Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 6 June 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 -

Councillors:	Nigel Champken-Woods	Nick Leverton	Freddie van Mierlo
	Jenny Hannaby	Michael O'Connor	Mark Lygo
	Jane Hanna OBE		
District Councillors:	Paul Barrow	Katharine Keats-Rohan	Dorothy Walker
	Susanna Pressel	Joy Aitman	
Co-optees:	Barbara Shaw		

Date of next meeting: *12 September 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

May 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.

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AGENDA

1. Election of Chair for the 2024/2025 Council Year

For the Committee to **AGREE** a Chair for the Joint Health Overview Scrutiny Committee for the 2024/2025 Council Year.

2. Election of Vice-Chair for the 2024/2025 Council Year

For the Committee to **AGREE** a Vice-Chair for the Joint Health Overview Scrutiny Committee for the 2024/2025 Council Year.

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 18)

To approve the minutes of the meeting held on 18 April 2024 and to receive information arising from them.

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

6. 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 31 May 2024. 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.

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7. Chair's Update (Pages 19 - 46)

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

There are THREE documents attached this item:

1. A HOSC report containing recommendations from the Committee on General Practice Provision in Oxfordshire, which was discussed during the 18 April 2024 HOSC meeting.

2. A HOSC report containing recommendations from the Committee on Dentistry Provision in Oxfordshire, which was discussed during the 18 April 2024 HOSC meeting.

3. A HOSC report containing recommendations from the Committee on the Oxford University Hospitals NHS Foundation Trust People Plan, which was discussed during the 18 April 2024 HOSC meeting.

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

8. Annual Report of the Oxfordshire Joint Health Overview Scrutiny Committee (Pages 47 - 74)

The purpose of this item is to approve the draft of the Annual Report of the Joint Health Overview Scrutiny Committee. This report will be presented to Full Council on 09 July 2024, and summarises the key scrutiny activities that the OJHOSC has engaged in throughout the course of the 2023-2024 civic year.

There are TWO documents attached to this item:

1. A cover report for the HOSC Annual Report.

2. Annex 1- The full draft and wording of the HOSC Annual Report.

The Committee is **RECOMMENDED** to Delegate authority to the Principal Scrutiny Officer:

1. for the design of the final report,

2. to make minor updates or amendments as required, in consultation with the Chair and the Health Scrutiny Officer,

3. for publication of the final report

9. Integrated Neighbourhood Teams (Pages 75 - 82)

Lily O' Connor (Programme Director Urgent and Emergency Care for Oxfordshire, BOB ICB) and Daniel Leveson (Oxfordshire Place Director, BOB ICB) have been invited to present a report with an update on Integrated Neighbourhood Teams in Oxfordshire.

There are TWO documents attached to this item:

1. A cover sheet for the Integrated Neighbourhood Teams Report.

2. The main report on Integrated Neighbourhood Teams.

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

10. Palliative/End of Life Care (Pages 83 - 96)

Dr Victoria Bradley (Clinical Lead for and Consultant in Palliative Medicine, Oxford University Hospitals NHS Foundation Trust) has been invited to present a report with an update on Palliative/End of Life Care in Oxfordshire.

There are TWO documents attached to this item:

1. A report containing an update on the Rapid Intervention for Palliative and End of Life Care (RIPEL) project.

2. A report providing a BOB Integrated Care Board Update on Palliative and End of Life Care.

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

11. Healthwatch Oxfordshire Update Report (Pages 97 - 106)

The Committee is invited to consider the Healthwatch Oxfordshire update report and **NOTE** it having raised any questions arising from the contents.

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12. Oxford Health NHS Foundation Trust Draft Quality Account

Rose Hombo (Deputy Director of Quality & Clinical Standards Oxford Health NHS Foundation Trust) has been invited to present the draft Quality Account of Oxford Health NHS Foundation Trust, specifically, the quality objectives for this year and the next.

The Committee is recommended to: -

a) **AGREE** to provide comments on the account, in particular in relation to whether the account corresponds with HOSC member experience of the Trust over the last year, and whether they support the key areas of focus for the Trust over the forthcoming year.

b) **DELEGATE** to the Health Scrutiny Officer the task of compiling the Committee's comments on the Quality Account in consultation with the Chair, and submit the feedback to Oxford Health prior to the publication date for the Quality Account on 30 June 2024.

PLEASE NOTE: The report for this item will be issued as an addendum.

13. Epilepsy Services in Oxfordshire

The Committee will receive a report from the NHS on the current state of Epilepsy Services within Oxfordshire.

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

PLEASE NOTE: The report for this item will be issued as an addendum.

14. Response to HOSC Recommendations (Pages 107 - 142)

The Committee has received Responses as well as Acceptances for the recommendations made as part of the following items:

1. The South Central Ambulance CQC Improvement Journey Update, which was held during the 08 February 2024 HOSC meeting.

2. The John Radcliffe Hospital CQC Improvement Journey, which was held during the 08 February 2024 HOSC meeting.

3. The Director of Public Health Annual Report, which was held during the 08 February 2024 HOSC meeting.

The Committee has also received TWO progress update responses to recommendations made as part of the following items:

1. Health and Wellbeing Strategy Update.

2. Oxfordshire Healthy Weight.

The Committee is recommended to **NOTE** the responses

15. Forward Work Programme (Pages 143 - 146)

To **AGREE** the Committee's proposed work programme for its upcoming meetings.

16. Actions and Recommendations Tracker (Pages 147 - 184)

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.

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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.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 18 April 2024 commencing at 10.00 am and finishing at 3.50 pm

Present:

Voting Members:	Councillor Jane Hanna OBE – in the Chair
	District Councillor Elizabeth Poskitt (Deputy Chair) Councillor Jenny Hannaby Councillor Nick Leverton Councillor Michael O'Connor District Councillor Paul Barrow City Councillor Sandy Douglas District Councillor Katharine Keats-Rohan Councillor Lesley McLean
Co-opted Members:	Barbara Shaw
	Councillor (for Agenda Item)
By Invitation:	Julie Dandridge, BOB ICB Lead for Primary Care across Oxfordshire Dan Leveson (BOB ICB Place Director, Oxfordshire) Hugh O'Keefe BOB ICB Senior Programme Manager – Pharmacy, Optometry and Dental Services Dr Veronica Barry, Executive Director Healthwatch Oxfordshire Terry Roberts Chief People Officer, Oxford University Hospitals NHS Foundation Trust
Officers:	Ansaf Azhar, Director of Public Health

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.

23/24 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies had been received from the following:

- Cllr Nigel Champken-Woods
- Cllr Mark Lygo.

24/24 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

The following interests were declared:

- Cllr Jane Hanna declared that she worked for SUDEP Action.
- Barbara Shaw declared that she was a chair of a cardiovascular charity.

25/24 MINUTES

(Agenda No. 3)

The minutes of the committee's meeting on 8 February 2024 were assessed for their accuracy.

The Committee **AGREED** the minutes as an accurate record of proceedings and that the Chair should sign them as such.

26/24 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Liz Peretz addressed the Committee on behalf of Oxfordshire Keep Our NHS Public.

She expressed deep concerns about the Primary Care Model, which she, along with the BOB Local Medical Committee, Oxford Patient Network, and others, opposed. Their concerns were:

- NHS England had not made this model mandatory, and if adopted, it could be much more expensive and potentially lead to worse health outcomes than the current system.

- If implemented, it could end the concept of the family doctor and risk the crucial connection between a local surgery and the population it served.

- The proposed two-tier system, distinguishing between users of Same Day Hubs and Neighbourhood Teams for the 'chronically sick', did not make sense. In this system, a patient who had not needed the doctor for years would be diverted to far less trained staff.

- The Primary Care Model had not been tried and tested. It was not a system tested to destruction by strong research, simply an idea put forward in the Fuller Stocktake report.

- The Committee was encouraged to speak up against the 'roll out' by their ICB of the new Primary Care Model. Instead, she asked for support for the GPs in their Primary

Care Networks to come up with their own solutions to the current crisis, and to listen when they said adequate funding and flexibility in how to use it was what they needed.

27/24 CHAIR'S UPDATE

(Agenda No. 5)

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

- A report (containing recommendations from HOSC) had been submitted to the Oxford University Hospitals NHS Foundation Trust regarding 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 Director of Public Health Annual Report could also be found in the agenda papers.

- The Chair and the Health Scrutiny Officer had requested a written briefing for the Committee relating to the temporary closure of the ADHD referral list, with a view to understanding the reasoning behind the closure as well as the potential impact it could have on those affected.

- The Committee had requested a briefing from Oxford University Hospitals NHS Foundation trust on the recent CQC maternity inspection at the Horton.

- The Committee made recommendations to the Integrated Care Board (ICB) and the parliamentary House Select Committee regarding a new policy issued by the medicines regulator. This policy pertained to anti-seizure medication and medication used for individuals with bipolar disorder called Valproate. As an update to that, the ICB established a task force comprising consultants, specialist nurses, medicines safety officers, representatives from charities and patients with lived experiences. The impact report outlined that there were unavoidable consequences, and current services were ill-equipped to handle the implementation of phase one of the medicines regulatory policy. Specifically, it was anticipated that approximately 2,855 outpatient appointments would be lost due to the new requirements.
  The report further predicted that reduced access would lead to increased mortality and greater morbidity, including emergency situations arising from uncontrolled epilepsy. Notably, this assessment did not encompass the impacts and risks associated with phase two of the policy, which could be even more significant.

- The Chair also paid tribute to the Senior Patient Safety Manager at the ICB for his leadership of this taskforce, and the Committee offered their condolences to his family and colleagues.

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

The Committee **AGREED** the following actions:

1. For the Committee to **DELEGATE** to the Chair and Health Scrutiny Officer to write to the Health Secretary (and copying in the Parliamentary Health Select Committee) to bring the likely impacts of the Valproate Pregnancy Prevention policy to their attention, and to request that until the likely impacts and risks of phase 1 of the policy are assessed and safely addressed, that they allow local systems to delay implementation.

2. For the Committee to **AGREE** to the establishment of a four member HOSC Working Group, for the purposes of engaging in ongoing scrutiny of the NHS's Oxford Community Health Hubs Project.

3. For the Committee to convene a public meeting item on medicine shortages, in line with increasing reports of such shortages across the board.

4. For the Committee to **AGREE** to **DELEGATE** to the Chair and Health Scrutiny Officer the responsibility to determine an approach to ongoing scrutiny of Oxford University's Hospital's Plan B for the expansion of Horton Hospital.

28/24 GP PROVISION IN OXFORDSHIRE

(Agenda No. 6)

Julie Dandridge (BOB ICB Lead for Primary Care across Oxfordshire) and Dan Leveson (BOB ICB Place Director, Oxfordshire) presented a report on GP provision in Oxfordshire.

The BOB ICB Lead for Primary Care across Oxfordshire introduced the report. Addressing an item on which the Committee had previously received a briefing, the partners at Botley Medical Centre had handed back their contract the previous year and the ICB worked with the residents and the Patient Participation Group around Botley Medical Centre and with local providers to find two new practices willing to take on the patients. The draft Primary Care Strategy had been co-produced with a number of stakeholders and the feedback was being collated into a final version, to be signed off by the ICB Board in May. There was a recognition of the increase in GP appointments, but also an acknowledgment that patients and the public were still having difficulty getting through to GPs by phone to get an appointment. There had been much progress in improving primary care estates. Some things were unfortunately beyond the control of the ICB, but work was continuing with GP leaders to try and improve access for patients.

The Committee asked in what respects had the National Recovery and Access to Primary Care Programme funded, influenced, and shaped the decisions and measures taken around GP provision in Oxfordshire. The BOB ICB Lead for Primary Care explained that the national primary care access and recovery. had come with some funding to support it. This funding was partly for practices to have time to implement what they called modern general practice, which involved assessing how and by whom patients should be seen. All their practices had submitted plans on how they would do this at the primary care network level. There was also funding for IT, specifically to ensure that all their practices had functioning cloud-based telephony and to drive forward other innovations in IT.

The Committee queried the extent to which the development of the Primary Care Strategy involved adequate levels of public and stakeholder engagement. The BOB ICB Lead for Primary Care had stated that engaging everyone was challenging. They had co-produced the draft strategy with GP leaders and Primary Care Network clinical directors, and held webinars and sessions for the public and professional colleagues. A detailed public engagement report was available, and Healthwatch had been used to disseminate information and hold seminars. Feedback received from public engagement indicated a need for more co-production of communications. The strategy would only work if the public was taken along, their concerns understood, and if they helped to drive it forward. Engagement on the strategy had closed as they wanted to get a final strategy out and ready. The strategy was put in place to help with the challenges faced by GPs and the public in terms of access. None of the components in the strategy were going to be mandated but were suggestions to colleagues in general practice on how to progress to enable better access for patients. There were good examples of where some of the integrated neighbourhood teams and acute same-day hubs really worked and made a real difference to patients and access, but it was not going to be universal. In terms of further engagement, this would now take place locally as they defined and shaped it for every local footprint.

The Committee asked for more information about the development of proactive and personalized care in the community setting for people with complex health needs.
The BOB ICB Lead for Primary Care emphasised the importance of the development of care closer to home, with services being moved out of hospitals into the community for easier patient access. Integrated neighbourhood teams were brought together, uniting experts in care to move things forward in a unified direction. This was part of developing a patient-focused approach, which had been implemented in some cases, but not optimally across all areas. Resources included NHS staff in the community and staff in general practice. The goal was to join up and streamline processes, using the same records to release capacity for personalized care for those who needed it most. There were many teams that needed to be brought together to drive this forward, and good work was being done across Oxfordshire to achieve this in certain places.

The Committee enquired as to whether any extensive progress had been made for the ICB to work closely with District Councils to enhance GP access and services and deal with primary care estate issues. The BOB ICB Lead for Primary Care had explained that their town planner was actively participating in the district councils' planning discussions, building relationships, and driving things forward in a more organised manner. The engagement with individual councillors was primarily through the officers rather than direct interactions with the councillors themselves.

The Committee queried whether the Great Western Park project in Didcot was going according to plan. The BOB ICB Lead for Primary Care stated that they had made significant progress with the Great Western Park development. This progress was marked by the ICB's agreement and the extension of the Section 1 agreement that was already in place with the developer. The council was preparing to receive the land and the fund. Despite the complexity of the legal agreement involving three or four parties, they were on the right path and intended to maintain the momentum. The next steps, which included finalising the legal agreements and submitting a planning application, were clearly in sight.

The Committee enquired as to whether there was any record keeping of ‘failed service requests’, and whether this was followed up. The BOB ICB Lead for Primary Care had responded that, at that time, the only method of testing was through the GP patient survey. Nationally, from October, call data would be collected. They acknowledged the existence of a significant amount of unmet need and emphasised the importance of reaching those individuals who might be deterred from accessing their GP if they failed to get through. Regarding how to assist these patients, more work needed to be done on the ground with patients, including working with support groups, to ensure these individuals could access the necessary services.

The Committee asked whether the ICB monitored each practice against requests for online and urgent appointments being closed. The BOB ICB Lead for Primary Care explained that the Primary Care Strategy was initiated to address the need for capacity in general practice. The ICB was aware and captured details about practices that struggled to remain open due to a lack of capacity and appointments. The default solution was to use the 111 service, which could perform early triage and determine the urgency of a patient's need to be seen, but efforts were being made to assist practices that regularly had to switch to the 111 service.

The Committee queried whether the ICB was reviewing the number of GPs and number of additional primary care roles per practice. The BOB ICB Lead for Primary Care acknowledged that there was variation across GPs. They utilised several data sets, including the Patient Access Survey, which consistently ranked practices and provided a clear indication of where they needed to focus on. This was something they constantly monitored and provided support to a number of practices for.

The Committee asked how the ICB was anticipating future housing developments and population increases. The BOB ICB Lead for Primary Care explained that their town planner played a crucial role. The planner was meeting with officers to review upcoming plans and submit requests for support for general practice primary care infrastructure. There were plans in place in some locations, for example they had strategies to increase provision across Bicester and Kidlington using developers' contributions. The planner was aiming to look ahead, to create long-term plans rather than reactive ones.

The Committee asked whether the ICB thought there was a need to explore more strategically the potential to partner with the local authorities in provision of new primary care premises. The BOB ICB Lead for Primary Care mentioned a Section 2 agreement for working in collaboration with local authorities and councils, which was a significant opportunity for general practice on the ground. They acknowledged that the ICB had no capital, and their only source of funding was through revenue. They saw potential opportunities in collaborating with local authorities and expressed a strong interest in exploring them.

The Committee asked why the initial focus was on prevention around cardiovascular disease. The BOB ICB Lead for Primary Care responded that they believed there was still significant room for improvement in cardiovascular disease. They acknowledged the substantial benefits this could have, not only for patients but also for the system and resources. They confirmed that cardiovascular prevention had

been agreed upon as a BOB system priority. However, they had also received feedback suggesting that prevention should not be limited to just cardiovascular disease but should also encompass areas such as oral health and children's preventative health. The ICB did not want their strategy to be so broad that it encompassed everything and ended up delivering nothing, which was why they narrowed their focus to one area. However, they anticipated that other aspects of prevention would be broader than just cardiovascular disease.

The BOB ICB Place Director for Oxfordshire added that cardiovascular disease was identified as the leading cause of premature death and noted a significant inequality in its occurrence, which explained their focus on it. The BOB ICB Place Director and the Director of Public Health chaired the Prevention Health Inequalities Forum and were examining better access to and advertisement of NHS health checks, and had made significant investments promoting activity. They emphasised that there was a lot to do, and that they needed to preserve with prevention and inequality work, as the positive impact from this would be more visible in the long term.

The Committee enquired as to how the GP retainer scheme would help to enhance the retention of GPs. The BOB ICB Lead for Primary Care explained that there was a 'new to practice' GP fellowship that provided support to new GPs and the implementation and delivery of the Primary Care Strategy could attract new GPs. The introduction of innovative ways of working with patients was thought to help retain GPs and the developments to roles were found to be very rewarding for the staff.

The Committee asked whether administrative staff received appropriate training in being able to support clinicians and patients. The BOB ICB Lead for Primary Care responded that the receptionist had traditionally been the first point of contact for someone trying to access a GP appointment. They were upskilling those receptionists to become care navigators so that they could direct the right patients to the right place. The reception staff were trained to understand what the important questions were so that they could point patients to the right clinician; whether that be a pharmacist, a physiotherapist, or the GP. There was a national training program for receptionist care navigators and most practices had their own training in place as well. All NHS staff, including administrative staff, were bound by confidentiality. The ICB was committed to work with the public to help shape what information they needed to participate and feel confident in the range of staff that were now working in general practice.

The Committee asked what could be done to alleviate the pressures in community pharmacy. The BOB ICB Lead for Primary Care replied that Pharmacy First had launched on the 31st of January and it was welcomed by the profession and by community pharmacists. As Pharmacy First developed and as more conditions became available for pharmacists to treat, it brought more income into the community pharmacy, which was really welcomed by their pharmacies, especially smaller independents.

It was **AGREED** that the BOB ICB Lead for Primary Care would provide the Committee with a breakdown of how funds from the National Recovery and Access to Primary Care Programme were being spent.

It was also **AGREED** that the BOB ICB Lead for Primary Care would liaise with the ICB Director of Comms and Engagement to respond to the Committee's question on what prevented the ICB and the local managers from taking on board the scrutiny committee feedback about engagement.

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

1. To ensure continuous stakeholder engagement around the Primary Care Strategy and its implementation, and for the ICB to provide evidence and clarity around any engagements adopted and on key feedback themes that were received from within Oxfordshire. It is also recommended that there is a clear implementation plan to be developed as part of the Primary Care Strategy, and for this to be shared with HOSC and key stakeholders.

2. To continue to work on prevention of medical and long-term conditions besides cardiovascular disease.

3. To review ICB capacity to ensure adequacy, with a view that the ICB can work in a timely way with all District Councils across Oxfordshire on the securement and spending of infrastructure funding.

4. That an expected date for the signing of the legal agreement on Didcot Western Park is provided to the JHOSC, so there can be reassurance about the likely timescale for the tendering process.

5. That the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons; and that there is a communication with the public to provide improved clarity and communication about the statistics concerning access to appointments.

6. For there to be clarity and transparency around the use of any competency frameworks and risk assessments around the role of non-medical staff who are involved in triaging or providing medical treatment to patients.

29/24 DENTISTRY PROVISION IN OXFORDSHIRE

(Agenda No. 7)

Hugh O'Keefe (BOB ICB Senior Programme Manager – Pharmacy, Optometry and Dental Services), Dan Leveson (BOB ICB Place Director, Oxfordshire) had been invited to present a report on Dentistry Provision in Oxfordshire. Ansaf Azhar (Director of Public Health) was also in attendance.

The BOB ICB Senior Programme Manager for Pharmacy, Optometry and Dental Services explained that the report included an update on the progress made since the last HOSC meeting they attended the previous year. They had been dealing with continuous issues related to dental practices leaving the NHS, which had become a serious concern, and the report covered their actions in response to these departures.

The Committee asked whether there was any indication as to the geographical spread of practices in Oxfordshire that had not met the minimum target contracted activity required for NHS dentists to avoid financial recovery, and what the reason

was for Oxfordshire's inferior performance to Buckinghamshire and West Berkshire. The BOB ICB Senior Programme Manager explained that contract delivery before the pandemic used to run at about 90% in Oxfordshire, and there had been more of an impact from the pandemic in the longer term in Oxfordshire. It could not be said that there was a particular area in Oxfordshire that was doing much better than others, although West Oxfordshire and the Vale of the White Horse were seeing slightly lower levels of provision.

As the distance from the capital increased, challenges arose, particularly in more rural areas. Similar patterns were observed in Buckinghamshire and the West of Oxfordshire, but not so much in West Berkshire. These areas, especially the West of Oxfordshire, faced significant challenges, with numerous practices deciding to leave the NHS and go private. This trend was more prevalent in this county than in other parts of the system. Since 2021, about 5% of the capacity was lost, with approximately three-quarters of that loss occurring in Oxfordshire. About half of the loss was specifically in the West of Oxfordshire as practices in these rural areas were making decisions to leave the NHS.

The Committee enquired as to the challenges facing patients trying to access local NHS dental services. The BOB ICB Senior Programme Manager clarified that, in contractual terms, dentists were only responsible for patients while conducting the course of treatment, so they were not registered. Due to the pandemic, many patients discovered that they had not attended for more than two years and when they then called back in to the dentist they appeared as new patients.
The recovery of access was fairly rapid early on in 2022. Since then, it had been slowing, and the report discussed some of the issues including gaps in treatment, leading to worse oral health, meaning those treatment plans were taking longer to complete. Thus, the backlog was taking time to clear because of the needs that were presenting.

In answer to the Committee's query about the low NHS pay to dentists, the BOB ICB Senior Programme Manager explained that when the NHS contract was introduced, it was argued that it would have a 'swings and roundabouts effect', as dentists would only need to see some patients for a short period of time for a check-up while other patients would need longer treatment. There had always been a recognition that there was some cross-subsidisation with private work in dentistry, as even if a dentist had a substantial NHS contract, they nearly always had private work that went with it. The problem was that this contracting model was impacted by COVID and dentists were tending to see patients with more complex needs, so the swings and roundabouts effect was not working as well. Some of the national changes aimed to adjust the pricing and bring in a new minimum price, as the pricing used for the dental contract was based on activity carried out in a reference year in 2004/5.
The dental contract had been introduced in 2006 and pilots for a different type of contract had been run since then, however they had an impact on access. Practices that took part in these schemes devoted more time to seeing patients, which led to a fall in access and patient charge revenues.

The Committee enquired about the basis of the NHS contract and the effect on dentists that did not meet their targets. The BOB ICB Senior Programme Manager elaborated that the contract provided unit payments based on treatment bands, and

dentists were paid units of dental activity (UDAs) based on the numbers of treatment bands they did in a given year, within a capped allocation. Some practices opted to leave due to the risk associated with delivering these units, especially when dealing with patients with more complex needs that required more treatment, but only represented a fixed unit payment. The introduction of flexible commissioning was partly to help patients who had been struggling to get into the system, with practices participating in the scheme opening up to see these patients. It also helped practices reduce their business risk by converting a portion of their activity target to access sessions, allowing them to receive the same amount of money without having to hit as high an access target.

The Committee asked whether any efforts were being made by ICB or NHSE to influence the government to increase financial uplifts applied to dental contracts.
The BOB ICB Senior Programme Manager explained that there were contract changes in 2022 and 2024, and when these changes were considered collectively, there were benefits to dental practices. A new patient premium was introduced to incentivise dental practices to take on new patients. There was talk about a new contract in 2025, but there was a financial barrier to introducing a new contract, as the dental system was heavily dependent on patient charges, which in turn depended on patient attendance. There was a significant risk to financial stability if substantial changes were made, therefore previous changes have been incremental.

The Committee enquired about progress on ensuring that new dentist trainees were registered swiftly. The BOB ICB Senior Programme Manager answered that arrangements had been made for overseas dentists to be added to the performer list more quickly, as previously, they had to undergo an examination process before they could start working on the NHS.

The Committee asked what was being done to help those patients from dental surgeries that had handed their contracts back. The BOB ICB Senior Programme Manager explained that a programme had been implemented, which involved approaching local practices to try to replace the activity that had been lost due to contract hand backs. In Oxfordshire, there had been some success and about another 20,000 units of dental activity (UDAs) had been commissioned, the equivalent of 3 1/2 surgeries. However, there were still significant gaps, and it was recognised that the flexible commissioning was an interim solution. The next stage was to go out to formal market procurement with the aim of seeking new practices to come into the areas where capacity had been lost.

The Committee queried how the ICB made sure that patients were being given correct and accurate information about where they can go to access the NHS dentists. The BOB ICB Senior Programme Manager highlighted that flexible commissioning had been helping with the access issue. When the scheme was started, practices were nervous about widely publicising their access because they feared being inundated with patients due to limited access. As a result, a requirement was introduced in the contract for practices to update their information. More practices were opening up in Oxfordshire, which was an early sign that the extra activity being put into the system was helping practices.

The Committee asked whether the ICB would be commissioning new contracts, particularly in those areas with no NHS dentists and what the time scale was for opening new practices in areas that expressed interest. The BOB ICB Senior Programme Manager acknowledged that in the past, seeking expressions of interest in very rural areas could yield no responses, and recognised that it was not enough to commission without ensuring this could be delivered. However, expressions of interest had been received in some of these areas in Oxfordshire with little NHS provision. There was a timeline from the start of procurement to opening of about 18 months to two years. Finding and obtaining planning permission for premises represented the majority of that time.

The Committee enquired whether having patients on their books prevented dentist surgeries from taking on new patients. The BOB ICB Senior Programme Manager replied that a significant portion of the capacity was being utilised by patients who were regular attenders. The ICB had been attempting to restore this capacity as swiftly as possible, enabling practices to move beyond merely recalling individuals who had previously been in the system. They had suggested extending recall times, as it was not clinically indicated that everyone needed to attend as frequently as every six months. This could also create additional capacity for new patients.

The Committee asked whether the NHS was conducting any work to help increase awareness of the importance of oral health and hygiene. The BOB ICB Senior Programme Manager explained that the oral health promotion service in the area was run by the local authority. However, dentists had played a crucial role in promoting oral health and ensuring access, emphasizing the importance of quickly integrating children into the system. This was to prevent situations where a child's first visit was due to a serious dental problem, which could instigate fear. The ICB had been considering moving beyond just looking at access, which had been a significant focus area, and starting to delve into a more preventative agenda.

The Committee enquired as to what was being done in schools to monitor children's oral health. The Director of Public Health clarified that Oxfordshire was one of the local authorities that still commissioned an oral health needs assessment and conducted an oral health survey. They commissioned the Community Dental Service, which included liaising with school health nurses to influence oral health in children and carry out preventative activities. They tried to incorporate preventative oral health messages through their other physical health services. There was a pathway in place linking with the Community Dental service, for children with oral health needs, and the committee could be provided with more detail on this at a later date.

The Committee asked what steps have been taken to support the oral health of residents with mental illnesses. The BOB ICB Senior Programme Manager replied that there was a community dental service in Oxfordshire that had seen residents with mental illnesses, with dentists who had undergone special care training, and there were numerous ways that patients could access this service.

The Committee enquired as to whether, in evaluation of the programme, they had looked at how people from areas of health inequality had been affected. The BOB ICB Senior Programme Manager clarified that flexible commissioning aimed to identify deprived patient groups like looked after children and asylum seekers. There

was always a cohort of patients who did not attend the dentist and only went when they were in pain, which tended to link to deprivation. The scheme assisted them in getting to the dentist because although it was not designed for urgent treatment, it was picking up on that need in the population to get patients into the system.

The Committee asked what the ICB's position on fluoridating Oxfordshire's water supply was, and whether any consultations were planned around this. The BOB ICB Senior Programme Manager responded that there were no plans at this stage to have consultations about fluoridating the water supply. The information that came from the 2024 contract changes referenced water fluoridation, but it was referencing the schemes that were currently running. The BOB ICB Place Director, Oxfordshire added that this was a Public Health matter and not something the ICB was commissioned to do.

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

1. It is reiterated that underspends should be spent in Oxfordshire, and that priority is given to areas within Oxfordshire that have experienced the worst shortfall in capacity. It is recommended that the ICB prioritises areas within Oxfordshire in light of the increased need within the County relative to other areas under the BOB footprint.

2. To support the creation of new practices within Oxfordshire with urgency, and to explore avenues of funding to support the ICB in developing solutions in this regard.

3. That urgent progress is made in improving the accuracy and the accessibility of information on dentistry services available to people; and that where groups are targeted for help, they can benefit from an effective outreach.

4. For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.

30/24 HEALTHWATCH OXFORDSHIRE UPDATE REPORT

(Agenda No. 8)

Following on from the previous item, Veronica Barry, Executive Director of Healthwatch Oxfordshire, described a visit to asylum refugee hotel accommodations in the Banbury area and where they spoke with several key stakeholders regarding the integration into flexible commissioning in dentistry. Efforts were directed towards collaborating with the welfare office in those specific hotels, as it was observed that their awareness of flexible commissioning was limited.

Additionally, work was undertaken with parents through community connectors in the Banbury area, focusing on oral health. Notably, parents of children with special educational needs were identified as potential users of specialist services. A report detailing these findings is currently in progress. Moving forward, the plan involved partnering with community-based dental services to highlight developmental information specifically for this group of parents. An effort was made to incorporate the voices of the public into the discussion through the appendix. The Executive Director of Healthwatch Oxfordshire reiterated that effective communication with the public was crucial. However, it was acknowledged that the public were currently navigating a complex system with various constraints.

Healthwatch had conducted a Mystery Shopper exercise that simulated patient calls to dental surgeries. This exercise highlighted the time-consuming nature of navigating the system for a member of the public. Despite this, the flexible commissioning scheme was seen as encouraging, although certain groups still lacked clarity on how to access it.

In response to concerns about Patient Participation Groups (PPGs) not being involved in the Primary Care Strategy, the Executive Director of Healthwatch Oxfordshire emphasised that Healthwatch made efforts to promote PPG engagement, including through webinars. An ongoing appraisal of the current state of PPGs revealed a strong need for improved communication around changes. The hope is that Healthwatch's report will enhance support for PPGs, and discussions with the ICB will address communication gaps with these groups.

Additionally, patients had raised the issue of access to ADHD medication to Healthwatch and clarity had been sought from the ICB regarding patient pathways; especially considering changes in national guidelines.

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

31/24 OXFORD UNIVERSITY HOSPITALS NHSFT PEOPLE PLAN

(Agenda No. 9)

Terry Roberts (Chief People Officer, Oxford University Hospitals NHS Foundation Trust) was invited to present a report on the Oxford University Hospital's NHSFT People's Plan. Dan Leveson (BOB ICB Place Director, Oxfordshire) was also in attendance.

