OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 6 March 2025 commencing at 10.01 am and finishing at 3.54 pm

Present:

Voting Members:	Councillor Jane Hanna OBE – in the Chair District Councillor Katharine Keats-Rohan (Deputy Chair) Councillor Jenny Hannaby Councillor Nick Leverton Councillor Michael O'Connor District Councillor Paul Barrow District Councillor Elizabeth Poskitt District Councillor Susanna Pressel District Councillor Dorothy Walker
Co-opted Members:	Barbara Shaw
Other Members in Attendance:	Cllr John Howson, Cabinet Member for Children, Education and Young People's Services
Officers:	Neil Flint, Associate Director, Performance & Delivery for Planned Care, BOB ICB Matthew Tait, Chief Delivery Officer BOB ICB Tony Collett, Connect Health Mike Carpenter, Connect Health Suraj Bafna, Connect Health Phil Gomersall (Adult Audiology Team Leader OUH NHS Foundation Trust Katharine Howell, Senior research and projects Officer at Healthwatch Oxfordshire Felicity Taylor Drewe, Chief Operating Officer, OUH NHS Foundation Trust Andy Peniket, Clinical Director for Oncology & Haematology OUH NHS Foundation Trust Ansaf Azhar, Director of Public Health at Oxfordshire County Council Donna Husband, Head of Public Health Programmes Frances Burnett, Public Health Registrar Tom Hudson, Scrutiny Manager Omid Nouri, Health Scrutiny Officer

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.

14/25 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Cllr Lygo, and Sylvia Buckingham.

15/25 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

None were made.

16/25 MINUTES
(Agenda No. 3)

The Minutes of the meeting held on 30th January 2025 were **APPROVED** as a true and accurate record.

17/25 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

Cllr John Howson (Cabinet Member for Children, Education and Young People's Services) raised several points regarding the Director of Public Health annual report. He felt it presented mental health issues as a recent discovery, despite historical recognition, citing a 1970s study by Tony Travis on educational funding disparities. He emphasised the need for more data on neurodiversity, particularly post-COVID, and expressed disappointment at the lack of CAMHS (Child and Adolescent Mental Health Services) locality data. Cllr Howson stressed the importance of analysing Key Stage 2 performance in reading, writing, and maths by school, noting Oxford City's poor results. He highlighted that primary and special schools in Oxfordshire outperformed the national average in attendance, whereas secondary schools fell below. He questioned the estimated 35,000 children with mental health problems, comparing it to current EHCP (Education Health and Care Plan) and SEND action plan figures. He also argued against the report's portrayal of young people with mental health issues being marginalised, referencing low claimant counts for 18 to 24-year-olds in Oxfordshire. Additionally, he mentioned the budget's extra £2,000,000 for SEND and £1,000,000 for under-fives, calling for a more comprehensive view of Oxfordshire.

18/25 RESPONSE TO HOSC RECOMMENDATIONS
(Agenda No. 5)

The Committee **NOTED** the responses to the Maternity Services recommendations, however Members expressed concerns that many of the recommendations were only "partially accepted".

The Committee also **NOTED** that they were awaiting responses to the Healthy Weight item Recommendations.

19/25 CHAIR'S UPDATE

(Agenda No. 6)

The Chair provided a verbal update on recent issues including HOSC Report Submissions. Reports with recommendations on the Health and Well-being Strategy Outcomes Framework, the BOB ICB Operating Model, the Oxfordshire Health NHS Foundation Trust People Plan, and on support for individuals leaving hospital were to be imminently submitted to relevant system partners.

Letters were sent to Oxford City and Cherwell District Councils, urging them to adopt policies promoting healthier food advertising and restricting new fast-food outlets near schools and in areas with high levels of childhood obesity.

Epilepsy Services saw positive developments, including a change in MHRA policy and the distribution of a patient safety leaflet in 30 languages. However, there had been no progress on medication access for girls and women.

Concerning the government's devolution plans, the Chair expressed that in the context of any future local authority changes, that efforts should continue in addressing rural inequities and supporting community integration in healthcare.

It was also highlighted that the Committee's Working Groups on Wantage Community Hospital and on the Oxford City Community Hubs Project successfully contributed toward collaborative efforts to secure additional resources.

