Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 18 April 2024 at 10.00 am

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

If you wish to view proceedings online, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Membership

Chairman - Councillor Jane Hanna OBE
Deputy Chairman - District Councillor Elizabeth Poskitt

Councillors:	Nigel Champken-Woods	Nick Leverton	Michael O'Connor
	Jenny Hannaby	Mark Lygo	Freddie van Mierlo
District Councillors:	Paul Barrow	Katharine Keats-Rohan	
	Sandy Douglas	Lesley McLean	
Co-optees:	Barbara Shaw		

Date of next meeting: *6 June 2024*

Notes:

For more information about this Committee please contact:		
Scrutiny Officer	-	*Email: scrutiny @oxfordshire.gov.uk*
Committee Officer	-	*Scrutiny Team* *Email: Email: scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

April 2024

What does this Committee review or scrutinise?

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

How can I have my say?

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

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 16)

To approve the minutes of the meeting held on 08 February 2024 and to receive information arising from them.

The Committee is recommended to **AGREE** the minutes as an accurate record having raised any neccesary amendments.

4. Speaking to or Petitioning the Committee

Members of the public who wish to speak at this meeting can attend the meeting in person or 'virtually' through an online connection.

To facilitate 'hybrid' meetings we are asking that requests to speak or present a petition are submitted by no later than 9am four working days before the meeting i.e., 9am on Friday 12 April. Requests to speak should be sent to Scrutiny@oxfordshire.gov.uk

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that your views are taken into account. A written copy of your statement can be provided no later than 9am 2 working days before the meeting. Written submissions should be no longer than 1 A4 sheet.

5. Chair's Update (Pages 17 - 46)

Cllr Hanna will provide a verbal update on relevant issues since the last meeting.

There are THREE documents attached this item:

A HOSC report containing recommendations from the Committee on the South Central Ambulance Service's CQC Improvement Journey, which was discussed during the 08 February 2024 HOSC meeting.

A HOSC report containing recommendations from the Committee on the John Radcliffe Hospital's CQC Improvement Journey, which was discussed during the 08 February 2024 HOSC meeting.

A HOSC report containing recommendations from the Committee on the Director of Public Health Annual Report.

The Committee is recommended to **NOTE** the Chair's update having raised any relevant questions.

One matter that has arisen since the previous meeting involves the need for the Committee to agree a future arrangement for ongoing Scrutiny of the NHS's Oxford City Community Health Hubs Project. It is **RECOMMENDED** that the Committee **DELEGATES** to the Chair and Health Scrutiny Officer to establish a small HOSC Working Group to engage in detailed and ongoing scrutiny of this project.

6. GP Provision in Oxfordshire (Pages 47 - 56)

Julie Dandridge (BOB ICB Lead for Primary Care across Oxfordshire) has been invited to present a report on GP provision in Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

7. Dentistry Provision in Oxfordshire (Pages 57 - 74)

Hugh O'Keefe (BOB ICB Senior Programme Manager – Pharmacy, Optometry and Dental Services) has been invited to present a report on Dentistry Provision in Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

8. Healthwatch Oxfordshire Update Report (Pages 75 - 88)

Veronica Barry, Executive Director of Healthwatch Oxfordshire will present the Healthwatch update report. The Committee is invited to consider the report and **NOTE** it having raised any questions arising from the contents.

PLEASE NOTE: There are TWO documents attached to this item:

1. The main Healthwatch Oxfordshire Update Report.

2. An additional summary report on a mystery shopping exercise on NHS Dentistry.

9. Oxford University Hospitals NHSFT People Plan (Pages 89 - 132)

Terry Roberts (Chief People Officer, Oxford University Hospitals NHSFT) has been invited to present a report on the Oxford University Hospital's NHSFT People's Plan.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

PLEASE NOTE: There are THREE documents attached to this item:

1. The main report submitted for this item providing an update on Oxford University Hospital's People Plan.

2. The Oxford University Hospital People's Plan Document.

3. A summary of the Engagements undertaken by Oxford University Hospitals as part of developing the People Plan.

10. Responses to HOSC Recommendations (Pages 133 - 142)

The Committee has received Responses as well as Acceptances for the recommendations made as part of the item on the Oxfordshire Place-Based Partnership, which was held during the 23 November 2023 HOSC meeting.

The Committee has also received an additional progress update response to the recommendations made as part of the Oxfordshire Healthy Weight item, which was held during the 23 September 2023 HOSC meeting.

The Committee is recommended to **NOTE** the response and update.

11. Forward Work Programme (Pages 143 - 146)

To **AGREE** the Committee's proposed work programme for the upcoming meetings throughout the remainder of the 2023/24 civic year and beyond, having raised any questions

12. Actions and Recommendations Tracker (Pages 147 - 170)

The Committee is recommended to **NOTE** the progress made against agreed actions and recommendations having raised any questions.

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.

Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests

Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:

Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 8 February 2024 commencing at 10.00 am and finishing at 4.00 pm

Present:

Voting Members:	Councillor Jane Hanna OBE – in the Chair
	District Councillor Elizabeth Poskitt (Deputy Chair) Councillor Jenny Hannaby Councillor Nick Leverton Councillor Mark Lygo Councillor Michael O'Connor District Councillor Paul Barrow City Councillor Sandy Douglas District Councillor Katharine Keats-Rohan Councillor Roz Smith
Co-opted Members:	Barbara Shaw
Other Members in Attendance:	
By Invitation:	Dan Leveson (Place Director, BOB HOSC) Daryl Lutchmaya (Chief Governance Officer, SCAS) Kirsten Willis- Drewett (Assistant Director of Operations, SCAS) Dai Tamplin (Senior Transformation Programme Manager, SCAS) John Dunn (Head of Risk and Security, SCAS) Eileen Walsh (Chief Assurance Officer, Oxford University Hospitals NHS Foundation Trust) Andrew Grant (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust) Lisa Glynn (Director of Clinical Services, Oxford University Hospitals NHS Foundation Trust) Veronica Barry (Executive Director of Healthwatch Oxfordshire)
Officers:	Ansaf Azhar (Director of Public Health, OCC) Dr Rosie Rowe (Head of Healthy Place Shaping, OCC) Dr Louisa Chenciner (Public Health Registrar and Academic Clinical Fellow, OCC)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting [, together with a schedule of addenda tabled at the meeting/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and

schedule/additional documents] are attached to the signed Minutes.

11/24 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies had been received from Freddie Van Mierlo, Nigel Champken-Woods, and Lesley Mclean.

12/24 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Cllr Sandy Douglas declared that he had an honorary contract with Oxford University Hospitals NHS Foundation Trust.

13/24 MINUTES
(Agenda No. 3)

The minutes of the committee's meeting on 16 January 2024 were assessed for their accuracy.

The Committee **AGREED** the minutes as an accurate record of proceedings, subject to a minor amendment to the spelling of Cllr Haywood's name.

14/24 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

No requests to speak had been received.

15/24 CHAIR'S UPDATE
(Agenda No. 5)

The Committee Chair outlined the following points to update the Committee on developments since the previous meeting:

1. The Committee had been strongly interested in developments around access to GP services, particularly in the Didcot area. The Committee had asked for urgent priority for GP provision to be enhanced in this area, and was pleased to hear of the promised GP newbuild at the Great Western Site. Didcot had a 30 percent population growth trend, and it was therefore critical that residents had access to General Practice.

2. The BOB Joint Health Overview Scrutiny Committee had met on 24 January, during which three items were discussed including the BOB ICB's Primary Care Strategy and the Digital and Data Strategy.

3. The Chair and the Health Scrutiny officer had attended a BOB HOSC Working Group meeting on 17 January to collate and submit written feedback to BOB ICB on its Digital and Data Strategy.

4. A report (containing recommendations from HOSC) had been submitted to the NHS regarding the future of Wantage Community Hospital. This could be found in the agenda papers. This report was also published in Oxford Health NHS Foundation Trust's board papers and was discussed at the Oxford Health NHS Foundation Trust board meeting on 31 January.

5. The Chair, Health Scrutiny Officer, Barbara Shaw, Elizabeth Poskitt, and Katharine Keats-Rohan, had attended a HOSC site visit on 30 January to the Warneford Hospital as part of the scrutiny of the Warneford hospital redevelopment project and the bids for government funding for this.

6. A report (containing recommendations from HOSC) had been submitted to the BOB ICB Director of Place in relation to the Place-Based Partnership. This could also be found in the agenda papers.

The Committee **NOTED** the Chair's Update.

16/24 SOUTH CENTRAL AMBULANCE SERVICE CQC IMPROVEMENT JOURNEY UPDATE

(Agenda No. 6)

Daryl Lutchmaya (Chief Governance Officer, SCAS); Kirsten Willis- Drewett (Assistant Director of Operations, SCAS); Dai Tamplin (Senior Transformation Programme Manager, SCAS); and John Dunn (Head of Risk and Security, SCAS) were invited to present a report providing an update on the South Central Ambulance Service's Care Quality Commission improvement journey.

The South Central Ambulance Service (SCAS) Chief Governance Officer informed the Committee that the Trust had an ambition to be an outstanding team, and to deliver good outcomes through innovation and partnership. The SCAS mission was that 'the right care is delivered as best as it can'. In order to achieve these ambitions, the Trust had 4 key values which are to be:

- Caring.
- Innovative.
- Professional.
- A teamworking organisation.

The Chief Governance Officer highlighted that in order to achieve the results that the Trust was striving toward, it had formulated six strategic objectives:

- High quality care and patient experience.
- Partnership and stakeholder engagement.
- Sustainability.
- People and Organisation.
- Technology Transformation.

- Being well-led.

The Committee were informed that SCAS had received some assistance from the NHS National Improvement Team, who had put together an improvement plan for SCAS to work to.

The Assistant Director for Operations explained that SCAS was in a challenging position in relation to the increase in volume of workload coming through, particularly category 1 and category 2 calls (immediately life-threatening calls). The service had to declare a critical incident on the 23 January, which occurred due to the sudden increase in category 1 and 2 calls. Over the course of two or three days, these had constituted 72 percent of calls; which was an incredibly high number. Such high levels of category 1 and 2 calls would have a knock-on effect on the system, particularly the acute Trusts, as most of those patients who were calling in would require hospital admission. This also had knock-on effects in creating ambulance service handover delays.

The Committee were informed that there was good work within the system to try to keep patients away from Emergency Departments. There had been an increase, on average, in 8 patients a day who were able to be referred into other areas or departments. SCAS were grateful for the good partnership working that existed within the Oxfordshire system.

The Committee enquired as to whether there was any progress in improving structures of governance within SCAS. The Chief Governance Officer outlined that the recent CQC inspection and report rightly highlighted that there were a number of issues that were not operating appropriately. Whilst trying to address the issues of the improvement programme, a governance team was being established. The service also received support from the governance institute, which had helped the service with its risk management solutions.

The Committee also queried whether there were independent members on the SCAS governance board. It was explained to the Committee that initially, the board was comprised of executive as well as non-executive directors, which felt top heavy. The service sought to make the improvement programme a ‘business as usual’ practice, which meant that the improvement programme board was led by the chief executive. There was representation from a national improvement director, who provided direct challenge to the chief executive. There was also membership from Hampshire and Isle of Wight Integrated Care Board (ICB).

The Committee enquired as to whether SCAS would look to other authorities or areas for the purposes of identifying and learning best practice. The Chief Governance Officer outlined that having previously worked in a number of public Trusts, he had brought insights of good practice alongside him when he initiated his role at SCAS. There was also regular communication with other ambulance services nationwide, where comparisons as well as identifications of best practice were made in that context. The Trust’s terms of reference were also being reviewed.

The Committee queried as to how well resourced the internal audit function of the Trust was, and how this had fit in the broader context of the structures of governance

in general. It was responded that the Trust had experienced some delays in completing internal audit functions. The Trust had a risk insurance compliance group, which oversaw audit functions and brought executive directors into direct contact with internal auditors, where the auditors could speak directly to directors.

In response to a query regarding patient experience and how this was imputed into the Trust's ways of working, it was explained that patient experience did not actually formulate one of the Trust's improvement workstreams, but was swept up under the patient safety workstream. A system director was leading on this, and the Trust was implementing a number of new measures to ensure that the patient voice was heard all the way up to the executive level. There was a patient panel, and various members were recruited to this. There was also work within the Trust's communications department to ensure that there was effective communication regarding an honest picture of the services and the experience of patients from the ground upwards. An observation from the CQC found that less positive stories regarding patient experiences had not been heard at the executive level; the Trust was actively seeking to address this.

The Committee emphasised that one concern identified by the CQC was that the service did not consistently control infection risk very well. The Committee enquired as to the measures the Trust were taking to address this, and how confident SCAS was that equipment, vehicles and premises were kept clean and that there was consistent monitoring of this throughout the service. It was responded that the Trust were actively monitoring infection risk and control, which was also a crucial element of the CQC improvement journey. The Trust's IPC service was working closely with operational colleagues to minimise risks of infection and to ensure cleanliness. A company named Churchill had been contracted to provide a rolling rota of cleaning on the Trust's vehicles; including deep cleans. The Assistant Director of Operations confirmed that every frontline vehicle was required to be cleaned once every 24 hours as part of a standard clean and restock service. Additionally, vehicles received a deep clean every 6 weeks. There had also been an observed process of handwashing for frontline staff, and staff were being trained and educated in cleanliness and infection control.

The Committee referred to the importance of risk assessments, and queried how extensive and sophisticated the Trust's risk assessments were, as well as the level of frequency with which such assessments were undertaken. It was responded that the Trust carried out task based assessments in operations. The risk assessments had to legally identify all foreseeable hazards for patients. Therefore, some of the risk assessments could be relatively extensive in their nature and scope. In terms of how risk assessments were reviewed, it would be ideal to have annual reviews with some of the task-based risk assessments, although the Trust had not managed to undertake such a review in over two years. In terms of the display screen equipment work station assessments, these had to be - and had been - undertaken annually.

The Committee referred to page 142 of the report, which highlighted that the Information Technology supporting SCAS's operational function (including safeguarding) remained a significant concern, challenge and reputational risk. The Committee Chair therefore enquired as to what the enablers and barriers were in relation to resolving this area of risk. It was responded that one of the significant

challenges with safeguarding referrals was that there were server facilities on the premises that handled such data transmission. This had begun to fail, and in November 2023 the Trust had transitioned to a cloud-based server, which was designed to resolve many of the outages and delays to referrals experienced previously. However, since early December 2023, the Trust then suffered a number of outages not with the server, but with the actual transmission process. The Trust currently utilised a mailbox system, and had undertaken due diligence. The Committee were informed that the Trust had been actively exploring ways to improve the process around the above. There was a risk of patient harm if safeguarding referrals were delayed, but that significant enhancements in the safeguarding service had been made. The safeguarding service was operating smoothly and efficiently, and monitored the occurrence of outages to minimize harm to patients. All delayed referrals also received risk assessments. The Committee queried as to whether patients and their families who were affected by such IT challenges were clearly communicated with, and the Trust responded that any affected patients were clearly communicated with.

The Committee queried how effectively staff were being provided with training to equip them with the basic skills of how to deal with patients who may be mentally ill. All frontline clinicians were trained to support people experiencing a mental health crisis. Call handlers also had the ability to pass calls onto clinical staff within the control room. It was emphasised that the service would always act with immediacy in circumstances where it dealt deal with mentally ill patients. From a force negotiation perspective, the service would also engage and liaise with the Police force.

The Committee highlighted that the CQC inspection outcome outlined that some people were not given the necessary pain-relieving medicines. It was queried as to whether staff had been sufficiently trained in this regard, particularly given the importance of ambulance staff being able to provide pain-relieving medications promptly and appropriately. It was responded that paramedics were trained in what is known as a step-wide approach in the management of pain, and that the Service was ensuring that paramedics would be adequately trained in pain management and in the administering of pain relieving medications.

The Committee referred to how the report outlined the Trust's commitments to staff wellbeing, and enquired as to whether the Trust had sufficient resources to maintain or potentially enhance the support provided to staff. It was outlined to the Committee that there was a comprehensive support package for staff, and that there was a fully-staffed health and wellbeing team that supported staff; including staff who required additional interventions such as Occupational Health. Trauma risk management was also prevalently utilised to support staff members who may have had to deal with traumatic incidents. The Committee were also informed that the Trust had good access to psychological medicines, and that there was an unfortunately high uptake of these amongst some of the Trust's staff.

The Committee enquired as to how the Trust was performing in the realm of staff recruitment and retention. It was responded that the Trust was widening its recruitment drive in order to attract and recruit staff from oversees. There were a cohort of SCAS personnel who would be travelling to Australia in March to help facilitate further recruitment of staff from Australia and New Zealand. It was explained

to the Committee that in Australia in particular, there was a shortage of employment opportunities for ambulance service staff, and that SCAS were utilising this as an opportunity to enhance recruitment from that region.

The Committee **AGREED** to finalise a list of recommendations offline subsequent to the meeting, and to then issue these recommendations to SCAS.

17/24 JOHN RADCLIFFE HOSPITAL CQC IMPROVEMENT JOURNEY UPDATE
(Agenda No. 7)

Eileen Walsh (Chief Assurance Officer, Oxford University Hospitals NHS Foundation Trust); Andrew Grant (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust); and Lisa Glynn (Director of Clinical Services, Oxford University Hospitals NHS Foundation Trust) had been invited to present a report with an update on the John Radcliffe Hospital CQC Improvement Journey.

The Chief Assurance Officer informed the Committee that the report provided an insight into how the organisation addressed the specific areas of improvements listed in the CQC report and placed them in the context of the wider strategic and operational developments that had been made.

The Committee enquired as to the level of staff and patient involvement in the development of the Trust strategy. The Chief Medical Officer informed the Committee that the strategy was developed with extensive staff and patient engagement. Staff engagement continued beyond the point of publication and adoption of the strategy in the form of regular staff listening events that included members of the leadership team, and were an opportunity to hear staff concerns.

Patient engagement had contributed to service development work in the form of patient partners and experts by experience, and individual work streams had involved patient recommendations where possible.

The Chief Assurance Officer added that the patient's voice was kept at the heart of the strategy, and that Listening Events were held involving patients and stakeholders that had influenced the development of the strategy, as co-creation was the key platform for developing future strategies.

The Chair queried what opportunities there were for the strategic ambition of the Trust to integrate with the wider prevention agenda. The Director of Clinical Services explained that one of the Trust's key priorities was the part that key acute providers could play in prevention. The Trust was heavily involved with early detection of cancer through the Targeted Lung Health Check Programme, that would be initiating in April 2024. The Trust worked closely with the community and partners in relation to Wantage Community hospital, and were looking to expand additional services that would meet the needs of local populations and support the demand seen in local hospitals for acute services. In order to address the demand on urgent care services, the Trust had been involved with the Integrated Neighbourhood Teams as well as the Primary Care Strategy. The Trust had also been looking at admission and attendance avoidance, and the development of same day emergency care services.

The BOB ICB Place Director for Oxfordshire explained that the Trust was trying to strike a balance between treatment and prevention. Oxford University Hospitals NHS Foundation Trust (OUH) was involved in many prevention projects, such as co-location of maternity services within 'Flos in the Park', the Early Lives Project, and the Hospital at Home service to support acutely sick people at home. The BOB ICB Place Director emphasised that the greatest long-term impact on prevention was to focus on children and young people, and the Community Paediatrics service was fundamental to this.

The Chief Medical Officer also highlighted the Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) service for palliative care at home, and that the service had made a fundamental difference to the patients it had served.

The Committee queried whether resources would be increased for the Hospital at Home Service to ensure coverage in rural areas, and whether RIPEL would include Primary Care Networks (PCNs). The Director of Clinical Services informed the Committee that OUH were looking at what services were having the most effect to reduce attendance to acute hospitals, including the Hospital at Home service, which was a key programme to manage demand and to support patients to be at home. RIPEL was a service that the Trust was committed to and wanted to evolve further and would build into PCNs and integrated neighbourhood teams. The challenge would lie in the reorganisation of resources and the allocation of funding, and the Trust was assessing this for next year to determine how resources could be used to the best effect.

The Committee enquired about how technology was being used to improve patient safety. The Chief Medical Officer informed the Committee that a lot had happened in the last five years to develop the Trust digitally. The Trust invested in the electronic incident reporting service Ulysses that provided a digital architecture for a greatly strengthened patient safety response framework. Electronic patient records provided electronic observations so that teams could view vital signs on patients remotely. Another important change was the introduction of daily Patient Safety Response meetings where senior leaders from across the organisation reviewed every incident from the last 24 hours with moderate harm or above, which allowed close oversight of patient safety in the organisation, and ensured the Trust was responsive to incidents and had the right learning response. The new national framework for responses (PSIRF) focused on changing the culture from one of blame to one of learning and improvement, and offered a range of different incident learning responses such as After-Action Review, Multi-Disciplinary Team Learning Reponses and Patient Safety Incident Responses (PSIIs).The framework introduced thematic responses, so that when incidents occurred, they fed into the broader longer term improvement plan rather than being taken independently. The work was supported by patient safety partners, service users who were part of the safety response framework and contributed to reviews of cases, and some committees that oversee these workstreams. Alongside this, there had been significant safety retraining for all staff, from basic training for all staff to more detailed levels for patient safety experts.

The Committee enquired as to who monitored the databases created by the collection of data. The Chief Medical Officer explained that there was a Governance

team that overlooked the databases and provided monthly reports with breakdowns of all incidents by harm level and type of incident. For example, there had been an increase in incidents of violence and aggression against staff over the last year that had been tracked, and which the Trust had provided staff support for. The database allowed the Trust to track specific incidents such as hospital-acquired pressure ulcers and this had been the focus of integrated quality improvement work, the result of which there had been a third reduction in these incidents. The data was important in helping the Trust to understand what the incident risk profile was, and to target learning and improvement responses accordingly.

The Committee queried whether the Trust had programmes for staff wellbeing, such as self-harm diversions built into search engines. The Chief Medical Officer informed the Committee that there were numerous internal and external supports for staff clearly signposted on their intranet, and a staff support service had been created, although he was not aware of wellbeing programmes built into the Trust's search engines. The Chief Assurance Officer added that there was an employee assistance programme available 24/7 to provide counselling to staff for both personal and professional issues.

The Chair queried whether significant learning was communicated to patients and families affected, and whether they were involved in the learning journey. The Chief Medical Officer informed the Committee that communication with families was essential and would always occur after these incidents under the Trust's duty of candour. Patients were always invited to share their questions after serious incidents, and outcome reports were shared with them. The Trust had sought to triangulate the learning from complaints, so if a complaint had been received it would be examined to see whether an incident needed to be created to learn from it, and a weekly meeting aimed to derive learning from this.

The Chief Assurance Officer highlighted that the Trust board and non-executive members took a strong interest in patient safety, and the Chief Executive implemented a direct feedback mechanism with clinical teams who were involved with serious incidents to present their reflections to the executive team. Several key committees had been introduced; including the Risk Committee to discuss proactive risks and thematic risks; the Productivity Committee to focus how to progress performance in the organisation; and the Delivery Committee to ensure large programmes of work had been implemented. The Trust had ensured that patients had been involved in the aftermath of incidents, and had been provided with both clear explanations to understand what went wrong as well as a swift apology when the Trust was at fault.

The Committee queried how the values of kindness and caring were taught in the organisation and how this was evaluated. The Chief Medical Officer responded that the organisation prioritised kindness, and kindness interaction training was provided to all senior leaders. The success of this was measured by examining metrics produced from staff surveys and by looking at sickness and turnover rates.

The Committee asked if data could be provided to show how improvements had been made. The Chief Assurance Officer informed the Committee that the Trust could provide metrics that demonstrated the improvement trajectory over the last few years.

This data could be supplemented by staff and patient surveys that provided anecdotal and human experiences. The Chief Medical Officer added that the board adopted a nationally recommended approach of presenting data, using Statistical Process Control (SPC) charts that helped focused discussions and identified improvement areas.

The Committee enquired as to how strong the internal audit function was and how the sharing of patient stories was imbedded in the organisation. The Chief Medical Officer explained that not all incidents generated patient stories that go to the board, but the patient experience team supported stories that generated different learning to help the board gain insight into the range of issues faced by the organisation.

The Chief Assurance Officer added that although patient stories were not heard at every committee, stories were sometimes made into videos that could be shown before conferences. The Trust had a very strong internal audit function that developed a comprehensive audit plan every year, which was formed with cooperation from all the executive directors and the areas of examination were stress-tested. The audit committee, chaired by non-executives, received this plan, and examined it with auditors to determine key risk and concerns.

The Committee **AGREED** to submit further questions to OUH around the specific service areas of gynaecology, Surgery, Maternity, and urgent & emergency care, and to request written responses to these questions subsequent to the meeting.

The Committee **AGREED** to issue the following recommendations to OUH:

1. For the Trust to continue to take improved measures to improve patient safety at the John Radcliffe. It is recommended that staff are sufficiently supported and trained in being able to maximise patient safety.

2. For ongoing stakeholder engagement and coproduction to be at the heart of the John Radcliffe Hospital's efforts to address the concerns identified by the CQC, and for there to be clear transparency around this, with further evidence of this to be provided.

3. For clear transparency around the Trust's efforts to address the CQCs concerns around the John Radcliffe. It is recommended that there are clear indicators that could help determine how improvements in the John Radcliffe are being driven overall as well as in the specific service areas of Gynaecology, Maternity, Surgery, and Urgent & Emergency Care.

4. For sufficient resources to be secured for the purposes of delivering and potentially expanding the Hospital at Home Service.

5. For a site visit to be orchestrated for the purposes of providing the Committee with insights into the measures taken by the Trust to improve patient safety at the John Radcliffe.

18/24 HEALTHWATCH OXFORDSHIRE UPDATE REPORT
(Agenda No. 8)

The Executive Director of Healthwatch Oxfordshire explained to the Committee that Healthwatch had received feedback from patients at the John Radcliffe Hospital through online feedback reviews from October to December 2023. The online reviews provided an average of 4 stars (Good) for services at the John Radcliffe

The Executive Director also informed the Committee that between October and December 2022, Healthwatch England undertook national research to understand the extent to which mental health support had improved during and subsequent to pregnancy, and to explore whether new mental health checks were taking place at postnatal consultations. Healthwatch England had provided Healthwatch Oxfordshire with the anonymous responses of the 45 women from Oxfordshire who participated in the survey so we could analyse these responses separately. The Committee were informed that this information could be found in the report submitted by Healthwatch Oxfordshire for this item.

It was explained to the Committee that Healthwatch Oxfordshire had published reports on Community Research in Oxfordshire. These were a series of in-depth reports on both community members, system and organisational views on community research. What Healthwatch Oxfordshire heard was directly relevant to all organisations which worked with communities throughout the county, with insights as to how to meaningfully engage, listen and learn and to support development and design of services.

The Committee thanked Healthwatch Oxfordshire for their work and **NOTED** the report.

19/24 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT
(Agenda No. 9)

Ansaf Azhar (Director of Public Health); Dr Rosie Rowe (Head of Healthy Place Shaping); and Dr Louisa Chenciner (Public Health Registrar and Academic Clinical Fellow) were invited to present the Director of Public Health's (DPH) Annual Report.

The Committee Chair outlined that the Committee would return to this item again in the near future for the purposes of scrutinising the full DPH annual report subsequent to its publication.

It was explained to the Committee that this particular DPH annual report and its focus on climate action and health did not emerge from a vacuum, and that in late 2023, over 120 countries backed the COP28 climate and health declaration. Additionally, the United Kingdom's (UK) Health Security Agency published reports in 2023 which outlined some of the health effects of climate change on the UK. The Committee were also informed that major journals such as the Lancet and the British Medical Journal had also highlighted the impacts of the climate crisis on health.

The DPH annual report emphasised that health was the untold story of the climate emergency, but that this was surprising given the immediate and positive health benefits for individuals, families and communities which could be delivered through climate action. Climate action could be a means for achieving better health for all people and for all ages.

It was highlighted to the Committee that the DPH report explained the reasoning behind the focus on climate change and health; and that an elemental approach was adopted which included five domains including temperature, air, water, food, and nature. Local evidence and data would be drawn on to outline what the impact was in Oxfordshire in all the aforementioned areas.

Steps were already being taken as part of climate action which could produce health benefits for Oxfordshire's residents. These related to the following:

1. Creating energy efficient homes and buildings.
2. Sustainable travel and clean air.
3. Green Health and Social Care.
4. Healthy and sustainable diets.
5. Accessible green and blue spaces and nature.

The Committee were also informed that the DPH Annual Report included a set of recommended actions that revolved around two key areas including:

Actions that the Oxfordshire System could embark on including: working together for cleaner indoor and outdoor air; improving access for all residents to safe and inclusive green and blue spaces; adapting and upgrading buildings, estates and facilities; working with suppliers and the supply chain to reduce carbon emissions; support the establishment of an Oxfordshire Climate Mitigation and Adaptation Healthcare Network; build and continuously bolster community resilience.