The Committee asked for clarification on the Oxford University Hospitals NHS Foundation Trust (OUH) vacancy freeze and whether an impact assessment had been completed to assess its effect. The Chief People Officer clarified that it was not a vacancy freeze, but a vacancy pause. This measure was implemented following instructions from the Integrated Care Board and NHS England, with the aim of balancing their financial books. The pause affected both clinical and non-clinical posts that were Band 8C and above, which included senior roles like managers with a salary of £70,000. Administrative and clerical roles were also paused. OUH still actively recruited to Band 5 and Band 6 nursing vacancies, healthcare support workers, and other direct healthcare roles. The primary goal of this action was to ensure financial stability. A quality impact assessment was conducted not only for the overall programme but also for each post under consideration. Recruitment to posts was not undertaken unless they were fully aware of the potential impact on patient care and their ability to meet constitutional standards.

The Chief People Officer added that OUH was directed to implement these measures. They had been striving to increase productivity and had a significant productivity programme in place for the entire previous year. It was noted that at the end of 2023/24, they finished with a deficit of £10 million. However, this was in the context of achieving £90 million in efficiency savings during the same period.

The Chief People Officer clarified that they did not want to pause the posts, as they were not extra and were indeed needed. However, they had been instructed to review them, a task not unique to Oxford University hospitals. They acknowledged the difficulty of the situation, particularly the administrative burden placed on staff due to the thorough quality impact assessment. They highlighted the financial constraints they were operating under, with a finite budget and a requirement to balance their books. They emphasised that unless key changes were made and tough decisions taken, they would not be able to fund investments to improve both patient and staff experience, as highlighted in the people plan.

The Committee enquired about the effect this could have on staff that were already under strain. The Chief People Officer stated that they were aware of the initiative's impact on their staff. They were constantly monitoring the staff's mood through quarterly staff surveys, a large annual staff survey, retention questionnaires, and regular people plan listening events where they heard directly from the staff. These methods helped them understand the feelings of their staff and were instrumental in developing the people plan.

The BOB ICB Place Director, Oxfordshire acknowledged that their costs, like many systems across the country, had exceeded the allocated funds. The proportion of money spent on staff, was typically between 75% and 80%. They emphasised their responsibility to deliver a balanced budget and considered it absurd to do so without considering how they spent the major proportion of their money. In financially challenging circumstances, one of the first actions they took was vacancy control, as it was something they could control. They ensured that people were still able to staff safely. While doing so, they saw an opportunity to explore different care models that could deliver better value and outcomes at lower costs. They were introducing new integrated models for better value and were considering the introduction of technology. However, they acknowledged the difficulty of these tasks, given the growing cost of care and health demands beyond their resources. Vacancy control was a normal and understandable first action when demonstrating financial control and responsible stewardship of public funds.

The Committee asked how the NHS People Plan influenced the OUH People Plan, and whether the OUH People plan was sufficiently tailored toward any potential specificities for Oxfordshire. The Chief People Officer stated that they had a specific Oxfordshire remit, part of which involved attracting and retaining people from Oxfordshire. They had a scheme to recruit locally for their apprenticeships. They worked on the health inequalities agenda for Oxfordshire and were part of the Anchor Institute. Their goal was to reduce health inequalities and recruit people from local communities into their organization. When they first developed this, they looked at the NHS plan and the ICB people plan, integrating all the key elements from the NHS plan. They conducted extensive engagement to hear what their people thought. Over 75% of the people who worked for them came from Oxfordshire, so they heard what was important for them to live and thrive.

The Committee asked whether there was still a heavy reliance on agency and bank staff and whether cheaper housing for staff would help attract the workforce. The Chief People Officer responded that there was a reliance on agencies due to existing

vacancies and a national shortage of trained nurses and doctors. They had not only depended on agencies and banks but also on overseas recruitment due to the poor supply of trained medical professionals. They had a target to reduce their reliance on banking agencies by 700 whole time equivalents that year and were exploring different ways to achieve this. The cost of living was a factor that made it difficult for people to afford living in Oxford. They had been working with outside agencies to secure cheaper accommodation for their staff, an effort that was ongoing. They appreciated any support that could help them offer low-cost accommodation to their people and key workers. They were also considering the introduction of an Oxford Weighting, similar to the London Weighting received by hospitals in London, given that the cost of living in Oxford was not much lower than in London. They expressed appreciation for any assistance that could be provided in this regard.

The Committee enquired whether there was any extensive collaboration underway with Oxford University to help support the recruitment of young and talented individuals for employment roles within the trust? The Chief People Officer stated that they regularly met with the university, and they had been exploring creating joint initiatives and developing a joint office. This joint office would focus on joint recruitment for both the university and OUH. This was an ongoing effort that they had been working on for a year but competing demands had prevented an early resolution.

The Committee asked about the protection of staff from abuse and violence and whether there was a whistleblowing policy in place. The Chief People Officer stated that addressing abuse towards their staff was a high priority due to an increase in such incidents. They had a specific group focused on supporting staff in relation to violence, aggression, and sexual harassment. Several initiatives were in place, including body cams for Emergency Department staff, psychological support from their Psychological Medicine service, a poster campaign, and a revisited policy about violence and aggression. They had strengthened their warning system for aggressive or violent patients. They were also encouraging staff not to tolerate abuse, which had sometimes led to staff leaving their jobs. They were working to lower staff tolerance of violence and aggression, even when it came from patients with dementia or other illnesses. They wanted staff to report incidents so they could take action, and were even willing to deliver final warnings to patients at an executive level. They were making progress on this significant agenda, but not as quickly as they would have liked.

The Chief People Officer had confirmed that the majority of the issues were from patients. Upon reviewing the data and staff survey results, they found that incidents involving staff-on-staff were less than half of those involving patients-on-staff.

The Chief People Officer stated that they had a whistleblowing policy encouragement to speak up, however, they believed more needed to be done. As part of their action plan, they were exploring ways to provide psychological safety for people to voice their concerns. They were seeking charity funding to establish an external whistleblowing system, assuring that it would be anonymous and allow people to raise their concerns without fear of being traced. This was aimed at addressing these concerns effectively.

The Committee asked how OUH would be evaluating and measuring the overall effectiveness of the Plan and its tangible outcomes and delivery. The Chief People Officer had responded that they had 15 metrics in their report, that they believed were crucial to measure. The end of Year Three of the People Pan, which was also the end of the financial year, was the time they would measure against all the metrics such as bullying and harassment, time to hire, and vacancy rates. An annual evaluation was conducted to assess their position, and for the second year, they had met the majority of the metrics. The areas they identified as having the most significant gaps were some of the equality and diversity metrics. They also noted the importance of employees taking the majority of their annual leave throughout the year, as it was crucial for rest and recovery. Another concern was the number of people leaving within a year of starting, particularly among admin and clerical and healthcare support workers. This indicated issues with the work environment and the selection process. They found that sometimes, people did not realise the nature of the job they were taking on; and with admin and clerical staff, they could earn the same or more working at Amazon or Tesco. Therefore, they were considering how they paid and how they marketed their non-monetary benefits. These were the key areas they planned to focus on in their third year.

The Committee emphasised the quality of the report and the presentation, and commended the comprehensive metrics and creative solutions being produced.

The Committee **AGREED** to issue the following recommendations to Oxford University Hospitals NHS Foundation Trust:

1. For Oxford University Hospitals NHSFT to provide the Committee with a written briefing around the reasoning behind the pause in recruitment of certain OUH staff, as well as around any risk assessments that have been conducted around the recruitment pause.

2. To ensure that there is ongoing engagement with staff and key stakeholders around the continuing design and delivery of the OUH People Plan.

3. To continue to secure the necessary levels of resources required to deliver on the key objectives of the People Plan.

4. To explore avenues of improving pay for staff in line with the increases in financial hardships generated by the Cost-Of-Living Crisis. It is recommended that the Trust works with relevant system partners to explore the prospect of achieving an Oxford Weighting.

5. To continue to develop clear processes through which to evaluate and measure the effectiveness of the People Plan and its delivery.

32/24 RESPONSES TO HOSC RECOMMENDATIONS

(Agenda No. 10)

The Committee 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 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 **NOTED** the response and update.

33/24 FORWARD WORK PROGRAMME
(Agenda No. 11)

The Committee **AGREED** the proposed forward work programme.

34/24 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 12)

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

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OXFORDSHIRE COUNTY COUNCIL

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

General Practice Provision in Oxfordshire:

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

INTRODUCTION AND OVERVIEW

1. At its meeting on 18 April 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the current state of General Practice (GP) provision in Oxfordshire.

2. The Committee felt it crucial to receive an update on the current state of GP services, particularly in light of the increased demand for such services throughout the County. The Committee also sought to assess the degree to which the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (ICB) was taking adequate steps to address the increases in demand for GP 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 GP services, which are often the first point of contact for patients in the healthcare system. When commissioning this report on GP provision, some of the insights that the Committee sought to receive were as follows:

    - The levels of workforce within GP settings, and whether there is an adequacy of workforce.
    - Any measures that have been taken by the ICB to improve workforce recruitment and retention.
    - Whether any steps are being or will be taken to avert GPs from handing in their notice.
    - The steps being taken to improve capacity in Primary Care.
    - The capacity of existing Primary Care estates, and whether the ICB has specific plans to improve and increase Primary Care estates.
    - Whether there is an increased use of portacabins, and the feasibility and appropriateness around the use of these in specific contexts/surgeries.
    - As per the previous HOSC recommendation around access to Primary Care, whether any progress has occurred in regard to

working with the City/District Councils to coordinate the use of section 106 funds for primary care.

- The impact of increased housing developments on primary care and how the ICB is taking this into account.

- Details on any progress made toward expanding GP capacity in the Didcot area.

- The extent to which there is an increased use of physician associates, and if so, whether there is a standardised competencies assessment for such staff who are not trained doctors.

- The degree to which administrative/receptionist staff are sufficiently trained to facilitate not only their administrative work, but also their interaction with and support for patients.

SUMMARY

4. The Committee would like to express thanks to Julie Dandridge (Lead for Primary Care across Oxfordshire, BOB ICB) and Daniel Leveson (BOB ICB Place Director, Oxfordshire) for attending this meeting item on 18 April 2024 and for answering questions from the Committee.

5. The BOB ICB Lead for Primary Care across Oxfordshire introduced the report. The draft Primary Care Strategy had been co-produced with a number of stakeholders and the feedback was being collated into a final version, to be signed off by the ICB Board in May. There was a recognition of the increase in GP appointments, but also an acknowledgment that patients and the public were still having difficulty getting through to GPs by phone to get an appointment. There had been much progress in improving primary care estates. Some things were unfortunately beyond the control of the ICB, but work was continuing with GP leaders to try and improve access for patients.

6. The Committee asked in what respects had the National Recovery and Access to Primary Care Programme funded, influenced, and shaped the decisions and measures taken around GP provision in Oxfordshire. The BOB ICB Lead for Primary Care explained that the national primary care access and recovery had come with some funding to support it. This funding was partly for practices to have time to implement what they called modern general practice, which involved assessing how and by whom patients should be seen. All their practices had submitted plans on how they would do this at the primary care network level. There was also funding for IT, specifically to ensure that all their practices had functioning cloud-based telephony and to drive forward other innovations in IT.

7. The Committee queried the extent to which the development of the Primary Care Strategy involved adequate levels of public and stakeholder engagement. The BOB ICB Lead for Primary Care had stated that engaging everyone was challenging, and HealthWatch also stated that their involvement had been

rushed. They had co-produced the draft strategy with GP leaders and Primary Care Network clinical directors, and held webinars and sessions for the public and professional colleagues. A detailed public engagement report was available, and Healthwatch had been used to disseminate information and hold seminars. Feedback received from public engagement indicated a need for more co-production of communications. The Lead for Primary Care committed to find out from the ICB's communications team as to whether there was a reason for the rushed engagement.

8. The Committee asked for more information about the development of proactive and personalised care in the community setting for people with complex health needs. The BOB ICB Lead for Primary Care emphasised the importance of the development of care closer to home, with services being moved out of hospitals into the community for easier patient access. Integrated neighbourhood teams were brought together, uniting experts in care to move things forward in a unified direction. This was part of developing a patient-focused approach, which had been implemented in some cases, but not optimally across all areas. Resources included NHS staff in the community and staff in general practice. The goal was to join up and streamline processes, using the same records to release capacity for personalised care for those who needed it most.

9. The Committee enquired as to whether any extensive progress had been made for the ICB to work closely with District Councils to enhance GP access and services and deal with primary care estate issues. The BOB ICB Lead for Primary Care had explained that their town planner was actively participating in the District Councils' planning discussions, building relationships, and driving things forward in a more organised manner.

10. The Committee queried whether the Great Western Park project in Didcot was going according to plan. The BOB ICB Lead for Primary Care stated that they had made significant progress with the Great Western Park development. This progress was marked by the ICB's agreement and the extension of the Section 1 agreement that was already in place with the developer. The council was preparing to receive the land and the fund. Despite the complexity of the legal agreement involving three or four parties, they were on the right path and intended to maintain the momentum. The next steps, which included finalising the legal agreements and submitting a planning application, were clearly in sight.

11. The Committee enquired as to whether there was any record keeping of 'failed service requests', and whether this was followed up. The BOB ICB Lead for Primary Care had responded that, at that time, the only method of testing was through the GP patient survey. Nationally, from October, call data would be collected. They acknowledged the existence of a significant amount of unmet need and emphasised the importance of reaching those individuals who might be deterred from accessing their GP if they failed to get through.

12. The Committee asked whether the ICB monitored each practice against requests for online and urgent appointments being closed. The BOB ICB Lead for Primary Care explained that the Primary Care Strategy was initiated to

address the need for capacity in general practice. The ICB was aware and captured details about practices that struggled to remain open due to a lack of capacity and appointments. The default solution was to use the 111 service, which could perform early triage and determine the urgency of a patient's need to be seen, but efforts were being made to assist practices that regularly had to switch to the 111 service.

13. The Committee asked how the ICB was anticipating future housing developments and population increases. The BOB ICB Lead for Primary Care explained that their estates town planner played a crucial role. The planner was meeting with officers to review upcoming plans and submit requests for support for general practice primary care infrastructure. There were plans in place in some locations, for example they had strategies to increase provision across Bicester and Kidlington using developers' contributions. The planner was aiming to look ahead, to create long-term plans rather than reactive ones.

14. The Committee asked whether the ICB thought there was a need to explore more strategically the potential to partner with the local authorities in provision of new primary care premises. The BOB ICB Lead for Primary Care mentioned a Section 2 agreement for working in collaboration with local authorities and councils, which was a significant opportunity for general practice on the ground. They acknowledged that the ICB had no capital, and their only source of funding was through revenue. They saw potential opportunities in collaborating with local authorities and expressed a strong interest in exploring them.

15. The Committee asked why the initial focus was on prevention around cardiovascular disease. The BOB ICB Lead for Primary Care responded that they believed there was still significant room for improvement in cardiovascular disease. They acknowledged the substantial benefits this could have, not only for patients but also for the system and resources. They confirmed that cardiovascular prevention had been agreed upon as a BOB system priority. However, they had also received feedback suggesting that prevention should not be limited to just cardiovascular disease but should also encompass areas such as oral health and children's preventative health.

16. The Committee enquired as to how the GP retainer scheme would help to enhance the retention of GPs. The BOB ICB Lead for Primary Care explained that there was a 'new to practice' GP fellowship that provided support to new GPs and the implementation and delivery of the Primary Care Strategy could attract new GPs. The introduction of innovative ways of working with patients was thought to help retain GPs and the developments to roles were found to be very rewarding for the staff.

17. The Committee asked whether administrative staff received appropriate training in being able to support clinicians and patients. The BOB ICB Lead for Primary Care responded that the receptionist had traditionally been the first point of contact for someone trying to access a GP appointment. They were upskilling those receptionists to become care navigators so that they could direct the right patients to the right place. The reception staff were trained to understand what the important questions were so that they could point patients to the right

clinician; whether that be a pharmacist, a physiotherapist, or the GP. There was a national training program for receptionist care navigators and most practices had their own training in place as well. All NHS staff, including administrative staff, were bound by confidentiality. The ICB was committed to work with the public to help shape what information they needed to participate and feel confident in the range of staff that were now working in general practice.

18. On the point relating to the increasing use of non-GP staff for the purposes of treating patients, the Committee queried and emphasised the use of any competency frameworks, in addition to the level of communication with the public, around the increasing use of such staff. It was highlighted by the Committee that there was public concern around the imperative for clear transparency for each alternative role. It was vital that there were clear impact and risk assessments, a clear competency framework, and a thorough communication plan with patients and the wider public.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

19. Overall, the Committee observes that there is a significant advancement around the serious issue of GP estates. The ICB's recruitment of a specific estates role is a positive development, and will enable serious and longstanding barriers on the spending of funding to be overcome. Given the urgent public need for funding to be spent and secured from developments, the Committee reiterates and urges that the estates' workforce are further increased in Oxfordshire to accelerate progress. The Committee observes that in light of the demands on primary care as well as workforce shortages, which are clearly also national issues, the Committee cannot give full assurance to the public about the state of primary care. Nevertheless, the Committee recognises the local work and makes the points of observation below as constructive points for local improvement.

20. Below are 6 key points of observation that the Committee has in relation to GP provision in Oxfordshire. These 6 key points of observation relate to some of the themes of discussion during the meeting on 18 April, 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.

Public Engagement and the Primary Care strategy: The Committee is supportive of the development of a primary care strategy by the ICB, and perceives the commitment to such a strategy as constituting a method through which to clarify the ICB's priorities around GP services. Nonetheless, the committee strongly feels that engagement with key stakeholders and the wider public should be at the heart of how the strategy is designed and delivered.

Therefore, that public engagement should be at the heart of the strategy is crucial for two reasons:

1. It can help to gather views and experiences from the public as to how they feel regarding the GP services they have been

receiving. This will prove valuable for how the strategy, as well as GP services more broadly, are designed in a manner that reflects public views and experiences.

2. The engagements with stakeholders and the public could help to inform the ICB as to which aspects of GP services are not functioning optimally, and could therefore help to further inform ways in which to improve frontline primary care.

Given the fact that the Primary Care strategy outlines the ICB's commitments to new and transformative methods for providing GP services, it is vital that the public and key stakeholders thoroughly understand the nature of such changes and how these will affect the ways in which residents could expect to receive GP services.

The Committee urges and recommends that in the spirit of transparency and effective public communication, that the ICB publishes the responses and/or provides evidence and sheds some light on some of the key feedback themes that were received from residents or stakeholder organisations from within Oxfordshire as to the strategy. The Committee also recommends that the ICB shares information regarding the engagement that has taken place in the context of the strategy's development, including which stakeholders had been identified and targeted as part of this. The committee recommends that any ICB considerations or responses to the key feedback themes are also made public.

Furthermore, the Committee feels strongly that the primary care strategy should also be accompanied by an explicit and elaborate delivery plan. This delivery plan should ideally outline the immediate, medium, and long-term priorities of the strategy (particularly in relation to GP provision given the increase in demand for this area). It is also crucial that clear and realistic timescales, as well as considerations around workforce and funding, should also be incorporated into such a delivery plan. This could help to set healthy targets for the ICB to work toward gradually implementing the strategy in a manner that produces tangible benefits for Oxfordshire's residents who strongly depend on GP services.

Additionally, the Committee also recognises that as with any strategy, there is a need for continuous stakeholder engagement, and that this should be well planned and should take on board the feedback from the public as well as the Oxfordshire and the BOB HOSCs.

Recommendation 1: *To ensure continuous stakeholder engagement around the Primary Care Strategy and its implementation; and for the ICB to provide evidence and clarity around any engagements adopted, to include evidence on key feedback themes and from which groups within Oxfordshire such themes were received from. It is also recommended that there is a clear implementation plan to be developed as part of the Primary Care Strategy, and for this to be shared with HOSC and key stakeholders.*

Importance and role of Prevention: The Committee understands that the ICB's initial focus on prevention would be around cardiovascular disease. The Committee acknowledges the substantial benefits this could have for the population, not only for patients but also for the system and resources. Nonetheless, it is vital that the ICB expands the focus of prevention to other areas as much as possible. Whilst it is understandable that the primary care strategy cannot feasibly encompass every aspect of health and prevention, there is also a point about tangible commitments that the NHS should ideally adopt around prevention of other long term medical conditions besides an exclusive focus on cardiovascular disease. The Committee is strongly supportive of the initiative to focus on prevention of cardiovascular disease, but urges and recommends that the focus of prevention is broadened to encompass other areas also.

The ICB could make use of some of the feedback heard as part of the public engagement around the development of the primary care strategy to understand how various other long-term conditions could be heavily impacting the lives of residents. This could help to inform and shape the ICB's commitments to other forms of prevention or to prevention for other long-term conditions. Additionally, the Committee encourages for there to be close coordination with local Primary Care Networks (PCNs), Healthwatch Oxfordshire, patient groups, as well as Oxfordshire County Council's Public Health team, to work toward a comprehensive prevention agenda.

Recommendation 2: *To continue to work on Prevention of medical and long-term conditions besides cardiovascular disease.*

Working with District/City Councils: The Committee is glad to see that the ICB has been working with District and City Councils for the purposes of improving primary care estates. The Committee would like to stress the importance of continued work with District Councils, and perceives the ICB's recruitment of a role for working with Districts as a positive step toward addressing some of the challenges around primary care capacity against the backdrop of the substantial increases in demand within Oxfordshire. It is vital that there is continued work for the purposes of coordinating the use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care.

It is crucial that the ICB works to ensure that there is adequacy in capacity. This does not simply require close working with district authorities, but also that such work is coordinated in a timely manner so as to ensure demand is being met in a timely way which precludes undue risks to the health and wellbeing of residents, who are increasingly experiencing difficulties in accessing GP services. The Committee previously recommended role(s), and whilst one role is significant progress, it is urged that adequate capacity to enable the release of funding is made a priority.

Furthermore, another issue which highlights the importance of working with District Councils in a timely manner relates to how increases in housing developments in one part of the County could result in an increase in demand for GP services in a neighbouring authority (owing to the fact that the closest GP surgery for some may be across a district boundary). Hence, whilst general increases in housing developments create challenges around primary care capacity, the effects of increases in housing developments on primary care demand in neighbouring district boundaries is also an issue that the Committee urges the ICB to explore.

Recommendation 3: *To review ICB capacity with a view to increasing this to ensure adequacy, with a view that the ICB can work in a timely way with all District/City Councils across Oxfordshire on the securement and spending of health-infrastructure funding.*

Monitoring of practices closing e-connect & telephone requests: The Committee believes that econnect or telephone requests for urgent appointments are a crucial avenue through which patients can access GP services. For many patients, these are the two primary means through which to seek an appointment with their GP. Often, patients may be experiencing a health issue that they feel, or that may genuinely, requires urgent medical attention from a medical professional. Patients are often reluctant to contact 111 or to make a trip to emergency departments for two reasons:

1. They would fear the prolonged waiting times they would have to experience if they take these avenues.

2. They may not be sure as to whether their condition merits a trip to an emergency department, or whether it is an issue that could be resolved and treated by a GP.

The Committee understands that there have been reports of increasing difficulties experienced by patients in being able to access their GP. Patients may make telephone requests for an appointment, or often find that the practice they are registered with have closed e-connect and telephone requests for urgent appointments. This could, and indeed has, resulted in patients experiencing distress in not being able to simply access a GP when they need to, and in some cases patients have given up seeking help as their condition deteriorates.

The Committee recommends to the ICB that urgent action is taken to monitor which particular GP practices have been closing e-connect and telephone requests for urgent appointments, and for what reason this may be the case. It is also requested that HOSC are informed about these temporary closures. Such monitoring is important for two reasons. Firstly, it could help with the overall monitoring and performance management of individual GP practices. Secondly, it could act as a form of reassurance to patients and wider residents as to the steps the NHS

are taking to ensure that there is both transparency and accountability over such closures, as well as the commitments by the NHS to enhance access for patients to GP services. The Committee urges the ICB to support GP practices in communicating with their patients and the public as to the reasons they may no longer be taking requests for appointments and when such services are expected to be restored.

Furthermore, the Committee understands that some patients may even feel reluctant or put off from constantly seeking to navigate through the process of accessing a GP. This could also occur as a result of feeling powerless in being able to access a doctor to discuss any medical concerns they have. The risks with such scenarios are that such patients who feel this way could experience further decline in their physical or even their mental health as a result. Therefore, the Committee urges that the ICB effectively monitors patterns of closures for telephone requests and e-connect and identifies the reasons for this as well as where such closures are taking place.

The statistics on access suggest an improvement on last year, but if there are temporary closures the statistics may not be capturing people trying to access a service. We urge the ICB to consider the statistics on temporary closures and the likely numbers of people failing to make an appointment; and that the statistics on access are reviewed in the light of this with a view to further clarification on this matter.

Recommendation 4: *That the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons, and that it is also checked as to whether/how the public have been communicated with around such closures. It is recommended that there is improved clarity and communication about the statistics concerning access to appointments.*

Competency Frameworks: The Committee is aware of the NHS's plans to make increasing use of physician associates in the context of GP services, who are not qualified medical doctors, and is also aware of the development of alternative roles. The Committee has received concerns from the public, but does not perceive the development of alternative roles to be an entirely negative thing. Whilst this may constitute a means through which to manage the increases in demand for primary care, it could also potentially produce risks to patient safety if the necessary precautions and steps are not taken to effectively manage this.

The Committee is therefore recommending that there is clear transparency around any competency frameworks or risk assessments that staff who are not qualified as doctors, and who may be triaging or providing treatment to patients, are measured against. Such competency frameworks (which could include training as well as monitoring processes) and risk assessments would be crucial for two reasons.

1. This could help to maximise the safety of patients and minimise any risks involved with using staff who are not qualified doctors.

2. It can act as a form of reassurance to patients as well as the wider public as to what this means for the kind of GP services they will receive.

In addition, given that individuals who visit GP services may often be from vulnerable population groups, the Committee stresses the importance of ensuring that staff who treat such patients are as qualified or trained as possible so as to be able to draw the necessary conclusions from such patients' historical and medical records, and for them to be aware of and able to support or escalate their advocacy needs. This would help to inform the type of treatment they would provide to such patients.

Recommendation 5: *For there to be clarity and transparency around the use of any competency frameworks as well as impact and risk assessments around the role of non-GP qualified medical staff who are involved in triaging or providing medical treatment to patients. The Committee urges that the advocacy needs of patients are considered/provided for, and that patients are clearly informed about the role of the person who is treating them and the reasons as to why this is a good alternative to seeing their GP.*

Great Western Park development: The Committee is well aware of some of the key challenges around GP provision within the Didcot area. Didcot is an area that has witnessed increasing levels of demand for Primary Care services, including GP services. The increase in housing developments within the area is the primary reason for the increase in demand as new residents will need to access GP services. According to the Office of National Statistics mid-year population estimates, the population of Didcot increased from 24,373 in mid-2009 to 27,426 in mid-2019.

The Committee has been particularly concerned for some time that demand in Didcot is not being met, and has therefore strongly and consistently urged the ICB to take action to address this. The Committee is strongly supportive of, and is pleased to see, that the ICB has approved the business case for a new building and that it has agreed to provide funding in addition to the money from developer contributions. The Committee is also supportive of how Woodlands Medical Centre will manage the estate as a branch surgery. However, the Committee is recommending to the ICB that an expected date for the signing of the legal agreement on the Didcot Western Park site is provided to the JHOSC. This would help to reassure both the Committee as well as the wider public as to the likely timescale for the tendering process.

Recommendation 6: *That an expected date for the signing of the legal agreement on Didcot Western Park is provided to the JHOSC, so there can be reassurance about the likely timescale for the tendering process.*

Legal Implications

21. 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.

22. 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'.

23. 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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May 2024

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OXFORDSHIRE COUNTY COUNCIL

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

Dentistry Provision in Oxfordshire:

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

INTRODUCTION AND OVERVIEW

1. At its meeting on 18 April 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the current state of Dentistry provision in Oxfordshire.

2. The Committee felt it crucial to receive an update on the current state of Dentistry services, particularly in light of the increased demand for such services throughout the county, as well as the increasing difficulties that residents are experiencing in being able to access NHS dentistry services. The Committee also sought to assess the degree to which the ICB was taking adequate steps to address both the increases in demand for Dentistry services as well as the challenges around accessing NHS dentistry.

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 Dentistry services. When commissioning this report on Dentistry provision, some of the insights that the Committee sought to receive were as follows:

   - As per a previous HOSC recommendation to the Secretary of State for Health and Social Care around this matter, whether there were any ongoing considerations for fluoridating Oxfordshire's water supply.

   - Details around the NHS dentistry contracts, and the extent to which changes to the contacts are having an impact in improving capacity and access.

   - Whether there is sufficient capacity in the NHS to provide NHS dentistry services in light of increased demand for such services given the difficulties of residents being able to afford private dental care.

   - Whether there is any progress in enabling new dental trainees to be placed on the NHS dental register as swiftly as possible.

   - The extent to which information on how to access NHS dental services, or on eligibility around NHS treatment, is easily accessible and available for residents.

- Any steps that will be taken to avert the prospects of dentistry deserts.

- For clarity around the amount of dentistry underspends in Oxfordshire as well as how these are being utilised.

- An update on any general Countywide Oral Health patterns since the Committee held this item last year in April 2022.

SUMMARY

4. The Committee would like to express thanks to Hugh O'Keefe (Senior Programme Manager – Pharmacy, Optometry and Dental Services Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board) and Daniel Leveson (BOB ICB Place Director, Oxfordshire) for attending this meeting item on 18 April 2024 and for answering questions from the Committee.

5. The BOB ICB Senior Programme Manager for Pharmacy, Optometry and Dental Services explained that the report included an update on the progress made since the last HOSC meeting they attended the previous year. The ICB had been dealing with continuous issues related to dental practices leaving the NHS, which had become a serious concern, and the report covered their actions in response to these departures.

6. The Committee asked whether there was any indication as to the geographical spread of practices in Oxfordshire that had not met the minimum target contracted activity required for NHS dentists to avoid financial recovery, and what the reason was for Oxfordshire's inferior performance to Buckinghamshire and West Berkshire. The BOB ICB Senior Programme Manager explained that contract delivery before the pandemic used to run at about 90% in Oxfordshire, and there had been more of an impact from the pandemic in the longer term in Oxfordshire. It could not be said that there was a particular area in Oxfordshire that was doing much better than others, although West Oxfordshire and the Vale of the White Horse were seeing slightly lower levels of provision.

7. As the distance from the capital increased, challenges arose, particularly in more rural areas. Similar patterns were observed in Buckinghamshire and the West of Oxfordshire, but not so much in West Berkshire. These areas, especially the West of Oxfordshire, faced significant challenges, with numerous practices deciding to leave the NHS and go private. This trend was more prevalent in this county than in other parts of the system. Since 2021, about 5% of the capacity was lost, with approximately three-quarters of that loss occurring in Oxfordshire. About half of the loss was specifically in the West of Oxfordshire as practices in these rural areas were making decisions to leave the NHS.

8. The Committee enquired as to the challenges facing patients trying to access local NHS dental services. The BOB ICB Senior Programme Manager clarified that, in contractual terms, dentists were only responsible for patients while

conducting the course of treatment, so they were not registered. Due to the pandemic, many patients discovered that they had not attended for more than two years and when they then called back in to the dentist they appeared as new patients. The recovery of access was fairly rapid early on in 2022. Since then, it had been slowing, and the report discussed some of the issues including gaps in treatment, leading to worse oral health, meaning those treatment plans were taking longer to complete. Thus, the backlog was taking time to clear because of the needs that were presenting.