The Chair reminded the Committee of pending follow-ups on repeat prescriptions by telephone, on ophthalmology services, and on the closure of the ADHD waiting list.

20/25 MUSCULOSKELETAL SERVICES IN OXFORDSHIRE

(Agenda No. 7)

Neil Flint (Associate Director, Performance & Delivery for Planned Care, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board) was invited to present a report on Musculoskeletal (MSK) Services in Oxfordshire. The Committee had previously been involved in scrutiny of MSK services and had commissioned a report on this area, with a view to receive an update on the current state of MSK services for local residents/patients.

Matthew Tait (Chief Delivery Officer BOB ICB); Ansaf Azhar (Director of Public Health at Oxfordshire County Council), and Connect Health Officers Tony Collett, Mike Carpenter, and Suraj Bafna attended to answer questions the Committee had in relation to the MSK Services in Oxfordshire report.

The Associate Director and the Connect Health officers discussed the initial challenges when they assumed the contract. These included staffing shortages, a backlog of 19,000 patients, and the need to rebuild stakeholder relationships.

By February 2025, all service lines except pelvic health were within the target wait times of six weeks. The pelvic health service had a wait time of ten weeks. The service was nearly at its full staffing level, with only a 0.6 full-time staff shortfall.

Delays in Health and Care Professions Council (HCPC) registration affected the start dates for new pelvic health clinicians.

The team conducted three community engagement events and planned to attend more, including those organised by the Oxfordshire Play Association. They arranged for Healthwatch to assess their services in April and May. A five-year plan to address health inequalities was implemented at the beginning of 2025, with quarterly updates provided.

The team engaged with primary care through network group meetings, stakeholder meetings, seminars, and newsletters. They also collaborated with secondary care teams, including rheumatology, orthopaedics, radiology, and gynaecology, to streamline pathways and address wait times. Contact with independent providers like Cherwell Hospital was maintained to help manage wait lists and alleviate service pressures. Finally, ongoing efforts were made to develop a unified model across the three counties (Buckinghamshire, Oxfordshire, and West Berkshire) to ensure consistent service delivery and mitigate postcode disparities.

Ansaf Azhar, Director of Public Health, joined the meeting at this stage.

Members asked about the innovative delivery models mentioned in the report, specifically how these models and the use of technology and Artificial Intelligence (AI) have contributed to reducing waiting lists. They suggested that if these models were effective, they could potentially be applied to other areas to cut down waiting lists.

The Associate Director, along with the Connect Health Officers explained that the innovative delivery models mentioned in the report included the use of technology and AI to manage musculoskeletal conditions. These models aimed to triage patients effectively, allowing those with less complex issues to self-manage with targeted advice and exercises. This approach freed up appointments for more complex cases, contributing to reduced waiting lists. The effectiveness of these models suggested that they could potentially be applied to other areas to cut down waiting lists.

Members had highlighted concerns regarding the long waits for rheumatology and orthopaedics, acknowledging these as serious long-term conditions. They questioned the effectiveness of the diagnosis process since only 10% of referrals proceeded to orthopaedics or rheumatology. They also sought clarification on how the referral process functioned for more complex patients.

Officers recognised the significance of these long-term conditions. It was stated that the diagnosis process was effective, as only 10% of referrals required forwarding to orthopaedics or rheumatology. This was attributed to the comprehensive assessment and treatment provided by the Tier 2 service, which included advanced practitioners skilled in managing complex cases, conducting diagnostics, and providing treatments such as injections. The referral process for more complex patients involved a detailed triage to ensure all necessary information and prior approvals were secured before referring them to secondary care.

Members raised questions about Musculoskeletal (MSK) services in the southern parts of the county, particularly at Wantage Hospital. They discussed improving

service distribution, especially in the southern regions, and enhancing recruitment and retention within the MSK workforce. The conversation also touched on demographics and the aging community.

Connect Health officers stated that efforts were underway to improve MSK service distribution. Wantage Hospital continues to provide physiotherapy services, with active recruitment to maintain staffing levels. Recruitment measures include travel time and mileage coverage for clinicians and collaboration with Oxford Brookes University for student placements. The distribution of services is data-driven, ensuring appropriate coverage based on patient postcodes. Addressing rural inequalities and catering to the growing aging population remain priorities.