A call to actions around national policy and funding including: reducing air pollution by investing in low-carbon and climate-resilient infrastructure; creating good, secure employment and reduce inequalities; improving resident's health and wellbeing by upgrading peoples' homes, healthcare facilities and schools; and boosting our physical and mental health by making it easy for people to walk and cycle.

The Committee enquired as to whether the DPH report would be explicit around the balance between any national directives around climate action and health on the one hand, and local concerns, nuances, or sensitivities on the other. The Director of Public Health responded that broadly speaking, the work around climate action and health was something that had to be undertaken locally within, as well as with the support of the community. It was imperative to understand what the specific benefits and needs of the local population of Oxfordshire were when embarking on climate action. The overall reframing of health was ultimately of significant benefit to the local community in Oxfordshire. This approach was not stemming from a purely climate angle, but was one that emanated from a local health and wellbeing perspective also.

It was also explained to the Committee that there was also work around anchor institutions, where all system leaders were being brought together. Within this

context, an outcomes framework around climate action and health would also be developed.

In response to a query from the Committee around the level of stakeholder engagement taking place around climate action and health, it was confirmed that there was stakeholder collaboration with healthcare partners as well as with District Councils in order to gain their input and views. There was also input from the City and District Councils into the development of the report as well as its recommendations.

The Committee enquired as to what the end-product would be of the DPH report as well as its overall direction of travel around climate action and health. The Director of Public Health responded that the overarching message within this report was one that would be conveyed not only at the local level, but that it would also be adopted as a national lobbying effort to encourage further conversations and actions around climate and health. It was reiterated to the Committee that there was a strong commitment to close the gap between the two conventionally separate topics of climate on the one hand, and health on the other. The rationale of this report was to merge these two considerations into a more holistic understanding and approach toward climate and health in a manner that recognised the interconnections between the two areas.

The Committee enquired as to whether there was any work with schools to help educate and raise awareness amongst children at an early age around the importance of climate action and health. It was confirmed that there was an outreach officer who would work with schools around climate action. However, there was no explicit work with schools that involved raising awareness of the interconnectivities between climate action and health. The purpose of this year's DPH report again was to therefore to raise awareness of this disconnect.

The Committee queried as to whether the pressures in the NHS were having an impact on the wider system and the objectives and measures being taken by the Council's Public Health team. The BOB ICB Place Director responded that each NHS organisation exercised transparency over their net zero plans, which could be found on each Trust's website. It was also explained to the Committee that the Director of Place had worked closely with the Director of Public Health to focus on reducing health inequalities countywide.

The Committee enquired as to what was new about the message in the DPH report on climate action and health, and how such commitments and recommendations outlined therein would differ from some of the work that was already being undertaken by the Oxfordshire system. It was responded that the County and District Councils as well as the NHS had already been making existing efforts and arrangements in an attempt to reach climate action targets. However, what the DPH report emphasised was the need for further integration of these efforts to accelerate the reaching of climate action targets but to also improve how the system understands the impact of climate on health. The Council's Public Health Team were also having conversations with Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust around encouraging active forms of travel for NHS staff.

The Committee **AGREED** to issue the following recommendations to the Director of Public Health:

1. For the fully published DPH Annual report to come to a future HOSC meeting, with a view to further scrutinise the report and the deliverability of the commitments around climate action and health.

2. For the full DPH report to incorporate a section with insights into Population Health, and to include an update on progress on recommendations from the previous DPH Annual report.

3. For there to be clear and thorough engagement and coproduction with key stakeholders around the commitments to climate action and health after the publication of the report. It is recommended that the local contexts and sensitivities are taken into account, with a view to balance these with national directives around climate action and health.

4. For there to be clear transparency and indications as to the barriers and enablers surrounding commitments to climate action and health. It is recommended that sufficient avenues of funding and resources are secured for the purposes of delivering these ambitions, and for collaboration with key system partners for the purposes of this.

5. For there to be clarity around any governance structures or processes around climate action and health. It is recommended that there is transparency around any key leads responsible for relevant policy areas around climate and health to understand individual/organisational commitments, as well as to understand any associated regulatory or legislative barriers to these commitments.

6. To ensure that clear processes are in place for monitoring and evaluating the measures taken as part of climate action, with specific attention to the implications that such measures may have on residents' health and wellbeing.

7. To raise educational awareness and understanding of the importance of climate action and its implications on health.

8. For next year's DPH Annual report to be brought as a full draft to the Committee's spring meeting, with a view to scrutinise the draft and provide feedback in a public meeting ahead of its official publication.

20/24 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 10)

The Chair outlined that the Committee had received Acceptances and Responses to its recommendations on the following two items:

1. Children's Emotional Wellbeing and Mental Health Strategy.
2. CAMHS Services.

It was explained to the Committee that one particular recommendation that was issued to CAMHS around training had been rejected. The reason behind the rejection was outlined in the response form which was within the agenda papers.

The Committee **NOTED** the responses.

21/24 FORWARD WORK PROGRAMME
(Agenda No. 11)

The Committee **AGREED** the forward work plan.

22/24 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 12)

The Committee **NOTED** the progress made against agreed actions and recommendations.

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Date of signing .....

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OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

South Central Ambulance CQC Improvement Journey Update.

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 08 February 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the South Central Ambulance Service's (SCAS) Care Quality Commission (CQC) improvement journey.

2. The Committee felt it crucial to receive an update on progress made by the Trust in addressing the concerns highlighted by the CQC in its most recent inspection of the Service. Having held an item on this over a year ago, the Committee sought now to assess the degree to which the measures taken by the Trust had been proving effective.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of Ambulance services as well as the initiatives taken by NHS Trusts to address concerns raised by CQC inspections. When commissioning this report on the SCAS CQC improvement journey update, some of the insights that the Committee sought to receive were as follows:

   - The degree to which there have been any changes in the governance-related structure and activities of the Service.

   - To share written details and feedback received by SCAS from the December 2022 assurance visit by colleagues from the NHS Integrated Care Boards covering the area. This would have been approximately 6 months subsequent to the CQC inspection and may provide a useful indication on any potential improvements made by the Service subsequent to the CQC inspection earlier that year.

   - Details of any measures embarked on by the Trust to improve staff recruitment and retention.

   - Details of any support that staff are receiving for their wellbeing, particularly in light of some of the pressures that ambulance staff in particular may face.

   - Whether Health and Safety at work requirements were being met.

- The extent to which staffing and resources are able to meet the demand experienced by the service.

- The degree to which there is a stronger understanding of the Mental Capacity Act (2005) by staff.

- The extent to which there is close attention to infection prevention and control measures.

- Whether there are formal appraisals and whether all staff are now completing mandatory training.

- Whether the Trust is making improvements in reducing delays in reaching people who request emergency assistance.

SUMMARY

4. The Committee would like to express thanks to Daryl Lutchmaya (Chief Governance Officer, SCAS); Kirsten Willis- Drewett (Assistant Director of Operations, SCAS); Dai Tamplin (Senior Transformation Programme Manager, SCAS); and John Dunn (Head of Risk and Security, SCAS) for submitting a report and for attending the meeting to answer questions from the Committee. The Committee would also like to express thanks to Daniel Leveson (BOB ICB Place Director, Oxfordshire) for also attending this meeting item on 08 February and for contributing to the discussion.

5. The South Central Ambulance Service (SCAS) Chief Governance Officer informed the Committee that the Trust had an ambition to be an outstanding team, and to deliver good outcomes through innovation and partnership. The SCAS mission was that 'the right care is delivered as best as it can'. In order to achieve these ambitions, the Trust had 4 key values which are to be:

    - Caring.
    - Innovative.
    - Professional.
    - A teamworking organisation.

6. The Chief Governance Officer highlighted that in order to achieve the results that the Trust was striving toward, it had formulated six strategic objectives:

    - High quality care and patient experience.
    - Partnership and stakeholder engagement.
    - Sustainability.
    - People and Organisation.
    - Technology Transformation.
    - Being well-led.

7. The Committee were informed that SCAS had received some assistance from the NHS National Improvement Team, who had put together an improvement plan for SCAS to work to.

8. The Assistant Director for Operations explained that SCAS was in a challenging position in relation to the increase in volume of workload coming through, particularly category 1 and category 2 calls (immediately life-threatening calls). The service had to declare a critical incident on the 23 January, which occurred due to the sudden increase in category 1 and 2 calls. Over the course of two or three days, these had constituted 72 percent of calls; which was an incredibly high number. Such high levels of category 1 and 2 calls would have a knock-on effect on the system, particularly the acute Trusts, as most of those patients who were calling in would require hospital admission. This also had knock-on effects in creating ambulance service handover delays.

9. The Committee were informed that there was good work within the system to try to keep patients away from Emergency Departments. There had been an increase, on average, in 8 patients a day who were able to be referred into other areas or departments. SCAS were grateful for the good partnership working that existed within the Oxfordshire system.

10. The Committee enquired as to whether there was any progress in improving structures of governance within SCAS. The Chief Governance Officer outlined that the recent CQC inspection and report rightly highlighted that there were a number of issues that were not operating appropriately. Whilst trying to address the issues of the improvement programme, a governance team was being established. The service also received support from the governance institute, which had helped the service with its risk management solutions.

11. The Committee also queried whether there were independent members on the SCAS governance board. It was explained to the Committee that initially, the board was comprised of executive as well as non-executive directors, which felt top heavy. The service sought to make the improvement programme a 'business as usual' practice, which meant that the improvement programme board was led by the chief executive. There was representation from a national improvement director, who provided direct challenge to the chief executive. There was also membership from Hampshire and Isle of Wight Integrated Care Board (ICB).

12. The Committee enquired as to whether SCAS would look to other authorities or areas for the purposes of identifying and learning best practice. The Chief Governance Officer outlined that having previously worked in a number of public Trusts, he had brought insights of good practice alongside him when he initiated his role at SCAS. There was also regular communication with other ambulance services nationwide, where comparisons as well as identifications of best practice were made in that context. The Trust's terms of reference were also being reviewed.

13. The Committee queried as to how well resourced the internal audit function of the Trust was, and how this had fit in the broader context of the structures of

governance in general. It was responded that the Trust had experienced some delays in completing internal audit functions. The Trust had a risk insurance compliance group, which oversaw audit functions and brought executive directors into direct contact with internal auditors, where the auditors could speak directly to directors.

14. In response to a query regarding patient experience and how this was imputed into the Trust's ways of working, it was explained that patient experience did not actually formulate one of the Trust's improvement workstreams, but was swept up under the patient safety workstream. A system director was leading on this, and the Trust was implementing a number of new measures to ensure that the patient voice was heard all the way up to the executive level. There was a patient panel, and various members were recruited to this. There was also work within the Trust's communications department to ensure that there was effective communication regarding an honest picture of the services and the experience of patients from the ground upwards. An observation from the CQC found that less positive stories regarding patient experiences had not been heard at the executive level; the Trust was actively seeking to address this.

15. The Committee emphasised that one concern identified by the CQC was that the service did not consistently control infection risk very well. The Committee enquired as to the measures the Trust were taking to address this, and how confident SCAS was that equipment, vehicles and premises were kept clean and that there was consistent monitoring of this throughout the service. It was responded that the Trust were actively monitoring infection risk and control, which was also a crucial element of the CQC improvement journey. The Trust's IPC service was working closely with operational colleagues to minimise risks of infection and to ensure cleanliness. A company named Churchill had been contracted to provide a rolling rota of cleaning on the Trust's vehicles; including deep cleans. The Assistant Director of Operations confirmed that every frontline vehicle was required to be cleaned once every 24 hours as part of a standard clean and restock service. Additionally, vehicles received a deep clean every 6 weeks. There had also been an observed process of handwashing for frontline staff, and staff were being trained and educated in cleanliness and infection control.

16. The Committee referred to the importance of risk assessments, and queried how extensive and sophisticated the Trust's risk assessments were, as well as the level of frequency with which such assessments were undertaken. It was responded that the Trust carried out task based assessments in operations. The risk assessments had to legally identify all foreseeable hazards for patients. Therefore, some of the risk assessments could be relatively extensive in their nature and scope. In terms of how risk assessments were reviewed, it would be ideal to have annual reviews with some of the task-based risk assessments, although the Trust had not managed to undertake such a review in over two years. In terms of the display screen equipment work station assessments, these had to be - and had been - undertaken annually.

17. The Committee referred to page 142 of the report, which highlighted that the Information Technology supporting SCAS's operational function (including

safeguarding) remained a significant concern, challenge and reputational risk. The Committee Chair therefore enquired as to what the enablers and barriers were in relation to resolving this area of risk. It was responded that one of the significant challenges with safeguarding referrals was that there were server facilities on the premises that handled such data transmission. This had begun to fail, and in November 2023 the Trust had transitioned to a cloud-based server, which was designed to resolve many of the outages and delays to referrals experienced previously. However, since early December 2023, the Trust then suffered a number of outages not with the server, but with the actual transmission process. The Trust currently utilised a mailbox system, and had undertaken due diligence. The Committee were informed that the Trust had been actively exploring ways to improve the process around the above. There was a risk of patient harm if safeguarding referrals were delayed, but that significant enhancements in the safeguarding service had been made. The safeguarding service was operating smoothly and efficiently, and monitored the occurrence of outages to minimize harm to patients. All delayed referrals also received risk assessments. The Committee queried as to whether patients and their families who were affected by such IT challenges were clearly communicated with, and the Trust responded that any affected patients were clearly communicated with.

18. The Committee queried how effectively staff were being provided with training to equip them with the basic skills of how to deal with patients who may be mentally ill. All frontline clinicians were trained to support people experiencing a mental health crisis. Call handlers also had the ability to pass calls onto clinical staff within the control room. It was emphasised that the service would always act with immediacy in circumstances where it dealt deal with mentally ill patients. From a force negotiation perspective, the service would also engage and liaise with the Police force.

19. The Committee highlighted that the CQC inspection outcome outlined that some people were not given the necessary pain-relieving medicines. It was queried as to whether staff had been sufficiently trained in this regard, particularly given the importance of ambulance staff being able to provide pain-relieving medications promptly and appropriately. It was responded that paramedics were trained in what is known as a step-wide approach in the management of pain, and that the Service was ensuring that paramedics would be adequately trained in pain management and in the administering of pain relieving medications.

20. The Committee referred to how the report outlined the Trust's commitments to staff wellbeing, and enquired as to whether the Trust had sufficient resources to maintain or potentially enhance the support provided to staff. It was outlined to the Committee that there was a comprehensive support package for staff, and that there was a fully-staffed health and wellbeing team that supported staff; including staff who required additional interventions such as Occupational Health. Trauma risk management was also prevalently utilised to support staff members who may have had to deal with traumatic incidents. The Committee were also informed that the Trust had good access to psychological medicines,

and that there was an unfortunately high uptake of these amongst some of the Trust's staff.

21. The Committee enquired as to how the Trust was performing in the realm of staff recruitment and retention. It was responded that the Trust was widening its recruitment drive in order to attract and recruit staff from oversees. There were a cohort of SCAS personnel who would be travelling to Australia in March to help facilitate further recruitment of staff from Australia and New Zealand. It was explained to the Committee that in Australia in particular, there was a shortage of employment opportunities for ambulance service staff, and that SCAS were utilising this as an opportunity to enhance recruitment from that region.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

22. Below are some key points of observation that the Committee has in relation to SCAS's CQC improvement journey. These key points of observation relate to some of the themes of discussion during the meeting on 08 February, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Ensuring effective governance: The Committee notes the updates that were provided by SCAS with regard to the developments around governance. The Committee strongly feels that good governance should and will be at the heart of the Trust's efforts to improve its services in a manner that addresses the concerns raised by the CQC. This means that governance arrangements should be structured and operated in a manner that enables clear flow of information both to and from the senior management of the Service. The CQC's 'inadequate' rating of the Trust's services being Well-Led serves as an indication that governance processes are in need of improvement. Improving governance structures and processes would help to ensure services are managed, led, and delivered effectively and efficiently. This could also help with establishing clarity over which each staff and managers responsibilities are, as well as who they are accountable toward. Good governance is vital for the following reasons:

- It can help to create clarity over roles and responsibilities.
- Effective monitoring of staff performance as well as the provision and uptake of staff training.
- Effective budgetary management.
- Transparency and accountability over decisions.
- Ensuring compliance with legal as well as company processes and policies.

- Having clear flow of information to the board and vice-versa.

The Committee also recommends that consideration is given to the inclusion of independent members, as well as avenues for input from patient experience, as a key component of the Trust's CQC improvement journey. This could help to increase the breadth and depth of experience, expertise, and insight that could be of significant benefit to the Trust's articulation of its priorities as well as how to go about designing and delivering its services in a manner that allows for a successful and insightful improvement journey.

Furthermore, the Committee lays strong emphasis on the importance of having clear monitoring, assessment and audit processes, as this could contribute to an improvement in the quality of the services that are being delivered by SCAS. Thus, consideration should be given to the incorporation of internal audit into the Trust, and such a function should benefit from having the resources that it requires.

Recommendation 1: *To ensure that the Service takes all possible timely measures to improve the effectiveness of its governance structures, particularly the flow of information to the board and consideration of the inclusion of independent members and the patient experience in the improvement journey. It is recommended that there are clear monitoring, assessment and audit processes in place to improve both the quality and safety of all services. Internal audit should be adequately resourced, and consideration might be given to bringing it into the organisation.*

Monitoring adherence to Health and Safety: The Committee understands that one concern identified by the CQC was that the service did not consistently control infection risk very well, and that equipment and control measures were not always used to protect patients, staff and others from infection. The Committee also understands that a company has been contracted to provide a rolling rota of cleaning to SCAS vehicles. It is pivotal that clear processes are in place for the purposes of monitoring adherence to health and safety. The effective implementation of health and safety policies is a twofold process:

- There is a need for clear articulation of health and safety policies and procedures that conform to the relevant health and safety legislation. In addition, the Trust should, where appropriate, formulate its own Trust-specific policies around health and safety.

- The Trust should develop mechanisms through which adherence to health and safety policies are routinely monitored.

Patient wellbeing and safety should be at the heart of how any ambulance service operates, and staff should be sufficiently trained in the health and safety aspects of their work; the implications on patients can be significant in the event of lack of adherence to these. It is vital that there is a clear process through which any uptake of such training is

monitored, and that the training is routine as opposed to being provided on a one-off basis. There is also a point about the Trust being able to clearly identify which staff members had not been adhering to health and safety policies, and for such staff to receive the appropriate training as a refresh of their comprehension of the Trust's health and safety policies.

Additionally, it is equally important that risk assessments are routinely made, and that all risk assessments can effectively identify any potential or foreseeable hazards for patients. The Committee recommends that there are annual reviews with some of the task-based risk assessments.

Recommendation 2: *For clear mechanisms to be established for the purposes of effectively monitoring adherence to health and safety policies.*

Demand and Workforce: The Committee acknowledges that challenges around workforce recruitment as well as retention are felt nationwide, and that such challenges are not unique to SCAS. The Committee is pleased to see that the Trust is widening its recruitment drive in order to attract and recruit staff from oversees. This would play a significant role in contributing to any lack of staffing for the organisation. However, the Committee urges that two factors are taken into account in the event of recruiting from abroad:

1. That those being recruited receive adequate levels of training so as to enable them to fulfil their job roles to the maximum standard and that conforms to local regulations.

2. That such staff receive good relocation packages as well as adequate support upon their arrival so as to further bolster the retention of oversees staff.

The Committee is pleased to hear that the levels of staffing requirements are reviewed by SCAS. However, the Committee would like to emphasise that given the increased demand for SCAS services, it is crucial that the levels of staffing correlate with the increased demand. This could only feasibly be achieved if staffing requirements are reviewed on as frequent a basis as possible.

Furthermore, the retention of staff will also rest on the support that the Trust can provide to enhance the wellbeing of its staff. A crucial part of this would involve work around improving the culture within the SCAS workforce in a manner that addresses the CQC's workforce culture concerns. Staff should feel confident that they work in a supportive and encouraging environment where they are not subjected to any form of bullying or mistreatment. Additionally, the Committee is glad to see the commitments to supporting the mental health of staff, and recommends that such support is expanded as much as possible so as to help address any mental health challenges experienced by the Trust's staff, who are understandably exposed to what could potentially constitute mentally traumatic experiences and circumstances.

Recommendation 3: *To ensure that demand and staffing requirements are frequently reviewed so as to secure adequate levels of workforce, and for there to be further resourcing of employees to support staff wellbeing.*

Provision of pain-relieving medications: The committee understands that a key concern raised by the CQC was around ambulance staff not always providing patients with the necessary pain relieving medications. It is vital that ambulance staff are explicitly aware that the kind of patients that ambulance crews would have to deal with are often those who may have had significant injuries or who may be in high levels of pain; hence their need for ambulance services in the first instance. Therefore, ambulance staff need to receive clear training and guidance on how to provide patients with the necessary pain relieving medicines. Indeed, this is not just a matter of training staff to be aware that some patients may require pain relief, but also explicit guidance and information on the types of pain relieving medications that need to be provided to different patients and in which specific contexts.

Furthermore, it is also the case that each patient may have different levels of pain tolerance, and may require different amounts and types of pain relieving medications. Hence, staff need to also be aware of how to assess the circumstances and patients they are faced with and make suggestions (or provide pain relieving medications) to patients accordingly.

In essence, ensuring that patients receive appropriate pain-relieving medications can contribute to improving the overall patient experience. It can also prove as an act of reassurance in a manner that patients could feel confident in the care that they will receive at the hand of paramedics when they are in a moment of vulnerability.

Recommendation 4: *To ensure that all ambulance staff are trained in and aware of how to promptly and appropriately provide patients with pain-relieving medication.*

Dealing with Mentally Ill Patients: The Committee is satisfied to see that all frontline clinicians are trained by SCAS to support people experiencing a mental health crisis. It is vital that given the increasing rise in mental ill health, particularly since the Covid-19 pandemic, that ambulance services are equipped with the skills to be able to deal not only with physically ill patients, but also with those that may be suffering a mental health crisis or simply poor mental health more generally. That all staff should be trained in being able to deal with mentally ill patients is pivotal for three reasons:

1. It is becoming increasingly commonplace for ambulance services to have to deal with patients who may be experiencing a mental health crisis for a variety of reasons.

2. It could also be the case that physically-ill patients, including those with injuries or those who have long-term conditions, may also be suffering from poor mental health as a result of their physical condition.

3. Ambulance staff could be dealing with vulnerable and elderly patients, who may suffer from poor mental health as a result of loneliness or a variety of other reasons.

Therefore, the Committee believes that all staff who are in direct contact with patients, be they call handling or ambulance crew staff, should have continuous training on how to interact with mentally ill patients. It is also the case that call handling staff, for instance, may receive calls from somebody in a suicidal circumstance. Whilst the Committee understands that call handlers also have the ability to pass calls onto clinical staff within the control room, it is crucial that call handling staff who are not clinicians also have some basic level of training in how to interact and communicate with mentally ill patients. This could prove useful in the event of a shortage of clinical staff on site or in the event of having to act with immediacy in very troubling circumstances.

Furthermore, all ambulance staff would significantly benefit from some basic level training and understanding of the role of the police, as well as where the ambulance service sits vis-à-vis the police force with regard to dealing with mentally ill patients. Effective liaison with the police force would be critical in circumstances where mentally ill patients are involved in conduct that may be a risk to themselves or others.

Recommendation 5: *To ensure that all call handling as well as ambulance staff are sufficiently trained and equipped with the necessary skills on how to deal with mentally ill patients.*

Addressing IT challenges: The Committee understands that the Information Technology which supports SCAS's operational functions (including safeguarding) remained a significant concern, challenge and also posed a reputational risk. It is of vital importance that the servers utilised for safeguarding referrals are secure, and that every effort should be invested to avert failures with the servers. Indeed, there is a serious risk of patient harm if safeguarding referrals are delayed as a result of any IT issues. Therefore, any delays to safeguarding referrals as a result of IT outages or challenges should be risk assessed, and any patients or families who have been affected should be clearly communicated with.

The Committee understands that a mailbox system is currently being utilised. However, more sustainable solutions for the IT challenges should be sought by the Trust. It is therefore recommended that SCAS observes and conducts learning from how other Trusts nationwide have addressed IT outages, as well to identify any exemplars of how Trusts have developed a long-term and sustainable solution to IT outages if this nature.

Recommendation 6: *That the Service continues to address the challenges around the IT outage with urgency.*

Legal Implications

23. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

24. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

25. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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April 2024

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OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

John Radcliffe Hospital CQC Improvement Journey.

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 08 February 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the John Radcliffe Hospital's Care Quality Commission (CQC) improvement journey.

2. The Committee felt it crucial to receive an update on progress made by the Trust in addressing the concerns highlighted by the CQC around the John Radcliffe and some of the services delivered at the hospital. There have been a few areas of concern that have been identified by the CQC in its most recent inspections of the John Radcliffe, including around the degree to which the hospital's services are "safe", "responsive", and "well led" overall. Other areas of concern revolved around the improvements required in gynaecology, maternity services, surgery, and urgent and emergency services.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of hospital services as well as the initiatives taken by NHS Trusts to address concerns raised by CQC inspections. When commissioning this report on the John Radcliffe CQC improvement journey update, some of the insights that the Committee sought to receive were as follows:

    - The degree to which services at the John Radcliffe are "safe".
    - The extent to which services at the hospital are "responsive".
    - The measures taken by the Trust to address the CQC's concerns around services at the hospital being "well led".
    - The steps taken by the Trust to address the CQC's identification of improvements required in gynaecology, maternity services, surgery, and urgent and emergency services.

SUMMARY

4. The Committee would like to express thanks to Eileen Walsh (Chief Assurance Officer, Oxford University Hospitals NHS Foundation Trust); Andrew Grant (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust); and Lisa Glynn (Director of Clinical Services, Oxford University Hospitals NHS Foundation Trust) for attending the meeting on 08 February and for answering questions from the Committee.

5. The Chief Assurance Officer informed the Committee that the report provided an insight into how the organisation addressed the specific areas of improvements listed in the CQC report and placed them in the context of the wider strategic and operational developments that had been made.

6. The Committee enquired as to the level of staff and patient involvement in the development of the Trust strategy. The Chief Medical Officer informed the Committee that the strategy was developed with extensive staff and patient engagement. Staff engagement continued beyond the point of publication and adoption of the strategy in the form of regular staff listening events that included members of the leadership team, and were an opportunity to hear staff concerns.

7. Patient engagement had contributed to service development work in the form of patient partners and experts by experience, and individual work streams had involved patient recommendations where possible.

8. The Chief Assurance Officer added that the patient's voice was kept at the heart of the strategy, and that Listening Events were held involving patients and stakeholders that had influenced the development of the strategy, as co-creation was the key platform for developing future strategies.

9. The Chair queried what opportunities there were for the strategic ambition of the Trust to integrate with the wider prevention agenda. The Director of Clinical Services explained that one of the Trust's key priorities was the part that key acute providers could play in prevention. The Trust was heavily involved with early detection of cancer through the Targeted Lung Health Check Programme, that would be initiating in April 2024. The Trust worked closely with the community and partners in relation to Wantage Community hospital, and were looking to expand additional services that would meet the needs of local populations and support the demand seen in local hospitals for acute services. In order to address the demand on urgent care services, the Trust had been involved with the Integrated Neighbourhood Teams as well as the Primary Care Strategy. The Trust had also been looking at admission and attendance avoidance, and the development of same day emergency care services.

10. The BOB ICB Place Director for Oxfordshire explained that the Trust was trying to strike a balance between treatment and prevention. Oxford University Hospitals NHS Foundation Trust (OUH) was involved in many prevention projects, such as co-location of maternity services within 'Flos in the Park', the Early Lives Project, and the Hospital at Home service to support acutely sick

people at home. The BOB ICB Place Director emphasised that the greatest long-term impact on prevention was to focus on children and young people, and the Community Paediatrics service was fundamental to this.

11. The Chief Medical Officer also highlighted the Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) service for palliative care at home, and that the service had made a fundamental difference to the patients it had served.

12. The Committee queried whether resources would be increased for the Hospital at Home Service to ensure coverage in rural areas, and whether RIPEL would include Primary Care Networks (PCNs). The Director of Clinical Services informed the Committee that OUH were looking at what services were having the most effect to reduce attendance to acute hospitals, including the Hospital at Home service, which was a key programme to manage demand and to support patients to be at home. RIPEL was a service that the Trust was committed to and wanted to evolve further and would build into PCNs and integrated neighbourhood teams. The challenge would lie in the reorganisation of resources and the allocation of funding, and the Trust was assessing this for next year to determine how resources could be used to the best effect.