9. In answer to the Committee's query about the low NHS pay to dentists, the BOB ICB Senior Programme Manager explained that when the NHS contract was introduced, it was argued that it would have a 'swings and roundabouts effect', as dentists would only need to see some patients for a short period of time for a check-up while other patients would need longer treatment. There had always been a recognition that there was some cross-subsidisation with private work in dentistry, as even if a dentist had a substantial NHS contract, they nearly always had private work that went with it. The problem was that this contracting model was impacted by COVID and dentists were tending to see patients with more complex needs, so the swings and roundabouts effect was not working as well. Some of the national changes aimed to adjust the pricing and bring in a new minimum price, as the pricing used for the dental contract was based on activity carried out in a reference year in 2004/5.

10. The Committee enquired about the basis of the NHS contract and the effect on dentists that did not meet their targets. The BOB ICB Senior Programme Manager elaborated that the contract provided unit payments based on treatment bands, and dentists were paid units of dental activity (UDAs) based on the numbers of treatment bands they did in a given year, within a capped allocation. Some practices opted to leave due to the risk associated with delivering these units, especially when dealing with patients with more complex needs that required more treatment, but only represented a fixed unit payment. The introduction of flexible commissioning was partly to help patients who had been struggling to get into the system, with practices participating in the scheme opening up to see these patients.

11. The Committee asked whether any efforts were being made by the ICB or NHSE to influence the government to increase financial uplifts applied to dental contracts. The BOB ICB Senior Programme Manager explained that there were contract changes in 2022 and 2024, and when these changes were considered collectively, there were benefits to dental practices. A 'new patient premium' was introduced to incentivise dental practices to take on new patients. There was talk about a new contract in 2025, but there was a financial barrier to introducing a new contract, as the dental system was heavily dependent on patient charges, which in turn depended on patient attendance.

12. The Committee enquired about progress on ensuring that new dentist trainees were registered swiftly. The BOB ICB Senior Programme Manager answered that arrangements had been made for overseas dentists to be added to the performer list more quickly. Previously, they had to undergo an examination process before they could start working on the NHS.

13. The Committee asked what was being done to help those patients from dental surgeries that had handed their contracts back. The BOB ICB Senior Programme Manager explained that a programme had been implemented, which involved approaching local practices to try to replace the activity that had been lost due to contract hand backs. In Oxfordshire, there had been some success and about another 20,000 units of dental activity (UDAs) had been commissioned, the equivalent of 3 1/2 surgeries. However, there were still significant gaps, and it was recognised that the flexible commissioning was an interim solution. The next stage was to go out to formal market procurement with the aim of seeking new practices to come into the areas where capacity had been lost.

14. The Committee queried how the ICB made sure that patients were being given correct and accurate information about where they could go to access NHS dentists. The BOB ICB Senior Programme Manager highlighted that flexible commissioning had been helping with the access issue. When the scheme was started, practices were nervous about widely publicising their access because they feared being inundated with patients. As a result, a requirement was introduced in the contract for practices to update their information. More practices were opening up in Oxfordshire, which was an early sign that the extra activity being put into the system was helping practices.

15. The Committee asked whether the ICB would be commissioning new contracts, particularly in those areas with no NHS dentists and what the time scale was for opening new practices in areas that expressed interest. The BOB ICB Senior Programme Manager acknowledged that in the past, seeking expressions of interest in very rural areas could yield no responses, and recognised that it was not enough to commission without ensuring this could be delivered. However, expressions of interest had been received in some of these areas in Oxfordshire with little NHS provision.

16. The Committee enquired whether having patients on their books prevented dental surgeries from taking on new patients. The BOB ICB Senior Programme Manager replied that a significant portion of the capacity was being utilised by patients who were regular attenders. The ICB had been attempting to restore this capacity as swiftly as possible, enabling practices to move beyond merely recalling individuals who had previously been in the system. They had suggested extending recall times, as it was not clinically indicated that everyone needed to attend as frequently as every six months. This could also create additional capacity for new patients.

17. The Committee asked whether the NHS was conducting any work to help increase awareness of the importance of oral health and hygiene. The BOB ICB Senior Programme Manager explained that the oral health promotion service in the area was run by the local authority. However, dentists had played a crucial role in promoting oral health and ensuring access, emphasising the importance of quickly integrating children into the system. This was to prevent situations where a child's first visit was due to a serious dental problem, which could instigate fear.

18. The Committee asked what steps have been taken to support the oral health of residents with mental illnesses. The BOB ICB Senior Programme Manager replied that there was a community dental service in Oxfordshire that had seen residents with mental illnesses, with dentists who had undergone special-care training, and there were numerous ways that patients could access this service.

19. The Committee asked what the ICB's position on fluoridating Oxfordshire's water supply was, and whether any consultations were planned around this. The BOB ICB Senior Programme Manager responded that there were no plans at this stage to have consultations about fluoridating the water supply. The information that came from the 2024 contract changes referenced water fluoridation, but it was referencing the schemes that were currently running. The BOB ICB Place Director for Oxfordshire added that this was a Public Health matter and not something the ICB was commissioned to do.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

20. Below are four key points of observation that the Committee has in relation to Dentistry provision in Oxfordshire. These four key points of observation relate to some of the themes of discussion during the meeting on 18 April, and have also been used to shape the four recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Dentistry Underspends and prioritisation of Oxfordshire: The Committee appreciates that the new flexible commissioning model constitutes a positive step toward helping to improve the prospects of local residents being able to access dental treatment through the NHS. This certainly represents an improvement over earlier commissioning models and contracts. However, the Committee also understands that there is an urgent need for dental services within the county. This need is compounded by the fact that in the context of a cost of living crisis, many residents are struggling to afford private dental care, hence an increasing reliance on the NHS. Therefore, demand within Oxfordshire for NHS dental services has increased for two reasons:

1. There are residents whose oral health may have deteriorated for a variety of reasons including not visiting a dentist in the course of the Covid-19 pandemic.

2. Due to the difficulties around the cost of living, those on the margins of affording private dental care are no longer in a financial position to do so. Indeed, further, the Committee has received multiple reports of residents actively opting not to seek or to avoid dental treatment at all given the financial constraints they are faced with.

With this in mind, the Committee is recommending that any underspends within the Oxfordshire system are spent for and within Oxfordshire. This

spending should ideally be utilised for the purposes of both improving access to NHS dentistry for residents, as well as potentially for investments into oral health overall for Oxfordshire's population. The Committee is urging that the ICB works with relevant system partners, including the County Council, to target areas and communities of deprivation in this regard, particularly given the strong likelihood of tooth decay incidences being amongst deprived populations.

Furthermore, the Committee feels that the need for NHS dental services in Oxfordshire outweighs the need present in other areas under the BOB footprint. Therefore, it is being recommended to the ICB that priority is given to Oxfordshire in light of this increased need. The ICB should ideally work with system partners to determine how best to reinvest underspends within the Oxfordshire system for improving the overall state of dentistry access as well as oral Health for Oxfordshire's population.

Recommendation 1: *It is reiterated that underspends should be spent in Oxfordshire, and that priority is given to areas within Oxfordshire that have experienced the worst shortfall in capacity. It is recommended that the ICB prioritises areas within Oxfordshire in light of the increased need within the County relative to other areas under the BOB footprint.*

Supporting creation of new Dental practices: The Committee understands that efforts are being made in the realm of commissioning to try to improve access to NHS dentistry for residents. Nonetheless, the ICB could potentially go a step further. Given the rise of 'dentistry deserts' in certain parts of the county, the Committee recommends that the ICB also includes, within its work, support for the creation of new dental practices within Oxfordshire. The creation of new practices that would be prepared to provide NHS dental services to locals will help reduce the tendency for dentistry deserts in certain areas where many practices may have chosen to cease providing NHS treatment. The Committee is pleased to see that the ICB is working toward the establishment of new practices. This is a positive development and step, and the Committee would like to see that the ICB is closely monitoring the potential development of dentistry deserts, and that it is taking further measures, including through supporting the creation of new practices, to do so. The Committee understands that such an undertaking may require additional levels of funding or resources that the ICB may not already easily have at its disposal. Therefore, it is being recommended that the ICB works with other system partners to seek to explore avenues to fund the establishment of new dental practices in areas that may have the greatest need.

Recommendation 2: *To support the creation of new practices within Oxfordshire with urgency, and to explore avenues of funding to support the ICB in developing solutions in this regard.*

Improving Information on Dentistry Services: The Committee strongly believes in the importance of thorough communications not only with key stakeholders, but also the wider public as to the accuracy as well as the availability of information on which dentistry services are available to residents. Often, residents may not have a strong awareness of how to access dentistry services. Added to this is the confusion that residents may have around whether they are indeed eligible for NHS dental treatment. The Committee urges that the ICB works with key organisations (including Healthwatch Oxfordshire, patient groups, or even Primary Care Networks) so as to improve the availability and the accessibility of information on NHS dentistry services to residents. The increasing availability of such information would help reassure residents also that there are indeed NHS dentistry services that they may be able to access, and as to how they can go about seeking this.

The Committee understands that whilst people may feel put off from accessing GP services due to the difficulties with accessing an appointment, in the context of dentistry services, some residents may be reluctant to continue to seek dentistry services due to a lack of awareness of what is available for residents. Additionally, there is also a point about making information on dentistry services available in various languages so as to allow residents from a greater variety of ethnic backgrounds to access and understand such important information.

Furthermore, the Committee would like to emphasise the importance of providing support for vulnerable population groups. The Committee is also highly supportive of the system's commitment to do so. Nonetheless, it is vital that any vulnerable population groups that have been identified as targets for support should be able to benefit from an outreach that is as clear and effective as possible.

Vulnerable population groups may struggle to have the mental or physical capacity to seek dental care and treatment. They may also struggle to access what may ostensibly appear to be easily accessible information on dentistry. The Committee also urges that elderly residents benefit from an effective outreach. This will be particularly crucial for elderly individuals who struggle with or who do not have access to information technology.

Recommendation 3: *That urgent progress is made in improving the accuracy and the accessibility of information on dentistry services available to people; and that where groups are targeted for help, they can benefit from an effective outreach.*

Fluoridating Oxfordshire's Water Supply: During a public meeting item on dentistry provision held last year, the Committee made a recommendation around supporting a local consultation within Oxfordshire for the purposes of considering the fluoridation of Oxfordshire's water supply. Research suggests that fluoridating the water supply can produce positive oral health benefits, particularly with fluoride's ability to reduce the prospects of tooth decay. Given the

increases in patterns and incidences of tooth decay, fluoridating the county's water supply may actually produce significant benefits for residents. However, the Committee understands perfectly well that such an undertaking would most likely require a public consultation of some sort; not merely gather people's views on fluoridation but to publicise the oral health benefits of fluoride being contained in the water supply.

The Committee has written to the Secretary of State for Health and Social Care, and has recommended to the Secretary of State to support a local public consultation on the topic of fluoridating the water supply. The Committee is now recommending that the Oxfordshire system works to support a local and timely public consultation around fluoridating the county's water supply. Such systemic efforts could help to add further momentum toward achieving not merely a consultation, but also fluoridation.

Recommendation 4: *For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.*

Legal Implications

21. 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.

22. 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'.

23. 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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May 2024

OXFORDSHIRE COUNTY COUNCIL

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

Oxford University Hospitals NHS Foundation Trust People Plan:

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

INTRODUCTION AND OVERVIEW

1. At its meeting on 18 April 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the Oxford University Hospitals NHS Foundation Trust People Plan.

2. The Committee felt it crucial to receive an update on the Trust's People Plan, particularly in light of the increased Nationwide challenges around workforce recruitment and retention. The Committee also sought to assess the degree to which the Trust was taking adequate steps to promote and support the wellbeing of staff.

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 strategies, plans, and decisions taken by NHS Foundation Trusts to support and improve the recruitment, retention, and wellbeing of staff. When commissioning this report on the Oxford University Hospitals NHS Foundation Trust (OUH) People Plan, some of the insights that the Committee sought to receive were as follows:

    - How the 2020 NHS People plan has shaped the direction of OUH's People Plan.
    - What the overall objectives of the People Plan are.
    - How the plan was formulated (and whether this included liaison with stakeholders).
    - How the Trust's workforce will be recruited as well as retained.
    - The degree to which the wellbeing of OUH staff will be supported and maintained.
    - Is there public communications work around the plan and its promotion.
    - The extent to which there is sufficient resource (including funding and workforce) for the purposes of delivering the objectives of the Plan.

- Whether there was any evidence to indicate how effectively the Plan has been delivered thus far.

SUMMARY

4. The Committee would like to thank Terry Roberts (Chief People Officer, Oxford University Hospitals NHS Foundation Trust) for attending the meeting on April 18 and for answering questions from the Committee in relation to the OUH People Plan. The Committee would also like to thank Dan Leveson (BOB ICB Place Director, Oxfordshire) for his attendance and for his contribution to the discussions around the Plan.

5. The Committee asked for clarification on the Oxford University Hospitals NHS Foundation Trust (OUH) vacancy freeze and whether an impact assessment had been completed to assess its effect. The Chief People Officer clarified that it was not a vacancy freeze, but a vacancy pause. This measure was implemented following instructions from the Integrated Care Board and NHS England, with the aim of balancing their financial books. The pause affected both clinical and non-clinical posts that were B and 8C and above, which included senior roles like managers with a salary of £70,000. Administrative and clerical roles were also paused. OUH still actively recruited to Band 5 and Band 6 nursing vacancies, healthcare support workers, and other direct healthcare roles. The primary goal of this action was to ensure financial stability.

6. The Chief People Officer added that OUH was directed to implement these measures. The Trust had been striving to increase productivity and had a significant productivity programme in place for the entire previous year. It was noted that at the end of 2023/24, OUH finished with a deficit of £10 million. However, this was in the context of achieving £90 million in efficiency savings during the same period. The Chief People Officer clarified that they did not want to pause the posts, as they were not extra and were indeed needed. However, they had been instructed to review them, a task not unique to Oxford University hospitals. The Trust acknowledged the difficulty of the situation, particularly the administrative burden placed on staff due to the thorough quality impact assessment.

7. The Committee enquired about the effect this could have on staff that were already under strain. The Chief People Officer stated that they were aware of the initiative's impact on their staff. The Trust were constantly monitoring the staff's mood through quarterly staff surveys, a large annual staff survey, retention questionnaires, and regular people plan listening events where they heard directly from the staff. These methods helped them understand the feelings of their staff and were instrumental in developing the people plan.

8. The BOB ICB Place Director, Oxfordshire acknowledged that their costs, like many systems across the country, had exceeded the allocated funds. The proportion of money spent on staff, was typically between 75% and 80%. They emphasised their responsibility to deliver a balanced budget and considered it absurd to do so without considering how they spent the major proportion of their

money. In financially challenging circumstances, one of the first actions they took was vacancy control, as it was something they could control. The Trust ensured that people were still able to staff safely. While doing so, they saw an opportunity to explore different care models that could deliver better value and outcomes at lower costs. They were introducing new integrated models for better value and were considering the introduction of technology.

9. The Committee asked how the NHS People Plan influenced the OUH People Plan, and whether the OUH People plan was sufficiently tailored toward any potential specificities for Oxfordshire. The Chief People Officer stated that OUH had a specific Oxfordshire remit, part of which involved attracting and retaining people from Oxfordshire. The Trust had a scheme to recruit locally for their apprenticeships. They worked on the health inequalities agenda for Oxfordshire and were part of the Anchor Institute. Their goal was to reduce health inequalities and recruit people from local communities into their organization.

10. The Committee asked whether there was still a heavy reliance on agency and bank staff and whether cheaper housing for staff would help attract the workforce. The Chief People Officer responded that there was a reliance on agencies due to existing vacancies and a national shortage of trained nurses and doctors. The Trust had not only depended on agencies and banks but also on overseas recruitment due to the poor supply of trained medical professionals. There was a target to reduce their reliance on banking agencies by 700 whole time equivalents that year and were exploring different ways to achieve this. The cost of living was a factor that made it difficult for people to afford living in Oxford. OUH had been working with outside agencies to secure cheaper accommodation for their staff, an effort that was ongoing; and were also considering the introduction of an Oxford Weighting, similar to the London Weighting received by hospitals in London, given that the cost of living in Oxford was not much lower than in London. The Trust expressed appreciation for any assistance that could be provided in this regard.

11. The Committee asked about the protection of staff from abuse and violence and whether there was a whistleblowing policy in place. The Chief People Officer stated that addressing abuse towards their staff was a high priority due to an increase in such incidents. There was a specific group focused on supporting staff in relation to violence, aggression, and sexual harassment. Several initiatives were in place, including body cams for Emergency Department staff, psychological support from their Psychological Medicine service, a poster campaign, and a revisited policy about violence and aggression. The Trust had strengthened its warning system for aggressive or violent patients, and were also encouraging staff not to tolerate abuse, which had sometimes led to staff leaving their jobs. There was work to lower staff tolerance of violence and aggression, even when it came from patients with dementia or other illnesses. They wanted staff to report incidents so they could take action, and were even willing to deliver final warnings to patients at an executive level. They were making progress on this significant agenda, but not as quickly as they would have liked.

12. The Chief People Officer had confirmed that the majority of the issues were from patients. Upon reviewing the data and staff survey results, the Trust found that incidents involving staff-on-staff were less than half of those involving patients-on-staff. The Chief People Officer stated that OUH had a whistleblowing policy encouragement to speak up, however, it was acknowledged that more needed to be done. As part of their action plan, they were exploring ways to provide psychological safety for people to voice their concerns. They were seeking charity funding to establish an external whistleblowing system, assuring that it would be anonymous and allow people to raise their concerns without fear of being traced. This was aimed at addressing these concerns effectively.

13. The Committee asked how OUH would be evaluating and measuring the overall effectiveness of the Plan and its tangible outcomes and delivery. The Chief People Officer had responded that they had 15 metrics in their report, that they believed were crucial to measure. The end of Year Three of the People Pan, which was also the end of the financial year, was the time they would measure against all the metrics such as bullying and harassment, time to hire, and vacancy rates. An annual evaluation was conducted to assess their position, and for the second year, they had met the majority of the metrics. The areas they identified as having the most significant gaps were some of the equality and diversity metrics. They also noted the importance of employees taking the majority of their annual leave throughout the year, as it was crucial for rest and recovery. Another concern was the number of people leaving within a year of starting, particularly among admin and clerical and healthcare support workers. This indicated issues with the work environment and the selection process.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

14. Below are some 4 points of observation that the Committee has in relation to the OUH People Plan. These key points of observation relate to some of the themes of discussion during the meeting on 18 April, 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.

Importance of risk assessments for recruitment pauses: The Committee is supportive of the OUH People Plan, and perceives the development of such a plan as constituting a positive development. The principles of the Trust's People Plan also appear to be in line with those outlined by the NHS's overall People Plan. Nonetheless, it has come to the Committee's attention that the Trust has paused the recruitment of certain types of staff. The key concern revolves round any serious implications of the recruitment pause on the delivery of the priorities and objectives of the People Plan. The vacancy pause at OUH is occurring at a time of unprecedented waiting lists and demands, and is also taking place in a national context where other Integrated Care Systems in other areas have already warned that the scale of staffing cuts to balance the books are wholly unrealistic without putting patients at risk. Therefore, it will be crucial for there to be sufficient reassurances, as soon as possible, both to the Committee as well as key stakeholders and the wider public,

as to what the implications of such a recruitment pause in Oxfordshire could be.

If the pause includes a ceasing of recruitment for clerical or administrative staff, then this may apply further pressure on clinical staff, some of whom significantly depend on the administrative support that such staff provide; and this will be likely to impact on patients as well as staff. Any pause on clerical appointments will have an impact on patients. The Committee also understands that the pause is on certain managerial level staff. Again, it is important for there to be clarity and reassurances around the implications that this could have on the management structure and the effectiveness of the Trust's management of its staff overall. In addition, it is understood that clinical staff may also be affected by this pause, which could also potentially have an impact on patients. Therefore, the Committee urges and recommends for there to be mechanisms in place so as to enable frequent reviews of the Trust's managerial, administrative, and clinical circumstances so as to allow for the hiring of such posts (which have been subjected to the pause) in scenarios when they may be urgently needed.

Related to the above point regarding frequent reviews of staffing affected by the pause, it is important for there to be adequate risk assessments of sufficient quality and frequency. This would help the Trust to identify with immediacy whether any negative implications have arisen, for either staff or patients.

Therefore, the committee is requesting for a written briefing to be provided to it; one that outlines the reasoning behind the recruitment pause for certain OUH staff, in addition to information on any risk assessments that may have been, or that may be, conducted in the context of the pause.

Recommendation 1: *For Oxford University Hospitals NHSFT to provide the Committee with a written briefing around the reasoning behind the pause in recruitment of certain OUH staff, as well as around any risk and impact assessments that have been conducted around the recruitment pause; to also include assessments that are ongoing.*

Importance of ongoing engagement with staff/stakeholders: The Committee is pleased to see that there has been some level of engagement around the development of the People Plan, including with staff. It is crucial for such engagements to continue as much as possible. Continuing engagement should be sought over the very design and essence of the plan and its principles, as well as in the process of its ongoing delivery.

It is important that staff feel as being part of the process of the designing and the delivery of the People Plan. The staff represent the beating heart of the Trust, and in the case of some clinical staff, the pressures they could often face at work are significant. The Committee is glad to see

that staff listening events had taken place, but urges that further listening events take place and that such events are inclusive for all types of staff. The importance of engagement with staff is also reflected in the fact that allowing staff to have a voice could further inform the Trust of some of the challenges that its staff often face, which could in turn shape not just the content of the People Plan but also contribute to the development of very tangible support structures and processes for staff.

Furthermore, the pressure that frontline clinical staff are subjected to may also make them more susceptible to developing mental health challenges. Ensuring that there is adequate engagement with staff will allow for staff to be reassured that their concerns and experiences are taken on board, and it can help to determine the kind of support structures that the Plan should have in place for clinical staff who may experience mental health decline.

Moreover, the Committee encourages the Trust to continue to engage with any other relevant stakeholders beside staff. Engaging and listening to Healthwatch Oxfordshire and patient groups could help the Trust to understand how patients feel about the services they are receiving, and such feedback could be utilised as a means to develop support for staff that will enable them to provide the kind of care and support that patients would want and require.

Recommendation 2: *To ensure that there is ongoing engagement with staff and key stakeholders around the continuing design and delivery of the OUH People Plan.*

Securing adequate resources for delivering the Plan: The Committee is generally supportive of the priorities and objectives of the People Plan. The plan reflects a comprehensive and extensive commitment by the Trust to improve the people aspect of the organisation. Nonetheless, as with any extensive plans of this nature, it is necessary for the Trust to explore avenues through which it can continue to fund and resource the plan. There may be aspects of the plan that could be delivered with the Trust's existing resources or through existing workstreams. However, there may almost certainly be other commitments within the plan that may require the Trust to secure further resources to deliver on.

The aforementioned temporary pause on the recruitment of certain staff may constitute one of the many limitations or barriers toward meeting the objectives of this plan in as optimal a manner as possible. However, this is not the only challenge that could arise. The Trust is also operating in a broader national context where challenges with recruitment, retention, and resourcing are widespread. The Committee therefore urges the Trust to identify which aspects of the plan may be easily deliverable, and which other aspects will have dependencies on other resource related factors, and for adequate steps to be taken to address this as early as possible.

Furthermore, the Committee also understands that a key element of attracting staff for the Trust would be the incentives provided through

offering wages that would allow them to avoid significant financial hardships. Clinical staff, in particular, are often subjected to physically and psychologically demanding work. Such staff should therefore not be subjected to additional financial burdens that could affect their personal life. Whilst the challenges around the cost of living are not unique to Oxfordshire and are experienced nationwide, it is pivotal that the Trust engages with staff and explore avenues through which to increase benefits which would be valued by staff, especially those that are most exposed to the pressures of the cost of living and housing in Oxfordshire. This would help enable staff to manage their finances in a manner that enables them to have a healthy work-life balance.

Additionally, and as part of measures taken to improve pay and financial wellbeing for staff, the Committee is recommending that the Trust works with relevant system partners, including HOSC, to make the case and explore the prospect of achieving an Oxford Weighting. Much like the London weighting which enables workers in the capital to receive an additional increment that allows them to cope with the additional local costs, an Oxford weighting would allow Trust staff to cope with the increasing financial constraints faced by those living or working in Oxford. This will provide significant benefits for staff given that living in Oxford could be just as costly as living in parts of London.

Recommendation 3: *To continue to secure the necessary levels of resources required to deliver on the key objectives of the People Plan, and for the Trust to explore avenues of improving pay for staff in line with the increases in financial hardships generated by the Cost-Of-Living Crisis. It is recommended that the Trust works with relevant system partners to explore the prospect of achieving an Oxford Weighting.*

Monitoring effectiveness of the People Plan: The committee believes that with the adequate securement of resources, as well as with the collaboration between various staff and teams within the Trust, that the People Plan could indeed produce positive outcomes for the Trust and its staff. However, equally important for the plan's deliverability is the imperative for a clear understanding and identification by the Trust as to the amount of funding and resources that would be necessary to deliver the plan. Part of this would rely on what was emphasised earlier in this report in respect to identifying areas of risk and dependency when it comes to resourcing the plan. However, an additional important aspect would be to develop important performance indicators that are separate to the Trust's overall indicators and that are tailored specifically toward monitoring the deliverability of the People Plan.

The key principles as well as the objectives of the plan should ideally be measured on a frequent basis, and efforts should be made to clearly identify any complications or delays to any set timescales that could arise. Indeed, timeliness is also an important factor which should be applied when measuring the delivery of the objectives of the plan. Realistic timescales for each indicators should be produced and assessed against.

Furthermore, the Committee urges for there to be an explicit role for staff in being able to be a part of the process of evaluating the plan's effectiveness. Staff can provide first hand insights which could demonstrate the degree to which they feel happy in the environment that they work in, as well as the extent to which they feel they have received adequate levels of support and training to be able to execute their roles and responsibilities confidently and effectively. Additionally, related to this is also the importance for there to be clear transparency and accountability over the monitoring of the plan and its overall effectiveness. Each indicator/measurement should ideally have a clearly identifiable lead, and there should be regular reporting against any targets/indicators associated with the plan. At the internal Trust level, this reporting should take place at the most senior level.

Recommendation 4: *To continue to develop clear processes through which to evaluate and measure the effectiveness of the People Plan and its delivery.*

Legal Implications

15. 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.

16. 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'.

17. 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

Contact Officer: Dr Omid Nouri
Scrutiny Officer (Health)
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

May 2024

Divisions Affected – All

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

06 JUNE 2024

Draft HOSC Annual Report 2023/24

Report by Director of Law and Governance

RECOMMENDATION

1. **The Committee is RECOMMENDED to: -**

   1.1 Note the requirement for the Committee to produce an annual report

   1.2 Approve the wording of the annual report, annexed to this report in draft, subject to any required amendments of the Committee

   1.3 Delegate authority to the Principal Scrutiny Officer:

      1.3.1 for the design of the final report,

      1.3.2 to make minor updates or amendments as required, in consultation with the Chair and the Health Scrutiny Officer,

      1.3.3 for publication of the final report

Executive Summary

2. The Health Overview and Scrutiny Committee is under a constitutional duty to prepare an annual report. This paper seeks to obtain agreement from the Committee on the content and wording of the draft annual report, which is annexed to this report, subject to any amendments that may be required.

Background

3. Under the Health and Social Care Act 2012, Regulation 28(1) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council has a duty to "review and scrutinise any matter relating to the planning, provision and operation of the health services in its area".

4. As part of this overarching duty it has a duty, enshrined in the Council's Constitution, to report on its activity over the preceding year. The Committee complies with it by producing an annual report on its activity over the preceding year

5. The Constitution specifies in Part 6.1B s 23 that this report is to be produced each year. The aim is to publish this year's annual report in the agenda papers for the Council meeting on 09 July 2024.

Corporate Priorities

6. Improving health and wellbeing of residents and reducing health inequalities are stated ambitions within the Council's Strategic Plan.

Financial Implications

7. There are no financial implications arising directly from this report and it is expected that any additional costs relating to co-optees or advisors can be met within existing budgets.

   Comments checked by: Kathy Wilcox

   Kathy Wilcox, Head of Corporate Finance and Deputy Section 151 Officer. kathy.wilcox@oxfordshire.gov.uk

Legal Implications

8. Part 6.1B, s. 23 of the Council's constitution states that:

   The Committee shall produce in April each year a report for the Appointing Authorities on its activities during the preceding year. That report shall also be published to health bodies and the public.

   The Committee is currently not compliant with this requirement and should take steps to publish its Annual Report as soon as practicable.

   Comments checked by: Anita Bradley

   Anita Bradley, Director of Law and Governance and Monitoring officer. Anita.Bradley@oxfordshire.gov.uk

Staff Implications

9. None arising from this report.

Equality & Inclusion Implications

10. None arising from this report.

Sustainability Implications

11. None arising from this report.

Risk Management

12. If Members do not agree to sign off the report, the draft will have to be considered at the next HOSC meeting, meaning further delay to its publication.

Anita Bradley
Director of Law and Governance and Monitoring Officer

Annex:	1. Draft Annual Report
Background papers:	None
Other Documents:	None
Contact Officer:	Dr Omid Nouri, Health Scrutiny Officer Omid.nouri@oxfordshire.gov.uk

June 2024

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Chair's Introduction:

This annual report comes after a year of unprecedented and increasing challenges for health services including rising health demands as well as rising pressures in most areas (particularly in areas where there is a workforce shortage). These are national issues which the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) has scrutinised locally. Some patients have inevitably faced delays and disruption to the quality of their care. The JHOSC drew attention to the shortfall in the workforce before the pandemic and all pressures have significantly worsened since then. Some health workers will inevitably be continuing to work above and beyond their expected responsibilities. The JHOSC has therefore become more heavily involved in the scrutiny of healthcare services in light of some of the recent challenges, but it has also sought to act as a "critical friend" toward the individuals and organisations responsible for providing health services to local residents, including the County Council, the BOB Integrated Care Board (ICB), Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust, and the newly created Oxfordshire Place-Based Partnership, as leaders of the local system work together to plan and deliver improvements. The County Councillors on the Committee have served on both the Oxfordshire JHOSC and on the three-county health scrutiny committee (known as the Buckinghamshire, Oxfordshire, and Berkshire West JHOSC, referred to as BOB HOSC), and have contributed to detailed scrutiny on the ICB strategy overall and on both the ICB's Primary Care Strategy and its Digital and Data Strategy.