Members inquired whether the organisation recognised the importance of supporting staff once they were in post to ensure they felt valued and rewarded. They sought information on the HR measures being implemented to maintain staff retention and prevent employees from feeling overwhelmed by their workload. Officers responded that regular feedback was solicited from staff, and efforts were made to enhance the working environment. Initiatives included team-building activities, allocated time for personal development, external funding for courses, and well-being surveys. Additionally, the organisation provided administrative support, mental health resources, and opportunities for internal training and upskilling. These measures aimed to ensure that staff felt valued, rewarded, and not overburdened by their responsibilities.

Members inquired about the organisation's involvement in planning and development discussions to ensure that future service sites are adequately planned for local communities. They asked if the organisation had been consulted regarding their requirements for future developments, particularly in regions with significant population growth. The Associate Director and Connect Health Officers confirmed that the organisation participated in these discussions to guarantee that healthcare needs are considered in planning. Efforts were made to attend consultations and advocate for healthcare integration in future development plans. The organisation sought to engage with local authorities and other stakeholders to address the needs of expanding communities.

Members inquired about the reasons for not meeting three key performance indicators (KPIs), and the measures being taken to address this issue. Connect Health Officers clarified that the organisation had not met three KPIs related to routine access times, urgent access times, and contacting patients within 10 working days of receiving a referral. The reasons included actions by the administrative team and clinicians, such as booking routine patients into urgent slots. Measures to improve the situation involved modifying these actions, monitoring the use of urgent slots, and implementing a plan to contact patients sooner. Additionally, the organisation considered alternative methods, such as texting patients, to improve contact times.

Members inquired about the provision of long-term support and pain management for MSK patients, particularly those experiencing chronic or long-term pain, and how occasional outpatient appointments translated into ongoing support and pain management. Connect Health Officers explained that long-term support and pain

management for MSK patients, especially those with chronic or long-term pain, were delivered through a low-level pain management programme. This programme included a team of senior pain clinicians and advanced pain practitioners who provided assistance to patients with mild psychosocial factors impacting their pain.
For patients suffering from severe pelvic pain, urgent appointment slots were made available to ensure they received timely care. The organisation recognised the need to enhance support for patients awaiting appointments and committed to reviewing and improving their waiting well messages and resources. Additionally, efforts were being made to streamline pathways and collaborate with various stakeholders to better support patients with comorbidities.

Members asked about the impact of pelvic pain, referencing a national survey by the Pelvic Pain Foundation, and inquired to what extent the service was collaborating with key partners such as the Pelvic Pain Foundation to support patients. Connect Health Officers indicated that pelvic pain significantly affects women, often resulting in severe pain, inability to work, and challenges in managing family responsibilities.

A national survey by the Pelvic Pain Foundation provided evidence of these challenges. The service acknowledged the importance of collaborating with key partners and mentioned ongoing collaborations with various NHS stakeholders. It was noted that there had not yet been engagement with the Pelvic Pain Foundation. The service committed to exploring this potential partnership to enhance support for patients waiting for care.

Members inquired about handling negative feedback, especially regarding pelvic health, and steps taken to improve patient interactions. Connect Health Officers explained that complaints were investigated through contact with patients and review of clinician notes. Trends were identified via thematic analysis and findings were reported to senior leadership and the ICB. Lessons from complaints were shared with the team through meetings, training, and individual sessions. The service maintained a low complaint rate and received high positive feedback, showing overall patient satisfaction.

Members inquired about how the service was collaborating with diagnostic physiotherapists available at every GP surgery through primary care networks. They also questioned the coordination of ongoing care for MSK patients between GP surgeries and specialist services/consultants, as well as the key challenges involved.

Connect Health Officers detailed that the service worked closely with diagnostic physiotherapists (First Contact Practitioners or FCPs) available at GP surgeries through primary care networks. They conducted seminars and collaborated with Integrated Care Boards (ICBs) and rheumatology teams to support FCPs and GPs. Additionally, they implemented a GP engagement plan to identify and address challenges faced by practices with low referral rates. Coordination for ongoing care of MSK patients between GP surgeries and specialist services/consultants involved regular meetings and direct communication to streamline pathways and tackle any issues. Key challenges included variations in FCP providers and ensuring seamless integration of services.

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

1. To address variances around the county, with a view to residents being able to access local MSK services more swiftly.

