Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 5 June 2025 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, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Membership

Chair:	To be elected		
Deputy Chair:	To be elected		
Councillors:	Ron Batstone	Gareth Epps	Paul Austin Sargent
	Imade Edosomwan	Emma Garnett	
	Judith Edwards	Jane Hanna OBE	
District Councillors:	Paul Barrow	Elizabeth Poskitt	Dorothy Walker
	Keats-Rohan	Louise Upton	
Co-Optees:	Sylvia Buckingham	Barbara Shaw	

Date of Next Meeting: *11 September 2025*

For more information about this Committee please contact:

Committee Officer: *Scrutiny Team*

Email: *Email: scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

May 2025

What does this Committee review or scrutinise?

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

How can I have my say?

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

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Election of Chair for the 2025/26 Council Year

2. Election of Deputy-Chair for the 2025/26 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 06 March 2025 and to receive information arising from them.

6. Speaking to or Petitioning the Committee

Members of the public who wish to speak on an item on the agenda at this meeting, or present a petition, can attend the meeting in person or 'virtually' through an online connection.

Requests to present a petition must be submitted no later than 9am ten working days before the meeting, i.e. Friday 23 May 2025.

Requests to speak must be submitted no later than 9am three working days before the meeting, i.e. Monday 02 June 2025.

Requests should be submitted to scrutiny@oxfordshire.gov.uk AND omid.nouri@oxfordshire.gov.uk

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9am on the day of the meeting. Written submissions should be no longer than 1 A4 sheet.

7. Response to HOSC Recommendations (Pages 19 - 36)

The Committee has received Acceptances and Responses to recommendations made as part of the following item(s):

1. Oxfordshire Healthy Weight
2. Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board Operating Model.
3. Health and Wellbeing Strategy Outcomes Framework.
4. Support for Patients Leaving Hospital.
5. Oxford Health NHS Foundation Trust People Plan.
6. Director of Public Health Annual Report

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

8. Annual Report of the Oxfordshire Joint Health Overview Scrutiny Committee (Pages 37 - 66)

The purpose of this item is to approve the draft of the Annual Report of the Oxfordshire Joint Health Overview Scrutiny Committee. This report will be presented to Full Council on 08 July 2025, and summarises the key scrutiny activities and accomplishments of the JHOSC throughout the course of the 2024-2025 civic year.

There are TWO documents attached to this item:

1. A cover report for the JHOSC Annual Report.

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

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.

1.3 Delegate authority to the Health 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,

1.3.3 for publication of the final report

9. Oxford Community Health Hubs Working Group Update (Pages 67 - 78)

The purpose of this item is for the Committee to receive and **NOTE** the update report from its Oxford Community Health Hubs Working Group. This report provides an update on the ongoing scrutiny of the Oxford Community Health Hubs Project launched by Oxford Health NHS Foundation Trust.

There are TWO documents attached to this item:

1. The update report of the Oxford Community Health Hubs Working Group.

2. A brief slide deck from Oxford Health NHS Foundation Trust which provides a status update of the three Community Health Hubs in Oxford City.

The Committee is **RECOMMENDED** to:

1. **NOTE** the work of the HOSC Oxford Community Health Hubs working group around scrutinising the Community Health Hubs project for Oxford City since the working group's establishment in April 2024.

2. **CONFIRM** its support for the continuation of the working group's existence and its ongoing scrutiny of the project to establish three Integrated Community Health Hubs in Oxford City.

3. **AGREE** to the appointment of a fourth working group member given that former Cllr Michael O'Connor is no longer a member of Oxfordshire County Council.

10. Chair's Update (Pages 79 - 152)

The Chair will provide a verbal update on relevant issues since the last meeting.

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

The Committee needs to provide written feedback to the Quality Accounts for both Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust. The Committee will discuss Oxford Health's Quality Account as a public item during this meeting. In regards to the Oxford University Hospitals NHS Foundation Trust Quality Account, the Committee is **RECOMMENDED** to:

a) **AGREE** to hold a private briefing with the Trust to discuss the Quality Account.

b) **AGREE** to finalise the wording of the feedback subsequent to and outside this meeting, and to submit the feedback to the Trust prior to the publication date for the Quality Account at the end of June 2025.

NHS England have requested that Integrated Care Boards share the following news with local HOSCs in relation to the redesignation of Urgent Care Centres and Minor Injuries Units into Urgent Treatment Centres:

'Oxfordshire has three Minor Injury Units (MIUs); Abingdon, Witney, and Henley. They presently report monthly in the 4-hour standard for Oxford Health NHS Foundation Trust. NHS England has requested that all these units are redesignated as Urgent Treatment Centres, otherwise they will not be able to continue to report the 4-hour standard. Before NHS England will complete the final assessment for designation, they have requested that the HOSC committee is aware of the redesignation.

Any units of this type (Minor Injuries Units and Urgent Care Centres) not to get the designation of an Urgent Treatment Centre, will have to stop reporting their activity in the 4-hour standard.

The regional and National NHS England team have requested that the HOSC is made aware of the potential redesignation of the Minor Injuries Units in Oxfordshire to Urgent Treatment Centres, to comply with full transparency.'

It has also been brought to the Committee's attention that Professor Ben Burton (Royal College of Opthamologists) has written a letter to Stephen Kinnock MP (Minister of State for Care) in relation to Eye Care Services. The Committee will imminently receive a briefing from the BOB Integrated Care Board on the current state of Eye Care Services.

There are NINE documents attached to this item:

1. EIGHT reports containing recommendations from the Committee on: the BOB Integrated Care Board Operating Model; the Health and Wellbeing Strategy Outcomes Framework; the Support for People Leaving Hospital; the Oxford Health NHS Foundation Trust People Plan; Audiology Services; Cancer Services; Musculoskeletal Services; the Director of Public Health Annual Report.

2. The letter written by Professor Ben Burton to Stephen Kinnock MP (Minister of State for Care) in relation to Eye Care Services.

11. NHS Reforms Update

Matthew Tait (Chief Delivery Officer- Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board) and Stephen Chandler have been invited to provide an update to the Committee on the recent and ongoing NHS reforms. These reforms include the government's plans to integrate NHS England into the Department of Health and Social Care, and to further reduce Integrated Care Board running costs.

The Committee is invited to; discuss the implications of these developments on Oxfordshire Place; raise any relevant questions; and **AGREE** any recommendations arising it may wish to make.

12. System Pressures Update (Pages 153 - 162)

Karen Fuller (Director for Adult Social Care, Oxfordshire County Council) has been invited to present a report on pressures within the Oxfordshire Health and Care System.

PLEASE NOTE: This item will encompass key pressures affecting all of Oxfordshire's health and care system partners in general, as well as some insights into the preparations being made for the pressures of the ensuing Winter season.

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

13. Healthwatch Oxfordshire Update (Pages 163 - 170)

Veronica Barry (Executive Director, Healthwatch Oxfordshire) has been invited to present the Healthwatch Oxfordshire Update Report.

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

14. Oxfordshire as a Marmot Place (Pages 171 – 182)

Ansaf Azhar has been invited to present a report on Oxfordshire becoming a Marmot Place.

This is an opportunity for the Committee and the wider public to receive further insight into the work and progress to date on Oxfordshire becoming a Marmot Place.

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

15. Oxford Health NHS Foundation Trust Quality Account 2024-2025 (Pages 183 - 252)

Oxford Health NHS Foundation Trust has been invited to present the Trust's Annual Quality Account for the year 2024-2025.

The Committee is **RECOMMENDED** to:

a) **AGREE** to provide feedback on the Trust's Quality Account.

b) **AGREE** to finalise the wording of the feedback subsequent to and outside this meeting, and to submit the feedback to the Trust prior to the publication date for the Quality Account at the end of June 2025.

16. Forward Work Plan (Pages 253 - 254)

The Committee is recommended to **AGREE** to the proposed work programme for its upcoming meetings.

17. Actions and Recommendations Tracker (Pages 255 - 270)

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

Councillors declaring interests

General duty

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

What is a disclosable pecuniary interest?

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

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

Declaring an interest

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

Members' Code of Conduct and public perception

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

Members Code – Other registrable interests

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

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

Other registrable interests include:

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

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

Members Code – Non-registrable interests

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

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

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

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

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

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

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 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 .....

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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

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

Issue: Oxfordshire Healthy Weight

Lead Cabinet Member(s) or Responsible Person:

- Derys Pragnell (Consultant in Public Health)
- Ansaf Azhar (OCC Director of Public Health)
- Claire Gray (Public Health Practitioner)
- Angela Jessop (Personalised Care Lead BOB ICB)
- Alicia Siraj (Head of Health Promotion, Health Prevention, and Personalised Care BOB ICB)

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

Deadline for response: Tuesday 18th February 2025.

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 explore support to local businesses supplying food in the takeaway market to provide healthier offers that meets both business and health needs. It is recommended that effective measures are adopted to address the concerns of local takeaway businesses about losing business in the event of switching to healthier food products.	Partially Accepted.	Could this just read to explore support to local businesses supplying food in the takeaway market to provide healthier offers that meets both business and health needs (this would naturally encompass the second part of the recommendation)
2. To support food banks and in providing healthier food options; and for there to be further liaison and cooperation between the County Councils' Public Health Team and food larders and banks. It is recommended that there is further celebration of the role of volunteers and voluntary sector organisations in this regard.	Partially accepted – Rationalle: District Councils have their own food strategies and this should be included within their work as they are closer to. There needs to be exploration of how best to increase the healthiness of the food offer which is quite a complex issue and public health can develop this.	To support food banks in providing healthier food options; and for there to be further liaison and cooperation between the District/City Councils and food larders and banks. Work to understand best practice behind improving the quality and quantity of food reaching food banks to be undertaken. It is recommended that there is further celebration of the role of volunteers and voluntary sector organisations in this regard

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

3. For the development of clear and measurable KPIs so as to evaluate the impacts and progress of the work to promote healthy weight.	Accepted	There is already a clear action plan associated with healthy weight with KPIs which is reported to the Health Improvement Board
4. For there to be clear communications as soon as possible with residents as to the benefits and risks associated with obesity medications, especially for anyone who has not been encouraged to lose weight by their GP and is considering buying weight loss drugs privately or online without medical supervision.	Rejected	Currently the ICB does not have a commissioned pathway for NICE approved medications (tirzepatide, liraglutide or semaglutide) for treatment of overweight or obesity on the ICB primary care formulary. Therefore, our local general practice cannot prescribe these medications. Patients who are prescribed these drugs in specialist weight management services should seek advice from the service provider and will be provided with the relevant patient information leaflets/resources as appropriate. People who access these medications from a private provider should be advised by the providing service, they should also have their own resources they provide for the patient. There is advice for patients seeking support (including medications) for the management of overweight and obesity on the NHSE national website. The ICB are currently working to develop local pathways access to Mounjaro (tirzepatide) which is the most recent NICE approved medication for treatment of obesity. This drug will be accessible within primary care settings and the ICB will consider publishing public facings communications and developing resources at this point.
5. For there to be clear mapping and identification of individuals with comorbidities. It is crucial that there is ongoing coproduction of healthy weight services that would include input from those with comorbidities or from	Partially Accepted Suggested re-word It would not be appropriate for us to be working with or seeking out individuals systematically but we can work with organisations	For there to be clear mapping and identification of organisations working with individuals with comorbidities. To ensure ongoing co-production and signposting for these groups.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

	vulnerable population groups.	supporting such organisations to do this	
6.	For system partners to work collaboratively to promote greater physical activity amongst residents of all ages. It is recommended that consideration is given to launching a public event to celebrate good practice in schools around promoting eating well and moving well. This could help to raise awareness of the importance of healthy eating and physical activity for all children.	Accepted.	We gave already worked with schools on such an event.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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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: Health and Wellbeing Strategy Outcomes Framework

Lead Cabinet Member(s) or Responsible Person:

- Matthew Tait- BOB ICB Chief Delivery Officer and Executive Sponsor for Oxfordshire
- Daniel Leveson- BOB ICB Director of Places and Communities

It is requested that a response is provided to the recommendation outlined below:

Deadline for response: Tuesday 13th May 2025.

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. For the ICB's Executive Sponsor for Oxfordshire and the Director for Places and Communities to meet with the HOSC chair and Health Scrutiny Officer, as well as to meet with local MPs (as part of the national offer for facilitation), to initiate proper engagement with Oxfordshire Place. It is recommended that clear indicators are developed which demonstrate the levels of engagement being undertaken between the ICB and key stakeholders in Oxfordshire Place.	Accepted.	Oxfordshire Executive Sponsor and Director for Places and Communities are happy to meet with the HOSC Chair, Scrutiny Officer and local MPs to initiate engagement. We assume Oxfordshire's Health Scrutiny Officer will help find a date, time and venue and facilitate. We would prefer in-person meeting but happy to do online. Re: indicators of levels of engagement there are several existing mechanisms including the maturity matrix self-assessment of Oxfordshire's Place-based Partnership, ICB Annual Report and ICB Annual Assessment that can be used to assess extent of engagement.

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.

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Issue: Health and Wellbeing Strategy Outcomes Framework

Lead Cabinet Member(s) or Responsible Person:

- Liz Leffman- Leader, OCC.
- Ansaf Azhar- Director of Public Health OCC.
- Kate Holburn- Deputy Director of Public Health.
- Karen Fuller- Director of Adult Social Care OCC.
- Dan Leveson- BOB ICB Director of Place and Communities.
- Matthew Tait- BOB ICB Chief Delivery Officer and Executive Sponsor for Oxfordshire

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

Deadline for response: Tuesday 13th May 2025.

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 support sustainable funding in the Oxfordshire County Council budget for early years readiness for school.	**partially accepted**	The whole Oxfordshire system, not just OCC, is responsible for early years school readiness but rather the wider Oxfordshire partners. Health partners also have a crucial part to play in delivering these outcomes. The Early Years Strategy identifies that there needs to be collective system action for ensuring children have the best start in life and are ready for school. This will involve all organisations to identify sustainable funding to deliver the ambitions, including Oxfordshire County Council.
2. To ensure that rural geographies in Oxfordshire are also at the heart of implementing the priorities and actions of the Health & Wellbeing Strategy.	Accept	Rural inequalities are part of the commitments under the Marmot principles, and addressing this is an important factor for embedding Marmot in Oxfordshire.

Joint Health Overview and Scrutiny Committee

Response to Report of the Joint Health Overview and Scrutiny Committee (HOSC): Support for People Leaving Hospital

Response to report:

We thank the Committee for their report on Support for People Leaving Hospital. The HOSC meeting on 30 January 2025 was a welcome opportunity to update the committee on the performance of the Home First D2A service and impact on the Oxfordshire system, noting particularly the successful outcomes for Oxfordshire residents following reablement and ongoing joint working across health and social care partners.

As highlighted in the HOSC meeting and supporting papers, reducing non-elective admissions aligns closely with the Oxfordshire Way and ambition to work proactively as a system to support people to live independently at home. Reducing admissions is therefore a key focus for the Better Care Fund plan for 25/26. On 30th April we received confirmation from NHS England that our plan has been recommended for approval and we are working to ensure we can deliver it.

As articulated in the report, we have now several Integrated Neighbourhood Teams in Oxfordshire and we have committed Better Care Funding to continue developing these in 25/26. This aligns with both our Oxfordshire ambition to build community and neighbourhood capacity and the national policy ambition to transform health and social care delivery in line with neighbourhood.

Response to recommendations

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
To support data sharing across the whole system to help to understand the causes of non-elective admissions into hospital. It is recommended that there is good relationship building across the system to support this.	Partially accepted	**Action –** Continue to interrogate and share data relating to non-elective admissions in existing system-wide forums to prevent an increase in emergency admissions activity. This work will continue throughout 25/26, monitored at regular intervals and evaluated fully at year-end. As a system we recognise the importance of data sharing and we already work collaboratively across organisations to facilitate this. Operationally, we share data across the Oxfordshire system to support management of care pathways and we have data sharing agreements in place between Oxfordshire County Council, Oxford University Hospitals, Oxford Health and Buckinghamshire, Oxfordshire and

		Berkshire West ICB, and Age UK Oxfordshire to support this.
		
		In addition, we have developed system-level reports that support analysis of trends and opportunities to avoid emergency admissions. This data is reviewed by operational and system leaders to develop practical insights and solutions and support system planning priorities:
		
		• Oxfordshire Urgent Care Delivery Group (fortnightly)
		  ○ A system-wide meeting to discuss operational issues arising in the UEC landscape, including non-elective admissions
		
		• Urgent & Emergency Care Board (monthly)
		  ○ A senior system-wide strategic oversight meeting where the Oxfordshire system sit-rep (which has recently been further developed by the Information Team meeting group in the below bullet) is presented and discussed at length. This sit-rep has improved visibility of overall system performance. The report includes data from emergency, acute, community, mental health, adult social care and primary care services and has enabled us to identify trends in admissions.
		
		• Oxfordshire System Information Team Meeting (weekly)
		  ○ A meeting with information teams and lead commissioners across all providers including social care. This includes a focus on non-elective admissions, numbers admitted from each GP practice, age groups and diagnostic reasons for admission. The group has also met with some GP practices to review the rate and reasons for admission by age group.
		  ○ The BCF 25/26 is continuing to fund a system Business Intelligence post to continue developing our data analysis capacity
		
		• Oxfordshire systems call (daily)

		○ A system-wide meeting focusing on individual cases. Daily analysis of cases over the last few months has enabled identification of trends relating to readmissions. Oxfordshire's 25/26 BCF plan is to prevent an increase in non-elective admissions. To deliver this we have several schemes which include: - Continuing to invest in services that address health inequalities and avoid admissions: ○ Our analysis has shown that biggest growth in non-elective admissions in Oxfordshire is people aged 50-64, especially in deprived areas. We are therefore focusing on developing community responses in these areas ○ Provide support and alternatives to admission for adults and children living with learning disability and/or autism ○ Provide step up support through dedicated homelessness pathways - Continuing to further join up working and focus on community-based care models: - Developing our Single Point of Access to coordinate community resources, utilise call before convey, and reduce admissions - Working with our care homes to determine what support is needed to reduce hospital admissions from care homes - Ongoing work with the system Falls group to understand how we can work with ambulance and community responders to prevent falls and, by extension, hospital admissions and enable people to stay safely at home
To continue to support sufficient funding and resource for integrated neighbourhood teams. It is recommended that measures are taken to ensure workforce availability to maximise support for discharged	Accepted	**Action –** Continue to develop our existing INTs throughout 25/26 in line with NHSE Neighbourhood Planning Guidance. This will be evaluated within the governance structures for the Better Care Fund 25/26. Funding from the Better Care Fund 25/26 has been used to continue the development of INTs throughout Oxfordshire. These INTs will continue to

patients in both urban and rural areas across Oxfordshire.		focus on support for people to either keep them at home or follow up post-hospital admission. As outlined in the previous section, supporting this patient cohort in the community is a key part of our strategy to reduce non-elective admissions. Aligned with this, our HomeFirst system teams are currently being realigned to ensure an equitable response to the demand in each area. In the current model West and Vale form one team. We hope the creation of a separate Vale team will help to ensure workforce availability within those areas. The Neighbourhood Health Guidelines 25/26 published by NHS England highlight core components associated with effective neighbourhood services. These cover both the emergency preventative response delivered by INT and the wider preventative model that supports system, community and individual resilience. The relationships and opportunities from a neighbourhood approach to care is a key part of the agenda at a system-wide away day scheduled for 15th May.

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: Oxford Health NHS Foundation Trust People Plan

Lead Cabinet Member(s) or Responsible Person:

- Charmaine Desouza (Chief People Officer, Oxford Health NHS Foundation Trust)
- Zoe Moorhouse (Head of HR, Oxford Health NHS Foundation Trust)
- Amelie Bages (Executive Director of Strategy and Partnerships, Oxford Health NHS Foundation Trust)

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

Deadline for response: Wednesday 14th May 2025.

Response to report:

Thank you for the comprehensive report on the presentation made by Oxford Health NHS Foundation Trust People Plan to the Joint Health Overview and Scrutiny Committee (HOSC). We welcome the insights and recommendations provided by the Committee.

We appreciate the Committee's observations and recommendations and will look forward to feeding back our progress to the committee on a future date. Thank you for your continued support and collaboration.

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 work toward reducing reliance on agency staff where possible. It is recommended that processes are in place to ensure that the quality of care provided by agency staff is appropriate and up to standard so as to ensure consistency in the quality of care for patients.	Accepted	We already have a priority identified in our people plan for 2025/26 which is focused on safely reducing our reliance on agency workers by having a Bank First approach which is underpinned by strong recruitment strategies. Our bank fill rates as of April 2025 are 76% which is an improvement of 11% points since April 2024.
2. To create a positive and supportive work environment for staff, and to foster an environment and processes where staff can easily make complaints or express legitimate grievances.	Accepted	We have engaged positively with the NHS People Promise which helps define our staff experience at Oxford Health. One element of the people promise is focused on our staff feeling safe and confident to speak up. It is well defined and combined with our Freedom to Speak Up Guardians and our recently updated Grievance policy will support a positive and supportive work environment where we take the time to really listen to understand the hopes and fears that lie behind the words
3. To harness the use of technology to create a better and more	Accepted	Our IM&T team has worked hard to make business intelligence available at managers fingertips via a bespoke application.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

efficient working environment for staff. It is also recommended that the Trust takes steps to avert the prospects of future IT outages inasmuch as possible, and to provide evidence of this.		Additionally, we have begun exploring how we can work with Artificial Intelligence (AI) to improve processes. Our processes for managing system outages have been updated since the E-rostering outage last summer to make it more robust. Equally as part of the procurement process all systems must go through full IT checks to ensure they meet the Trust's cyber security standards and legacy systems are being gradually replaced by third party managed systems which are more secure.
4. To work with system partners to campaign for an Oxford salary weighting.	Reject	The NHS has a nationally agreed pay framework which the NHS uses to ensure fair and consistent pay across all its services. However, we have and do consider recruitment and retention premia or attraction incentives in specific services or for specific roles where it has been challenging to run those services due to difficulties in attracting or retaining staff. Additionally, we have worked with local services such as those we provide in Oxford City to allow staff to access parking where appropriate and we have negotiated discounts on Bus travel, in addition to our provision of staff accommodation.

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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

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

Issue: Director of Public Health Annual Report

Lead Cabinet Member(s) or Responsible Person:

- Ansaf Azhar (Director of Public Health).
- Donna Husband (Head of Public Health Programmes).
- Frances Burnett (Public Health Registrar).

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

Deadline for response: Tuesday 3rd June 2025.

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. 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.	Partially accept	The Health and Wellbeing Strategy 2024-2030 has a Start Well priority about children and young people's emotional health and wellbeing and mental health. There is also a priority about financial wellbeing and healthy jobs which supports those young people who are looking for employment. This recommendation can be taken forward by the Health and Wellbeing Board to monitor action across the partnership.
2. For clarity to be provided on who will have responsibility for implementing each of the recommendations being made in the DPH annual report.	Partially accept	The Public Health team are presenting the Director of Public Health Annual Report to stakeholders across the system with a view to then encouraging organisations to act based on the evidence and findings within the 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.	Accept	Collaboration across the Oxfordshire system is essential to create opportunities to innovate and improve outcomes for health and wellbeing in local communities.

Divisions Affected – All

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

05 JUNE 2025

Draft HOSC Annual Report 2024/25

Report by Director of Law and Governance and Monitoring Officer

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 Health 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,

      1.3.3 for publication of the final report

Executive Summary

2. The Joint Health Overview and Scrutiny Committee (JHOSC) 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 cover report, subject to any amendments that may be required.

3. The annual report annexed to this cover report explains some of the key accomplishments and highlights of the Committee's activities over the past municipal year including:

Supporting Oxfordshire Place in the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board Restructure: The Committee requested a call-in from the Secretary of State for Health and Social Care in regards to the Integrated Care Board's proposed restructure. Whilst the Secretary of State did not invoke the call-in power, they urged the Council and the ICB to continue to work together to find a resolution. The outcome was that the ICB made alterations to its initial proposals in response to the JHOSC's feedback and recommendations.

Securing additional primary care estate: As a result of its ongoing scrutiny of primary care services and its recommendations for primary care estate development in response to increased demand, the Committee was pleased to hear that planning permission was granted for primary care estate development on the Didcot Great Western Park.

Promoting healthy weight policies in Oxford and Cherwell: As part of efforts to promote Healthy Weight throughout the County, the Committee wrote to the Chief executives of Oxford City and Cherwell District Councils. The JHOSC urged both authorities to implement policies that promote healthier advertising and that restrict the opening of hot food takeaway outlets besides schools in areas with the highest levels of childhood obesity.

Securing further resource for epilepsy services: The Committee conducted a deep-dive into the current state of Oxfordshire's epilepsy services, and recommended that further resourcing for epilepsy services is sought by Oxford University Hospitals NHS Foundation Trust and NHS England South-East Region. This recommendation was accepted, with system partners committing to working with national bodies to achieve this.

Securing further CIL funds for redeveloping Wantage Community Hospital: The Committee's substantial change working group urged for and managed to secure additional Community Infrastructure Levy funding from the Vale District Council, to support the progress of the project to redevelop Wantage Community Hospital.

Background

4. 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".

5. 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.

6. 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 08 July 2025.

Corporate Priorities

7. Improving health and wellbeing of residents and reducing health inequalities are stated ambitions within the Council's Strategic Plan. This annual report indicates the Committee's scrutiny of the extent to which progress is being made by the Council and its NHS partners in achieving this.

Financial Implications

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

   Drew Hodgson, Strategic Finance Business Partner.

Legal Implications

9. 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.

   Kim Sawyer, Interim Head of Legal & Governance.

Staff Implications

10. None arising from this report.

Equality & Inclusion Implications

11. None arising from this report.

Sustainability Implications

12. None arising from this report.

Risk Management

13. 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 2025

Chair's Update:

This annual report follows a year marked by unprecedented and growing challenges for health services, including increasing health demands and pressures in most areas, particularly where there are shortages of resources. These are national issues that the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) has examined locally. The quality of care that patients have been receiving has been impacted by long wait times as well as disruptions. In its previous Annual Report, the JHOSC highlighted the issue of workforce shortages, and how pressures as a result of these shortages had significantly worsened since then. One year on, workforce shortages continue to affect healthcare services, particularly those provided by Oxford University Hospitals NHS Foundation Trust (OUH) and Oxford Health NHS Foundation Trust (OH).

In the context of rising pressures on the health service, which are both national and regional in scope, the JHOSC has intensified its scrutiny of healthcare services in Oxfordshire with a specific focus on some of these challenges. Nonetheless, in doing so, the Committee continues to operate as a "critical friend" to those with responsibility for providing health services to local residents. As a Committee with both County and District Council representation, the Committee benefits from significant county and neighbourhood level expertise and insights into some of the positive and challenging aspects of health services for Oxfordshire's population groups, be they urban or rural residents. In line with the health and social care landscape in Oxfordshire, the JHOSC has closely coordinated with and kept a spotlight on the commissioning and provision of health services by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), Oxford University Hospitals NHS Foundation Trust, and Oxford Health NHS Foundation Trust, and the recently developed Oxfordshire Place-Based Partnership.

The Committee also continues to contribute to scrutiny at the level of the Buckinghamshire, Oxfordshire, and Berkshire West (BOB) geography, with the County Council members of the JHOSC participating in the Buckinghamshire, Oxfordshire, and Berkshire West Joint Health Overview Scrutiny Committee (BOB JHOSC). The cross-county JHOSC continues to engage in scrutiny of the ICB's efforts to improve access to primary care and to explore further avenues to digitise health services against a backdrop of increased demand for services and technological advancements. The importance of continuing to participate in BOB-level scrutiny is greater at a time when government has announced plans to abolish NHS England, cut ICB running costs by 50 percent, and for ICB's to potentially lose their health-provider oversight roles. This inevitably raises questions and concerns as to the impacts this could have on Place-level health and care services, and on the extensive and productive partnership working and collaboration that has been achieved between Oxfordshire County Council and its NHS partners.