13. The Committee enquired about how technology was being used to improve patient safety. The Chief Medical Officer informed the Committee that a lot had happened in the last five years to develop the Trust digitally. The Trust invested in the electronic incident reporting service Ulysses that provided a digital architecture for a greatly strengthened patient safety response framework. Electronic patient records provided electronic observations so that teams could view vital signs on patients remotely. Another important change was the introduction of daily Patient Safety Response meetings where senior leaders from across the organisation reviewed every incident from the last 24 hours with moderate harm or above, which allowed close oversight of patient safety in the organisation, and ensured the Trust was responsive to incidents and had the right learning response. The new national framework for responses (PSIRF) focused on changing the culture from one of blame to one of learning and improvement, and offered a range of different incident learning responses such as After-Action Review, Multi-Disciplinary Team Learning Reponses and Patient Safety Incident Responses (PSIIs).The framework introduced thematic responses, so that when incidents occurred, they fed into the broader longer term improvement plan rather than being taken independently. The work was supported by patient safety partners, service users who were part of the safety response framework and contributed to reviews of cases, and some committees that oversee these workstreams. Alongside this, there had been significant safety retraining for all staff, from basic training for all staff to more detailed levels for patient safety experts.

14. The Committee enquired as to who monitored the databases created by the collection of data. The Chief Medical Officer explained that there was a Governance team that overlooked the databases and provided monthly reports with breakdowns of all incidents by harm level and type of incident. For example, there had been an increase in incidents of violence and aggression against staff

over the last year that had been tracked, and which the Trust had provided staff support for. The database allowed the Trust to track specific incidents such as hospital-acquired pressure ulcers and this had been the focus of integrated quality improvement work, the result of which there had been a third reduction in these incidents. The data was important in helping the Trust to understand what the incident risk profile was, and to target learning and improvement responses accordingly.

15. The Committee queried whether the Trust had programmes for staff wellbeing, such as self-harm diversions built into search engines. The Chief Medical Officer informed the Committee that there were numerous internal and external supports for staff clearly signposted on their intranet, and a staff support service had been created, although he was not aware of wellbeing programmes built into the Trust's search engines. The Chief Assurance Officer added that there was an employee assistance programme available 24/7 to provide counselling to staff for both personal and professional issues.

16. The Chair queried whether significant learning was communicated to patients and families affected, and whether they were involved in the learning journey. The Chief Medical Officer informed the Committee that communication with families was essential and would always occur after these incidents under the Trust's duty of candour. Patients were always invited to share their questions after serious incidents, and outcome reports were shared with them. The Trust had sought to triangulate the learning from complaints, so if a complaint had been received it would be examined to see whether an incident needed to be created to learn from it, and a weekly meeting aimed to derive learning from this.

17. The Chief Assurance Officer highlighted that the Trust board and non-executive members took a strong interest in patient safety, and the Chief Executive implemented a direct feedback mechanism with clinical teams who were involved with serious incidents to present their reflections to the executive team. Several key committees had been introduced; including the Risk Committee to discuss proactive risks and thematic risks; the Productivity Committee to focus how to progress performance in the organisation; and the Delivery Committee to ensure large programmes of work had been implemented. The Trust had ensured that patients had been involved in the aftermath of incidents, and had been provided with both clear explanations to understand what went wrong as well as a swift apology when the Trust was at fault.

18. The Committee queried how the values of kindness and caring were taught in the organisation and how this was evaluated. The Chief Medical Officer responded that the organisation prioritised kindness, and kindness interaction training was provided to all senior leaders. The success of this was measured by examining metrics produced from staff surveys and by looking at sickness and turnover rates.

19. The Committee asked if data could be provided to show how improvements had been made. The Chief Assurance Officer informed the Committee that the Trust could provide metrics that demonstrated the improvement trajectory over the

last few years. This data could be supplemented by staff and patient surveys that provided anecdotal and human experiences. The Chief Medical Officer added that the board adopted a nationally recommended approach of presenting data, using Statistical Process Control (SPC) charts that helped focused discussions and identified improvement areas.

20. The Committee enquired as to how strong the internal audit function was and how the sharing of patient stories was imbedded in the organisation. The Chief Medical Officer explained that not all incidents generated patient stories that go to the board, but the patient experience team supported stories that generated different learning to help the board gain insight into the range of issues faced by the organisation.

21. The Chief Assurance Officer added that although patient stories were not heard at every committee, stories were sometimes made into videos that could be shown before conferences. The Trust had a very strong internal audit function that developed a comprehensive audit plan every year, which was formed with cooperation from all the executive directors and the areas of examination were stress-tested. The audit committee, chaired by non-executives, received this plan, and examined it with auditors to determine key risk and concerns.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

22. Below are some key points of observation that the Committee has in relation to the John Radcliffe Hospital's CQC improvement journey. These key points of observation relate to some of the themes of discussion during the meeting on 08 February, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Improving Patient Safety: The committee is pleased to see the Trust's commitments to improve patient safety at the John Radcliffe, and hopes that further measures are taken to address the concerns raised by the CQC around patient safety at the hospital. Patient safety should be at the heart of how the Trust operates, including in relation to how acute hospitals are managed throughout the entire management structure. Patients should also feel safe and reassured that their safety is of utmost concern, and that there are clear protocols and procedures in place that are followed through by all staff that patients get into contact with.

Therefore, the committee strongly believes in the importance of appropriate and adequate training for staff at the John Radcliffe so as to improve staff awareness and understanding of processes and procedures to enhance patient safety. There may also be a point about not merely adhering to statutory obligations around patient safety, but also about exploring ways in which the Trust can enhance its own internal processes to improve the safety of patients.

Given that many residents or patients would attend and utilise the services provided at the John Radcliffe, it is vital that their views,

thoughts, and experiences are also taken into account when thinking about how to improve patient safety. The Committee recommends that there is some measure of patient and stakeholder engagement so as to enable the Trust to understand how patients who receive services from the hospital feel about their safety and overall wellbeing in that context.

Additionally, technology should be maximised for the purposes of improving patient safety, and strong considerations should be given to how to avert the prospects of IT outages or IT system failures. The safety and reliability of the storage of medical records of patients is also crucial in this regard, as clinical staff depend significantly on such records (as well as technology more broadly) for the purposes of treating both in-patients as well as outpatients.

Furthermore, the importance of ensuring patient safety and getting this right is also reflected in the fact that many of the patients who may attend the hospital are vulnerable individuals who may exhibit physical and mental vulnerabilities. It is also the case that the families of such vulnerable patients would want to be reassured that their safety is of paramount concern to the hospital and its staff.

Recommendation 1: *For the Trust to continue to take improved measures to improve patient safety at the John Radcliffe. It is recommended that staff are sufficiently supported and trained in being able to maximise patient safety.*

Importance of stakeholder engagement: The Committee is pleased to see that there has been some level of staff and patient engagement in the development of the OUH Trust strategy, which should ideally have a knock-on effect on the improvement of services at the John Radcliffe. Nonetheless, the Committee strongly believes that given that several services and overall areas of concern have been raised by the CQC, it is crucial for there to be further stakeholder engagement (including although not limited to patients and staff) around the hospital's improvement journey. Staff listening events are a useful avenue for the Trust to directly engage with staff in a manner that could allow them to express their views and experiences. In the context of the hospital's improvement journey specifically, listening events can allow staff to reflect on how they feel about the services they provide to patients, and could therefore generate additional insights and further inform the hospital and wider Trust's management around the ways in which services could be improved. There are indeed significant benefits to having extensive engagements with staff, as this could help bolster the morale of hospital staff in a manner that could have a positive impact on how services are delivered to patients at the John Radcliffe.

In addition, avenues for patients to formally share their recommendations as to how services at the hospital could be improved are also crucial. Any workstream that is relevant to addressing the CQC's concerns. For instance, the insights from maternity patients who had recently given birth could help determine crucial ways in which both inpatient as well as

outpatient maternity services could be enhanced in ways that improve the birthing experience as well as the safety and wellbeing of mothers and newborn babies.

Furthermore, there is also a point about engaging with patients and families who may have had poor experiences with the services they have received at the hospital. In such instances, such engagements should form part of a wider co-production exercise to determine and identify patterns of where improvements are required in the hospital's services.

Recommendation 2: *For ongoing stakeholder engagement and coproduction to be at the heart of the John Radcliffe Hospital's efforts to address the concerns identified by the CQC, and for there to be clear transparency and further evidence of this to be provided.*

Importance of Transparency and key indicators: Related to the point above around the importance of public/stakeholder engagement, the Committee feels that general transparency around the hospital's improvement journey should be a key commitment for the Trust. Transparency is important in this regard for two reasons:

1. It helps to create an environment where patients, staff, the wider public, as well as other system partners feel a sense of reassurance that the Trust is immensely committed to improving services at the John Radcliffe in a manner that addresses the CQC's identified areas of improvement.

2. Transparency would help improve the level of accountability around the improvement journey. This could help to determine and provide clarity around which bodies/individuals are responsible for driving improvement not only in the overall sense, but also in each of the four service areas of genecology, maternity, surgery, and urgent and emergency care.

Related to the point about transparency is the importance of developing clear key performance indicators that could help to determine the extent to which the Trust is producing outcomes that indicate improvements at the John Radcliffe. Each of the aforementioned four service areas should have clearly identifiable leads as well as indicators that could measure, with realistic timescales, the improvements being made. In this respect, such indicators could be utilised for the purposes of achieving any of the improvements recommended by the CQC, as well as any further improvements to the hospital and its services that the Trust sees fit.

Recommendation 3: *For clear transparency around the Trust's efforts to address the CQCs concerns around the John Radcliffe. It is recommended that there are clear indicators that could help determine how improvements in the John Radcliffe are being driven overall as well as in the specific service areas of Gynaecology, Maternity, Surgery, and Urgent & Emergency Care.*

Resourcing Hospital at Home: The Committee is supportive of the use of Hospital at Home services, as this could potentially allow patients to receive the care that they require within their own homes in a convenient and safe manner. This way, patients do not always necessarily have to make hospital trips or be admitted into hospital. However, it is important that the service operates in as safe and effective a manner as possible, particularly given the likely risks involved. Getting the hospital at home service right is a process that would involve the need for adequate levels of resources to make it work.

Indeed, with the increasing resort to providing support to people in their own homes as opposed to in hospital wards, it is crucial that there are adequate levels of staff members to support this. This may require the Trust to train existing staff to provide this service, coupled with securing external staff who may already have experience and expertise in providing hospital at home.

Recommendation 4: *For sufficient resources to be secured for the purposes of delivering and potentially expanding the Hospital at Home Service.*

Recommendation 5: *For a site visit to be orchestrated for the purposes of providing the Committee with insights into the measures taken by the Trust to improve patient safety at the John Radcliffe.*

Legal Implications

23. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  - Power to scrutinise health bodies and authorities in the local area
  - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
  - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

24. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

25. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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April 2024

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OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Director of Public Health Annual Report.

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 08 February 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing a summary of the upcoming Director of Public Health (DPH) Annual Report.

2. The Committee felt it was vital to receive an update on the ensuing DPH report and what it would outline in terms of Public Health's direction of travel. The Committee had not received the full DPH Annual Report, which had not yet been published at the time of the meeting on 08 February. The Committee understands that the DPH Annual Report, which has a specific focus on climate action and health, will be published and launched at Full Council in April.

3. The Committee had scrutinised this year's ensuing DPH Annual Report as an item in order to have an initial conversation around the overall direction of travel around climate action and health, which will be set out in the fully-published report. The Committee will therefore scrutinise the fully-published report at a later date in order to assess the deliverability of the stated objectives and recommendations around climate action and health.

4. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes any objectives, recommendations, or measures taken by the County Council to consider the relationship between climate and health, and the potentially adverse impacts of the former on the latter. Upon commissioning this item, the Committee sought to receive insights into the following:

    - The priorities and overall direction of travel being set by the Council's Public Health team for the upcoming year.
    - A summary of the key messages outlined in the upcoming DPH annual report.
    - An outline of some of the recommendations contained within the DPH annual report.
    - An understanding as to the rationale behind adopting a focus on climate action and health.

SUMMARY

5. The Committee would like to thank Oxfordshire County Council's Ansaf Azhar (Director of Public Health); Dr Rosie Rowe (Head of Healthy Place Shaping); and Dr Louisa Chenciner (Public Health Registrar and Academic Clinical Fellow) for attending the meeting on 08 February and answering questions from the Committee in relation to the upcoming DPH annual report.

6. The Committee Chair outlined that HOSC would return to this item again in the near future for the purposes of scrutinising the full DPH annual report subsequent to its publication.

7. It was explained to the Committee that this particular DPH annual report and its focus on climate action and health did not emerge from a vacuum, and that in late 2023, over 120 countries backed the COP28 climate and health declaration. Additionally, the United Kingdom's (UK) Health Security Agency published reports in 2023 which outlined some of the health effects of climate change on the UK. The Committee were also informed that major journals such as the Lancet and the British Medical Journal had also highlighted the impacts of the climate crisis on health.

8. The DPH annual report emphasised that health was the untold story of the climate emergency, but that this was surprising given the immediate and positive health benefits for individuals, families and communities which could be delivered through climate action. Climate action could be a means for achieving better health for all people and for all ages.

9. It was highlighted to the Committee that the DPH report explained the reasoning behind the focus on climate change and health; and that an elemental approach was adopted which included five domains including temperature, air, water, food, and nature. Local evidence and data would be drawn on to outline what the impact was in Oxfordshire in all the aforementioned areas.

10. Steps were already being taken as part of climate action which could produce health benefits for Oxfordshire's residents. These related to the following:

    - Creating energy efficient homes and buildings.
    - Sustainable travel and clean air.
    - Green Health and Social Care.
    - Healthy and sustainable diets.
    - Accessible green and blue spaces and nature.

11. The Committee were also informed that the DPH Annual Report included a set of recommended actions that revolved around two key areas including:

    1. Actions that the Oxfordshire System could embark on including: working together for cleaner indoor and outdoor air; improving access for all residents to safe and inclusive green and blue spaces; adapting and upgrading buildings, estates and facilities; working with suppliers and the supply chain to reduce carbon emissions; support the

establishment of an Oxfordshire Climate Mitigation and Adaptation Healthcare Network; build and continuously bolster community resilience.

2. A call to actions around national policy and funding including: reducing air pollution by investing in low-carbon and climate-resilient infrastructure; creating good, secure employment and reduce inequalities; improving resident's health and wellbeing by upgrading peoples' homes, healthcare facilities and schools; and boosting our physical and mental health by making it easy for people to walk and cycle.

12. The Committee enquired as to whether the DPH report would be explicit around the balance between any national directives around climate action and health on the one hand, and local concerns, nuances, or sensitivities on the other. The Director of Public Health responded that broadly speaking, the work around climate action and health was something that had to be undertaken locally within, as well as with the support of the community. It was imperative to understand what the specific benefits and needs of the local population of Oxfordshire were when embarking on climate action. The overall reframing of health was ultimately of significant benefit to the local community in Oxfordshire. This approach was not stemming from a purely climate angle, but was one that emanated from a local health and wellbeing perspective also.

13. It was also explained to the Committee that there was also work around anchor institutions, where all system leaders were being brought together. Within this context, an outcomes framework around climate action and health would also be developed.

14. In response to a query from the Committee around the level of stakeholder engagement taking place around climate action and health, it was confirmed that there was stakeholder collaboration with healthcare partners as well as with District Councils in order to gain their input and views. There was also input from the City and District Councils into the development of the report as well as its recommendations.

15. The Committee enquired as to what the end-product would be of the DPH report as well as its overall direction of travel around climate action and health. The Director of Public Health responded that the overarching message within this report was one that would be conveyed not only at the local level, but that it would also be adopted as a national lobbying effort to encourage further conversations and actions around climate and health. It was reiterated to the Committee that there was a strong commitment to close the gap between the two conventionally separate topics of climate on the one hand, and health on the other. The rationale of this report was to merge these two considerations into a more holistic understanding and approach toward climate and health in a manner that recognised the interconnections between the two areas.

16. The Committee enquired as to whether there was any work with schools to help educate and raise awareness amongst children at an early age around the

importance of climate action and health. It was confirmed that there was an outreach officer who would work with schools around climate action. However, there was no explicit work with schools that involved raising awareness of the interconnectivities between climate action and health. The purpose of this year's DPH report again was to therefore to raise awareness of this disconnect.

17. The Committee queried as to whether the pressures in the NHS were having an impact on the wider system and the objectives and measures being taken by the Council's Public Health team. The BOB ICB Place Director responded that each NHS organisation exercised transparency over their net zero plans, which could be found on each Trust's website. It was also explained to the Committee that the Director of Place had worked closely with the Director of Public Health to focus on reducing health inequalities countywide.

18. The Committee enquired as to what was new about the message in the DPH report on climate action and health, and how such commitments and recommendations outlined therein would differ from some of the work that was already being undertaken by the Oxfordshire system. It was responded that the County and District Councils as well as the NHS had already been making existing efforts and arrangements in an attempt to reach climate action targets. However, what the DPH report emphasised was the need for further integration of these efforts to accelerate the reaching of climate action targets but to also improve how the system understands the impact of climate on health. The Council's Public Health Team were also having conversations with Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust around encouraging active forms of travel for NHS staff.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

19. Below are some key points of observation that the Committee has in relation to the upcoming DPH annual report as well as the proposed overall direction of travel around climate action and health. These key points of observation relate to some of the themes of discussion during the meeting on 08 February, and have also been used to shape the recommendations made by the Committee.

Stakeholder Engagement and co-production: The Committee is glad to hear of the commitments to engage with relevant stakeholders around pursuing objectives around climate action and health. The Committee does not doubt that key stakeholders or the wider public will oppose the proposed approach to climate and health, and is confident that there could potentially be widespread support for this. However, the Committee urges for the Public Health Team to embark on a strong and focused journey of co-production. This will be crucial for three reasons:

1. To help raise awareness and understanding of the importance of climate action and the health ramifications that climate can have on people's overall health and wellbeing.

2. Helping residents to appreciate the importance of the climate action message, particularly at a time when other health or economic related challenges might be experienced by locals.

3. Creating a policy environment that is as transparent and democratic as possible in a way that is inclusive and that also takes into account the voices of vulnerable groups and communities.

Resources for Climate Action and Health: The Committee is broadly supportive of the message contained within the upcoming DPH report on climate action and health. However, it is vital that a commitment to a pioneering direction of travel around climate action and health should be accompanied with careful and strong considerations as to how to secure adequate levels of resources for this. This should include considerations as to:

1. The nature and levels of resources that will be required to embark on climate action in a manner that improves health and wellbeing for residents.

2. How such resources could be secured, as well as the specific contributions that system partners can each play to contribute to this. This should also include considerations as to how system partners could collaborate effectively to pool resources toward embarking on climate action in ways that has a knock-on effect on health and wellbeing.

Furthermore, and related to the point outlined earlier in this report around stakeholder/public engagement, the Committee feels that sufficient resources should be explored for embarking on the public communications aspect of the report's message around climate action and health. This communications and public engagement aspect could be a significant undertaking that could require a certain level of resource that may not be readily available.

Moreover, it is crucial that the Public Health Team, alongside relevant system partners, work to identify what the potential barriers as well as enablers are that could either facilitate or complicate the efforts to embark on climate action for the purposes of improving health and wellbeing. This should also include consideration as to how certain climate action measures may have financial implications on residents who may already be struggling in the context of a cost-of-living crisis. Therefore, the long-term objectives of climate action should be balanced with the current state of financial and economic affairs within the County.

Clarity around Governance Structures: The Committee believes that if the message and recommendations that the DPH report is making around climate and health are to prove as tangible as possible, then there should be some measure of processes and governance structures in the

realm of climate action as well as health. Whilst governance processes and arrangements around climate action and health may not readily exist, those organisations and individuals responsible for driving policy in these two separate areas should be clearly identified, and careful considerations should be made as to how identified leads can work effectively and collaboratively as a system so as to embark on climate action in a manner that benefits residents' health and wellbeing. The Committee feels that any associated legislative or regulatory barriers to the commitments to climate action should be made transparent and must be clearly understood amongst relevant system partners.

In addition, and related to the importance of governance arrangements, it is pivotal for there to be clear processes in place for the purposes of monitoring and evaluating any measures taken as part of climate action and health. Given that the work on climate action and health is at an early stage, the County Council and its system partners would significantly benefit from being in a position to evaluate the early steps being taken around climate action, and to be able to measure any impacts of such action on the health and wellbeing of Oxfordshire's residents.

RECOMMENDATIONS:

Below are the full list of recommendations issued by the Committee as part of the item on the DPH Annual Report held on 08 February 2024:

1. *For the fully published DPH Annual report to come to a future HOSC meeting, with a view to further scrutinise the report and the deliverability of the commitments around climate action and health.*

2. *For the full DPH report to incorporate a section with insights into Population Health, and to include an update on progress on recommendations from the previous DPH Annual report.*

3. *For there to be clear and thorough engagement and co-production with key stakeholders around the commitments to climate action and health after the publication of the report. It is recommended that the local contexts and sensitivities are taken into account, with a view to balance these with national directives around climate action and health.*

4. *For there to be clear transparency and indications as to the barriers and enablers surrounding commitments to climate action and health. It is recommended that sufficient avenues of funding and resources are secured for the purposes of delivering these ambitions, and for collaboration with key system partners for the purposes of this.*

5. *For there to be clarity around any governance structures or processes around climate action and health. It is recommended that there is transparency around any key leads responsible for relevant policy areas around climate and health to understand individual/organisational commitments, as well as to understand any associated regulatory or legislative barriers to these commitments.*

6. *To ensure that clear processes are in place for monitoring and evaluating the measures taken as part of climate action, with specific attention to the implications that such measures may have on residents' health and wellbeing.*

7. *To raise educational awareness and understanding of the importance of climate action and its implications on health.*

8. *For next year's DPH Annual report to be brought as a full draft to the Committee's spring meeting, with a view to scrutinise the draft and provide feedback in a public meeting ahead of its official publication.*

Legal Implications

20. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

21. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

22. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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April 2024

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NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Oxfordshire Joint Health Overview and Scrutiny Committee

Date of meeting: 18 April 2024	**Paper no:**

Title of paper: Oxfordshire General Practice provision and access

Paper is for:	**Discussion**	✓	**Agreement**		**Information**	✓

Purpose of paper:
The paper sets out the key aspects of the provision of primary care services in Oxfordshire, specifically general practice services. It includes access data as well as reference to Oxfordshire practice workforce and estates. It builds on the work of the draft Primary Care Strategy.

The paper is presented to provide Members with data relating to provision of services

Recommendations

Members of HOSC are invited to note the contents of this update paper.

Authors:	Julie Dandridge. Head of Primary Care Infrastructure Head of Pharmacy, Optometry and Dentistry, NHS Buckinghamshire, Oxfordshire and Berkshire West ICB

Date of paper: 3 April 2024

Oxfordshire General Practice provision and access

1. Introduction

This report is provided to the Joint Health Overview and Scrutiny Committee for information and discussion. The paper sets out the key aspects of delivery in the provision of primary care services in Oxfordshire, specifically general practice services. It provides an update to the paper presented in May 2022.

2. Context

As of 1 April 2024, Oxfordshire has 64 General Practices providing general medical services to between 3,500 and 42,000 individuals. The reduction in the number of practices follows two separate practice mergers in Oxford City – 27@Northgate and 28@Northgate; St Bartholomew's Medical Centre and Hollow Way Medical Practice. In both cases there was no change to the provision or location of services. Merging of two practices can often strengthen the resilience of smaller practices and allow more services to be provided.

In October 2023 there was the closure of Botley Medical Centre following the hand back of the contract by the partners. As a result, the ICB worked with local practices to secure the continued provision of services from both the Elms Road and Kennington site. The practice team at the Manor Surgery in Headington now provide services to patients from the Kennington Health Centre site, while the team at 19 Beaumont Street, (now Beaumont Elms Practice), provide services to patients jointly from the Botley Medical Centre and 19 Beaumont Street sites. Feedback from patients and staff has been very positive following this change.

3. Improving capacity in general practice

In May 2023 the national 'Recovery and Access Primary care programme'[1] (PCARP) was launched which defined actions to be taken to ensure improved access and capacity to general practice. A full report[2] on progress was presented to the Integrated Care Board (ICB) board in November 2023.

The PCARP plan focused on four main initiatives including empowering patients, implementing modern general practices access, building capacity and cutting bureaucracy. Details of the 2024/25 programme are expected soon.

One of the features of the PCARP plan was to ensure cloud-based telephony was in place across all practices. This enables call back functions and 'off site' use and allows call volumes to be monitored. By the end of March all practices in Buckinghamshire, Oxfordshire and Berkshire West (BOB) will have this functionality.

[1] https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf
[2] https://www.bucksoxonberksw.icb.nhs.uk/media/3478/20231121-bob-icb-board-item-11-primary-care-access-and-recovery-plan.pdf

The next step is for the ICB to support practices to make more use of the functionality making it easier for patients to contact GP practices by telephone together with using other solutions like the NHS app and online consultations.

4. BOB Primary Care Strategy

The ICB has put primary care at the heart of transformation with the development of a primary care strategy[3] to transform general practice, community pharmacy, optometry (eye care) and dentistry.

The strategy has been developed with the support of health and care partners and local people to meet the challenges facing primary care, including high demand and reduced access to these services, an ageing population requiring more complex care, and workforce pressures around recruitment and retention of staff.

This programme of work is underpinned by the ICB's Integrated Care Strategy and Five-Year Joint Forward Plan published last year (2023). These set out an ambition to integrate primary care with community services across the ICB and to develop new ways of providing care for patients.

The **draft Primary Care Strategy** outlines three priorities to help deliver these ambitions:

- to improve access so patients get the right support first time to manage their health and wellbeing;
- to develop proactive and personalised care in the community setting for patients with complex health needs;
- to prevent ill health by using and sharing data with our partners about the health needs of local communities.

To help deliver these priorities we are proposing to develop the following services:

- Non-complex same day care
- Integrated Neighbourhood Teams
- Prevention; with an initial focus on cardiovascular disease

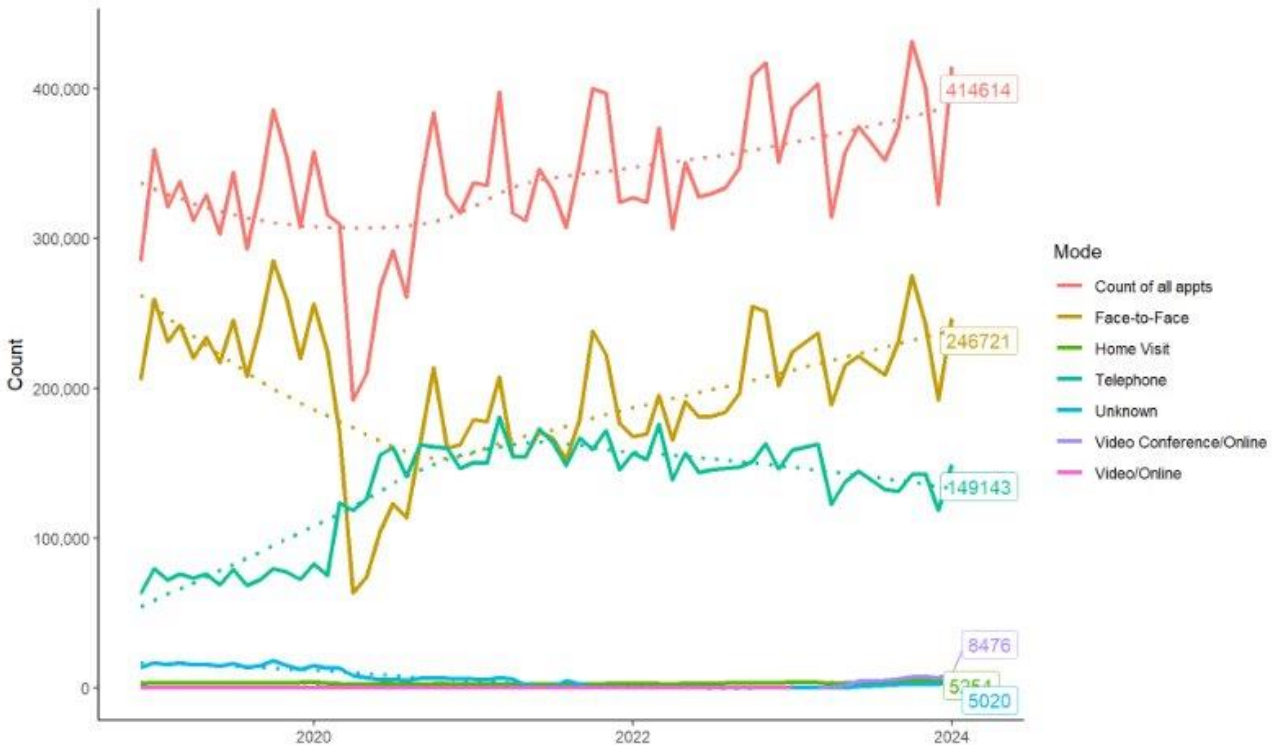
The strategy is currently in draft and been subject to extensive engagement. The final strategy should be available in May 2024.