2. To continue to develop further collaboration with GPs and other services to improve MSK services. It is recommended that efforts are made to reduce the number of steps (and time) required to access MSK services.

3. For efforts to be made to create improvements to pelvic health outcomes. It is recommended that there is engagement with the Pelvic Pain Foundation around support for those who are waiting for support.

21/25 AUDIOLOGY SERVICES IN OXFORDSHIRE
(Agenda No. 8)

Neil Flint (Associate Director, Performance & Delivery for Planned Care, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board) was invited to present a report on Audiology Services in Oxfordshire.

Matthew Tait (Chief Delivery Officer BOB ICB), and Phil Gomersall (Adult Audiology Team Leader Oxford University Hospitals NHS Foundation Trust) (OUH), also attended to answer questions from the Committee in relation to the Audiology Services in Oxfordshire report.

The Associate Director, Performance & Delivery for Planned Care discussed service commissioning in Oxfordshire and Buckinghamshire, which aimed to improve accessibility through the "any qualified provider" model with 26 community locations. He noted that there had been minimal complaints and positive patient feedback. Phil Gomersall described the adult audiology team, differentiating between community services for age-related hearing loss and hospital services for complex needs, including Ear Nose and Throat (ENT) diagnostics, specialist testing, balance assessments, and rehabilitation for non-age-related conditions.

Members inquired about the broader engagement process related to the commissioning of audiology contracts, beyond the market engagement mentioned in the document. The Associate Director and the Adult Audiology Team Leader explained that this process involved collaboration with communications leads to promote public involvement, although no members of the public attended the sessions. The team also reviewed historical complaints and feedback to address issues within the new service model.

The objective was to enhance accessibility and reduce waiting times. While detailed national comparisons were not provided, the service was designed to meet national minimum standards and effectively address local needs.

Members inquired about how the long waiting lists for more complex audiology services compared to the situation before the contract and the current scenario. Officers clarified that the waiting lists for these specialised audiology services had deteriorated since the pre-contract period. This was primarily due to the impact of COVID-19, which increased waiting times because of the close contact nature of

audiology assessments. Additionally, there were national challenges concerning ear, nose, and throat services. Efforts are underway to enhance community providers to help ease some of the burden on secondary care.

Members inquired about the decision-making process for prioritising areas and determining which patients received services at the community diagnostic centres. Officers clarified that this process was directed by a national programme from NHS England. This programme outlined key diagnostic tests that centres had to offer to achieve accreditation. Initially, the centres focused on tests such as MRIs, X-rays, and ultrasounds, and later expanded to include audiology. The process involved submitting bids for additional funding to support these services. Access to the centres was managed through hospital pathways and self-referrals.

Members asked about efforts to improve access to the service, raise awareness, KPIs for providers and contractors, and exclusions from the service. The Associate Director and Adult Audiology Team Leader explained that efforts to improve access and awareness included addressing complaints about ear wax removal and informing patients about the service.

Providers were encouraged to market the service effectively, and communications were sent to primary care colleagues to inform them about the service. The KPIs for providers and contractors included a 16-day target for completing assessments and a 20-day target for fitting hearing aids after assessment. Exclusions from the service were based on professional body guidance and included conditions like troublesome tinnitus, which required specialist treatment in a hospital setting.

Members raised concerns about the lack of demographic forecasting data for hearing assessments. They sought to understand plans for future demand, noting that one in six individuals might need such services. The inquiry questioned how this projected demand was being incorporated into planning strategies.

Officers acknowledged that while the current service was flexible to meet demand, there was no specific data on the proportion of self-referrals or the exact future demand. It was noted that the service had stabilised and was meeting current needs, but future planning would involve a population health needs assessment.

The response also highlighted that the increase in demand might not continue at the same rate due to factors like improved hearing protection in workplaces. The planning strategies would be revisited during the recommissioning process, considering the projected demand and demographic trends.

Members inquired about the current appropriateness of the balance between the usage and supply of the audiology service, and whether this balance was expected to remain suitable in the future. Officers responded that the current balance between usage and supply is appropriate, with the service effectively meeting the population's needs. They noted that the transition from the old model had been successful, characterised by high levels of access and low complaint rates.