Notwithstanding some of the key challenges in healthcare, the JHOSC has worked to retain and support strong relations with key stakeholders and organisations within the Oxfordshire system. The Committee seeks to support continued system collaborative work, as this would have a knock-on effect on the quality of services for residents throughout the county. Democratic oversight of health services is a crucial aspect of ensuring that healthcare systems function effectively, transparently, and equitably. It

involves the active participation and scrutiny of health services by elected representatives, and the general public. The JHOSC has therefore worked to ensure that this oversight is essential for maintaining public trust, promoting accountability, and ensuring that health services meet the needs of Oxfordshire residents. Much of the health scrutiny work of the Committee had been made possible through the extensive engagements with key stakeholders, individuals, and organisations in the Oxfordshire health and care landscape (including NHS representatives and Oxfordshire County Council Cabinet Members and Senior Officers) outlined 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)
- Olivia Clymer (Director of Strategy and Partnerships, Oxford University Hospitals NHS Foundation Trust)
- Daniel Leveson (former Oxfordshire Place Director, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board)
- Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board)
- Lily OConnor (Urgent and Emergency Care Director for Oxfordshire)
- Neil Flint (Associate Director of Planned Care, Buckinghamshire, Oxfordshire, and Berkshire West ICB)

Oxfordshire County Council

- Ansaf Azhar (Director of Public Health, Oxfordshire County Council)
- Stephen Chandler, (Executive Director for People, Oxfordshire County Council)
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council)
- Cllr Nathan Ley (Cabinet Member for Public Health)
- Cllr John Howson (Cabinet Member for Children, Education and Young People's Services)

I also wish to express thanks to the following members of the Committee for the previous year, all of whom had provided significant contributions and efforts toward the JHOSC's scrutiny functions and responsibilities:

- District Cllr Katharine Keats Rohan (Vice-Chair 2024-2025)
- District Cllr Elizabeth Poskitt (Vice-Chair 2023-2024)
- Cllr Jenny Hannaby
- Cllr Nick Leverton
- Cllr Nigel Champken-Woods

- Cllr Freddie Van Mierlo
- Cllr Michael OConnor
- Cllr Mark Lygo
- Cllr Yvonne Constance
- District Cllr Dorothy Walker
- District Cllr Paul Barrow
- City Cllr Susanna Pressel
- Barbara Shaw
- Sylvia Buckingham

The Committee issued a total of 53 recommendations in the previous council year of 2024/2025. Of these, I would draw particular attention to a few as illustrating the Committee's ongoing impact. These recommendations, the majority of which were accepted and implemented, revolved around key themes relating to medicine shortages, NHS workforce recruitment and retention, cancer services wait times and treatments, healthy weight promotion, and the support for patients discharged from hospital. One prime example was that as per the Committee's recommendation to the ICB to retain the urgent and emergency care director post in the context of the recent ICB proposed restructure, the decision was made to retain this post given the important role the director contributed to urgent and emergency care coordination and services jointly administered by the NHS and the County Council. Another example was the commitment by Oxford University Hospitals NHS Foundation Trust and NHSE South-East Region to follow the JHOSC recommendation to seek further funding and resource for epilepsy services in light of increased demand for these services and the shortages of epilepsy staff that Oxfordshire had relative to other areas around the Country with similar levels of demand. Additionally, in the context of its scrutiny of the development of Integrated Neighbourhood Teams, the Committee's recommendation to system partners to investigate health needs and population patterns for each locality and to allocate resources for these Teams accordingly was also accepted. System partners committed to working with Public Health, local councils and the information team in the Oxford University Hospitals to create a data pack for each Integrated Neighbourhood Team.

In line with its strong emphasis on coproduction, the Committee's substantial change working group remains closely involved in ongoing scrutiny of the Project Delivery Plan to expand hospital-like services at Wantage Community Hospital. This marks a continuation of the commitments by the Committee since January 2024 to monitor the delivery of the promises made by the NHS to the JHOSC, and the Committee's recommendations for Community Infrastructure Levy (CIL) funds to be utilised to expand clinical services for Wantage in light of the closure of the inpatient beds since 2016.

I believe the Committee operates in a collaborative spirit, and possesses a solid understanding of the landscape and factors impacting health and care services for

Oxfordshire residents. I wish to thank District Cllr Katharine Keats-Rohan for her contributions as vice-chair in the past year. The Committee is also fortunate to have Sylvia Buckingham join its membership as a co-optee. Sylvia brings a wealth of knowledge, expertise, and experience to the Committee's work.

I also wish to thank Healthwatch Oxfordshire for their extensive contributions to the Committee's work and insights into health and care services from the place-based perspective of service users on the ground. The JHOSC is again also grateful to members of the public that had invested efforts in writing to as well as speaking to the Committee.

Special thanks also goes to Dr Omid Nouri, the Health Scrutiny Officer, whose dedicated efforts toward supporting the Committee had proven exceptional. The Council's increased investment into the scrutiny function has proven to increase the support for Health Scrutiny as well as the value and impact it provides.

Councillor Jane Hanna OBE Chair of the Oxfordshire Joint Health Overview and Scrutiny Committee 2024/2025

What is the Oxfordshire Joint Health & Overview Scrutiny Committee:

The Oxfordshire Joint Health and Overview Scrutiny Committee (JHOSC) is a Committee within Oxfordshire County Council which focuses on health scrutiny. As a joint Committee, it consists of 7members from the County Council, five (one each from the Districts and City. Additionally, the membership also includes three co-optees (one of which is vacant at the point of writing this report) who are not councillors but have expertise in health-related areas. Work to recruit a third co-optee is in progress, with the aim of initiating a recruitment exercise immediately following the County Council elections in May 2025.

The JHOSC does not make decisions or amend policies directly. Instead, it scrutinises health services across Oxfordshire and can call individuals or organisations involved in health service commissioning or delivery to appear before it. The Committee leverages the diverse expertise of its members to provide oversight and issue recommendations (to Oxfordshire County Council's Cabinet, senior officers and NHS commissioners/providers) to improve health services and in ways that add value to such services. These recommendations adhere to the SMART (Specific, Measurable, Attainable, Realistic, Timely) criteria, and in line with statutory requirements, recipients are required to respond to these in writing within 28 days.

The JHOSC also uses its influence to highlight where national constraints limit local improvements and often seeks support from the national government to address these issues. Whilst HOSCs have lost the power to formally refer matters to the Secretary of State for Health and Social Care since January 2024, this does not prevent Health Scrutiny Committees from informally writing to the Secretary of State or from requesting the Department of Health and Social Care (DHSC) to call-in any decision by commissioners or providers to amend services in ways that could be perceived as a substantial change by the Committee. In fact, as outlined in further detail below in this report, the Committee issued a call-in request to the Secretary of State in relation to the ICB's initially proposed restructure, which the JHOSC and other key Oxfordshire stakeholders were concerned by as a result of the potentially negative impacts on the commissioning and delivery of health and care services at the level of place.

Summary of Activity

HOSC Activity in Brief

The Committee convened six Public Meetings in the previous municipal year 2024/2025. Over the course of these meetings it had scrutinised 18 substantive items this municipal year. Some of the key items of scrutiny involved:

- Winter Planning.
- Health and Wellbeing Strategy outcomes framework.
- BOB Integrated Care Board Restructure.
- Support for People Leaving Hospital.
- Maternity Services.
- Medicine Shortages.
- Epilepsy Services.
- Cancer Services.
- Musculoskeletal Services.
- Audiology Services
- Director of Public Health Annual Report.
- Oxford Health NHS Foundation Trust People Plan.

Within the past civic year, the Committee has issued 66 formal recommendations to the NHS as well as Oxfordshire County Council's Cabinet. Of these 66 recommendations, 32 were accepted, 22 were partially accepted, and 3 rejected. At the time of writing this report, the JHOSC is awaiting responses to 9 recommendations, which it should receive imminently.

The Committee had also received briefings from the NHS on a number of areas including:

- Changes to the BOB Integrated Care Board's operating model.

- Measures taken to improve maternity services in light of the findings of both an October 2023 Care Quality Commission (CQC) Inspection and the publication of a birth dossier produced by Keep the Horton General (KTHG).

- Patient safety from Oxford University Hospitals NHS Foundation Trust. This was to provide further detail on the steps taken by the Trust to address the CQC's previously flagged concerns regarding the handling of patient safety.

- The Committee also held an online meeting with Oxfordshire's MPs and the Council's Senior Leadership Team for the purposes of briefing local MPs on the likely impacts of the initially proposed changes to the ICB's operating model.

The Committee's substantial change working group had also held three online check-in briefings with representatives from the ICB and Oxford Health NHS Foundation Trust in the previous municipal year 2024/2025. This was to receive updates on the progress being made in implementing the JHOSC's recommendations for the NHS to deliver on the project delivery plan to expand hospital-like services at Wantage Community Hospital. The Committee's Oxford Community Health Hubs working group

also held three online check-in briefings with representatives of Oxford Health NHS Foundation Trust in the past year for the purposes of examining progress being made on establishing three key community health hubs in Oxford City, which will provide a variety of outpatient services to the Northern, Centre, and Southern sections of the City.

Key Accomplishments

The JHOSC had dedicated significant time and work to scrutinising various areas that involved crucial developments and decisions impacting the health and wellbeing of Oxfordshire's residents. Over the past municipal year (as with the year prior to that), the Committee embraced a comprehensive and holistic approach to Health and Wellbeing, aligning with both national and local initiatives to further integrate health and care services for residents and to emphasise a broader model of health and wellbeing.

The success of the JHOSC can be measured by the positive outcomes of its work in contributing to developments that benefit the Health and Wellbeing of Oxfordshire's residents. The following constitute the JHOSC's most significant contributions.

i. Safeguarding Oxfordshire Place in the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board restructure:

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board commenced a consultation in July 2024 on a new and revised operating model. The ICB perceived the consultation as relating to a staff restructuring and therefore limited its engagement with key partners. However, it remained clear from the consultation document that was shared with key stakeholders (including the JHOSC) that the proposed restructure constituted a significant change to the way that NHS services would be commissioned (and potentially delivered) in Oxfordshire. The proposed changes primarily related to key areas such as prevention and early intervention, urgent care services, infection control resources, and the place convenor (Director of Place for Oxfordshire) role. The proposed changes involved a centralisation of functions and activities that were previously managed effectively at place level, and the ICB had initially not provided appropriate reasonings and justifications as to why those changes were necessary, nor that they would result in improved outcomes for Oxfordshire residents.

The Committee was concerned given that a significant aspect of these changes revolved around the ICB role of Director of Place for Oxfordshire, which up until the summer of 2024 was a role that was pivotal in coordinating place-based collaborative work between system partners. This role was to be removed, and a new role of Director of Places and Communities to be created by the ICB, with a responsibility for Directing all three places of Buckinghamshire, Oxfordshire, and Berkshire West.

The Committee's view was that the ICB had not effectively and adequately reached out to Oxfordshire County Council (as well as other key stakeholders/member organisations of the Oxfordshire Place-Based Partnership) prior to formally presenting and announcing these proposals to key stakeholders. The ICB was of the view that the proposed operating model did not constitute a substantial change, and that there

was therefore no statutory obligation to engage in a formal public consultation. However, the JHOSC was of the view that the proposed operating model did indeed constitute a substantial change. The Committee understood that the ICB was instructed to make reductions to staffing costs. However, it believed that the proposals being made by the ICB reflected more than simple staffing changes or a minor amendment of the ICB's management structure. Services could be negatively and directly impacted in a manner that would make the proposed operating model a substantial change.

Upon hearing of the ICB's proposed changes to its operating model, a strong consideration was whether the Committee should submit a call-in request to the Secretary of State for Health and Social Care in relation the ICB restructure. The timing of the ICB's consultation period was problematic for the JHOSC from a scrutiny standpoint for two key reasons:

1. The timescales allocated to the consultation were too short for a proposal of great importance to Oxfordshire.

2. The consultation initiated in July, which was a period when the JHOSC, like other public meetings of the Council, did not have a planned meeting. This necessitated urgent action from the Committee.

Upon hearing of these proposals, the Committee convened an extraordinary meeting on 02 August 2024. The meeting had in attendance representatives from most of Oxfordshire's key stakeholder organisations and individuals, including MPs. During the meeting, there was a unanimous agreement by the Committee as well as those present that the ICB's proposed operating model would not be in the interests of Oxfordshire's residents. However, to allow further discussions between the ICB and key stakeholders, the decision to request a call-in by the Secretary of State was deferred. This request was made at a subsequent meeting in September 2024. The outcome of this was the Department of Health and Social Care declined to invoke ministerial powers to call-in the decision, although the government urged the Council and the ICB to continue to work together and to negotiate a resolution to the dispute over the ICB's changes to its operating model.

Nonetheless, the value of the JHOSC's involvement in this matter is manifested in the fact that notwithstanding the Department of Health's reluctance to utilise the call-in process, the work of the Committee had contributed toward the ICB's decision to revise their original proposed restructure in four ways:

1. Contrary to the original proposition to centralise budgets, a number of delegated budgets would be retained at place level.

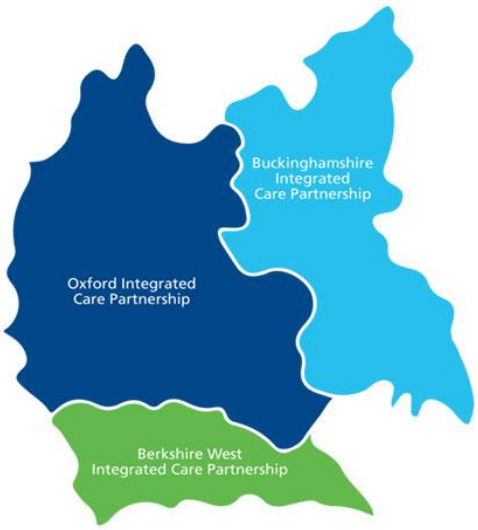
2. The ICB had decided to retain the post of Urgent and Emergency Director for Oxfordshire.

3. The ICB expressed that although they would no longer host the role of Place Director for Oxfordshire, that they would be supportive of any initiatives taken by Oxfordshire County Council and its partners to establish an Oxfordshire Place convenor role.

4. The ICB had also expressed a commitment to dedicate a member of their executive team to be an executive sponsor for Oxfordshire Place.

The Committee is involved in ongoing scrutiny of the developments taking place around the operating model and the ongoing negotiations taking place between the County Council and the ICB. The importance of ongoing scrutiny of these developments is even more crucial in light of central government's recent announcement to cut ICB running costs by 50 percent. The JHOSC seeks to remain at the forefront of ensuring that the importance and centrality of place is not diminished in the context of such revisions to ICB budgets and structures.

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board



ii. Continuing to secure the future of Wantage Community Hospital

Since the 'temporary' closure of the inpatient beds at Wantage Community Hospital in 2016, the Committee has remained engaged in ongoing scrutiny of the future of Wantage Community Hospital. A proposal to develop a solution with Wantage Town Council and local stakeholders came to the JHOSC in June 2023, and the Committee accepted the proposal to support and participate in a process of coproduction to determine the future of the services to be delivered on the ground floor of the hospital. Intensive work followed with stakeholder and public engagement involving coproduction with Wantage Town Council health representatives and the regular scrutiny undertaken by the JHOSC's substantial change working group. The outcome of this was to hold a JHOSC public meeting in January 2024, where it was agreed that the Committee would not refer the closure of the community hospital beds to the Secretary of State for Health and Social Care, and where the following specific recommendations were issued to Oxford Health NHS Foundation Trust and the ICB:

1. That there is no undue delay in securing the Community Infrastructure Levy (CIL) funding available in full for the purposes of providing the additional proposed clinical services on the ground floor of Wantage Community Hospital.

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.

During the previous municipalyear 2024/2025, the Committee continued to scrutinise the delivery of the NHS' proposed project delivery plan for the future of hospital-like services through two key avenues:

- The Wantage Community Hospital Governance and Oversight Group, which comprises key representatives of system organisations responsible for contributing to the implementation of the project delivery plan for the future of services to be delivered at the hospital. This group met regularly in the previous year, and the JHOSC Chair and Health Scrutiny Officer also sit on this group.

- The HOSC substantial change working group (comprising Cllr Hanna, District Cllr Paul Barrow, and former Councillors Nigel Champken-Woods and Damian Haywood), held two meetings with key representatives from Oxford Health NHS Foundation Trust and the ICB on 22 October 2024, and on 16 December 2024.

Given that CIL funds would need to be accessed for the purposes of providing the clinical services that the NHS had committed to, the JHOSC's substantial change working group and the wider Committee had, during the previous municipal year, closely campaigned and monitored the process of ringfencing the available £600,000 CIL funds from the Vale of White Horse District Council for the purposes of financing the delivery of the hospital's project delivery plan. The fact that the Committee (and the working group) had District Council representation was also conducive to this.

In addition, the Committee had been emphasising and urging the NHS on the need to explore any further additional funds that could be made available for delivering the project, which would have had to be delivered in stages with delays to the originally planned timetable had available funds remained limited to £600,000. As a result, in the summer of 2024, the ICB and Vale of White Horse District Council had further discussions to increase the CIL fund amount to provide a total of £950,000 toward the project. The JHOSC welcomes this development and believes this will enable the project to be delivered in one tranche, without the need to phase its delivery. An additional fund of £100,000 will also be released by Oxford Health NHS Foundation Trust's charitable fund from a legacy intended for Wantage Community Hospital. Securing this fund was made feasible because of partnership working on the hospital's refurbishment. This additional charity fund will be utilised for providing an enhanced digital facility for the hospital.

Moreover, the Committee expressed its concerns on the potential impact that the removal of the Oxfordshire place director post could have on the project's delivery

and the significant progress that had been achieved by that stage. It was partly the contributions of a place director which enabled the coproduction exercise to be completed in 2023 and which established clear communication channels between the ICB and the local community in Wantage. The chief executive of the ICB provided assurance at the BOB JHOSC meeting in November 2024 that the removal of the place director post would not have any negative impacts on the project for Wantage.

iii. Working to improve Primary Care access and the use of Digital Technology through the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview Scrutiny Committee.

In 2024/25, the Committee has played a key role in scrutiny at the cross-county level of the Buckinghamshire, Oxfordshire, and Berkshire West geography. The BOB JHOSC includes Councillors from Oxfordshire County Council, as well as representatives from Buckinghamshire, West Berkshire, Wokingham, and Reading. This Committee focuses on scrutinising the Integrated Care System at a strategic, or 'system' level, rather than at the county level, which is primarily examined by the Oxfordshire JHOSC. Additionally, the BOB JHOSC investigates system-level developments that affect all member authorities collectively.

The BOB JHOSC convened a public meeting on 24 November 2024. As well as receiving an update on the changes to the ICB's operating model during this meeting, the BOB JHOSC had been actively involved in scrutinising two major strategies of the Integrated Care Board (ICB). The first is the *Primary Care Strategy*, which aims to enhance and transform the delivery of general practice, community pharmacy, optometry, and dentistry services within the BOB region. The second is the *Digital &*

Data Strategy, which outlines the ICB's digital, data, and technology goals for the next three years.

Regarding the changes to the ICB's operating model, the BOB JHOSC strongly urged the ICB to retain its commitments to place. The Committee expressed concerns relating to potential dilutions of the ICB's place-based focus if the ICB were to increasingly centralise its operating model and functions. The BOB JHOSC also emphasised that if the ICB was expressing commitments to supporting initiatives taken by each of the three places to establish place convenors of their own, that it should clarify how this would be the case if such convenors would not be employees of the ICB (meaning they may not have access to ICB data/intelligence in the same manner that an ICB Place Director post would).

Regarding the *Primary Care Strategy*, the BOB JHOSC received an update after having initially reviewed this as part of an item held in its meeting in January 2024. The Committee reiterated its recommendation for there to be greater transparency around the use of physician associates or administrative staff who were involved in triaging or treating patients, as well as over the existence of any competency frameworks that were being adopted to maximise patient safety and reassurance. Another key point emphasised by the Committee was the imperative for coproduction to remain at the forefront of the ongoing design and implementation of the strategy. Given that the strategy could have significant implications on how front facing primary care services are configured and provided, it is pivotal that patients and service users within the BOB geography have opportunities to provide input into a crucial component of healthcare services in local communities. The BOB JHOSC therefore agreed to issue the following recommendation to the ICB in relation to the strategy:

> *'To ensure that coproduction remains at the heart of the design and delivery of primary care services. It is recommended that acute providers and local authorities are engaged with on any planned changes to primary care services.'*

The Committee is yet to receive a formal response to this recommendation, although the ICB has provided indications that they are adopting coproduction as part of the strategy. Moving forward, the BOB JHOSC will continue to request a formal response to this recommendation, and will be requesting evidence to indicate the degree to which coproduction is being exercised.

Another significant contribution made by the BOB JHOSC in regard to primary care scrutiny was the decision made to write to the Secretary of State for Health and Social Care to highlight the potential implications of the government's announced increases in the Living Wage and National Insurance Contributions on General Practice. The Committee highlighted to the government that there would be significant financial and operational challenges faced by GP surgeries in BOB due to increases in the living wage and national insurance contributions; and that while aimed at improving the economic welfare of workers, could hinder the functioning and sustainability of GP practices. The BOB JHOSC received a response from the Secretary of State with an acknowledgement of its concerns, and a commitment by the government to increase funding for general practice for 2025/26 with an increase of 7.2 per cent in cash terms. The response also outlined that the government would begin discussions on the

annual GP contract, and that the matter of the employers' National Insurance increase would be dealt with as part of that process.

In relation to the *Digital and Data Strategy*, the Committee urged the ICB and its chief executive officer (who attended the meeting on 22 November 2024) to exercise further transparency around the use of technology and how this will be governed and monitored, particularly in an age where health systems could make increasing use of Artificial Intelligence.

Looking forward, the Oxfordshire JHOSC will continue to actively participate in BOB JHOSC scrutiny, with a view to receiving further updates on developments in primary care and on any further changes to the ICB's operating model. Such updates will be particularly crucial given the government's recent plans to cut ICB running costs by 50 percent and the prospect of ICB's losing their provider oversight roles.

iv. Securing further resource for Epilepsy Services

The Committee conducted an in-depth review of epilepsy services during its meeting on 12 September 2024. To provide some context, the Committee had received written evidence at its previous public meeting on 16 January 2024 from the voluntary sector (SUDEP Action and Epilepsy Action), as well as from Professor Marian Knight (University of Oxford). The letter from Professor Knight concerned the findings of MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) of a near doubling of sudden deaths against a backdrop of the introduction of the Pregnancy Prevention Programme. The third sector raised a red flag to the Committee about the likely local safety impacts on residents and impacts on all stakeholders of a new national framework that valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently

consider and document that there is no other effective or tolerated treatment. The Committee was alerted to this being a very dramatic shift in clinical practice.

The Committee wrote to Steve Brine MP, Chair of the Parliamentary Health Select Committee in January 2024, requesting national scrutiny of the MHRA (Medicines and Healthcare products Regulatory Agency) alert, the proposed timescales for implementation, the lack of a national impact assessment, and the lack of resources to support the new requirements. The Committee received a response that this was included on the list of potential scrutiny items for the Parliamentary Select Committee. Additionally, in April 2024, the Committee received the ICB local impact assessment on the MHRA Pregnancy Prevention Update of November 2023. The impact report outlined that there were unavoidable consequences, and current services were ill-equipped to handle the implementation.

Having received the evidence, the Committee conducted a deep-dive into the current state of epilepsy services at its 12 September 2024 meeting, receiving two reports on this item: from Oxford University Hospitals NHS Foundation Trust, and NHS England South-East Region. The Committee's areas of interest included: the health inequalities implications surrounding epilepsy; the number of full-time equivalent neurologists/specialists and patterns of demand on clinical time and pressures; the steps being taken to address sudden death in epilepsy; and the local impacts of the MHRA regulations on Valproate and Topirimate.

Through the evidence it received and its own investigations, it became apparent to the Committee that there were especially severe local impacts due to poor provision of the epilepsy service and because of unfunded and unbalanced national mandatory policies. Therefore, the Committee issued the following recommendations to the ICB, Oxford University Hospitals NHS Foundation Trust, and NHSE South-East Region.

For the ICB and Oxford University Hospitals NHSFT to:

- *Give priority to patient safety for people with epilepsy and their families in Oxfordshire, and to the welfare of the Oxfordshire epilepsy team, and to set out how that priority will be addressed through their governance and management at a board level. The governance and management of these priorities should also be inclusive of people with lived experience and their charity representatives, as well as their concerns regarding tailored and balanced communications and the use of existing empowerment tools.*

- *To secure further funding and resource for epilepsy services.*

For NHS England South-East Region to:

1. *Give support to the ICB and Oxford University Hospitals NHS Foundation Trust to help achieve the above prioritisations.*

A key success for the Committee was that through bringing some of its evidence to the local and regional NHS bodies, its above recommendations were accepted; with both Oxford University Hospitals and NHSE South-East committing to working to secure further resource toward epilepsy services.

The Committee also submitted a separate recommendation to Oxfordshire County Council's cabinet, urging it to consider the likely impacts of the Valproate policy for the local authority commissioning arrangements and the provision of safe residential care and out of county placements. It was also recommended that the Cabinet Member for Public Health and the Director of Public Health consider the epilepsy population as part of the Council's programme to tackle public health inequalities. The cabinet partially accepted this recommendation and committed to examining the impact of the valproate policy on the services they commission for special education and residential care for children and adults with learning disabilities and/or autism (who may be affected by patient safety concerns).

The Committee also wrote to Karyn Smith MP (Minister of State for Secondary Care) on 18 October 2024, urging greater resource to be allocated to epilepsy services, and for the suspension the MHRA regulatory updates of 2024 pending an independent national review of the UK's Pregnancy Prevention Programme. Letters were also sent to Layla Moran MP (Chair of the Parliamentary Health Select Committee) urging for the Select Committee to embark on thorough scrutiny of the Pregnancy Prevention Programme, and to NHSE Specialist Commissioning to ask for greater resource allocations for epilepsy services in Oxfordshire. To date, a response was received from Layla Moran's office, with a commitment to add this topic to the list of considerations for items for the Parliamentary Select Committee work programme.

v. Promoting healthier advertising and restrictions on fast food outlets in Oxfordshire:

Excess weight poses significant challenges to healthy living, being a leading cause of early deaths. Excess weight levels also raise susceptibility to a vast array of health conditions (including some cancers and Type 2 diabetes) and can also worsen one's mental health. For children, this can result in reduced educational performance and for adults increased sickness in employment. An individual's overall life expectancy can also be reduced by obesity.

It is for these reasons that the JHOSC continued to retain a spotlight on the measures taken by Oxfordshire County Council and its key NHS partners to promote healthier weight amongst Oxfordshire's residents. The Committee continues to stress that tackling excess weight should remain a key priority for both the Health and Wellbeing Board as well as the Health Improvement Board in Oxfordshire.

In its 21 November 2024 public meeting, the JHOSC commissioned and received a report which provided an update on the work undertaken by system partners to promote Healthy Weight. The report received included input from Oxfordshire County Council's Public Health team, as well as from the ICB. The Committee initially examined this topic in its September 2023 public meeting, and sought to receive a progress update on the work undertaken by the Council and its partners to promote healthy weight, as well as on the recommendations issued by the Committee last year. Some of the insights sought by the Committee involved: details of any new data relating to excess weight in Oxfordshire; any ongoing coproduction that had been adopted as part of the work to tackle excess weight; and an update on the licensing of both fast-food outlets and advertising of HFSS (High in Fat, Salt and Sugar) products.

The Committee issued a key recommendation calling for the development of clear and measurable Key Performance Indicators (KPIs) so as to evaluate the impacts and progress of the work to promote healthy weight. This recommendation was accepted by system partners, with expressed commitments to continuing to work with a clear action plan associated with healthy weight which includes KPIs. These KPIs would then be reported to the Health Improvement Board.