5. GP Appointments

Appointments in General Practice are collected and reported nationally each month[4]. The graph below sets out the appointments since December 2019.

[3] https://yourvoicebob-icb.uk.engagementhq.com/primary-care-strategy

[4] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice



Graph 1 General Practice appointments by mode

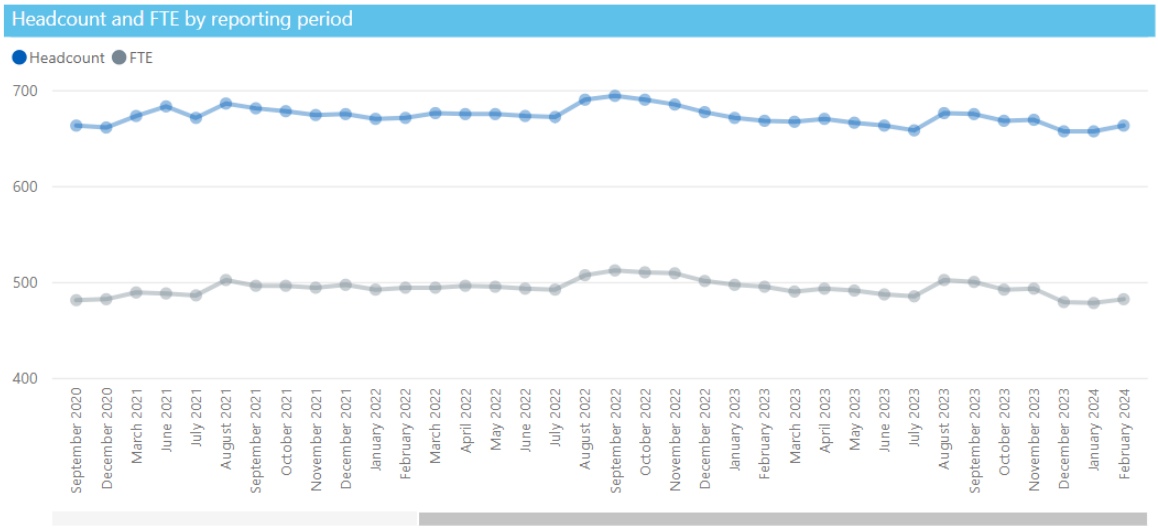
In Oxfordshire appointment levels have been sustained at pre pandemic numbers since September 2020 with the number of appointments being delivered increasing over time. The appointment patterns follow the seasonal trends seen in previous years and the majority of appointments are delivered face to face and this proportion is still increasing.

A recent focus has been to ensure that those patients that need an appointment with their GP practice gets an appointment within 2 weeks where appropriate and that those who contact their practice urgently are assessed the same day or next day according to clinical need. 86% of Oxfordshire patients are seen within 2 weeks of contacting their practice which compares favorably with the national position of 84% with 45.4% being seen on the day comparted to the national position of 44.7%.

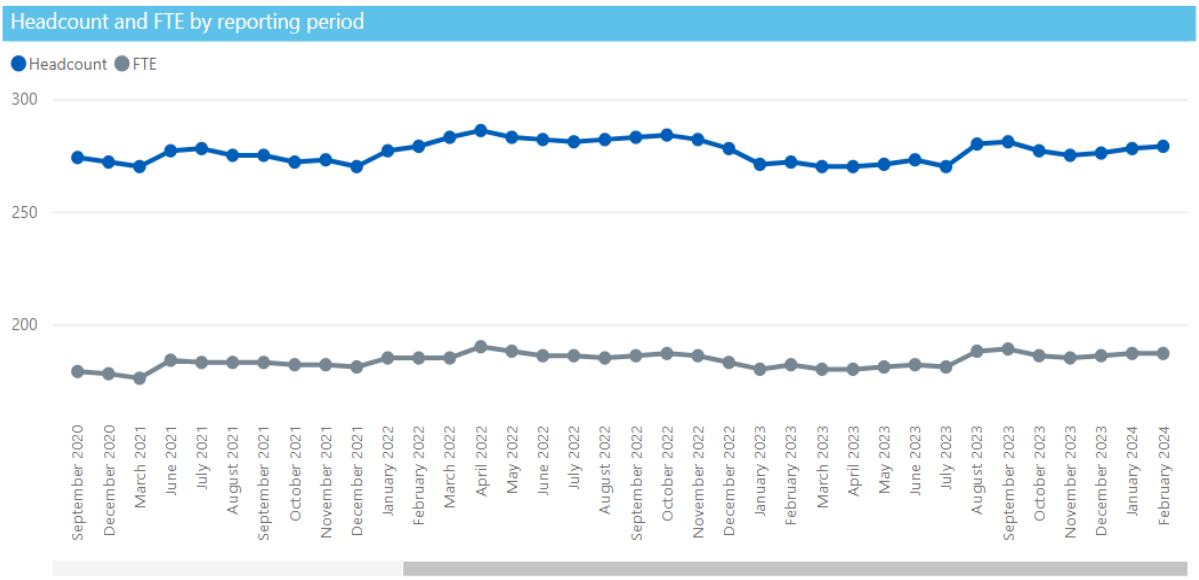
6. General Practice workforce

Practices are individual businesses and as such are able to decide on the number and type of staff that they employ. Data shows that Oxfordshire has slightly more GPs per 10k patients than the national average but slightly less nurses although the number of nurses and GPs have been slowly decreasing over time despite the demand for

appointments increasing[5]. However the number of additional role reimbursement scheme (ARRS) staff has increased from 313in April 2022 to 339 in March 2024. From April 2024 Primary Care Networks will have more flexibility on how they use their ARRS funding.

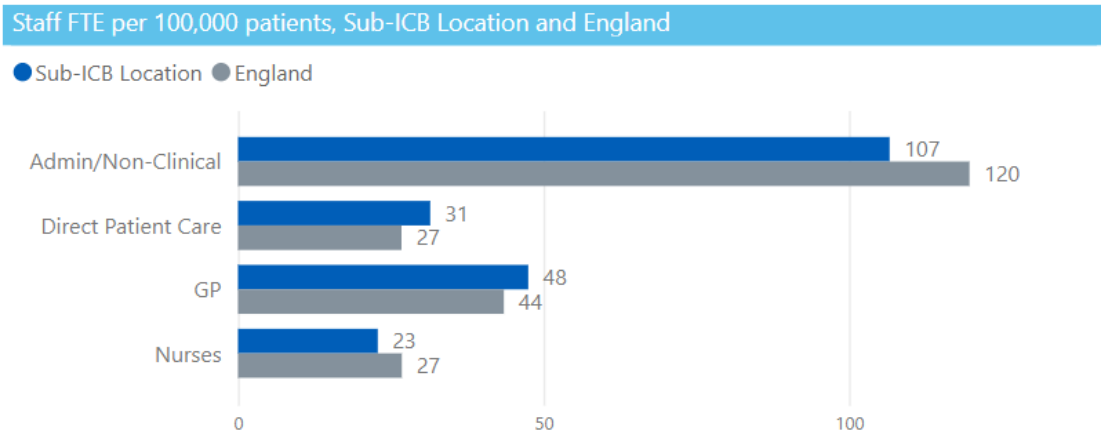


Graph 2 Oxfordshire GP Headcount and full time equivalent (FTE)



Graph 3 Oxfordshire primary care Nurse Headcount and full time equivalent (FTE)

5 https://app.powerbi.com/view?r=eyJrIjoiZTEwODNkOTItZjVmYS00OTNjLWJhNDktNjdkYTRlOGY3Njg4IiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9



Graph 4 Oxfordshire primary care staff per 100,000 pts

There are a number of schemes in place to improve the recruitment and retention of general practice staff including a GP retainer scheme which provides more flexibility and training support for those GPs thinking of leaving the profession and a new to practice fellowship scheme open to doctors and nurses who are new to general practice.

Alongside this there are both national and local training schemes (Care Navigator training) for practice staff including receptionists to ensure that patients are triaged to the most appropriate person or place first time.

7. Primary care Estate

7.1. Current context

It is recognised that many GP premises across BOB need additional capacity and modernisation, due to the mix of house conversions or older purpose-built surgery buildings not designed for modern day healthcare. There are currently 154 practices across BOB operating out of 223 practice sites. Very few have room to expand which means practices have outgrown their existing space.

The draft BOB Primary care Strategy recognises that primary care estates is becoming pressured from population growth as well as less fit for purpose over time. A lack of capital, the high rental costs and lack of suitable options make investment and improvement in primary care estates difficult.

Despite this Oxfordshire has seen two major expansions in primary care estate over the past two years.

Development	Year	Type
Northgate Health Centre new build	2022	Part of a 4-storey mixed use new development in heart of Oxford City co-locating 3 practices.
Wantage Health Centre extension	2023	Significant extension and remodelling of existing

		premise housing two practices

Table 1: Oxfordshire new primary care developments

Furthermore, after extensive work and negotiations with the medical estates developer of the site, and due consideration of the significant needs of the increasing Didcot population, the executive Board of BOB ICB has accepted the business case for the GP new building on the Great Western Park housing development. The ICB has agreed to provide the required revenue funding to add to the capital contribution resulting from a S106 Agreement.

The project now requires full planning consent and a series of legal agreements (between Vale of White Horse District Council, the ICB, the Woodlands Medical Centre, the medical estates developer and NHS England) before a construction tender can be entered into and building work started.

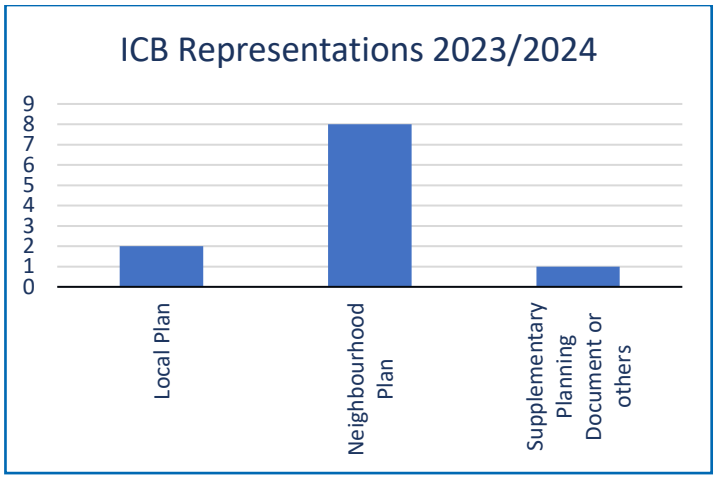
7.2. Health service planning

The ICB is a duty-to-cooperate prescribed body under the Town and Country Planning (Local Planning) (England) Regulations 2012 and as such local planning authorities and county councils are under a duty to cooperate with the ICB on strategic matters that cross administrative boundaries.

As a result the ICB has regular meetings with local Council partners in Oxfordshire to ensure that primary healthcare is considered in planning. The ICB is also invited to attend a regular planning forum, which is formed by all Oxfordshire authorities and coordinated by Oxfordshire County Council Public Health team.

In 2023/2024, the ICB reviewed more than 11 Oxfordshire draft local plan and/or neighbourhood plan documents and made formal representation to 4 consultations including both local plans and neighbourhood plans, which have implications for primary healthcare in the local area, including:

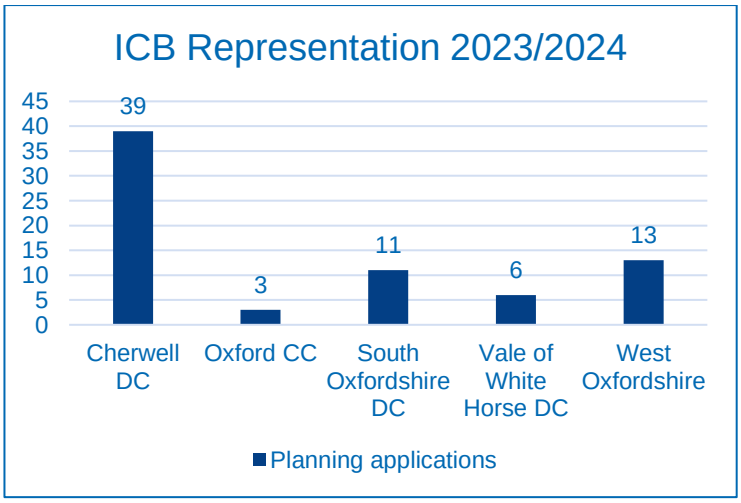
- Oxford Local Plan 2040 Regulation 19 consultation
- South Oxfordshire and Vale of White Horse Joint Local Plan 2041 Preferred Options Regulation 18 consultation
- Mid-Cherwell Neighbourhood Plan 2040 Regulation 14 consultation
- Heyford Park Neighbourhood Area Designation application



Graph 5 ICB representations on Oxfordshire planning in 2023/24

Despite the ICB not being a statutory consultee in planning applications the ICB is proactively work with local Council partners to ensure appropriate primary healthcare mitigation is identified for those strategic and major developments within Oxfordshire. Mitigation may include the provision of land and/or a new facility and/or financial contributions towards primary care estate projects of existing premises. Currently, the ICB is responding to those major developments which have more than 50 units or have significant impact on a local Primary Care Network (PCN).

In 2023/2024, ICB has provided comments on 72 planning applications including pre-applications in Oxfordshire.



Graph 6 ICB representations on Oxfordshire planning applications in 2023/24

7.3. Developers Contributions

The ICB considers many requests for expansion/extension of GP premises some of which can be funded or part funded by housing developer contributions through the Town Planning system. However, these contributions are not generally easily

allocated nor sufficient to fund major new build projects in areas of significant population growth.

Healthcare has been allocated 20% of the infrastructure proportion of Community Infrastructure Levy (CIL) funding from South Oxfordshire District Council and Vale of White Horse District Council for primary healthcare projects supported by ICB.

These contributions have currently been approved for extensions to two existing practice estate in Abingdon as well as for the Great Western Park development with plans emerging for Henley and other areas.

8. Next steps

The Primary Care Strategy will be instrumental to ensuring we have a resilient and efficient primary care services across BOB. Once approved by the ICB Board, the Primary care strategy will be implemented using the principles of quality improvement in order to drive change. The ICB will oversee delivery of the strategy at a local level, whilst empowering staff working in primary care and system partners to make the required changes where necessary. There is already good practice across Oxfordshire such as the Same Day Urgent hub in the south east of the City and integrated neighbourhood teams in Bicester, Banbury and Headington. The aim will be to spread this good practice.

A key part of the strategy and things we have heard from the feedback is the need to engage more with the patients and public so that they understand what services are available and how to contact them when needed. This will include when they can self refer without having to visit the GP practice. As mentioned practices are also training up their reception staff so that they can direct patients to the right person and place.

Digital tools can provide a way of streamlining processes for both the patient and the practice although it is recognised that not all individuals will wish to use a digital/online route. The ICB will continue to promote the use of the NHS app as its functionality increases (including ability to track prescription requests between a GP practice and a community pharmacy and being able to book appointments through the NHS app). There are also good examples of where Patient Participation Groups are actively supporting others with use of the app. A scheme to allow patients to register online with a practice (rather than needing to visit a practice) is also being rolled out.

In order to increase capacity in general practice it is important to consider all of our healthcare professionals. The newly introduced Pharmacy First scheme allows community pharmacies to assess and if appropriate treat patients for 7 common conditions. This scheme launched in February 2024 and work will be done to ensure it is fully embedded so releasing pressure on general practice.

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Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

NHS Dental services in Buckinghamshire, Oxfordshire and Berkshire West

Report to:

Oxfordshire Health Overview and Scrutiny Committee, 18th April 2024

Hugh O'Keeffe, Senior Programme Manager - Pharmacy, Optometry and Dental

April 2024

Contents

1. Introduction

On 1st July 2022 the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board took on delegated responsibility for Dentistry, alongside Pharmacy and Optometry. Integrated Care Boards (ICBs) have an explicit purpose to improve health outcomes for their whole population and the delegation will allow the ICB to integrate services to enable decisions to be taken as close as possible to their residents. The ICB is working to ensure their residents can experience joined up care, with an increased focus on prevention, addressing inequalities and achieve better access to dental care and advice.

The ICB discharges its responsibility for dental commissioning in partnership with NHS Frimley who host a Commissioning hub for Pharmacy, Optometry and Dental Services, providing operational leadership within ICB governance structures.

Clinical engagement is achieved via a Local Dental Network (LDN) covering the Thames Valley area (Buckinghamshire, Oxfordshire, Berkshire West and Berkshire East). This is a clinically led group involving Dentists, Dental Public Consultants, representatives from Health Education England and the Local Dental Committees and service commissioners. Reporting to the LDN are specialist led Managed Clinical Networks for Oral Surgery, Orthodontics, Restorative Dentistry and Special Care and Paediatrics.

Patients are not registered with a dentist in the same way as they are with a GP. A dental practice is only responsible for a patient's care while in treatment, although many will maintain a list of regular patients so may only have the capacity to take on new patients when patients do not return for scheduled check-ups or advise they are moving away from the area.

Dental practices deliver services via cash limited contracts with the NHS in which they are required to deliver agreed levels of activity each year.

Since the onset of the pandemic dental services have faced major challenges. Enhanced infection control procedures, necessitated by the types of procedures carried out in dental surgeries, led to reduced dental capacity. Their capacity has been gradually increased as infection rates have dropped, under strict guidance aimed at keeping patients and staff safe. Since July 2022 that practices have returned to full capacity.

Although the gradual increase has improved access to dental care there remains backlog of care from earlier in the pandemic that will take some considerable time to address. The rate of recovery is being impacted by the greater oral health needs of patients due to gaps in their attendance with

treatment plans taking longer to complete and some practices have decided to cease NHS provision. This has impacted primary care dental services and referral services including hospital and a range of community-based services.

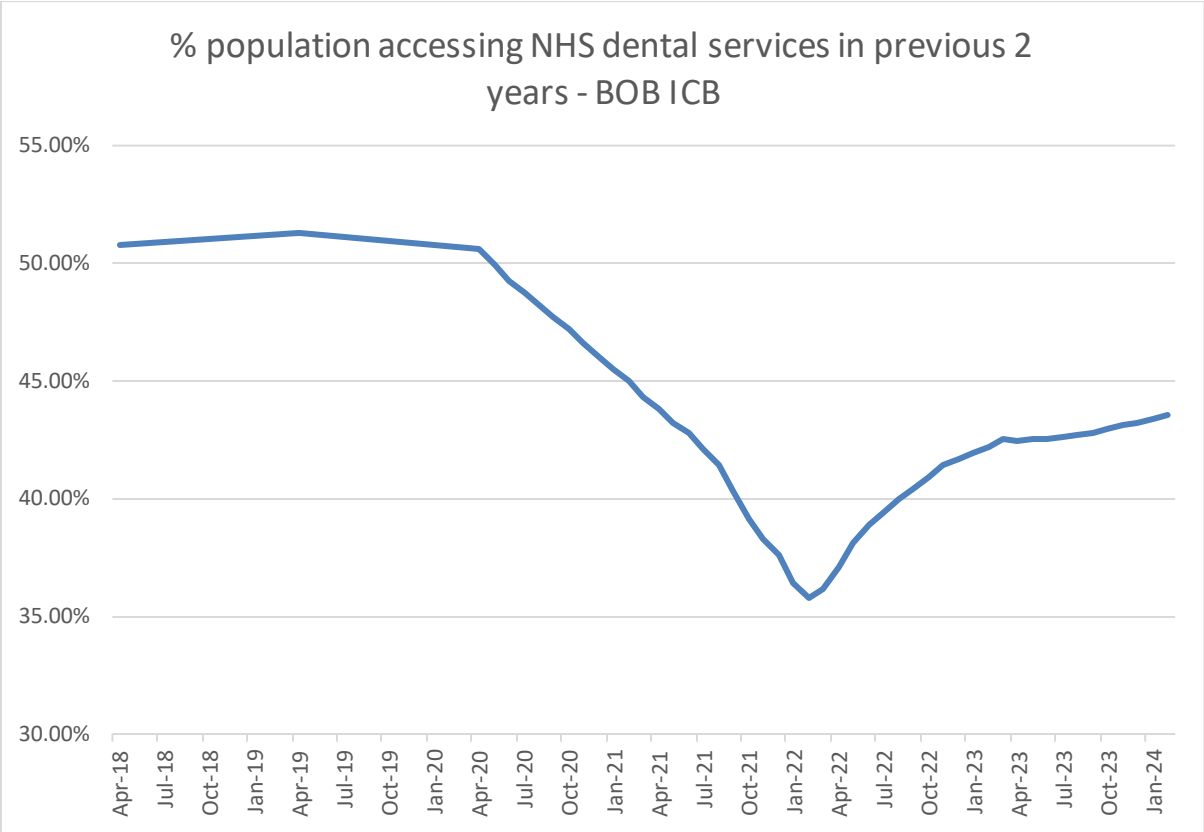
This paper provides update position in terms of access to primary care dental services and the actions being taken to address challenges.

2. Access to services

Access to primary care dental services is measured on the basis of the number of unique patients attending over a 2 year period. The introduction of the current dental contract in 2006 was accompanied by a programme of ringfenced financial investment under the Dental Access Programme designed to recover NHS dental access which had fallen significantly following the introduction of the 1992 contract. Access to NHS Dentistry in the Thames Valley (BOB plus Berkshire East) increased from about 43% of the population in 2008 to about 51% in 2019 (an increase of about 250,000 people; 25%).

The impact of the pandemic was such that by early 2022, the number of patients attending BOB ICB dental practices in the previous 2 years fell below 36%. Since then, there has been a recovery in access. In February 2024, 43.59% of the BOB ICB population (751,324 people, an increase of 134,716 compared to February 2022) had attended an NHS dental practice in the previous 2 years. This is the second highest percentage in the South-East Region.

Table 1 Access to NHS Dental services in BOB 2018 – 2024

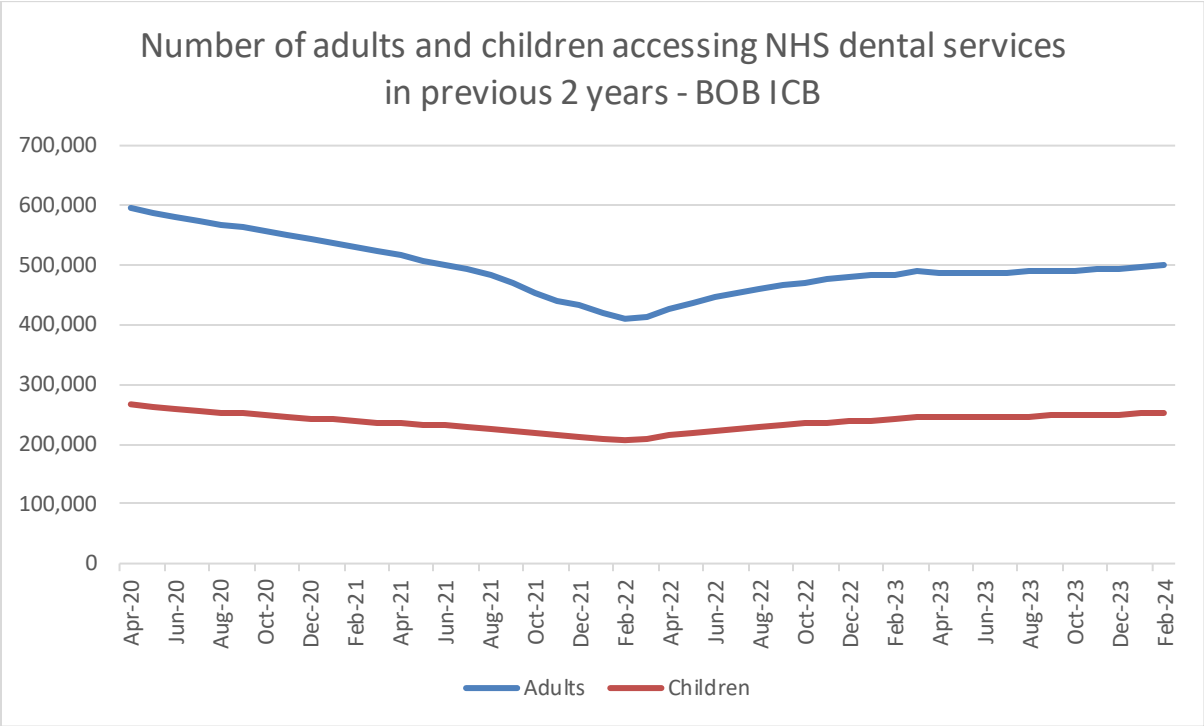


The rate of increased access has been similar for adults and children. The table and chart below detail the numbers of adults and children in BOB accessing NHS dental services in this period:

Table 2 Number of people accessing NHS Dental services in BOB February 2022 and February 2024

Patient group	**Number attending Feb '22**	**Number attending Feb '24**	**Increase**	**% increase**
Adults	409,943	498,539	88,596	21.6%
Children	206,665	252,695	46,030	22.3%
Total	**616,608**	**751,324**	**134,716**	**21.8%**

Table 3 Number of adults and children accessing NHS Dental services 2020 - 2024



However, the number attending is still some way below the pre-pandemic figures of 51.29% attending pre-pandemic.

As capacity has been increased practices have been able to deliver more of their contracted activity. Practices are required to deliver an agreed number of Units of Dental Activity (UDAs) each year. The UDA payment bands relate to the patient treatment bands under the NHS Patient Charges Regulations 2005.

https://www.nhs.uk/nhs-services/dentists/dental-costs/how-much-will-i-pay-for-nhs-dental-treatment/

3. Contract Delivery

Practices are paid on the basis of delivery of an agreed level of activity each year. In BOB, in April 2022 the ICB commissioned about 1.26 UDAs per head with Oxfordshire the highest at 1.41; Berkshire West 1.20 and Buckinghamshire 1.12. There is also variation between each local authorities, varying from 0.94 in Bucks East to 1.85 in Oxford.

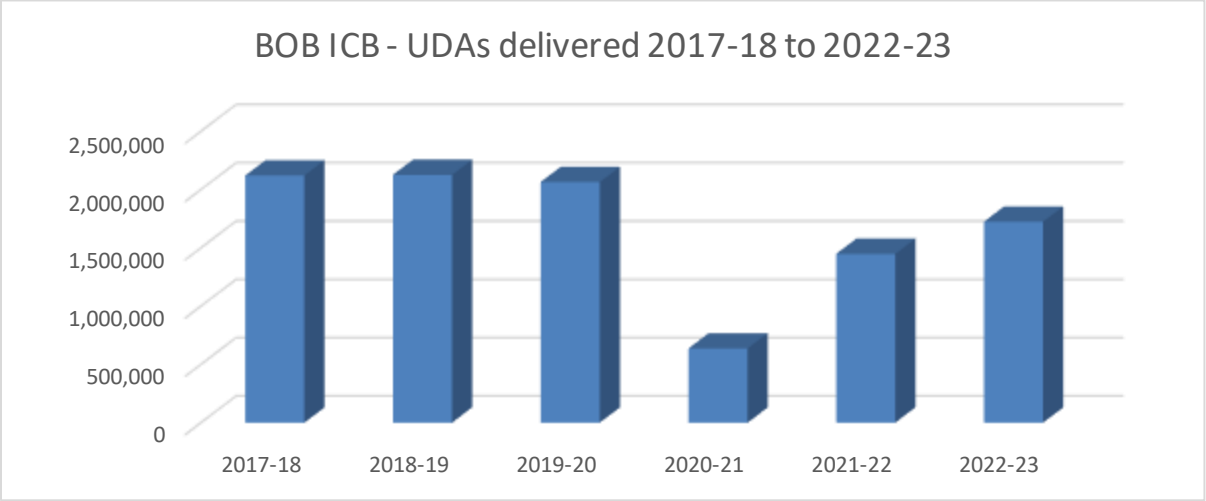
These levels are based on levels of activity commissioned at the point the current dental contract took effect in 2006 and any additional activity commissioned by the PCT or NHS England since then.