However, it was acknowledged that ongoing monitoring and adjustments would be necessary based on emerging trends and population needs. Future planning would

involve reassessing the service during the recommissioning process to ensure it continues to meet demand effectively.

Members asked about the proportion of self-referrals to the community audiology service and how many received equipment versus wax removal. They also inquired if the 16 working days assessment time applied to self-referrals. Officers stated that specific data on self-referrals was not available but would be provided later. It was confirmed that the 16 working days assessment time applies to all referrals, including self-referrals. Providers must meet this timeframe, and any delays will be reviewed in contract meetings.

Members requested information on whether remote appointments for cochlear implants and bone-anchored hearing aids required patients to attend remotely or if the provider would come to a nearby location. It was clarified that these remote appointments involved patients attending from their home. Patients used a smartphone connected to the device, and the clinician joined the appointment via video on either the smartphone or a separate computer. This arrangement enabled patients to receive care without needing to visit the hospital.

Members inquired about the practice of providing finance options for hearing aids and the issue of upselling or uplifting, where patients might be sold unnecessary products. A Healthwatch report was also referenced, which mentioned a patient who had been offered private hearing aids instead of NHS devices.

Officers expressed their concern regarding the practice of offering financing options for hearing aids and the possibility of upselling or uplifting, noting that this matter had not previously been reported to the ICB. It was stated that further investigation into these practices would be conducted. Additionally, it was emphasised that NHS hearing aids should adhere to a national minimum standard and should not be considered inferior products.

Members inquired about the determination of complex audiology needs for patients and whether children's cases were adequately identified and addressed. Officers clarified that these needs are determined through established guidance and criteria set by professional bodies, which are clearly defined and understood by both community and hospital providers. It was noted that any ambiguous areas are sometimes resolved through direct communication between providers.

Regarding children's cases, it was stated that paediatric audiology services are managed by the hospital due to the specialised training and equipment required. Officers indicated that there are no current plans to alter this model, although ongoing inspections and reviews may result in future adjustments.

Members requested information about the proportion of patients who were followed up after receiving audiology services and the outcomes indicated by the follow-up data. Officers responded that all patients who received audiology services were followed up, with follow-ups taking place shortly after the initial fitting and then annually for up to three years.

Members inquired about the national evidence indicating a gap between those who need audiology treatment and those who receive it, and whether communications about the service were effectively reaching the public to address this gap. Officers acknowledged the national evidence indicating a gap between those who needed audiology treatment and those who received it. It was mentioned that communications about the service had improved, with efforts made to market the service and inform primary care colleagues.

However, it was also noted that more could be done to increase public awareness and address the gap effectively. Officers indicated that while there had been some success in reaching the public, improvement was still needed to ensure that everyone who needed the service was aware of it and could access it.

Members inquired about the issues with the audiology patient management system, particularly its separation from the OUH electronic patient record system, and what actions were being undertaken to resolve these problems. Officers acknowledged that the separation was identified as an issue. It was mentioned that, despite a unified referral system, patient information continues to be managed locally by each provider.

Members inquired about the national initiative for audiology services and how the ICB managed the workload and responsibilities at the local level. The Associate Director explained that the national initiative for audiology services was integral to the ICB's core commissioning responsibilities. The ICB addressed the workload and responsibilities locally by sustaining the current service model and planning for future demand. They continuously monitored the performance of the services and collaborated with providers to ensure sustainability. Additionally, the ICB engaged with regional and national NHS England colleagues to tackle wider challenges and sought further support when necessary.

Members inquired about the workforce issues in audiology, specifically regarding recruitment and retention challenges and how these were being addressed. They also asked about the risks acknowledged at the beginning of the contract.

Officers explained that the workforce issues in audiology, particularly in recruitment and retention, presented significant challenges. Community providers managed these effectively by partnering with national universities for training and placements, ensuring a steady flow of new audiologists. However, the secondary care sector faced difficulties due to competition with the private sector, which offered more attractive salaries and benefits. The training environment had also evolved, with fewer programmes and a shift to an apprenticeship model, resulting in a delay in qualified professionals entering the field.

The ICB acknowledged that these challenges were not fully anticipated at the beginning of the contract, and the increased community provision had an unintended impact on the hospital sector's sustainability. Efforts to address these issues included engaging with regional and national NHS England colleagues to seek additional support and exploring the option of in-sourcing staff from outside Oxfordshire.