In addition, the Committee issued another recommendation on the imperative for ongoing coproduction of healthy weight services that could include input from those with comorbidities or from vulnerable population groups. This recommendation was also accepted, and whilst it may be difficult or potentially inappropriate to be seeking out individuals systematically, Oxfordshire County Council's public health team will now work on coproducing healthy weight services with organisations supporting such vulnerable residents. Moving forward, it would be ideal for the JHOSC to receive further information on which particular organisations had been approached, and on which vulnerable population groups are represented by these organisations.

Furthermore, the Committee also agreed to and submitted two letters to both Oxford City Council and Cherwell District Council in relation to urging both councils to adopt policies that:

1. Promote healthier food advertising.

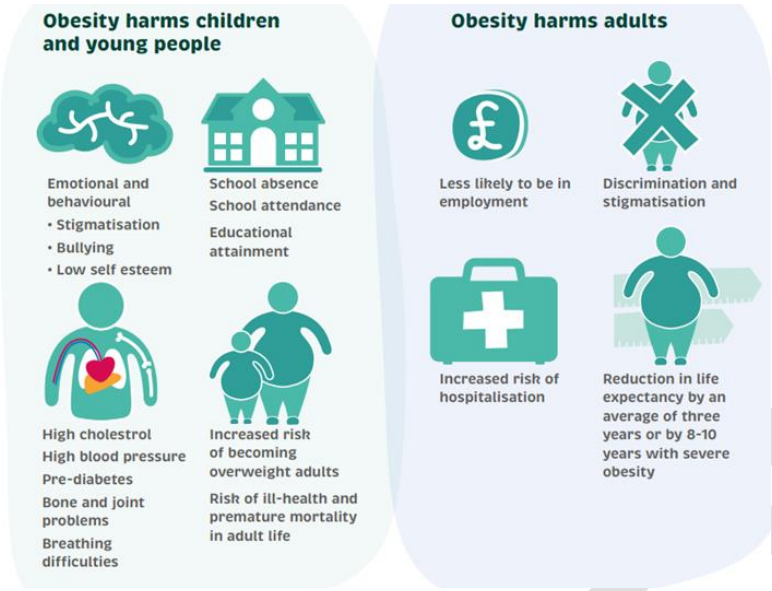
2. Restrict the opening of new hot food takeaway shops in areas with the highest level of childhood obesity and in close proximity to schools.

The Committee shared evidence it received from the County Council's public health team around which particular areas of Oxford City and Cherwell contained populations with the highest levels of excess weight; and urged both Councils to build on their own work to support the health and wellbeing of residents by taking a number of crucial steps to address the advertising of unhealthy food products as well as the presence of new hot food takeaway shops.

The JHOSC sought to reassure both Councils that they need not be concerned, if indeed it was a concern about losing revenue as a result of implementing healthier advertising policies for two reasons:

1. These policies would not require a ban on any particular brand from advertising, only that brands would have to switch to advertising healthier products that they are able to offer customers.

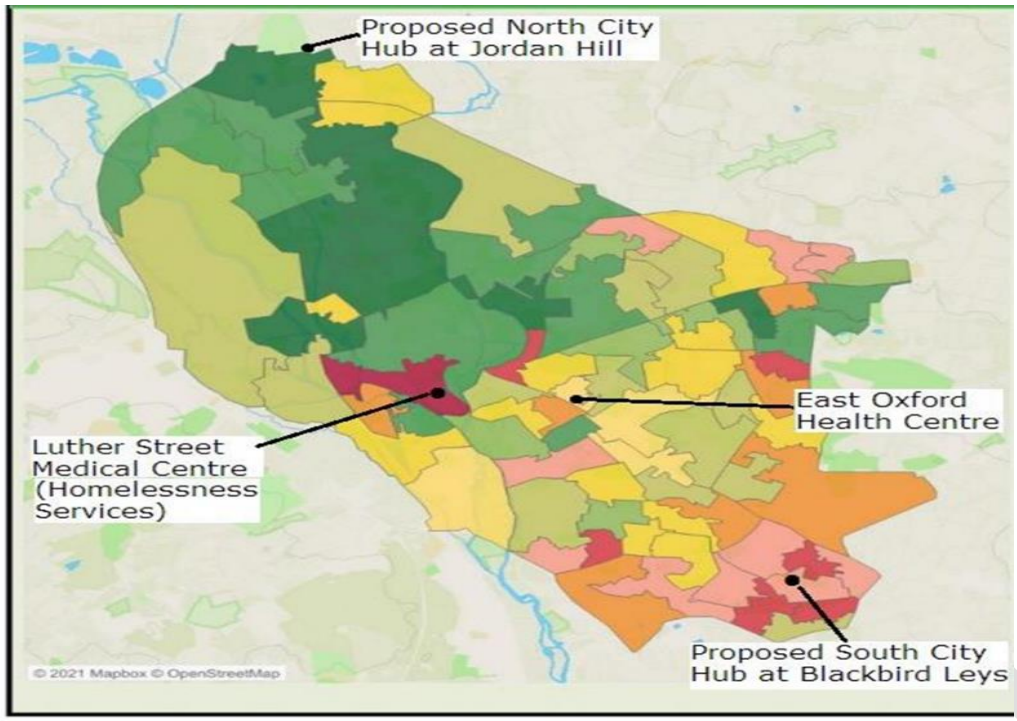
2. To date of the local authorities who had implemented such policies, none have reported revenue losses. For example, Haringey Council confirmed that there had been no loss in revenue as a result of allocating advertisement places to advertisers of non-HFSS products.



Other Key Highlights of HOSC Activity:

Supporting improvements in community health provision via the Oxford Community Health Hubs Project:

A key area of JHOSC scrutiny had been around the Oxford Community Health Hubs Project launched by Oxford Health NHS Foundation Trust. The purpose of this project is to integrate primary, community, and dental care services within Oxford City (comprising 300 staff, 40 teams, and nine existing bases) into three hubs. The Trust believes that the integration of such community-based services into three key hubs will enable a more effective delivery of these services to patients in their communities. The project aims to establish three health hubs, each located in the North, Centre, and the South of the City respectively. Below is a map of where these Hubs will be established:



The JHOSC has scrutinised the progress made against this project via its Oxford Community Health Hubs (OCHH) working group (which was established in January 2024). The working group held four meetings with representatives from Oxford Health NHS Foundation Trust in the previous municipal year on 11 July 2024, 11 September 2024, 9 December 2024, and on 4 March 2025. The working group, on behalf of the JHOSC, had and continues to express its support for this project as it could lead to better health and care outcomes for patients in Oxford City who rely on these community-based services. For instance, the services within the scope of this project that patients will benefit from include children's services (including therapies and community nursing), community nursing and therapy for adults, podiatry, community specialist services (including dietetics and respiratory services), and dental community services. The hubs will also host quality and directorate management teams.

The JHOSC working group believes that these health hubs would serve as a space for the co-location of health and care professionals that provide services to local communities. The increasingly multidisciplinary nature of community healthcare necessitates greater integration and collaboration between both clinical and managerial/administrative teams, which the working group believes these hubs can help foster through accommodating various professionals and staff in single and larger integrated hubs.

Nonetheless, the working group, on behalf of the Committee, urged the Trust to strongly consider the likely impacts of integrating these community services into large hubs on both staff as well as accessibility for patients. In terms of staff, whilst there could be benefits in creating integrated multidisciplinary working and a pleasant physical work environment, some services are delivered through clinics that will change location by a few miles to a new, purpose-built clinical facility better equipped to deliver patient care (e.g. dental, podiatry). This change could impact some patients and staff who attend these clinics. To help remedy this, the JHOSC working group had facilitated early discussions between the County Council's Transport Services and the

Trust for the purposes of exploring avenues to allow easier access for staff and patients to these hubs. This included facilitating contact with Transport services officers as well as the Council's Cabinet Member for Transport, who was invited to attend one of the working group meetings with the Trust. A key point raised by the working group was the imperative for staff who conduct home visits from these hubs to be able to easily access patients who happen to reside on roads with restrictions. Extensive travel planning should therefore form a key part of the Trust's engagements with its staff and patients/carers; particularly for those who may experience impacts with transportation and accessibility.

The working group will continue to engage in scrutiny of key developments in this project, as this represents a new model of community healthcare provision that should be handled delicately, with all variables and dependencies taken into account. At the time of writing this annual report, the next working group meeting with the Trust is scheduled to take place at the North City Health Hub. This will constitute a briefing as well as an opportunity for all members of the JHOSC to witness first hand the progress made in establishing the North City Hub.

Scrutinising improvements to Maternity Services:

Maternity services play a crucial role in supporting the health and wellbeing of mothers and their babies. These services encompass prenatal care, delivery, and postnatal support, each phase being instrumental in ensuring healthy outcomes for both mother and child. With this in mind, the Committee was also alarmed by key developments around maternity services including the outcome of a CQC inspection in 2023, as well as the publication of a dossier by Keep the Horton General (KTHG) which outlined the experiences of several mothers and families who had experienced difficult births in Oxfordshire.

The JHOSC commissioned a report from Oxford University Hospitals NHS Foundation Trust, which was discussed during its public meeting on 21 November 2024, with a view to examining the steps taken by the Trust and its partners to overcome the challenges around maternity services throughout the County.

The challenging experiences of service users served as an indication as to not only the challenges with maternity, but also in the specific lines of enquiry and recommendations that the Committee adopted as part of its scrutiny.

Some of the themes the JHOSC investigated included: details of any partners, stakeholders or patients that had been engaged with for the purposes of coproducing and improving maternity services; data on local trends with regard to injuries, deaths, and birth trauma; and the specific actions taken to improve maternity services in ways that address concerns raised by the CQC and the KTHG birth dossier.

The Committee was also of the view that staff should be thoroughly supported throughout the process of improving Oxfordshire's maternity services. This should include a two-pronged approach of not only ensuring that staff receive appropriate training, but that they are also not subjected to any additional negative pressures in addition to existing pressures they are facing as frontline healthcare workers. In an informal briefing held with the Trust, the Committee urged the Trust's Chief Executive

and Chief Medical Officer to ensure that a careful balance was achieved in regard to generating improvements whilst upholding staff wellbeing.

As part of its scrutiny of maternity services, 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 had been accepted and how the Trust is taking steps to take these recommendations from the Committee on board:

1. The Committee recommended that maternity staff received ongoing training around improving maternity services, and that staff should also be trained in patient-centred care. The Trust accepted this recommendation, and committed to enhance communication skills training for all maternity staff, with an emphasis on empathy, compassion, and kindness. The Trust would also be conducting monthly reviews and monitoring through the Trust's training compliance portal, with the aim of reporting progress through clinical governance processes.

2. The Committee also recommended for the development of a maternity trauma care pathway for ongoing support for mothers (and their partners) to include those who had experienced difficult births, complications, premature babies, still births and bereavement. This recommendation was also accepted, with the Trust committing to continued working with Oxford Health NHS Foundation Trust on a shared Birth Trauma Pathway. The Trust will also work alongside specialised mental health midwives to identify and address any mental health concerns that may require different referrals.

3. Another key point raised and recommended by the Committee was around the importance of coproduction remaining at the heart of the design as well as the improvements of Maternity Services. The Trust accepted this recommendation, and plans to continue to coproduce improvement activities with the Oxfordshire Maternity and Neonatal Voices Partnership, healthcare professionals, service users, family members, and relevant system partners to discuss and review Maternity Services. The Trust will also continue to create channels for service users and families to provide feedback on these services, and will utilise this feedback to make continuous improvements.

The JHOSC is pleased to see some of the initial steps embarked upon by Oxford University Hospitals NHS Foundation Trust to improve maternity services, and will continue to engage in scrutiny of this area moving forward with a view to receiving concrete evidence as to how improvements have been made and achieved.

Oxford University Hospitals
NHS Foundation Trust

Securing local and national mitigations to tackle Medicine Shortages:

The Committee has received several reports of medicine shortages impacting local residents. The JHOSC understands that such shortages are also national in scope and are occurring as a result of several complex and interacting factors which often erupt at short notice and that can rapidly change. It is for this reason that the Committee commissioned reports (for its 12 September 2024) meeting from the ICB as well as Oxford University Hospitals NHS Foundation Trust to further investigate the causes of medicine shortages, the impacts such shortages were having on patients, and the steps being taken by local NHS system partners to address this.

A key concern for the Committee were the implications and risks this could have on patients. Community Pharmacy England conducted a survey with pharmacy teams across England, which outlined that 97% of pharmacy teams reported patients being inconvenienced as a result of medicine supply issues, and 79% reported that patient health is at risk due to these issues. The Committee also received a statement on Medicine Shortages from Dr Leyla Hannbeck (Chief Executive of the Independent Pharmacies Association [IPA]), and the Committee agreed with the IPAs concern around the lack of transparency regarding the supply of medicines. The Committee also supports the IPA's view that the DHSC should bring healthcare professionals on the frontline, as well as wholesalers, suppliers and patient groups together to discuss these challenges with a view to explore solutions.

As part of its scrutiny of medicine shortages, the JHOSC laid emphasis on and issued some key recommendations around mitigating some of the challenges with medication shortages. All these recommendations were accepted by the ICB and Oxford Health NHS Foundation Trust. A summary of how these recommendations were accepted is below:

1. The JHOSC recommended that efforts were made to reduce the prospect of additional excessive workloads on both clinical and administrative staff in the event of medicine shortages, and for staff to be provided with meaningful support as well as additional resource if need be for the purposes of tackling any additional demand/burdens. This recommendation was accepted, with the

ICB and Oxford University Hospitals NHS Foundation Trust committing to minimising the impact on staff workloads through coordination with national bodies and the use of national resources to help to support this. There is a dedicated Medicines Supply Shortages practitioner at Oxford University Hospitals who will lead on this local and national coordination to mitigate excessive burdens on staff.

2. The Committee also recommended that there was effective communication, coordination, and transparency within and between the local and national levels to help mitigate risks associated with medicine shortages. The ICB accepted this recommendation, with a commitment by its Medicines Optimisation Team to provide advice to local practices and community pharmacies on medicine shortages and communicating current shortages and suitable alternatives via its regular newsletter and website, both of which are available to all primary care clinicians. The team will also add certain information to ScriptSwitch, which is a software tool used by prescribers to provide real-time information and recommendations at the point of prescribing.

3. The JHOSC issued a strong recommendation for there to be processes in place to recognise and identify patients with cliff-edge conditions, and to ensure that mitigations are in place to reduce the risk of harm to these patients in the event of supply disruptions. This recommendation was also accepted by the ICB and Oxford University Hospitals NHS Foundation Trust, with expressed commitments to closely monitor national impact assessments, which would determine which shortages were deemed higher risk or those that were expected to have the most impact. These impact assessments and determinations are communicated specifically, in the form of a Medicine Supply Notification (MSN) or National Patient Safety Alert (NatPSA). There would also be local observations of any Serious Shortage Protocols (SSPs) when these are put in place. This would then enable community pharmacists to supply patients with specific alternative medicines; which are available to view on the NHS Business Service Authority's dedicated SSP web page, along with any supporting guidance.

Looking Ahead 2025-2026:

Staffing and Capacity:

The Committee continues to produce a significant number of recommendations as well as reports which are being issued to the NHS and to a lesser extent Oxfordshire County Council's Cabinet. Within the previous municipal year 2024/2025, the Committee benefited from additional support from a democratic support officer. This has contributed to undertaking the administrative work associated with the Committee's business. This additional support has allowed Scrutiny Officer time to be diverted to higher-value work, enabling the Committee to be better informed through briefing and research, building stronger relationships and closer joint-working with system partners at local and national levels, and contributing more to the output of the BOB HOSC.

Co-optees:

The JHOSC's membership allows room for three co-optees. Again, the presence of co-optees adds two key values to the Committee's work. First, such members are recruited based on the level of expertise they have with health services in Oxfordshire, which provides professional and insightful reflections for the JHOSC in determining what to scrutinise and how to do so. Second, given that they are recruited outside the County Council, they do not necessarily have a clear affiliation with any political party, enabling the JHOSC to receive apolitical stances and contributions.

In last year's annual report, it was highlighted that there were two vacant co-optee posts on the Committee. Since then, a recruitment exercise was launched, and one further co-optee has been recruited. Sylvia Buckingham applied for the advertised vacancy, and was interviewed by a panel comprising the Health Scrutiny Officer, Chair and Vice-Chair of the JHOSC on Wednesday 09 October 2024. The Panel recommended to the Committee that Sylvia Buckingham be appointed as a co-optee member of the JHOSC. She was formally appointed at the 21 November 2024 public meeting. Since then, Sylvia has actively participated in the Committee's work, providing extensive input into the JHOSC's forward work planning and has contributed to the drafting of key lines of enquiry and recommendations for public meetings. Sylvia brings a wealth of expertise from her background as a nurse and as an academic, and is also a Healthwatch Oxfordshire Trustee and a patient safety partner at Oxford University Hospitals NHS Foundation Trust. This experience provides further perspective and reflections into the JHOSC's scrutiny of health services.

The Committee seeks in the course of the coming civic year to fill its final vacancy.

Practicing Equality, Diversity and Inclusion:

A key commitment outlined in last year's Annual Report was to increasing diversity and engagement, in addition to further public involvement in Scrutiny. In continuation of the trend from the year before last, there has been an ongoing improvement in the diversity of public speakers who have registered to speak at HOSC meetings. The Committee had a total of 13 public speakers within the last civic year. The public speakers were from a variety of backgrounds and organisations, and spoke on a range of issues including epilepsy, medicine shortages, and SEND services. The Health Scrutiny Officer will work with the JHOSC Chair to explore ways to increase opportunities for further public input into health scrutiny. Allowing greater public input would contribute toward the JHOSC's perspectives and insights into key issues being experienced by patients who use health services.

Furthermore, as part of the process of improving equality, diversity and inclusion, the JHOSC is committed to appointing its third co-optee from a BAME (Black and Asian Minority Ethnic) background. This would enable further input and expertise to be received from a BAME perspective. The Committee understands and recognises that there are specific and unique challenges that BAME residents can experience, both in terms of their own health and wellbeing, as well as in terms of their experiences with health services. Hence, appointing a BAME co-optee would constitute a lot more than a tick box exercise of ensuring greater ethnic representation on the Committee, and

will also yield further tangible benefits for how the Committee recognises, understands, and investigates the experiences of ethnic minorities. This is also in keeping with the overall principles of Equality, Diversity, and Inclusion which Oxfordshire County Council is committed to as a local authority encompassing a geography containing a diverse ethnic footprint.

Future items of scrutiny:

Noting that the new membership has control over its Forward Work Programme there are a variety of themes that could constitute potential items of scrutiny in the ensuing municipal year for the JHOSC. These include ongoing scrutiny of existing priorities and new developments and may include:

Abolition of NHS England:

The government made a series of recent announcements that could significantly impact the health and care landscape both nationally and locally; including on how services are commissioned and delivered. The changes include:

1. The abolition of NHS England and its integration into the Department of Health and Social Care.
2. The need for ICB's to reduce their running costs by 50 percent.
3. The prospect of ICB's losing their provider oversight function.

These changes will naturally have a significant impact on the local health landscape, and the Committee will seek to champion patient outcomes throughout the process.

Primary Care:

Access to GP and dentistry services, should also constitute a key focus of ongoing scrutiny for the JHOSC. The Committee last examined GP and dentistry services in the municipal year before last, and the time is ripe for further in-depth reviews into the steps being taken to increase access to primary care. The Committee had previously raised concerns around population increases as well as rising residential developments. In line with previously made recommendations to the ICB on this, the Committee should therefore review the degree to which efforts have been made to secure further funding for primary care estates. Collaboration between the ICB and District Councils will be crucial in this regard for the purposes of coordinating the use of available funds. Further reassurances should also be sought around how the ICB is working to avert the prospects and appearances of dentistry deserts throughout the County, particularly in rural areas (which can often be elicited by practices refusing to provide NHS treatments as a result of less rewarding NHS dentistry contracts.

Health and wellbeing strategy outcomes framework:

The Committee continues to support the ongoing development and delivery of Oxfordshire's health and wellbeing strategy, and recognises the collective efforts of system partners in this regard. To build on its ongoing scrutiny of the strategy's implementation, it is crucial to retain a spotlight on the outcomes framework developed

by the Health and Wellbeing Board, and to receive regular updates on the incremental evaluation of the strategy's delivery by the Board. The strategy is in the process of being evaluated in stages, with the Board incrementally focusing on certain key strategy priorities at each of its meetings.

Children's Emotional Wellbeing and Mental Health Services:

The Committee previously examined Oxfordshire's Emotional Wellbeing and Mental Health Strategy for Children in its November 2023 meeting. The Committee agreed on the imperative for there to be a follow-up update on key progress made around the strategy's delivery and how it produced tangible benefits to the emotional wellbeing and mental health of Oxfordshire's youngest residents. The Committee examined the theme of children's emotional wellbeing as part of its scrutiny of this year's Director of Public Health (DPH) Annual Report (which focused primarily on this area), and it will be crucial to examine how the commitment and recommendations outlined in this year's DPH Annual Report interlinked with the objectives and Key Performance Indicators being utilised in the context of the Emotional Wellbeing and Mental Health Strategy. This is an important are of policy given the increases in mental health decline amongst children and young people, particularly since the Covid-19 pandemic.

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

05 JUNE 2025

Update report on the work of the Oxfordshire Joint Health Overview Scrutiny Committee Oxford Community Health Hubs Working Group

Report by Director of Law and Governance and Monitoring Officer

RECOMMENDATIONS

The Committee is **RECOMMENDED** to

1. **NOTE** the work of the HOSC Oxford Community Health Hubs working group around scrutinising the Community Health Hubs project for Oxford City since the working group's establishment in April 2024.

2. **CONFIRM** its support for the continuation of the working group's existence and its ongoing scrutiny of the project to establish three Integrated Community Health Hubs in Oxford City.

3. **AGREE** to the appointment of a fourth working group member given that former Cllr Michael O'Connor is no longer a member of Oxfordshire County Council.

CONTEXT

1. Since its public meeting on 18 April 2024, a key area of the Committee's scrutiny had been around the Oxford Community Health Hubs Project launched by Oxford Health NHS Foundation Trust. This was brought initially to the attention of the Committee in a briefing delivered on 27 November 2023 by key representatives of the Trust including its Chief Executive.

2. The purpose of this project is to integrate primary, community, and dental care services within Oxford City (comprising 300 staff, 40 teams, and nine existing bases) into three hubs. The Trust believes that the integration of such community-based services into three key hubs will enable a more effective delivery of these services to patients in their communities.

3. The project aims to establish three health hubs, each located in the North, Centre, and the South of the City respectively. During the briefing it received from the Trust on 13 March 2024, the Committee were informed that the establishment of these three hubs will help to achieve the broader aims of the project which are to provide:

- Improvements in health and well-being outcomes for local residents.
- Sustainability around travel for patients, carers and staff.
- Direct contributions to the delivery of the Trust's Green Plan.
- Locations which support the Trust's work to reduce health inequalities.
- Colocation of teams and services for maximum collaboration.

4. The services within the scope of this project that patients will benefit from include children's services (including therapies and community nursing), community nursing and therapy for adults, podiatry, community specialist services (including dietetics and respiratory services), and dental community services. The hubs will also host quality and directorate management teams.

5. Below is an outline of the three Hubs, their planned locations, and the services/staff they would accommodate:

   - **North City Hub**: Murray House, Jordan Hill, is envisioned to have multiple clinical and therapy rooms, 24/7 home visiting services, and integrated teams.
   - **South City Hub**: Blackbird Leys, facing the most health-deprived community, will have a flexible clinic and therapy space.
   - **Central City Hub**: East Oxford Health Centre will provide clinic, team/admin space, and therapy space with good public transport links.

6. As part of the project's development, the Trust embarked on a series of public engagements with patients**,** carers, families, and the wider public and key stakeholders (including the JHOSC). The focus was on engaging with affected patient groups, informing them, and gaining their involvement in the design and travel planning of the hubs. The engagement themes adopted by the Trust up to September 2024 included the design and layout of the North and South City Hubs, clinic locations, travel plans, and addressing health inequalities.

KEY SUMMARY OF WORKING GROUP ACTIVITY AND POINTS OF OBSERVATION

7. Since the working group was established in April 2024, it held four meetings with representatives from Oxford Health NHS Foundation Trust on 11 July 2024, 11 September 2024, 9 December 2024, and 4 March 2025.

8. A key reason for this project having been shared with the Committee by the Trust was to receive its endorsement and support as a JHOSC for the planned project, which is now in motion. The working group, on behalf of the JHOSC, had and continues to express its support for this project as it could lead to better health and care outcomes for patients in Oxford City who rely on these community-based services.

9. Below is a summary of some key themes/areas of discussion that the working group has had in its interactions with the NHS since January 2024. The below

themes also include some points of observation that the working group has in relation to the ongoing Community Health Hubs project.

Colocation of Health & Care Professionals: The working group understands that the three community health hubs would serve as a space for the colocation of health and care professionals that provide services to local communities throughout the City. The increasingly multidisciplinary nature of community healthcare necessitates greater integration and collaboration between both clinical and managerial/administrative teams, which the working group believes these hubs can help foster through accommodating various professionals and staff in single and larger integrated hubs.

Accessibility for patients and staff: The working group has been urging the Trust to take into account the impacts of integrating the City's community services into larger hubs on both staff as well as on patient accessibility. For staff, whilst there are advantages in fostering integrated multidisciplinary working and a pleasant physical work space, some services are delivered through clinics that will be relocated by a few miles to a new, purpose-built clinical facility better equipped to deliver patient care (e.g. dental, podiatry). These changes could impact some patients and staff who attend these clinics. To help remedy this, the working group facilitated discussions between the Trust and the County Council's Transport Services team to explore avenues to enable easy access for patients and staff to these hubs. The working group also invited the Council's Cabinet Member for Transport, who attended one of the working group meetings with the Trust.

Supporting Oxfordshire's Health and Wellbeing Strategy: The working group believes that this project could significantly support the aims and objectives of Oxfordshire's Health and Wellbeing Strategy. The strategy aims to support the County's residents through the three life stages of Start Well, Live Well, and Age Well; all of which can be bolstered by the nature of the services that will be delivered through the integrated health hubs.

- *Start Well*: The project could support this aspect of the strategy through Integrating 0-19 universal children's and young people's services into locality teams; co-locating family and SEND support services with children's therapies services; and providing clinical bases to support children's hospital-at-home.

- *Live Well*: The proposed Health Hubs could support this aspect of the strategy through; hosting more sustainable GP out-of-hours and minor injuries care; providing locally accessible services in the most health-deprived areas; improving facilities for specialist community and pediatric dental care; creating more joined up and sustainable health services for people with long-term health conditions.

- *Age Well:* The project could help elderly residents through providing single points of access to support the holistic assessment of need and to coordinate health and care responses across various services. The hubs could also provide a base for 24-hour, seven-day-a-week urgent community visiting services serving Oxford and surrounding areas.

Impact of ICB restructure: The working group (as does the wider Committee) understands that the ICB had recently undergone a restructure of its staffing, with one aspect having been the removal of the post of place director for Oxfordshire. The working group has expressed concern regarding the impact that the Oxfordshire place director removal could have on the delivery of the health hubs project and the immense progress that has been made so far in reaching the current point. It was partly through the presence and contributions of a place director which enabled the stakeholder engagement to be undertaken, and which established a clear channel and avenues of communication between the Trust, the ICB, and other key system partners (including the JHOSC). The working group has therefore urged the ICB and its Chief Delivery Officer (who is the ICB's Executive Sponsor for Oxfordshire) to continue to support the progress an development of such place-based projects. This will be crucial in light of the fact that the ICB has been instructed by the government to make further reductions to its running costs.

Importance of ongoing coproduction: The working group understands that the Trust has engaged with patients, carers, families and the wider public around this project's development. Coproduction should remain at the heart of determining the nature of this project and the services to be delivered at the three proposed health hubs in the City. The working group was informed that the Trust sought to map out seldom heard groups. It is crucial for there to be transparency around which specific patient/population groups were approached and engaged with, and what the format of this engagement was. The working group was also pleased to hear that four key themes were utilised as part of the public engagements which included:

- Design and layout of North and South City Hubs.
- Locations of the clinics and the opportunities around the changes.
- Informing travel plans for each hub.
- Addressing health inequalities, particularly around increasing patient awareness of and making services accessible.