Table 4 UDAs commissioned per head April 2022

Local Authority	UDAs commissioned per head April '22
Bucks Central and North (formerly Aylesbury Vale)	1.02
Bucks East (formerly Chiltern)	0.94
Bucks South (formerly South Bucks)	1.70
Bucks West (formerly Wycombe)	1.13
Bucks	**1.12**
Cherwell	1.70
Oxford	1.85
South Oxon	1.04
Vale of the White Horse	0.96
West Oxon	1.36
Oxon	**1.41**
Reading	1.46
West Berks	1.08
Wokingham	1.07
Berks West	**1.20**
BOB	**1.26**

Practices are contractually required to deliver a minimum of 96% of contracted activity each year to avoid financial recoveries. If they fall below this threshold financial recovery will be made. Prior to the pandemic the average annual delivery in the BOB area was about 95%. Contract delivery requirements were relaxed during the pandemic as the practices operated at below 100% capacity between 2020 -22. Since the peak of the pandemic contract delivery has been increasing and this has supported increased access. In 2022-23, about 80% of contracted activity was delivered in BOB.

Table 5 BOB ICB – UDAs delivered 2017-18 to 2022-23



Whilst this is significant increase on the peak pandemic year of 2020-21 (28% of UDAs delivered) it is still some way below pre-pandemic levels.

There is also significant variation within the ICB. In Buckinghamshire and Berkshire West in 2022-23, about 85% of contracted activity was delivered; in Oxfordshire it was about 74%.

4. Access challenges

There are a number of challenges that continue to impact access to NHS services. Many of the patients who have attended dental practices since the pandemic have increased treatment needs due to increased gaps in attendance. This means their treatment plans are taking longer to complete. For some patients who had previously attended local practices prior to the pandemic it has been difficult to access care and that challenge has been even greater for people who have not attended a local service for a number of years or who have relocated to the area.

The commissioner has received high numbers of queries, concerns, complaints, and MP letters as a result.

For some Dentists this has had an impact on whether they wish to continue providing NHS services. To seek to retain Dentists, many practices have increased pay to their staff but, if many patients have increased treatment needs this may impact on the practices' ability to achieve contracted activity targets. The annual financial uplifts applied to dental contracts are set nationally, but many practices have advised that these increases fall below the additional costs being incurred. This combination of factors has two main

effects. It can make practices reluctant to take on new patients (due to likely additional treatment need and costs of treatment) and their NHS business may become less profitable. This has meant that some practices have decided to either hand back their contracts or reduce their NHS commitment. When they leave the NHS, they provide dentistry on a private basis. Patients are then invited to join them on that basis and the practice will also advise about other NHS practices in the area, with the effect of increasing pressure on those practices.

Since 2021, 17 practices in BOB have handed back their contracts and 8 have reduced their NHS commitment. A total of 108,872 UDAs have been lost as a result of this, which is about 4.9% of the total capacity. The table below details the contract handbacks:

Table 6 Contract handbacks and reductions

County	Local Authority	Practice name	Dare of contract expiry	Number of UDAs handed back	% UDAs lost to area
Buckinghamshire	Aylesbury Vale (now Bucks North and Central)	Mr C J Morris	19.07.2022	1,443	
		Miss E H Nichols	31.03.2023	500	
		Long Crendon Dental Practice	31.08.2023	2,164	
		Dr Balaji	31.03.2024	360	
	Aylesbury Vale Total			**4,467**	**2.20%**
	South Bucks (now Bucks South)	Mr P C Brash	30.06.2022	760	0.64%
	Chiltern (Bucks East)	Mr M A Ladak	Reduction 2023-24	3,306	3.67%
	Wycombe (now Bucks West)	No handbacks			
Bucks total				**8,533**	**1.40%**
Oxfordshire	Cherwell	Market Square Dental Practice, Bicester	28.02.2023	8,424	
		Bicester Dental Care	Reduction 2023-24	6,194	
	Cherwell total			**14,618**	**5.73%**
	Oxford	Mr AK Murgai	30.09.2022	200	

		Mr D Duggan	Reduction 2021-22	2,784	
	Oxford total			**2,984**	**1.06%**
	South Oxfordshire	Mr S Patel, Henley	31.10.2022	190	
		Portman Healthcare, Henley	31.07.2022	1,308	
	South Oxon total			**1,498**	**0.97%**
	Vale of the White Horse	Nicholas Harrison and Caitlin Devlin, Abingdon	31.05.2023	10,982	
		Portman Dental, Gloucester House, Faringdon	30.09.2023	19,387	
	Vale of the White Horse total			**30,369**	**23.20%**
	West Oxfordshire	Broadshires Dental Practice, Carterton	Reduction 2021-22 and handback 28.02.2023	5,111 6,000	
		Ratti GDS Partnership Witney	Reduction 2023-24	12,367	
		Charlbury Dental Practice	Reduction 2023-24	588	
		Oxford Therapy Ltd, Carteron	Reduction 2022-23	2,000	
		Mr MD Jackson	Reduction 2022-23	300	
		Tafft and Patel (Partnership)	Reduction 2023-24	926	
	West Oxon total			**27,292**	**17.25%**
Oxfordshire total				**76,761**	**7.88%**
Berkshire West	Reading	Greystone Dental Practice	31.10.2021	963	
		Alexandra Dental Practice	31.10.2021	675	

		Castle Hill Dental Practice	31.03.2023	8,250	
	Reading total			**9,888**	**4.03%**
	West Berkshire	No handbacks			
	Wokingham	Mr Z R Anwar	30.04.2023	9,276	5.08%
		The Gallery Dental Practice	31.01.2024	4,414	
	Wokingham total			**13,690**	**7.50%**
Berkshire West total				**23,578**	**3.90%**
BOB TOTAL				**108,872**	**4.90%**

5. Actions to address the challenges

5.1 Temporary UDAs

When contracts are handed back, local practices are approached about replacing the lost activity on a temporary basis. A total of 18,100 UDAs have been commissioned until 31st March 2024, detailed below:

Table 7 Temporary UDAs commissioned to 31st March 2024

Location	**Number of temporary UDAs to 31st March 2024**
Bucks Central	2,500
Buckinghamshire total	**2,500**
South Oxfordshire	1,000
West Oxfordshire	1,100
Oxfordshire total	**2,100**
Reading	3,500
Wokingham	10,000
Berkshire West total	**13,500**
BOB total	**18,100**

5.2 Payment for contract overperformance

National changes were made to the dental contract in late 2022 with practices able to deliver higher levels of activity each year; receive higher payments for more complex treatments and use greater skill mix in delivering services. A minimum UDA price of £23 was introduced; practices were reminded of the need to follow national guidance on recall intervals; they were required to update information about patient acceptance status on https://www.nhs.uk/service-search/find-a-dentist and ICBs could unilaterally rebase contracts for persistent underperformance from 2024-25 onwards.

One of the key changes was to allow practices to be paid to deliver up to 110% of their contracted activity in 2023-24 (up from 102%). In October 2023, the ICB wrote to the dental practices to say that it would pay for contract performance of up to 110% for the year. Twenty-seven practices replied to say they planned to deliver up to 110% of contracted activity, breaking down as follows:

Table 8 Impact of 110% contract performance 2023-24

County	Number of additional UDAs 2023-24
Buckinghamshire	6,635
Oxfordshire	2,184
Berkshire West	19,909
BOB	**28,728**

The financial impact is just over £900k. Due to the activity caps placed on dental contracts, some practices have to slow down their activity as they get towards the end of the financial year. This allows increased provision in the final few months of the year if the practices have the capacity to provide it.

5.3 Additional Access sessions

During the coronavirus pandemic, NHS South-East commissioned Urgent Dental Centres where a small number of practices could provide treatment for patients with an urgent treatment need. In early 2021, a few months after practices began to re-open, these arrangements were changed to Additional Access sessions for patients who struggle to access care and need urgent dental treatment. There are 2 practices currently involved in the scheme in BOB; one in Reading and the other in Buckinghamshire. In the period April to October 2023, they provided 276 (3.5 hour) sessions with 1,022 patient attendances. The take-up of this scheme has been low mainly due to the

requirement to provide additional sessions when many practices are facing capacity constraints.

5.4 Flexible Commissioning

The ICB has also commissioned a Flexible Commissioning scheme for patients who have faced challenges access dental care. The allows dental practices to convert up to 10% of their contract value (national guidance issued in October 2023 increased this to up to 20%) from delivering activity targets to providing access sessions for patients who have struggled to access dental care. This allows more time for practices to treat patients with more complex needs

The following patient groups have been identified in priority groups for the scheme:

- Patients who have not attended a local dental practice for more than 2 years
- Patients relocating to the area
- Looked After Children
- Asylum seekers and refugees
- Families of Armed Forces personnel
- Other groups as identified by the practice

This is a pilot scheme for the period 1st June 2023 to 31st March 2024. 33 practices in BOB are taking part with plans to deliver just over 3,000 access (3.5 hour) sessions across the year.

The table below provides a breakdown of practices taking part in the scheme by Local Authority:

Table 9 Flexible Commissioning practices

Local Authority	Number of practices in FC scheme	Number of sessions June 2023 to March 2024
Bucks Central	2	221
Bucks East	0	0
Bucks North	1	95
Bucks South	0	0
Bucks West	5	326
Buckinghamshire	**8**	**642**
Cherwell	6	658
Oxford	6	834
South Oxfordshire	3	297

Vale of the White Horse	2	178
West Oxfordshire	3	203
Oxfordshire	**20**	**2,170**
Reading	1	23
West Berkshire	1	50
Wokingham	3	209
Berkshire West	**5**	**282**
BOB	**33**	**3,094**

The table below details the number of sessions provided and the type of patients seen.

Table 10 Flexible Commissioning activity June 2023 to February 2024

County	Number of practices	Planned sessions to March '24	Sessions delivered to Feb '24	No seen for 2 years	Relocating to area	Looked After Child	Family of Armed Forces	Asylum Seeker	Other*	New patients	Total attendances	Did Not Attend
Bucks	8	642	530	1,134	375	24	11	56	265	1,865	2,540	311
Oxon	20	2,170	1,883	4,834	699	69	105	205	340	6,252	8,721	778
Berks West	5	282	237	480	304	15	3	2	10	814	986	79
BOB	**33**	**3,094**	**2,600**	**6,448**	**1,378**	**108**	**119**	**263**	**615**	**8,931**	**12,247**	**1,168**

*includes urgent, vulnerable patients, maternity, clinical need

There was a higher take-up of the scheme in Oxfordshire where more practices have struggled to deliver their activity targets and patient access has been more difficult. The practices have seen an average of about 4.7 patients per session. Of the new patients seen about 87.6% were those who had not attended a dentist for 2 years or were relocating to the area.

The table below details the proportion of patients treated within each of the NHS treatment bands in the period up to the end of January 2024:

Table 11 Treatment bands under Flexible Commissioning

County	**Band 1**	**Band 2a**	**Band 2b**	**Band 2c**	**Band 3**	**Band 1a (urgent)**
Bucks	60%	17.1%	5.3%	0.3%	1.0%	16.3%
Oxon	46.9%	23.2%	8.6%	0.5%	1.2%	19.6%
Berks West	54.3%	20.3%	10.9%	0%	0%	14.5%
BOB	**50.2%**	**21.7%**	**8.0%**	**0.3%**	**1.1%**	**18.7%**

About half of the patients received check-ups, about 20% less complex Band 2 treatment and just under 20% were treated for an urgent need. Just under 10% of the patients received treatment for complex needs.

The scheme has been evaluated in terms of patient and provider feedback with positive responses received from both.

The ICB has agreed that the service should continue for a further year from 1st April 2024. Thirty-five practices have signed up to take part in the scheme, breaking down as follows:

- Buckinghamshire 9
- Oxfordshire 21
- Berkshire West 5

5.5 Replacing the lost activity

Arrangements for the commissioning of temporary UDAs end on 31st March 2024. The ICB has been working as part of an NHS South-East programme to replace UDAs that have been lost due to contract handbacks and reductions, with the aim of commencing implementation from April 2024. This has been pursued as a two-stage process. The first has been to approach local practices to apply to provide additional activity to replace what has been lost in their area. If this falls short of the activity sought the ICB will go out to procurement to seek new provision into the area.

The first stage of the process has been completed and practice applications for additional activity have been approved from 1st April 2024 on the following basis:

Table 12 Number and locations of approved applications for additional activity

Local Authority	**Additional UDAs to be commissioned from April 2024**	**Location(s)**
Bucks Central	7,356	Haddenham and Aylesbury
Bucks South	117	Chalfont St Peter
Bucks West	12,082	High Wycombe, Wooburn Green and Loudwater
Buckinghamshire total	**19,555**	
Cherwell	3,995	Bloxham and Banbury

Oxford	7,800	Cowley and Headington
South Oxfordshire	4,500	Thame and Henley
West Oxfordshire	2,601	Witney
Oxfordshire	**18,896**	
Reading	13,250	Reading and Tilehurst
West Berkshire	4,800	Newbury and Thatcham
Wokingham	14,047	Woodley, Wokingham and Twyford
Berkshire West	**32,097**	
BOB	**70,548**	

No applications were received for Bucks East, Bucks North or Vale of the White Horse.

Formal offers have been made to these practices during March 2024. If the offers are accepted as above then the re-commissioning of the activity lost in both Buckinghamshire and Berkshire West will have been restored. It was likely that take up in Buckinghamshire and Berkshire West would be higher than in Oxfordshire as less capacity has been lost and therefore practices are more likely to have capacity to provide additional activity. Whilst the first phase of re-commissioning will increase capacity in Oxfordshire by nearly 20,000 UDAs significant gaps remain in the county. The next phase of the programme will focus particularly on increasing provision in Cherwell, the Vale of the White Horse and West Oxfordshire.

5.6 Changes to the NHS Dental contract in 2024

At the end of 2022, the government introduced changes to the NHS Dental contract which were implemented in 2023. Further changes were announced in February 2024. These are:

- The payment of a new patient premium for the period March 2024 to March 2025; ranging from £15 - £50, depending on treatment need.
- Support the Dentists to treat around one million new patients and launch a new public health campaign to raise awareness about how to find a Dentist.
- Increasing the minimum UDA price to £28 (current minimum is £25.33).
- A ‘Golden Hello’ payment for Dentists to work in areas of need, starting with a cohort of 240 Dentists later in 2024.

- Actions to increase the dental and dental therapy workforce.
- Legislation to support to development of skill mix.
- Making it easier for overseas dentists to work in the NHS, including legislation for the introduction of provisional registration status.
- Ringfence on NHS Dentistry budgets for 2024 to 2025 so ICBs can seek to improve dental access within this budget.
- Commence work in 2024 to ensure that the funding provided to ICBs better reflects changing population demographics.
- Reform the contract to make NHS work more attractive with options for consultation with dental profession with any changes phased in from 2025 onwards.
- The deployment of dental vans in under-served areas while longer term solutions are established.
- Support oral health improvement in Family Hubs and other settings that provide Start for Life services.
- Improve oral health of children by providing oral health advice to parents and a 'Smile for Life' programme into early years settings.
- Deploy dental teams to schools in areas of the country where oral health and NHS access is worst.
- A national programme of water fluoridation with new legislation to make it easier to start programmes to systematically bring water fluoridation to more of the country.

More details are to follow, but the ICB is reviewing the implications for implementation in BOB. Arrangements are now being put in place for the new patient premium and the minimum UDA price of £28; the latter of which impacts 25% of practices in BOB.

6. Summary

There have been significant improvements in access to and delivery of dental services since the peak of the coronavirus pandemic. Dental services only returned to full capacity in July 2022 and the levels of provision are now moving back towards pre-pandemic levels, particularly in Buckinghamshire and Berkshire West.

Local actions such as allowing practices to deliver more activity; additional access sessions; the Flexible Commissioning scheme and replacing activity

lost due to contract handbacks/reductions has helped to ease the reductions. Many practices have actively engaged with the ICB in responding to these challenges.

Changes have been made to the national dental contract with the aim of increasing support to the profession and improving access for patients. One of the key features of the national changes is the increased focus on prevention through the 'Smile for Life' programme. This is likely to increase opportunities for joint working between local authorities and the ICBs to address the causes of demand for dental services.

Significant challenges remain. Practices are still working through backlogs of patients built up as a result of the pandemic which is impacting the rate of growth in access. For patients who have not attended local services access is still a challenge. Workforce issues remain with contract handbacks and reductions continuing.

The recent announcement of changes to the national contract are designed to help further address the access and workforce challenges, but they also start to outline plans to improve oral health.

The ICB is working with a range of local stakeholders to develop a primary care strategy, which includes dental services, with the aim of commissioning services to meet local needs in ways that are sustainable. The ICB is also working in partnership with other ICBs across the South-East Region to re-commission referral services.

It will be important to continue work collaboratively and innovatively to maintain progress.

Your voice on health and care services

Report to the Oxfordshire Joint Health Overview Scrutiny Committee

18th April 2024

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1. Healthwatch Oxfordshire reports to external bodies

Healthwatch Oxfordshire attended and reported on what we hear from the public to the Health and Wellbeing Board (March), Health Improvement Board (HIB in Feb), and Oxfordshire Place Quality Committee.

For all external bodies we attend our reports can be found online at: https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/

We attend **Oxfordshire Place Based Partnership** meetings under Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). We work together with the five Healthwatch groups at place across BOB ICB to give insight to committees at BOB ICB wide level, including BOB ICB Quality Committee, BOB Health Overview Scrutiny Committee and BOB Integrated Care Partnership.

2. Update since the last Health Overview Scrutiny Committee (HOSC) Meeting 8 February 2024:

Healthwatch Oxfordshire reports published to date:

Summary of our **Quarter 3** (Oct-Dec 2023) activities and outcomes can be seen here: https://healthwatchoxfordshire.co.uk/wp-content/uploads/2024/03/Quarterly-report-Oct-to-Dec-2023.pdf

Reports published since the last meeting can be seen here https://healthwatchoxfordshire.co.uk/reports all available in **easy read**, and word format. Since the last meeting we published the following reports on our:

Enter and View Visits

Reports on the following services:

- Bicester Community Hospital – inpatient ward
- Day Lewis Pharmacy – Didcot
- The Close Care Home – Abingdon

All published Enter and View reports are available here: https://healthwatchoxfordshire.co.uk/our-work/enter-and-view and https://healthwatchoxfordshire.co.uk/wp-content/uploads/2024/01/Enter-and-View-easy-read-information.pdf

Our current work:

Note: any forthcoming reports will be published at the end of the Local Election Purdah period in May.

- We currently have a survey to hear from the public on **Eye Care Services** in Oxfordshire https://healthwatchoxfordshire.co.uk/news/eye-care-services-in-oxfordshire-tell-us-your-views/
  And survey link: https://www.smartsurvey.co.uk/s/eyeservices/
- Survey of **Patient Participation Groups** (PPGS) in the county to identify state of play, information and support needs. Received 79 responses – report forthcoming.
- **Core 20 Plus focus on oral health** needs of children under 10 - working in Banbury Ruscote and Neithrop areas (Part funded by NHS via BOB ICB Core 20 funds). We worked with 'community connectors' in this area to link to local networks in order to gather insights. Supplemented with additional wider survey on oral health needs of children with Special Educational Needs and Disabilities (SEND). In total we heard from almost 100 people. Report forthcoming (See Appendix below for initial findings). Insights shared with health and care professionals on 15 April in Banbury.
- **Focus on rural communities –** we commissioned Community First Oxfordshire (CFO) to undertake a profile of a rural community near Bicester (Ambrosden, Arncott, Blackthorn and Piddington) this is completed and report forthcoming.
- **Community Participatory Action Research** (CPAR2) we continued to support and mentor two community researchers from Oxford Community Action to focus on cost of living and food insecurity in OX4. (Part supported by NHS S.E. CPAR 2 Programme). This project will end in May, with launch of a film and report. Researchers will be presenting at a community research showcase event in June in London to share their work.
- Together with the community researchers from Oxford Community Action, we presented our learning about community research to over 130 participants at the launch of the **Local Policy Lab** (Oxford University and others) in March.
- We have been working with **My Life, My Choice** to support development of a 'Health Forum' to bring dialogue with health and care system. The first session was held in February, where a learning disability nurse from Oxford University Hospitals NHS Foundation Trust spoke and listened to views and experiences of care.

- We hosted a **webinar on 28 February** for members of the public to feed into the BOB ICB **Primary Care Strategy**, attended by 43 people, with presentations by Dan Leveson, BOB ICB Place Director for Oxfordshire, Louise Smith, Deputy Head of Primary Care Integration. Slides and video of the webinar can be found here: https://healthwatchoxfordshire.co.uk/news-and-events/patient-webinars/
- We presented along with Healthwatch Bucks on the importance of Patient Engagement to an audience of over 150 at the Primary Care Network event. Together we also produced a joint written response to the Primary Care Strategy which we sent to BOB ICB – see here: https://healthwatchoxfordshire.co.uk/wp-content/uploads/2024/03/Joint-response-from-Healthwatch-Bucks-and-Healthwatch-Oxfordshire.pdf

3. Key issues we are hearing from the public:

We hear from members of the public via phone, email, online feedback on services (https://healthwatchoxfordshire.co.uk/services), and when out and about. This enables us to pick up and inform the health and care providers and commissioners on emerging and current themes.

See Appendix 1 which highlights in detail what we have been hearing in relation to **GP and NHS dental services** – still our top area of inquiry and feedback.

We hear praise for the **good care** most people receive from health professionals once they receive treatment:

> *"What great care - examined, blood tests, ECG, X ray and then CT scan of chest following blood results. All interpreted, diagnosed and treated (on ward pharmacy) within about 5 hours - Unbelievably thorough care, I was very impressed and grateful"* (John Radcliffe Hospital Care)

We also continue to hear about challenges of **communication and administration for appointments, SEND and CAMHS waiting times, and cancellation** of appointments:

> *"I have always had outpatient appointments throughout my life because of my breathing problems but since the beginning of Covid I have had one appointment which lasted less than two minutes. My appointment for last August has so far been cancelled five times and is now due next May, if it isn't cancelled".*

- We have also been contacted by people concerned about provision of **medication for ADHD**, with unclear information about GP support and uncertainty about 'shared care agreements' for medication. Some GPs are not taking on new patients for this medication, and others are reviewing existing patients. Clarity is needed for patients to understand pathways and support.

Healthwatch Oxfordshire Board

Our open forum event for the public to attend was held online on Tuesday 27th February https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/ We published the **priorities and goals** for the coming year (2024-5) based on feedback from the public, our research and outreach insights, and strategic drivers. They can be seen here: https://healthwatchoxfordshire.co.uk/about-us/our-priorities/

Appendix A- hearing about NHS Dentistry and GP services

Speaking to the HOSC meeting agenda items on GP services and NHS dentistry we note the following feedback.

People continue to praise the support and care they receive from all health professionals within the NHS, and value this support hugely – at the same time as understanding the pressures faced.

However, here we highlight some of the challenges people share with us. This is sourced from our online service review feedback, from phone calls and emails from the public, from our outreach, and from our more focused work, and links with community and voluntary groups across the county.

- ***What we are hearing about people's experiences of NHS Dentistry***

Mystery Shopper - Access to NHS Dentistry (see attached summary sheet):

Building on a similar review undertaken in April 2023, we carried out a further NHS dentistry 'mystery shopper' exercise in March 2024. We asked dental practices in Oxfordshire if they were taking on both adults and children for NHS appointments. Of the 57 practices we managed to speak to, 6 were taking on NHS adult patients and 15

were taking on children (compared to 4 taking on adult NHS patients and 17 taking on children in a similar exercise in April 2023). See here for the summary of what we found: https://healthwatchoxfordshire.co.uk/ . Website information on NHS 'Find a Dentist' was not always up to date – 13 had not been updated in 90 days and 7 gave inaccurate information.

We continue to hear from the public about issues with access to NHS dentists, uncertainty about where to go, and unclear information about charging and what treatments are available on the NHS and feeling pressure to pay privately. People valued "friendly and caring staff".

> *"I cannot find an NHS dentist since the dentist I was with went private. Over the last couple of years I have pulled every top tooth I had left. I now feel extremely embarrassed when out in public, that I rarely go out anymore, and my mental health has been affected"*
>
> *"My husband visited with a problem tooth, told it had to be extracted but was 'too difficult' to do as an NHS patient and would have to be done privately. Feeling rather railroaded and in pain he agreed. Another dentist walked into the room and pulled it out in less than two minutes and was charged £300"*
>
> *"I care for a disabled child, we need help but can't access it. The NHS careline just tells me to keep ringing round and trying but I have tried all leads to no avail, and frankly have given up"*
>
> *"I registered with a dentist in as an NHS patient on universal credit. I cracked my tooth. They said that root canal treatment is not available on the NHS and all they could do for me was extract the tooth, but that I could get root canal treatment done privately with one of their dentists."*

Core 20 Plus focus on oral health, and for parents and carers of children with SEND:

Report for this work is forthcoming, and we held a meeting to share findings with health system on 15th April. Our work with community connectors under Core 20 Plus, reached 45 parents and carers of 74 children in Banbury - Neithrop and Ruscote. 31 of these parents and carers have children who have special educational needs and disabilities (SEND).

An additional county wide survey reached a further 36 parents and carers of 39 children or young people with special educational needs and disabilities. We also

had in-depth conversations with 9 parents and carers of children with special educational needs and disabilities. Six of these also responded to our survey. We spoke to parents and carers who are seeking asylum and who are temporarily housed in hotels in or near Banbury.

Summary of what we heard:

People face challenges finding an NHS dentist and getting appointments with them. When people manage to get appointments, challenges they told us about include:

- Having enough time in the appointment for the dentist to get the child comfortable enough to let them look in their mouth.
- Dental practice staff not knowing how to support children with SEND.
- Lack of flexibility around appointment times.
- A lack of continuity of staff, for example at a training practice, meaning that the child has to get used to a new person and the caregiver has to repeat information.
- The waiting room environment being distressing for children with sensory needs or anxiety.
- Caregivers feeling shame around their children's poor oral health, and/or feeling blamed or judged by oral health professionals.

We heard that people's experiences of dental and oral health services were more positive when oral health professionals had sufficient time and patience to support the child to feel comfortable. This was more common at a specialist community dentist but caregivers also told us about good experiences of mainstream NHS dentists. Examples of good practice included having a series of monthly appointments to get children used to going to the dentist and working up to opening their mouth, dentists explaining every step to the child, and allowing the child to see and touch the different instruments.

Hearing from asylum seekers and refugees [1]

[1] Note: Some of this feedback from asylum seekers and refugees has been shared by Asylum Welcome during BOB ICB listening towards the development of the Primary Care Strategy – but has also been highlighted to Healthwatch Oxfordshire during outreach in communities - as a result it has been included here to highlight some of the issues faced by this group – relevant to the HOSC agenda on both dentistry and GP access.

Links with those providing support to asylum seekers and refugees in addition to outreach by Healthwatch Oxfordshire include the following insights about dental care and oral health:

- Residents of some hotels struggling with oral pain and problems - oral health poor, due to a mixture of a lack of knowledge, access to dentistry and support, and poor food environment.
- Wider refugee and asylum seeker community also facing similar barriers to dental access as the wider population.
- The BOB ICB Flexible Commissioning Scheme is working well in some areas but is still not widely known about .
- Feedback that dental practices are not always clear about rights and responsibilities, including interpreting, paperwork and ID documentation, eligibility, and charging.
- People with No Recourse to Public Funds (NRPF) struggle to afford dental treatment.
- ➢ We convened a roundtable meeting for system partners to support communication and coordination around asylum seekers and refugees and oral health in the Banbury area.

➢ Access to interpreters:

We continue to hear about access to interpreters for health and care from people for whom English is not their first language, and those who use BSL and other interpreting. This includes what we have heard from grassroots community groups, and from asylum and refugee communities and is relevant to all health provision People using services are still not always aware of their entitlement to receive support – and it is not always offered. In addition, correspondence from health system, and health information is not often offered in translated format, making patients reliant on a third party.

Other feedback includes:

- Appointments need to be longer if using interpreter.
- Lack of out of hours interpreting support.
- Challenges ongoing with accessing interpreting for some languages e.g. Tetum, Sorani.
- Family and community members still being used as interpreters – need for formal recognition, capacity building and formal training if this practice is continued – although NHS guidance is not to use.

- Feedback from patients not provided with an interpreter including having medical/ dental treatment and not understanding what was going to happen.
- Some report feeling they perceive a more hostile reception if non-English speaking, or get a better response if supported by an advocate.

"Sometimes you can sense irritation when you are trying to explain to them (on the phone) They want to cut you off. That makes you feel your issue doesn't matter"

➢ What we are hearing about people's experiences of GP services.

Below summarises what we have heard since our report to BOB ICB on Primary Care in November 2023 (https://healthwatchoxfordshire.co.uk/wp-content/uploads/2023/11/Primary-Care-report-Nov-2023-final-1.pdf)

We have heard from:

- 140 people who left reviews of their GP practice – mix of ratings. (See here: https://healthwatchoxfordshire.co.uk/services/?filter=gp).
- 33 people who contacted us by emailing or phone for signposting and information about GPs – and access.
- People we spoke to in our day-to-day outreach and engagement work, including those from seldom heard communities.