The discussion ended with an emphasis on reducing waiting lists, improving communication with patients about audiology services, integrating patient management systems, and addressing workforce challenges.

The Committee **AGREED** to the following actions:

- Phil Gomersall would supply specific data on self-referrals in relation to patients receiving hearing equipment versus ear wax removal.

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

1. For further information to be provided around the level of need for audiology services (including amongst children), and on supply at the local and acute levels.

2. To support further resourcing to tackle waiting lists and prioritisation, particularly around Community Diagnostic Centres.

3. For improvements to be made around communications with the wider public to increase awareness of available support from audiology services.

That Community Audiology is brought onto the same Electronic Patient Record system as the rest of Oxford University Hospitals NHSFT.

22/25 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 9)

Katharine Howell (Senior research and projects Officer) was invited to present an update report from Healthwatch Oxfordshire.

The Healthwatch representative highlighted insights from their reports on various agenda items, including audiology and MSK services, cancer waiting times, prevention, and support for children and young people's mental health.

Members raised concerns about long wait times at Boots pharmacy in the city centre, mentioning issues with computer breakdowns and staff shortages. The Healthwatch representative acknowledged the feedback and encouraged reporting such issues directly to Boots and Healthwatch for further action.

The Committee paused for lunch at 12:45, and restarted at 13:27

23/25 CANCER WAIT TIMES AND TREATMENTS

(Agenda No. 10)

Oxford University Hospitals NHS Foundation Trust were invited to present a report on Cancer Services in Oxfordshire. The Committee was particularly interested in waiting times as well as treatments being offered for cancer patients.

Felicity Taylor Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust), Andy Peniket (Clinical Director for Oncology & Haematology OUH

NHS FT), Matthew Tait (BOB ICB Chief Delivery Officer), and Ansaf Azhar (Director of Public Health), attended to answer questions from the Committee in relation to the cancer wait times and treatment report.

The Chief Operating Officer at Oxford University Hospitals (OUH), discussed the Annual Cancer Survey feedback, noting improvements and performance against other trusts. The report included Cancer Outcomes and Services Dataset (COSD) data on treatment access and clinical outcomes, with an emphasis on personalised care.

Members inquired about the methods used by staff to provide patients with relevant information on available support and treatments. The Chief Operating Officer at OUH and Clinical Director for Oncology and Haematology described the various approaches utilised to inform patients about available support and treatments. These methods included distributing informational leaflets, offering direct communication during appointments, and employing marketing strategies to promote NHS hearing tests and treatments. Additionally, there was a strong emphasis on patient follow-ups to ensure the effectiveness of treatments and to promptly address any issues. This comprehensive approach aimed to enhance patient awareness and engagement with the services provided.

The Committee inquired about the support available for patients who do not speak English, citing a Healthwatch report that highlighted an instance where a non-English speaking patient was unaware of their diagnosis due to communication barriers. Members asked about the challenges and monitoring of support for these individuals. The OUH Chief Operating Officer acknowledged that providing support for non-English speaking patients was a significant concern. The Committee therefore reiterated the need to address the challenges and monitor the support mechanisms for such patients.

Members inquired about the commitment to the well-being of patients and their families, particularly concerning mental health, and whether this responsibility rested with the hospital or was referred back to the local GP. The Chief Operating Officer and Clinical Director explained that the responsibility for the well-being of both patients and their families, especially regarding mental health, was recognised as significant.

The Officers clarified that this responsibility was shared between the hospital and the local GP, depending on the specific circumstances and needs of the patient. The hospital provided immediate and specialised mental health support, while ongoing care and follow-up were typically managed by the local GP. This collaborative approach ensured comprehensive and continuous care for the patient's mental health and overall well-being.

Members inquired about OUH's performance in the National Cancer Patient Survey, particularly concerning the KPI that measures patients definitively receiving the appropriate level of support from their GP practice during treatment, which was at 50%. They also asked about patient involvement in discussing their treatment and ways to enhance the support experience from GPs.

It was acknowledged, by Officers, that the 50% KPI indicates an area needing improvement. Efforts are being made to ensure patients are more actively involved in discussions about their treatment. To improve the experience of support from GPs, it was suggested that better communication and coordination between the hospital and GP practices were essential. This would help ensure patients receive consistent and comprehensive support throughout their treatment journey.