The JHOSC has also worked hard to build much stronger relationships with many key individuals and organisations within the Oxfordshire system for the purposes of facilitating effective and healthy forms of scrutiny and partnership working; the aim of which is to help work with system partners to improve the healthcare services that Oxfordshire's residents receive. It is vital that HOSCs are able to work effectively within local systems and with good relationships, and the JHOSC has relied on this for the purposes of pursuing effective healthcare outcomes for the local population. This also helped to achieve detailed scrutiny reviews which had proven valuable not merely from a scrutiny perspective but also for the wider system. The work of this significant body of democratic scrutiny is only possible because of extensive engagements, and our thanks go to all colleagues from the health and social care system who have supported the JHOSC's work including local NHS leaders and Cabinet Members and officers from the County Council who have reported to and spoken to the Committee who are listed below:

NHS

- Susannah Butt (Transformation Director- Community Health Services, Dentistry and Primary Care, Oxford Health NHS Foundation Trust)
- Rachel Corser (Chief Nursing Officer, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board)

- Julie Dandridge (Deputy Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board)
- David Eltringham (Chief Executive, South Central Ambulance Service)
- Lucy Fenton (Transformation Lead – Primary, Community & Dental Care Oxford Heath NHS Foundation Trust)
- Lisa Glynn (Director of Services Oxford University Hospitals NHS Foundation Trust)
- Daniel Leveson, (Place Director, Berkshire, Oxfordshire and Buckinghamshire Integrated Care Board)
- Hugh O'Keefe. Senior Programme Manager -Pharmacy, Optometry and Dental Services, BOB ICB
- Dr Ben Riley (Managing Director, Oxford Health NHS Foundation Trust)
- Sam Shepard (Deputy Director of Strategy & Partnerships, Oxford University Hospitals NHS FT)
- Eileen Walsh (Chief Assurance Officer, Oxford University Hospitals NHS Foundation Trust)

Oxfordshire County Council

- Ansaf Azhar (Director of Public Health, Oxfordshire County Council)
- Cllr Tim Bearder (Cabinet Member for Adult Social Care)
- Liz Brighouse (Former Cabinet Member for Children, Education and Young People's Services)
- Cllr Michael O'Connor (Former Cabinet Member for Public Health)
- Stephen Chandler, (Executive Director for People, Oxfordshire County Council)
- Cllr Kate Gregory (Cabinet Member for Special Educational Needs and Disabilities)
- Cllr John Howson (Cabinet Member for Children, Education and Young People's Services)
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council)
- Cllr Nathan Ley (Cabinet Member for Public Health)

The Committee has made 81 formal recommendations to the NHS as well as Oxfordshire County Council's cabinet within the last civic year. The JHOSC had issued these recommendations in the form of reports which outlined key feedback themes on policies as well as proposals. The vast majority of these 81 recommendations had been accepted, and they relate to key areas ranging from (although not exclusively on) General Practice Provision, Dentistry, CAHMS and Children's Emotional Wellbeing and Mental Health Services, Children's SEND provision, Ambulance services, support for people leaving hospital, and on Healthy Weight Promotion. One important example was that in line with the JHOSC's recommendation, the ICB recruited a dedicated estates post to work with district councils on the use of significant funds already held for the NHS and to claim health funding for new developments. The Committee also made recommendations again following our in-depth workshop and scrutiny review

last year on primary care that the overdue GP practice development at Great Western Park is established with urgency, and the Committee welcomed the significant progress announced that the ICB had approved the business case with the additional funding needed so that a new GP premises can be progressed for the growing population. Another example was the identification of the serious underspend for NHS Dentistry in Oxfordshire, and the need for flexible measures, particularly for rural areas of the County and vulnerable populations that have been worst affected, and for the ICB and NHS England to reinvest any underspends in Oxfordshire at Place.

Furthermore, within the previous civic year as of 1 February 2024, HOSC's have lost the power to formally refer matters to the Secretary of State for Health and Social Care. Although, HOSCs may still informally write letters to the Secretary of State to raise any concerns they may have regarding local health services. Whilst the Committee tried to influence a formal consultation on this change, it was successful locally in encouraging and scrutinising co-production and public engagement between the NHS and the Wantage Town Council Health Committee and local community on the future of Wantage Community Hospital. In 2024, there is ongoing co-production on a major refurbishment of the hospital by 2025 with delivery of outpatient clinics, a new long term conditions clinic, and other local improvements.

Whilst the JHOSC's focus is on understanding local services and impacts and on opportunities for local improvements, the Committee had received a response from government to our local findings with recommendations on primary care and from the Parliamentary Select Committees regarding national scrutiny on new medicines regulations for people with bipolar and epilepsy disorder. The Committee is awaiting a response to our August 2023 letter concerning deep concerns and key measures that could be taken around dentistry provision, and welcomes the recent dentistry report to the Committee that includes government plans for developing local consultations on fluoridation.

I believe we are a great and maturing team with an increasingly good overview as to the factors which affect the provision of healthcare across Oxfordshire. I would like to put on record particular thanks to Cllr Elizabeth Poskitt as vice-chair over the last year. With other departures, the Committee also said goodbye to its longstanding and deeply appreciated co-opted member, Jean Bradlow. The people of Oxford are fortunate to have had such a knowledgeable and hard-working champion working on their behalf, though the Committee is acutely aware that there are many people who support them behind the scenes too.

The fundamental purpose of the JHOSC is to provide democratic oversight into the provision of our health services. I would like to express thanks to Health Watch Oxfordshire, as the Committee benefits from unique insights from their work with the public and with the Oxfordshire Place Committee, which are helpful at every JHOSC meeting. The Committee welcomes and is thankful for the members of the public that

have given up their time to speak or to write to the Committee, and for the engagement from public local stakeholders and groups and local Councillors.

Particular thanks also goes to Dr Omid Nouri, the Health Scrutiny Officer, who, has dedicated exceptional effort into supporting the Committee and the process of Health Scrutiny more broadly. The increased investment by the Council in the scrutiny function has resulted in increased value and impact and support.

Councillor Jane Hanna OBE Chair of the Oxfordshire Joint Health Overview and Scrutiny Committee 2023/2024

What is the Oxfordshire Joint Health & Overview Scrutiny Committee:

The Joint Health Overview and Scrutiny Committee (JHOSC) is a Joint Committee of Oxfordshire County Council. Is it fundamentally a Scrutiny Committee that conducts Health Scrutiny on behalf of the Council and is comprised of 15 Members. The Committee's membership is derived from Oxfordshire County Council members, as well as members from the City and District Councils within Oxfordshire (Cherwell, Oxford City, South Oxfordshire, Vale of White Horse, West Oxfordshire). In addition, the JHOSC contains spaces for three members who are not Councillors but who may have extensive exposure or expertise related to the Health remit of the Committee; these are referred to as co-optees. Currently, one of these posts remains filled by Barbara Shaw, although work is underway to secure two further co-optees.

The JHOSC is not a decision-making body of the Council. In other words, it does not possess the ability to make or amend policies directly. As a scrutiny body, the JHOSC's purpose is to engage in scrutiny of any matter relating to the development and delivery of health services throughout Oxfordshire. Hence, the Committee has the power to summon before it any individuals or organisations involved in the commissioning or the delivery of health services throughout the County. The Committee benefits from, and can harness the expertise, knowledge and understanding of the diversity of its members to not only ensure effective oversight over health services, but also to do so in a manner that contributes and adds value toward policies and decisions. Hence, the true power of the JHOSC lies in its ability to issue, as per the Health & Social Care act and the Local Government Act, recommendations to the NHS or Oxfordshire County Council as to how health services could be improved for residents. In doing so, the Committee seeks to, inasmuch as possible, issue recommendations that are viable, reasonable, and that also adhere to the SMART (Specific, Measurable, Attainable, Realistic, Timely) criteria. The JHOSC issues recommendations to Cabinet or to local NHS commissioners or providers, and recipients of such recommendations are required to provide a written response to the Committee within 28 days.

The JHOSC also uses its soft power as a means to shed light on where national constraints limit local improvements, and where possible, raises local concerns with the national government as a means of seeking further support for improving services at the local level.

The Committee's power is also to give improved clarity to where local improvements are constrained by national powers, resource and guidance; the Committee has been able in these cases to make these local findings and correspond with government to seek support for local improvements. This has particularly been the case in relation to the national challenges around General Practice and Dentistry Provision in light of the increased demand for such services.

Summary of Activity

HOSC Activity in Brief

The Committee convened 7 Public Meetings throughout the course of the last municipal year. This exceeds the minimal requirement of 5 Public Meetings for each municipal year. Over the course of these meetings it has scrutinised 21 substantive items this municipal year. Some of the key items of scrutiny involved:

- Winter Planning.
- Local Area Partnership SEND Provision.
- Oxfordshire Healthy Weight.
- Health and Wellbeing Strategy.
- Children's Emotional Wellbeing and Mental Health.
- Oxfordshire Place-Based Partnership.
- The future of Wantage Community Hospital.
- Support for People Leaving Hospital.
- South Central Ambulance Service CQC Improvement Journey.
- John Radcliffe Hospital CQC Improvement Journey.
- Director of Public Health Annual Report.
- General Practice Provision in Oxfordshire.
- Dentistry Provision in Oxfordshire.
- Oxford University Hospitals NHS Foundation Trust People Plan.

Within the past civic year, the Committee has issued 85 formal recommendations to the NHS as well as Oxfordshire County Council's cabinet. Of these 85 recommendations, 60 were accepted, 8 were partially accepted, and 2 rejected. 15 of these recommendations were issued during the 18 April 2024 meeting, and the JHOSC is awaiting responses to these.

The Committee has also received briefings from the NHS on a few areas including:

- An online as well as a written briefing on the Warneford Park Hospital Redevelopment Project.

- An online briefing on the Oxford Community Health Hubs Project.

- A written briefing on the ICB's efforts to secure the future of local GP services in Botley and Kennington.

- A written briefing on the closure of Short Stay Hub Beds in Chiltern Court.

The Committee's Substantial Change Working Group had also met 3 times within the last civic year to discuss the recommendations it was issuing to the wider JHOSC as to the future of Wantage Community Hospital. This Working Group also held 3 online check-in briefings with representatives from the ICB and Oxford Health NHS Foundation Trust for the purposes of receiving updates on the NHS's Public Engagement Exercise around the future of Wantage Community Hospital.

Key Accomplishments

The HOSC has invested immense effort into engaging in the scrutiny of a variety of areas which involved important developments and decisions which have significant impacts on the health and wellbeing of Oxfordshire's residents. Throughout the course of the previous municipal year, Committee has adopted a holistic approach to Health and Wellbeing, and this in line with National as well as Local efforts to further integrate health and care services for residents as well as to focus on a broader model of health and wellbeing.

Nonetheless, a good indication of the HOSC's success is also the impact of its work in contributing to developments that could have positive outcomes for the Health and Wellbeing of Oxfordshire's residents.

i. Securing the future of Wantage Community Hospital:

The Committee has been engaged in ongoing scrutiny of the future of Wantage Community Hospital since the 'temporary' closure of the inpatient beds 2016. The loss of HOSCs' powers to refer matters to the Secretary of State in January 2024, however, put a hard deadline on one of the Committee's possible options to resolve the situation, meaning this has been an area where HOSC has invested significant time and effort, with positive outcomes for all stakeholders.

The Committee was at the forefront of recommending the launch of a public engagement exercise with key stakeholders and local residents for the purposes of securing as well as co-producing a plan for the future of hospital-like services to be delivered on the ground floor of Wantage Community Hospital. The Committee's Substantial Change Working Group held 3 check-in meetings with Oxford Health NHS Foundation Trust and the ICB throughout the course of the NHS's public engagement exercise to receive updates on the format and the effectiveness of the exercise. The Working Group itself convened twice throughout the course of the exercise to determine the recommendations it would make to the wider Committee as to the decisions over whether to refer the matter of the closure of the inpatient beds to the Secretary of State for Health and Social Care. The powers of HOSCs to formally refer matters to the Secretary of State were to cease at the end of January 2024, however, the Committee chose to abstain from referring this matter to the Secretary of State on the condition that the NHS would honour its commitments to securing the future of the ground floor of the hospital by providing a multitude of clinical outpatient services that would benefit the health needs of the local community.

The Committee played a crucial role in working closely with the NHS to secure the future of hospital-like services in Wantage Community Hospital, and contributed to the development of a project delivery plan which determines the steps that would be taken at each stage of the process of expanding the outpatient clinical services provided at the hospital. The Chair and Health Scrutiny Officer have fed into the Wantage Community Hospital Governance and Oversight Group, which includes key representatives of Oxford Health NHS Foundation Trust, the ICB, Oxfordshire County Council, and the local Primary Care Network. This has helped to ensure ongoing scrutiny and oversight of the project delivery plan to ensure that it remains

on schedule. The Committee also made recommendations for, and has been at the forefront of supporting the Community Infrastructure Levy (CIL) funding available from the Vale of the White Horse District Council for the purposes of financing the expansion of the aforementioned services. The Committee issued the following recommendations as part of securing the future of Wantage Community Hospital, all of which were fully accepted by the NHS:

1. That there is no undue delay in securing the CIL funding available in full for the purposes of providing the additional proposed clinical services on the ground floor of Wantage Community Hospital given the removal of the in-patient beds since 2016. It is recommended that there is a maximisation of the ground floor of the hospital for the purposes of expanding a mix of specialist outpatient clinics.

2. That the Project Delivery Plan for the future of the hospital's ground floor services is delivered on schedule as much as possible, and that there is ongoing scrutiny over the process of delivering the plan and its outcomes for the local population.

3. For a meeting to be convened as early as possible between identified leads within BOB ICB, Wantage PCN, Oxford University Hospitals NHS Foundation Trust, Oxford Health NHS Foundation Trust, Oxfordshire County Council, Wantage Town Council, and HOSC; with a view to plan for continued momentum on co-production and agreed scrutiny moving forward.

The JHOSC has played a crucial role in supporting and overseeing the co-production around the future of the hospital, and continues to engage in ongoing scrutiny over the delivery plan for this project. This case was indicative of the strong role of the Committee in helping to achieve a resolution over the Hospital's future, which had remained unresolved for several years.


Oxfordshire NHS
Wantage Community Hospital

ii. **The reconvening of the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (BOB JHOSC)**

During the previous municipal year, the Committee has been involved in orchestrating the reconvening of the BOB JHOSC. The BOB JHOSC is comprised of Councillors from Oxfordshire County Council, in addition to the local authorities of Buckinghamshire, West Berkshire, Wokingham and Reading. This JHOSC has a renewed emphasis and commitment to engage in system-level scrutiny of the BOB the Integrated Care System, as opposed to developments at 'Place' (county) level which are examined primarily by the OJHOSC. The BOB JHOSC also examines system level developments that would collectively impact all the member authorities. As well as receiving an update on the Integrated Care Board's (ICB) new priorities, the BOB JHOSC has been involved in the Scrutiny of two key ICB strategies:

- *Primary Care Strategy*: which aims to improve and transform the ways in which general practice, community pharmacy, optometry, and dentistry services are delivered under the BOB footprint.

- *Digital & Data Strategy*: which outlines and will guide the ICB's digital, data and technology ambitions for the forthcoming three years.

Prior to the Public meeting of the BOB JHOSC on 24 January 2024, the Chair of the Oxfordshire JHOSC and Health Scrutiny Officer participated in a BOB JHOSC Working Group meeting to develop and agree on a feedback report which was submitted to the ICB in relation to the Digital & Data Strategy. A separate feedback report was also submitted to the ICB in relation to the Primary Care Strategy. Below are some key points of feedback that the BOB JHOSC (through the active contribution of the OJHOSC) provided to the ICB in relation to both strategies:

- *Primary Care Strategy*: It was recommended that further and continuous public and stakeholder engagement was crucial as part of the design of the strategy; and that the public and key stakeholders should have a role in being able to feed back into the process of evaluating the delivery of the strategy. It was also emphasised that the ICB should seek to learn from best practice elsewhere; this could involve learning from how other systems have managed increases in demand for primary care, as well as how primary care has been at the forefront of Prevention work for long-term conditions. Further emphasis was also placed on the imperative for transparency over both the extent to which physician associates or administrative staff are involved in the triaging or treatment of patients, as well as over the existence of any competency frameworks that are being adopted to maximise patient safety and reassurance.

- *Digital & Data Strategy:* It was recommended by the BOB JHOSC that there are clear governance processes around the use of technology and data sharing on the context of healthcare services; and that there is continuous stakeholder engagement as well as clear evidence of good collaboration with and between Adult Social Care, mental health providers, Hospital Trusts, and providers across Primary Care. The BOB JHOSC also fed back and strongly recommended that there were clear

timescales as part of the phased delivery of the Digital and Data Strategy, and that explicit Key Performance Indicators are established for the purposes of monitoring and evaluating the deliverability of the strategy.

iii. Warneford Park Hospital Redevelopment Project:

A key development the Committee has been involved in is the project to redevelop Warneford Park Mental Hospital. It is important to note that poor mental health in the UK continues to pose social and economic effects, yet it has not received the same level of resources and investment when compared with physical health conditions. It is also the case that since the advent of the Covid 19 Pandemic as well as the cost of living crisis, mental ill health has seen an increase. Therefore, and as part of the JHOSC's holistic approach to health and wellbeing, the Committee has been involved in ongoing scrutiny of, and has been actively supporting the ambitions of Oxford Health NHS Foundation Trust to embark on a bid for government funding to support a project to redevelop and modernise the hospital.

The Warneford Park Hospital has been treating local residents suffering poor mental health for over two centuries. However, it has become increasingly difficult for clinical staff to support patients with effective therapeutic activities, particularly in light of recent clinical emphasis on the importance of positive therapeutic environments and activities for aiding patient recovery.

The project involves a 'Warneford Park Campus' proposal, which is part of a joint venture between Oxford Health NHS Foundation Trust and Oxford University. The ambition is to seek government funding to help establish a state-of-the-art mental health hospital offering the best therapies, care, and therapeutic environment. This would be co-located with a global brain-health research facility as well as an on-site college to educate future postgraduate researchers and clinicians. The JHOSC has received a written briefing on this redevelopment proposal and project, and 5 members of the Committee (alongside the Health Scrutiny Officer) conducted a site visit at the Warneford on 30 January 2024. The visit helped shed light on the importance and timeliness of this project given the increasingly ageing and untherapeutic environment that patients were being treated in, as well as a constructive challenge that was welcomed on how the development would be integrated with community-based provision across Oxfordshire for people with serious mental health needs.

It is vital that Oxford Health NHS Foundation Trust receives support from the JHOSC for the purposes of securing government funding for this redevelopment project, and the Committee is in the process of providing its endorsement. However, the Committee has set a number of conditions as part of its endorsements for the redevelopment:

1. That adequate reassurances should be provided that in the event of the necessary funding being provided by government, the project can proceed without significant obstacles or delays.

2. That there is sufficient engagement with key stakeholders around the redevelopment project and proposals.

3. That the Warneford development in Oxford City is integrated in a hub and spoke model and plan, through which working with partners and communities, provides prevention and rehabilitation to residents with serious mental health conditions in local communities across Oxfordshire

4. That any negative impacts that the redevelopment of the hospital may have on patients during the duration of the redevelopment are minimised.

iv. General Practice Provision in Oxfordshire:

A key and continued area of focus for the Committee remains the state of GP provision within the county. The Chair and Health Scrutiny Officer have held meetings with the ICB's Director of Place for Oxfordshire on 2 occasions in the last municipal year to discuss the state of GP services and the importance of meeting the increased demand for such services. In November 2023, the Committee requested a response to the recommendations previously issued to the ICB:

> *That specified roles are filled within the ICB with the primary responsibility to work with District Councils at Place Level to coordinate the use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care.*

The ICB confirmed that they had recruited a Primary Care Estates Manager who would play a key role in working with City and District Councils in terms of planning for new housing developments. Such housing developments have been resulting in an increase in population and demand for GP services in many parts of the County, including the Didcot area.

In regards to the Didcot area, the JHOSC was particularly concerned that demand was not being met, and therefore strongly urged the ICB to take action to address this. However, the Committee strongly supported and was pleased to see that the ICB had approved the business case for a new building and that it agreed to provide funding in addition to the money from developer contributions known as section 106 funding. The Woodlands Medical Centre will manage the estate as a branch surgery. The JHOSC had also convened a public meeting item on GP provision during its 18 April 2024 meeting, during which it issued a recommendation to the ICB that an expected date

for the signing of the legal agreement on the Didcot Western Park site is provided to the Committee, so that there can be reassurances to both the JHOSC as well as the wider public as to the likely timescale for the tendering process.

As part of its ongoing scrutiny of GP provision, the Committee also recommended that the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons. This recommendation was crucial given the increasing difficulties residents have been experiencing in being able to communicate with practices in order to book appointments. The JHOSC has urged the ICB for there to be communication with the public to provide improved clarity regarding the statistics concerning access to appointments.

In addition, in line with the concerns raised through the BOB JHOSC regarding the increasing reliance on administrative staff as well as physician associates for triaging and treating patients, the OJHOSC has strongly recommended to the ICB that there is clear transparency around the use of any competency frameworks and risk assessments that staff who are not trained doctors will be subjected to. Patient safety is key, and any increases in demand for GP services should not be met in a manner that may entail a risk to patients. This is of high public interest, and I relation to this matter, the Committee recommended the publication of the themes of responses from stakeholders and groups in Oxfordshire about the ICB's Primary Care Strategy.

Dentistry Provision in Oxfordshire:

Another key area of focus for the JHOSC has been on the current and future state of dentistry services for Oxfordshire residents. The Committee has taken a keen interest and focus on NHS dentistry services in particular. The reason for this is due to the difficulties that many residents increasingly experience in being able to afford private dental care. In the context of the cost-of-living crisis, residents have been struggling to afford private dental checkups and treatments. This has often resulted in residents abstaining from visiting a dentist or seeking dental treatment after an initial check-up. This is also concerning given that poor dental health is a leading cause for child admission to hospital. The challenges around receiving effective and adequate dentistry services is further compounded by the fact that residents have experienced difficulties in being able to receive NHS dentistry treatments and services.

To highlight the challenges around NHS dentistry provision within Oxfordshire, and to bring these to the attention of government, the Committee wrote to the Secretary of State for Health and Social Care in relation to this matter in July 2023. There were two comprehensive and overarching themes that the Committee had highlighted to the Secretary of State which related to:

1. The underlying oral health challenges and patterns relating to tooth decay and deprivation, which requires further collective national and systemwide efforts to resolve. One key recommendation that the JHOSC made to the Secretary of State to address these long-term challenges was for government to support a local public consultation to raise awareness of the importance of, as well as to consider local views regarding the fluoridation of the County's water supply. Given the proven benefits of fluoridating the water supply, the JHOSC strongly urged the Secretary of State to support this.

2. There are also challenges with how dentistry services are being delivered, which are complicating ease of access to dentistry services for ordinary residents. This partly relates to the limitations of existing NHS dentistry contracts and the lack of adequate incentives to encourage dentists/practices to offer NHS dental treatments and to opt for prioritising/favouriting private treatments as a result of the increasing financial incentives of doing so. This has often resulted in dental practices terminating NHS contracts for fears of financially losing out.

Therefore, the Committee urged that the Secretary of State supports urgent action to rectify the aforementioned challenges around NHS dentistry access for Oxfordshire's residents.

Furthermore, at its meeting on 18 April 2024, the JHOSC received a report providing an update on the current state of Dentistry provision in Oxfordshire. This marked one year since the Committee had received a previous update on the state of NHS dentistry services. As part of this item, the Committee enquired about and emphasised the following key points:

- The extent to which changes to NHS dentistry contacts were having an impact in improving both access to dentistry services as well as the capacity of the NHS in this regard. This is particularly important given the challenges around residents struggling to afford private dental treatments.

- The extent of any progress in enabling new dental trainees to be placed on the NHS dental register without any undue delays. This point was particularly crucial given the ease with which new trainees could register for private dental practice.

- The degree to which information on how to access NHS dental services is easily accessible and available for residents. The Committee also urged that there is clarity on the possible exemptions to charges for dental care that residents may be eligible for.

- The importance of clarity around the amount of dentistry underspends in Oxfordshire as well as how these were being reinvested into improving dentistry and oral health within the Oxfordshire system, especially in the areas identified as worst served and vulnerable populations.

The Committee has been assured that the development of flexible contracting arrangements is making improvements and that there is work progressing on whether the ICB can itself advance new practices in the worst affected areas; as under new governance commissioning arrangements dentistry in Oxfordshire is overseen outside the ICB area by Surrey.

The JHOSC will continue to monitor closely access to NHS dentistry within Oxfordshire, and will continue to support the system by lobbying government to do more to support improvements to dentistry access for Oxfordshire's residents.

Other Key Highlights of HOSC Activity:

Health And Wellbeing Strategy for Oxfordshire:

Given its comprehensive remit over policies and measures taken by the Oxfordshire system to improve the overall Health and Wellbeing of the County's residents, the JHOSC commissioned and received a report by the Director of Public Health on the Updating of the Health and Wellbeing Strategy for Oxfordshire for its meeting on 21 September 2023. However, this strategy has remained a focus of the JHOSC's scrutiny ever since, and the Committee has commissioned a progress update response on the recommendation it had made on the strategy as part of this item.

The Committee recognises the immense work by key system partners (including the County Council, the City and District Councils, the NHS, Healthwatch Oxfordshire, and other key stakeholders) to develop and update the Health and Wellbeing Strategy. The strategy was therefore a product of joint production by system partners, and was also coproduced. The JHOSC understands, but also urged that the focus of the strategy was not to be on the nature of clinical services, but on the broader building blocks which should be health inclusive of residents living with physical and mental health conditions. In a report submitted to Oxfordshire County Council's cabinet in 2023, the Committee emphasised the importance of this being the key strategy at Place, where the system carefully identifies the key building blocks of health, and explores avenues through which to improve the overall Health and Wellbeing of Oxfordshire's residents.

Through its discussions with system partners during its public meeting on 21 September, as well as through a detailed feedback document provided by the JHOSC on the Updated Health and Wellbeing Strategy, the following key themes/points were highlighted. These points ultimately shaped the substance and wording of the recommendation that the Committee made to the Cabinet and the wider system in relation to the strategy:

1. That the cost-of-living crisis is negatively impacting the overall health and wellbeing of residents; particularly given the difficulties in households being able to afford healthy balanced diets. Additionally, the financial pressures generated by the cost of living is having a negative impact on mental health. The JHOSC therefore urged for there to be stronger clarification and understanding by the system to both determine how the crisis is affecting residents' health, and to explore avenues through which to collectively alleviate these pressures on the local population.

2. That individuals experiencing homelessness, in addition to those living in unsuitable, overcrowded, or badly maintained accommodation, could experience challenges to their mental and physical health. The JHOSC therefore urged that housing was a factor that should strongly be taken into account when updating the strategy, and that the system should work closely, including with the City and District Councils, to find ways to improve the accommodation and living conditions of Oxfordshire's population.

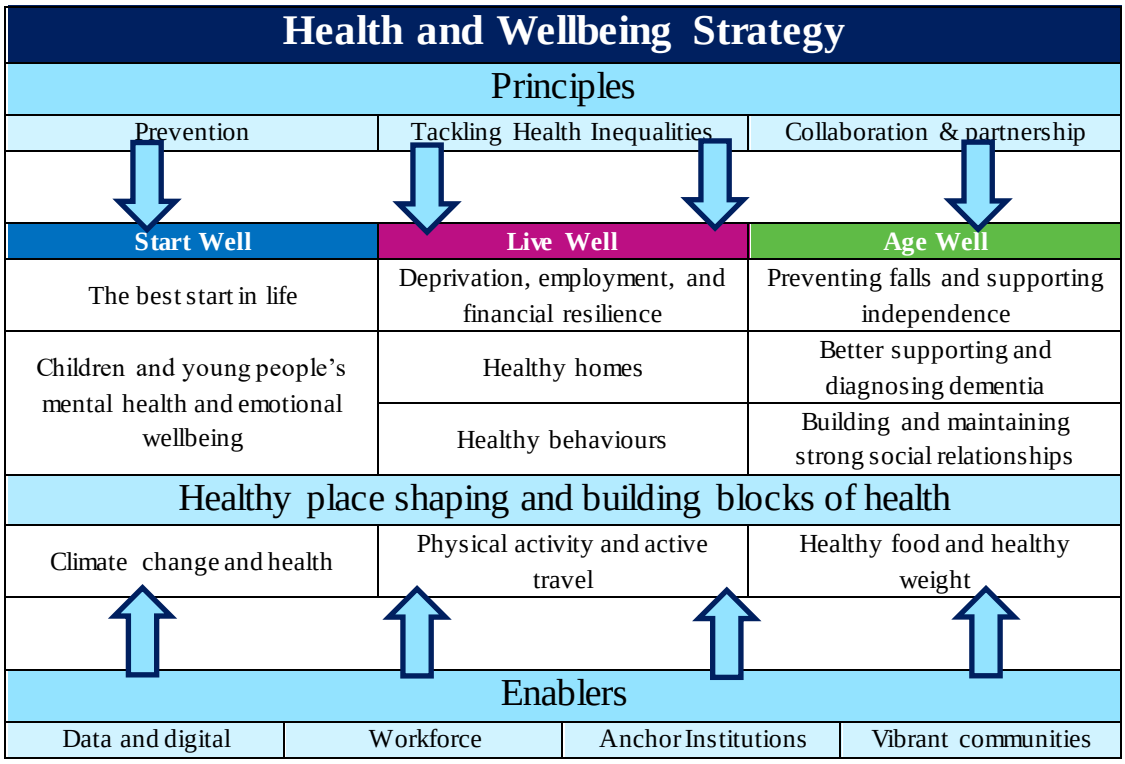
3. That inclusivity should be embedded within the continuous development of the strategy. Residents should be able to have efficient access to

healthcare services and support. Whilst the JHOSC recognises that the strategy is not clinical in its nature, it urged key partners to work collaboratively on improving information to residents on the services available to them, and for relevant system partners to tackle long wait times for services. The Committee also recommended to Cabinet and the wider system that input from disadvantaged groups should be fed into the strategy.

The Committee therefore issued the following specific recommendation to Cabinet on 17 October 2023:

> *To ensure careful, effective, and coordinated efforts amongst system partners to develop 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.*

This recommendation was accepted by Cabinet, and the JHOSC was pleased to see in Cabinet's response that a delivery plan and outcomes framework for the updated strategy was to be developed and approved by the Health and Wellbeing Board in the near future, and that this would build on the extensive public engagements undertaken as part of the efforts to update the strategy. Moving forward, the Committee plans to retain its scrutiny of the strategy, particularly in light of the development of the delivery plan.



Local Area Partnership SEND:

In light of the JHOSC's remit over Health for all ages, a key area of scrutiny that the JHOSC has been involved in is around Special Educational Needs Provision for Children and Young People. At its public meeting on 21 September 2023, the JHOSC discussed an outcome of a report that was published by Ofsted and the Care Quality Commission (CQC) on Children's SEND provision in Oxfordshire. At the time, the JHOSC worked closely with the People & Overview Scrutiny Committee (which then had a remit over Children and Educational services) to collectively scrutinise the outcome of the Ofsted/CQC inspection as well as the measures that the Local Area Partnership would take in order to address the concerns highlighted in the report. The JHOSC issued a list of recommendations to the Partnership which were in two segments; 1 segment of which were jointly issued between the JHOSC and the People and Overview Scrutiny Committee, and a second segment of which was issued specifically by the JHOSC.

The JHOSC therefore issued a total of 13 recommendations, all of which were accepted by the Local Area Partnership. The Committee is glad to see the publication of a Priority Action Plan by the Partnership. The JHOSC was also pleased to see that many of the recommendations it made as part of this item had influenced the nature and substance of the Partnership's Priority Action Plan. Some key themes highlighted in the recommendations included an emphasis on the following:

1. Ensuring that children and their families are aware of the SEND services available, and that they are aware of how to go about accessing these services, be they provided by Oxfordshire County Council, schools, or the NHS.

2. For there to be greater reductions in waiting times, in addition to clear timeframes to be created for reducing any backlogs.

3. For the voices of children and their families to be adequately taken into consideration for the purposes of designing as well as providing support services for children with SEND.

4. To address the concern highlighted by Ofsted and the CQC around the imperative for agencies within the Local Area Partnership to work more cohesively in order to be able to effectively and efficiently provide support for children at the right time.

As per a recommendation issued and agreed in its 21 September 2023 meeting, and in line with its remit over health for all-ages (as specified in the Council's constitution as well as by the Health and Social Care Act 2012), the JHOSC plans to commission a report with a 12 months-on update on the Local Area Partnership's SEND improvement journey and its Priority Action Plan. The aim is to scrutinise the impacts of the Priority Action Plan and the SEND improvement journey on the physical and mental health of Children and Young People with SEND in Oxfordshire. As a natural subject of scrutiny for the JHOSC, the Committee is also keen to understand the role of the ICB in contributing toward the improvement of the physical and mental health of Children and Young People with SEND.

