposal: Option 2 (Figure 3).

The following parts of the proposed structure are as described previously in Option 1:

- **i. Oral Health Strategy Group (OHSG)**
- **ii. Sustainability and Transformational Advisory Group**
- **iii. Oral Health Quality and Safety Committee (OHQ&SC)**
- **iv. Oral Health Operational Group (OHOG)**

However, the Integrated Oral Health Service Networks are not established.

8. Implications of Options 1 and 2 (Table 1)

Table 1 summarises the key differences between Options 1 and 2.

Table 1

	Option 1	Option 2
Commissioning – Delivery Principle	Demonstrated	Demonstrated but potentially reduced compared to Option 1 due to lack of integration of speciality groups
Governance	Established	
Efficiency	i. Reduction in overall number of Groups	i. Group numbers remain largely unchanged
	ii. Less individual speciality representation on OH Operational Group	ii. Maximum individual speciality representation on OH Operational Group
	iii. Limited but key membership to OH Operational Group with more discrete agendas	iii. Potentially large membership of OH Operational Group with large agendas
	iv. Potential reduced demands on LDC, DPGDE and DePHW.	iv. Potential unchanged demands on LDC, DPGDE and DePHW.
	v. Consistent with proposed management structures.	v. Unchanged pressures on management team – probable need to identify additional admin support for advisory groups.
Effectiveness	Maximises potential for inter-speciality working	Remains unchanged
Strong Partnerships	Specialist Network has limited common operational elements	Maintains speciality specific groups

9. Operating Parameters

Each group will have Terms of Reference agreed by PCSDU Board and which will contain the following standardised common elements:

i. Purpose
ii. Membership and their responsibilities
iii. Method of identifying a Chairperson and term of office
iv. Frequency of meetings
v. Methods of reporting and accountabilities

It is expected that modern methods of working, communication and data collection will be adopted whenever possible throughout the structure to minimise the need for

conventional face-to face meetings, administrative support, travel and time away from the workplace.

10. Consultation Process

The proposals will be circulated by email to the following stakeholders who will be asked to distribute appropriately:

i. Local Dental Committee
ii. Chairs of:
   a. Orthodontic and Special Care Dentistry Managed Clinical Networks
   b. Operative Dentistry Advisory Group
   c. Designed to Smile Steering Group
iii. Dental Public Health Wales
iv. Director of Dental Postgraduate Education
v. Community Health Council
vi. Morriston Hospital Service Unit
vii. Primary & Community Services Units, including
   a. Post Graduate Dental Training Unit
   b. Community Dental Service

There will be a consultation period of 4 weeks ending 24th April 2017: Responses should be returned to Lindsay Davies, Head of Primary Care Lindsay.davies@wales.nhs.uk. These will be collated in a report to the next available Primary Care Forum together with associated final recommendations.

Figure 1:

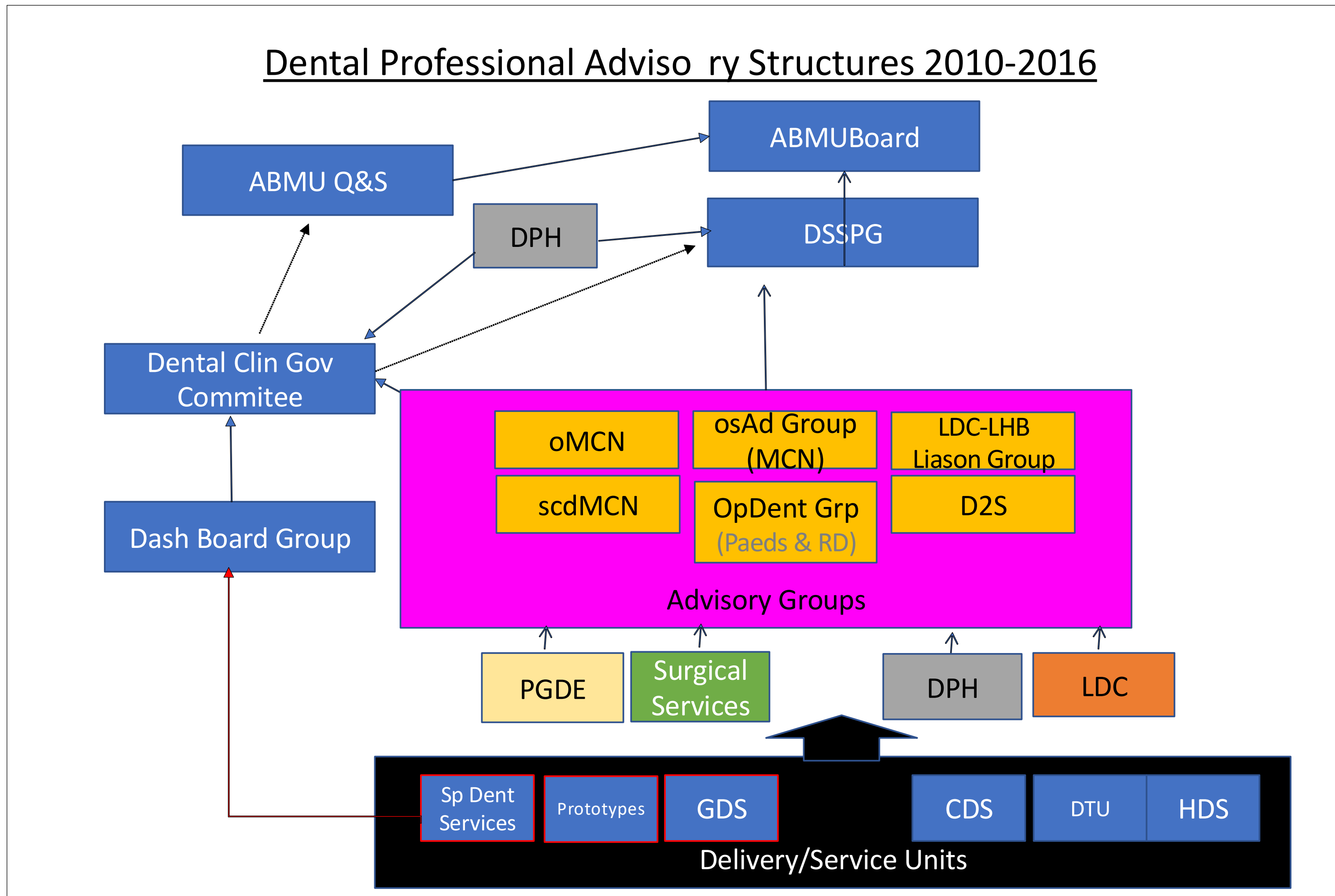


Figure 2: Option 1

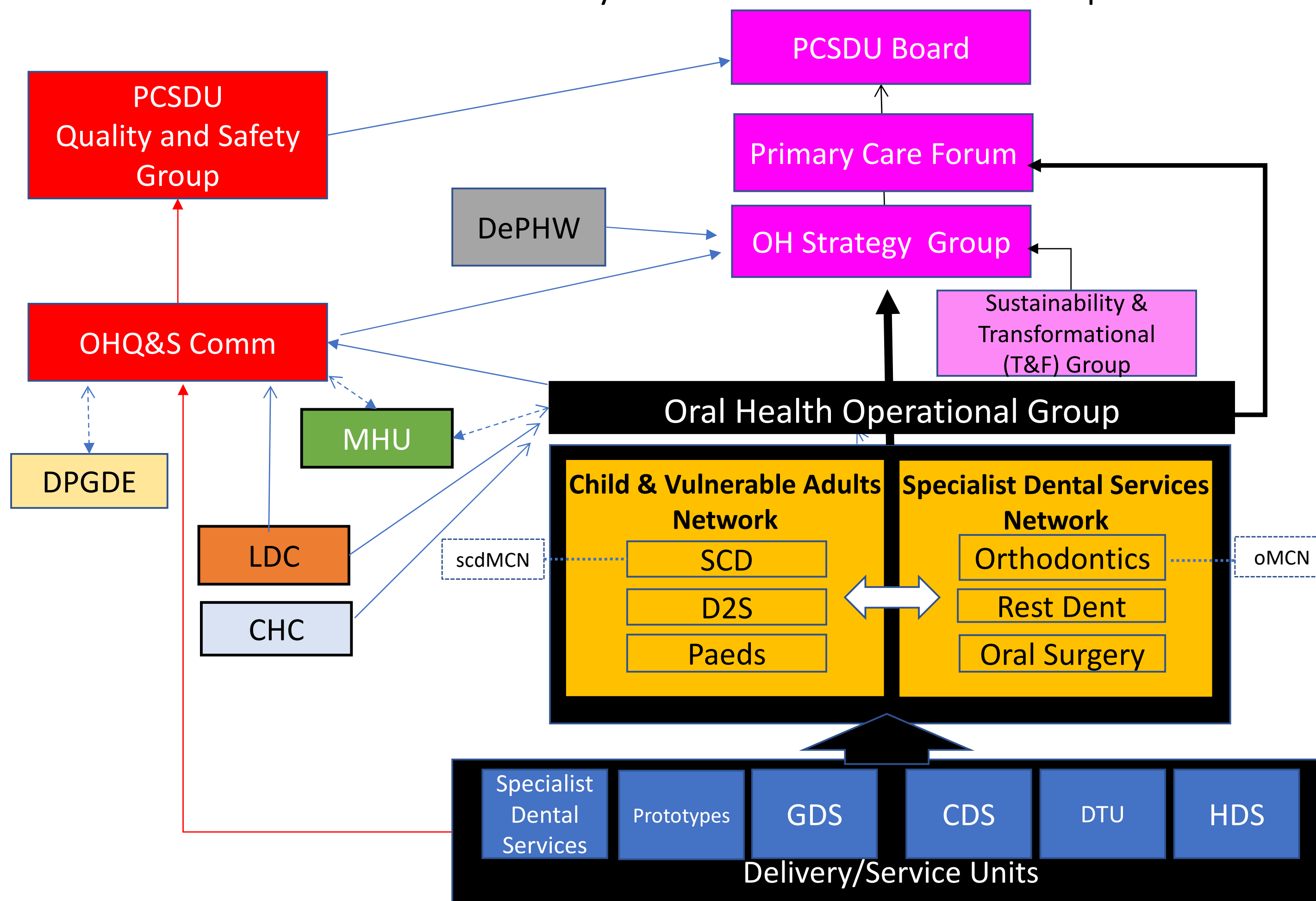
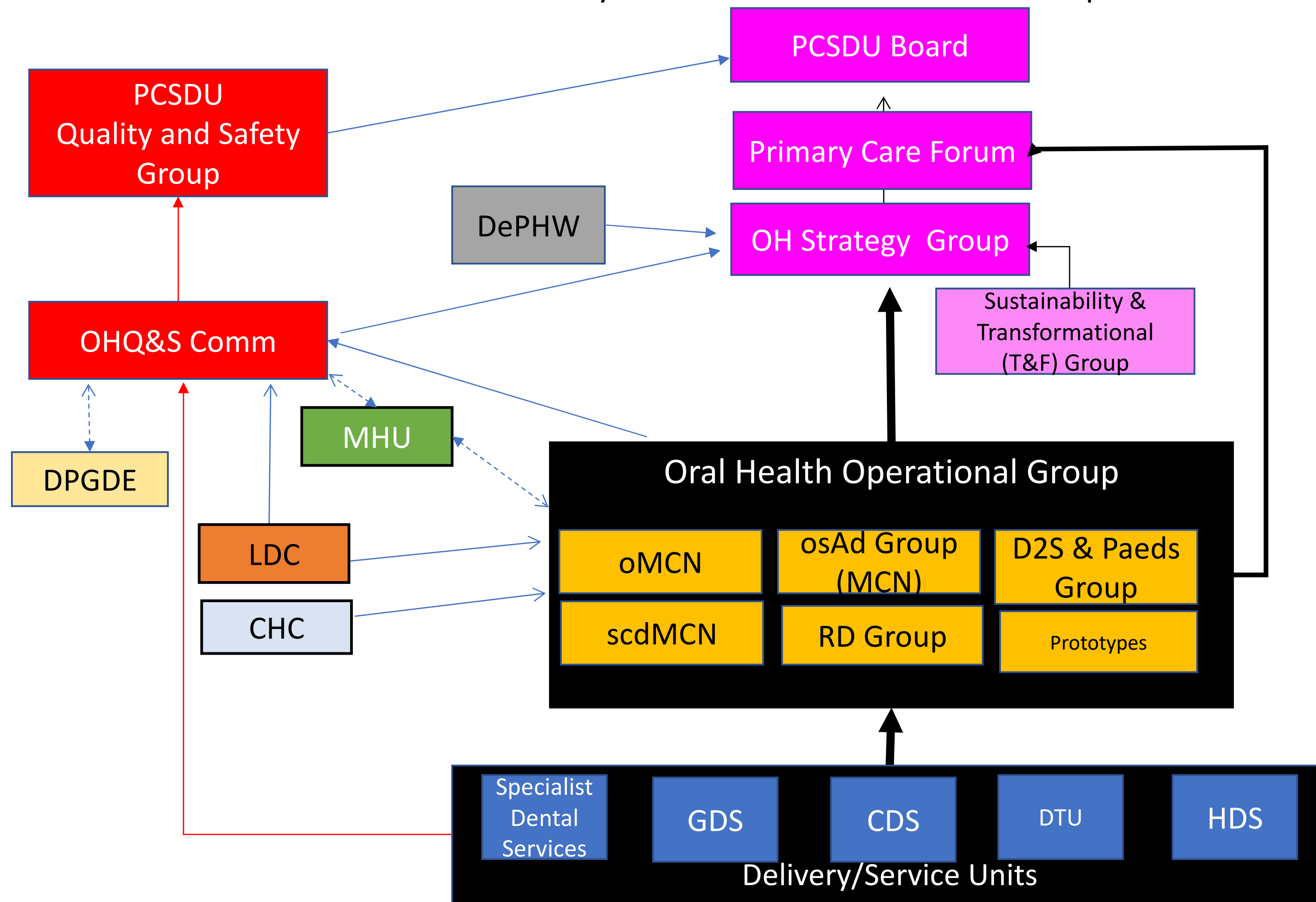


Figure 3: Option 2



Legend

PCSDU Board- Primary & Community Service Delivery Unit

OHQ&S Comm – Oral Health Quality and Safety Committee

DePHW – Dental Public Health Wales

LDC – Local Dental Committee

DPGDE - Department of Postgraduate Dental Education

MHU – Morriston Hospital Unit

CHC- Community Health Council

CDS –Community Dental Services

HDS – Hospital Dental Services

GDS – General Dental Services

DTU – Dental Training Unit

SCD – Special Care Dentistry

D2S – Designed to Smile

Paeds – Paediatric Dentistry

Rest Dent – Restorative Dentistry including the monospecialities of Perio, Prostho and Endo