Members inquired about the increase in cancer referrals across Oxfordshire, seeking to determine whether this rise was associated with specific towns, districts, PCNs, or GP practices, and if there were any demographic factors influencing this trend. The Chief Operating Officer and Clinical Director clarified that the rise in cancer referrals was not linked to specific locations or PCNs. Instead, it was observed as a general trend throughout the region, with no particular demographic factors identified as contributing to the increase. The rise in referrals appeared to be part of a broader pattern rather than being connected to specific localities or demographic groups.

Members inquired about the challenges faced by the workforce in cancer services and discussed the potential impact and necessary support if the assisted dying Bill, which was under review in Parliament, were legislated. The Clinical Director emphasised that the workforce in cancer services was experiencing significant difficulties, including high demand and staffing shortages. These issues were adversely affecting the ability to deliver timely and comprehensive care to patients.

Concerning the possible implications of the assisted dying Bill, it was recognised that substantial support and resources would be required for effective implementation if it became law. This included training for healthcare professionals, the establishment of clear guidelines, and robust support systems to ensure the new legislation could be integrated into existing cancer care services without compromising the quality of care.

Members enquired about the role of co-production in the development of cancer services and requested an update on stakeholder involvement in this process. Officers clarified that co-production had played a significant role in the development of cancer services. Key stakeholders, which included patients, healthcare professionals, and community organisations, were actively engaged in the process. This collaborative approach ensured that the services were tailored to meet the needs of those affected by cancer. Regular engagement sessions, feedback mechanisms, and working groups were utilised to gather input and integrate it into service planning and improvement. This approach aimed to create more patient-centred and effective cancer care services.

Cllr Leverton left the meeting at this stage.

Members inquired about the modifications to the national cancer standards of measurement, specifically addressing the rationale behind these changes, the implications of eliminating the two-week waiting period for patients, and the performance of OUH in relation to these new standards. The Clinical Director and Chief Operating Officer elucidated that the revisions to the national cancer standards were implemented to streamline procedures and enhance patient outcomes. The elimination of the two-week waiting period was designed to minimise delays and ensure timely and appropriate care for patients.

The expected impact on patients was positive, with an emphasis on quicker diagnosis and treatment. OUH was performing commendably against these newly established standards, meeting the targets and ensuring that patients received necessary care within the updated timeframes.

Members inquired about the significance of outcome data in cancer treatment, the national comparison of OUH's outcomes, and the gap in treatments to achieve optimal results. The Chief Operating Officer and Clinical Director underscored the vital role of outcome data in cancer treatment, as it provided valuable insights into the effectiveness of therapies and highlights areas needing enhancement. OUH's performance favourably compared to national outcomes, excelling in several key areas.

Nonetheless, there remained a recognised treatment gap in achieving the best outcomes, attributed to factors such as resource limitations and the necessity for ongoing improvements in treatment protocols. Initiatives were underway to address these gaps and improve the overall quality of cancer care.

The Committee **AGREED** to recommendations under the following headings:

1. For further detail to be shared on outcomes across different cancer types, and how that compares nationally and regionally.

2. For there to be clear communications with cancer patients who cannot speak in English (or who struggle to communicate in general), and for mechanisms to be in place to help with advocacy for such patients.

3. For OUH to collaborate with the Oxfordshire County Council Public Health Team on awareness campaigns with communities with low take-ups of cancer screening.

24/25 DIRECTOR OF PUBLIC HEALTH DRAFT ANNUAL REPORT - SUPPORTING THE MENTAL WELLBEING OF CHILDREN AND YOUNG PEOPLE

(Agenda No. 11)

Ansaf Azhar (Director of Public Health at Oxfordshire County Council), was invited to present the draft Director of Public Health (DPH) Annual Report 2024-2025. This report focused on supporting the mental wellbeing of children and young people.

Donna Husband (Head of Public Health Programmes), and Frances Burnett (Public Health Registrar), also attended to support the Director and help answer questions from the Committee.

This year's DPH annual report focused on the mental health and well-being of children and young people, alongside economic inactivity among them. The report aimed to highlight these key issues and encourage action. The Public Health Director emphasised the importance of viewing mental health as an asset and the necessity for a diverse workforce in Oxfordshire by 2040.