What we heard:

People valued high quality treatment and care, being kept informed about what was happening, having appointments on time and being seen quickly where needed, kind, knowledgeable and caring staff, feeling listened to, and primary care colleagues working together to ensure patient safety (for example effective GP and pharmacy communication about medication that was not in stock).

> *"Her professional approach was on point. She put me at ease and did a fantastic job."*

> *"The receptionist did her upmost best to support me, kept calm and very sympathetic. I am so grateful of her support."*

" They communicate well by text and email. Great consultation by phone, and the NHS app works well for me".

"The staff have been caring and kind. Most of all they hear me."
"The GPs and nurses, the receptionists and staff overall are all approachable and professional. My GP listens, never rushes me and helps always. Since the surgery opened again after Covid I have had a few face to face GP appointments where I feel valued and respected. A first class gold service offered."

There is still a need for clear communication and education with the public about the varied and emerging roles in a surgery, beyond the GP, including functions of different health professionals, and the role of care coordinators – to support better understanding of the routes to access, treatment and care.

"Without giving personal health information to untrained staff it is impossible to get to see a GP. Instead of, pre covid, simply ringing for an appointment or booking it online we now have to complete a form, wait for a phone call and 9 times out of 10 still NOT get to actually see a GP. The surgery has now removed our ability to book blood tests and routine nurse appointments online. Levels of service are non existent in this practice".

Challenges people noted included difficulty making an appointment or contacting the practice (online and on phone), long waits for appointments, lack of continuity of care, needing longer appointments, lack of follow-up and poor-quality care. Some people described their journey of being sent back and forth between their GP practice and 111.

Several people told us some practices were not responding to formal complaints – Healthwatch Oxfordshire signposts people on to BOB ICB helpline as commissioner if this is the case, although this service faces capacity issues around response time.

"If you telephone the surgery, there are exceptionally long waits before the phone is answered. If you fill in an e-consult form, the surgery frequently fails to ring back during the time period they've promised".

"Extremely difficult to gain an appointment routine. Appointments cannot be booked if they're not "open". I work in a [name] with poor

coverage so it's difficult to call again and again to get an appointment. I was told to go to A&E by admin staff who refused to put me through to a clinician."

"Dad is receiving palliative care at home but we are having issues with his surgery in terms of getting prescriptions written and even just getting through to them. Doesn't feel like he's being treated like a priority at all".

"I saw my GP in February – I told her that one of my breasts had changed shape. She did not examine me very thoroughly and failed to find a significant lump. In July I organised my own mammogram. In September I had one operation to remove a 4 inch lump, followed by second operation to remove more cancer. My surgeon said that the delayed had resulted in my having to lose my nipple. This was extremely disappointing to say the least."

"Felt unwell and needed to see GP in opening hours. GP said no appointments - call 111. 111 said call GP - called GP they said no appointments ring 999."

During community outreach we heard from several African heritage women who described experiences of feeling dismissed or poorly treated by staff at their GP practice. As a result some of them commented they had not attended their GP (or taken their children) for several years, and commented they would rather self-medicate or go to A&E.

We also heard about additional challenges faced by Asylum seekers and refugees including: digital barriers, language barriers, lack of trust, information and understanding about navigating and accessing the NHS system, charging and lack of funds to pay for medications.

Healthwatch Oxfordshire is working with Asylum Welcome to relaunch its 'Access to NHS' cards for use by refugees and asylum seekers and those with no fixed address.

healthwatch Oxfordshire

Your voice on health and care services

March 2024

Accessing NHS dentists in Oxfordshire

Access to NHS dentists for adults and children for both routine and urgent appointments and treatment continues to be **one of the main issues raised by members of the public** who contact us. We regularly hear from people who have tried contacting several practices across the county without success, and do not know what to do next, as they cannot afford private treatment.

What we have heard:

"I cannot find an NHS dentist since the dentist I was with went private. Over the last couple of years I have pulled every top tooth I had left. I now feel extremely embarrassed when out in public, that I rarely go out anymore and my mental health has been affected."

"Been trying to find an NHS dentist for the past seven years. My partner now has a rotten and broken tooth which needs to be extracted. NHS 111 gives us numbers of practices which will not give us an appointment, urgent or otherwise."

"Dentist deregistered all adult NHS patients and asked us to subscribe to private check up service instead. Cannot get appointments for the kids either. Last appointments were cancelled and not rearranged by surgery. There are no NHS dentists here. We need help but we can't access it. The NHS careline just tells me to keep ringing round and trying but I have tried all leads to no avail and frankly have given up."

Between 25th and 27th March 2024, we carried out a 'mystery shopper' exercise, calling 76 dental practices in Oxfordshire to ask if they were taking on adults or children for NHS dentistry.

19 did not answer with the call either ringing out, going to voicemail or to a callback option.

Of the 57 practices we spoke to, 6 were taking on adult NHS patients and 15 were taking on children *(compared to 4 taking on adult NHS patients and 17 taking on children in April 2023).*

76 dental practices	Yes - were taking NHS	No - were not taking NHS	No reply
Adults	6 practices	51 practices	19 practices
Children	15 practices	42 practices	19 practices

What dental practices told us:

If the practice was not taking on NHS patients, we asked for advice on what to do. Some suggested trying other specific surgeries or calling around, and others suggested checking the NHS 'find a dentist' search tool. Two mentioned a flexible access scheme in partnership with NHS offered at some practices for certain patients to book an NHS check up and undergo treatment . 13 practice websites had not been updated in 90 days, and 7 gave inaccurate information.

"Had to close our waiting list last year due to high volume."

"At full capacity. Not taking on NHS or private."

"Will only see children on the NHS if the parent is privately registered."

March 2024

Getting dental care

What to do if you need emergency dental treatment

- Call your dentist – some practices offer appointments at short notice.
- If you don't have a dentist, call NHS 111 for advice.

Find out more about emergency and out-of-hours dental care on the **www.nhs.uk** website.

How to find an NHS dentist

You can attend a dental practice anywhere. To find dental practices near you, put in your postcode into **www.nhs.uk/service-search/find-a-dentist**

You can also go to **www.dentalchoices.org** which is an independent website which gives updates on dental practices which are accepting NHS patients.

You may have to call several dental practices in your area to see if they are accepting NHS patients.

What to do if you can't find a dentist

If after contacting several dental practices in your local area you still can't find a dentist accepting NHS patients, you should call **NHS England's Customer Contact Centre** on **0300 311 2233** or at **england.contactus@nhs.net**

You can also raise this with the **Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)** by calling **0800 0526088** or emailing **bobicb-ox.palscomplaints@nhs.net**

For more information see **www.bucksoxonberksw.icb.nhs.uk/your-health/dentists**

Oral health advice

- The NHS Live Well website has information on how to loo after your teeth and gums and how to keep your teeth clean - see **www.nhs.uk/live-well/healthy-teeth-and-gums**
- The NHS youtube channel also has lots of useful videos if you search for 'oral health' - see **www.youtube.com/@TheNHSEngland/videos**

Other useful organisations

Oxfordshire Community Dental Service (OCDS) - provide specialised dental care to children and adult patients, who are unable to receive care from a general dental practitioner, but do not necessarily need to be seen in a hospital. You need to be referred to OCDS which caters for a range of people with medical conditions, learning or physical disabilities, anxiety or phobia, mental health issues and those who need special care dentistry, including orthodontics. Its website also has useful advice and leaflets on dental care and oral health - see **www.oxfordhealth.nhs.uk/dental-services-oxfordshire/our-service/resources**

Oxfordshire Oral Health Improvement - is commissioned by Oxfordshire County Council to deliver and promote oral health programmes and education services. This includes providing oral health training to health and non- health professionals, including The Healthy Smiles award programme, which supports services working with young and primary school children to adopt tooth-friendly practices. See **www.communitydentalservices.co.uk/oral-health-improvement/oxfordshire**

Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

HOSC Paper – 18th April 2024

Title:	**Oxford University Hospitals NHS Foundation Trust's People Plan 2022-2025**

Status:	**For Information**

Board Lead:	**Chief People Officer**
Author:	**Sarah Taylor, Head of People Improvement Programmes**
Confidential:	**No**
Key Purpose:	**Assurance**

Contents

Oxford University Hospitals NHS Foundation Trust's People Plan 2022-2025

1. Purpose

1.1. The purpose of this paper is to present a summary of how Oxford University Hospital (OUH) Foundation Trust has developed our strategic workforce planning document, known as our 'People Plan 2022-25'.

1.2. We seek to address the following points posed by the Oxfordshire Joint Overview and Scrutiny Committee:

1.2.1. The overall objectives of the People Plan

1.2.2. How the plan was formulated (including how we have involved stakeholders)

1.2.3. How the 2020 NHS People plan has shaped the direction of OUH's People Plan.

1.2.4. Our approach to recruitment and retention

1.2.5. How we support staff wellbeing

1.2.6. The communications work we have done around the plan

1.2.7. A summary of the resource for our plan

1.2.8. An indication of how effective delivery on the plan has been to date.

2. Introduction

2.1. We developed our People Plan 2022-25, to reflect the views and needs of our diverse workforce and population, to support our commitment to our workforce and high quality patient care.

2.2. The plan focuses on creating a culture of inclusion and belonging, where everyone feels valued and respected, and where diversity is celebrated and harnessed. The plan also promotes the health and wellbeing of our staff, who are our greatest asset, by providing them with the support, resources, and opportunities they need to thrive and grow.

2.3. By implementing the People Plan, we aim to make OUH a great place to work where everyone feels they belong, and to deliver the best care for our patients by working in new and innovative ways within OUH and beyond.

2.4. The vision of the plan is:

2.4.1. "Together we make OUH a great place to work where we all feel we belong"

2.5. It covers three strategic themes:

2.5.1. health, wellbeing and belonging for all our people;

2.5.2. making OUH a great place to work;

2.5.3. more people working differently;

2.6. There are enabling workstreams including estates and facilities, Digital, communications and the People function. This document provides assurance to HOSC around the People Plan, and provides an overview of the key elements of the plan, the commitments to and from our people, and measures of success.

3. Formulation of the People Plan

3.1. The People Plan 2022-25 was formulated through a collaborative and inclusive process that involved a wide range of stakeholders from across the Trust and the System. This included extensive engagement with staff, leaders, managers, stakeholders and partners across the Trust and the system.

3.2. The process involved away days and workshops with Senior staff. We then went out to all our staff, and engaged in four listening events (and two follow-up events) with over 600 staff in May and June 2022, to share the draft plan, hear from staff stories, and incorporate suggestions and amendments. These listening events were influential in shaping the final plan and the changes made as a result of feedback were shared with staff in two follow up event held in the week beginning 20 June 2022. Over 200 staff attended these follow up events. The OUH Trust Board approved the plan in July 2022 and a launch followed shortly after. Appendix two outlines the process.

3.3. A communication plan accompanied the whole programme of work to ensure we reached out and captured the views of all our stakeholders.

4. Link to the 2020 NHS People Plan

4.1. The 2020 NHS People Plan sets out four key themes for the NHS workforce: looking after our people; belonging in the NHS; new ways of working and delivering care; and growing for the future.

4.2. The OUH People Plan 2022-25 is consistent with these themes, but also tailors them to the specific needs and aspirations of our people and our organisation. For example, we have emphasised the importance of creating a physical and psychological environment that enhances wellbeing, ensuring equal value and recognition for everyone's role in patient care, supporting our leaders and managers to shine, and improving

our recruitment and retention processes. We have also aligned our plan with the Trust Strategy[1] 2020-25.

5. Overall Objectives

5.1. The 'plan on a page' (Appendix one) sets out the overall objectives of the plan in a clear and concise manner. The overall objectives of the OUH People Plan 2022-25 are to:

5.1.1. Make OUH a great place to work where we all feel we belong, by living our values, rewarding and recognising our people, supporting their careers and development, and making continuous improvement a priority.

5.1.2. Prioritise the health and wellbeing of all our people, by creating a physical and psychological environment that enhances wellbeing, enabling happier working lives with flexibility and autonomy, and fostering a culture where everyone feels they belong.

5.1.3. Enable more people to work differently, by planning how best to use our workforce at OUH and beyond, ensuring the right skills are in place to deliver our services, and improving our recruitment and onboarding processes.

5.1.4. Deliver the plan through four enabling workstreams: creating a suitable environment and estates; digital fundamentals in place; communications and engagement; and having a fit for purpose OUH people function.

6. Communication of the Plan

6.1. The communication strategy for the plan includes the following elements:

6.1.1. Alignment and integration with the Trust Strategy, the Trust values, the national NHS People Plan, and system-wide people workstreams, to ensure consistency and coherence.

6.1.2. Initial and continued staff involvement and co-creation, through surveys, focus groups, workshops, listening events, and other methods, to seek input and feedback from staff and stakeholders on the plan and its delivery.

6.1.3. Internet and intranet pages, with supporting materials such as animations, videos, and other accessible versions, to showcase the plan and its progress.

[1] https://www.ouh.nhs.uk/about/strategy/documents/ouh-strategy-2020.pdf

6.1.4. Social media campaigns, to promote the plan and its themes, actions, and outcomes, and to celebrate the achievements and stories of our people.

6.1.5. Regular updates and feedback, through newsletters, blogs, podcasts, webinars, and other channels, to keep staff and stakeholders informed and engaged.

6.1.6. Print versions of the plan, both full and pocket sized, distributed to staff and stakeholders.

7. Focus on Recruitment and Retention

7.1. One of the key themes of the OUH People Plan 2022-25 is to enable more people to work differently, which includes improving our recruitment and retention processes. Some of the actions being taken to achieve this are:

7.1.1. Improved recruitment processes to reduce ‘time to hire’ and get people in post as quickly as possible, by streamlining and digitising the processes, providing ‘Inclusive Recruitment’ training and support ‘toolkits’ to managers. This includes ensuring compliance and quality standards are maintained.

7.1.2. Support diverse careers and across all staff groups, by developing career pathways, career conversations and succession planning, supporting research and innovation opportunities, and ensuring personalised development plans for all staff.

7.1.3. Offer a best in class NHS benefits package for our people, by providing competitive pay and reward, flexible working options, recognition schemes, and practical support such as cost of living, childcare and transport.

7.1.4. Collaborate with our partners to allow the workforce to be deployed where patients need it most, by working across the system and the region, supporting staff mobility and flexibility, and developing new workforce models and roles.

7.2. In terms of recruiting locally, the following are underway:

7.2.1. Oxford Town Hall recruitment events

7.2.2. Apprenticeship team visiting local schools when open days take place

7.2.3. An ongoing relationship with Saïd business school to recruit local graduates

7.2.4. Onsite and virtual careers events

8. Wellbeing of our Staff

8.1. Another key theme is to prioritise the health and wellbeing of all our people, which includes creating a physical and psychological environment that enhances wellbeing. Key areas of focus include the following, and achievements in these areas are identified below:

8.1.1. Continue to drive forward initiatives to tackle violence and aggression towards staff, including enhancements to training, reporting, support, and prevention.

8.1.2. Continue to expand our offer to meet psychological needs through wellbeing check-ins, safety to speak up, Leading with Care, and post-pandemic trauma recovery.

8.1.3. Ensure our leaders and managers have the knowledge and resources to support and signpost people to wellbeing support, such as the Staff Support Service, Occupational Health, Here for Health (healthy lifestyle support), and the Hospitals Charity.

8.1.4. Enable people to have open conversations and resolve difficulties at an early stage, utilising Kindness Into Action resources.

8.1.5. Introduce initiatives to support working lives with flexibility and autonomy, such as hybrid working, flexible contracts, and self-rostering.

8.1.6. Improve facilities to support hydration, nutrition, and equipment.

9. Measuring Success

9.1. The plan is monitored and evaluated through a set of metrics that measure impact and outcomes. These metrics are reported up to the Trust Management Executive and through to Board, and consist of:

9.1.1. Key workforce metrics (turnover, sickness, vacancy, core skills training, appraisal) - our ambition is to be consistently within target for all these metrics by the end of Year 3 of our Plan.

9.1.2. An additional 15 specific metrics that we will use to track the impact of the themes of our Plan, drawn from the Model Hospital, Staff Survey and some additional, internal measures related to sickness and turnover.

9.1.3. The plan is also informed and influenced by the feedback and input from our staff and stakeholders, through regular communication and engagement activities, including our Staff Survey and People Plan listening events. We also celebrate and

share the achievements and stories of our people, and recognise and reward their contribution to the plan and its goals.

9.2. The delivery of the People Plan requires the commitment and contribution of all our people, from the organisation, our leaders and managers, and each individual. We have developed a set of commitments to and from our people, which set out the roles and responsibilities that we all need to play to make the plan a success. These commitments are based on the principles of leading OUH, leading others, and leading self, and are based on “We’ll know we’ve achieved this when our people say” statements.

10. Key Achievements to Date

Some of the key achievements of the plan so far are:

10.1. Delivered the ‘Growing Stronger Together’ programme, supporting recovery post-covid, utilising the ABC model set out by the King’s Fund, prioritising the health and wellbeing of our staff. This included recruitment of a Head of Wellbeing, establishment of the Staff Support Service, which offers psychological support to staff for work-based issues, with over 150 referrals made April – December 2023, a ‘recovery, readjustment and reintegration’ programme which has been accessed by over 400 members of staff

10.2. Implemented the Kindness into Action programme to promote a culture of respect, dignity and compassion; at end of February, 488 managers have completed against a 1,800 target for ‘Leading with Kindness’ course, 963 current staff have completing the ‘kindness into action’ e-learning.

10.3. Instant note of appreciation is receiving positive feedback with over 1,600 having been sent since the launch in Jan-24 (as at end of March).

10.4. Annual Staff Recognition Awards nomination window saw 2,868 nominations, and the Culture and Leadership Service are working with our panels to process the nominations.

10.5. Improved time to hire from 57.6 days (June 2020) to Shelford median of 51 days and reduced some of the pressures associated with vacancies for staff and temporary staffing costs

10.6. “No excuses” campaign for Freedom to Speak Up launched including communications suite of resources.

10.7. Developed Equality Diversity and Inclusion (EDI) dashboards and action plans to monitor and improve diversity and inclusion across the Trust at a Directorate and Divisional level.

10.8. Included an EDI objective in every member of staff’s individual objectives.

10.9. Salary finance platform accessed by 6,550 unique users in 2023.

10.10. In 2023, we funded 128 loans for staff worth over £500,000, of which over a third were for debt consolidation and helped save the average person over £500 in unpaid interest.

10.11. In 2023, we made 2,728 salary advances with an average value of £149 - that's over £400,000 in salary advances to help people avoid payday loans and doorstep lenders.

10.12. Enhanced the induction and onboarding process for new starters, including a managers' onboarding programme and core skills training.

10.13. Delivered the leadership development programme for senior leaders and managers, covering topics such as sexual safety, safeguarding and feedback skills; 4 cohorts from Oct 2023 to Dec 2024, with 96 places in total

10.14. Rolled out wellbeing capital projects, such as outdoor gym equipment, changing rooms and bike storage, to support staff wellbeing.

10.15. In terms of our HR metrics and standard Key Performance Indicators in the last 12 months, there has been:

10.15.1. A reduction in turnover from 12% to 10.3%

10.15.2. A reduction in vacancies from 7.7% to 6.7%

10.15.3. A reduction in sickness absence rates from 4.5% to 3.8%

10.15.4. A reduction in nursing turnover from 12% to 9%

10.16. Staff Survey 2023: In total, 6,576 staff (46%; 3rd in Shelford Group[2]) had their say and made their voice heard by completing the annual survey

- Results are better than the national average - 77% of questions in the survey scored above the national average and 42% of these were significantly better (3% or more above the national average).
- 79.35% of staff agree that care of patients is OUH's top priority - the national average is 74.83%
- 74.84% of staff would be happy with the standard of care provided at OUH if a friend or relative needed treatment - the national average is 63.32%
- 63.55% of staff would recommend OUH as a place to work - the national average is 60.52%

[2] The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.

- The introduction of a Values Based Appraisal window at OUH for the last two years has had a positive effect - 93.42% of those who took part in the Staff Survey in 2023 reported that they had an appraisal in the previous 12 months, compared with 71.87% in 2021. The national average is 83.12% and our target set was >85%
- We have provided data packs to each division and directorate, and asked them to set up "Time to Talk" sessions with their staff to discuss the results and agree on local actions. This way, we hope to make the action planning more relevant, responsive, and inclusive.

10.17. When comparing our 'Staff Engagement Scores' from the Staff Survey across the Shelford Group, we continue to score extremely well, moving to second in group this year (Since 2014 we scored between 9th and 5th). We are the only trust in the Shelford Group to be above the national average across all People Promise elements, themes, and response rate and the Trust is placed within the top three across each of these. The Trust ranks 1st for "We are a team" and 3rd for "We work flexibly".

11. What our staff are saying at our latest People Plan Listening Events

"Some really great stuff happening - thank you"

"I was initially sceptical about the instant recognition awards but having seen how much they mean to my team (and receiving one myself)- I can see the value and how much they mean to people"

"What's been done is a significant improvement."

"Staff perspectives heard at Trust Board have been VERY POWERFUL and really appreciated by the Board"

"Leadership Development Programme has been very good"

"Really like the front page on remote working policy - clear summary. Could be replicated on others"

"Sounds good! Good progress!"

"Thank you for taking the time to really listen, makes me feel re-assured."

12. Resource for the Plan

12.1. Many initiatives within the People Plan are already funded and/or we expect to deliver from existing resource across the People and Communications Directorate, other Corporate functions and clinical Divisions.

12.2. Where specific initiatives are not yet costed, the development of implementation plans and business cases will follow. There is no available surplus for any net investment at present nor can we expect recurrent additional income to fund any additional staff related costs. We may need to reprioritise our future spending commitments in order to achieve some of the environmental goals of the People Plan. NHSE income may be available non-recurrently via bids to fund one-off implementation costs.

13. Focus for 2024-25

Some examples of our actions for the coming year include:

13.1. Eradicate bullying and harassment, especially from colleagues and patients, and implement the Sexual Safety Charter.

13.2. Further reduce the time to hire to 42 days for medical and general staffing, and explore the use of robotic process automation and BOB-wide initiatives to support recruitment (currently at 47 days)

13.3. Increase the uptake of annual leave among staff and ensure they have regular breaks and opportunities to switch off.

13.4. Implement and monitor local action plans based on staff survey results and time to talk sessions.

13.5. In terms of our 25/26 ‘business case benefits realisation’ metrics, we are on track to deliver:

13.5.1. Retention levels >87% and above the national median (Model Hospital).

13.5.2. Mitigation of the impact of the expected 30% increase in mental health absence and associated reduction in bank and agency spend.

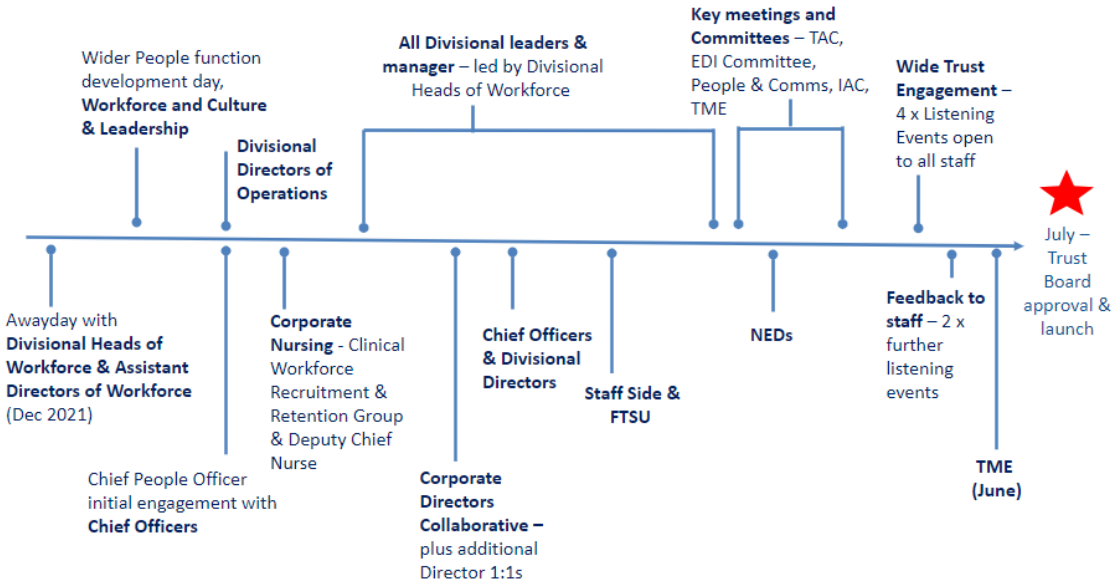
13.5.3. A 15% reduction in legal expenditure.

14. Appendix one: People Plan on a Page

15. Appendix two – stakeholder engagement plan

Oxford University Hospitals NHS Foundation Trust

Developing the People Strategy – key stakeholders involved



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Oxford University Hospitals
NHS Foundation Trust

People Plan

2022-2025

Together we make OUH a great place to work

Contents

We want to make OUH a place you are excited to work in every day!

Professor Meghana Pandit
Chief Executive Officer

Foreword

by Professor Meghana Pandit

As one of the largest teaching trusts in the UK, we are more than 12,000 colleagues providing care through over 1 million patient contacts each year. We have a fantastic reputation for provision of a range of acute and specialist services to patients across Oxfordshire, the South East and beyond that is innovative, evidenced by world-class research, resulting in excellent clinical outcomes and in partnership with the Universities, and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

As a Trust, we have a clear vision: *delivering compassionate excellence for our People, our Patients, and our Populations.*

While our vision and strategic themes are clear, we face many challenges and have many opportunities. Demand continues to grow, placing more pressure on our services and more importantly, on those who deliver them. Our healthcare system is changing rapidly which requires us to work in new ways with our partners and with one another. Above all, we are still feeling the impact of the pandemic and the associated recovery – a task that will be with us well into the future.

Every day I hear and see the great work that takes place at OUH. I know that your commitment, dedication and talents are at the heart of our organisation.

Achieving our vision for the future will only be possible through you, working collaboratively to put the patient at the centre of all we do.

We must respond to the challenges we face by supporting each other, working in new and innovative ways to improve productivity and efficiency. During the pandemic, we learned that our wellbeing is critical to motivation, resilience and our ability to adapt. That is why health and wellbeing is a key priority within our People Plan, along with ensuring that OUH is a great place to work and that we respond to our challenges through more people, working differently.

I know that many of you have contributed to the development of this People Plan and I want to thank you for that contribution. I am truly excited to see what we can achieve together and look forward to sharing the journey with you.

Professor Meghana Pandit
Chief Executive Officer

Introduction

by Terry Roberts

Terry Roberts
Chief People Officer

This OUH People Plan is here for you, our people, to demonstrate our commitment to making your working lives better. We have developed this with you at the centre, focusing on what more we can do, to make OUH a place you are excited to work in every day. By providing you with the opportunity to tell us what you want to see from working at OUH, we were rewarded by some humbling feedback.

Thank you for helping us to strengthen this People Plan so that it means more to you. We know from considering the wider NHS context and what we're being asked to do as well as our discussions with you, that there are some key areas that we need to focus on to improve how it is for you working at OUH.

Our vision:

Together we make OUH
a great place to work
where we all feel we belong.

We will focus on the following three **key themes** to deliver this vision:

THEME 1:
Health, wellbeing and belonging for all our people

Sub-themes:

- A physical and psychological environment that enhances wellbeing.
- Happier working lives – autonomy, flexibility and relationships.
- A culture where everyone feels they belong.

THEME 2:
Making OUH a great place to work

Sub-themes:

- Living our values.
- Great reward and benefits for working at OUH.
- Supporting our leaders, teams and managers to shine.
- Careers our people feel excited by.
- Making continuous improvement a priority.

THEME 3:
More people working differently

Sub-themes:

- Plan how best to use our workforce at OUH and beyond.
- Right skills in place to deliver our services.
- Improved recruitment processes and onboarding.

This document outlines how we are going to meet these commitments with some clear actions. We have included some 'I statements' that came from the listening events – these are things that we expect you to be saying when we have successfully delivered the Plan.

Any improvement initiative should be measured to ensure that it is having the desired impact. We have designed a set of metrics for the Plan to help us monitor our impact and the Trust Board will be keeping a close eye on these.

More importantly, we will be regularly holding more of the listening events that were so popular and valuable during the development of this Plan. We will be able to tell you first-hand about what we are doing to deliver and hear your feedback about how it feels to you.