The working group has also continually stressed the need for the Trust to continue to engage in coproduction with local residents in the City so as to not only determine the locations and services of the proposed hubs, but also in the event of any potential future barriers that arise that could result in complications or delays to the project's delivery.

LEGAL IMPLICATIONS

There are no direct financial implications arising from this report.

Kim Sawyer, Interim Head of Legal and Governance.

FINANCE IMPLICATIONS

There are no direct financial implications arising from this report.

Drew Hodgson, Strategic Finance Business Partner.

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June 2025

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Oxford Health
NHS Foundation Trust

Oxford City Community Healthcare Hubs

Update for Joint Health Overview and Scrutiny Committee Working Group

20 May 2025

Services in scope

Oxford Health NHS Foundation Trust

- Children and young people's services (including 0-19 healthy child and young person's services, therapies and community nursing)
- Urgent and emergency community care services (home visiting)
- Community nursing - adults
- Community therapy - adults
- Community specialist services e.g. dietetics, therapy, respiratory
- Community dental care services
- Podiatry
- Health improvement services
- Quality and directorate management teams

North City Hub update

Murray House, Jordan Hill Business Park

Oxford Health NHS Foundation Trust

- Teams started to move into Murray House in sequence between 22 April and 2 May
- First patients started to be seen at clinics in Murray House from 5 May
- Outstanding snagging works being completed, including around new external storage facility, car park operation and securing the building's longer term electricity needs with energy supplier
- Hosting HOSC Working Group site visit on 11 June

Central City Hub update

East Oxford Health Centre, Manzil Way

- This building was in existence already and is the base for several Oxford Health teams
- Now that Murray House is operational, over the coming months we will be refreshing our patient demand/needs at the same time as reviewing space usage and which services need to be based there

South City Hub update

Location to be confirmed

- 63 Blackbird Leys (existing Oxford Health staff base) remains in operation
- Alternative solutions are still being scoped activelyand increasingly with system partners where longer-term development plans for south and east parts of the City are now starting to formalise
- We will be refreshing our patient demand/needs and staff travel mapping over the coming months now that Murray House is operational
- Oxford Health anticipates being able to provide an update during the Autumn of 2025

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

Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board Operating Model:

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

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report by the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) on the changes to the ICB's Operating Model.

2. The Committee would like to thank Matthew Tait (BOB ICB Chief Delivery Officer) and Stephen Chandler (Oxfordshire County Council Deputy Chief Executive) for attending the meeting item on the BOB ICB Operating Model on 30 January 2025 and for answering questions from the Committee in relation to this.

3. The Committee understands that the ICB had made changes to its operating model since the summer of 2024. A significant aspect of these changes revolved around the ICB role of Director of Place for Oxfordshire. This role was to be removed, and a new role of Director of Places and Communities was created by the ICB, with a responsibility for Directing all three places of Buckinghamshire, Oxfordshire, and Berkshire West.

4. The Committee also issued a call-in request to the Secretary of State for Health and Social Care in September 2024. The outcome of this was a reluctance by the Department of Health and Social Care to invoke ministerial powers to call-in the decision, although the government urged the Council and the ICB to continue to work together and to negotiate a resolution to the dispute over the ICB's changes to its Operating Model.

5. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole. When commissioning the report for this item on the ICB Operating Model, some of the insights that the Committee sought to receive were as follows:

   - The current state of affairs around negotiations between the County Council and the ICB.

   - How the ICB will continue to work with Oxfordshire County Council to ensure that health and care services operate optimally.

- Details of any delegated budgets that will be retained at place level.

- Any details on the Urgent Care Director for Oxfordshire, including on whether this role will continue to operate as usual.

- Given that the ICB will merge the place director roles into a single role of Director of Places, and that the ICB had expressed that it is supportive of initiatives taken by Oxfordshire to establish a Place convenor role if its own, how will this role be supported if it is not hosted formally by the ICB?

- Clarity around the nature and extent of the ICB's Oxfordshire Executive Sponsor's role and responsibilities.

SUMMARY

6. The BOB ICB Chief Delivery Officer provided the Committee with a brief summary of the updated operating model. The Urgent Care Director role for Oxfordshire would focus on addressing local needs based on feedback the ICB received during its consultation period in the summer of 2024. As the Executive Sponsor for Oxfordshire, the Chief Delivery Officer would attend key meetings, engage with stakeholders, and represent Oxfordshire at the ICB board to address local issues. The Chief Delivery Officer would also participate in the Health and Wellbeing Board and Place-Based Partnership Boards, acting as the main representative for scrutiny Committees and involving experts when necessary. They were to act as a key decision-maker for joint decisions between the ICB and local structures, particularly in joint commissioning.

7. Efforts were being made to establish a place convener for Oxfordshire with the Oxfordshire County Council Executive Director for People. The joint commissioning model supported by a section 75 agreement remained unchanged, with budgetary decisions staying the same.

8. The Oxfordshire County Council Executive Director for People highlighted that a strong partnership with the BOB ICB Chief Delivery Officer was being built, and referred to their collaboration in managing organisational tensions effectively. The solid section 75 agreement as well as the Joint Commissioning Unit were cited as critical factors in mitigating the risks of organisational changes. Both organisations were committed to fulfilling the recommendations set by the Committee last summer, making substantial progress in addressing feedback and realigning their relationship with a clear future vision.

9. The discussion also emphasised the importance of commissioning at the system level to be evidence-based, and for the ICB to continue to engage with Oxfordshire County Council as a key partner to ensure this was the case.

10. The discussion also highlighted the imperative to expand primary care services in response to increased demand in Oxfordshire Place. The

Committee was assured that the new Executive Sponsor for Oxfordshire would play a crucial part in understanding and prioritising primary care issues, mobilising resources, and ensuring the model's effective operation in Oxfordshire. It was emphasised that investment in primary care estates was a key priority, especially given the urgency driven by new housing developments.

11. Another crucial point discussed revolved around establishing a Place convener for Oxfordshire, including whether the ICB supported this initiative and if it was committed to sharing its data, and what role the ICB played in making this position effective. The ICB endorsed the establishment of a place convener for Oxfordshire and was committed to supporting and integrating this role effectively within its operations. The place convener was to be provided with necessary data, resources, and intelligence by the ICB to ensure coordination and informed decision-making.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

12. This section highlights some key observations and points that the Committee has in relation to the BOB ICB Operating Model. These key points of observation were also expressed during the formal meeting on 30 January, and have been used to determine the recommendation being made by the Committee which is outlined below:

13. It is worth noting that during the meeting on 30 January, the Committee agreed on the urgent need for the ICB to:

    a. Engage in ongoing negotiations with Oxfordshire County Council to ensure that the ICB's operating model supports effective commissioning and delivery of health and social care services at Place.

    b. Ensure that delegated budgets relevant to Oxfordshire Place were retained at Place.

    c. Support the continued existence of the role of Urgent Care Director for Oxfordshire.

    d. Support the initiative to establish a Place Convenor for Oxfordshire, and for the ICB to clarify how it will be supportive of this role despite it not formally hosting this.

    e. Clarify the nature and extent of the ICB Oxfordshire Executive Sponsor's role and responsibilities.

    f. Clarify the role of associate directors for place.

14. Effective engagement by the ICB with key partners/stakeholders at Oxfordshire Place is crucial for the purposes of building confidence in the ICB

and enhancing trust. The Oxfordshire Joint Health Overview Scrutiny Committee as well as the Oxfordshire Place-Based Partnership expressed, on 02 August 2024, concerns with the nature of the engagement embarked upon by the ICB as part of communicating the changes to its Operating Model to its key partners. The Committee therefore urges that engagement is crucial for reasons outlined below.

***Assurances of commitments to strengthening Place**:* The ICB outlined that it would like to strengthen and enhance its place role and its partnership with the view of improving the health and wellbeing of Oxfordshire residents. However, the replacement of the three place directors with a single director across the entire BOB geography could come across as diminishing this place role and as hindering the overall ambition of the ICB. It is therefore crucial that the ICB engages with its key partners, including Oxfordshire County Council, to provide assurances by way of explaining how the ICB will continue its commitments and capacity for its Place-based work in a manner that is not jeopardised by the merger of the Place Director role into a Director of all three places in the BOB geography. The Committee raised concerns regarding the centralisation of Place directorship and the impact it could have on relationships at Oxfordshire Place and on ongoing projects being supported by the ICB at place-level. The ICB should thoroughly engage with the Committee as well as key stakeholder organisations in Oxfordshire (including the County Council, Oxford Health NHS Foundation Trust, and Oxford University Hospitals NHS Foundation Trust) to provide reassurances on the extent of the ICB's commitments toward as well as its capabilities to support ongoing improvements to healthcare services at place.

Specificities of Oxfordshire Place: Although major public health challenges and structural drivers for health inequalities remain largely the same in all 3 places across the BOB footprint, the solutions for these challenges are often systematically different and require ownership across the communities in their local authority areas, taking their specific demographics, insights and needs into account. Oxfordshire has its unique experiences and challenges with regard to health and wellbeing (one aspect being the rural nature of many parts of the County). Engagement with key stakeholders in Oxfordshire place, including Healthwatch Oxfordshire, would be crucial to determine:

1. What some of the key health challenges are in Oxfordshire.

2. How the ICB can explore ways to use its expertise and resources to support collaborative efforts to address these challenges.

The Oxfordshire place director previously played a key role in understanding and determining these place-based dynamics in depth, and would progress important partnership initiatives across place in a way that was supportive of as well as appropriate to local communities. Indeed, the Committee firmly places this expectation on what a Place

Director should be involved in. It is therefore pivotal that the ICB continues to engage with local stakeholders to help continue the progression of this work and to avert the prospect of any shortfalls in this regard as a result of the removal of the Oxfordshire Place Director post.

ICB involvement in Health & Wellbeing Strategy: The Oxfordshire Health and Wellbeing Board brings together all key partners to agree on and deliver the Health and Wellbeing Strategy. The Board is at the heart of fostering collaborative work at Oxfordshire place to help set the overall direction of travel for improving health and wellbeing of all the County's residents. It holds all partners to account to properly resource to deliver against these agreed priorities. The NHS is a key partner in this important partnership, and often the clinical lead from place assumes the vice chair role. As such, the ICB should continue to closely engage with Oxfordshire County Council and other place-based partners who sit on the Board for two reasons:

1. To provide assurances that the ICB will continue to be represented and engaged with the Board as effectively as had been the case in the past.

2. To continue to actively contribute toward the development of the Strategy, its delivery, and the monitoring and evaluation of its effectiveness through the strategy's outcomes frameworks.

Democratic oversight, transparency, and accountability: It is vital that there is more, and not less accountability and transparency in the way that the NHS operates. Under the previous operating mode, the ICB Director of Place would attend all Health Scrutiny meetings and would actively answer questions from the Committee on behalf of the ICB and key NHS providers. The Place Director would often act as a first point of contact between the Joint Health Overview Scrutiny Committee and the ICB/NHS, facilitating the process of democratic oversight and accountability through assisting in the process of commissioning reports and attendances at public Committee meetings. The Committee requests that the ICB continues to commit to this form of active engagement. This would also help to build trust and confidence in the ICB by the Committee.

Abolition of NHSE & further ICB budget cuts: The recent announcement by the government to abolish NHS England and to integrate it into the Department of Health and Social Care (DHSC), as well as the announcement of further budget cuts of 50 percent to ICB running costs, has elicited further anxieties both nationally and locally. The prospect of ICBs losing their provider oversight roles inevitably raises further uncertainties. Further clarity is required as to the implications of these rapid developments on commissioning arrangements at place, including the degree to which joint commissioning arrangements between the County Council and the ICB

could be impacted with further cuts being made to the ICB's running costs and the potential further centralisation of commissioning toward the national level. Again, in the context of such developments, the ICB should engage with and work with its system partners (primarily Oxfordshire County Council) to provide reassurances where it can as to how any prospect of a dilution of Place could be averted.

RECOMMENDATION:

15. The observations above have shaped the recommendation issued by the Committee to the ICB outlined below:

For the ICB's Executive Sponsor for Oxfordshire and the Director for Places and Communities to meet with the HOSC chair and Health Scrutiny Officer, as well as to meet with local MPs (as part of the national offer for facilitation), to initiate proper engagement with Oxfordshire Place. It is recommended that clear indicators are developed which demonstrate the levels of engagement being undertaken between the ICB and key stakeholders in Oxfordshire Place.

Legal Implications

16. 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.

17. 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'.

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

Annex 1 – Scrutiny Response Pro Forma

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April 2025

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

Health and Wellbeing Strategy Outcomes Framework:

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

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report by the Director of Public Health on the Health and Wellbeing Strategy for Oxfordshire during its meeting on 30 January 2025.

2. The Committee would like to thank the Leader Cllr Liz Leffman; Ansaf Azhar (Director of Public Health, Oxfordshire County Council); David Munday (former Deputy Director of Public Health); and Daniel Leveson (Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB] Director of Places and Communities); for attending and answering questions in relation to the report.

3. The Committee would like to express that it recognises the immense work being invested into delivering the Health and Wellbeing Strategy, and thanks system partners for their overall contributions to this work. The Committee also supports the initiatives by system partners to monitor and evaluate the progress made in delivering the strategy's priorities.

4. The Committee understands that the strategy is being evaluating through an outcomes framework, and that outcomes are being gradually measured, with some priorities still not yet having been evaluated.

5. This report was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole. When commissioning this report on the health and wellbeing strategy outcomes framework, some of the insights that the Committee sought to receive were as follows:

   - The extent to which continuous engagement with stakeholders is at the heart of the work on delivering the strategy.

   - Whether there is any new information on relevant public health patterns that would be used to inform any changes/updates to the strategy.

   - How effective system level partnership working has been around coordinating and implementing the Health and Wellbeing Strategy thus far.

- How marginalised, disadvantaged, or deprived communities are being targeted and supported with their health and wellbeing.

- Details of any criteria or KPIs that are being adopted to assess the effectiveness of the strategy's delivery.

SUMMARY

6. The purpose of this item held on the 30 January 2025, was to receive an update on the Health and Wellbeing Strategy for Oxfordshire. The Committee last reviewed the strategy and its updated aims and objectives in September 2023. However, this particular item focused on the deliverability of the strategy and how system partners are working collectively to implement its priorities.

7. It has been brought to the Committee's attention that there is an outcomes framework for monitoring the strategy's implementation, and the Committee was keen to understand how this works and how far Oxfordshire's system partners have come in delivering the strategy.

8. The Leader of the Council explained that the strategy emphasised health prevention, and highlighted the importance of collaboration with district councils and health partners for better outcomes. By March 2023, the outcomes framework was approved, and ongoing progress reviews were initiated. At each Health and Wellbeing Board meeting, specific priorities were reviewed to ensure effective changes.

9. The Deputy Director of Public Health explained that the strategy represented a system-wide effort involving multiple partnerships and detailed the outcomes framework, including shared outcomes, key activities, and indicators. The Committee were informed that three priorities had been reviewed thus far, with additional priorities to be addressed in future meetings. The 10 Health and Wellbeing Strategy priorities, derived from the Joint Strategic Needs Assessment, reflected Oxfordshire's population needs and were collaboratively agreed upon, focusing on short- to medium-term progress indicators to achieve long-term goals.

10. The Committee inquired as to the communications work around the strategy, stressing the importance of including key stakeholders as well as the wider public as part of coproducing the strategy's ongoing development and delivery. It was also emphasised that some aspects of achieving the strategy's goals would involve the need for residents to make active lifestyle choices on their own accord and to adopt certain living habits through taking their own initiative. The Committee therefore urged officers to take this into account when delivering and evaluating the strategy.

11. A key aspect of the discussion revolved around the imperative to address health inequalities, particularly given that this represents one of the priority areas for the strategy. It was agreed that the launch of Oxfordshire as a Marmot Place would help to achieve this.

12. The discussion also addressed the start well aspect of the strategy, which focused on improving the health and wellbeing of children and young people. The Committee emphasised the importance of school readiness amongst children and the need to ensure children are both healthy and socially ready to start school. It was also highlighted that children in rural areas struggle to access early support services.

13. Regarding the government's devolution plans, the Committee urged system partners to minimise any potential negative impacts of devolution on delivering the strategy, and stressed the need to maintain legacies and expertise from district councils.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

14. This section highlights two key observations and points that the Committee has in relation to the Health and Wellbeing Strategy and its delivery. These key points of observation were also expressed during the formal meeting on 30 January, and have been used to determine the recommendations being made by the Committee which are outlined below:

Sustainable funding for early years readiness for school: The early years of a child's life are critical for their development and future success. Ensuring that children are ready for school is not only beneficial for their academic achievement but also for their social and emotional well-being. Sustainable funding for early years readiness programs is essential to provide all children with the opportunities they need to thrive.

Early years readiness for school encompasses a range of skills and abilities that children need to succeed in a formal educational setting. These include cognitive skills, such as language and literacy, as well as social and emotional skills, such as self-regulation and cooperation. Research has shown that children who enter school with a strong foundation in these areas are more likely to perform well academically and have better long-term outcomes. In a 2019 study published in the Journal of *Contemporary Issues in Early Childhood*, it was found that children who receive strong foundational support and skills not only perform well academically, but that they also feel a sense of being part of a wider system and society[1]. In another 2011 study published by the *Institute of Labour Economics,* it was argued that it was this very sense of feeling part of a wider system that enabled children to better cope psychologically and cognitively with the transition into school life and full-time academic learning in a school setting[2].

[1] School readiness, governance and early years ability grouping - Guy Roberts-Holmes, 2021
[2] Inequality during the early years: Child outcomes and readiness to learn in Australia, Canada, United Kingdom, and United States

Upon commissioning this item, the Committee was concerned regarding children not being adequately prepared to start school. It has been reported to the Committee that there were challenges with early years readiness for schooling in Oxfordshire. Some of the concerns the Committee had revolved around issues such as children lacking social skills, or not being sufficiently toilet trained, particularly due to insufficient family services in rural areas. The Committee was therefore pleased to hear the commitment to allocate over £1,000,00 in support of early years.

As part of this, the Committee urges that there is a strong focus on identifying and assisting children who require help early on. This would avoid scenarios of belatedly identifying children and then having to unrealistically prepare them for schooling within short timeframes. It is vital that children are assessed ideally by the age of 2 onwards for school readiness. The Committee urges that the public health team continues to allocate funding to help ensure that children were systematically assessed at ages 2 1/2 and 4 for school readiness.

It has been brought to the Committee's attention that an early years strategy and a new board were formed to provide services and support for early years school readiness. Whilst this represents a positive development, the Committee recommends that clear Key Performance Indicators are developed which can help determine the extent to which early years readiness support is being effectively delivered, monitored, and evaluated.

Furthermore, there are also health inequalities implications. Oxfordshire is now a Marmot Place, and in line with Marmot principles, it should be the Council and its partner's priority to provide each child with the best start in life by addressing inequalities in deprived areas and understanding holistic needs across the county.

Moreover, social and emotional development is equally important for school readiness. Children who can manage their emotions, follow instructions, and work well with others are better equipped to navigate the school environment. Early childhood programs that foster these skills help children develop the resilience and confidence they need to succeed. In a 2017 study published by the *Journal of Early Years Education*, it was found that children who receive early years support are more inclined to better cope with the structured nature of school environments. Such early years support can also therefore prove beneficial for children with Special Educational Needs and Disabilities (SEND).

Therefore, on the basis of the above, securing sustainable funding should remain a priority for system partners in Oxfordshire. Many programs may rely on inconsistent and short-term funding sources, which can lead to disruptions in services and limit their effectiveness.

Recommendation 1: *To support sustainable funding in the Oxfordshire County Council budget for early years readiness for school.*

Keeping rural areas at the heart of the strategy: The Committee is pleased to see that the strategy has been updated as well as being gradually evaluated for its effectiveness. The effectiveness of the strategy can only be determined through a robust process of regular monitoring by all system partners. Transparency is a key aspect of such monitoring and evaluation, both between system partners as well as amongst the wider public.

In order for the Health & Wellbeing Strategy to be as inclusive and holistic as it is setting out to be, it is essential that rural geographies in Oxfordshire are given due consideration and are placed at the core of its design and implementation. System partners should adopt an approach that acknowledges the unique challenges and opportunities faced by rural communities and ensures that their health and wellbeing are prioritised alongside urban areas.

Rural areas in Oxfordshire often face distinct health challenges compared to their urban counterparts. The fact that Oxfordshire is becoming Marmot Place is promising in that Marmot principles include commitments to tackle health inequalities in both rural and urban areas. Indeed, Oxfordshire is a two-tier council with five districts with an amalgam of city, town and rural areas. According to a February 2025 report published by the *Local Government Association*, Oxfordshire faces distinct challenges such as rural isolation, including older people with significant assets who are living alone and isolated from their communities, alongside significantly deprived households in pockets of deprivation that can be hard to detect[3]. For instance, the assumption that affluency translates into better health outcomes is not entirely accurate in rural parts of Oxfordshire, where some elderly residents live alone with limited ability to access support or services.

Furthermore, the role of academic research should not be underestimated in its ability to identify some of the key challenges associated with living in rural parts of Oxfordshire. The Committee is pleased that the council had formed an alliance with Oxford and Oxford Brookes universities to better understand local public health patterns and trends, but urges that specific research collaboration with both universities is embarked on to identify what some of the key health challenges are for rural communities and to develop workstreams and programmes accordingly.

Exemplars where an existing work programme had started to start tackle health inequalities in a rural area is the OX12 programme and the programme of work that came to the Committee in January 2024. The Wantage project report submitted to the Committee referenced one of

[3] Oxfordshire County Council: tackling hidden inequalities | Local Government Association

the highest rates of population growth (not matched by infrastructure) as well as an increasingly ageing population. Unlike city populations where there is more complex need in young and old, there are additional challenges including isolation, transport, and wider impacts. The work to bring hospital services to the community and to start a community bus service is an exemplar project of working with a health committee of a rural Town Council which could serve as a rural pilot to evaluate rural inequality.

In addition, in a July 2023 project commissioned by *Healthwatch Oxfordshire*, it was found that some rural residents in Oxfordshire reported numerous challenges including poor pavements and roads, the need to improve footpaths, speeding and road safety, poor bus services, problems in getting to healthcare appointments, and no GP surgery, chemist, or dentist in the community[4]. It is pivotal that the Health and Wellbeing strategy's holistic nature includes a commitment by system partners to address some of these challenges.

Moreover, another challenge associated with rural areas in the County revolves around workforce shortages. The Committee is aware of the national context of workforce shortages which are not unique to Oxfordshire. In Oxfordshire's context, it has been reported to the Committee that workforce shortages have affected the capacity of services for rural residents. This is partly attributed to a reluctance of some workers who reside in urban areas to relocate to or to work in rural locations. Such workforce challenges are not as prevalent in Oxford City in that many healthcare workers in the City commute from other urban areas including London. The Health and Wellbeing Strategy should therefore include commitments to address workforce challenges for rural areas inasmuch as possible. Regular reporting should be practiced by all system partners around initiatives they are taking to address workforce shortages that affect rural localities throughout the County.

Recommendation 2: *To ensure that rural geographies in Oxfordshire are also at the heart of implementing the priorities and actions of the Health & Wellbeing Strategy.*

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.

[4] Health and wellbeing in Ambrosden, Arncott, Blackthorn and Piddington – a summary - Healthwatch Oxfordshire

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

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April 2025

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

Support for People Leaving Hospital

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to: Karen Fuller (Director Adult Social Care)
Hannah Berry (Home First System Lead)
Sally Steele (Head of Service – Hospitals)
Tamsin Cater (Head of Transfer of Care Hub)
(As representative of the Health and Social Care System)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report by the Director for Adult Social Care on the support being provided for people who leave hospital.

2. The Committee would like to thank Matthew Tait (BOB ICB Chief Delivery Officer); Hannah Berry (Home First System Lead); Sally Steele (Head of Service – Hospitals); Tamsin Cater (Head of Transfer of Care (TOC) Hub); and Karen Fuller (Director Adult Social Care, Oxfordshire County Council) for attending the meeting item on the support for patients discharged from hospital on 30 January 2025 and for answering questions from the Committee in relation to this.

3. The Committee received a report on this item 12 months ago on 16 January 2024, and was keen to receive an update on the collective work by system partners around the Discharge-to-Assess (D2A) process and on the extent to which patients leaving hospital are provided with as adequate support as possible when returning home.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the support that patients could expect to receive after leaving hospital. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

   - An overall update on the current state of affairs around D2A and in providing support for people leaving hospital (including support in people's homes).

   - An update on any progress made on implementing the HOSC recommendations issued to system partners when this item last came to the Committee in January 2024.

- How system partners perceive the outcome of the recent Healthwatch Oxfordshire project on discharged patients, and any actions being taken to address the recommendations issued by Healthwatch Oxfordshire around supporting people who leave hospital.
- Details of any challenges system partners may be facing around providing support to discharged patients.

SUMMARY

5. During the meeting on 30 January, the Director of Adult Social Care emphasised the collaborative approach and ongoing improvements in performance and reablement outcomes. They also mentioned the positive work undertaken in partnership with Healthwatch.

6. It was explained to the Committee that since January 2024, Oxfordshire's Home First Discharge to Assess (D2A) service had significantly improved hospital discharge performance, reducing the average length of stay and increasing patient support. Despite higher demand and funding challenges, many patients were gaining independence through reablement pathways, with more referrals from community settings.

7. A key aspect of the discussion revolved around the suitability of a discharged patient's home environment. It was conveyed to the Committee that during the 72-hour assessment delay, known home environment issues were discussed prior to discharge, and a care provider assessed the home on the day of discharge to flag any rehabilitation challenges.

8. The Committee sought information on the equality of the rollout of services across Oxfordshire, focusing on staffing levels in urban and rural areas. It was explained that the rollout had been planned using demand and capacity modelling, which considered the geography and specific needs of different areas

9. Another aspect discussed was the sustainability of funding for additional discharge services given the financial pressures, and how the system planned to manage this in the future. The Director of Adult Social Care and the Commissioning Manager explained that the success of the discharge services had increased the need for more funding in community services. They were discussing fund allocation within the system to support these services and were utilising the Better Care Fund (BCF) planning process to align different funding streams to maximise resources.

10. Steps were discussed to investigate and understand the causes behind hospital readmissions and the measures implemented to reduce this. The Director of Adult Social Care and the Head of Service explained that reducing readmissions was a priority, focusing on providing comprehensive care for individuals with long-term conditions to prevent acute flare-ups and hospital readmissions. They utilised integrated neighbourhood teams and primary care resources to understand individual needs and baselines

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

11. This section highlights 2 key observations and points that the Committee has in relation to supporting people discharged from hospital. These 2 key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Data sharing to determine causes of non-elective admissions: The Committee is pleased to hear that reducing readmissions was a priority for system partners in Oxfordshire. Indeed, the focus should be on delivering all-rounded and personalised care for patients suffering with long-term conditions. This would help avert the likelihood of patients being abruptly or frequently readmitted to hospital. The Oxfordshire Way emphasises prioritising care in people's homes, and support in people's homes can only be safe, effective, and sustainable if patients are supported in ways that prevent them from developing abrupt flare ups in their condition.

The ability to share data effectively across the system is crucial in understanding the causes of non-elective hospital admissions. Non-elective admissions, often sudden and unplanned, can be challenging to manage and predict. By enhancing data sharing practices and building strong relationships amongst system partners, the system can offer better care and possibly reduce the frequency of these admissions. According to a 2016 study published in the *Medical Research Methodology Journal,* it was found that on an individual patient-level, understanding the causes of non-elective admissions and preventing these involved the need to share data across all relevant health and care providers that a patient would have been in contact with, only then will a comprehensive all-rounded understanding of a patient's condition and health tendencies be achieved[1].