The report detailed current mental health support provisions and underscored the significance of general settings in supporting young people. It recommended increasing the use of existing interventions, reframing discussions about mental health, and utilising anchor institutions to create opportunities for young people.

Members asked whether there were measures in place to assess the effectiveness of the various schemes and activities listed in the report. It was explained to the Committee that the principle avenue through which to evaluate the overall effectiveness of measures or projects to improve children's mental health and emotional wellbeing was via the Health and Wellbeing Strategy's Outcomes Framework. Children's mental health sat within the Start Well category of the Health and Wellbeing Strategy, and the Health and Wellbeing Board was due to evaluate Start Well aspects of the strategy in April 2025.

Members asked whether it would be helpful for the DPH annual report to include information on how Oxfordshire compares in terms of deprivation and apprenticeships. They recognised the successes already achieved in these areas but also highlighted the importance of addressing ongoing mental health challenges. The discussion emphasised the need for a comprehensive approach that acknowledges both achievements and areas requiring further attention.

Members asked whether the various programmes listed in the report were working together in an integrated manner or operating separately from each other. It was responded that whilst some programmes aimed at improving children's emotional wellbeing and mental health operated separately, they would all be evaluated as part of the Health and Wellbeing strategy's aforementioned Outcomes Framework. Whilst each programme had their unique specificities and objectives, they all shared the common purpose of driving improvements to children's mental wellbeing in Oxfordshire.

Members asked whether early intervention efforts were being coordinated with partners to determine who should concentrate on what and making recommendations more specific in this regard. They questioned whether these efforts were being coordinated with partners to determine specific areas of focus and to make recommendations more targeted. It was explained to the Committee that early intervention efforts were being coordinated between system partners, and that more work would follow in this regard. Various system partners would have their own contributions that they could make toward implementing the recommendations outlined in the DPH annual report.

Members asked about the educational issues in deprived areas, specifically the disparity between primary school attainment and secondary school underachievement. They inquired about the challenges and opportunities for collaboration among schools, local authorities, and the NHS to get all partners on the same page, particularly in relation to the CAMHS waiting list. It was responded that all partners were working toward achieving the Start Well objectives of the Health and Wellbeing Strategy, but that the Public Health team per se was limited by its own remit of services it could deliver.

Members asked what could be behind the rise of mental health issues in Oxfordshire, specifically mentioning the impact of smartphones and social media. The discussion emphasised that more could be done in terms of examining or minimising the potentially negative impacts of social media on children's mental health.

The Healthwatch Senior Research and Projects officer asked whether there had been or would be any opportunities for children and young people to shape the report or provide their input. It was explained that the Council and its partners did seek the input of children and young people on services. It was agreed amongst the Committee and the officers in attendance that system partners should continue to engage in coproduction with children and young people inasmuch as possible around implementing the plans or recommendations outlined in the DPH annual report.

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

1. For the Public Health Team to provide details of how system partners will work with schools to improve children's emotional wellbeing and mental health.

2. For clarity to be provided on who will have responsibility for implementing each of the recommendations being made in the DPH annual report.

3. For there to be greater collaboration and sharing of ideas between communities for the purposes of improving health and wellbeing at the local community/neighbourhood level.

25/25 POTENTIAL HOSC CONSTITUTION CHANGES

(Agenda No. 12)

Tom Hudson, Scrutiny Manager, was invited to present an update report on the work of the Council's Constitution Working Group, specifically as it related to potential changes to the HOSC elements of the Constitution.

The Council updated its constitution, focusing on the Health Overview and Scrutiny Committee (HOSC). Motivated by the Health and Care Act, they revised the terms of reference for the Buckinghamshire, Oxfordshire, and Berkshire West Health Overview Scrutiny Committee, and the procedure for making referrals to the Secretary of State. They aimed to gather feedback from District and co-opted members before finalising the amendments.

The Committee discussed the need for flexibility in the order of deputy chairs. They suggested maintaining the current order but allowing changes with District Council agreement. Flexibility was important to accommodate practical reasons for deviations.

26/25 FORWARD WORK PLAN

(Agenda No. 13)

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

27/25 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 14)

The Committee **NOTED** the action and recommendation tracker.

..... in the Chair

Date of signing .....