Lastly, I just want to say that this will only be the very best it can be with everyone pulling together to make it so. We have expressed these as the People Plan's 'commitments' – the things that we need to each do to ensure success. I look forward to this journey over the next three years and seeing just how much of a difference we can make together.

Terry Roberts
Chief People Officer

Without our people, we wouldn't have a service to offer our patients.

A culture where everyone feels they belong

Staff networks are key to our OneTeamOneOUH

Our staff networks enable members of staff to come together to drive positive change within the workplace. They play a fundamental role in helping shape and deliver the equality, diversity, and inclusion agenda at OUH by giving a voice to staff from under-represented groups and providing safe, supportive spaces for our people.

Our staff networks all have key Executive Directors as their sponsors:

- **Black, Asian and Minority Ethnic (BAME) Network**
  SPONSOR: Sam Foster (Chief Nursing Officer)
- **Disability and Accessibility Network**
  SPONSOR: Eileen Walsh (Chief Assurance Officer)
- **LGBT+ Network**
  Jason Dorsett (Chief Finance Officer)
- **Women's Network**
  SPONSOR: Professor Meghana Pandit (Chief Executive Officer)
- **Young Apprentices Network**
  SPONSOR: Sara Randall (Chief Operating Officer)

OUH staff networks provide safe, supportive spaces for our people.









Our Plan on a Page

Our Vision:

Together we make OUH a great place to work where we all feel we belong.

Our **STRATEGIC THEMES** and **SUB-THEMES**

Health, wellbeing and belonging for all our people

SUB-THEMES:

- A physical and psychological environment that enhances wellbeing.
- Happier working lives – autonomy, flexibility and relationships.
- A culture where everyone feels they belong.

Making OUH a great place to work

SUB-THEMES:

- Living our values.
- Great reward and benefits for working at OUH.
- Supporting our leaders, teams and managers to shine.
- Careers our people feel excited by.
- Making continuous improvement a priority.

More people working differently

SUB-THEMES:

- Plan how best to use our workforce at OUH and beyond.
- Right skills in place to deliver our services.
- Improved recruitment processes and onboarding.

OUR ENABLING WORKSTREAMS:

Creating a suitable environment and estates

Digital fundamentals in place

Communications and engagement

Fit for purpose OUH People function – leading improvement, innovation and change

This plan has been informed by:

Trustwide listening events with over 600 of our people

Local discussions with our people across all Divisions

Feedback from our people through the **NHS National Staff Survey**

Discussions with our **managers and leaders**

Collaboration with Staff Side and our **Staff Networks**

Discussions though attendance at **Divisional Team Meetings**

OUH People Plan

Our themes in detail

THEME 1:

Health, wellbeing and belonging for all our people

Our aim is that:

We each take responsibility for the health and wellbeing of ourselves and others and everyone is treated with civility, respect and dignity.

SUB-THEME:	WHAT WE'LL DO:
1. **A physical and psychological environment that enhances wellbeing**	• Identify and implement initiatives to meet basic physical needs in the workplace where these are not met, e.g., in relation to hydration, nutrition and facilities • Implement initiatives to tackle violence and aggression towards staff • Continue to expand our offer to meet psychological needs through wellbeing check-ins, Freedom to Speak Up, Leading with Care, and post-pandemic trauma recovery • Ensure our leaders and managers have the knowledge and resources to support and signpost people to wellbeing support
2. **Happier working lives**	• Enable people to have open conversations and resolve difficulties at an early stage • Introduce initiatives to support working lives with flexibility and autonomy • Implement the NHS Civility & Respect Framework
3. **A culture where everyone feels they belong**	• Targeted initiative to address the discrimination and inequities we know about from our data, e.g., in relation to race and disability • Ensure all teams and leaders have measurable objectives on Equality, Diversity & Inclusion (EDI) • Support equal value and recognition for everyone for their role in patient care, 'no more nons', e.g., non-clinical!

WE'LL KNOW WE'VE ACHIEVED THIS WHEN OUR PEOPLE SAY:

- ✔ I have adequate time and space to rest during my breaks
- ✔ I am able to switch off when not working
- ✔ I take my annual leave at regular intervals
- ✔ I know where and how to access wellbeing support
- ✔ I work flexibly with hybrid options where possible
- ✔ I feel included and that I belong
- ✔ I am assured all will be treated equally in our recruitment processes
- ✔ I see everyone being valued for their role in patient care

THEME 2:

Making OUH a great place to work

Our aim is that:

People choose to work at OUH because we live our values and recognise and reward everyone, enabling them to develop their potential.

SUB-THEME:	WHAT WE'LL DO:
1. **Living our values**	• Be clear about expected standards and the roles everyone needs to play • Embed our values in all our processes, e.g., recruitment • Enable our people to feel safe to speak up when standards fall short
2. **Great reward and benefits for working at OUH**	• Offer a best in class NHS benefits package for our people • Support our people with the practical challenges that they face e.g. Cost of Living • Focus on rewarding and recognising everyone
3. **Supporting our leaders, managers and teams to shine**	• Provide training and ongoing support to our managers for the role they do • Deliver compassionate, collective, inclusive leadership programmes and team development
4. **Careers our people feel excited by**	• Develop everyone's talent through career pathways, career conversations and succession planning • Support diverse careers across all staff groups, including research • Ensure our people have personal development plans (PDPs) that are personalised to them • Support team development opportunities and objective setting that everyone contributes to at all levels
5. **Making continuous improvement a priority**	• Enable our people to contribute to quality improvements within their working area

WE'LL KNOW WE'VE ACHIEVED THIS WHEN OUR PEOPLE SAY:

- ✔ I am proud to work at OUH
- ✔ I had a great new starter experience
- ✔ I feel recognised and fairly rewarded for my contribution
- ✔ I know I have a voice that counts and I feel safe to raise concerns
- ✔ I am always learning and so is the Trust
- ✔ I have a PDP that I'm excited by
- ✔ I am empowered to develop my own career within OUH
- ✔ I am excited about the development opportunities available to me in my career
- ✔ As a leader or manager I feel supported and developed to be the best I can be

THEME 3:

More people working differently

Our aim is that:

We deliver the best for our patients by working in new ways within OUH and beyond so we have the right people and skills, in the right place, at the right time.

SUB-THEME:	WHAT WE'LL DO:
1. **Plan how best to use our workforce at OUH and beyond**	• Provide high quality workforce information that enables decisions to be made about how to resource our services • Develop and support our managers and teams to plan their workforce and to work in the most efficient way • Collaborate with our partners to allow the workforce to be deployed where patients need it most
2. **Right skills in place to deliver our services**	• Make best use of our temporary and permanent workforce across OUH and other trusts • Understand how best to grow and attract the talent we need in all staff groups • Support leaders at all levels to develop and adopt new workforce models and new roles
3. **Improved recruitment processes and onboarding**	• Improve recruitment processes to get people in post as quickly as possible • Deliver the best candidate experience and welcome/ induction to OneTeamOneOUH

WE'LL KNOW WE'VE ACHIEVED THIS WHEN OUR PEOPLE SAY:

- ✔ I know that my team can influence how we deploy our workforce and this improves patient safety and supports staff wellbeing
- ✔ I see the Trust collaborating across the local area and with all partners for the benefit of our people and patients
- ✔ I see new and more effective ways of delivering services being implemented
- ✔ I see better patient care being delivered through a workforce with new roles and different skill mix
- ✔ I know the recruitment process is as quick as it can be to support my vacancies
- ✔ I had a great recruitment experience
- ✔ I have increased opportunities to work in new and different roles

> Stakeholders want a clear statement of who needs to commit to do what to ensure delivery of our People Plan and the shaping of our culture …

Our commitment

to delivering the People Plan

From THE ORGANISATION

LEADING OUH:

- ✔ Develop our people at all levels
- ✔ Create a safe, trusting, transparent and open culture
- ✔ Encourage opportunities to innovate
- ✔ Recognise and celebrate our successes and positive stories
- ✔ Make our processes simple and efficient
- ✔ Prioritise the delivery of the People Plan within budget, whilst seeking opportunities for external investments and efficiencies.

From OUR LEADERS AND MANAGERS

LEADING OTHERS:

- ✔ Define clear purpose, objectives and role clarity with your team
- ✔ Facilitate regular team communication, learning and development
- ✔ Take positive action to ensure colleagues are treated with civility and respect
- ✔ Ensure people have time and opportunity for development
- ✔ Act on data that relates specifically to how you can improve the environment in your team
- ✔ Support choice and flexibility in work

From INDIVIDUALS

LEADING SELF:

- ✔ Invest time in building and maintaining relationships
- ✔ Treat colleagues with civility and respect and challenge uncivil behaviour
- ✔ Demonstrate acceptance of others who are different
- ✔ Be responsible for the impact of your actions and in proactively resolving issues
- ✔ Recognise you do not have to have leadership responsibility to lead
- ✔ Be open to opportunities presented by the organisation for ongoing personal development

Investment for the Plan

Many initiatives within the People Plan are already funded and/or we expect to deliver from existing resource. Where specific initiatives are not yet costed, the development of implementation plans and business cases will follow. We may need to reprioritise our future spending commitments in order to achieve some of the environmental goals of the People Plan. NHS England or Health Education England income may be available non-recurrently via bids to fund one-off implementation costs.

Governance

The delivery of the People Plan be overseen by the People and Communications Committee, which reports to the Trust Management Executive (TME) and, in turn, to the Trust Board. People Plan updates will be provided to the Committee and directly to TME and Trust Board.

Evaluating our impact

Measuring the impact of the People Plan is essential for success.

We had feedback from stakeholders that our measures should stretch us, as well as articulate interim milestones to demonstrate progress.

We will continue to measure our impact on the key workforce performance indicators of vacancy, turnover, sickness absence, core skills training and values-based appraisal rates. We will also measure our performance against the following specific measures:

METRIC:	TARGET YEAR 3:
1. Leavers Rate (Turnover) across AHPs, Medical and Dental (M&D); RNs; and Support to Nurses	Model Hospital Quartile 1 (green)
2. Reduce leavers in the first 12 months from 20% to 10%	10%
3. Meet the NHSE/I target for HCSW vacancies/Vacancy Rate for Support to Nurses	Model Hospital Quartile 1 (green); in top three in Shelford
4. Staff Survey: I have experienced harassment, bullying or abuse at work from other colleagues	Model Hospital Quartile 1 (green)
5. Staff Survey: My organisation takes positive action on health and wellbeing	Model Hospital Quartile 4 (green)
6. WRES2: Recruitment: Relative likelihood of white staff to Black, Asian and Ethnic Minority staff	Move to best in Shelford (0.93) Model Hospital (green)

	METRIC:	TARGET YEAR 3:
7.	**WDES2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts**	Move to best in Shelford (1.07) Model Hospital (green)
8.	**Reduction in recruitment time to hire (TtH)**	42 days Model Hospital (Quartile 1; current best performing Shelford Trust)
9.	**Medical staff cost per weighted activity unit (WAU)**	Model Hospital Quartile 2 (green)
10.	**Professional, Technical and Therapies staff cost per weighted activity unit (WAU)**	Model Hospital Quartile 2 (green)
11.	**Staff Survey: Relationships at work are strained**	Model Hospital Quartile 1 (green)
12.	**Staff Survey: Recommend my organisation as a great place to work**	Model Hospital Quartile 4 (green); move to the top in Shelford
13.	**Staff Survey: I feel safe to speak up about anything that concerns me in this organisation**	Model Hospital Quartile 4 (green); move to the top in Shelford
14.	**All staff booking 80% of leave by October each year**	100%

Get involved

More information

If you'd like to know more about our People Plan please get in touch via the following channels:

peopleplan@ouh.nhs.uk

www.ouh.nhs.uk

@OUHospitals #One**Team**One**OUH**

@OUHospitals

We want to make OUH a place you are excited to work in every day.


THEME 1:
Health, wellbeing and Belonging for all our people
THEME 2:
Making OUH a great place to work
THEME 3:
More people working differently

OUH People Plan

2022-2025

Published by Oxford University Hospitals NHS Foundation Trust, November 2022

www.ouh.nhs.uk

Oxford University Hospitals
NHS Foundation Trust

DEVELOPING A PEOPLE STRATEGY: THE STORY SO FAR

Oxford University Hospitals
NHS Foundation Trust

People Strategy OUH – initial plan on a page

Our overarching strategic people priorities – aligned to the NHS People Plan

1. Looking after our people
2. Belonging at OUH
3. New ways of working and delivering care
4. Growing for the future

Our strategy workstreams

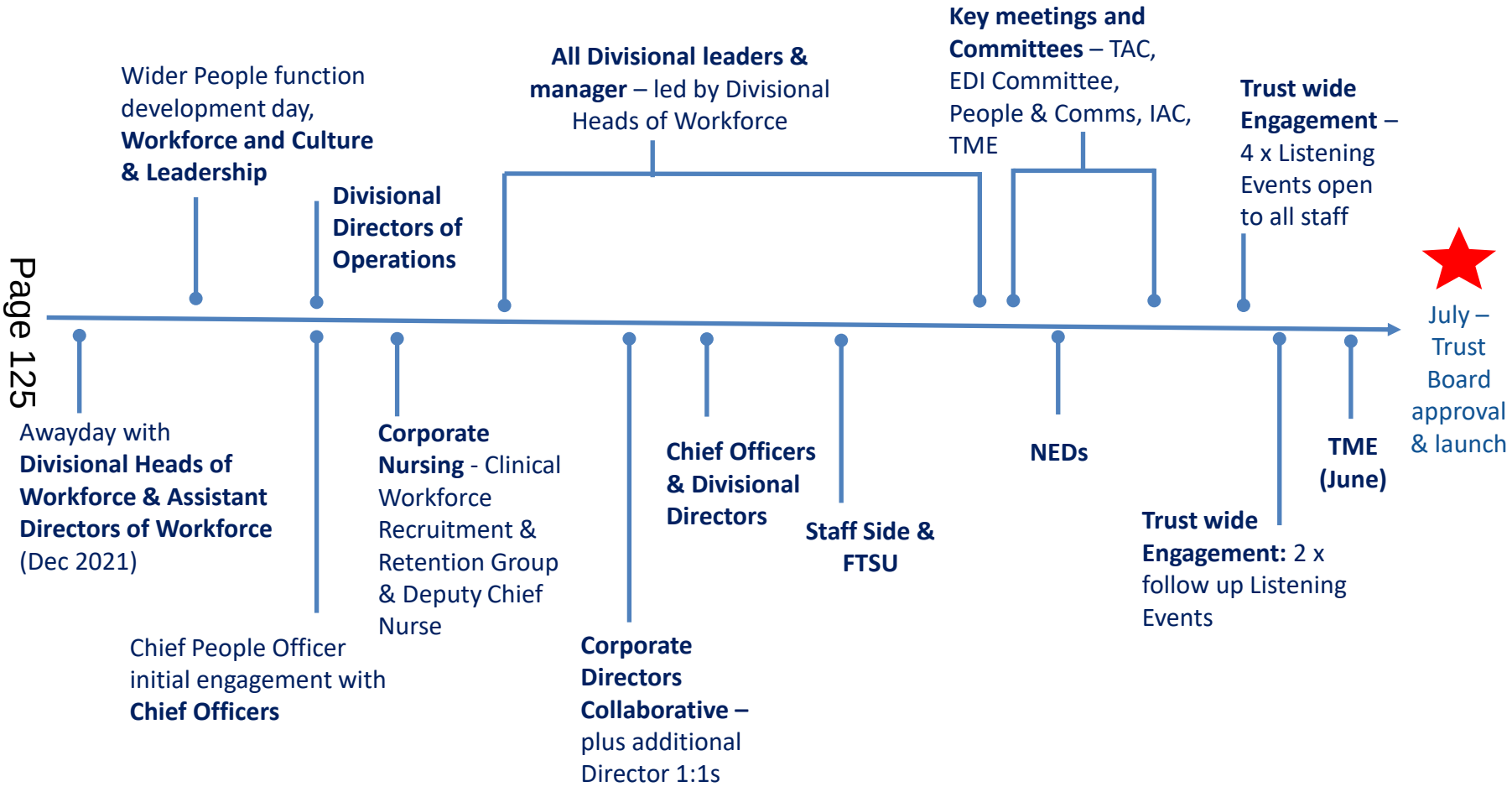
- Prioritising the health & wellbeing of all our people
- Ensuring inclusion and belonging for all
- Enabling new ways of working and planning for the future
- Harnessing the talents of all our people
- Creating a great employee experience

Our enabling workstreams

- Fit for purpose people function – leading improvement, innovation and change
- Digital people solutions
- Collaborating across the system
- Communications & Engagement

Oxford University Hospitals NHS Foundation Trust

Developing the People Strategy – key stakeholders



Oxford University Hospitals
NHS Foundation Trust

WHAT WE HEARD FROM OUR PEOPLE

Oxford University Hospitals
NHS Foundation Trust

SUMMARY OF PEOPLE PLAN GAPS FROM LISTENING EVENTS (1)

Theme	Sub-theme
1. Environment / estates	(a) Prioritise the basics – pleasant changing facilities and working toilets, water, hot food etc as per NHS Employers graphic
	(b) Space to relax and recharge during breaks
	(c) Access to the resources to do a good job
2. Well-being	(a) Everyone has basic human needs met – sufficient rest, nutrition – As above, reference NHS Employer graphic
	(b) A work environment that enhances well-being (e.g. no-smoking policy enforced, MSK support / desk set-up, proactive OH support)
3. Process improvement / automation	(a) Streamline processes (and involve staff in doing so)
	(b) Digitise where possible
	(c) Clear communication of sign-off processes / what's required
4. IT	(a) Modernised IT equipment to promote productive working
	(b) IT resources to provide more support in resolving issues

Oxford University Hospitals
NHS Foundation Trust

SUMMARY OF PEOPLE PLAN GAPS FROM LISTENING EVENTS (2)

Theme	Sub-theme
7. Safe staffing	(a) Sufficient time to complete (mandatory) training
	(b) Feel safe to speak out about any concerns
8. EDI / inclusion	(a) Less divide between staff on different pay grades. Job roles, not bands. No more 'non-clinical'
9. Collaboration / teamwork	(b) Breaking down team boundaries to truly embrace OneTeamOneOUH (focused around patient pathway)
	(c) Equal value and recognition for role in patient care whether clinical or 'non-clinical' (and find a different term to non-clinical!)
	(d) Awareness of the front line no matter your role
	(e) Department goals / strategy developed with opportunity to contribute from all and understand where they fit in
11. Retention	(a) Provide more job security
	(b) Creating an employee experience that matches expectation
12. Ways of working	(a) Getting the basics right as a springboard to more innovative practices

Oxford University Hospitals
NHS Foundation Trust

Updates to content

1. **Fewer overall themes** with **clearer sub-themes**
2. Greater **emphasis on enablers like IT and Estates**
3. Proposed **'I statements'** from our staff
4. **Refined actions** to show what we'll do
5. An **overarching vision** for our people
6. Development of an **overarching 'contract'** to set out the contributions and responsibilities needed from:
   a. The organisation
   b. Line manager
   c. Individuals

Oxford University Hospitals
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REVISED THEMES AND SUB-THEMES

Oxford University Hospitals
NHS Foundation Trust

People Plan Amendments

Overarching Vision– Highlighting why our people should stay in the NHS and how we will help the acclimatise to the new normal

Our strategy workstreams

Prioritising the health & wellbeing of all our people

Enduring inclusion and belonging for all

Enabling new ways of working and planning for the future

Health, Wellbeing & Belonging for all our people

More People & Working Differently

Harnessing the talents of all our people

Creating a great employee experience

Making OUH a great place to work

Our enabling workstreams

Change to Creating a suitable environment and Estates

Fit for Purpose IT and Digital solutions

Communications & Engagement

Fit for purpose OUH people function – leading improvement, innovation and change

Oxford University Hospitals
NHS Foundation Trust

Amended People Plan overview – themes and sub-themes

Health, Wellbeing & Belonging for all our people	Create a working environment that enhances well-being
	Recover from the effects of the pandemic
	Happier working lives (flexibility, autonomy, culture)
	Everyone understands what Equality Diversity and Inclusion (EDI) is and the role they play
	Recognise how everyone contributes to the care of our people & patients
Making OUH a great place to work	Living out our values
	Great reward and benefits for working at OUH
	Support to allow our leaders, managers and teams to shine
	Careers our people feel excited by
	Everyone enabled to support quality improvement
More People, Working Differently	Plan how best to use our workforce at OUH and beyond / across the System
	Right skills in place to deliver our services
	Improved recruitment processes

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Oxfordshire Place-Based Partnership Item

Lead Cabinet Member(s) or Responsible Person:

- Daniel Leveson – BOB ICB Oxfordshire Place Director.

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Thursday 29th February 2024

Response to report:

I welcomed the opportunity to discuss the development of Oxfordshire's Place-based Partnership (PBP) and the associated report. I am also grateful to the Health Overview and Scrutiny Committee for their engagement and support in our work to improve outcomes and experiences for people with health and social care needs.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. For the Place-Based Partnership to operate in a manner that avoids duplication of other bodies or their associated activities; including the Health and Wellbeing Board.	Accepted	Continue to oversee and assure partners of the work underway for priority populations. To receive updates and take partnership actions required from existing parts of the system including SEND Improvement Board, Mental Health Transformation Programme Board, Urgent and Emergency Care Board and Prevention and Health Inequalities Forum.
2. For the Place-Based Partnership to consider collective work around finding avenues to improve oral health throughout the county, particularly for vulnerable groups or disadvantaged communities.	Partially accepted	Work to reduce health inequalities is part of the priorities for the place-based partnership and jointly overseen by Public Health and Place Director at the Prevention and Health Inequalities Forum. We will support work identified to improve oral health for vulnerable groups through this forum. Dentistry is a BOB ICB function (as opposed to Place) and as such does not form part of our collective responsibility. This forms part of the HOSC scrutiny of dentistry that is undertaken separately to PBP.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

3. To develop robust processes through which to monitor the effectiveness of the Place-Based Partnership, including its collaboration as well as the outcomes of its work. It is recommended that there is clear transparency around this.	Accepted	We will continue to measure and monitor the PBP and system working maturity using annual self-assessment. The Health and Wellbeing Strategy Outcomes Framework will also enable us to focus on our collective actions to improve population outcomes. We have an emphasis on evaluation of value i.e. assessing outcomes for the resources we use / investments we make.
4. To develop robust principles and processes around transparency of decision-making within the Partnership, so as to mitigate the loss of place-based statutory board CCGs which were open to the public.	Accepted	Decision-making when agreeing allocations of future resources will continue to be made in a transparent way. This is generally done either via Joint Commissioning Executive (for services included as part of the Section 75 Agreement between Oxfordshire County Council and ICB) and for things like Better Care Fund seeking approval via Health and Wellbeing Board or other statutory Boards. We are committed to ongoing engagement, involvement and co-design of new models of care that are fit to meet the future needs of Oxfordshire's population.

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Oxfordshire Healthy Weight Scrutiny Item

Lead Cabinet Member(s) or Responsible Person:
Cabinet Member for Public Health, Inequalities, and Community Safety (Cllr Nathan Ley)

For a response to be provided to all the recommendations outlined below (Excluding recommendation 6 which is aimed at the BOB Integrated Care Board)

Deadline for initial response: Tuesday 14th November 2022

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

NOTE from public health re frequency of catchup. Most of the changes required for excess weight are require actions over a long ter. ie unlikely to change/progress at the bi-monthly frequency of HOSC meeting.

Recommendation	**Accepted, rejected or partially accepted**	**Proposed action (if different to that recommended) and indicative timescale (unless rejected)**	**Update April 2023**
1. To ensure adequate and consistent support as part of secondary prevention for those living with excess weight; and to improve access to, as well as awareness of, support services that are available for residents living with excess weight.	Accepted	We currently commission two healthy weight services at Local Authority level, one that works with adults and another working with children. We also link closely with partners (NHS) who offer services at tiers above and below our own with a view to offering a seamless pathway. We identified some gaps in service as part of the recent Health Needs Assessment (HNA) on Healthy Weight. The current contract is coming to an end and we are planning to commission an 'all age service' with some additional elements to meet the gaps identified in the HNA. We are also planning a review and refresh of	We are in the process of recommissioning an all age service (and will know the outcome soon). The service will commence in September 2023.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		opportunities to raise awareness of support that is available.	
2. To ensure effective support for ethnic groups that are more likely to develop excess weight, and to raise awareness amongst these groups of the support available to them.	Accepted	The current healthy weight service has specific programmes for ethnic groups who are more likely to develop excess weight. This includes innovation pilots working in mosques, women only sessions, and tailoring content to be specific (e.g. on food types) The new service will build on this learning/modelling and is likely to have community development as a delivery component within key priority areas and populations, including ethnically diverse.	This detail remains the same. We can provide specific numbers and details of groups if HOSC require.
3. To work on providing support to the parents, carers, or families of those living with excess weight, and to help provide them with the tools to help manage children's weight.	Partially Accepted (word children added)	To work on providing support to the parents, carers, or families of children living with excess weight, and to help provide them with the tools to help manage children's weight.	Current level 2 services (as commissioned by public health) have bespoke services for children

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

4. To explore avenues of support for residents who may struggle to afford healthy diets in the context of the cost-of-living crisis.	Comment	This should be an action/link for Food Strategy work across Oxfordshire, which is led by Laura, Rushen, Senior Policy Officer at OCC– each District Council has been commissioned to undertake work for their District. LR comments: As part of implementing the Oxfordshire Food Strategy, each district/city area has develop a Food Strategy Action Plan which includes specific actions that will seek to address how healthy diets can be promoted and support that can be offered as part of the cost-of-living crisis. A co-ordinated approach to support all residents affected by the cost of living crisis has been undertaken. A Residents Support Scheme was launched in June 2023 which can support residents with the cost of food when experiencing a financial emergency*	Action plans have been developed and adopted by the following councils: Cherwell – 4 March Oxford – 13 March West Oxfordshire – 9 March South Oxfordshire and Vale of White Horses' action plans are being finalised. Following an extension of the Household Support Fund, County Council leads are engaged with Good Food Oxford to identify sustainable projects to support residents on low incomes to access affordable, healthy food.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

5. To ensure that consideration of the ill-effects of being underweight is also built into the language adopted, and the services being commissioned, as part of promoting Healthy Weight overall within the County.	Reject	This didn't inform part of the discussion at the meeting which was focussing on excess weight. Whilst this is a very important issue we need to remain focussed on tackling excess weight. There are significant differences between the causes, behaviours and actions that can be taken associated with underweight as opposed excess weight and none of the preventative, environmental actions or services commissioned for excess weight link to underweight. To set context while over 30% of children in year 6 and 60% of adults in Oxfordshire are living with excess weight around 1% of children experience underweight.	
6. In light of recent findings relating to the risks of excess weight medication (GLP-1 receptor agonists), it is recommended that the BOB Integrated Care Board review the availability of these medications and any associated risks; and to update the Committee on this (tier 3)		ICB response	Update to be provided by ICB

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

7. To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils, as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and advertising of HFSS products.	Partially Accepted	To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils and lead officer responsible for advertising/sponsorship policy as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and advertising of HFSS products.	We believe this meeting was being co-ordinated by HOSC. We have met several times with planning leads and provided detailed backing information to support each DC to put in place a policy to restrict Hot Food Takeaways.

Work Programme 2023/24
Joint Health Overview and Scrutiny Committee

Cllr J Hanna OBE Chair | Dr Omid Nouri Omid.Nouri@Oxfordshire.gov.uk

COMMITTEE BUSINESS

Topic	Relevant strategic priorities	Purpose	Notes / Context	Lead witnesses
18 APRIL 2024				
GP Provision in Oxfordshire	Prioritise the Health and Wellbeing of Residents	To receive a report on GP Provision within Oxfordshire	Overview and Scrutiny	Julie Dandridge Dan Leveson
Oxford University Hospitals NHSFT People's Plan 2022-2025	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To receive a report on the Oxford University Hospital NHSFT People's Plan, with details on the support mechanisms in place for the Provider's staff, (including staff recruitment, retention, and wellbeing).	Overview and Scrutiny	
Dentistry Provision in Oxfordshire	Tackle Inequalities in Oxfordshire	To receive a report from NHS England/BOB ICB with a second/additional update on the state of	Overview and Scrutiny	Hugh O keefe Julie Dandridge Dan Leveson

	Prioritise the Health and Wellbeing of Residents	dentistry provision within Oxfordshire, particularly in light of the recent delegation of dentistry commissioning responsibilities from NHS England to the ICBs.		
6 JUNE 2024				
Oxford University Hospitals Quality Account	Prioritise the Health and Wellbeing of Residents	To receive the most recent annual Quality Account report produced by Oxford University Hospitals, and to provide feedback as appropriate on services delivered by OUH.	Overview and Scrutiny	
All-Age Mental Health	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To receive a report from Countywide System Partners on All-Age Mental Health, and on the nature and effectiveness of All-Age Mental Health Services.	Overview and Scrutiny	
Palliative Care	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	As per a recommendation from the Committee's June 2023 meeting, the Committee would like to receive a report from	Overview and Scrutiny	

		Countywide System Partners with a further update on Palliative Care Services.		
Epilepsy Services	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an outline on the nature of Epilepsy Services delivered throughout the County.	Overview and Scrutiny	
12 SEPTEMBER 2024				
Oxfordshire Healthy Weight	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on Oxfordshire Healthy Weight 12 months since this item previously came to HOSC.	Overview and Scrutiny	Ansaf Azhar David Munday Derys Pragnell
Health and Wellbeing Strategy Delivery Plan	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an outline as to a delivery plan for the updated Health and Wellbeing Strategy for Oxfordshire.	Overview and Scrutiny	
Oxford Health NHS Foundation Trust People Plan	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report from OHFT on the Trust's People Plan, with a view to examine the Trust's support for workforce.	Overview and Scrutiny	
Winter Planning	Tackle Inequalities in Oxfordshire	To receive a report on the systemwide preparations and plans	Overview and Scrutiny	

	Prioritise the Health and Wellbeing of Residents.	to manage the pressures of the ensuing winter months.		