Moreover, on a broader structural-level, data sharing between Oxfordshire's system partners would enable health and care professionals to analyse patterns and identify potential causes of non-elective admissions amongst the County's population. This data can include medical histories, demographic information, and previous hospital visits, which can be aggregated and examined to uncover trends and risk factors.

Some of the benefits of data sharing amongst system partners include:

- Improved Patient Care: Access to complete patient data helps doctors and nurses make informed decisions quickly, enhancing the quality of care.

[1] Comparison of predictive modeling approaches for 30-day all-cause non-elective readmission risk | BMC Medical Research Methodology

- Predictive Analytics: By examining shared data, healthcare professionals can identify patients at risk of non-elective admissions and take preventative measures.

- Efficient Resource Management: Understanding the causes of non-elective admissions can help the NHS and the County Council to allocate resources more effectively, ensuring patients receive the care they need without undue delays.

Therefore, strong relationships and collaboration across the healthcare system are essential for successful data sharing, which would have a knock-on effect not only in reducing non-elective admissions but also in improving patient outcomes overall. The role of prevention is also important in this regard, and can help to reduce health inequalities by supporting those patients and residents who are the most vulnerable.

In terms of the practicalities of how data sharing could be maximised amongst system partners, there are two ways to achieve this. Firstly, system partners should hold regular meetings to discuss data sharing practices and challenges to help foster a collaborative environment and stronger understandings of trends in non-elective admissions. Secondly, system partners should identify common goals and objectives related to patient care and data sharing. This could further unify efforts and encourage cooperation.

Recommendation 1: *To support data sharing across the whole system to help to understand the causes of non-elective admissions into hospital. It is recommended that there is good relationship building across the system to support this.*

Funding/resources for Integrated Neighbourhood Teams: The Committee previously examined the role of Integrated Neighbourhood Teams (INTs) in previous HOSC public meetings, and remains supportive of the role of these teams. These teams can provide a strong network support base for patients who are discharged from hospital. INTs are vital components in the delivery of effective community-based health care. A key benefit of INTs lies in the presence of multidisciplinary professionals working collaboratively to provide holistic care to local communities. According to a 2025 study by the *Health Equity Evidence Centre*, Health inequalities are forecasted to increase over the next two decades and for people living in the poorest areas of the country, and that INTs are at the forefront of initiating work to tackle inequalities on a local level by providing integrated and multidisciplinary care for residents in their communities[2].

INTs should aim to provide seamless care by integrating services that address the physical, mental, and social well-being of residents throughout Oxfordshire, and particularly in rural localities where residents may experience difficulties accessing services or where health

[2] Integrated-neighbourhood-teams.pdf

personnel and infrastructure do not have a particularly heavy presence relative to urban areas. These teams should include general practitioners, nurses, social workers, mental health professionals, and other specialists who can collaborate to offer comprehensive care plans tailored to the individual needs of discharged patients throughout Oxfordshire. By working in neighbourhoods, these teams should ensure that care is accessible and responsive, reducing the strain on hospital services and promoting preventive health measures also.

For INTs to function effectively and for their potential to be maximised, sufficient funding and resources are paramount. Proper funding is crucial for the sustainability and effectiveness of INTs. Adequate financial support could enable these teams to:

- Recruit and retain skilled professionals.
- Invest in necessary equipment.
- Provide ongoing training and development for staff.
- Facilitate communication and coordination between different services.
- Expand services to meet growing demand for healthcare services and community needs.

Ensuring such teams are sufficiently resourced would involve the need to assess the demand for services that provide support for patients discharged from hospital. This would form a crucial part of the system being able to assess the degree to which individual neighbourhood teams should be resourced. System partners should also work toward securing additional local or national funding for such teams if necessary.

Ensuring the availability of a skilled workforce is crucial for maximizing support for discharged patients in both urban and rural areas across Oxfordshire. The Committee is calling for a thorough assessment of the current workforce for supporting discharged patients. This is essential to identify gaps and areas requiring immediate attention where they may be shortages of professionals. Therefore, system partners should evaluate the number of healthcare professionals, their distribution, and the services they provide.

In urban areas (including Oxford City), the focus should be on ensuring there are adequate numbers of healthcare professionals to cater to the higher population density and diverse patient needs. In rural areas, as one 2020 study in the *International Journal of Environmental Research and Public Health* outlines, the aim should be to address the challenges of geographical dispersion and limited resources, ensuring that patients receive consistent and high-quality care[3].

[3] The Whole-of-Person Retention Improvement Framework: A Guide for Addressing Health Workforce Challenges in the Rural Context

Recommendation 2: *To continue to support sufficient funding and resource for integrated neighbourhood teams. It is recommended that measures are taken to ensure workforce availability to maximise support for discharged patients in both urban and rural areas across Oxfordshire.*

Legal Implications

12. 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.

13. 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'.

14. 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.

15. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – in the Chair
District Councillor Katharine Keats-Rohan (Deputy Chair)
Councillor Yvonne Constance OBE
Councillor Jenny Hannaby
Councillor Michael O'Connor
Councillor Freddie van Mierlo
Councillor Mark Lygo
District Councillor Paul Barrow
District Councillor Elizabeth Poskitt
District Councillor Susanna Pressel
District Councillor Dorothy Walker

Annex 1 – Scrutiny Response Pro Forma

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April 2025

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

Oxford Health NHS Foundation Trust People Plan:

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

REPORT TO: Oxford Health NHS Foundation Trust

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report by the Oxford Health NHS Foundation Trust (OH) Chief People Officer on the Trust's People Plan in its public meeting on 30 January 2025.

2. The Committee would like to thank Charmaine DeSouza (Chief People Officer, Oxford Health NHS Foundation Trust); Zoe Moorhouse (Head of HR, Oxford Health NHSFT); and Amelie Bages (Executive Director of Strategy and Partnerships, Oxford Health NHSFT) for attending the meeting on 30 January and for answering questions from the Committee on the OH People Plan.

3. The Committee received a report on the Oxford University Hospitals NHS Foundation Trust People Plan in April 2024, and was keen to receive an update on the Oxford Health People Plan to examine the measures taken by the Trust to improve workforce recruitment, retention, and staff wellbeing.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by NHS providers to enhance recruitment, retention, and wellbeing of staff. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

    - How the NHS People plan had shaped the direction of the Oxford Health NHS Foundation Trust People Plan.
    - What the overall objectives of the People Plan are.
    - How the plan was formulated (and whether this included engagement with stakeholders).
    - How the Trust's workforce will be recruited and retained.
    - How the wellbeing of staff will be supported and maintained.
    - Whether there is any public communications work around the plan.
    - The extent to which there is sufficient resource to implement the plan.

- Any evidence of how effectively the plan has been delivered thus far.

SUMMARY

5. During the 30 January 2025 meeting, the Chief People Officer presented the People Plan's development, emphasising its alignment with the Trust's broader objectives. The Head of HR overviewed workforce demographics, noting 80% female employees, 25% from a BAME background, and 7.4% with declared disabilities. It was also highlighted that there is extensive collaboration with universities for recruitment purposes. The Executive Director of Strategy and Partnerships explained the strategic context, explaining that the NHS long-term workforce plan strongly influenced the development and objectives of the OH People Plan.

6. The issue of workforce recruitment and retention was raised by the Committee, and the Trust explained that it was enhancing workforce planning, recruitment, and retention to support service delivery. They focused on ensuring a well-planned and stable workforce to maintain the quality and availability of their services.

7. The Committee inquired about how Oxford Health NHSFT supported continuous professional development (CPD) for clinical and administrative staff. For clinical staff, the Trust provided CPD through a well-established education centre and collaborated with Oxford Brookes University for postgraduate and master's modules for nurses. They also offered apprenticeship schemes allowing staff to pursue further education, including leadership and management apprenticeships.

8. The issue of support for staff wellbeing and mental health compared to other NHS Trusts was also discussed. The Executive Director of Strategy and Partnerships explained that the trust had provided a 24/7 Employee Assistance Programme (EAP) and a robust occupational health service that was available for self-referrals or manager referrals. Health and wellbeing representatives in all teams offered proactive support.

9. The Committee raised concerns regarding reliance on agency staff and how well integrated such staff were in Trust teams. It was explained that the Trust had heavily relied on agency staff but aimed to reduce this by promoting permanent or bank roles. In the previous year, approximately 100 agency staff transitioned to permanent or bank positions. To ensure patient care, agency staff were integrated into teams and provided with continuous professional development. This was done to uphold Trust principles and maintain the quality of patient care.

10. The discussion also emphasised technology's role in improving workforce efficiency, and how digitalisation could impact patient care and interaction. The Trust explained that integrated systems streamlined administrative tasks, enhancing staff satisfaction and efficiency by simplifying processes. It was discussed that there should be caution when implementing AI (Artificial Intelligence), ensuring that any AI applications were piloted within a defined

framework to avoid compromising safety or quality. In terms of patient interaction, the Trust was aware of digital exclusion and ensured that digital tools were integrated with face-to-face services to maintain accessibility for all patients.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

11. This section highlights four key observations and points that the Committee has in relation to the Oxford Health NHS Foundation Trust People Plan. These four key points of observation have been used to determine the recommendations being made by the Committee which are outlined below. It is important to note that the Trust may somewhat be implementing the substance of the recommendations being issued by the Committee, although the Committee had not received as much information as to the extent to which this is the case. The Trust will be provided with an opportunity to respond to these recommendations with further evidence as to how they are being implemented.

Reliance on agency staff: The Committee was pleased to hear that agency staff were integrated into teams and provided with continuous professional development by the Trust. This would help to ensure that agency staff are working in accordance to the principles that the Trust stands for, and would help create consistency in the quality of clinical care that patient receive. Nonetheless, the focus should be on reducing reliance on agency staff in general. Having said that, the Committee does recognise that agency staff would be required for a variety of reasons and circumstances which are unavoidable. However, it is inevitable that excessive dependence on agency staff can lead to inconsistencies in the quality of care provided. To mitigate this issue, it is crucial to work toward reducing reliance on agency staff and ensuring that the care they provide meets the standards of the Trust.

In one 2009 study published in the *International Journal of Nursing Studies*, it was found that reducing reliance on agency staff involves a multi-faceted approach; focusing on recruitment, retention, and efficient workforce planning[1]. This three-pronged model could potentially be utilised by the Trust to achieve reduced reliance on agency staff:

- *Robust recruitment practices:* The Trust could implement effective recruitment strategies to help attract permanent staff. This includes offering competitive salaries, robust benefits packages, and opportunities for career advancement. Partnering with educational institutions to offer internships and placements can also create a pipeline of potential permanent employees.

[1] A review of workload measures: A context for a new staffing methodology in Western Australia - ScienceDirect

- *Enhancing Employee Retention*: Retention programs are vital in maintaining a stable workforce. Regular professional development, recognition programs, and supportive management can improve job satisfaction and reduce turnover. The Trust should also continue to enhance employee well-being initiatives, such as flexible working hours and stress management programs, which could also contribute to higher retention rates amongst clinical or administrative staff.

- *Effective workforce planning:* Strategic workforce planning by the Trust is also essential in predicting and managing staff shortages. Utilising data analytics can help in forecasting staffing needs and planning accordingly. Developing a flexible staffing model that includes part-time and temporary staff could also be conducive toward reducing the need for agency staff.

While working to reduce reliance on agency staff, it is equally important that the Trust takes specific steps to ensure that the quality of care they provide is up to standard. This could potentially be achieved in three ways. Firstly, agency staff should undergo thorough orientation programs to familiarise them with the Trust's policies, procedures, as well as its culture. This helps in aligning them with the Trust's standards and its expectations of its clinical and administrative staff. Secondly, ongoing training and regular evaluations are crucial in maintaining high standards of care. Agency staff should have access to the same training opportunities as permanent staff. Regular performance reviews or even potential feedback sessions can help identify areas for improvement and ensure consistent quality of clinical care. Thirdly, the Trust should establish clear communication channels between agency staff, permanent staff, and management. This would ensure that agency staff are well-informed and integrated into the team, promoting a cohesive working environment.

Recommendation 1: *To work toward reducing reliance on agency staff where possible. It is recommended that processes are in place to ensure that the quality of care provided by agency staff is appropriate and up to standard so as to ensure consistency in the quality of care for patients.*

Supporting a positive work environment for staff: The Committee firmly believes in the importance of supporting the wellbeing of healthcare staff. Particularly given the pressures they could face in the work environment in the context of a nationally stretched health service. It is commendable that the Trust provides a 24/7 Employee Assistance Programme as well as an occupational health service that staff or their managers could refer them to. The fact that the Trust has health and wellbeing representatives in all its teams is also a positive development.

A positive and supportive work environment is essential for the well-being and productivity of the Trust's employees. It would not only enhance job satisfaction but also fosters a sense of belonging and loyalty towards the

Trust. An important aspect of creating such an environment is to ensure that staff can also easily make complaints or express legitimate grievances.

Encouraging open communication is the cornerstone of a supportive work environment. The Trust's employees should feel comfortable sharing their thoughts, ideas, and concerns without fear of any negative consequences. This can be achieved by; establishing regular team meetings and one-on-one check-ins; creating an open-door policy where employees can approach managers at any time; or even using anonymous suggestion boxes or digital platforms for anonymous feedback.

Acknowledging and celebrating employee achievements can also significantly boost the morale and motivation of Trust staff. This could be exercised in a variety of ways including monthly or quarterly awards for outstanding performance, public recognition during team meetings, or even personalised thank you notes from management.

Furthermore, investing in employee growth would indicate that the Trust appreciates the contribution of its staff and is committed to their professional development. This can be facilitated through offering training and development programs. encouraging attendance at relevant health-related conferences and seminars (in the case of clinical staff), as well as providing mentorship programs of some sort to guide career progression.

Moreover, it is crucial that the Trust's employees feel safe and supported in voicing their concerns, and that there are clear and effective processes for handling complaints and grievances. This could be achieved in the following ways:

- *Developing a clear staff complaints policy*: A clearly defined policy on complaints and grievances should be communicated to all Trust employees. This policy should outline the types of issues that can be reported, the steps involved in filing a complaint, and a potential timeline for addressing and resolving staff complaints:

- *Providing multiple reporting channels:* Employees should have access to various channels for reporting their concerns. These can include direct communication with supervisors or HR representatives or anonymous online reporting systems.

- *Ensuring confidentiality and protection*: Confidentiality is paramount in handling complaints and grievances. The Trust's employees should be assured that their concerns will be kept private and that they will be protected from any form of retaliation or negative consequences. The Trust could potentially reinforce this by clearly stating confidentiality policies in employee handbooks, training managers and HR staff on the importance of confidentiality, or

implementing strict measures to prevent retaliation against complainants.

Recommendation 2: *To create a positive and supportive work environment for staff, and to foster an environment and processes where staff can easily make complaints or express legitimate grievances.*

Harnessing the use of technology: The Committee is pleased to hear that the Trust's use of integrated systems is helping to streamline administrative tasks and that this is having a knock-on effect on enhancing staff satisfaction and efficiency. In today's fast-paced digital environment, the integration of technology into the healthcare workplace is imperative for enhancing productivity, communication, and overall efficiency. For the Trust, leveraging technological advancements is essential not only to improve the working environment for staff but also to ensure the continuity and reliability of services being provided to patients. In a 2020 study published in the Journal of *International Health,* it was found that advancements in the use of IT maximises efficiencies in a way that improves healthcare staff satisfaction and makes them feel strongly supported in their roles; and that the increased staff productivity helps improve patient experiences, satisfaction, and outcomes[2].

Technology can offer the Trust a plethora of tools that can foster seamless communication and collaboration among staff members. Staff should make as much use of platforms such as Microsoft Teams or Zoom to enable real-time messaging, video conferencing, and file sharing, as this can enhance interaction between staff in ways that creates more efficient planning for treatments for patients or for other administrative tasks.

Advancements in IT have also meant that data can be stored securely and accessed from anywhere at any time. The Trust should make use of this flexibility to not only enhance data management (including patient data) but to also ensure that critical information is protected and easily retrievable (including in cases of emergencies).

To ensure that the Trust's staff can effectively utilise new technology, continuous training and development programs should be implemented. Workshops, online courses, and hands-on training sessions can help employees to remain updated with the latest technological platforms and tools available to them.

The Trust has also recently been the subject of cyber-attacks. The Committee has routinely called on the Trust to do as much as it can to recover from such attacks. It is also vital that patient records are securely maintained and that these are not lost. According to a 2024 study published by the *National Center for Biotechnology Information*, 'the healthcare industry is the perfect cyber-attack victim because it depends

[2] ihaa007.pdf

on technology for patient care', and that this potentially places healthcare providers in a state of vulnerability[3]. It is therefore pivotal that the Trust takes every measure feasible to work with local or national partners/bodies to explore collaborative ways to reduce the occurrences of such attacks. The Trust should regularly maintain and update its IT systems to preclude outages. This could include software updates, hardware checks, and network security assessments. The Trust should also ideally schedule maintenance windows to minimise disruption. Continuous monitoring of IT systems can help with early detection of potential outages or cyber-attacks impacting the Trust. Implementing alert systems that notify the Trust's IT staff of any anomalies or failures can allow for swift responses and resolutions to any cyber threats.

The Committee remains slightly concerned regarding the utilisation of Artificial Intelligence (AI) in the NHS; as this could potentially raise issues around patient safety and safeguarding. It is therefore crucial that if the Trust is to make further use of AI (particularly for dealing with patients or maintaining records), that there are clear governance or safety processes in place so as to increase reassurances as to the appropriateness of its use. Utmost caution should be applied by the Trust if it is increasingly resorting to AI use. In a 2023 research piece published in the *British Medical Journal*, it was outlined that whilst there are clear benefits to UK-based healthcare providers maximising the potential of AI, it is important for there to be national and local processes, protocols, or procedures around the use of AI so as to reduce any potential risks to patient safety[4].

Overall, by harnessing the power of technology, the Trust can create a better and more efficient working environment for staff. Taking proactive steps to prevent IT outages and providing evidence of these efforts not only ensures the reliability of IT services but also fosters a culture of continuous improvement and innovation. Investing in technology is not just about upgrading systems; it is about empowering the workforce to increase their productivity. This can have a knock-on effect on improving patient care.

Recommendation 3: *To harness the use of technology to create a better and more efficient working environment for staff. It is also recommended that the Trust takes steps to avert the prospects of future IT outages inasmuch as possible, and to provide evidence of this.*

Campaign for an Oxford salary weighting: As part of the initiatives undertaken by the Trust to support its staff, the Committee firmly believes in the imperative for an Oxford Salary Weighting that would support healthcare workers. Indeed, the influx of talent and the city's growing economy have driven up housing costs and other living expenses, making it increasingly challenging for individuals to make ends meet on

[3] Cyber Attacks on Interoperable Electronic Health Records: A Clear and Present Danger - PMC
[4] Validation framework for the use of AI in healthcare: overview of the new British standard BS30440 - PMC

standard salaries. Healthcare workers in the City have also been increasingly feeling financial strains as a result. In order for healthcare staff to undertake their role as effectively as possible, it is vital that they are not subjected to immense stresses and strains beyond the already existing pressures they could face in undertaking their roles. The introduction of an Oxford salary weighting would serve as a crucial step towards alleviating this financial pressure.

Oxford's housing market is among the most expensive in the UK, with property prices and rental rates continuing to climb. For many workers, especially those in public sector roles such as education, healthcare, and local government, salaries have not kept pace with these rising costs. An Oxford salary weighting would help to bridge this gap, ensuring that employees can afford to live and work within the city without undue financial strain.

Providing competitive salaries that reflect the cost of living is essential for attracting and retaining talent. Oxford's reputation as a hub of academic and professional excellence should extend to the wellbeing of its workforce. By implementing a salary weighting, employers can enhance their attractiveness to potential candidates and reduce turnover rates, fostering a stable and motivated workforce. The Committee is therefore recommending that the Trust works with system partners to campaign for an Oxford salary weighting. The Committee had also issued this recommendation to Oxford University Hospitals NHS Foundation Trust last year, and is willing to provide any support it can in pursuit of this.

Recommendation 4: *To work with system partners to campaign for an Oxford salary weighting.*

Legal Implications

12. 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 n consultations.

13. 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'.

14. 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.

15. The recommendations contained in this report were agreed to by the following members of the Committee:

Councillor Jane Hanna OBE – in the Chair
District Councillor Katharine Keats-Rohan (Deputy Chair)
Councillor Yvonne Constance OBE
Councillor Jenny Hannaby
Councillor Michael O'Connor
Councillor Freddie van Mierlo
Councillor Mark Lygo
District Councillor Paul Barrow
District Councillor Elizabeth Poskitt
District Councillor Susanna Pressel
District Councillor Dorothy Walker

Annex 1 – Scrutiny Response Pro Forma

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April 2025

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

Audiology Services in Oxfordshire

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:

- Matthew Tait (Chief Delivery Officer-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Neil Flint (Associate Director of Planned Care-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Phil Gomersall (Clinical Lead, Oxford University Hospitals NHS Foundation Trust).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report providing an update on the current state of Audiology Services in Oxfordshire during its public meeting on 06 March 2025.

2. The Committee would like to thank Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB]); Neil Flint (Associate Director of Planned Care, BOB ICB); and Phil Gomersall (Clinical Lead, Oxford University Hospitals NHS Foundation Trust [OUH]); for attending the meeting on 06 March and for answering questions from the Committee in relation to Audiology services in Oxfordshire.

3. The Committee had received reports of some of the challenges experienced by patients with audiology services, and urges NHS partners to work closely toward improving these services. The Committee was also keen to gain insights into the different types of audiology services provided in both hospital as well as in the community.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by commissioners and providers to improve audiology services, particularly against a backdrop of general increases in demand for health services. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

    - Details of the geographical coverage of audiology services. Were services accessible to patients in rural and urban areas?

- Waiting periods for initial consultations, diagnostic tests, and treatment sessions; and whether there were any strategies in place to reduce these waiting times.

- How easy is it for patients to book, reschedule, or cancel appointments? What technological solutions are being utilised to streamline this process?

- How was patient satisfaction measured? What mechanisms were in place to collect and analyse patient satisfaction data, and how this feedback was used to improve audiology services?

- Details of the protocols and technologies used in diagnostics, and whether they were up-to-date and reliable.

- Details of the variety of treatments offered, and the extent to which treatment plans were comprehensive and personalised.

- Information on any new advanced technologies being utilised including modern hearing aids, implants, and other assistive devices.

- Whether there was effective follow-up care, and what protocols were in place for monitoring patient progress post-treatment?

- Whether there were adequate resources (including funding, staffing levels, equipment, and facilities) to meet patient needs.

- The level of collaboration between audiology and other medical departments, including how well they coordinated to provide holistic care for patients with comorbid conditions?

- The extent to which audiology services were coproduced?

SUMMARY

5. During the 06 March 2025 meeting, the ICB's Associate Director for Performance & Delivery of 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. The OUH Clinical Lead 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.

6. A key aspect discussed revolved around the broader engagement process related to the commissioning of audiology contracts, beyond the market engagement mentioned in the report. 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.

7. The Committee 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 were underway to enhance community providers to help ease some of the burden on secondary care.

8. The discussion also examined 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.

9. The Committee 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. 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.

10. The Committee inquired about 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 this gap, mentioning that communications regarding the service had improved, with efforts made to market the service and inform primary care colleagues.

11. The discussion also addressed the issues with the audiology patient management system, particularly its separation from the OUH electronic patient record system. Officers acknowledged that the separation was identified as an issue. It was mentioned that, despite a unified referral system, patient information continued to be managed locally by each provider.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

12. This section highlights three key observations and points that the Committee has in relation to audiology services in Oxfordshire. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below. The Trust may be implementing the substance of the recommendations being issued by the Committee to some degree already, although the Committee did not receive sufficient information as to determine the extent to which this is the case. The Trust will be provided with an opportunity to respond to these recommendations with further evidence as to how they are being implemented:

Level of need for audiology services: Hearing impairments can affect individuals of all ages, but the prevalence tends to increase with age. In the general population, hearing loss is a common condition that can lead to a variety of symptoms and challenges. In a 2022 study published in the *Journal of General Internal Medicine*, it was found that hearing loss could lead to communication difficulties, social isolation, and an overall decreased quality of life[1]. Factors such as exposure to loud noises, genetic predisposition, and certain medical conditions contribute to the need for audiology services.

The Committee acknowledges the assurances it received that the current the audiology service for Oxfordshire was flexible to meet demand. However, it remains slightly concerned that there is no specific data on the proportion of self-referrals or the exact future demand. Whilst precise data on future demand may be problematic to determine, it is crucial that likely demand is forecasted, and for this to be incorporated into future planning. It is also likely that future planning would require a population health needs assessment, and this could perhaps be incorporated into the work around the Health and Wellbeing Strategy for Oxfordshire.

Amongst children, the capacity for audiology services to meet demand is particularly crucial. According to a 2021 study in the *International Journal of Paediatric Otorhinolaryngology,* early detection and intervention are essential for addressing hearing impairments in children, as untreated hearing loss can adversely impact language development, academic performance, and social interactions[2]. Common causes of hearing loss in children include congenital conditions, infections, and exposure to ototoxic medications. A 2019 study in the Journal of *Ear and Hearing* found that regular hearing screenings in infants and school-aged children are vital for identifying issues promptly and providing appropriate treatment[3].

[1] The Impact of Hearing Loss and Its Treatment on Health-Related Quality of Life Utility: a Systematic Review with Meta-analysis | Journal of General Internal Medicine
[2] Therapeutic approaches to early intervention in audiology: A systematic review - ScienceDirect
[3] Ear and Hearing

The Committee is pleased to hear that complex audiology needs (including children-related ones) are determined through established guidance and criteria set by professional bodies. Although, such guidance and criteria should be clearly defined and understood by hospital as well as community providers in Oxfordshire. Given that specialist equipment and training are required for children's cases, the Committee firmly believes that paediatric audiology services should remain managed by the hospital. This emphasis is made given that the Committee was informed that this may be readjusted in future. However, if paediatric audiology is to continue to be managed by the hospital, then efforts should be made to ensure that hospital audiology services are adequately resourced for this. In other words, utilising community audiology services for children should not be resorted to as a means of simply coping with any increased demand for paediatric audiology services.

Furthermore, the Committee is concerned to hear about the workforce issues in audiology, particularly in recruitment and retention. Challenges with recruitment and retention could indeed be attributable to competition with the private sector, which offers more attractive salaries and benefits to audiology staff. The Committee also understands that the training environment had also evolved, with fewer programmes being available and a shift to an apprenticeship model, resulting in a delay in qualified professionals entering the field in Oxfordshire. The Committee is therefore recommending that efforts are made to address this, including through the ICB working with NHS England or NHS South East Region to explore avenues through which to secure further support/funding. The Committee understands that there are commitments to explore in-sourcing staff from outside Oxfordshire to help address shortages, but urges that clear plans are developed promptly to work toward this, including how to attract and incentivise staff from outside Oxfordshire. Given the importance of local Community Diagnostic Centres being able to provide timely diagnosis and treatment at the neighbourhood level, it is vital that there is adequate resource (including funding and workforce) to support this.

Recommendation 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. It is recommended that further resourcing is sought to tackle waiting lists and prioritisation, particularly around Community Diagnostic Centres.*

Raising awareness of available support: Audiology services play a crucial role in providing support to individuals with hearing impairments, yet awareness of these services remains limited among the wider public. This was indicated by national evidence from a 2019 survey conducted by the Royal National Institute for the Deaf, which found that fewer than 1 in 5 (19%) of people with hearing loss have actually accessed an NHS audiology service in the past 3 years in England[4]. To bridge this gap and

[4] 9 out of 10 CCGs in England don't hold basic information needed to provide good hearing aid services - RNID

ensure that those in need can access the available support, it is essential to improve communication strategies around the audiology services available in Oxfordshire and the support that patients can expect to receive. The Committee is concerned that this gap could widen, particularly given the rise in ageing and vulnerable population groups throughout the county (and specifically those in rural areas).