Promoting Healthy Weight in Oxfordshire:

The JHOSC has developed a keen interest in maintaining ongoing focus and scrutiny of the efforts embarked upon by the County Council's Public Health Directorate to promote Healthy Weight within the County. The Committee is also pleased to see that work is being invested into promoting Healthy Weight in Oxfordshire, and endorses the initiative by the Council's Public Health team to tackle excess weight in particular.

As part of its scrutiny of the measures being taken to improve excess weight, the Committee was keen to understand a few important issues including; how the work to promote Healthy Weight sits in the broader context of a preventative public health agenda, what the causes of excess weight were in Oxfordshire, and whether there was a strong correlation between excess weight and deprivation. The Committee also sought to explore whether there were any significant obstacles to promoting healthy weight amongst the population, as such an initiative could be an extensive and challenging undertaking for a variety of reasons.

There were some key themes of emphases that the JHOSC had, which also shaped some of the recommendations made by the Committee. Such themes of emphasis included the following:

1. For there to be consistent support as part of secondary prevention for those living with excess weight; and for there to be improved means of accessing, as well as being aware of, the support services that are available for residents living with excess weight.

2. For there to be effective support for ethnic groups that may be more likely to develop excess weight, and for measures to be taken to raise awareness amongst these groups of the support available to them.

3. For the parents, carers, or families of children living with excess weight to receive adequate support, and it is crucial that they are provided with the tools to help manage them childrens' weight.

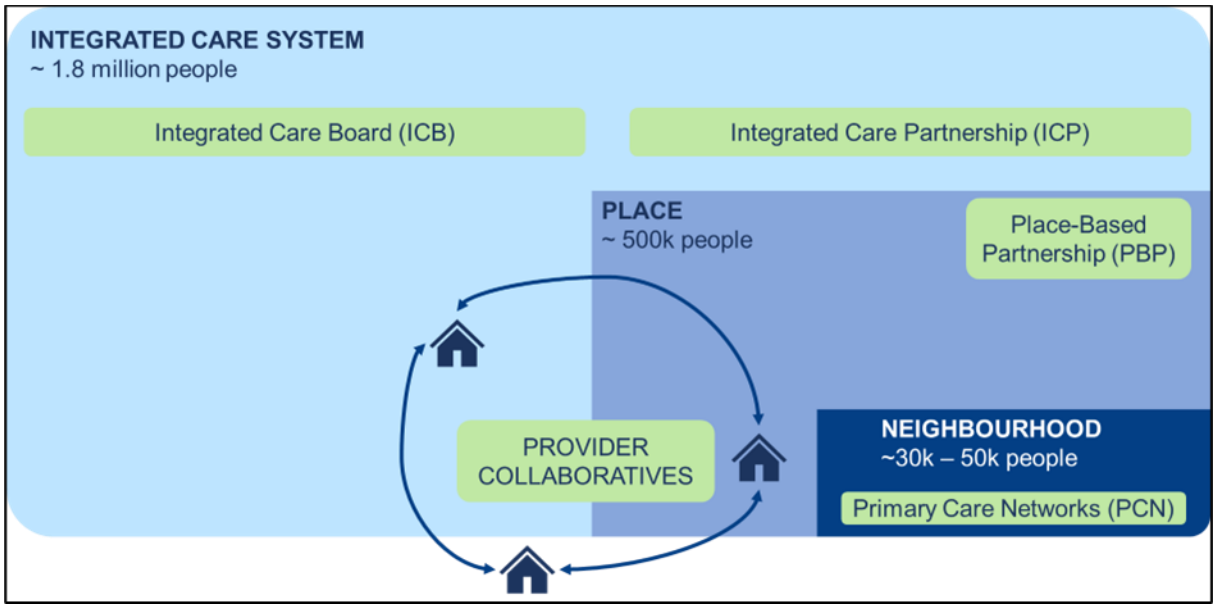
The Committee was pleased to see that some of the steps taken by Public Health were in line with its recommendations. For instance, there were plans to commission an 'all age service' with some additional elements to meet the gaps identified in the Health Needs Assessment. Additionally, the Public Health team were planning to review opportunities to increase awareness of support that is available amongst residents. The Committee was also glad to hear that more support systems for grassroots communities and ethnic groups were being explored, and would like to see the continuation of this work, which would also complement the aims and objectives of the Health and Wellbeing Strategy.

The development of the Oxfordshire Place-Based Partnership:

Another key area of interest and focus for the Committee is on the recent and ongoing development of the Oxfordshire Place-Based Partnership. Given its broad remit over health and healthcare services as a whole, the JHOSC was keen to understand the membership of the Partnership, how it is developing at the level of Place, and any early measures taken by the Partnership to improve the health and wellbeing of Oxfordshire's residents. The JHOSC commissioned and received a report on the development of the Place-Based Partnership during its public meeting on 23 November 2023. The Committee believes that given the loss of place-based Clinical Commissioning Groups (which were also open to the public), it was vital that the Place-Based Partnership helped to fill this void inasmuch as possible.

The Committee laid strong emphasis on the importance of the Partnership being able to develop robust mechanisms through which to monitor its effectiveness. This should include monitoring both the extent and the effectiveness of its collaboration, as well as the outcomes of any of its work. The JHOSC also recommended that there is clear transparency around the operation and the activities of the Partnership, as this would help to further instil public confidence in the ICB as well as the new structures of healthcare decision-making replacing Place-Based Clinical Commissioning Groups.

Another key emphasis and recommendation made by the JHOSC revolved around the need for the Partnership to operate in a manner that avoids simply duplicating the work of other bodies or their associated activities; particularly the Health and Wellbeing Board. The Committee understands that the Partnership exists parallel to other partnership bodies such as the Health and Wellbeing Board, and it therefore recommended that the Place-Based Partnership could constitute (and should conduct itself) as a useful mechanism through which to bolster the aims and activities of the Health and Wellbeing Board.



Children's Emotional Wellbeing and Mental Health:

Given the increasing challenges around children's emotional wellbeing and mental health, which are not unique to Oxfordshire but which are being experienced nationwide, the Committee commissioned a report from the Director of Public Health and the Interim Director of Children's Services on the Children's Emotional Wellbeing and Mental Health Strategy during its meeting on 23 November 2023.

As part of seeking to understand and scrutinise the services available to improve children's emotional wellbeing and mental health, the Committee requested information on and sought to explore a variety of themes including; the level of engagement that the Oxfordshire system has had with children, young people as well as their parents or carers; whether there was ease of access to the range of services related to children's emotional wellbeing and mental health; and if any digital platforms have been developed for children and young people to access to receive support for their mental health and emotional wellbeing. Indeed, this is a topic of ongoing interest to the Committee, and by commissioning the aforementioned paper and item, the JHOSC sought to receive an update since the update received in 2022 on this topic. In fact, the Committee was keen to, and laid emphasis on the imperative for the various partners in the Oxfordshire system, including in the County Council and the NHS (including CAMHS), to work more closely toward exploring further avenues of funding and resourcing to deliver on the commitments to improve children's mental health and emotional wellbeing.

The Committee also commissioned and received a paper in November 2023 with a specific update on the current state of CAMHS services. Some key lines of enquiry that the Committee commissioned and queried in relation to CAMHS involved: details on waiting lists and how they are being managed/reduced; how effective and efficient the process of referrals are; and the extent to which staff training is sufficiently rigorous and monitored.

The Committee was pleased to see that the Oxfordshire system had worked together to produce the Children's Emotional Wellbeing and Mental Health Strategy. The Committee believes that the adoption of a strategy in relation to children's mental health can help to aggregate and organise the system's commitments and resources in a coherent manner toward addressing challenges around children's emotional wellbeing.

In relation to children's emotional wellbeing and mental health more broadly, the JHOSC laid emphasis on and issued some key recommendations (which were accepted) around some of the areas highlighted below. Below is also a brief outline of the indications of how some of these recommendations have been accepted and how the system is taking steps to take these recommendations from the Committee on board:

1. The Committee recommended for there to be adequate co-production with children and their families as part of the continuing efforts to deliver the Emotional Wellbeing and Mental Health Strategy. The County Council Cabinet, on behalf of the Oxfordshire system as a whole, accepted this recommendation and committed to ensuring that co-production is a critical

part of both the development of the strategy as well as more specifically during the commissioning cycle.

2. The Committee also recommended that children and young people as well as their families continue to receive support that is specifically tailored toward their needs. As part of this, it was specifically recommended that a 'needs-based approach' should be explicitly adopted by the system, as opposed to a purely diagnosis-based approach. The Committee argued that the adoption of a Needs-Based Approach could allow for intervention to be initiated earlier, improving outcomes. Again, Cabinet had accepted this recommendation, and clarified that system partners recognise the importance of this recommendation from the JHOSC of the imperative for services to be needs-led. The system expressed a strong commitment to provide support to children, young people and families at the earliest opportunity through using the Think Family Approach. An Early Help Strategy was also developed which endorsed the imperative to offer the right support at the right time.

Additionally, the JHOSC also issued recommendations which more specifically revolved around the nature and effectiveness of CAMHS services. The Committee was pleased to see that two of these recommendations (outlined below) were not only accepted but that the service was taking crucial steps to address these:

1. The Committee was keen to see that children and their families who are on waiting lists for treatment received appropriate communication as well as support to preclude their mental health from further declining. In line with this recommendation, the service committed to mitigation calls being made to families as a check in to ensure that their circumstances and symptoms had not changed. The Committee was also pleased to hear that the service would also launch the SHaRON online peer support platform from Spring 2024, where families would have monitored access to sharing their experiences with other families.

2. The JHOSC also issued another crucial recommendation around the importance for CAMHS to work on improving public communications campaigns to create a better understanding of the service and how it also relates to any other early intervention services. The Committee was also pleased to hear that in line with this recommendation, CAMHS was committed to working on a communication strategy to ensure that they are communicating to all their external stakeholders, and that this would be used as a vehicle to share all CAHMS-related developments including any challenges or successes that the service was experiencing. The service also committed to exploring communication by different platforms such as newsletters, in-person events, and social media.

Looking Ahead to 2024/2025:

Staffing and Capacity:
One of the key challenges that the JHOSC had experienced, particularly during the civic year 2022/2023, related to staffing capacity. However, with the appointment of a permanent Health Scrutiny Officer in July 2023, the Committee was in a stronger position to undertake its scrutiny and relationship building work much more effectively. The number of recommendations and reports being issued to both Cabinet and the NHS increased within the last civic year, and the Committee now has the staffing capacity to pursue and request responses to its recommendations within the statutory response period of 28 days as stipulated by the Health and Social Care Act 2012.

Additionally, the work of the Committee is, and will continue to be further supported given the recent appointment of a permanent Democratic Services Officer, who will be providing some additional administrative support to the Committee's business under the guidance of the Health Scrutiny Officer. This will allow for the timely completion and publications of agenda papers, minutes, and reports. In removing a number of the process aspects of the role from the Health Scrutiny Officer, such as preparation of agenda papers and minutes, this will enable the Health Scrutiny Officer to dedicate focus on ways to increase the value of Health Scrutiny, submitting higher quality scrutiny reports to Cabinet and the NHS, undertaking greater research and communication with partners, and establishing Committee Working Groups for the purposes of conducting deep-dives into specific areas of healthcare services.

Co-optees:
The structure of the JHOSC's membership is such that there is room for three co-optees on the Committee. The presence of co-opted members provides two advantages for the JHOSC. Firstly, co-opted members are usually selected on the basis of them having relevant expertise in health-related issues or healthcare services, and this allows them to provide specific expertise to the Committee's work. Secondly, co-optees are recruited from outside the Council and are therefore not elected officials, usually affiliated with a party. This provides further apolitical input into the JHOSC and its work, and will contribute to the purpose of scrutiny to improve health services across political boundaries.

Within the past civic year, two co-optees have submitted their resignation, Jean Bradlow and Siama Ahmed. The Committee would like to express its gratitude for their contribution to the JHOSC's scrutiny work. The Committee currently has one co-optees in post, Barbara Shaw, and would like to express thanks to Barbara for her ongoing contributions to the Committee's business.

Moving forward, the Committee's Chair and Health Scrutiny Officer will work closely to identify potential suitable candidates to fill in the two vacant co-optee posts.

Commitments to increasing Diversity, Engagement, and Public input:
One of the commitments outlined in last year's HOSC Annual Report was to increasing diversity, engagement, as well as representation and input from the public. One improvement in this regard has been around the increasing diversity of public speakers who have participated in the JHOSC's public meetings during this year. Public speakers who have participated in the JHOSC's meetings have come from a broader

array of organisations, and have also been speaking on a more comprehensive range of issues/topics. The Committee had a total of 12 public speakers within the last civic year. These public speakers have spoken on a range of areas that relate strongly to the JHOSC's items of scrutiny. These include speaking on access to GP services, the current difficulties around accessing NHS dentistry services, Children's SEND provision, Children's Emotional Wellbeing and Mental Health, the Support for people leaving hospital, and on the future of Wantage Community Hospital. These public speakers have represented a variety of organisations including Townlands Steering Group; Bell Surgery Patient Participation Group; and Keep Our NHS Public. The Health Scrutiny Officer and the JHOSC Chair will continue to work towards increasing public input into the Committee's business and scrutiny, as this can help to further inform the Committee's knowledge and understanding of some of the challenges that residents may be facing when using healthcare services. It will be ideal for the JHOSC to move toward incorporating and inviting individuals who are on the receiving end of healthcare services to particular public meeting items to voice their experiences, as opposed to simply inviting commissioners or providers of the services in question. Moreover, in light of the need to recruit two further co-optees on the Committee, and given the commitments to increasing equality, diversity, and representation, the JHOSC will commit to ensuring that co-optees do provide voices that highlight inequalities and that champion diversity, inclusion, and public participation.

Future Themes/Items of Scrutiny:

The Committee has identified medicines shortages as a matter of high public concern, and is keen to understand how these are managed and the impacts of these shortages locally. This would clearly affect anyone who relies on medication to stay well; and so this has provisionally been identified for scrutiny at the JHOSC's September meeting.

There are some additional key areas that the JHOSC can commit itself toward scrutinising over the next civic year. Whilst new developments may likely arise and may merit the attention of the JHOSC, some areas would include items that will naturally remain an ongoing subject of scrutiny as outlined below.

Access to Primary Care:

The Committee would like to closely retain its focus on access to primary care; with particular attention to access to GP services as well as dentistry services. In regards to GP services, the Committee would like to keep a spotlight on how the ICB is taking adequate measures to work with relevant partners, including District Councils, to coordinate the use of funds for the purposes of increasing the capacity of GP services in light of the increase demand. In regards to dentistry services, the Committee would like to receive further reassurances that the ICB is taking adequate steps to support the creation of new dental practices and to avert the emergence of 'dentistry deserts' in disadvantaged areas and rural parts of the county, particularly given the tendency for some dentists and practices to cease NHS treatments due to the lack of incentives produced by NHS dentistry contracts.

Children's SEND Provision:

The JHOSC is committed to reviewing the steps taken by the Local Area Partnership to address the concerns raised by Ofsted and the CQC, and would like to convene a second public meeting item on this topic (with a specific focus on the physical and mental health implications) to seek reassurances that the Partnership's Priority Action Plan is producing tangible and effective results in improving SEND provision for Children and Young People in Oxfordshire.

Health and Wellbeing Strategy:

The JHOSC is supportive of the work undertaken by Oxfordshire County Council and its partners to update the Health and Wellbeing Strategy, and is pleased to hear that a delivery plan is to be developed. The JHOSC would like to review the delivery plan of the strategy as well as the overall deliverability of the commitments outlined in the updated version of the Strategy.

Future of Wantage Community Hospital:

As outlined earlier in this report, the JHOSC intends to engage in ongoing scrutiny of the project delivery plan around the future of Wantage Community Hospital. The JHOSC's Substantial Change Working Group will continue to hold regular check-in meetings with representatives from Oxford Health NHS Foundation Trust and the ICB to receive regular updates on the status and delivery of the project delivery plan for the future services to be delivered at the hospital. The JHOSC opted not to refer this matter to the Secretary of State in the hope that a local resolution – and thus better outcomes for all stakeholders - could be achieved. However, this decision was only made on the condition that the Committee remains engaged in continuous scrutiny of the NHS's commitments to deliver and expand hospital-like services in Wantage.

Workforce recruitment and retention:

In light of some of the increasing challenges around workforce recruitment and retention, which are not unique to Oxfordshire but are experienced nationwide, the Committee would like to retain an ongoing theme of enquiry relating to staff recruitment and retention within all its relevant scrutiny items. Related to this is also the JHOSC's commitment to continue to investigate the degree to which staff within healthcare services are suitable trained and supported. The Committee is keen to see that all staff within the sector receive not only fair pay, but also adequate support for their overall wellbeing, and that they feel sufficiently confident and supported to execute their roles and responsibilities. Indeed, this will have a knock-on effect on the wellbeing of patients and on the quality of healthcare services that residents will receive.

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Joint Health Overview and Scrutiny Committee (JHOSC)

Date of meeting: 6th June 2024	**Item:**

Title of paper Integrated Neighbourhood Teams, Oxfordshire

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

Purpose and executive summary:

This paper outlines the programme of work in Oxfordshire for the implementation of Integrated Neighbourhood Teams (INT's).

The papers cover:

- What are Integrated Neighbourhood Teams (INT's)
- Co-production with the local population
- Areas where they have been implemented.

Action required:
HOSC members are asked to:

- Note the work undertaken by the Oxfordshire programme to implement Integrated Neighbourhood teams.
- Discuss the content and any further points for consideration.

Author: Lily O' Connor, Programme Director Urgent and Emergency Care, Oxfordshire.

Date of paper: 6th June 2024

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Buckinghamshire, Oxfordshire and Berkshire West Joint Overview and Scrutiny Committee

Integrated Neighbourhood Teams, Oxfordshire

Introduction

1. This paper outlines the programme of work in Oxfordshire for the implementation of Integrated Neighbourhood Teams (INT's).

2. The papers cover:

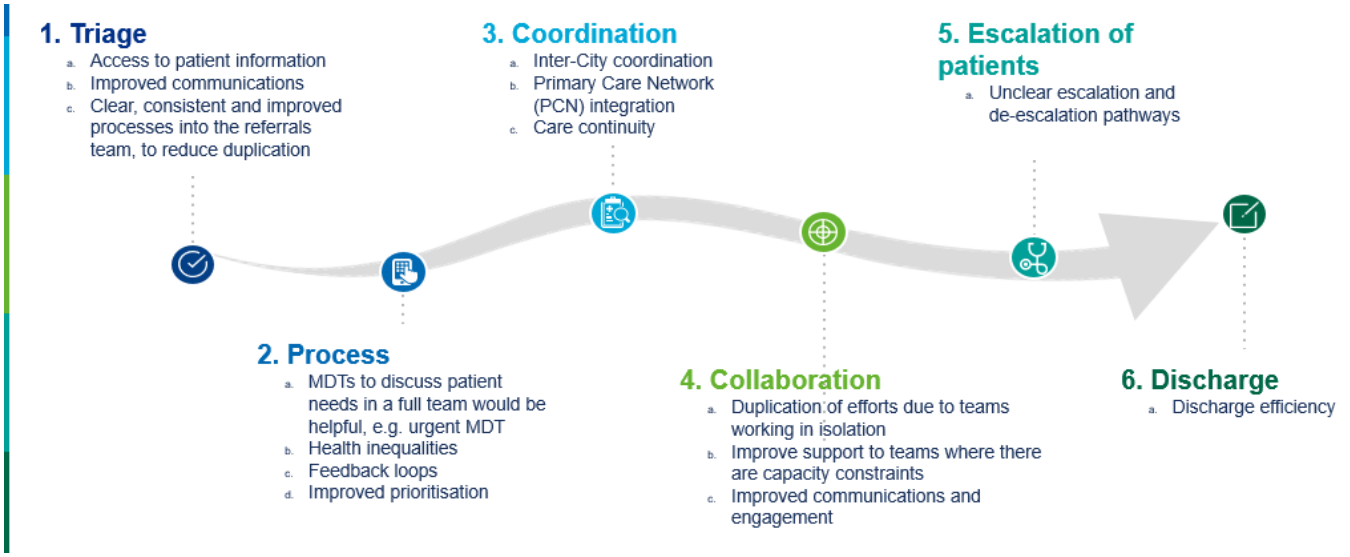
   - What are Integrated Neighbourhood Teams (INT's)
   - Areas where they have been implemented.
   - Co-production with the local population

Integrated Neighbourhood Teams

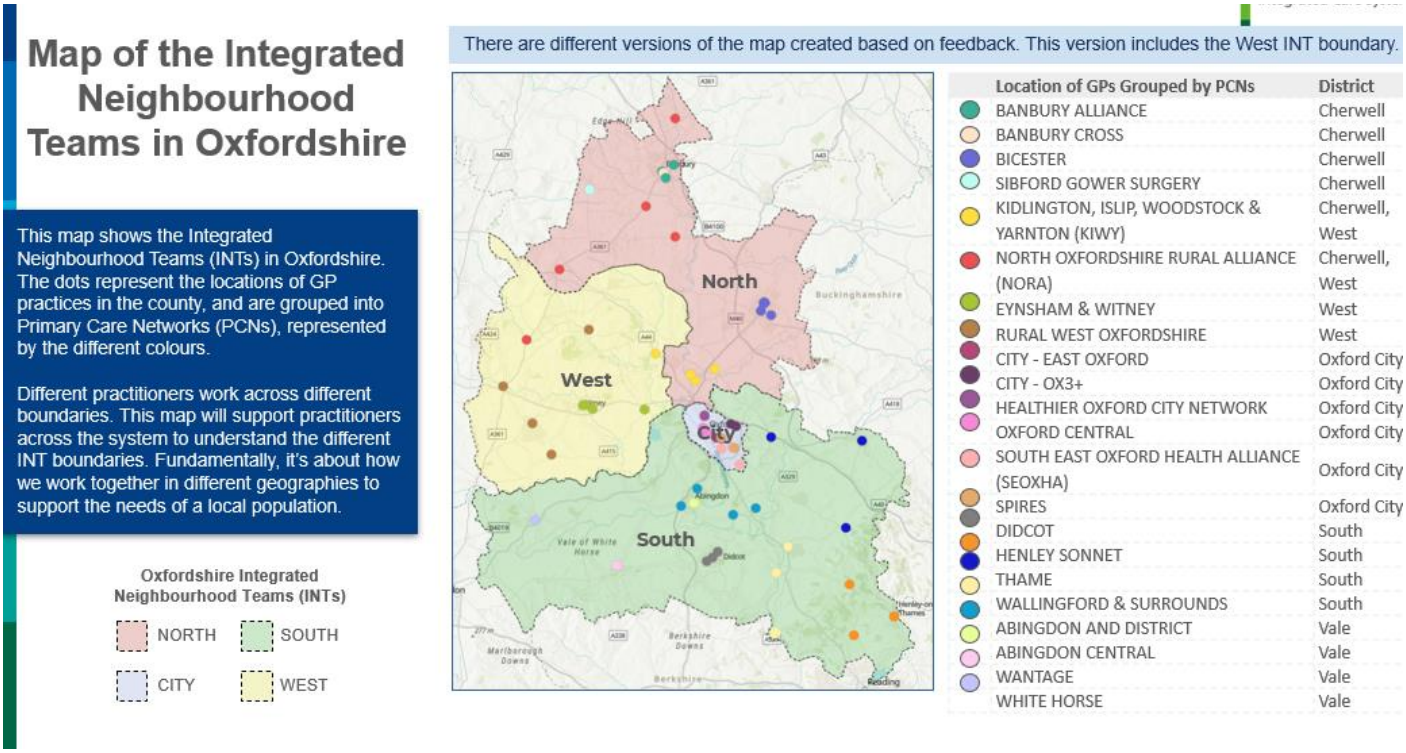
3. Integrated Neighbourhood Teams are an NHS England collaborative approach that brings together healthcare providers, social care services, and community resources within a geographic area (https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf).
4. The development of Integrated Neighbourhood Team's is a key component of the BOB ICB Primary Care strategy.
5. Its goal is to provide coordinated, person-centered care that meets the immediate needs of a patient, and prevention of further healthcare needs.
6. INTs bring together health care professionals from different organisations across health and care services with the aim of delivering a coordinated approach for the local population whose health and social care need cuts across multiple teams.
7. INTs aim to develop the community integration close to the person who requires the intervention e.g., at GP practice or Primary Care Network (PCN) level.
8. INTs will join-up services by simplifying pathways and coordinating care for people with complex needs.
9. INTs aim to reduce inequalities (deprived areas & minority groups) by providing a consistency of service across an area.
10. INTs streamline the access to care and advice for people when they need it. This will provide patients with much more choice about how they access care and ensure care is always available to patients in their communities when they need it.
11. INTs provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions; as well as patients that use services less frequently.
12. For more information, please read the Fuller Stocktake Report.

Integrated Neighbourhood Teams Process

13. This process has been piloted across the City of Oxford and Bicester INT's. The process works through the current challenges and identify areas for further development which are worked through during the regular meetings.



Map of Oxfordshire, split into North, City, West and South areas.



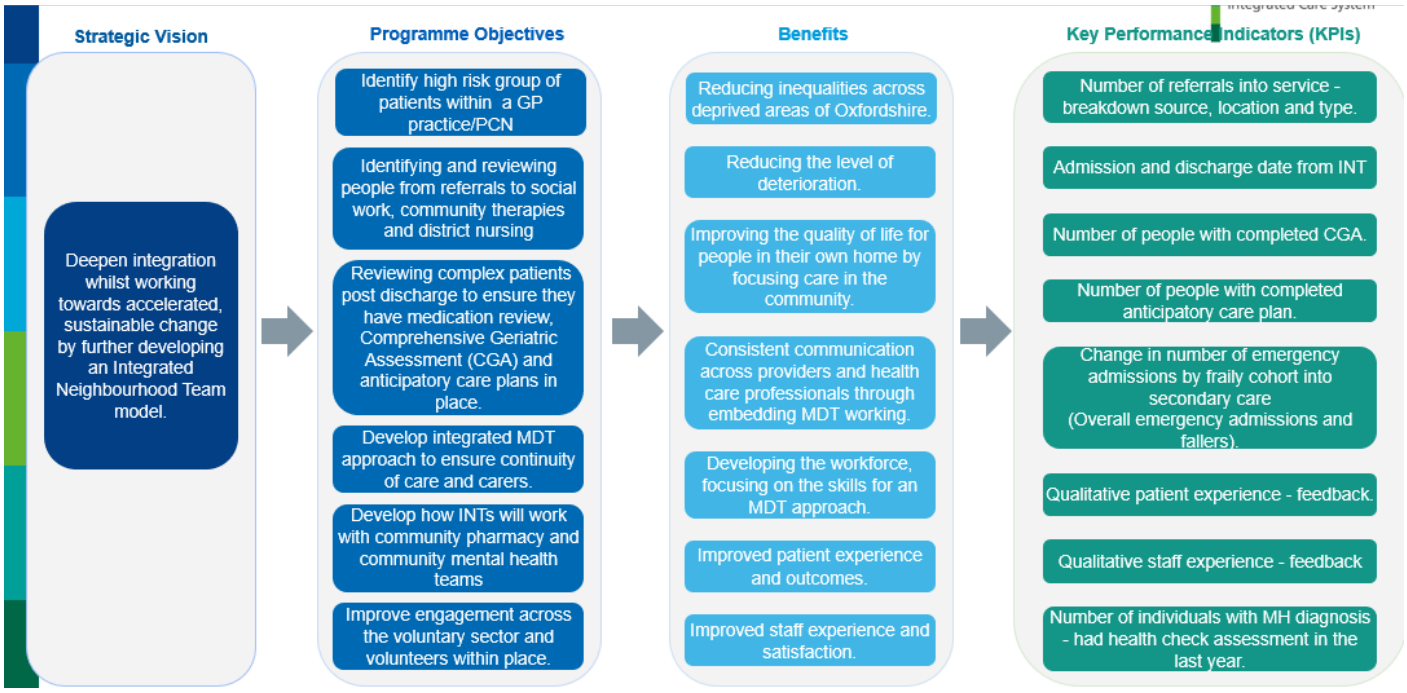
Vision of INTs for Oxfordshire

14. INTs cover 30,000-50,000 population and once established cost approximately £400,000 per INT.

15. The cost effectiveness is based on bed days saved e.g., a monthly run rate of £30,000 and savings of £180,000 following bed days saved.

16. The outcomes for INTs focus on the following.

    a. Increased proactive prevention services and care to keep people well for longer, rather than waiting for illness to set in.
    b. Levelling up of outcomes e.g., people in deprived areas to experience better outcomes, equivalent to those in other areas.
    c. Reducing the need to access emergency or other unplanned health services because patients are provided integrated personalised care in the community.



Areas with Integrated Neighbourhood teams

17. INTs are being developed across North, City, West and South Oxfordshire. The first INT was developed within Bicester Primary Care Network. This was closely followed by the development of an INT within the OX3 area, The Manor surgery, and Hedena Practice. We have started an INT with the two PCN's in Banbury and are at the early stage in Witney and Eynsham PCN and are due to start one in south Oxfordshire.

Operational model

Oxford City

18. The operating model is based on the needs of the local population. In Oxford OX3 area, the focus is on frailty and those with social and mental health needs. This covers areas such as Barton, Wood farm and Headington. The INT in this area, covers two GP practices and areas of deprivation. Referrals come into the INT from on the day triage calls, post home visits or from any health care professional working within OX3 and registered with one of the two GP surgeries. The INT care coordinators also screen a daily email from the OUH discharge team to identify high risk discharges.

19. They hold a daily meeting with key health care professionals to triage new referrals, to review the caseload and agree any urgent actions, and to plan the visits for the day. In addition, they

run a weekly meeting with the wider group such as Gerontology consultants, social care, district nursing, and any health care professionals who they need an opinion from for the list of patients they are discussing.

20. The focus is working with people and what is important to them and maintaining them safely within their own home if that is what the person wants.
21. The INT within this area has funding for additional GP time, care coordinator, Gerontology consultants and the voluntary sector. This has created the capacity required to provide assessment interventions, treatments, and the overall coordination of those who have the highest care needs.
22. Over the forthcoming 12 months, INTs will be rolled out in different PCN's across the city of Oxford.

Banbury

23. In Banbury the focus is on the population, all ages within the deprived areas. This involves integrated working with Cherwell District Council, local volunteer groups, community services, social care, and Primary Care. The operating model varies from council colleagues delivering webinars for all healthcare staff who visit people in their own homes, to ensure they know what to look out for and refer housing or other issues to the relevant service. The areas of focus in the deprived areas of Banbury are as follows.
    a. Respiratory disease and investigating why the admissions are increased for this area all ages.
    b. Childhood obesity- mainly primary school ages
    c. Heart failure
    d. Frailty population living in the deprived areas.
    e. Reducing the risk of stroke by early diagnosing high blood pressure and irregular heart rates (atrial fibrillation).

Bicester

24. The INT within Bicester PCN covers three GP practices. It was the first on and started in 2022. It focuses mainly of those who are the highest risk in the local population, mainly frailty. The team consists of GP sessions covering Monday to Friday, care co-ordinators, AGE UK, additional district nurse and community therapy. They have integrated working across all the visiting services and social care.

25. They run daily and weekly meetings to discuss new referrals and those on the INT caseload. GPs across the three surgeries refer people to them in addition to referrals from any healthcare professional within that area. Staff from the OUHFT refer any complex discharges to them for discussion prior to discharge and planning what support may be required after the person has returned to their own home.