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 21 September 2023.

	Item	Action/Recommendation	Lead	Progress update
1	Minutes of 23 September 2022	Health partners to be invited to the next OCC scrutiny training	Tom Hudson / Omid Nouri	To be actioned in the new municipal year for 23/24. In progress *Update – OCC scrutiny are working up a training proposal with CfGS.*
	24 November 2022 Meeting			
2	Primary Care	Recommendation: Specified roles are filled within the ICB with the primary responsibility to work with District Councils at Place Level to coordinate use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care.	Julie Dandridge/ Daniel Leveson	Progress/update response: The ICB have managed to recruit a Primary Care estates manager who will have a key role in working with Districts in terms of planning for new housing developments. The successful candidate starts in December 2023. Unfortunately, recruitment was delayed due to lack of suitable candidates.

	Item	Action/Recommendation	Lead	Progress update
3	Cllr Barrow's infection control report	OCC carries out a regular review of current infection control procedures in care homes and the support provided.	Karen Fuller, OCC	This is built into our routine procedures in relation to infection control and monitoring outbreaks. OCC works in partnership with Oxford Health care home support service, CQC and UKHSA. *UPDATE – Subsequent Care Home Visits to be arranged in conjunction with the Director for Adult Social Care.*
	10 March 2022 **Meeting**			
4	Access and Waiting Times	Information is supplied on the new elective care access offer across the BOB footprint (the provider collaborative)	Omid Nouri/Titus Burwell	BOB ICS Elective Recovery plan & provider collaborative would need to be presented by BOB ICS colleagues - In progress *Update – A scope is being drawn up for Titus Burwell, Chair of BOB Elective Recovery Backlog Group, to brief the Covid-19 Elective Recovery Backlog group on the subject with a particular focus on Symptomatic breast cancer 2WW and in respect of Urological Cancer referrals.*

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 21 September 2023.

	Item	Action/Recommendation	Lead	Progress update
5	Access and Waiting Times	That Members meet separately with James Scott to explore workforce challenges across Oxfordshire/the NHS	BOB HOSC, BOB ICS	*Eddie and OCC BOB HOSC Members to ask for the item to be placed on the BOB HOSC Work Programme.* In progress *Update – To be considered as part of future discussions amongst the BOB HOSC*
6	Chairs Update	That Members of the Committee come forward in which to develop a glossary of NHS acronyms.	Omid Nouri/ Cllr Nigel Champken-Woods	*Cllr Champken – Woods came forward at the last meeting to start an early draft. It was identified that Wokingham's HOSC glossary as a good model to follow.* In progress *This is currently being collated with Cllr Champken-Woods and will be appended at the back of HOSC agendas once finished.*
	14 July Meeting 2022			
7	Integrated Improvement Programme	Establish a sub group on the Integrated Improvement Programme to provide NHS / OCC colleagues the opportunity to engage with HOSC outside of formal Committee meetings (as well as in addition to). It should cover all aspects of comms and engagement and any issues relating to services at Wantage.	Cllrs Hanna, Edosomwan, Barrow and Barbara Shaw Omid Nouri	In progress – *UPDATE- The Integrated Improvement Programme met as a Member-only forum on 20 September 2022 and agreed to meet with a ICB representative in respect of the ICB's involvement in the IIP. The Group also agreed that a group would engage with representatives at OH in respect of the maternity closures and maternity closures across Oxfordshire.* *Terms of Reference for the Group will be drawn up for engagement in respect of the consultation and delivery plan relating to the IIP.*

Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 21 September 2023.

	Item	Action/Recommendation	Lead	Progress update
	22 September 2022 Meeting			
8	Action and Recommendation Tracker	NHS England Health and Justice to fill out the Committee's substantial change toolkit in relation to the SARC in Bicester; this is to then be reviewed by Members via email, with a view to meeting the Commissioner in person.	Lisa Briggs	In Progress - The Substantial Change Toolkit form has been received and was considered by Cllrs Champken-Woods, Hanna and Heywood. It was considered that there was no substantial change. However further information in respect of the service has been requested and waiting a response.
	24 November 2022 Meeting			
9	**Primary Care**	The Committee is informed as to how much Community Infrastructure Levy funding has been received by the Oxfordshire CCG and subsequently the BOB ICB (from Oxfordshire), the amounts received from the 5 individual District Councils, how much of those CIL funds have been spent, which health related CIL funded projects have been commissioned; and what projects have been completed or are in progress using executed Section 106 funds.	Julie Dandridge	In progress – The ICB has been reminded of these questions and will feedback to the Committee outside the formal Committee process. *UPDATE – Julie Dandridge to provide an update on a list in respect of where the funds currently sat, time restrictions and other obligations.*
10	**Serious Adult Mental Health**	A workshop on serious adult mental health is co-produced to allow further Committee exploration of the area.	Omid Nouri, OH, Karen Stephen Chandler	In progress – To be scoped after the 9th of February 2023 HOSC Meeting.
	9 February 2023 Meeting			
11	**SCAS Improvement Programme Update**	SCAS' performance data be regularly reviewed by the Committee's Covid-19 Elective Recovery Sub-Group.	Omid Nouri/ Tom Stevenson	In progress- The Committee is to be advised when the wait-time performance data can be broken

	Item	Action/Recommendation	Lead	Progress update
				down into (Middle Layer Super Output Areas) MSOA level. Likely to be Autumn 2023
12	**Committee Work Programming**	A Work Programming Meeting be arranged with all Committee Members	Omid Nouri/ Tom Hudson	In progress – a partial work plan has been suggested, but in light of the appointment of a new Scrutiny Officer the completion of the new work plan is to take place once they are in post and are better placed to help the committee deliver it.
	11 May 2023 Meeting			
13	**Dentistry Provision in Oxfordshire**	To collaborate with the Place Based Partnership, Public Health, and providers with a view to creating a base line dentistry data set that will mean local improvements to poor dental health of residents can be achieved and clearly communicated.	Hugh O' Keefe NHSE/Daniel Leveson BOB ICB	Response: The Oxfordshire Joint Strategic Needs Assessment (2023) contains information about the oral health of 5 year olds in the county. This information is derived from national epidemiological surveys. The ICB will work with Public Health colleagues to review and update this information. The ICB is developing a Primary Care strategy including dental services. This will include a review current data and the development of datasets to inform future commissioning plans. There is a strong link between socio-economic factors and health. The aim is to develop a strategy outlining how primary care via service delivery and partnership working with other agencies will improve the health of the

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				population with oral health to be a key element of the strategy.
14	**Dentistry Provision in Oxfordshire**	To resolve any remaining uncertainty regarding the local flexibilities available to the ICB, and to consider investment of the underspend in Oxfordshire in targeted action to improve access to health and better serve Oxfordshire's children and residents with the greatest need.	Hugh O' Keefe NHSE/Daniel Leveson BOB ICB	Response: The BOB ICB Flexible Commissioning pilot commenced on 1st June 2023. The pilot scheme will run to 31st March 2024 and is designed to support access to NHS dental care for patients who have struggled to access NHS dental care. The scheme supports access for patients who have not attended a local dental practice for 2 years; who have relocated to the area; Looked After Children, families of armed forces personnel, asylum seekers and Refugees. Practices can also see 'other' patients of they believe it to be clinically appropriate. It allows practices to convert up to 10% of their contractual capacity from the delivery of activity targets to access sessions, where more time can be set aside for patients likely to have higher treatment needs. 30 practices in BOB are taking part in the scheme (18 from Oxfordshire) with plans to provide nearly 3,000 Flexible Commissioning access sessions in the period July 2023 to March 2024. In the first 4 months about 900 sessions were provided with 3,000 patients attending (3,500 attendances). About 70% of patients attending to date have not attended a dental practice for 2 years; 14% have relocated to the area; 12% 'other' (includes patients who have

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				been unable to access care, urgent patients, maternity, patients with an on-going clinical need that requires dental intervention, vulnerable patients, children's emergency trauma and cancer patients needing dental treatment as part of their care). 4% of attendances have been from Looked After Children, families of armed forces personnel and asylum seekers and refugees. The service is subject to on-going review and development. National guidance in respect of Flexible Commissioning was issued in October 2023. Whilst access to NHS dental services is continuing to improve, some capacity has been lost following decisions by some practices to leave the NHS or reduce their NHS commitment. The ICB is working with local practices on a re-commissioning plan to replace this capacity from 2023-24 onwards.
	21 September 2023 Meeting			
15	**Oxfordshire Healthy Weight**	Recommendation: To ensure adequate and consistent support as part of secondary prevention for those living with excess weight; and to improve access to, as well as awareness of, support services that are available for residents living with excess weight.	Derys Pragnell	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024):

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				We currently commission two healthy weight services at Local Authority level, one that works with adults and another working with children. We also link closely with partners (NHS) who offer services at tiers above and below our own with a view to offering a seamless pathway. We identified some gaps in service as part of the recent Health Needs Assessment (HNA) on Healthy Weight. The current contract is coming to an end and we are planning to commission an 'all age service' with some additional elements to meet the gaps identified in the HNA. We are also planning a review and refresh of opportunities to raise awareness of support that is available.
16	**Oxfordshire Healthy Weight**	Recommendation: To ensure effective support for ethnic groups that are more likely to develop excess weight, and to raise awareness amongst these groups of the support available to them.	Derys Pragnell	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024): The current healthy weight service has specific programmes for ethnic groups who are more likely to develop excess weight. This includes innovation pilots working in mosques, women only sessions, and tailoring content to be specific (e.g. on food types) The new service will build on this learning/modelling and is likely to have community development as a delivery component within key priority areas and populations, including ethnically diverse.

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17	**Oxfordshire Healthy Weight**	Recommendation: To work on providing support to the parents, carers, or families of children living with excess weight, and to help provide them with the tools to help manage children's weight.	Derys Pragnell	Recommendation Accepted, HOSC will receive future progress update in April 2024.
18	**Oxfordshire Healthy Weight**	Recommendation: To explore avenues of support for residents who may struggle to afford healthy diets in the context of the cost-of-living crisis.	Derys Pragnell	Comment on Recommendation: This should be an action/link for Food Strategy work across Oxfordshire, which is led by Laura, Rushen, Senior Policy Officer at OCC– each District Council has been commissioned to undertake work for their District.
19	**Oxfordshire Healthy Weight**	Recommendation: To ensure that consideration of the ill-effects of being underweight is also built into the language adopted, and the services being commissioned, as part of promoting Healthy Weight overall within the County.	Derys Pragnell	Response and Rejection of Recommendation: This wasn't part of the discussion at the meeting which was focussing on excess weight. Whilst this is a very important issue we need to remain focussed on tackling excess weight. There are significant differences between the causes, behaviours and actions that can be taken associated with underweight as opposed excess weight and none of the preventative, environmental actions or services commissioned have synergy. To set context while over 30% of children in year 6 and 60% of adults in Oxfordshire are living with excess weight around 1% of children experience underweight.

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20	**Oxfordshire Healthy Weight**	Recommendation: In light of recent findings relating to the risks of excess weight medication (GLP-1 receptor agonists), it is recommended that the BOB Integrated Care Board review the availability of these medications and any associated risks; and to update the Committee on this.		A separate response to this recommendation will be sought from BOB ICB.
21	**Oxfordshire Healthy Weight**	Recommendation: To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils and lead officer responsible for advertising/sponsorship policy as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and the advertising of HFSS products.	Derys Pragnell/ Omid Nouri	Health Scrutiny Officer (Omid Nouri) to liaise with relevant officers to facilitate this meeting in the near future.
22	**Health and Wellbeing Strategy**	Recommendation: To ensure careful, effective, and coordinated efforts amongst system partners to develop an explicit criteria for monitoring the deliverability of the strategy; and to explore the prospect of enabling input/feedback from disadvantaged groups as part of this process.	David Munday	Recommendation Accepted: Initial Response (additional progress update response to be provided in April 2024): The Health and Wellbeing board has committed to the development of a delivery plan and outcomes framework for this new HWB strategy. This is to ensure the strategy is delivered by the partnership. We expect that an initial version of this will be presented to the HWB in March 24 and it will build on the strong public engagement that has already occurred in the strategy formation to date.

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Page 157	**Local Area Partnership SEND**	Recommendation: For Leadership over the Partnership and of Children and Young People's SEND provision to be explicitly set out and communicated clearly to families and all stakeholders; as well as clear measures of how leadership will be developed and demonstrated at all levels, and to demonstrate how new ways of working with stakeholders will put families at the heart of transformation.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Partnership leadership, assurance, and oversight of SEND provision is by the Oxfordshire SEND Improvement Board (SIB). The Board provides transparent visibility of progress, constructive and robust challenge, as well as celebrating what is working well and improving. The progress of improvements will be routinely scrutinsed by appropriate scrutiny arrangements (People Scrutiny, HOSC and ICB Quality Group). Operational delivery of the Priority Action Plan (PAP) is via the Partnership Delivery Group (PDG), supported by time-limited Task and Finish groups. SIB, PDG, and Task and Finish groups all include Parent/ Carer representation. Continued improved communication with families and stakeholders is a key focus of our SEND action planning. It underpins our governance arrangements, is a key priority within the PAP, and is a focus area of our Working Together Task and Finish group.
	Local Area Partnership SEND	Recommendation: To ensure good transparency around any action planning and the improvement journey for SEND provision for Children and Young People, and to	Stephen Chandler/Anne	Initial Response (additional progress update response to be provided in April 2024):

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		develop explicit Key Performance Indicators for measuring the effectiveness of improvements that are open to scrutiny. The Committee also recommends for more comprehensive action planning after the publication of the initial action plan requested by Ofsted, and for this action planning to be made fully transparent. The SIB will consider at its inaugural meeting how best to ensure information easily and publicly available.	Coyle/Rachel Corser	The Priority Action Plan includes development of an Integrated Local Area Partnership SEND dashboard, based on partnership KPIs, with performance overseen by the SIB. As above, ongoing PAP action planning is operationally overseen by PDG and Task and Finish Groups. PDG reports monthly to the SIB.
	Local Area Partnership SEND	Recommendation: For the Leadership to adopt restorative thinking and practices with utmost urgency to reassure affected families, and for this thinking to be placed at the heart of any co-production exercises to help families feel their voices are being heard as well as for the purposes of transparency.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Restorative Approaches are well-established within Children's Services. Co-production with children and families is at the heart of PAP and wider action planning. As noted, they are represented within all leadership & delivery bodies for SEND improvement.
	Local Area Partnership SEND	Recommendation: To ensure adequate and timely co-production of action planning to improve SEND provision, and for the voices of Children and their families to be considered in tackling the systemic failings highlighted in the report. The Committee also recommends that the Partnership considers timely allocation of seed funding for the development of co-production involving people with lived experience; and for joint commissioning	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): SIB responsibilities include ensuring that co-production is embedded in the culture of SEND services. Our Multi Agency Quality Assurance (MAQA) forum has the purpose of setting out consistent, service specific processes for the quality assurance of Education, Health, and Care

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		of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector, and families.		Plans, ensuring that good practice and learning is shared, informs training and professional development for all professionals involved in the process, underpinning our vision for shared responsibility for improving outcomes, on the improvements achieved and next steps. Partnership training, and impact measures, are included in the PAP. All PAP actions are time-specified, ranging from December 2023 to post-July 2025, dependent on prioritisation and practicability.
	Local Area Partnership SEND	Recommendation: To continue to improve working collaboration amongst the Local Area Partnership to integrate support mechanisms and services as effectively as possible, and for rapid improvements to be demonstrated on clear and efficient information and patient-data sharing on children with SEND.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): There are existing arrangements to enable the sharing of information across partners. The effectiveness of these will be considered as part of the improvement journey.
	Local Area Partnership SEND	Recommendation: For every effort to be made for children and young people with SEND to receive the support that is specifically tailored toward and appropriate to their own needs and experiences; and for those involved in providing support services to be aware of the additional/ alternative services available which a child may also need a referral to. It is also recommended that improvements in one-to-one communications with families should be prioritised by Oxfordshire County Council,	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Priority actions within the PAP include co-production of both refreshed Local Offer and development of local area partnership early help and early intervention strategy. Together with improved EHCP assessment process, and Team Around the Family, this will enable the delivery of needs-led provision and the progression of

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		using the budget agreed by cabinet immediately following the Ofsted report.		outcome led plans with families. As noted above (Paragraph 8), continued improved communication with stakeholders and families is a key priority.
Page 160	**Local Area Partnership SEND**	Recommendation: To consider the use of digital resources for enablement, including at an individual level; and to ensure EHCPs are up to date and that they constitute living documents for families.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Timeliness and quality of EHPCs, along with improved parental access to the digital portal, are addressed within PAP item 3. Actions include ensuring accurate, timely, and effective assessment, and effectively meeting needs, particularly at points of transition. Assessment timeliness is improving, despite increasing demand. Timeliness of completion within 20 weeks has improved from 40% in June 2023 to 50% in the last month.
	Local Area Partnership SEND	Recommendation: For SEND commissioning to be developed using the Ofsted report as a baseline, and to place person-centred mental and physical health of children and their families with SEND at the centre of decisions on how funding is spent to maximise social value. The Committee also recommends for the Local Area Partnership to map all funding sources available for, and to explore joint commissioning of services and training that could improve the overall health and wellbeing for children with SEND.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): PAP priority actions include a focus on improved commissioning and strong relationships with commissioned providers, to improve capacity, meet demand, and meet the needs of children, young people, and their families. The PAP is also focused on ensuring commissioning arrangements support timely decision making and transition arrangements, and that there is a multi-agency approach to meeting the

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				needs of children with emotional and mental health difficulties. The Leadership and Partnership Task and Finish group has responsibility for integrated commissioning of SEND services. The Oxfordshire Joint Commissioning Executive, which plays a key role in the delivery of many Priority Action Plan actions, reports into the Partnership Delivery Group.
	Local Area Partnership SEND	Recommendation: To ensure that there is clarity of information on any physical or mental health services for children with SEND, to reduce the risk of confusion and lack of awareness of such services amongst parents, carers or families of children who require support for their mental or physical health.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): A local area pathway is being developed for children and young people with emotional wellbeing and mental health concerns. The i-THRIVE framework (an integrated, person-centred, and needs-led approach to delivering mental health services for children, young people, and their parents/carers) will be linked to the Early Help Strategy and Team Around the Family.
	Local Area Partnership SEND	Recommendation: To exercise learning from how other Counties and Systems have provided well-coordinated and effective SEND provision; particularly where measures have been adopted to specifically reduce the tendency for poor mental or physical health amongst affected Children and Young People.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): Our response to the SEND inspection, including development of PAP and KPI dashboard, has been informed by learning from other local authorities. Children's Services senior leadership bring a wealth

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				of experience in delivering transformation and service improvement within other local authorities. This includes both the recently appointed independent chair of the SIB, Steve Crocker (Former President of Association of Director of Children's Services) and new SEND/ Children's Services Improvement. We have invested in an additional Assistant Director for Early Help & Prevention, and Strategic Lead for Specialist Projects. Deputy Directors for Children's Social Care/ Education are likewise experienced.
	Local Area Partnership SEND	Recommendation: To ensure that staff involved in Health, Care, Education, and any relevant Voluntary Sector organisations are sufficiently trained and aware of children that may be neuro-divergent, have a learning difficulty or a disability (SEND); and for such staff to be adequately aware of the support and resources available, and the processes for referring such children for any relevant mental or physical health services that they might require.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): As noted above, partnership training is embedded within the PAP. The Working Together Task & Finish group leads on Workforce Development.
	Local Area Partnership	Recommendation: For HOSC to continue to follow this item and to evaluate the impact of any changes or improvements made, with specific insights into the following; the Partnership's Action Plan as requested by HMCI; the overall measures taken to address the concerns raised by the Ofsted/CQC inspection; the progress made by CAMHS in reducing waiting times for treatment of children with SEND who require mental health	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): There are clear governance and reporting structures, as outlined above. We can provide updates as required.

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		support; and on how the NHS is working to increase the overall acquisition and availability of data on SEND children's mental health from key mental health providers.		
	23 November 2023 Meeting			
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: To work on developing explicit and comprehensive navigation tools for improving communication and referral for services at the neighbourhood level and within communities. It is recommended that piloting such navigation tools in specific communities may be a point of consideration.		Recommendation Partially Accepted: Initial Response (additional progress update response to be provided in June 2024): We work closely with partners across Oxfordshire who offer advice, support and interventions for children, young people and their families and are currently tendering for a peer support app for CYP to support their mental health and well-being with a directory of local services to meet their needs. We recognise the importance of ensuring that local communities and neighbourhoods are connected to service provision in their areas. This is also important to the workforce so that they know who their local link is for support and services. This recommendation applies to all system partners to ensure that information is made available. HOSC can also support this approach with members of the scrutiny committee sharing information through their networks.

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				The new SEND Local offer also provides details how to apply for help and includes a directory of local provision that both CYP and their families as well as professionals can access. This has been co-produced with Oxfordshire Parent Carer Forum and is key action in the priority action plan the link for the new website: Oxfordshire SEND local offer | Oxfordshire County Council As part of the early help strategy refresh this year OCC Children's Services will be ensuring the offer of early help is accessible to all families to find information to support them along with resources available within the local offer and linked with FIS. Co-production is a critical part of the strategy development and the commissioning cycle. This approach was adopted for the development of the emotional health and wellbeing strategy and in the commissioning of the digital offer. The Council recognises that improvements can be made and in future tenders we would like CYP to be able to be part of the evaluation process. We are working with procurement and legal colleagues to enable this to happen without being at risk of breaching contract procurement regulations and legal challenge.

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				We have built reviews and service improvement into the digital offer and will be able to provide updates in due course.
Page 165	**Children's Emotional Wellbeing & Mental Health Strategy**	Recommendation: To ensure adequate co-production with children and their families as part of continuing efforts to deliver the strategy, including considerations of how children and families can be placed at the heart of commissioning. It is also recommended for an early review with the users of the digital offer once this becomes available; to include testing with neurodivergent children and other children known to be at higher risk of mental ill health.		Recommendation Accepted: Initial Response (additional progress update response to be provided in June 2024): Co-production is a critical part of the strategy development and the commissioning cycle. This approach was adopted for the development of the emotional health and wellbeing strategy and in the commissioning of the digital offer. The Council recognises that improvements can be made and in future tenders we would like CYP to be able to be part of the evaluation process. We are working with procurement and legal colleagues to enable this to happen without being at risk of breaching contract procurement regulations and legal challenge. We have built reviews and service improvement into the digital offer and will be able to provide updates in due course.

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Page 166	**Children's Emotional Wellbeing & Mental Health Strategy**	Recommendation: To continue to explore and secure specific and sustainable sources of funding for the Strategy to be effectively delivered in the long-run.		Recommendation Accepted: Initial Response (additional progress update response to be provided in June 2024): Funding for supporting emotional health and wellbeing comes from a number of government departments and organisations. This includes Department for Education and NHS England as well as funding provided to the voluntary and community sector and for research and evaluation to grow the evidence base on what works. As a system we will strive to identify sustainable sources of funding for Oxfordshire. Local funding streams will be determined by the financial envelope provided to us nationally for this work. Any proposals to increase resources to better meet the needs of CYP in Oxfordshire are being managed by the SEND Priority Action Plan to address priorities identified during the Local Area SEND inspection by OFSTED and CQC.
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: To ensure that children and young people and their families continue to receive support that is specifically tailored toward their needs. It is recommended that a Needs-Based Approach is explicitly adopted, as opposed to a purely Diagnosis-Based Approach. This could allow for early intervention to be initiated as soon as possible.		Recommendation Accepted: Initial Response (additional progress update response to be provided in June 2024): System partners recognise the recommendation to be needs led and provide support to children, young people and families at the earliest opportunity

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				utilising the Think Family Approach and as endorsed within the Early Help Strategy to offer the right support at the right time. Oxford Health are already taking this needs-led approach through Universal Public Health Services for CYP. Oxford Health CAMHS service also commission Autism Oxfordshire to give CYP and their families pre-diagnoses support for those waiting for a Neuro-development Conditions assessment. We are exploring different ways of commissioning and delivering Neuro-development Conditions assessment services across the BOB ICB as long waits are a national issue. Addressing waits for Neuro-development Conditions assessments is also an action in the SEND Priority Action Plan.
	Children's Emotional Wellbeing & Mental Health Strategy	Recommendation: That consideration is given to the use of a simple and evidence-based standardised evaluation measure, that is suitable across all services that are working on Children's mental health in community settings.		Recommendation Partially Accepted: Initial Response (additional progress update response to be provided in June 2024): Evaluations tell us what works and what does not. An evaluation should be a rigorous and structured assessment of a completed or ongoing activity, intervention, programme or policy that will determine the extent to which it is achieving its objectives and contributing to decision-making.

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				Collecting feedback, data and local intelligence from children and young people, communities and services is essential to inform a needs-led approach. We will explore what guidance and evidence-based practice is available to address this recommendation. We would also like to recommend that this is broader than 'children's mental health in community settings' to recognise the impact of wider determinants on emotional health and wellbeing for children, young people and their families. Children's Services already utilise SDQ's to measure and evaluate children's Mental Health for Children We Care For and we could look to expand this practice to a wider cohort of children to further explore their needs.
	Place-Based Partnership	Recommendation: For the Place-Based Partnership to operate in a manner that avoids duplication of other bodies or their associated activities; including the Health and Wellbeing Board.	Daniel Leveson	Recommendation Accepted: Continue to oversee and assure partners of the work underway for priority populations. To receive updates and take partnership actions required from existing parts of the system including SEND Improvement Board, Mental Health Transformation Programme Board, Urgent and Emergency Care Board and Prevention and Health Inequalities Forum.

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Page 169	**Place-Based Partnership**	Recommendation: For the Place-Based Partnership to consider collective work around finding avenues to improve oral health throughout the county, particularly for vulnerable groups or disadvantaged communities.	Daniel Leveson	Recommendation Partially Accepted: Work to reduce health inequalities is part of the priorities for the place-based partnership and jointly overseen by Public Health and Place Director at the Prevention and Health Inequalities Forum. We will support work identified to improve oral health for vulnerable groups through this forum. Dentistry is a BOB ICB function (as opposed to Place) and as such does not form part of our collective responsibility. This forms part of the HOSC scrutiny of dentistry that is undertaken separately to PBP.
	Place-Based Partnership	Recommendation: To develop robust processes through which to monitor the effectiveness of the Place-Based Partnership, including its collaboration as well as the outcomes of its work. It is recommended that there is clear transparency around this.	Daniel Leveson	Recommendation Accepted: We will continue to measure and monitor the PBP and system working maturity using annual self-assessment. The Health and Wellbeing Strategy Outcomes Framework will also enable us to focus on our collective actions to improve population outcomes. We have an emphasis on evaluation of value i.e. assessing outcomes for the resources we use / investments we make.

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	Place-Based Partnership	Recommendation: To develop robust principles and processes around transparency of decision-making within the Partnership, so as to mitigate the loss of place-based statutory board CCGs which were open to the public.	Daniel Leveson	Recommendation Accepted: Decision-making when agreeing allocations of future resources will continue to be made in a transparent way. This is generally done either via Joint Commissioning Executive (for services included as part of the Section 75 Agreement between Oxfordshire County Council and ICB) and for things like Better Care Fund seeking approval via Health and Wellbeing Board or other statutory Boards. We are committed to ongoing engagement, involvement and co-design of new models of care that are fit to meet the future needs of Oxfordshire's population.