Effective communication with the public should start with an assessment of the current methods used to disseminate information about audiology services in Oxfordshire. Traditional methods, such as brochures and pamphlets should be maximised. It is also vital that such written communications are available in multiple languages as well as in large fonts for those for whom English is not a first language and for those with visual difficulties respectively. The Committee is not aware of this being the case, and such written information should be developed and disseminated as a priority if not. Additionally, it is also crucial that there are community outreach programs to target populations and neighbourhoods in local communities. This would be particularly crucial for rural areas in Oxfordshire, where residents may not be aware of the community audiology services available to them or how to make a referral for themselves. It is also encouraged that work is undertaken to reach out to voluntary sector organisations with grassroots in local communities throughout the county to provide those with comorbidities or with hearing impairments with communications regarding the services and support available.

However, it is also the case that the aforementioned methods may not reach a broader audience, even in today's digital age. Several challenges could hinder effective communication with the wider public around the availability and support provided around audiology, including:

- Lack of visibility: Audiology services are often not prominently featured in some of the public health campaigns organised and run by the local NHS or even the County Council. In fact, there is also a point about the imperative for the Health and Wellbeing Strategy to examine audiology as part of the Start Well, Live Well, and Age Well aspects of the strategy (given that audiology can affect Oxfordshire's residents of all ages).

- Information overload: It could very well be the case that communications around audiology services are in abundance, although it is worth noting that if residents are inundated with vast amounts of information relating to health and wellbeing, it could become difficult to highlight the importance of audiology services or for residents to be able to navigate this.

- Accessibility: Information may not be readily accessible to individuals with hearing impairments (be this written or digital). This could be due to a variety of factors including elderly residents living in a state of isolation or being technologically illiterate, or the

fact that some residents with hearing impairments suffer from other comorbidities which make it complex to access information on audiology services.

One way in which to increase awareness of audiology services and support amongst Oxfordshire residents could be through harnessing digital media platforms as much as possible. Notwithstanding challenges associated with digital illiteracy outlined above, such platforms can offer a powerful tool for reaching a larger audience, many of whom are able to access information on services on digital platforms. Social media campaigns and informative websites can provide valuable information about audiology services. There are two ways this could be achieved. Firstly, social media engagement is one useful avenue to raise awareness, and the Committee is not aware of any detailed social media campaigns being adopted to reach out to Oxfordshire's residents in relation to audiology services. Creating engaging content and interactive posts on platforms such as Facebook, Twitter, and Instagram could help engage residents who use these platforms. Secondly, websites should be as informative as possible in helping residents navigate information on hearing and associated services. Websites providing information on local audiology services should contain as much comprehensive information about these services, including contact information and Frequently Asked Questions (FAQs).

Furthermore, community organisations can serve as a bridge to connect audiology services with the wider public. A key example is the initiative launched by Surrey County Council and its local NHS partners since 2022 to develop partnerships with schools, senior centres, and local health clinics to facilitate the dissemination of information on audiology services available for Surrey's residents since 2022. Some key actions that could be undertaken by system partners in Oxfordshire in this regard could include conducting workshops at community centres to educate the public about hearing health and available services; participating in local health fairs to provide information and free hearing screenings; and implementing hearing health programs in schools to raise awareness among students and parents.

Moreover, to ensure that information about audiology services is accessible to everyone, including those with hearing impairments, it is vital to adopt inclusive communication practices. The Committee has not received much information on any initiatives taken in this regard, and therefore suggests that the following steps, as emphasised by a 2022 study in the *Journal of Health Communication*[5], are taken:

- *Closed Captioning*: Providing closed captioning for video content to make it accessible to individuals with hearing loss.

[5] Access to Effective Communication Aids and Services among American Sign Language Users across North Carolina: Disparities and Strategies to Address Them: Health Communication: Vol 37, No 8

- *Sign Language Interpretation*: Offering sign language interpretation for live events and webinars.

- *Accessible Formats*: Ensuring that printed materials are available in large print and braille.

Additionally, personal stories and testimonials can be powerful tools for raising awareness amongst residents of available audiology services. This is particularly crucial as the Committee had received reports of patients not being aware of how audiology services operate as well as what they can expect to experience when trying to access these services. Sharing success stories of individuals who have benefited from audiology services can inspire others to seek support. The use of video testimonials featuring individuals sharing their positive experiences with audiology services; publishing written testimonials on websites, blogs, and social media platforms; and encouraging satisfied clients to become ambassadors and advocate for audiology services within their communities could all help toward this.

In essence, improving communication strategies to raise public awareness of audiology services in Oxfordshire is essential for ensuring that residents with hearing impairments can access the support they need. By leveraging digital media, collaborating with community organisations, enhancing accessibility, and using testimonials, audiology services can significantly increase their visibility and impact. It is through these concerted efforts that we can create a more informed and supportive environment for those in need of audiology services.

Recommendation 2: *For improvements to be made around communications with the wider public to increase awareness of available support from audiology services.*

Integrating community audiology patient record systems: Integrating community audiology patient records into acute and hospital patient record systems is a crucial step towards enhancing the continuity and quality of healthcare. Audiology is a complex and important branch of healthcare encompassing hearing, balance, and related disorders, and plays a significant role in patient well-being. By ensuring that audiology records are seamlessly integrated into broader healthcare systems, patients can receive more comprehensive and effective care from community and hospital providers.

Upon commissioning the report for this item, the Committee was keen to explore how records were maintained for audiology patients. The Committee was concerned upon hearing that electronic patient record (EPR) system utilised by community audiology services remained separate from the Oxford University Hospitals NHS Foundation Trust (OUH) patient record system. The Committee is pleased that officers acknowledged that the separation was already identified as an issue, and urges that steps are taken to integrate community audiology records into the acute Trust's broader EPR.

The integration of community audiology records into the OUH EPR could offer numerous benefits including:

- *Improved continuity of care*: Seamless access to audiology records ensures that healthcare providers have a complete picture of a patient's health history, allowing for better-informed decision-making. In a 2019 study published in the *Journal of Speech, Language, and Hearing Research,* it was found that well integrated audiology patient records helped clinicians understand the likely causes of a patient's symptoms, whilst also helping to rule out likely reasons for a patient's symptoms that they could otherwise assume to be caused by more serious conditions[6].

- *Enhanced patient outcomes*: With integrated records, clinicians can more effectively monitor and manage hearing and balance disorders, leading to improved patient outcomes. One study published in the *Journal of Perinatology* found that integrated audiology records helped with the long-term tracking and monitoring of an audiology patient's treatment journey, with clinicians being able to regularly track what has been diagnosed, what interventions have thus far been implemented, and to evaluate current treatments whilst exploring new ones[7].

- *Efficient processes*: Integration reduces redundancy and administrative burden, facilitating more efficient care delivery. Research published in the British Journal of Nursing emphasised that integrated audiology records meant that clinicians could focus more time and energy on providing personalised care as opposed to having to deal with the administrative burdens of having to explore an audiology patient's history.

- *Better coordination*: Integration would enhance coordination between audiologists and other healthcare professionals, and this could help to foster greater collaboration and holistic patient care that is multidisciplinary.

Thus, on the basis of the aforementioned reasons, the Committee strongly urges and recommends for community audiology patient records to be integrated into the OUH hospital patient record system. This would constitute a transformative and positive step in healthcare delivery not merely for audiology patients but overall. This integration would create improved continuity of care, better patient outcomes, streamlined processes, and enhanced coordination among healthcare providers or clinicians.

[6] The Circle of Care for Older Adults With Hearing Loss and Comorbidities: A Case Study of a Geriatric Audiology Clinic | Journal of Speech, Language, and Hearing Research

[7] Impact of electronic medical record integration of a handoff tool on sign-out in a newborn intensive care unit | Journal of Perinatology

Recommendation 3: *That Community Audiology is brought onto the same Electronic Patient Record system as the rest of Oxford University Hospitals NHS Foundation Trust.*

Legal Implications

13. 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 n consultations.

14. 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'.

15. 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.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

    Councillor Jane Hanna OBE – in the Chair
    District Councillor Katharine Keats-Rohan (Deputy Chair)
    Councillor Jenny Hannaby
    Councillor Michael O'Connor
    District Councillor Paul Barrow
    District Councillor Elizabeth Poskitt
    District Councillor Susanna Pressel
    District Councillor Dorothy Walker
    Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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May 2025

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

Cancer Services in Oxfordshire

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:

- Matthew Tait (Chief Delivery Officer-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Felicity Taylor Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust).
- Andy Peniket (Clinical Director for Oncology & Haematology, Oxford University Hospitals NHS Foundation Trust).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report providing an update on the current state of cancer services in Oxfordshire during its public meeting on 06 March 2025.

2. The Committee would like to thank Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB]); Felicity Taylor Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust [OUH]); Andy Peniket (Clinical Director for Oncology & Haematology, Oxford University Hospitals NHS Foundation Trust); and Ansaf Azhar (Director of Public Health, Oxfordshire County Council); for attending the meeting on 06 March and for answering questions from the Committee in relation to cancer services in Oxfordshire.

3. The Committee had received reports of some of the challenges experienced by cancer patients with cancer services, particularly in the wake of and as a result of the covid-19 pandemic, and urges NHS partners to work closely toward improving these services through reducing wait times and addressing any backlogs. The Committee was also keen to gain insights into the different types of services provided for the various types of cancers, and the efficacies of these.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by commissioners and providers to not only deliver but to also improve cancer services, particularly against a backdrop of general increases in demand for health services. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

    - Whether there were any backlogs in cancer appointments and treatments since the Covid-19 pandemic?

- If there were any variations in wait times for cancer diagnoses and treatments within different geographies in Oxfordshire?

- Details of any variations in wait times for diagnosis and treatment for different forms of cancer.

- How does Oxfordshire compare to other areas nationally with regard to cancer wait times?

- How effective was the referral process for cancer diagnosis and treatment, from the point of primary care onwards?

- Details of the availability of healthcare resources, including specialised personnel, diagnostic equipment, and treatment facilities (including how resource levels impact waiting periods).

- Details of any processes in place to monitor the effectiveness of diagnoses and treatments for cancer patients.

- How were side effects of cancer treatments monitored routinely and effectively?

- To what extent were cancer treatments personalised?

- Details of how healthcare professionals were being trained in any latest diagnostic techniques and protocols.

- How were cancer patients being communicated with clearly whilst on waiting lists and regarding their treatment journey?

- How was the mental health of cancer patients being supported?

- Details of any collaboration with other system partners to provide long-term care to cancer patients who needed it.

SUMMARY

5. During the 06 March 2025 meeting, the Chief Operating Officer at Oxford University Hospitals NHS Foundation Trust (OUH), discussed the Annual Cancer Survey feedback, noting that there were improvements in 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.

6. The Committee 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 explained that methods included distributing informational leaflets, offering

direct communication during appointments, and employing marketing strategies to promote NHS hearing tests and treatments.

7. The discussion included a strong emphasis on the imperative for patient follow-ups to ensure the effectiveness of treatments and to promptly address any issues. It was agreed that this comprehensive approach would help to enhance patient awareness and engagement with the services provided.

8. 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. 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.

9. The increase in cancer referrals across Oxfordshire was also discussed, and the Committee sought 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.

10. The discussion also examined the role of coproduction in the development of cancer services and the Committee requested an update on stakeholder involvement in this process. Officers clarified that coproduction 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.

11. The Committee 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 highlighted 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.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

12. This section highlights three key observations and points that the Committee has in relation to cancer services in Oxfordshire. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below. The Trust may somewhat be implementing the substance of the recommendations being issued by the Committee (particularly around communication and advocacy for patients, and on encouraging cancer screening), although the Committee had not received as much information as to the extent to which this is the case. The Trust will be provided with an opportunity to respond to these recommendations with further evidence as to how they are potentially being implemented:

Outcomes across different types of cancer: Cancer remains one of the most formidable health challenges globally, affecting millions of people each year. As medical research and technology advance, the outcomes for various cancer types have shown significant variability. The report received by the Committee provided a summary of some of the key activities currently being undertaken within the cancer service of Oxford University Hospitals NHS Foundation Trust (OUH). However, the Committee had not received sufficient insight into the variations in outcomes for patients with different types of cancers in Oxfordshire.

Cancer is a complex and multifaceted disease that impacts individuals differently. Numerous factors can influence the variations in outcomes for cancer patients. These factors are not simply restricted to the clinical care provided by acute hospital Trusts. According to a study in the *Journal of Public Health*, there are wide ranging reasons for variations in the outcomes for different cancer types, from biological to socio-economic aspects, and understanding these factors is crucial for tailoring treatment plans and improving patient prognosis[1].

Wait times can be an important indicator of patient outcomes, notably in terms of how soon patients can be diagnosed as well as when treatments initiate. The Committee was pleased to hear that the Trust was meeting the NHS national Faster Diagnosis standard of *Communication of a cancer diagnosis or benign* to patients within 28 days of an Urgent Suspected Cancer referral. Nonetheless, given that the Trust is below the 31-day and 62-day treatment standards, work should urgently be undertaken to enhance performance against these standards. It is crucial that there is transparency and further information provided around:

1. The steps being taken to enhance performance in these treatment standards.

[1] Do social factors affect where patients die: an analysis of 10 years of cancer deaths in England | Journal of Public Health | Oxford Academic

2. How patients with various types of cancer have/are being affected by these treatment standards not being met.

The Committee understands that the Trust had observed significant increases in referrals, with overall Urgent Suspected Cancer Referrals rising further. Some key causal factors would include a rising as well as an ageing population in the County. It could also be the case that, as highlighted by a 2015 study published in the *British Journal of Cancer*, increased public awareness of both cancer symptoms and of the importance of early detection results in increases in referrals.

Furthermore, the Committee had been informed that the Trust is witnessing elevated referrals for subsequent treatments. This includes further treatment for a primary diagnosis, treatment for a recurrence, and treatment for metastases or secondary conditions. This trend is partly attributed to the increasing success of initial cancer treatments in extending survival rates and the development and availability of new treatments. It is crucial that there is further transparency and information for both the Committee and the wider public around why the Trust is witnessing an increase in elevated referrals for subsequent treatments. This phenomenon raises critical questions about the underlying causes of this and the implications for patient care and the healthcare system more broadly. This could allow further collaborative system work to investigate the specific causes of such referrals as well as how to address these through invoking more prevention work. The Committee understands that the evolution of diagnostic technologies has significantly impacted the frequency of cancer referrals. According to a 2020 study published in the *Journal of Technology in Society,* modern imaging techniques allow for earlier and more accurate detection of cancerous lesions. Consequently, oncologists can identify secondary cancers or metastases sooner, prompting additional treatment referrals[2]. Therefore, these advancements not only improve the chances of detecting smaller, previously undetectable tumours but also enable more precise staging of the disease, guiding the need for further intervention. Additionally, with this in mind, there is a point about understanding which cancer types in Oxfordshire have been characterised by subsequent referrals as a result of enhancements in imaging technology specifically.

Having said that, there may be other more complex reasons behind the causes of subsequent referrals besides advancements in technology, including the specific nature of particular types of cancer per se, or even potentially particular population groups who may reside in certain areas around the County. Hence, it is pivotal that further demographic and geographic research is conducted to understand these patterns, and the Committee encourages research collaboration with Oxford's Universities to help determine this.

[2] Deep learning technology for improving cancer care in society: New directions in cancer imaging driven by artificial intelligence - ScienceDirect

Furthermore, understanding variations in overall outcomes for cancer patients could help inform prevention work as well as any potential steps that could be taken as part of Oxfordshire's Health and Wellbeing Strategy. Whilst it may not be the responsibility of each and every system partner/actor to investigate the causes of cancer specifically, they certainly do all have a part to play in improving the overall health and wellbeing of cancer patients.

Moreover, cancer patients can often face significant emotional and psychological distress as a result of being diagnosed and the knowledge of how their lives have been transformed as a consequence. Such mental distress, according to one study in the *Journal of Cancer*, could be elicited by the knowledge of being diagnosed with cancer, as well as by the specific services available for such patients[3]. It is also the case that, as another study in the *Journal of the National Cancer Institute* identified, outcomes for various cancer types can be assessed through examining the psychological and mental health/state of cancer patients. Additionally, the study also found that patients who had worse physical cancer outcomes often had worse psychological symptoms and outcomes. The Committee therefore urges for psychological elements to also be taken into account when examining the outcomes for various types of cancers that patients in Oxfordshire are diagnosed with. Such assessments could help inform how to provide better support, physical and psychological, to residents living with cancer.

It is also crucial that the Committee and the wider public are made aware of how Oxfordshire compares with other geographies around the Country on the outcomes for different types of cancers. By outcomes, the Committee is pertaining to both:

- Health outcomes determined by the nature of the specific types of cancer as a disease.

- Health outcomes shaped by the efficacy of local cancer services in Oxfordshire.

Essentially, understanding these two things could help to determine where prevention work is best needed, as well as how services could be improved.

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

[3] A prospective multicentre study in Sweden and Norway of mental distress and psychiatric morbidity in head and neck cancer patients | British Journal of Cancer

Clear communication and advocacy for cancer patients: Communication is a vital component in the delivery of effective healthcare, particularly for cancer patients who often face complex and sometimes emotionally difficult decisions. Language barriers can significantly impede the quality of care and support that non-English-speaking cancer patients receive. It is essential to establish clear communication mechanisms and robust advocacy mechanisms to ensure these patients receive equitable care and can navigate their treatment journey with confidence.

Prior to commissioning the report on cancer services in Oxfordshire, the Committee was keen to explore the support available for patients who do not speak English. This also stemmed from concerns elicited by a recent Healthwatch report that highlighted an instance where a non-English speaking patient was unaware of their diagnosis due to communication barriers. The Committee was pleased that the imperative for clear communication with patients was acknowledged by the Trust, and that the Trust was committed to work on expanding such support for patients. Non-English-speaking cancer patients often encounter several challenges that impact their care:

- *Language barriers:* According to a 2016 study in the *Journal of Internal Medicine*, it was found that cancer patients with language barriers often have difficulty in understanding medical terminologies. Such patients also struggle with communicating symptoms, concerns, and treatment preferences[4].

- *Lack of culturally appropriate resources*: The Committee received reports that non-English-speaking cancer patients can often experience limited access to educational materials in their native language. Such materials are crucial in helping patients to understand the nature of their disease and how to cope with it, as well as how to navigate and access support from available cancer services in Oxfordshire.

- *Fear and anxiety*: Patients who cannot fluently understand or speak English can feel a sense of increased stress due to misunderstanding the nature and extent of their condition and the treatments that will ensue or that they could choose to proceed with. One study in the *Journal of Patient Experience* found that the anxiety that cancer patients face can be compounded by difficulties in being able to communicate in their first language, partly due to not being aware of the seriousness of their condition and the level of support they can expect to receive[5]. The Committee therefore urges for there to be translators available during appointments where patients cannot speak English to a reasonable level.

[4] Navigating Language Barriers: A Systematic Review of Patient Navigators' Impact on Cancer Screening for Limited English Proficient Patients | Journal of General Internal Medicine

[5] Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada - Danielle de Moissac, Sarah Bowen, 2019

- *Isolation*: One study published in the *Journal of Supportive Care in Cancer* discovered that cancer patients can already feel isolated with little expectations to any hope of receiving life-saving treatment. This could result in patients feeling disconnected from healthcare providers and support networks[6]. Reducing language barriers by providing verbal and written communications in a patient's own language could help reduce this sense of isolation.

The Committee had received reports of patients having to attend appointments in the absence of properly trained interpreters, or in some instances without the presence of an interpreter at all. The Committee had also not received sufficient evidence in the report it commissioned for this item around the extent of the support provided by trained interpreters. Therefore, employing trained medical interpreters can bridge the language gap and facilitate more accurate communication between patients and healthcare providers. Interpreters should ideally be available for all aspects of cancer care, including consultations, diagnostic procedures, treatment discussions, and follow-up appointments.

Furthermore, as patients navigate the complex and often overwhelming journey of diagnosis, treatment, and recovery from cancer, advocacy emerges as a crucial pillar of support. Advocacy for cancer patients serves not only to ensure their voices are heard but also that they receive optimal care, equitable access to support, and continuous support throughout their battle against the disease. According to a publication in the *Journal of Advanced Nursing*, patient advocacy is centred on empowering individuals diagnosed with cancer, ensuring their voices are heard, and their needs are met. This form of advocacy involves helping patients understand their diagnosis, treatment options, and potential side effects[7]. Advocates provide emotional support, assist with navigating the healthcare system, and connect patients with necessary resources. By championing the rights and needs of cancer patients, advocates foster a sense of empowerment and autonomy, enabling patients to make informed decisions about their care. In the case of cancer patients, the Committee had not received sufficient information or reassurance around the advocacy being provided for cancer patients by the Trust (particularly for patients who cannot speak English fluently). A useful case study is the steps taken by Guy's and St Thomas NHS Foundation Trust, who have developed a cancer centre which provides personalised care, including through sourcing potential advocates for patients by also connecting them with other people or organisations in their community for support as well as advocacy[8]. Therefore, the Committee urges that healthcare staff should undergo cultural competency training to better

[6] From inside the bubble: migrants' perceptions of communication with the cancer team | Supportive Care in Cancer

[7] Self-advocacy and cancer: a concept analysis - Hagan - 2013 - Journal of Advanced Nursing - Wiley Online Library

[8] Cancer care and support - Overview | Guy's and St Thomas' NHS Foundation Trust

understand the diverse backgrounds of their patients and provide care that respects their cultural values and beliefs. This training can enhance provider-patient communication and help to foster a more inclusive healthcare environment in Oxfordshire.

As such, clear communication and effective advocacy are paramount in providing equitable care to non-English-speaking cancer patients. By implementing comprehensive communication strategies and robust advocacy mechanisms, healthcare providers can ensure that these patients receive the support and care they need. This approach not only improves patient outcomes but also fosters a more inclusive and compassionate healthcare system for Oxfordshire's residents.

Recommendation 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.*

System collaboration to encourage cancer screening: Cancer screening is a critical tool in the early detection and prevention of cancer, potentially saving countless lives. However, as indicated by a study in the *European Journal of Cancer*, many communities, particularly those with lower socioeconomic status, ethnic minorities, and rural populations, exhibit low take-up rates for these essential screenings[9]. The Committee has requested and is yet to receive evidence from the Trust or the ICB as to Oxfordshire-specific data on cancer screening uptakes. Addressing any disparities in uptake is of paramount importance, and one of the most effective strategies is through collaborative efforts between system partners in Oxfordshire. By uniting various stakeholders, including the County Council's Public Health team, the ICB, and the Trust, awareness campaigns can be created and implemented that resonate with communities with the lowest uptakes, ultimately improving screening rates and health outcomes for Oxfordshire's population.

Collaborative efforts between Oxfordshire's system partners would allow for a deeper understanding of the specific needs and barriers faced by communities with low take-up rates of cancer screening in the County. Community organisations and local leaders or elected representatives can often have intimate knowledge of cultural, linguistic, and socioeconomic factors that affect health behaviours of local communities in Oxfordshire. By working together, system partners can tailor messages and interventions to address these unique challenges, ensuring that campaigns are relevant and impactful.

Trust would be a critical component in health communication with Oxfordshire residents, particularly amongst marginalised or minority communities that may exhibit distrust in the healthcare system or in vaccines or screening. Collaborating with trusted community leaders and grassroots organisations can bridge this gap. When campaigns are

[9] Uptake of the English Bowel (Colorectal) Cancer Screening Programme: an update 5 years after the full roll-out - ScienceDirect

endorsed and disseminated by familiar and respected figures within the community, they are more likely to be received positively and acted upon. One avenue would be to approach religious leaders and institutions within Oxfordshire, with the aim of not only building Trust but of harnessing this form/channel of communication that some communities might rely on.

Furthermore, launching effective awareness campaigns often requires significant resources, including funding, personnel, and materials. The Committee is yet to be informed of the degree to which resources are potentially being pooled between the Trust and the County Council as to supporting awareness campaigns for cancer screening. Collaboration allows for the pooling of these resources, making it possible to reach a broader audience and sustain efforts over a longer period. Healthcare providers can offer medical expertise and screening services, while community organizations can provide outreach and education. Local governments can support these initiatives through policy and funding. This approach was also utilised within Hampshire, where local NHS providers worked alongside the Council and Voluntary Sector community organisations to share resources to initiate a variety of cancer screening awareness initiatives[10].

In addition, a collaborative approach between the Trust and the County Council would enable the development of comprehensive and multifaceted strategies that address various aspects of cancer screening. This can include education on the importance of screening, logistical support such as transportation to screening sites, and follow-up care for those who need it. By integrating these components, campaigns can more effectively remove barriers and promote sustained engagement with cancer screening services.

As such, the importance of collaboration in launching awareness campaigns for cancer screening in communities with low take-up rates cannot be overstated. By leveraging the collective strengths of Oxford University Hospitals, the County Council, and community organizations, we can create tailored, effective, and sustainable interventions for the County. These collaborative efforts are essential to overcome barriers, build trust, and ultimately improve health outcomes for communities throughout Oxfordshire.

Recommendation 3: *For Oxford University Hospitals NHS Foundation Trust to collaborate with the Oxfordshire County Council's Public Health team on awareness campaigns with communities with low take-ups of cancer screening.*

[10] Breaking down barriers to cancer screening - Action Hampshire

Legal Implications

13. 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 n consultations.

14. 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'.

15. 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.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – in the Chair
District Councillor Katharine Keats-Rohan (Deputy Chair)
Councillor Jenny Hannaby
Councillor Michael O'Connor
District Councillor Paul Barrow
District Councillor Elizabeth Poskitt
District Councillor Susanna Pressel
District Councillor Dorothy Walker
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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May 2025

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

Musculoskeletal Services in Oxfordshire

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:

- Matthew Tait (Chief Delivery Officer-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Neil Flint (Associate Director of Planned Care-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Tony Collett (Connect Health)
- Mike Carpenter (Connect Health)
- Suraj Bafna (Connect Health)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on the current state of Musculoskeletal (MSK) Services in Oxfordshire during its public meeting on 06 March 2025.

2. The Committee would like to thank Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB]); Neil Flint (Associate Director of Planned Care, BOB ICB); Tony Collett (Connect Health); Mike Carpenter (Connect Health); Suraj Bafna (Connect Health) for attending the meeting on 06 March and for answering questions from the Committee in relation to MSK services in Oxfordshire.

3. The Committee previously received a report on MSK services and has been keen to explore progress made around addressing the lines of enquiry and recommendations made by the Committee.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by commissioners and providers to improve MSK services, particularly against a backdrop of general increases in demand for health services. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

    - An overview of the service and the clinical pathways, and whether GPs could bypass MSK services to refer directly to specialists.

    - Performance against Key Performance Indicators (including waiting times for appointments and treatment).

- An analysis of complaints and feedback from patients, what had been learned, and whether any improvements had been made as a result.

- Details of the county coverage of MSK services, including locations and distance patients had to travel to access MSK services.

- To report on patient outcomes EQ5D data and what had been learnt from this.

- How did the service work with Primary Care Network diagnostic physiotherapists?

- Insights into the role of the extended scope practitioners, whether they were being used, and how this benefited patients.

- Information regarding any patient and public involvement in service delivery and what changes or improvements had resulted?

SUMMARY

5. During the 06 March 2025 meeting, 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.

6. 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.

7. 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. Engagements were also undertaken with primary care through network group meetings, stakeholder meetings, seminars, and newsletters.

8. In response to concerns from the Committee regarding the long waits for rheumatology and orthopaedics, acknowledging these as serious long-term conditions, 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.

9. The discussion also examined the geographical spread of MSK services in the southern parts of the county, particularly at Wantage Hospital. There were expressed commitments to improve service distribution, especially in the southern regions, and enhancing recruitment and retention within the MSK workforce. It was clarified that the distribution of services was data-driven,

ensuring appropriate coverage based on patient postcodes. Addressing rural inequalities and catering to the growing aging population remained priorities.