26. The work in Bicester INT has shown that the intervention, discussion, and care plans developed have maintained people in their own home and reduce the need to return to hospital. The integrated working with the Rowan Day unit on the Horton has supported people being assessed in that unit and then followed up by the INT when they return home.

Witney

27. The development of an INT within the Witney and Eynsham PCN is at an early stage. The Primary care within his are keen to maintain continuity of care and are not at this stage looking for additional GP time dedicated to those with the highest needs. The focus in this area is developing what is already there, developing the joint working with the local Witney frailty unit know as Witney EMU and developing the capacity and skill set of the local primary care visiting service.
28. They run a weekly meeting with community services and social care where those that there is a concern about are discussed. This is supported by Gerontology input from the OUHFT.

Workforce and funding

29. The initial funding came from a successful bid from the national team and the continuation and further development funding will come from the Better Care Fund until a more permanent recurrent funding stream is organised.

Challenges, one size does not fit all.

30. The approach is based on the local population health and the gap in unmet health care needs. To understand this for each area, the following needs to be carried out.
    a. Scoping exercise of what services are already established within the area.
    b. Regular reviews of referrals into social care, community therapy and community services to help identify unmet health care needs.
    c. Identifying high risk people registered at the GP practice and those housebound.
    d. Rate of emergency admissions and reasons for admission
    e. Identifying what would make a difference to improve health outcomes.
    f. Establishing what is required in workforce and skill set.

31. There are challenges understanding the unmet health needs in each area. It requires the local populations views, analysis data from different sources and a project group to assess and agree what is required.

Co-production with the local areas

32. There has been significant assessment of view from the people living within the deprived areas of Banbury. However, this will continue as the INTs within Banbury are developed.
33. Within OX3, we have met with the Barton Health and Wellbeing Partnership group and are in the process of meeting Wood Farm Health and Wellbeing Partnership and Headington groups.
34. In Witney we have asked to meet with the public partnership group.

Future work and next steps

35. We are working with colleagues from the various information teams across OUHFT, County Council, OHFT and we are in the process of working with a health economist to establish how we can develop the data set to illustrate the benefits across the various pathways.
36. Each INT has developed using a bottom-up approach based on the local population health needs. When we have established the metrics that provide an accurate overview of an INT we can review and see how INTs can be implemented across the county of Oxfordshire.

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Oxfordshire Rapid Intervention for Palliative and End of Life Care - RIPEL

Update to Oxfordshire Joint Health Overview & Scrutiny Committee – Thursday 6th June 2024

1. Specialist palliative care needs are projected to **grow by over 40%** in the next 2 decades. We have considered how our systems can manage this, whilst continuing to provide compassionate, excellent care to our patients.

2. The **Rapid Intervention for Palliative and End of Life Care (RIPEL)** project was created as a response to critical gaps in the provision and co-ordination of community-based services. It has been set up to enhance the quality of care for patients with a life limiting condition in Oxfordshire and South Northamptonshire through:

   - **Offering personalised care to more people in their own homes** when they are dying, if this is their choice, through integrated and enhanced palliative care and support.
   - **Reducing the length of time in hospital**, so people can continue to be cared for at home with the right support in place in the last 12 months of life and have a better care experience.
   - **Early supported discharge from hospital**, where this is the choice of patients and their families.
   - **Complementing existing services** provided by a wide range of valued hospices and care providers (rather than replacing them).

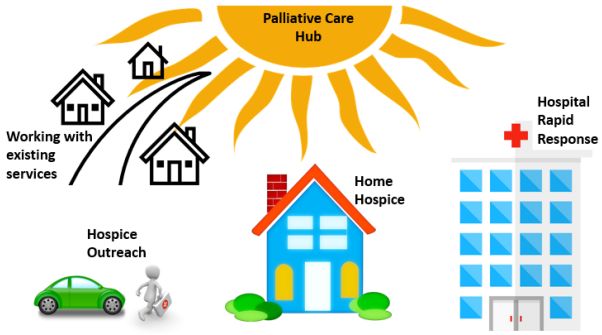


Figure 1 The 4 interlinked services of RIPEL working with existing services

The RIPEL Project is a **unique partnership** between:

- Oxford University Hospitals (OUH)
- Sobell House Hospice Charity
- Macmillan Cancer Support
- Social Finance.

The project is running from **April 2022 to May 2025** to test our hypothesis that these services are worthwhile.

The RIPEL Project includes **4 interlinked services** for adults with advanced life limiting illness who live in catchment, or who receive care from OUH:

2.1 Home Hospice [HH] (launched April 2022)

- This service supports people in the **last two weeks of their life** whose choice is to die at home.
- Patient Support Workers provide **domiciliary care and support** in the patient's home with specialist oversight and input from OUH Palliative Care teams.
- It is run as a **virtual ward**.
- Support is also provided for patients known to the palliative care team whilst in crisis, to enable them to stay safely at home.
- **Service hours are 8am to 10pm 7 days a week**.

2.2 Hospital Rapid Response [HRR] (launched October 2022)

- This extends the existing OUH Hospital Palliative Care Team to support **rapid discharge from hospital** for patients who are likely in the last few weeks of life, where going home is the choice for them and their families.

  Service hours are 8am to 6pm 7 days a week.

2.3 Palliative Care Hub [Hub] (launched July 2023)

- Patients already within palliative care and their carers can call the hub directly for advice.
- Through RIPEL, we have remodelled and expanded our telephone access to enable **quicker contact with the right professional in a timely manner**, with rapid support from the wider MDT as needed.
- Referrals are also made using EPR by OUH staff (for palliative care patients in our hospitals) and via ERS by a wide range of other professionals (for palliative care patients in the community)
- **Service hours are 9am to 5pm 7 days a week**.

2.4 Hospice Outreach [HO] (launched March 2024)

- An extension of the existing OUH Community Palliative Care Team to support **unstable or complex dying** palliative care **patients** in their own homes.
- It is run as a **virtual ward** or 'virtual hospice'.
- The aim is to **avoid unnecessary admission** to hospital for a person who has a palliative care crisis at home (or, if admission to hospital is necessary, making this planned to the appropriate unit rather than an emergency).
- Referrals expanded to urgent care partners (Urgent Community Response, Acute Hospital at Home, Single Point of Access, Oncology Triage, GPs) or community health care professionals already involved with a patient who deteriorates rapidly.
- **Service hours 9am to 5pm 7 days a week**.

3. RIPEL Project achievements (April 2022 - April 2024)

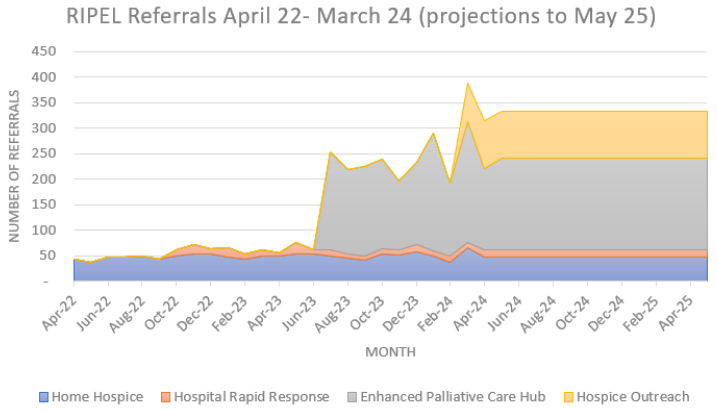


Figure 2 Distribution of referral to RIPEL services April 2022-March 2024

- 64.30/73.35 WTE Staff employed.
- **3,104 referrals** accepted (Figure 2).
- **11,729 days spent at home instead of in hospital in their last year of life** (average 9.03 per patient). Valued at **£4.27 million**.
- 29 Key Performance Indicators scrutinised via a PowerBI dashboard to ensure services meet quality requirements (waiting times etc.).
- RIPEL virtual wards are **contributing 76.8 (22%) of the virtual ward beds** intended for Oxfordshire.

The value of hospital bed days saved are projected to exceed cost of running service (Figure 3).
Assessment of financial viability is an inherent measure to ensure we are spending public money sensibly.
Feedback from patients, families, carers and staff is perhaps even more valuable:

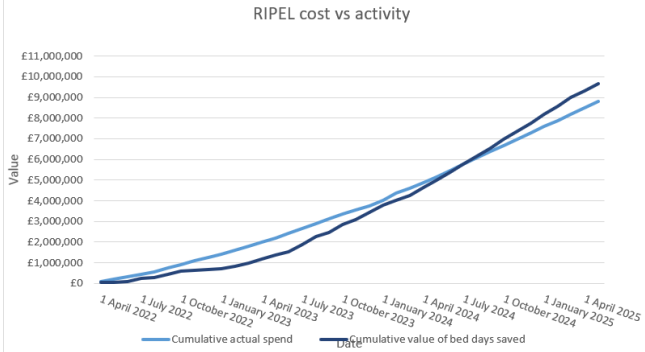


Figure 3 Value of saved hospital beds vs cost of RIPEL services April 2022-May 2025

"They were so kind, respectful, gentle, almost loving"

"Every member of the team showed tremendous care and humanity for them, which I and the rest of the family will always be thankful for"

"Her death had been perfect and all she had hoped for"

- 38/41 **(93%)** feedback postcards received rated Home Hospice as '**very good**'
- Finalist for HSJ Patient Safety Awards 2023
- Finalists for OUH Staff Recognition Awards 2023 and 2024
- Finalists in 4 categories for Palliative Care Awards 2024

4. Evaluations

4.1 Patient and Carer Feedback

- 100 feedback postcards were distributed to households who used Home Hospice.
- Compliments and complaints, informal and formal, continue to be logged and acted upon.
- A questionnaire which incorporates national 'Friends and Family Test' questions will be distributed to all households who have consented from May 2024.

4.2 Palliative Care Hub Service Hours

- We investigated the need to expand Palliative Care Hub hours beyond 5pm. A pilot took place over 6 weeks from Feb-March 2024 whereby a member of hub clinical staff accompanied the Single Point of Access (SPA) team between 5 and 8pm on weekdays. SPA is the most likely referral route for acute palliative care needs and a reasonable proxy of community needs. During the 27 shifts covered, advice was sought on only 5 occasions, all of which were either non-urgent (could have waited until following day) or had alternative advice routes already available (authorisation of admission to hospice must go through on-call medical staff as standard already).
- In conclusion, extending RIPEL Enhanced Palliative Care Hub hours beyond 9am to 5pm has not been justified. This case was presented to the RIPEL Steering Group in April 2024 who support the decision to not extend hours, with staffing plans to be revised appropriately.

4.3 Equality, Diversity, and Inclusion (EDI)

- The Palliative Care EDI Project Officer has chosen RIPEL as a use case to assess and improve our EDI reach into our communities across Oxfordshire and South Northamptonshire.
- Investigations in 2023 noted that up to 35% of ethnicity data each month was missing for patients using Home Hospice, inhibiting the reliability of mapping this cohort onto the background population. By working with frontline teams, we were able to find ways to include ethnicity simply and reliably in workflows. Our data is now >90% complete (100% is not expected as patients have the right not to state their ethnicity). We are now in a stronger position to map our data on ethnicity and further characteristics to our catchment to identify areas of unmet need, or confidently celebrate the diversity of those accessing our services. Work is ongoing to complete mapping with the 2022 data set.
- Virtual wards and developments of care available in one's home have prompted investigations with our hospital teams to ensure being at home at the end of life is an option appropriately explored without bias. Our teams are in conversation with the learning and disabilities teams at OUH to audit end of life choices for this cohort, directing further education if found necessary.

4.4 Home Hospice Toolkit

- We have assessed our Home Hospice service against the standards proposed in the Hospice UK toolkit. While the service scored high in all key areas (Skills and Ethos of care providers, Support directed at Carers, Sustainability, Volunteers, Integration and Coordination, Marketing and Referral), it was identified that improvements could be made in the areas of 'support directed at carers', 'Marketing & Referral' and 'Sustainability'.
  - Sustainability is already being addressed by the business case.
  - A research project is currently looking at unpaid carers of Home Hospice Patients, the outcome of which may inform how we can further support carers.
- The recommendations in the toolkit are being reviewed and suitable solutions will be adopted in consultation with our key partners.

4.5 Home Hospice impact on carers

- A colleague is working towards a PhD on the impact of Home Hospice on carer experiences. Initial development has been successful, and questionnaires are now actively being distributed to eligible persons.

4.6 Hospital Rapid Response Unmet need

- We noted that referrals accepted into to our HRR service were significantly lower than originally forecast. This prompted investigation into whether we are not reaching everyone we could have helped. An audit took place to assess experiences of patients who may have been eligible but not referred in Oct 2023. This only identified 3 eligible patients who were not referred for HRR. This audit is extended over additional months to further interrogate and understand the data and will be developed as a final honours paper for an Oxford University Medical Student.
- A deeper dive is underway into reasons referrals transpired to not be suitable for HRR.

4.7 Transport

- The importance of transport needs in palliative care has been recognised by transport partners, shown by their explicit incorporation of palliative care patients in their operating procedures.
- Despite this, transport remains a source of stress and delays to patient pathways for RIPEL patients as well as those in the wider palliative care service. We have collated formal and informal complaints related to transport from Feb 2023-Feb 2024, assessed transport use and documented this in a paper to take to senior management and charity partners to justify our proposal to pilot dedicated palliative transport services in 2024 which Sobell House Hospice Charity have agreed to fund.

4.8 Carbon Footprint

- We have linked in with OUH and national sustainability leads to see how to best assess the carbon footprint of RIPEL services. National data suggests that virtual wards have a lighter footprint than in-patient equivalents and we would like to assess this locally, particularly given the significant non-pay costs due to transport between patients of the Home Hospice Care Team. Data capture is underway.
- The carbon footprint of anticipatory medicines is to be investigated compared to in-patient stock.

4.8 Co-morbidities

- Diagnosis is captured as part of RIPEL monthly KPIs. We would like to utilise national tools to assess further the co-morbidities profile of our patients. The method for this has been proposed using the Cambridge co-morbidity score though is yet to be applied.

4.9 Pharmacy

- Gaps in desired pharmacy provision have been highlighted as a risk to Hospice Outreach standards. Options around this have been documented and are being investigated further.

4.10 Palliative Care Outcome Measures

- Our palliative care outcome measures data has been developed so that it can be visualised using the national PCOM360 tool. We are working with RIPEL partners to best use this to maximise the standards offered by each service, not just within RIPEL but across OUH Palliative Care.

5. Next Steps

- Finalise business case to bid for ongoing financial support of RIPEL from June 2025.
- Conclude projects outlined above.
- Enhance links with referrers including 111, Acute General Medicine and Emergency Departments.
- Continue to develop a Patient Participation, Involvement and Experiences (PPIE) group for Palliative Care and utilise this for feedback and ongoing co-design of services.
- Further assess staff experiences around RIPEL.
- Establish methods to capture documentation of Advance Care Plans.
- Work with external partners interested in researching RIPEL further.

If you would like any further information, please contact PallCareLeadNurse@ouh.nhs.uk

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Palliative and End of Life Care PEoLC

BOB ICB Focus

Responses for HOSC Review Meeting 6.6.24

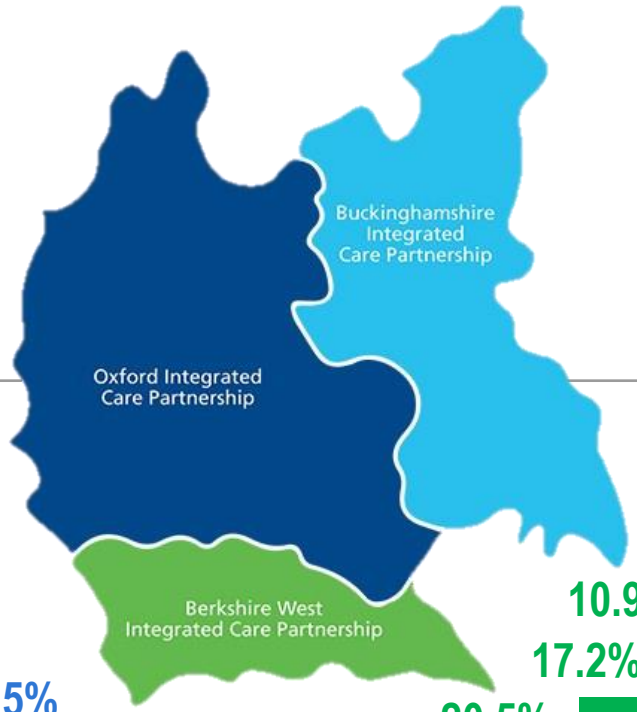
BOB ICB: Zo Woods Program lead; Dr Jane Bywater All age and Dr Emily Harrop CYP Clinical leads

Questions raised 1:

The geographical spread of palliative care services, and how these operate Countywide (BOB Wide)

BOB Over 18 PEoLC Snapshot

7.8%
Percentage of deaths with three or more emergency admissions in the last 90 days of life. (All ages)



40.5%
Percentage of deaths that occur in hospital (All ages)

0.4%
OF BOB population is on a Palliative care register

- Incurable Cancer 0.2%
- Organ Failure 1.0%
- Disability 1.1%
- Frailty/Dementia 1.4%
- LTC 24.5%
- Healthy/Well 71.7%

- 0.7% Care Home
- 3.1% Core 20
- 10.9% BAME
- 17.2% 65 and over
- 20.5% Under 18

2.0M
Total Population
0.8M Oxfordshire
0.6M Buckinghamshire
0.6M Berkshire West

10
10 Commissioned Hospice IPU units.

Age 84.0 Life Span
Age 56.4 Health Span

4
Day / Night Care Services

5
Hospice at home/Rapid Response Units

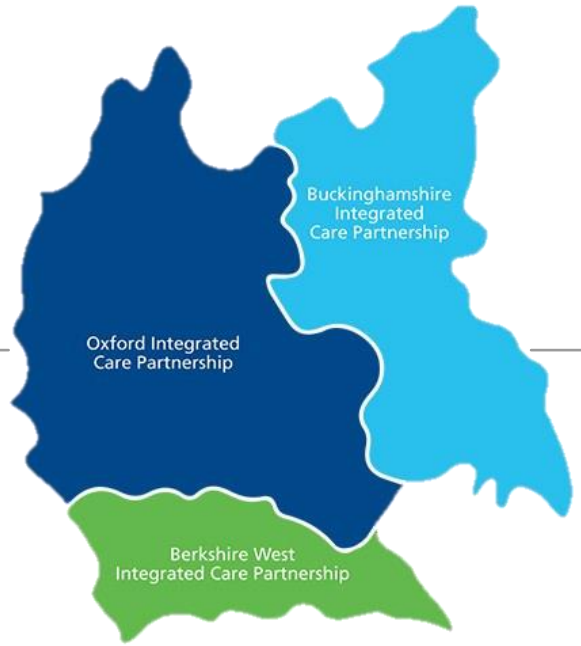
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Source: Workbook: ICB End of Life Dashboard V2 (england.nhs.uk), OHID Data set, PaPI dashboard

BOB CYP PEoLC Snapshot

Age 0 -17 BOB population:

- Organ Failure 0.1%
- Disability 1.3%
- LTC 4.0%
- Healthy/Well 94.6%



0.4M In BOB aged 0 – 17

20.5% BOB population is under 18

0.46% Under 18 prevalence on Palliative Care Register

1.6	Estimated neonatal death rate per 1,000 live births (YE March 2023)
2.6	Estimated infant death rate per 1,000 live births (YE March 2023)
12.7	Estimated death rate per 100,000 population of children aged 1 - 17 years in the same ICB (YE March 2023)
24.5	Estimated child death rate per 100,000 population in the same ICB (YE March 2023)

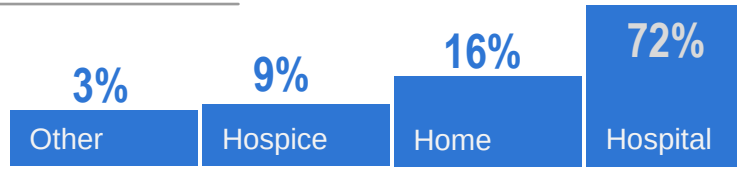
Age 0 -17 of BOB population:

- 3.3% Core 20
- 20.7% Ethnic minorities

1 Commissioned Hospice IPU units

3 Commissioned outpatient/home hospice services

24/7 EOL CYP support



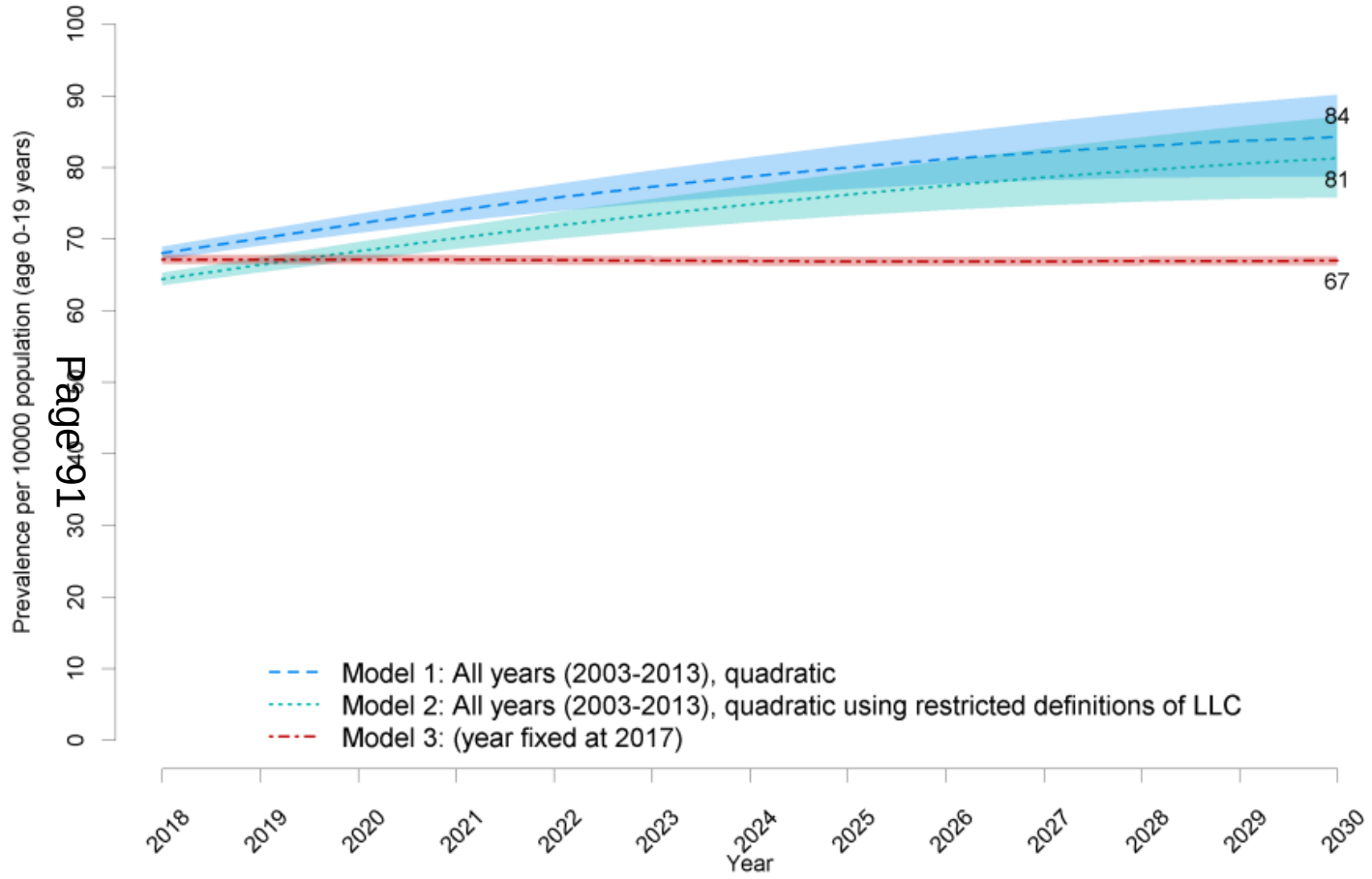
Under 18, place of all death % of total

Under 18 cause of death % of total:

- 16% Cancer
- 16% Other Terminal illness
- 25% Organ Failure
- 43% Sudden Death

Data from 2022 / 23

CYP projections up to 2030



Predicted prevalence (with 95% confidence intervals in lighter shading) of children (age 0–19) with life-limiting conditions for 2018–2030

The prevalence of children with a life-limiting or life-threatening condition in England has risen over the last 17 years and is predicted to increase.

Future data collections must include the data required to assess the complex health and social care needs of these children.

Source: Lorna Fraser Report https://www.togetherforshortlives.org.uk/resource/make-every-child-count/

Questions raised: 2.

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

The BOB-wide context: including any resources, support, or budgets being allocated for palliative care services by the ICB

- The ICS focus is defined through the joint forward plan and the ICS strategy.
- There are commissioned and contracted services for specialist palliative care across the ICB for all ages, this excludes the vital service delivery from generalist services so allocated budget, at this point, would not be a true reflection.
- Services are supported through monthly meetings and face to face. The ICB is supportive of creative commissioning and to think differently about how we collectively deliver services against the needs of the population to Oxfordshire and across BOB.
- Resources to this include, have been a recent dashboard which we have been working with PaPi data, National children's Mortality data, ONS.
- This helps us to better understand our position and focus our attention to meet the statutory guidance to deliver Health and Social Care.

BOB ICS Strategy and Joint Forward Plan

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Goal 1:
A robust model of 24/7 access to PEoLC services for patients, carers, and relatives

Goal 2:
A population health approach to early identify people needing PEoLC services.

Goal 3:
To co-design PEoLC through Provider Collaboratives in partnership with people with lived experience.

What are we aiming to achieve

Reducing inappropriate emergency admissions

- Improved access in and out of hours
- Reduce percentage deaths with three or more emergency admissions in last three months of life.
- Reduce unwarranted PEoLC South Central Ambulance Service call outs
- To improve patient/ carer experience

Personalised Care Planning using ReSPECT

- To focus on personalised care
- Increase number patients offered opportunity for Personalised Care and Support planning promoting use of ReSPECT
- To increase number clinicians trained in ReSPECT process
- To increase numbers patients on palliative care registers through early identification

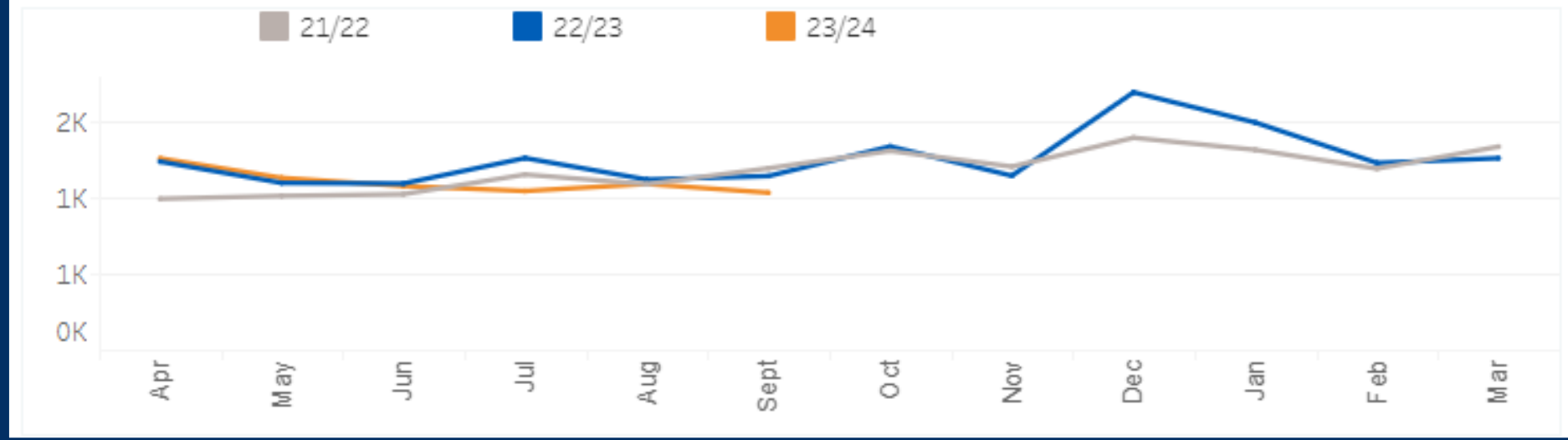
Collaboration

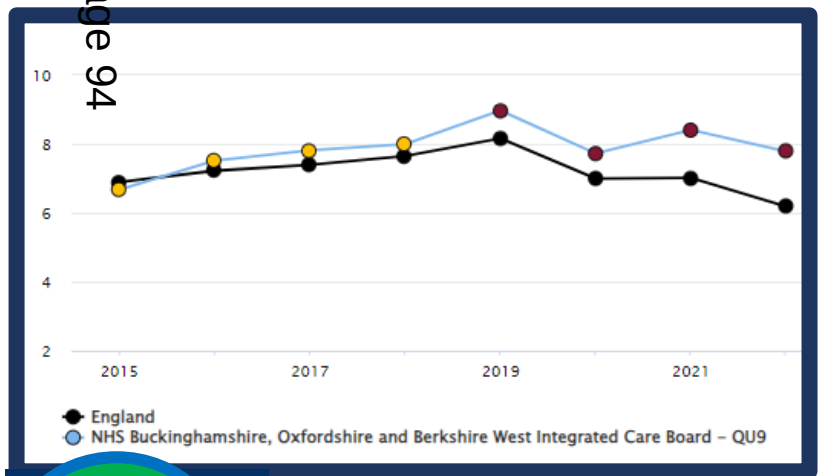
- Ensure fair access to PEOLC care in BOB
- Patients informed and empowered with sense of control over PEOLC needs.
- To ensure more people die in their preferred place of death.
- Engagement from providers VCSE, NHS and non-NHS services
- Consistent service specification for all providers.

To improve access and experience of palliative and end of life services to enable people of all ages to die well

Each Person is seen as an individual | Each Person gets fair access to care | Maximise comfort and wellbeing | Care is co-ordinated | All staff are prepared to care | Each community is prepared to help.