10. The issue of pelvic pain was also discussed, with the Committee referencing a national survey by the Pelvic Partnership, and inquired to what extent the service was collaborating with key partners such as the Pelvic Partnership to support patients. 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 Partnership, and there was a commitment to exploring this potential partnership to enhance support for patients waiting for care.

11. The discussion also emphasised the imperative for collaboration with diagnostic physiotherapists available at every GP surgery through primary care networks. The Committee 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.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

12. This section highlights three key observations and points that the Committee has in relation to MSK services in Oxfordshire. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Geographical spread of MSK services: The Committee stresses the importance of maximising and enhancing the distribution of MSK services throughout the county. One key concern of the Committee involved MSK provision in the southern regions of the county. Achieving this would also rely on enhancing recruitment and retention within the MSK workforce. Indeed, MSK conditions are among the most common health issues affecting people worldwide. These conditions can significantly impact a person's quality of life, making timely and accessible care essential. The geographical spread of MSK services in Oxfordshire would play a crucial role in ensuring residents can access these services swiftly wherever they happen to reside throughout the county.

There are some key factors to be taken into account when trying to ensure an adequate distribution of MSK services throughout the county These factors can also present challenges for residents in more rural parts of the County and could include:

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- *Limited Availability*: In many areas around the country including although not exclusively Oxfordshire, MSK services are

concentrated in urban areas. This could leaving rural residents with fewer options for MSK care and treatment.

- *Travel Time*: Residents in Oxfordshire's remote areas may face significant travel times to reach the nearest MSK clinic, delaying treatment and potentially worsening their conditions. This could be particularly challenging in the context of a rise in an ageing population and the relative paucity of public transport in rural areas.

- *Resource Allocation*: Uneven allocation of resources can lead to underfunded and understaffed facilities in certain areas. The Committee strongly believes that there should be an acknowledgement that it is not only urban areas that would naturally see increased demands for MSK services, but also Oxfordshire's rural areas. Whilst urban areas (including Oxford City) may have higher population counts, it does not imply that rural areas have less demand for such services.

Indeed, one of the most effective ways to improve access is to expand the number of locations offering MSK services. This can be achieved by either opening new clinics in underserved areas to reduce travel time for residents or by further integrating services through incorporating MSK services into existing healthcare facilities at the community level. In addition, utilising mobile clinics can bring MSK services more directly to residents in remote areas. Such mobile clinics could schedule regular visits to various locations to ensure consistent access to care and could provide access to MSK specialists who can diagnose and treat conditions on-site.

Improving the geographical spread of MSK services will have a significant impact on Oxfordshire's residents in three respects. Firstly, swifter access to MSK care can lead to early diagnosis and treatment, which can improve patient outcomes. Secondly, this could minimise the travel burden which could be most challenging for vulnerable, disabled, or elderly residents. There is also a point about minimising travel time and expenses for residents, particularly those in rural areas. Thirdly, easy access to MSK services could ultimately enhanced patients' quality of life. Providing timely care can alleviate pain and improve mobility, enhancing a patient's overall quality of life.

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

Collaboration with GP and other services: The Committee was pleased to hear that Oxfordshire's MSK service worked closely with diagnostic physiotherapists at GP surgeries. It is therefore crucial that there is thorough engagement with primary care networks throughout Oxfordshire to help facilitate this further. MSK disorders are among the most prevalent health issues in the UK, affecting individuals of all ages and backgrounds. To provide optimal care and improve patient

outcomes, it is essential for MSK services to foster collaboration between General Practitioners and other healthcare services throughout Oxfordshire.

Effective MSK care requires a multidisciplinary approach involving GPs, physiotherapists, orthopaedic specialists, and other healthcare providers. According to a 2014 study in the Journal of *Musculoskeletal Care,* collaboration and a multidisciplinary approach ensures that MSK patients receive comprehensive care, from initial assessment to specialised treatment and rehabilitation. By working together, healthcare professionals can share insights, resources, and best practices, ultimately improving the quality and efficiency of MSK services[1]. Some key benefits of collaborative MSK care could include:

- *Enhanced patient outcomes*: Coordinated care reduces the risk of misdiagnosis and ensures that treatment plans address all aspects of an MSK patient's condition.

- *Efficient use of resources*: Collaboration allows for better utilisation of healthcare resources, this can create a more efficient and improved cost-effective use of healthcare resources at a time when resources are stretched nationally.

- *Improved communication*: Regular interactions between GPs and specialists can facilitate timely information exchange and foster a cohesive treatment approach. As one 2016 study published by *International Journal of Physical Medicine and Rehabilitation,* it was highlighted such collaboration with GPs could contribute to more personalised care for MSK patients who might feel "bounced" between services and demoralised as a result[2].

One of the primary goals in improving MSK services is to minimise the number of steps and time required for patients to access care. The Committee appreciates the achievements in the reduction in waiting lists across various MSK service lines, including the CATS Tier 2 waiting list reducing from 3772 in January 2024 to 401 in January 2025, and similar waiting list reductions for physiotherapy, podiatry, and CATS paediatrics. Nonetheless, given the increased demand for health services as a whole, it is crucial that efforts continue to reduce waiting lists further, and to avert likely future increases. Lengthy and complex referral processes can delay treatment, exacerbate symptoms, and lead to patient dissatisfaction. There are a few ways in which this could potentially be achieved. Firstly, implementing direct referral pathways can prove more efficient. Clear guidelines should be established for direct referrals from

[1] Do Inpatient Multidisciplinary Rehabilitation Programmes Improve Health Status in People with Long-Term Musculoskeletal Conditions? A Service Evaluation - McCuish - 2014 - Musculoskeletal Care - Wiley Online Library

[2] What Musculoskeletal (MSK) Conditions are Referred from Routine General Practice (GP) and what Impact does this have on Developing Innovative Care Models for Patients with MSK Conditions in Primary Care? - Queen's University Belfast

GPs to MSK specialists, as this could help with bypassing unnecessary intermediate steps. Secondly, digital solutions and avenues should be maximised. This could include utilising remote appointments if need be in some instances where it may be appropriate to do so, and integrating patient's electronic health records to facilitate faster communication and reduce paperwork or administrative inefficiencies. Thirdly, GPs should ideally be equipped with the necessary tools and knowledge to make informed referrals and to be able to manage MSK conditions effectively. As one 2020 report published in the Journal of *Musculoskeletal Care* highlights, GPs are often the first point of contact for MSK patients, and should therefore receive adequate training on making more informed referrals and on being able to arrange ongoing/long term care for MSK patients who need it[3].

As such, to enhance MSK services in Oxfordshire and improve patient outcomes, it is crucial to foster collaboration between GPs and other local healthcare providers. By streamlining access procedures and reducing the number of steps required to obtain care, we can ensure that MSK patients throughout the County receive timely and effective treatment for their disorders and symptoms. These efforts will not only improve patient satisfaction but also contribute to the overall efficiency and effectiveness of the healthcare system more broadly.

Recommendation 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.*

Improving Pelvic Health Outcomes: Pelvic health is a crucial aspect of overall well-being that affects millions of people worldwide. Pelvic health issues can have a profound impact on quality of life, encompassing conditions such as pelvic pain, incontinence, and pelvic organ prolapse. Addressing these issues requires a comprehensive approach that includes medical interventions, patient education, and support networks.

The Committee is aware of the national survey by the Pelvic Partnership which provided evidence of some of the key challenges experienced by women suffering from this; including severe pain, inability to work, and challenges in managing family responsibilities. Indeed, one of the primary ways to improve outcomes for pelvic pain patients is to reduce their wait times for treatment, as prolonged wait times would result in these patients lacking support whilst experiencing pain for prolonged periods. The Committee is concerned that the average wait times for pelvic health services in Oxfordshire was 10-15 weeks between January 2024 and January 2025, and is pleased to hear that improvement plans are in place with improvements in pelvic health wait times expected by June 2025. In a 2023 study published in the *Journal of Endometriosis and Pelvic Pain Disorders,* it was found that women experiencing pelvic

[3] Development, implementation and evaluation of a bespoke, advanced practice musculoskeletal training programme within a clinical assessment and treatment service - Stevenson - 2020 - Musculoskeletal Care - Wiley Online Library

pain can develop more significant symptoms due to substantial wait times for treatments; with prolonged wait times resulting in physical and psychological deterioration and feelings of helplessness[4]. Hence, receiving early support can ensure that pelvic pain patients receive the appropriate assessment/diagnosis and could allow such patients to return to a sense of normality in their lives.

It is crucial that there is ongoing research to understand the underlying causes of pelvic health issues and to develop effective local means of treatments accordingly. Within Oxfordshire, as is the case nationally, pelvic pain affects many people as a result of underlying medical conditions or even injuries. It is therefore crucial to assess the causes and scale of pelvic pain in Oxfordshire so as to help develop long-term prevention work in this area. The Committee is yet to hear of any such research being undertaken, and if such research is being undertaken (even in the context of the Joint Strategic Needs Assessment), it would like to see evidence of this.

Furthermore, staff should be adequately trained and encouraged so as to not only enable them to provide effective clinical diagnosis and care to pelvic pain patients, but to also improve the empathy to such patients. In a 2021 study published by the *Journal of Women's Health Physical Therapy,* it was highlighted that a key aspect of patient-centred care toward pelvic patients was to display clinical empathy. The study found that such empathy would not only make these patients feel psychologically better, but that it would enable clinicians to diagnose and treat such patients with an open mind that takes their symptoms and experiences seriously; which has a knock-on effect pelvic pain outcomes for the individual and the wider community[5].

Moreover, effective patient education is also a key ingredient of improving pelvic health outcomes. Patients should be provided with extensive information on pelvic health, including prevention strategies and management options. Whilst the Committee heard commitments from system partners around improving pelvic health outcomes, it has not received any evidence indicating the extent to which patients will be educated regarding pelvic health and treatments. The pelvic floor muscles support the bladder, bowel, and reproductive organs. They play a vital role in urinary and bowel control, sexual function, and stability of the pelvis. Weakness or dysfunction in these muscles can lead to several health issues, making it imperative to maintain their strength and functionality. As indicated by a 2024 study in the *Journal of Pain,* much of the support that pelvic pain patients can benefit from involves the steps they take themselves to improve their pelvic floor and symptoms. This would help to supplement the clinical support they receive from face-to-face appointments[6]. Preventing pelvic health issues could involves a combination of lifestyle changes, exercises, and awareness of risk

4

5 The Journal of Women's & Pelvic Health Physical Therapy

6 PAIN

factors, all of which can be enhanced with effective patient education. In particular, the Committee highlights the following as particularly effective preventative or remedial actions to promote:

- *Pelvic Floor Exercises*: These can strengthen the pelvic floor muscles. These exercises involve contracting and relaxing the muscles that support the bladder and bowels. Regular practice can prevent urinary incontinence and improve sexual health. Patients should be educated on the types and techniques of exercises they can practice in their own time or at home. In a 2020 study in the *Journal of Psychology, Health and Medicine*, it was highlighted that regular pelvic floor exercises can speed up recoveries from pelvic pain and injuries in some instances, and that patients with the best outcomes are those that receive early and regular information and monitoring of such exercise regiments[7].

- *Healthy Diet and Hydration:* A balanced diet rich in fibre and adequate hydration can prevent constipation, a common contributor to pelvic floor dysfunction. A 2011 study in the Journal of *Nutrition Research Reviews* found that a good diet can reduce the prospect of constipation, which not only causes pelvic floor dysfunction but can aggravate pelvic symptoms if not treated. Avoiding excessive caffeine and alcohol can also reduce bladder irritation and maintain urinary health[8].

- *Maintaining a Healthy Weight:* Excess weight puts additional pressure on the pelvic organs and muscles, increasing the risk of pelvic floor issues. In both aforementioned studies, it was emphasised that maintaining a healthy weight through regular exercise and proper diet can alleviate this pressure and promote better pelvic health.

- *Proper Lifting Techniques*: Improper lifting techniques can strain the pelvic floor muscles. When lifting heavy objects, it is crucial to bend at the knees, keep the back straight, and engage the pelvic floor muscles to prevent injury. A 2019 study in the *Journal of Sports Medicine* highlighted that educating individuals on the negative effects of improper lifting on pelvic health and pain can make a substantial difference to those who may take lifting for granted and not consider such impacts. The study also found that such education should also be utilised as a form of prevention to guide even ostensibly healthy and active individuals on how to perform their regular exercises in ways that are pelvic friendly[9].

[7] Effectiveness of pelvic floor muscle and abdominal training in women with stress urinary incontinence: Psychology, Health & Medicine: Vol 26, No 6
[8] Dietary therapy: a new strategy for management of chronic pelvic pain | Nutrition Research Reviews | Cambridge Core
[9] Is Physical Activity Good or Bad for the Female Pelvic Floor? A Narrative Review | Sports Medicine

In line with the Committee's recommendation, another key aspect of improving pelvic health outcomes is to support those with pelvic pain whilst they are awaiting medical assistance. The Committee urges system partners to engage with the Pelvic Partnership. The Pelvic Partnership is dedicated to supporting individuals who suffer from pelvic pain and related conditions. Their involvement can be instrumental in providing support for those who are waiting to be seen by a clinician.

The Pelvic Partnership plays a vital role in supporting individuals with pelvic health issues through; raising awareness about pelvic health issues and advocating for better healthcare policies and funding; offering support services such as counselling, support groups, and educational resources to help individuals manage their conditions; and promoting/supporting research into pelvic health issues to advance the understanding and treatment of these conditions. The Committee was pleased to see that system partners welcomed the recommendation to engage with the Pelvic Partnership during the 06 March public meeting, and suggests that the following strategies could be adopted as part of this engagement:

- *Partnerships*: Establishing partnerships with the Pelvic Partnership to collaborate on initiatives aimed at improving pelvic health outcomes.

- *Information Sharing*: Sharing information and resources between local providers and the Pelvic Partnership to ensure patients receive comprehensive care.

- *Community Involvement*: Encouraging community involvement in supporting the foundation's efforts through fundraising, volunteering, and advocacy.

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

Legal Implications

13. 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 n consultations.

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recommendations to a responsible person on any matter it has reviewed or scrutinised'.

15. 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.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – in the Chair
District Councillor Katharine Keats-Rohan (Deputy Chair)
Councillor Jenny Hannaby
Councillor Michael O'Connor
District Councillor Paul Barrow
District Councillor Elizabeth Poskitt
District Councillor Susanna Pressel
District Councillor Dorothy Walker
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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May 2025

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

Director of Public Health Annual Report 2024/2025

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:
- Ansaf Azhar (Director of Public Health).
- Donna Husband (Head of Public Health Programmes).
- Frances Burnett (Public Health Registrar).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee discussed the draft Director of Public Health (DPH) annual report 2024-2025 during its public meeting on 06 March 2025.

2. The Committee would like to thank Ansaf Azhar (Director of Public Health, Oxfordshire County Council); Donna Husband (Head of Public Health Programmes); and Frances Burnett (Public Health Registrar) for attending the meeting on 06 March and for answering questions from the Committee in relation to the DPH annual report.

3. The Committee understands that this year's DPH annual report focused on the mental wellbeing of children and young people. The Committee had been involved in scrutiny of children's mental health as part of public meeting items on both CAMHs as well as the Emotional Wellbeing and Mental Health Strategy in November 2023. It was therefore crucial to examine the contributions this year's DPH annual report made toward collective systemwide efforts to improve children's mental health and emotional wellbeing, particularly given the decline in mental and emotional wellbeing amongst children since the Covid-19 Pandemic.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the County Council and its partners to commission and deliver services that improve children's emotional and mental wellbeing, particularly against a backdrop of general increases in demand for such services.

SUMMARY

5. During the 06 March 2025 meeting, it was explained to the Committee that this year's annual report focused on the mental health and wellbeing 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.

6. 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.

7. The Committee queried 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.

8. The discussion also focused on 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.

9. 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.

10. 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.

11. 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.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

12. This section highlights three key observations and points that the Committee has in relation to this year's DPH annual report. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below. System partners may somewhat be implementing the substance of the recommendations being issued by the Committee (particularly around working with schools), although the Committee had not received as much information as to the extent to which this is the case in the context of supporting children's emotional wellbeing and mental health. The Director of Public Health will be provided with an opportunity to respond to these recommendations with further evidence as to how they are potentially being implemented:

Working with schools: In recent years, and particularly since the Covid-19 pandemic, there has been a growing recognition of the critical role that schools play in promoting the emotional wellbeing and mental health of children. According to an October 2022 publication by the Care Quality Commission (CQC), schools are institutions where children spend a significant portion of their time, and as such are uniquely positioned to influence and support the holistic development of their students[1]. By working collaboratively with schools, parents, educators, and mental health professionals can create an environment that fosters emotional resilience, mental stability, and overall wellbeing.

Emotional wellbeing refers to the ability to understand, manage, and express emotions effectively. It is closely linked to mental health, which encompasses cognitive, psychological, and social aspects of a person's life. One study published by the *Nursing Forum* found that when children have good emotional wellbeing and mental health, they are better equipped to handle stress, build positive relationships, and engage in learning[2].

With this in mind, upon commissioning this item, the Committee was keen to explore the extent to which schools were or will be worked with to improve children's emotional and mental health. The Committee understands that all partners were working toward achieving the Start Well objectives of the Health and Wellbeing Strategy, and appreciates that the Public Health team per se was limited in what it could do alone. It is for this reason that the Committee sought further information to be provided around the extent to which system partners are working closely with schools for the betterment of children's emotional and mental wellbeing.

Research has shown a strong correlation between emotional wellbeing and academic performance. Children who feel emotionally supported

[1] Children's and young people's mental health - Care Quality Commission
[2] Emotional wellbeing in youth: A concept analysis - Courtwright - 2020 - Nursing Forum - Wiley Online Library

and secure are more likely to be engaged, motivated, and successful in their studies[3]. Conversely, as indicated by a 2017 study in the *Journal of School Health*, children who struggle with emotional and mental health issues may experience difficulties in concentration, memory, and overall cognitive functioning, leading to poorer academic outcomes[4].

Schools have a unique opportunity to provide a supportive environment that promotes mental health and emotional wellbeing. This can be achieved through:

- *Inclusive Policies*: Implementing policies that promote inclusivity, respect, and acceptance can create a safe and nurturing environment for all students. One study in the Journal of *Mental Health and Social Inclusion* found that schools that helped pupils feel that it is normal to experience mental and emotional health decline at some point in their lives created a more supportive and relaxed environment for such children[5].

- *Mental Health Education*: Integrating mental health education into the curriculum helps students understand and manage their emotions, recognise signs of mental health issues, and seek help when needed. According to research published in the *Canadian Journal of School psychology*, incorporating mental health education into the curriculum helped pupils not only understand the role and importance of mental health, but also helped them, their families, and peers recognise symptoms and to develop strategies to address these[6].

- *Support Services*: Providing access to counselling and psychological services within the school can offer immediate support to students facing emotional challenges. Research published in the *British Journal of Guidance and Counselling* found that support services such as counselling in school settings can boost both academic performance as well as a nurturing environment for pupils[7].

- *Training for Staff*: Equipping teachers and staff with the skills and knowledge to identify and respond to mental health issues can ensure that students receive timely and appropriate support. A study published in the *Children and Youth Services Review* discovered that teaching staff who received adequate mental health training have significantly more confidence in being able to determine the

[3] Implications of emotion regulation on young children's emotional wellbeing and educational achievement: Educational Review: Vol 68, No 4
[4] Academic Performance in Primary School Children With Common Emotional and Behavioral Problems - Mundy - 2017 - Journal of School Health - Wiley Online Library
[5] School inclusion for children with mental health difficulties | Emerald Insight
[6] Mental Health in Schools - Jacqueline A. Specht, 2013
[7] Counselling in schools: Looking back and looking forward: British Journal of Guidance & Counselling: Vol 27, No 1

signs of poor mental health amongst pupils as well as how to support such pupils with their learning[8].

- *Parental Involvement*: Encouraging parents to be actively involved in their children's emotional wellbeing can strengthen their support network and create a consistent approach to mental health.

Therefore, schools are well positioned to improve the mental and emotional wellbeing of children, particularly given that young residents spend significant portions of their time in school settings. A key case in point Is from West Sussex, where the County Council provides significant support and interventions in schools throughout the County; including through providing mental health education, training and advice for staff, and working with parents and carers to foster a supportive environment for children and young people's mental health and emotional wellbeing overall[9].

Hence, working collaboratively with schools to improve children's emotional wellbeing and mental health offers numerous benefits. One way is through contributing to Early Intervention. Early identification and intervention can prevent the escalation of mental health issues. Schools can play a pivotal role in recognising early signs of distress and providing necessary support. The Committee urges Oxfordshire's system partners to explore ways in which to support Prevention and Early Intervention through finding avenues of working with schools in this regard. Additionally, collaboration between schools, parents, and mental health professionals can create an integrated support system that addresses the diverse needs of children. This holistic approach ensures that students receive consistent care both at school and at home. By fostering an environment that prioritises emotional wellbeing, schools can empower students to take control of their mental health. Educated and supported students are more likely to develop resilience and coping strategies that will serve them throughout their lives.

Recommendation 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.*

***Responsibility for adopting recommendations*:** The Committee is pleased to see that a series of suggestions and recommendations were made in the DPH annual report as to how to improve the emotional and mental wellbeing of Oxfordshire's young residents. The manner through which these conclusions have been reached was also well articulated in the annual report. Adopting these recommendations would understandably require a collective effort amongst all system partners to deliver on them. Having said that, the successful implementation of such recommendations hinges on identifying which

[8] Educators' perceptions of youth mental health: Implications for training and the promotion of mental health services in schools - ScienceDirect
[9] Mental Health Support Teams in school celebrate 5th Birthday - West Sussex County Council

of Oxfordshire's system partners would have some form of responsibility for carrying out specific tasks. Whilst it is understandable that it is not the Director of Public Health's responsibility to assign recommendations onto all system partners, there is a point about having regular contact and interactions with relevant system partners as to how they could collectively determine which of them may be better placed to work on delivering each of the recommendations. Perhaps one way to achieve this is via the Health and Wellbeing Board, through looking at how these recommendations could be tied into the Start Well aspects of the Health and Wellbeing Strategy's work and the Board's evaluation of this.

A key reason for specifying who is responsible for implementing the annual report's recommendations is to enhance transparency and accountability within the Oxfordshire system. This would also facilitate the process of monitoring progress and ensure that potential work programmes are being executed effectively. This not only ensures that the recommendations are being adopted, but also helps in identifying areas where additional support or resources might be needed to further support services for children's emotional and mental wellbeing.

Furthermore, initiatives to improve children's emotional and mental health often require coordinated efforts from various system partners. Therefore, clear identification of which organisation could contribute in which way would help foster better coordination and collaboration among partners. It would allow for a more organised approach where each of Oxfordshire's key stakeholders understands their role in the broader framework of improving children's mental health. A key example of this is how Surrey County Council's Public Health Team worked closely with local NHS system partners to develop a 'Mental Health Improvement Plan', which involved the establishment of key recommendations which every system partner took accountability for and reported against at regular intervals. This approach led to improved coordination and collaboration between the County's system partners which felt more empowered to support children's mental health and wellbeing[10].

As such, when responsibilities around children's emotional and mental wellbeing are clearly defined, communicated, and agreed, it would help in building trust among Oxfordshire's partners, stakeholders and the wider general public. Transparency in this process would ensure that everyone involved knows who is accountable for different aspects of the efforts to improve children's mental health services, including prevention work around this. Such trust is crucial for gaining public support and engagement, which are indispensable for the success of any public health initiative.

[10] Report

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

Collaboration between Communities: Community collaboration and the sharing of ideas could play a vital role in enhancing health and wellbeing at the local community and neighbourhood level. By fostering connections and encouraging the exchange of knowledge, communities can create supportive environments that address common challenges and promote overall wellbeing. The Committee understands that coproduction is embedded in some form within the interactions that system partners have with key stakeholders around children's emotional and mental wellbeing. However, the Committee did not receive as much information as to the degree to which greater collaboration and sharing of ideas between communities (for the purposes of improving health and wellbeing at the local community/neighbourhood level) is being fostered or encouraged. This would not be the sole responsibility of the County Council's Public Health team and its NHS partners, but also rather the responsibility of key stakeholder or voluntary sector organisations also.

Further collaboration between communities in Oxfordshire could foster a sense of unity and shared purpose amongst the diverse group of residents in the County. When diverse groups pool their knowledge and resources, the results can be transformative for Oxfordshire. Some key benefits of this community-based collaboration could include:

- *Enhanced resource allocation*: Communities can play a crucial role in determining where resources should be allocated or reallocated, and this can help ensure that all communities throughout the County have greater access to necessary tools and facilities that can help children and young people lead healthier lives; such as healthcare centres, recreational spaces, and educational programs. This could help to reduce health inequalities also, which is a key objective of Oxfordshire's system partners. A key example of where this community-based collaboration was fostered with the support of the County Council is in Surrey. The Council had introduced the *Together for Surrey* programme, which involved supporting cand encouraging communities to share information and experiences in integrated platforms through websites and public events, with the aim of increasing contact and interaction within and between communities to understand where the key health and wellbeing challenges lie for the County's residents[11].

- *Improved knowledge exchange*: Collaborative efforts could allow communities to learn from each other's experiences and best practices, leading to more effective and innovative solutions to common problems.

[11] Introducing 'Together for Surrey' - Surrey County Council

- *Increased social cohesion*: Working together on shared goals fosters relationships and trust among community members, strengthening the social fabric and promoting a supportive environment. A key case in point is from Lancashire, where the County Council developed its *Cohesion and Integration Strategy 2024-2028,* which aims to generate community cohesion to mitigate inequalities within and between communities, ensuring that all community members have equal opportunities to thrive and live healthy lives[12].

Effective collaboration requires structured approaches and mechanisms to ensure that ideas and resources are shared efficiently. Some strategies to facilitate collaboration include community forums and workshops, where regular meetings and workshops can provide a platform for Oxfordshire's community members to discuss issues, share ideas, and contribute to the development of joint initiatives with the support of the County Council and the NHS. In addition, digital tools such as online platforms and social media should also be utilised to connect communities across Oxfordshire, allowing for the exchange of information and coordination of efforts. There is also a point about developing partnerships with local organisations. System partners should ideally collaborate with local businesses, voluntary sector organisations, and government bodies to provide additional resources and support for local community initiatives in the County. Much of this may already be somewhat practiced by the Public Health team and its NHS partners, and it would be useful for there to be greater transparency and sharing of information around this work.

As such, a collaborative approach to improving community health and wellbeing can have far-reaching impacts for Oxfordshire's residents. Some of the positive outcomes could include:

- *Better access to healthcare*: Shared resources and joint initiatives can improve access to healthcare services, ensuring that all community members, including children and young people, receive the care and attention that they need from services.

- *Promotion of healthy lifestyles*: Collaborative efforts can lead to the creation of programs and facilities that encourage physical activity, healthy eating, and mental wellness for children and young people, all of which are already-existing objectives for the Council and its partners.

- *Enhanced mental health*: Social cohesion and a supportive community environment can significantly improve mental health outcomes for children and young people, reducing feelings of isolation and fostering a sense of belonging.

[12] Councillors to discuss new strategy to promote community cohesion and integration | Lancashire County Council News

Therefore, greater collaboration and sharing of ideas between communities at the local level would be essential for improving health and wellbeing in Oxfordshire. By working together, communities can leverage their collective strengths to address common challenges, enhance resource allocation, and foster a supportive and cohesive environment. The positive impacts of such collaboration are profound, leading to healthier, happier, and more resilient neighbourhoods.

Recommendation 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.*

Legal Implications

13. 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 n consultations.

14. 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'.

15. 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.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – in the Chair
District Councillor Katharine Keats-Rohan (Deputy Chair)
Councillor Jenny Hannaby
Councillor Michael O'Connor
District Councillor Paul Barrow
District Councillor Elizabeth Poskitt
District Councillor Susanna Pressel
District Councillor Dorothy Walker
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

Contact Officer: Dr Omid Nouri

Health Scrutiny Officer
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

May 2025

Stephen Kinnock MP
Minister of State for Care
Department of Health and Social Care
39 Victoria Street
London, SW1H 0EU

16 May 2025

Dear Minister,

Following the very worrying issues around patient safety and value for money raised by the recent Sunday Times investigation, I am writing to urge the Department of Health and Social Care to initiate a review into the current use and oversight of independent sector providers (ISPs) in NHS-funded cataract surgery.