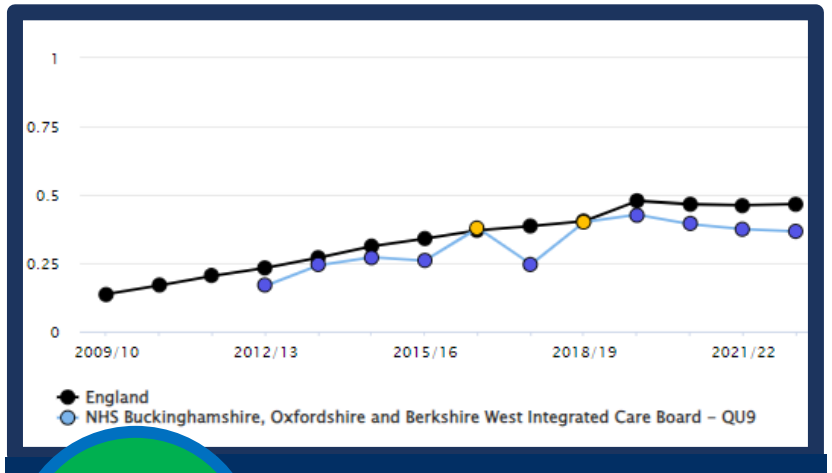
Trend of total deaths BOB ICB





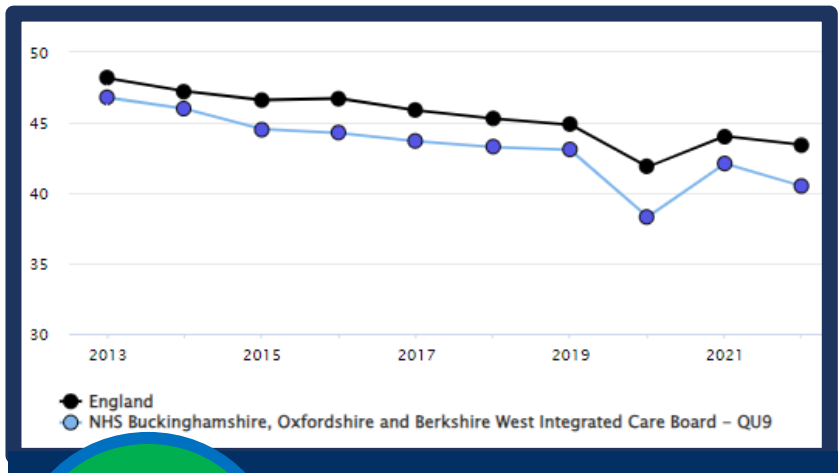
7.8%

Percentage of deaths with three or more emergency admissions in the last 90 days of life. (All ages)



0.4%

Palliative/supportive care: QOF prevalence (all ages)

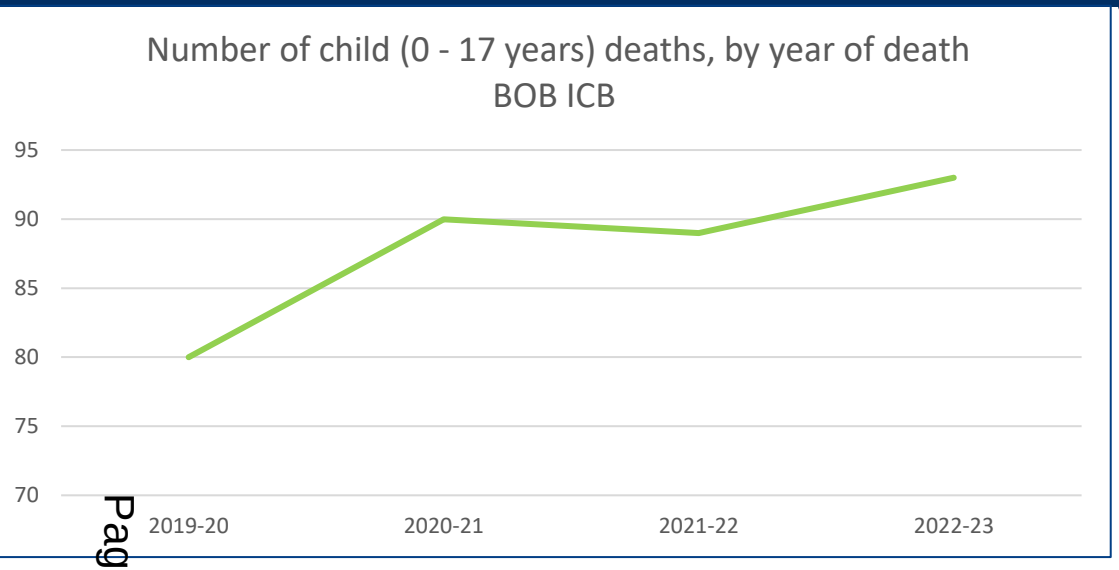


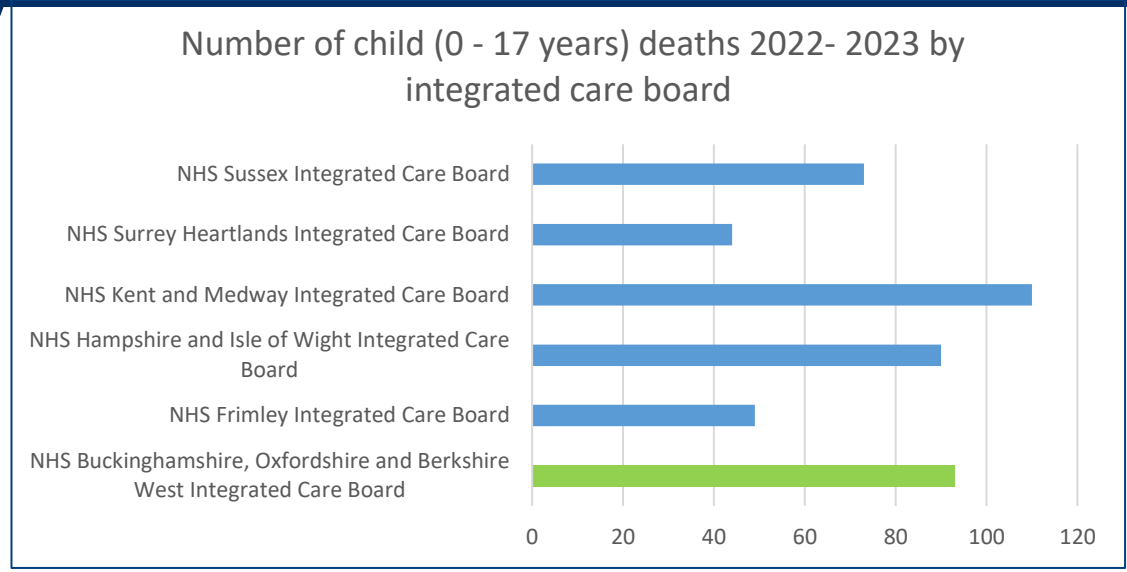
40.5%

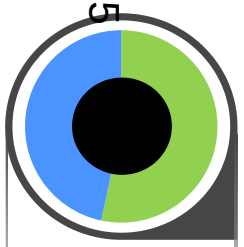
Percentage of deaths that occur in hospital (All ages)

Source: Palliative and End of Life Care Profiles - OHID (phe.org.uk)

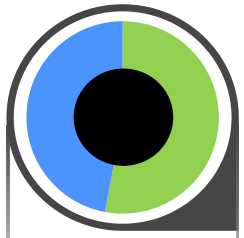
CYP



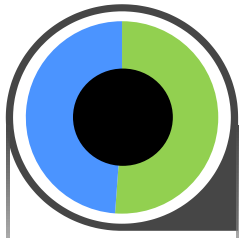




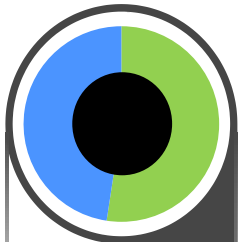
32%
Parallel Planning of all deaths
SE Average 28%



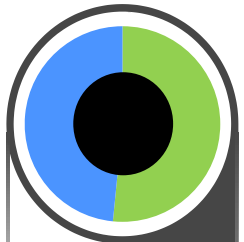
36%
Bereavement support offered
SE Av 32%



66%
EoL coordinator
SE Av 63%

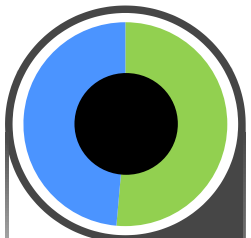


76%
EoL Medical lead
SE Av 69%

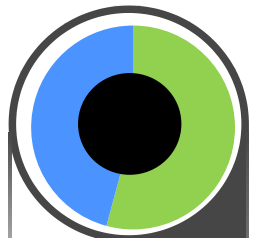


66%
ACP in Place
SE Av 62%

15%
ACP discussed with CYP
SE Av 13%



73%
Symptom management plan
SE Av 69%



45%
Use of cold room
SE Av 38%

16%
Medication issues
SE Av 12%

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Source: NCMD Report

Questions raised 3:

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

The status and the future of palliative care to be delivered in Wantage (in light of the NHS's expressed commitments to providing palliative care services in the context of the public engagement exercise around the future of Wantage Community Hospital).

- The ICB is open to creative ways to deliver services to meet the specific population needs around Wantage
- There are commissioned services that deliver palliative care services to the area of Wantage, this does not differ to other parts of the county.
- We note that there is collaborative service delivery between OUH and Sue Ryder in South Oxfordshire (when appropriate/ needed)
- There are palliative beds within Wallingford Community Hospice with agreement to flex up should we need more than 2 beds.
- The need for inpatient beds is monitored by local Service delivery teams teams, with access to ICB support when case-based need.
- There is review at monthly Local Palliative and End of Life Forums; held with all Oxfordshire Providers (including the Oxfordshire County Council),
- The ICB would happily extend the meeting to any member of HOSC or Councillors should they feel it appropriate to attend.

healthwatch Oxfordshire

Your voice on health and care services

Report to the Oxfordshire Joint Health Overview Scrutiny Committee

June 2024

Table of Contents

1. Healthwatch Oxfordshire reports to external bodies

Since the last HOSC meeting in April, Healthwatch Oxfordshire attended BOB ICB Quality Committee and Oxfordshire Safeguarding Adults Board.

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 into 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 April 2024:

Healthwatch Oxfordshire reports published to date:

Summary of our **Quarter 4** (Jan-Mar 2024) activities and outcomes can be seen here: https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

All the following reports published since the last meeting can be seen here: https://healthwatchoxfordshire.co.uk/reports All reports are available in **easy read**, and word format. Since the last meeting we published the following reports based on focused insight gathering:

- ***Health and wellbeing in Ambrosden, Arncott, Blackthorn and Piddington*** (May 2024). Focused on these communities in the North of the county, insight gathered by Community First Oxfordshire on behalf of Healthwatch Oxfordshire, built on our previous report on rural isolation (March 2022). They reached 162 members of the communities from November 2023 to January 2024. Based on what they heard the report identified pressures on access to services, public transport, and limits to community capacity and volunteering. The report and summaries can be seen here: https://healthwatchoxfordshire.co.uk/our-work/research-reports/ Together we will present what we have heard to Health and Planning Group in July, and further discuss insights it offers into **issues faced by rural communities here and more widely**.

- **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. (This programme took place between May 2023 and June 2024 enabled two community researchers time to be supported through by NHS S.E. CPAR 2 Programme. This involved training and mentoring from University of Reading and Scottish Community Development Centre, along with Healthwatch Oxfordshire acting as host and giving on the ground support). The final report and accompanying film (https://healthwatchoxfordshire.co.uk/our-work/our-videos/) is being presented to key stakeholders and system leaders at the CPAR 2 South-East showcase event on 6th June in London (same date as the HOSC meeting). The community researchers reached 170 people using community food services in OX4 area (using food support from Oxford Community Action, Oxford Mutual Aid and Waste2 Taste- each part of OX4 Food Crew). The report highlighted the significant impact of cost of living on people's ability to meet basic household expenses and the difficult choices made to make ends meet. The report also indicated the underlying drivers - including challenges faced by people with longer term health conditions. It also highlighted the positive contributions made by community food provision in giving support, reducing isolation, and building sense of community and suggested actions for community and system partners to better support. We continue to contribute learning from our work to support development of Oxfordshire Community Research Network.
- **Patient Participation Groups in Oxfordshire –** Between January and February we carried out a survey to hear from all those involved in Patient Participation Groups in the county. We heard from **78 people representing 35 Patient Participation Groups** and GP practices across Oxfordshire – amounting to 53% of the 66 GP practices in the county. We heard that some of the things that help PPGs to work well are:

- active, positive and enthusiastic members
- good, trusting relationships with GP practices
- engagement (and capacity to engage) from practice staff, especially GPs
- support from GP practices to communicate with patients and recruit new members
- clarity around the remit and role of the PPG

- opportunities to support the practice, for example with hands-on activities like vaccine clinics
- opportunities for collaboration and learning between PPGs in the PCN area and more widely.

There was a clear voice that patients and PPGs would like more opportunities and pathways to hear from and feed into local health policy, communicate and engage directly with decision-makers from Primary Care Networks (PCN), Oxfordshire Place Based Partnership and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). They would also like more clarity and structure around the role of a PPG, support to engage with a wider range of patients, and to be kept up to date with news and information about health and care in their local area.

- We completed the focused work on **oral health in under 10's** and with emphasis on hearing from parents and carers with children with special educational needs and disabilities. We will publish the report in July, along with a joint overview report on learning across the BOB ICB Core 20 Plus areas, in conjunction with Healthwatch Bucks and Healthwatch Reading.

Enter and View Visits

Since the last meeting we made visits to the following services- Health Visiting Service, Didcot (April), Oxford Eye Hospital (April), and Ambulatory Unit – Oncology at the Churchill (May). Reports forthcoming.

We published the following report on Enter and View visits to the following services:

- Alma Barn Lodge Care Home, Didcot (May 2024)

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:

- We currently have a survey to hear from the public on **experience of leaving Hospital (discharge)** in the last twelve months
  https://healthwatchoxfordshire.co.uk/news/leaving-hospital/
  The survey will be open until the end of August, and we are also following up people in their journey with more in depth stories.

https://www.smartsurvey.co.uk/s/leavinghospital/ We have been working closely with system partners to develop this work, with aim of understanding more from people about their experience of hospital discharge routes, and emphasis on supporting people to return to their usual place of home.

- We hosted a **webinar on 21 May** for members of the public hear about Pharmacy First with presentations by David Dean CEO Pharmacy Thames Valley, Dan Leveson, BOB ICB Place Director for Oxfordshire, and Julie Dandridge Head of Pharmacy, Optometry and Dentistry BOB ICB. Slides and video of the webinar can be found here: https://healthwatchoxfordshire.co.uk/news-and-events/patient-webinars/
- We presented on the importance of Patient Engagement to an audience of over 150 at the Primary Care Network event (along with Healthwatch Bucks). Our next webinar will be on Tuesday 18th June from 12-1p.m. and focus on involving patients at the heart of healthcare design with Dan Leveson and Sarah Adair from BOB ICB https://healthwatchoxfordshire.co.uk/news/webinar-join-us-on-tuesday-18th-june-to-hear-about-oxfordshire-patient-engagement/
- We continue ongoing outreach to groups and events across the county, including hospital stands, community groups and events e.g. Witney Pride, Hanwell Fields Event, libraries, Family Day - Sunshine Centre, and visits to hotel accommodation for refugees and asylum seekers.

Healthwatch Oxfordshire Board

Our open forum event for the public to attend was held online on Tuesday 28th May https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

Join us on **Tuesday 2nd July from 1pm - 2pm** for an online event showcasing our work during 2023-24. Members of the team will talk about some of our achievements over the past 12 months, and there will be a chance to ask questions. Find out more and how to join here: https://healthwatchoxfordshire.co.uk/news/join-us-on-tuesday-2nd-july-for-a-showcase-of-our-work-2023-24/ .

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 health and care providers and commissioners on emerging and current themes.

Since the last HOSC meeting (1st April – 20th May 2024) some of the themes we have been hearing include:

- Cancelled appointments (GP, hospital, community services)
- Challenges booking and accessing covid boosters – and limited access and coverage especially in Didcot area

> *"There was no service, I had to drive to Goring. Didcot is an expanding town with garden town status so should offer a service for local people and surrounding villages".*

> *"Both my wife and I are 80 so I decided to book our spring Covid jabs today. The NHS web site directs one to walk-in sessions. These are extremely thin on the ground (15 miles away or more and, in any case, we wanted to book an appointment. I tried to find how to book an appointment on line but ended up going round in circles so ended up dialling 119. This tried to send me back to the web site and even said that the person taking the call would just be doing the booking in the same way that I could".*

- Problems accessing pharmacy services – for example long queues or pharmacies being closed during opening times

> *"Massive queues, script takes a week to be processed and the pharmacy closes for lunch. It's unbelievably frustrating to have to go there for anything."*

- Concern about access to ADHD medications.

> *" I called my GP as I was worried about a notice on their website which said they will not be prescribing ADHD mediction to new patients. I asked how would it impact on me as I already have a regular prescription. I was told it wouldn't but that could change at any time. I worry every month now as I need my medecine to help me function".*

Of those people who contacted us **about hospital services**, the main issue commented upon were delays (13). Delays fell into three different categories:

- Delays receiving follow-up appointments with some appointments being cancelled meaning long waits between appointments.

"I raised issues pertaining to issues with follow on appointments - lengthy waiting times".

"I was referred to [service name] and waited 2 years due to their repeatedly cancelling my appointments.

"Waited 2 years due to their repeatedly cancelling my appointments."

- *Delays waiting for surgery*:

  "I want to complaint to OUH on the gynecology appointment and surgery wait times."

  "My surgery has been cancelled numerous times and I have now been waiting [number] years."

- *Delays in receiving diagnostic test results*:

  "MRI scan in December 2023. Despite emailing them 6 weeks ago I've still not heard anything".

  "I was referred for an MRI scan which took place on [date] September, and I still have not had result."

Five people complimented the Oxford University Hospitals on the quality of their service:

"Attended A&E at John Radcliffe Hospital and directed to Ambulatory Assessment Unit. Other than the wait (6hrs - doctors strike) the care could not be better. Saw Physicians Associate, had blood tests, ECG, X-ray and observations done and following interpretation of results by doctor, a CT scan. Medicines also supplied by pharmacy on site. Throughout the wait there was a supply of food and hot and cold drinks. I was kept informed about what was happening throughout."

"Always received excellent treatment. How the NHS manage all they do is a combination of dedication and miracle!"

Of those people who contacted us **about GP services,** the top issues were getting an appointment and communication. Of those who raised getting an appointment as a

problem some people indicated they were being directed to 111/999 by their GP practice.

> *"My surgery uses e-consult and it works very well if you send your request in early. I have always had a face-to-face appointment, a phone call or email reply within an hour or so. Downside is if you send in the e-consult after about 9.30 - 10am you often get a message to say appointment capacity has been reached and to contact 111."*
>
> *"Blood pressure readings requested and sent months ago. Haven't heard a thing since. I know the readings were high but no idea if I should be doing anything different."*
>
> *"Unable to obtain an appointment for my xx-year-old son until 6 weeks' time, as his need is not urgent".*
>
> *"*Long w*ait for appointment (one month)".*
>
> *"I have been with this GP practice for [20 plus] years. Sadly it has got worse and worse. It has expanded and this has made things worse. Impossible to get any continuity of GP. And communications between patients and GPs and between GPs made harder and harder".*

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

> *"Had a telephone call back and a very thorough consultation. The doctor and reception staff were all friendly".*
>
> *"This surgery is simply superb, nothing is too much trouble for anyone you speak to from the reception staff, nurses and GPs. Never before have I had a GP call me back without asking a few days after my consultation just to check I was ok. This surgery has all of the feel of a good old fashioned family doctors that really care and go above and beyond".*
>
> *"Kind staff - so understanding and helpful".*

People are still finding it difficult to **access NHS Dentistry** trying numerous practices across the county.

“Caller in Banbury has been trying to find an NHS dentist for her and her child, she has not seen a dentist for over 4.5 years”.

“My parents live in Banbury and still have not been able to register anywhere local for NHS treatment. They have worked all their life and have their pension, but this does not stretch to private healthcare. They just paid £45 for a checkup for my Mum, she needs dentures at a cost of £3000 do you know anywhere taking on new NHS patients”.

“After Covid my dentist wrote to me saying they were going private, and I was no longer on their books. I am a diabetic, on medication, I have no teeth in half my mouth as I have had to take them out due to pain, and emergency dentist telling me to take Paracetamol. This has now left me not leaving my house, due to being unable to eat properly, and when I do it causes me pain, and I have collapsed a couple of times due to not eating. I feel so low as my smile was the whole of me and it's gone and taken the best of me with it.”

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: South Central Ambulance Service CQC Improvement Journey Update

Lead Cabinet Member(s) or Responsible Person:

- 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)

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

Deadline for response: Thursday 9th May 2024

Response to report:

Enter text here.

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. 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.	**Accepted**	• Board forward planner with associated feeder board committees forward planners to be in place by the end of Q1 2024/25 • Published Governance Assurance Framework (Q1 2024/25) • Board Governance Structure Chart • The Patient Council in SCAS is now established and involved in discussing issues SCAS is working on. • The engagement officer in SCAS also works with governors and public on seeking opinions on key issues. • Governors are invited to Quality and Safety Committee and Public Board meetings • Patient and Staff stories of positive and negative experience shared with Board and are alternating standing agenda items at Public Board meeting • Patient stories at Patient and Safety and Safeguarding Committees each month
2. For clear mechanisms to be established for the purposes of effectively monitoring adherence to health and safety policies.	**Accepted**	The Trust has clear mechanisms for monitoring the adherence to health and safety policies and also other Trust policies that might have a health and safety dimension to them such as Human Resource policies, Estates policies, Infection Control policies,

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		Education policies and policies to do with the management and maintenance of equipment. The Trust also has arrangements in place for the reporting of adherence to all of these policies via the annual reports produced by the Head of Risk and Security and the reports from the aforementioned Service Areas to the Health, Safety and Risk Group (HSRG). Indeed, all of these reports are to give assurance to the HSRG that health and safety is being managed effectively and that there is adherence not just to Trust health and safety policies but also the statutory legislative requirements. These mechanisms are as follows: ➢ The Head of Risk and Security produces an annual report to the HSRG on the monitoring sections of policies. The last report was presented to the HSRG in September 2023 and was about compliance/adherence to having the necessary health and safety legal documentation displayed in all Trust premises. This documentation consisted of: the signed health and safety statement; the health and safety "What you should know" poster; and the Insurance Liability certificate. All of which are legally required to be displayed. The report also included details about the number of incidents reported and the number of risk assessments completed in accordance with the various health and safety policies, together with details of the number and type of risk assessment training courses and the number of managers and staff trained. ➢ The Head of Risk and Security also produces an annual report to the HSRG on the completion of actions on the

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		Health and Safety Action Plan. Included in this is where the Trust has adhered to health and safety policies and the wider statutory legislative requirements. Both of which inform this action plan which is presented and reviewed at each HSRG meeting. ➢ The HSRG group receives reports throughout the year from Service Areas such as Human Resources, Estates, Infection Control, Education and SCFS Ltd with regards to compliance/adherence to their respective policies and legislative requirements which have a specific health and safety dimension such as: ➢ Stress policy (HR) ➢ Asbestos policy, Legionella policy, Fire Safety policy, Electrical safety policy (Estates) ➢ Infection Prevention and Control policy (Needlestick injuries, dermatitis) (Infection Control) ➢ Education policies (Health and safety training compliance) (Education). ➢ Inspection and maintenance of equipment policies (Trust and SCFS Ltd). • The above was also included in the Health and Safety Action plan for 2023/24 and will be included in the Health and Safety Action plan for 2024/25.*

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		In addition to the above, the Health, Safety and Risk group provides an upward report to the Risk, Assurance and Compliance sub-committee who, in turn, report to the Executive Management Committee which is a sub-committee of the Board. • The Risk Team carry out health and safety inspections to identify and monitor adherence to health and safety policies and other policies listed above. • The Risk Team carry out and assist with the completion of numerous risk assessments to ensure that there is adherence to health and safety policies. These risk assessments consist of: ➢ task based risk assessments ➢ manual handling risk assessments ➢ display screen equipment risk assessments ➢ control of substances hazardous to health risk assessments ➢ stress risk assessments ➢ personal protective equipment risk assessments ➢ premises risk assessments ➢ Events risk assessments.

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		➢ The Risk Team have over the past year been placing the risk assessments that can be shared onto The Hub for staff to access them. • Trained managers also carry out risk assessments (stress, new or expectant mother, display screen equipment) to ensure adherence to health and safety policies. • The Risk Team also review the numbers and type of incidents reported on Datix and produce a report on these to the HSRG. Implicit in this is an identification of adherence to health and safety policies and where this is not the case recommendations will be made to ensure adherence. • The above mechanisms are the means by which the Trust monitors adherence to the health and safety policies. It is intended that the Trust will continue to use these mechanisms besides other mechanisms listed below. • *The Health and Safety Action Plan 2024/25 will include other key performance indicators to help identify adherence to health and safety policies such as: ➢ Ensuring that all of the health and safety policies are in date and are current and valid. (please note, all of the health and safety policies are in date). ➢ Ensuring that all of the health and safety policies are on The Hub for all staff to see. (please note, all of the health and safety policies are on The Hub).

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		➢ Ensuring that all of those with responsibilities listed in the polices are fulfilling their responsibilities. This would be identified by incident reports and subsequent investigations of incidents, in particular RIDDOR incidents. (Bearing in mind that we report on incidents and RIDDOR incidents to the HSRG.) It could also involve asking those with responsibilities for evidence of how they have fulfilled these responsibilities. ➢ Ensuring that all of the risk assessments that can be shared are on The Hub. Currently, all of the personal protective equipment (PPE) risk assessments on the Hub; we have also placed a significant number of control of substances hazardous to health risk assessments and their associated safe systems of work/safe operating procedure onto the Hub – this is an ongoing piece of work and it is being monitored by the HSRG; and we are in the process of placing all of the completed 'task' based risk assessments and the associated manual handling risk assessments and the preventing violence and aggression risk assessments onto The Hub. ➢ Ensuring the Risk Team keep and maintain a record of any enquiries from managers and staff about the health and safety policies and the Risk Team's advice to adhere to them.
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	**Accepted**	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.

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resourcing of employees to support staff wellbeing.		The Trust launched is People Strategy in 2023, based on the NHS People Plan. The strategy lays out our actions across four pillars, that give a clear direction for our cultural and staff wellbeing improvements over the next three years. Our ambition is to create a work environment where people feel happy, safe and have a sense of belonging and welcomes new people into SCAS. The Trust carries out annual planning process and uses modelling to predict required establishment based on the anticipated demand profile and also our agreed commitments to standards of patient care. Weekly performance reports are reviewed at Executive level along with monthly Workforce Planning meetings to ensure we remain well-sighted on the reality of staffing capacity to fluctuating demand as the year unfolds. In 2024/25 we will be looking to create a 5 year workforce plan in line with our vision to be fit for the future. We are recruiting internationally as well as in the UK to source clinicians to meet our vacancies. For international recruits we have a comprehensive relocation package and support of a Pastoral Care Lead who helps them before they arrive in the UK and through their transition into their new life. We also offer a relocation package to help clinicians who are moving within the UK and make SCAS a destination employer. They are offered thorough, in depth training on all aspects of the roles they are entering including classroom teaching and on the job learning. Early indicators suggest they are settling and performing well. The Trust has a retention plan in place, with comprehensive retention action plans and programmes in place for each

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		directorate, which are driven by our data and therefore updated regularly. We have seen improved in our retention over the last 6 months and are expecting this to continue in 2024/25 The Health and Wellbeing team, focus on 6 pillars of wellbeing with a raft of support mechanisms for staff and volunteers, such as financial, emotional, physical and mental health aspects. We have a broad offer of mental health support for all staff include access to national ambulance charities and support networks. All of the aspects above are reported and monitored through our Workforce Development Committee and/or the People and Culture Committee, in addition to Board oversight.
4. To ensure that all ambulance staff are trained in and aware of how to promptly and appropriately provide patients with pain-relieving medication.	**Accepted**	• Staff are trained in medicines administration and pain assessment and work has been undertaken to ensure that staff fill in the electronic patient record (EPR) when they have administered any analgesia and monitor its effectiveness. Improvements have been made in the EPR to make it easier and essential to record pain scores to measure effectiveness of analgesia. • Staff have access to an appropriate range of analgesic drugs to relieve symptoms. They also have access to JRCALC Clinical Practice Guidelines that includes information on medication dosing for both adults and children.

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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.	**Accepted**	• Mental health awareness training has continued in SCAS and we have introduced new training and improved the existing training on Mental Capacity Act which staff had highlighted was an area of concern for them. We are auditing the effectiveness of this. • Mental Health nurses are embedded in our 999 and 111 call centres to support staff and patients with Mental Health calls • Specifically commissioned Mental Health response team and vehicle is working in HIOW ICB footprint and the same approach would be beneficial in the BoB ICB footprint but is hampered by commissioning barriers. From a Clinical Coordination Centre perspective: In core module one (*all new starters*): • NHS Pathways Sensitive Management of Calls with a Mental Health Element • Occasionally comes up in the Pathways practice sessions, for example postpartum psychosis is included in one. • Mental Health Awareness - SCAS Created - P:\EOC Education - Development Team\2.1 MASTER Training Materials\9. 999 4 Week Course\Day 16\1. Mental Health • Mental Health resilience delivered by SCAS mental health team. This is focused on the ECTs mental health and building their resilience. • Dementia awareness eLearning - ESR Ongoing training for:

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		CM2 *(circa 12 weeks post sign off)* - Challenging calls covering stigma surrounding mental health, handling ill mental health callers. Last year's F2F had learning disabilities and mental health resilience focused on staffs' mental health.
6. That the Service continues to address the challenges around the IT outage with urgency.	**Accepted**	• The safeguarding referral application and process is now fully hosted. This has resulted in better stability and effectiveness of the referral process. We are currently process mapping all ways of making electronic safeguarding referrals and paper based referrals from all of our services (999/111/PTS) to ensure we have assessed any unseen risks or points of weakness in the processes. • We have also completed a clinical safety review of the referral process as part of the end to end mapping

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Issue: John Radcliffe Hospital CQC Improvement Journey

Lead Cabinet Member(s) or Responsible Person:

- Eileen Walsh (Chief Assurance Officer, Oxford University Hospitals NHS Foundation Trust)
- Andrew Brent (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust)
- Lisa Glynn (Director of Clinical Services, Oxford University Hospitals NHS Foundation Trust)

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

Deadline for response: Thursday 9th May 2024

Response to report:

We thank HOSC for their comments and recommendations. We offer a response against each recommendation in the below table.

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Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Response
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.	Accept	As a Trust, we take patient safety and quality improvement very seriously and so this work has been at both strategic and operational levels. As noted in our report to HOSC in February 2024, numerous developments across the Trust have taken place since the last inspections at the JR; all of which support and deliver improvements across each of the key questions: Safe, Responsive and Well Led. We continue to review all patient safety incidents with moderate or above impact at our daily Patient Safety Response (PSR) meeting which is chaired by senior clinical leaders with medical, nursing and governance representation from across the Divisions. In line with national requirements, we introduced Patient Safety Incident Response Framework (PSIRF) in 2023. This is an approach to developing and maintaining effective systems and processes for responding to patient safety incidents focussed on learning and improving patient safety. We have a new policy with associated training, and it is supported by a detailed Incident reporting and learning procedure. This has included the appointment of patient safety partners. We continue to monitor key patient safety metrics both internally and against national benchmarks. The latest Summary Hospital-level Mortality Indicator (SHMI) for October 2022 to September 2023 is 0.92 (0.89-1.12). This is banded 'as expected'. From May 2024, the Trust level SHMI will exclude deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts. Provisional NHSE data shared with the Trust shows a SHMI excluding the hospices of 0.86 for January to December 2023, which is banded as 'lower than expected'. The Trust's Hospital Standardised Mortality Ratio (HSMR) is 88.8 (95% CL

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Recommendation	Accepted, rejected or partially accepted	Response
		85.1 – 92.6) for September 2022 to August 2023. The HSMR remains banded as 'lower than expected'. The HSMR excluding both Hospices is 80 (71.5-97.6). All deaths undergo a mortality review to identify and implement any potential learning. Huge emphasis has been placed on core skill compliance. This includes statutory and mandatory training across a range of clinical and non-clinical domains; patient safety training; and role specific training. Compliance is monitored via our MyLearning Hub electronic learning platform and through appraisal. Similar emphasis is placed on appraisal completion and monitoring to support staff in their personal development and delivery of the Trust objectives. Compliance is now recorded on a central system, with rates published in the monthly 'Integrated Performance Report' monitored by our Trust Board (papers are published on our website). We introduced a values-based appraisal (VBA) window for the first time in 2022 which has had a positive impact. 94.2% of Trust wide staff completed an appraisal in the last financial year compared to 65% in 2021-22. The OUH CEO launched our new 'Kindness into Action' programme in October 2022 with a Leading with Kindness training programme for our leaders and managers, something that has been integral to the improvement and development of core services across all sites. By the end of March 2024, 519 leaders in the organisation had completed this comprehensive training package and a further 969 leaders were in the process of completing the training. In addition, 1060 other members of staff had completed the complementary 'Kindness into Action' training for all staff. Underpinning all that we do is a strong focus on Quality Improvement (QI), with ~1,500 staff now trained in Quality Improvement. Reflecting this is our positive feedback from the NHS Staff Survey, which highlights a significant cultural shift within our

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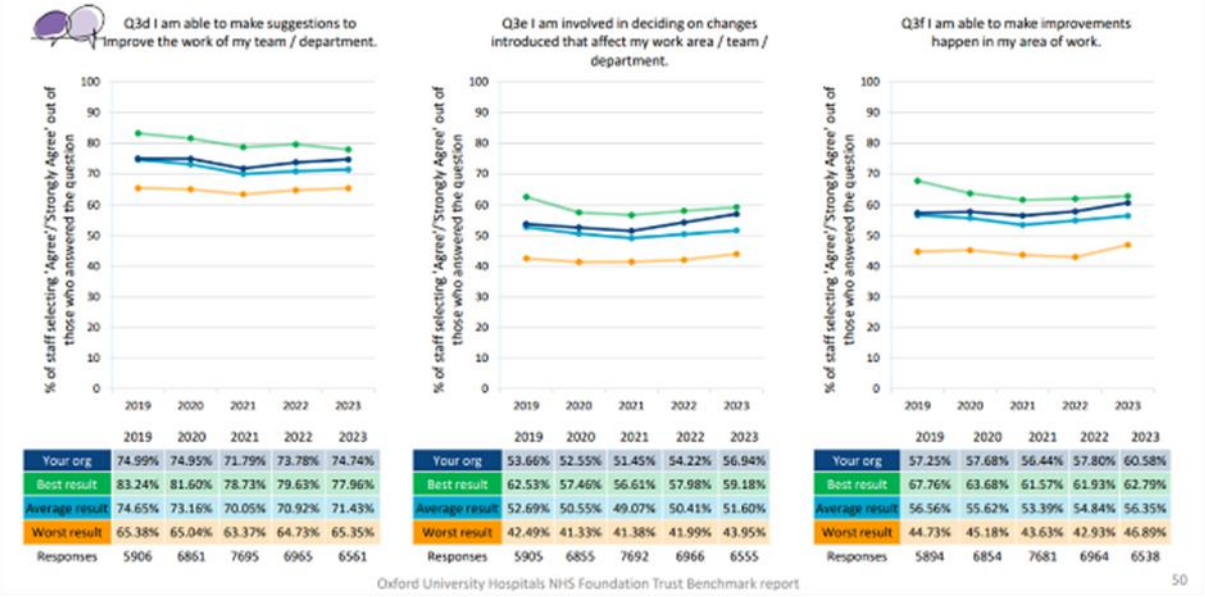
Recommendation	Accepted, rejected or partially accepted	Response
		organisation towards greater staff autonomy and involvement in decision-making processes related to their work areas. These survey results reflect our staff's increasing ability to contribute to improvements and compare favourably with many other NHS Trusts. The staff survey includes 3 questions on quality improvement. In all three questions OUH has seen improvement over the last few years and the scores remain above the average for staff survey results in England as shown below.



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Recommendation	Accepted, rejected or partially accepted	Response
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.	Accept	HOSC are thanked for their recognition of the importance of stakeholder engagement and co-production in NHS services. Stakeholder engagement is a vital part of both our strategic and operational efforts. The views of patients, families, carers, staff and partners help shape our services across the JR and the wider trust. By way of an example of our commitment to this, since the last CQC inspections we have published "Your Voice: Patient Experience and Engagement Plan 2023 – 26" which sets the vision and direction for improving how the Trust learns from lived experience and then puts this into practice with experts by experience working alongside us to implement change. We hold an annual patient safety engagement event which is geared to engage patients the public and our governors in helping set our annual quality priorities. In addition, as flagged in our report to HOSC, patient experience stories are presented to the Trust Board and our Integrated Assurance Committee, providing an insight into an individual's experience of our services. They often provide opportunities for learning. Supporting and involving staff and patients after a patient safety event is one of the four key elements of the Patient Safety Incident Response Framework and the integral work of our Patient Safety Partners. For our staff, we have worked to ensure everyone in the organisation feels they can have a say and that their voice is heard and listened to. Their views are taken into account when decisions are being discussed that affect them. Where we have improvement programmes across the Trust, we ensure there is a 'Development Programme' structure where staff can input, shape and influence those improvement programmes. We have also put mechanisms in place to enable an ongoing conversation with our staff, in different ways, to ensure every voice is heard and

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Recommendation	Accepted, rejected or partially accepted	Response
		actively listened to and the feedback used to guide action plans to address issues raised and celebrate when things are going well.
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.	Accept	We acknowledge the importance of transparency around the quality and improvement in our services. We have therefore ensured that the key reports for us, that play a central a role in monitoring, compliance and improvements, are routinely taken through the Trust's governance structures up to the Trust Board. This includes the publication of associated papers on our website. For example, our Integrated Performance Report (IPR) is reported to the Board and it contains performance indicators, assurance reports and development indicators. The IPR identifies actions to address risks, issues and emerging concerns. This help assist us understand the progress and impact of improvements. The outcomes and overview of our progress in response to CQC Inspections have been reported in the Trust's Annual Reports and Quality Accounts. These are also published on the Trust's website.
4. For sufficient resources to be secured for the purposes of delivering and potentially expanding the Hospital at Home Service.	Partially accepted	The Hospital at Home service (H@H) is a successful initiative that has been introduced, providing an alternative to acute hospital admission, for the treatment and monitoring of patients, enabling them to stay at home during an acute illness. We are committed to having a continuous focus on improving our urgent and emergency services; of which the H@H initiative is an important part. We look to deploy our limited NHS financial resources and workforce according to the needs of patients. As models of care evolve, the range of healthcare roles develop

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Recommendation	Accepted, rejected or partially accepted	Response
		and technology advances evolve, we will continually innovate to ensure the care we provide meets the needs of patients within the financial envelope we have available.
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.	Agreed	OUH would be happy to host a delegation from HOSC to visit the JR to provide first hand illustration of some of the measures taken to improve patient safety.

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Issue: Director of Public Health Annual Report

Lead Cabinet Member(s) or Responsible Person:

- Ansaf Azhar- Director of Public Health

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

Deadline for response: Tuesday 7th May 2024

Response to report:

Enter text here.

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Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
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.	Accepted	We have agreed to bring the 2023/24 DPH Annual Report to the HOSC meeting on xxxx to enable members to consider the deliverability of its recommendations.
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.	Accepted	The DPH report now includes a summary profile of Oxfordshire's Health and Wellbeing with signposting to the Joint Strategic Needs Assessment which provides more detailed and live data.
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.	Accepted	This recommendation is reflected in the engagement plan for the report.
4. For there to be clear transparency and indications as to the barriers and enablers	Accepted	All relevant avenues of funding and resources will be pursued to support delivery of the Report's recommendations.

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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.	Accepted	The report has already been submitted to the Future Oxfordshire Partnership Environment Advisory Group, which provides governance of system wide action to address climate change; it was welcomed and endorsed by this group. Within OCC the Climate Action Programme Board provides internal governance mechanisms for monitoring progress.
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.	Accepted	The report's recommendations are aligned with metrics that are reported against as part of OCC's Unity performance monitoring system. In addition, impact on health outcomes will be reported through the Joint Strategic Needs Assessment.
7. To raise educational awareness and understanding of the importance of climate action and its implications on health.	Accepted	As part of the engagement plan, schools will be engaged as part of a coordinated approach to secure the support of schools' strategic leadership teams for action on climate and health.

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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.	Accepted	Next year's DPH Annual report will be brought to the Committee's spring meeting with a view to scrutinise the deliverability of its recommendations.

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Issue: Health and Wellbeing Strategy Update Scrutiny Item

Lead Cabinet Member(s) or Responsible Person:
Leader of the Council and Chair of the Health and Wellbeing Board (Cllr Liz Leffman)
Cabinet Member for Public Health, Inequalities and Community Safety (Cllr Nathan Ley)

To respond on behalf of the System to the recommendation outlined below.

Deadline for initial response: Tuesday 14th November 2022

Response to report:

The report provides a useful summary of the discussion had at HOSC in September and we welcome HOSC's interest and input into the work. Particular focus in the report is made about input from disadvantaged groups, and we note this aligns well with one of the overall principles of the strategy being one of addressing health inequalities. One point to note with the report section on this topic is that of access to healthcare services. We make direct reference in the strategy to other pieces of system work that are addressing this more fully- such as the emerging primary care strategy and the 5 year joint forward plan for the BOB area - as opposed to directly addressing it in the strategy itself.

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Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)	Progress Update Response
1. 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.	Accept	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.	The Health and Wellbeing Strategy Outcomes Framework was agreed at the Health and Wellbeing Board in March 2024. The Outcomes Framework has broken each of the 10 priorities down into more tangible Shared Outcomes- between 3 and 5 of these per priority. It also maps existing programmes of work against each of the 10 priorities. The Framework also lists suggested metrics to monitor delivery- these are Key Outcomes (a measure of the strategic impact we want to see) and Supporting Indicators (the process measures that support achievement of the strategic change). Finally, the Outcomes Framework lists the governance forums within the Oxfordshire System that is the primary partnership responsible for delivery against each of the priorities. It is these forums and work programmes they have oversight of that ensure relevant engagement with residents over the

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			monitoring of progress in their work areas. It has been agreed by the board that it will review progress, data against the metrics and received narrative update on only one part of the strategy at each of its quarterly meetings, so that over the course of a 12 month work programme it will have reviewed once delivery against all parts of the strategy. Full papers on the Outcomes Framework are available on HWB March agenda

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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 response: Tuesday 14th November 2022

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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, Tier 1 & 2 service,and will know the outcome by late Spring 2024. The service will commence on 1st September 2023. The new Tier 1 and 2 service will include a range of programmes for residents to chose from, as well as developing innovation pilots with specific populations as identified by the HNA, to test and learn what works with these residents to support achieving a healthy weight. Communications and campaigns will be part of this contract to

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		opportunities to raise awareness of support that is available.	increase awareness of the service for residents and professionals.
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	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 Tier 1 and 2 services commissioned by public health have bespoke services for children. From September 2024 the new service will have innovation pilots to test and learn what works with cohorts aged 0-3 and teenagers. In addition,

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tools to help manage children's weight.			a range of digital and print resources for adults and families will be available from the provider to support a healthy weight. The provider will also be part of wider systems working, linking up a range of partners, for example NCMP and 0-19 providers. A children's healthy weight toolkit for health, social and voluntary/community professionals is in redevelopment. A 'You Said, We Did' response has been developed for Early Years professionals following a survey and interviews to support knowledge and skills in healthy eating. This includes Lunchbox Planners, Child Feeding Guide Training and a range of other resources. Finally, Public Health have led a working group to develop a suite of resources and assets to support uptake of Healthy Start across the County, including in ethnic minority groups. This has recently gone live.

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. *suggest Paul Wilding/Emily Urquhart update*	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. Any additional comments from Paul/Emily
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	

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		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 and evidence to support each District/City Council to put in place a policy to restrict Hot Food Takeaways if they choose. Public Health have commissioned Bite Back to develop a youth manifesto on food environments for Oxfordshire, including focusing on vending and HFSS advertising in different locations across the County.

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OXFORDSHIRE COUNTY COUNCIL

Work Programme 2024/25
Joint Health Overview and Scrutiny Committee

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

COMMITTEE BUSINESS

6 JUNE 2024				
Oxford Health NHSFT Quality Account	Prioritise the Health and Wellbeing of Residents	To receive the most recent annual Quality Account report produced by Oxford Health NHSFT, and to provide feedback as appropriate on services delivered by OH.	Overview and Scrutiny	
Integrated Neighbourhood Teams	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents	To receive a report from the BOB ICB on Integrated Neighbourhood Teams in Oxfordshire.	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				
All-Age Mental Health	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report from the Oxfordshire system with an update on All-Age Mental Health.	Overview and Scrutiny	
Winter Planning	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report on the systemwide preparations and plans to manage the pressures of the ensuing winter months.	Overview and Scrutiny	
Medicines Shortages	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on medicines shortages, and how these are affecting patients and residents in Oxfordshire,	Overview and Scrutiny	

Local Area Partnership SEND Improvement Journey	Tackle Inequalities in Oxfordshire Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on the Local Area Partnership's SEND improvement journey, with a view to examine the impacts of the improvement journey on the physical and mental health of Children with SEND.	Overview and Scrutiny	
21 NOVEMBER 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	

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Consolidated Action and Recommendation Tracker – Health Overview and Scrutiny Committee 6 June 2024.

	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 6 June 2024.

	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 6 June 2024.

	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/SCAS	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

	Item	Action/Recommendation	Lead	Progress update
				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

	Item	Action/Recommendation	Lead	Progress update
				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):

	Item	Action/Recommendation	Lead	Progress update
				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. Update April 2023: We are in the process of recommissioning an all age, Tier 1 & 2 service,and will know the outcome by late Spring 2024. The service will commence on 1st September 2023. The new Tier 1 and 2 service will include a range of programmes for residents to chose from, as well as developing innovation pilots with specific populations as identified by the HNA, to test and learn what works with these residents to support achieving a healthy weight. Communications and campaigns will be part of this contract to increase awareness of the service for residents and professionals.

	Item	Action/Recommendation	Lead	Progress update
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. Update April 2023: This detail remains the same. We can provide specific numbers and details of groups if HOSC require
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. Update April 2023: Current Tier 1 and 2 services commissioned by public health have bespoke services for children. From September 2024 the new service will have innovation pilots to test and learn what works with cohorts aged 0-3 and teenagers. In addition, a range of digital

	Item	Action/Recommendation	Lead	Progress update
				and print resources for adults and families will be available from the provider to support a healthy weight. The provider will also be part of wider systems working, linking up a range of partners, for example NCMP and 0-19 providers. A children's healthy weight toolkit for health, social and voluntary/community professionals is in redevelopment. A 'You Said, We Did' response has been developed for Early Years professionals following a survey and interviews to support knowledge and skills in healthy eating. This includes Lunchbox Planners, Child Feeding Guide Training and a range of other resources. Finally, Public Health have led a working group to develop a suite of resources and assets to support uptake of Healthy Start across the County, including in ethnic minority groups. This has recently gone live.
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. Update April 2023:

	Item	Action/Recommendation	Lead	Progress update
				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.
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. Update April 2023: We believe this meeting was being co-ordinated by HOSC. We have met several times with planning leads and provided detailed backing information and evidence to support each District/City Council to put in place a policy to restrict Hot Food Takeaways if they choose. Public Health have commissioned Bite Back to develop a youth manifesto on food environments for Oxfordshire, including focusing on vending and HFSS advertising in different locations across the County.

	Item	Action/Recommendation	Lead	Progress update
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. Update April 2023: The Health and Wellbeing Strategy Outcomes Framework was agreed at the Health and Wellbeing Board in March 2024. The Outcomes Framework has broken each of the 10 priorities down into more tangible Shared Outcomes- between 3 and 5 of these per priority. It also maps existing programmes of work against each of the 10 priorities. The Framework also lists suggested metrics to monitor delivery- these are Key Outcomes (a measure of the strategic impact we want to see) and Supporting Indicators (the process measures that support achievement of the strategic change). Finally, the Outcomes Framework lists the governance forums within the Oxfordshire

	Item	Action/Recommendation	Lead	Progress update
				System that is the primary partnership responsible for delivery against each of the priorities. It is these forums and work programmes they have oversight of that ensure relevant engagement with residents over the monitoring of progress in their work areas. It has been agreed by the board that it will review progress, data against the metrics and received narrative update on only one part of the strategy at each of its quarterly meetings, so that over the course of a 12 month work programme it will have reviewed once delivery against all parts of the strategy. Full papers on the Outcomes Framework are available on HWB March agenda.
	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).

	Item	Action/Recommendation	Lead	Progress update
				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 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.	Stephen Chandler/Anne Coyle/Rachel Corser	Initial Response (additional progress update response to be provided in April 2024): 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	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

	Item	Action/Recommendation	Lead	Progress update
		to help families feel their voices are being heard as well as for the purposes of transparency.		the heart of PAP and wider action planning. As noted, they are represented within all leadership & delivery bodies for SEND improvement.
Page 161	**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 of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector, and families.	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 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.

	Item	Action/Recommendation	Lead	Progress update
	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, using the budget agreed by cabinet immediately following the Ofsted report.	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 outcome led plans with families. As noted above (Paragraph 8), continued improved communication with stakeholders and families is a key priority.
	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

	Item	Action/Recommendation	Lead	Progress update
				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.
Page 163	**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 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:	Stephen Chandler/An	Initial Response (additional progress update response to be provided in April 2024):

	Item	Action/Recommendation	Lead	Progress update
		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.	ne Coyle/Rachel Corser	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 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.

	Item	Action/Recommendation	Lead	Progress update
	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 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.	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.
	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		Recommendation Partially Accepted: Initial Response (additional progress update response to be provided in June 2024):

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		recommended that piloting such navigation tools in specific communities may be a point of consideration.		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. 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

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Page 167				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. We have built reviews and service improvement into the digital offer and will be able to provide updates in due course.
	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		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

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		testing with neurodivergent children and other children known to be at higher risk of mental ill health.		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.
	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

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				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 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

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				Neuro-development Conditions assessments is also an action in the SEND Priority Action Plan.
Page 170	**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. 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.

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				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.
	8 February 2024			
	Director of Public Health Annual Report	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.	Ansaf Azhar	Recommendation Accepted: We have agreed to bring the 2023/24 DPH Annual Report to a future HOSC meeting to enable members to consider the deliverability of its recommendations.
	Director of Public Health Annual Report	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.	Ansaf Azhar	Recommendation Accepted: The DPH report now includes a summary profile of Oxfordshire's Health and Wellbeing with signposting to the Joint Strategic Needs Assessment which provides more detailed and live data.
	Director of Public Health Annual Report	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.	Ansaf Azhar	Recommendation Accepted: This recommendation is reflected in the engagement plan for the report.
	Director of Public Health Annual Report	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	Ansaf Azhar	Recommendation Accepted: All relevant avenues of funding and resources will be pursued to support delivery of the Report's recommendations.

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		for the purposes of delivering these ambitions, and for collaboration with key system partners for the purposes of this.		
	Director of Public Health Annual Report	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.	Ansaf Azhar	Recommendation Accepted: The report has already been submitted to the Future Oxfordshire Partnership Environment Advisory Group, which provides governance of system wide action to address climate change; it was welcomed and endorsed by this group. Within OCC the Climate Action Programme Board provides internal governance mechanisms for monitoring progress.
	Director of Public Health Annual Report	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.	Ansaf Azhar	Recommendation Accepted: The report's recommendations are aligned with metrics that are reported against as part of OCC's Unity performance monitoring system. In addition, impact on health outcomes will be reported through the Joint Strategic Needs Assessment.
	Director of Public Health Annual Report	To raise educational awareness and understanding of the importance of climate action and its implications on health.	Ansaf Azhar	Recommendation Accepted: As part of the engagement plan, schools will be engaged as part of a coordinated approach to secure the support of schools' strategic leadership teams for action on climate and health.
	Director of Public Health Annual Report	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	Ansaf Azhar	Recommendation Accepted: Next year's DPH Annual report will be brought to the Committee's spring meeting

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		draft and provide feedback in a public meeting ahead of its official publication.		with a view to scrutinise the deliverability of its recommendations.
	SCAS CQC Improvement Journey	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.	Daryl Lutchmaya, Kirsten Willis-Drewett, Dai Tamplin	Recommendation Accepted: Board forward planner with associated feeder board committees forward planners to be in place by the end of Q1 2024/25 Published Governance Assurance Framework (Q1 2024/25) Board Governance Structure Chart The Patient Council in SCAS is now established and involved in discussing issues SCAS is working on. The engagement officer in SCAS also works with governors and public on seeking opinions on key issues. Governors are invited to Quality and Safety Committee and Public Board meetings Patient and Staff stories of positive and negative experience shared with Board and are alternating standing agenda items at Public Board meeting Patient stories at Patient and Safety and Safeguarding Committees each month
	SCAS CQC Improvement Journey	For clear mechanisms to be established for the purposes of effectively monitoring adherence to health and safety policies.	Daryl Lutchmaya, Kirsten Willis-Drewett, Dai Tamplin	Recommendation Accepted: The Trust has clear mechanisms for monitoring the adherence to health and safety policies and also other Trust policies that might have a health and safety dimension to them such as Human

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				Resource policies, Estates policies, Infection Control policies, Education policies and policies to do with the management and maintenance of equipment. The Trust also has arrangements in place for the reporting of adherence to all of these policies via the annual reports produced by the Head of Risk and Security and the reports from the aforementioned Service Areas to the Health, Safety and Risk Group (HSRG). Indeed, all of these reports are to give assurance to the HSRG that health and safety is being managed effectively and that there is adherence not just to Trust health and safety policies but also the statutory legislative requirements.
	SCAS CQC Improvement Journey	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.	Daryl Lutchmaya, Kirsten Willis-Drewett, Dai Tamplin	Recommendation Accepted: The Trust launched is People Strategy in 2023, based on the NHS People Plan. The strategy lays out our actions across four pillars, that give a clear direction for our cultural and staff wellbeing improvements over the next three years. Our ambition is to create a work environment where people feel happy, safe and have a sense of belonging and welcomes new people into SCAS. The Trust carries out annual planning process and uses modelling to predict required establishment based on the anticipated demand profile and also our

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				agreed commitments to standards of patient care. Weekly performance reports are reviewed at Executive level along with monthly Workforce Planning meetings to ensure we remain well-sighted on the reality of staffing capacity to fluctuating demand as the year unfolds. In 2024/25 we will be looking to create a 5 year workforce plan in line with our vision to be fit for the future. We are recruiting internationally as well as in the UK to source clinicians to meet our vacancies. For international recruits we have a comprehensive relocation package and support of a Pastoral Care Lead who helps them before they arrive in the UK and through their transition into their new life. We also offer a relocation package to help clinicians who are moving within the UK and make SCAS a destination employer. They are offered thorough, in depth training on all aspects of the roles they are entering including classroom teaching and on the job learning. Early indicators suggest they are settling and performing well. The Trust has a retention plan in place, with comprehensive retention action plans and programmes in place for each directorate, which are driven by our data and therefore updated regularly. We have seen improved in our retention over the last 6 months and are expecting this to continue in 2024/25

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				The Health and Wellbeing team, focus on 6 pillars of wellbeing with a raft of support mechanisms for staff and volunteers, such as financial, emotional, physical and mental health aspects. We have a broad offer of mental health support for all staff include access to national ambulance charities and support networks. All of the aspects above are reported and monitored through our Workforce Development Committee and/or the People and Culture Committee, in addition to Board oversight.
	SCAS CQC Improvement Journey	To ensure that all ambulance staff are trained in and aware of how to promptly and appropriately provide patients with pain-relieving medication.	Daryl Lutchmaya, Kirsten Willis-Drewett, Dai Tamplin	Recommendation Accepted: Staff are trained in medicines administration and pain assessment and work has been undertaken to ensure that staff fill in the electronic patient record (EPR) when they have administered any analgesia and monitor its effectiveness. Improvements have been made in the EPR to make it easier and essential to record pain scores to measure effectiveness of analgesia. Staff have access to an appropriate range of analgesic drugs to relieve symptoms. They also have access to JRCALC Clinical Practice Guidelines that includes information on medication dosing for both adults and children.
	SCAS CQC Improvement Journey	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.	Daryl Lutchmaya, Kirsten	Recommendation Accepted: Mental health awareness training has continued in SCAS and we have

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			Willis-Drewett, Dai Tamplin	introduced new training and improved the existing training on Mental Capacity Act which staff had highlighted was an area of concern for them. We are auditing the effectiveness of this. Mental Health nurses are embedded in our 999 and 111 call centres to support staff and patients with Mental Health calls Specifically commissioned Mental Health response team and vehicle is working in HIOW ICB footprint and the same approach would be beneficial in the BoB ICB footprint but is hampered by commissioning barriers. From a Clinical Coordination Centre perspective: In core module one (all new starters): NHS Pathways Sensitive Management of Calls with a Mental Health Element Occasionally comes up in the Pathways practice sessions, for example postpartum psychosis is included in one. Mental Health resilience delivered by SCAS mental health team. This is focused on the ECTs mental health and building their resilience. Dementia awareness eLearning - ESR Ongoing training for: CM2 (circa 12 weeks post sign off) - Challenging calls covering stigma surrounding mental health, handling ill mental health callers. Last year's F2F had learning disabilities and mental health resilience focused on staffs' mental health.

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	SCAS CQC Improvement Journey	That the Service continues to address the challenges around the IT outage with urgency.	Daryl Lutchmaya, Kirsten Willis-Drewett, Dai Tamplin	Recommendation Accepted: The safeguarding referral application and process is now fully hosted. This has resulted in better stability and effectiveness of the referral process. We are currently process mapping all ways of making electronic safeguarding referrals and paper based referrals from all of our services (999/111/PTS) to ensure we have assessed any unseen risks or points of weakness in the processes. We have also completed a clinical safety review of the referral process as part of the end to end mapping
	John Radcliffe Hospital CQC Improvement Journey	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.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: As a Trust, we take patient safety and quality improvement very seriously and so this work has been at both strategic and operational levels. As noted in our report to HOSC in February 2024, numerous developments across the Trust have taken place since the last inspections at the JR; all of which support and deliver improvements across each of the key questions: Safe, Responsive and Well Led. We continue to review all patient safety incidents with moderate or above impact at our daily Patient Safety Response (PSR) meeting which is chaired by senior clinical leaders with medical, nursing and governance representation from across the Divisions. In line with national requirements, we introduced Patient Safety Incident

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				Response Framework (PSIRF) in 2023. This is an approach to developing and maintaining effective systems and processes for responding to patient safety incidents focussed on learning and improving patient safety. We have a new policy with associated training, and it is supported by a detailed Incident reporting and learning procedure. This has included the appointment of patient safety partners. We continue to monitor key patient safety metrics both internally and against national benchmarks. The latest Summary Hospital-level Mortality Indicator (SHMI) for October 2022 to September 2023 is 0.92 (0.89-1.12). This is banded 'as expected'. From May 2024, the Trust level SHMI will exclude deaths that occur in the two Trust hospices (Katherine House Hospice and Sobell House Hospice) in line with benchmarked Trusts. Provisional NHSE data shared with the Trust shows a SHMI excluding the hospices of 0.86 for January to December 2023, which is banded as 'lower than expected'. The Trust's Hospital Standardised Mortality Ratio (HSMR) is 88.8 (95% CL 85.1 – 92.6) for September 2022 to August 2023. The HSMR remains banded as 'lower than expected'. The HSMR excluding both Hospices is 80 (71.5 -97.6). All deaths undergo a mortality review to identify and implement any potential learning. Huge emphasis has been placed on core skill compliance. This includes statutory

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Page 180				and mandatory training across a range of clinical and non-clinical domains; patient safety training; and role specific training. Compliance is monitored via our MyLearning Hub electronic learning platform and through appraisal. Similar emphasis is placed on appraisal completion and monitoring to support staff in their personal development and delivery of the Trust objectives. Compliance is now recorded on a central system, with rates published in the monthly 'Integrated Performance Report' monitored by our Trust Board (papers are published on our website). We introduced a values-based appraisal (VBA) window for the first time in 2022 which has had a positive impact. 94.2% of Trust wide staff completed an appraisal in the last financial year compared to 65% in 2021-22. The OUH CEO launched our new 'Kindness into Action' programme in October 2022 with a Leading with Kindness training programme for our leaders and managers, something that has been integral to the improvement and development of core services across all sites. By the end of March 2024, 519 leaders in the organisation had completed this comprehensive training package and a further 969 leaders were in the process of completing the training. In addition, 1060 other members of staff had completed the complementary 'Kindness into Action' training for all staff.

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				Underpinning all that we do is a strong focus on Quality Improvement (QI), with ~1,500 staff now trained in Quality Improvement. Reflecting this is our positive feedback from the NHS Staff Survey, which highlights a significant cultural shift within ourorganisation towards greater staff autonomy and involvement in decision-making processes related to their work areas. These survey results reflect our staff's increasing ability to contribute to improvements and compare favourably with many other NHS Trusts. The staff survey includes 3 questions on quality improvement. In all three questions OUH has seen improvement over the last few years and the scores remain above the average for staff survey results in England.
	John Radcliffe Hospital CQC Improvement Journey	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.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: HOSC are thanked for their recognition of the importance of stakeholder engagement and co-production in NHS services. Stakeholder engagement is a vital part of both our strategic and operational efforts. The views of patients, families, carers, staff and partners help shape our services across the JR and the wider trust. By way of an example of our commitment to this, since the last CQC inspections we have published "Your Voice: Patient Experience and Engagement Plan 2023 – 26" which sets the vision and direction for improving how the Trust learns from lived experience and then puts this into practice with

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Page 182				experts by experience working alongside us to implement change. We hold an annual patient safety engagement event which is geared to engage patients the public and our governors in helping set our annual quality priorities. In addition, as flagged in our report to HOSC, patient experience stories are presented to the Trust Board and our Integrated Assurance Committee, providing an insight into an individual's experience of our services. They often provide opportunities for learning. Supporting and involving staff and patients after a patient safety event is one of the four key elements of the Patient Safety Incident Response Framework and the integral work of our Patient Safety Partners. For our staff, we have worked to ensure everyone in the organisation feels they can have a say and that their voice is heard and listened to. Their views are taken into account when decisions are being discussed that affect them. Where we have improvement programmes across the Trust, we ensure there is a 'Development Programme' structure where staff can input, shape and influence those improvement programmes. We have also put mechanisms in place to enable an ongoing conversation with our staff, in different ways, to ensure every voice is heard and actively listened to and the feedback used to guide action plans to address issues

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				raised and celebrate when things are going well.
Page 183	**John Radcliffe Hospital CQC Improvement Journey**	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.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: We acknowledge the importance of transparency around the quality and improvement in our services. We have therefore ensured that the key reports for us, that play a central a role in monitoring, compliance and improvements, are routinely taken through the Trust's governance structures up to the Trust Board. This includes the publication of associated papers on our website. For example, our Integrated Performance Report (IPR) is reported to the Board and it contains performance indicators, assurance reports and development indicators. The IPR identifies actions to address risks, issues and emerging concerns. This help assist us understand the progress and impact of improvements. The outcomes and overview of our progress in response to CQC Inspections have been reported in the Trust's Annual Reports and Quality Accounts. These are also published on the Trust's website.
	John Radcliffe Hospital CQC Improvement Journey	For sufficient resources to be secured for the purposes of delivering and potentially expanding the Hospital at Home Service.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Partially Accepted: The Hospital at Home service (H@H) is a successful initiative that has been introduced, providing an alternative to acute hospital admission, for the treatment and monitoring of patients, enabling them to stay at home during an acute illness. We are committed to having a continuous

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				focus on improving our urgent and emergency services; of which the H@H initiative is an important part. We look to deploy our limited NHS financial resources and workforce according to the needs of patients. As models of care evolve, the range of healthcare roles develop and technology advances evolve, we will continually innovate to ensure the care we provide meets the needs of patients within the financial envelope we have available.
	John Radcliffe Hospital CQC Improvement Journey	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.	Eileen Walsh, Andrew Brent, Lisa Glynn	Recommendation Accepted: OUH would be happy to host a delegation from HOSC to visit the JR to provide first hand illustration of some of the measures taken to improve patient safety.