The College has for some time expressed deep concern about the unintended consequences of moving the majority of NHS cataract surgery to ISPs. These concerns appear to be shared by your officials too; as reported by the Sunday Times, a leaked ministerial briefing note stated that "*NHS England have concerns covering value for money, unnecessary operations, impacts on workforce and training, poor follow-ups and patient safety*".

Recent research shows that between 2018/19 and 2022/23 NHS spending on ISPs delivering cataract surgery increased by at least 380% to £282 million annually and the overall proportion of the NHS ophthalmology budget spent on cataracts jumped from 27% to 36%. This shift has led to funding, workforce and infrastructure being diverted here at the expense of resourcing for conditions such as glaucoma and age-related macular degeneration that can cause irreversible sight loss if not treated swiftly.

Concerningly, 67% of ophthalmology clinical leads feel that independent sector provision has had a negative impact on patient care, and commissioners have told us they are unable to properly control their cataract spend and, therefore, effectively resource services that can prevent irreversible sight loss. This is backed up by recent research that found in 2021/2022 14% of ISP-delivered cataract surgery was on a non-contracted basis – rising to 25% in seven integrated care boards.

This question of value for money and making the best use of scarce resources is paramount. A review must address issues including non-contracted activity, potential upcoding practices, and payments in referral pathways. Equally, patient safety must be central – particularly in relation to the management of post-operative complications.

To ensure we have comprehensive, sustainable eye care services into the future, we must invest in NHS ophthalmology – its workforce, training, estate and infrastructure. We hope that the forthcoming 10 Year Plan and Long Term Workforce Plan refresh will reflect these priorities.

I look forward to working with you and all stakeholders in the eye care sector to address the challenges relating to independent sector provision of NHS-funded cataract surgery to ensure we do all we can to prevent avoidable irreversible sight loss.

Yours sincerely,

Professor Ben Burton
President, The Royal College of Ophthalmologists

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

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

Date of meeting: 5th June 2025	**Item:**

Title of paper Oxfordshire Urgent and Emergency Care system pressures

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

Purpose and executive summary:

This paper describes the urgent and emergency care system pressures in Oxfordshire.

The papers cover:

- System pressure for Urgent and Emergency Care (UEC) within Oxfordshire
- Oxfordshire Integrated improvement programme

Action required:
HOSC members are asked to:

- Note the UEC system pressure and Integrated Improvement Programme.
- Discuss the content and any further points for consideration.

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

Date of paper: 5th June 2025

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Buckinghamshire Oxfordshire and Berkshire West Joint Overview and Scrutiny Committee

Urgent and Emergency Care pressures, Oxfordshire

Introduction

1. This paper outlines the system pressures within Urgent and Emergency Care (UEC) in Oxfordshire.
2. The papers cover:

- System pressures
- Oxfordshire Integrated Improvement plan

Urgent and Emergency Care system pressures

3. Urgent and emergency care (UEC) services perform a critical role in keeping Oxfordshire residents healthy and play a specific part in supporting patients to receive the right care, by the right person, as quickly as possible.
4. **Emergency Care:** This involves life-threatening illness or injury resulting from an accident, both requiring immediate treatment from both ambulance services and Emergency Departments (ED's).
5. **Urgent Care:** This mainly covers non-life-threatening illness or injury but requires clinical assessment.
6. The system delivering urgent and emergency care needs to continue to develop to meet the continued increase in demand.
7. We have an integrated improvement programme to support the system to meet the increase in demand.
8. **Key areas of pressure:**

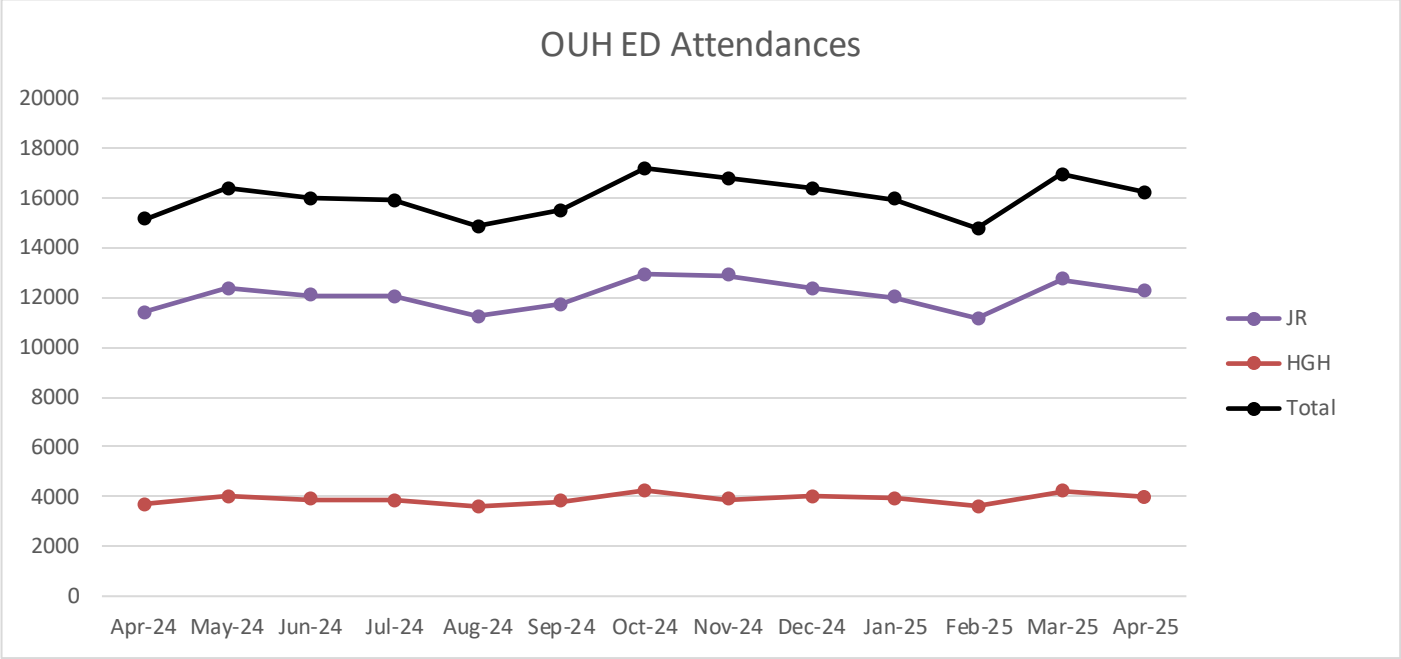
- **People struggle to access care at the right time in the most appropriate setting.**
  - As we continue to develop and improve pathways, patient, carer and family feedback is incorporated in the design of services to ensure that people are assessed in the right place to meet their needs.
- **Potential delay in ambulances getting to people who require it in an emergency**
  - Prevent avoidable ambulance dispatches to create capacity for those who require it in an emergency.
  - The ambulance service to maximise alternative pathways to the Emergency Department (ED)
  - For ambulances that convey people to ED, staff are focussed on ensuring handover takes place within 15 minutes of arrival to the ED., This allows ambulance crews to leave to assess the next person who requires an emergency assessment.
- **Unable to meet demand - Capacity Management**
  - Optimising the urgent care offer to meet the needs of the local population, including the use of urgent treatment centres (UTCs), minor injury units and same day emergency care units.
  - Increasing capacity within the virtual ward to support all those who can be assessed in their own home are.
- **Mental Health meeting crisis response within the community setting**
  - Increasing the provision of crisis response 24/7 to refine further opportunities to divert people from the ED and to a more appropriate setting.
  - Reducing inappropriate mental health placements
  - Reducing Length of stay across Mental Health inpatient beds

Challenges

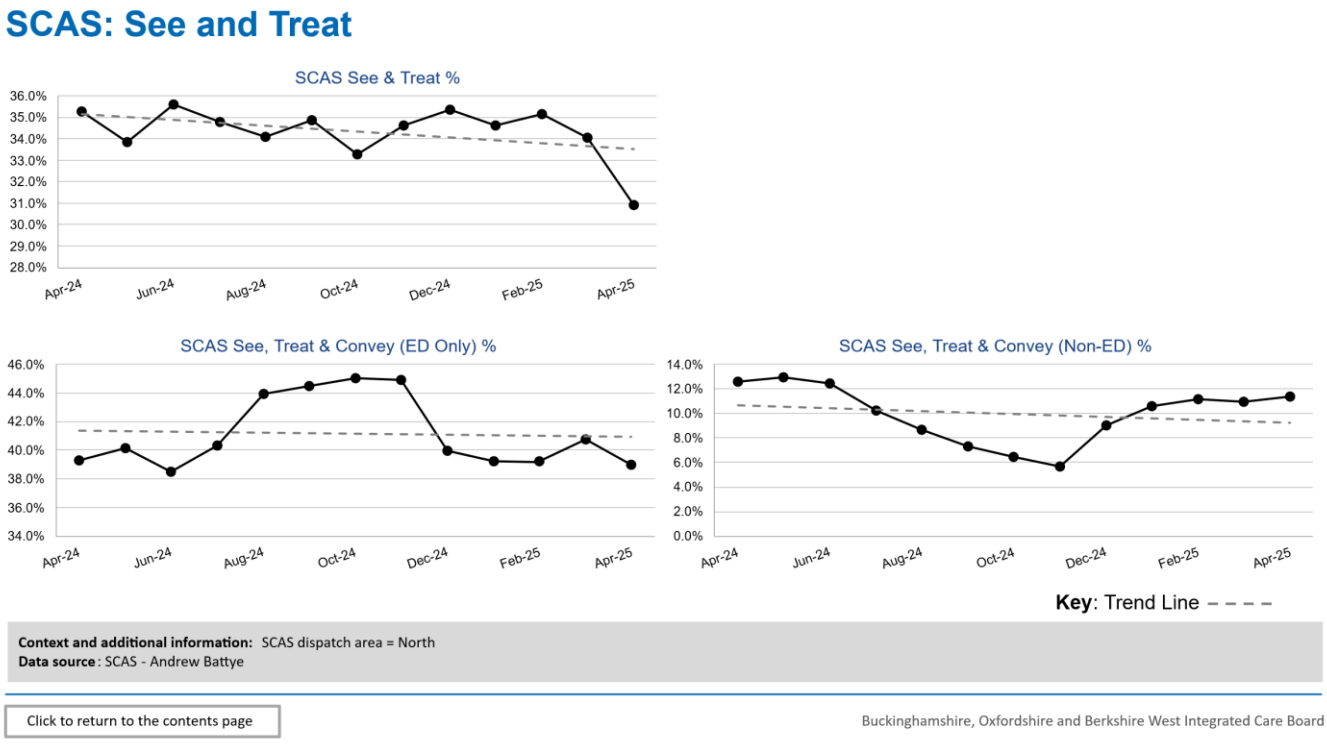
9. Workforce and funding remain a challenge.

10. Continue to observe an increase in emergency attendances to ED and admissions resulting in an increase in demand in the hospital setting. Figure 1.1 illustrates the fluctuating demand across the Oxfordshire ED's.

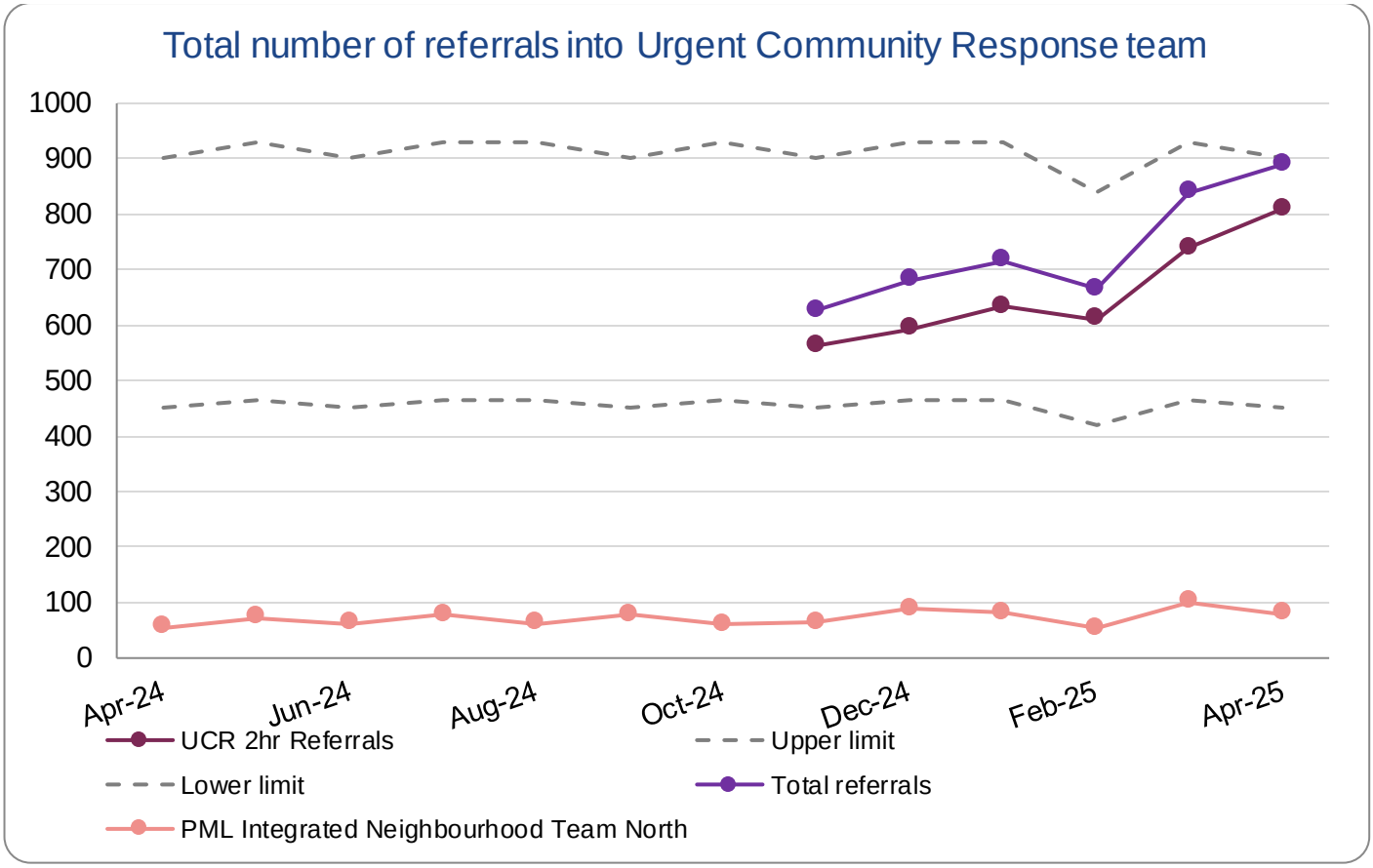
Figure 1.1 **Demand in Oxfordshire Emergency Departments**



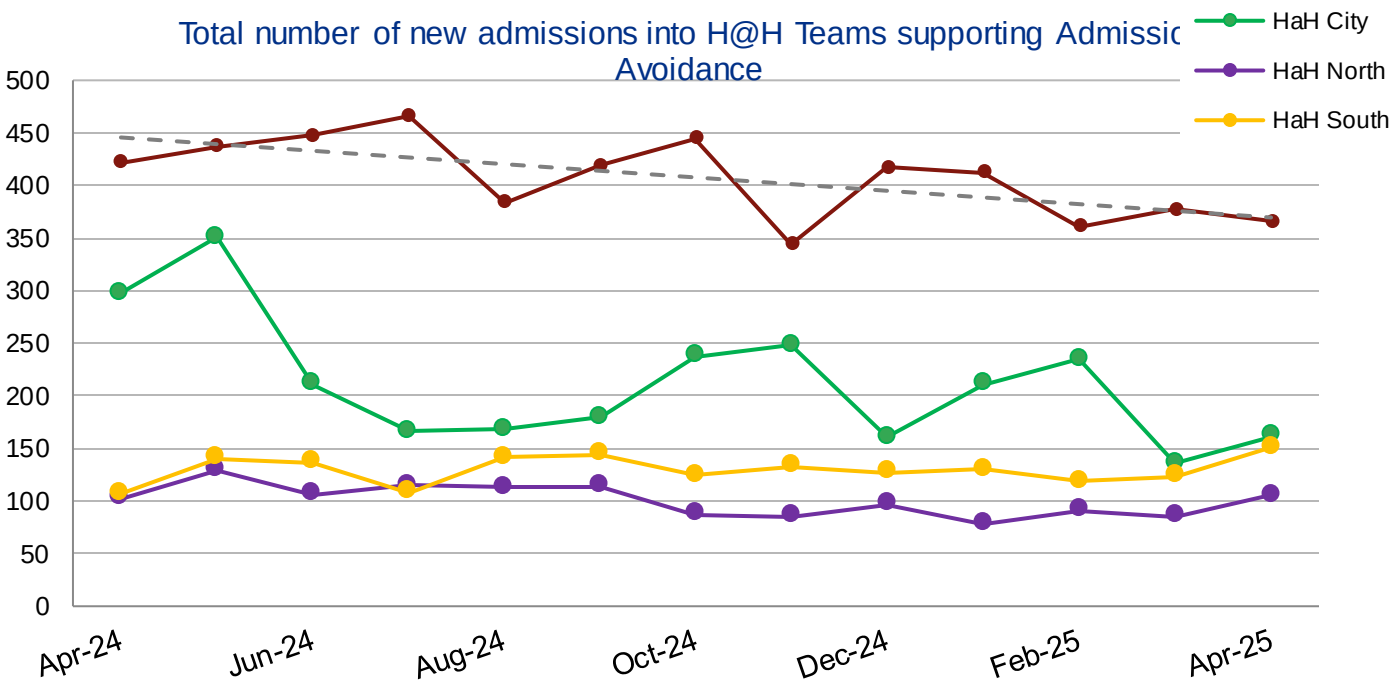
11. Figure 1.2 The number of people seen, treated and conveyed by the ambulance service



12. Over 2024/25, South Central Ambulance Service (SCAS) have seen a reduction in the number of people seen and treated in their own home and an increase in the number of people conveyed to non-ED locations.
13. Figure 1.3 The total number of referrals to urgent community response.

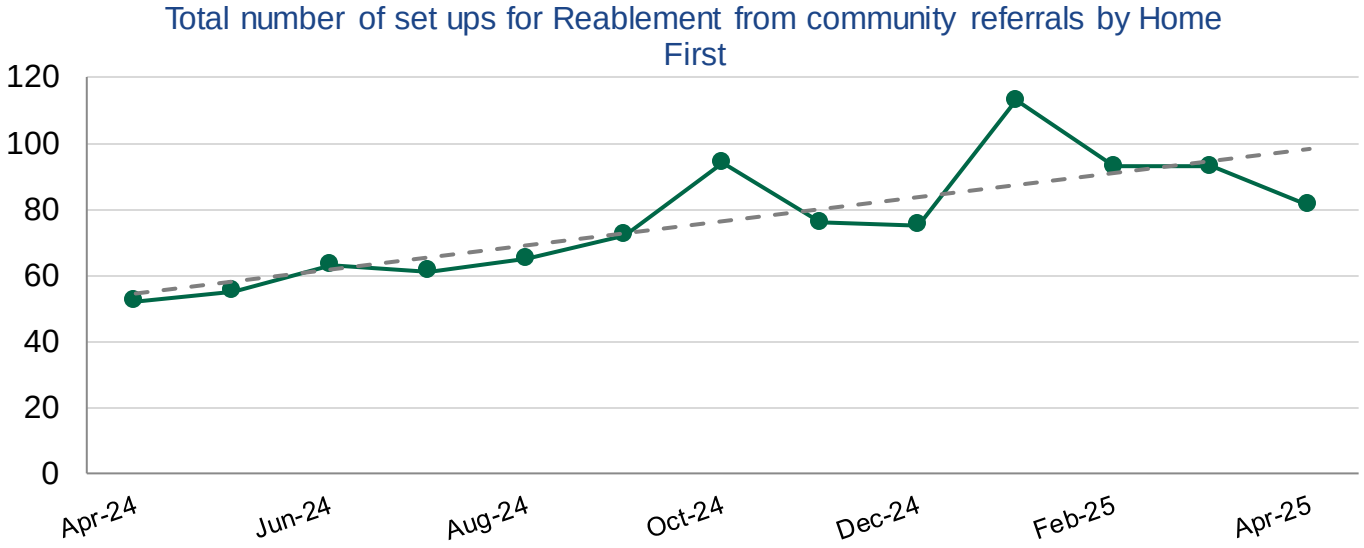


14. Figure 1.3 illustrates the increase in referrals to Urgent Community Response. This represents some of the increase in urgent care demand in Oxfordshire.
15. Figure 1.4 Total number pf people cared for in Hospital @ home service

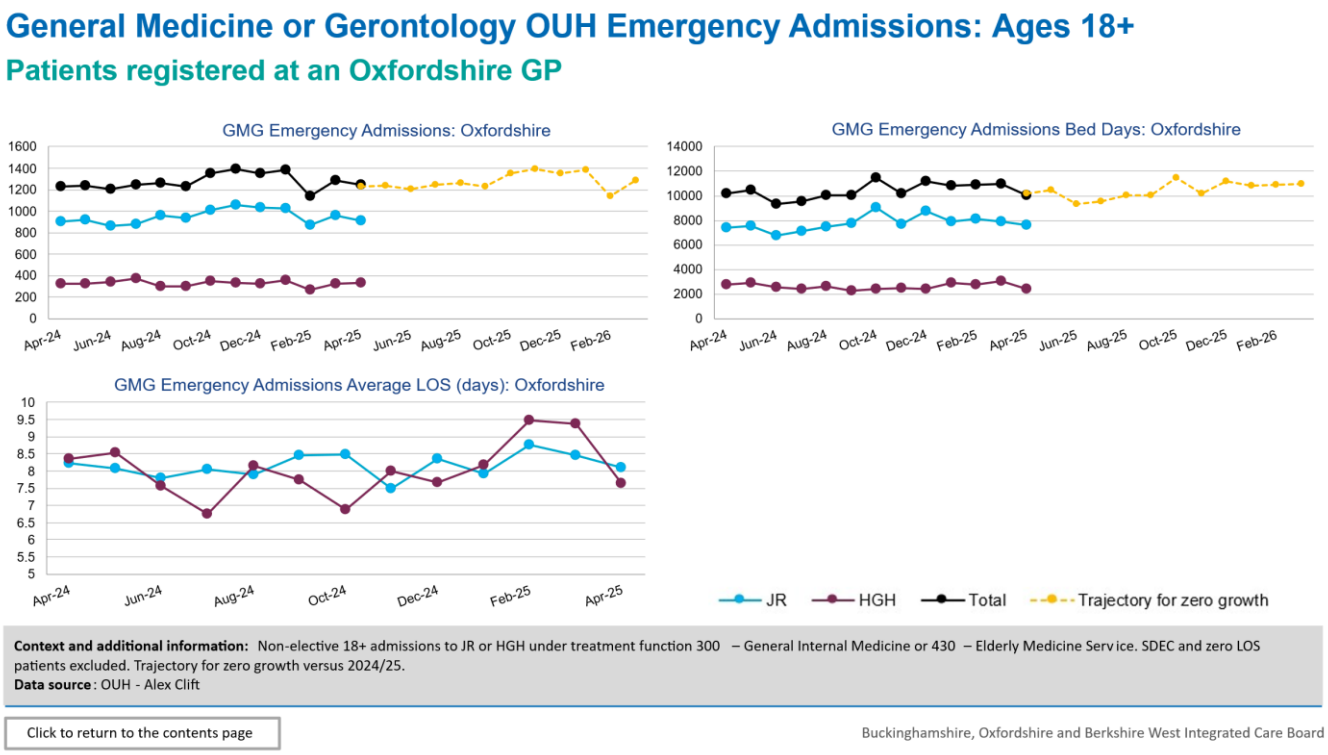


16. Figure 1.4 on the previous page shows the slight decrease in the number of people assessed and treated in the hospital @ Home service. This related to the service being at full capacity with people who require additional visits to keep them in their own home.

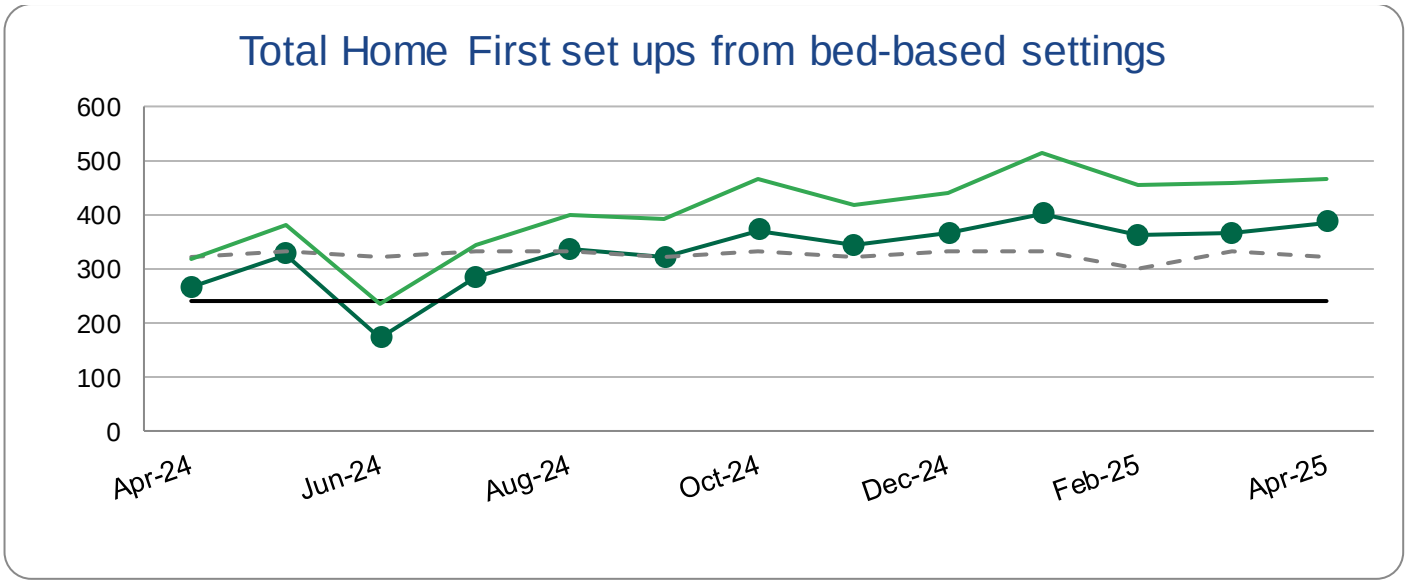
17. Figure 1.5 The increase in the number of people who received home first whilst in the community.
18. Figure 1.5 Total number of people receiving Home First in the community.



19. Figure 1.6 Emergency admissions to general medicine and gerontology



20. Figure 1.6 shows the total number of emergency admissions over the last year and the average length of stay. In Oxfordshire we are aiming to have zero increase in emergency admissions to general medicine and gerontology for Oxfordshire residents. The yellow line is the trajectory for the forthcoming 12 months.
21. Figure 1.7 Total number of set ups from bed-based care which has been increasing over the last 12 months.
22. Figure 1.7 Total number of Home First set ups from bed-based care.



Oxfordshire priority areas for 2025/2026.

23. **Set the foundations for the neighbourhood model**: A consistent system wide population health management
24. **Improve flow through mental health crisis and acute pathways and access to children and young people's services**.
25. **Improve waiting time in the Emergency Departments**: A minimum of 78% of people assessed, discharged and transferred out of the Emergency Department (ED) within 4hrs of arrival. 98% of people spend less than 12hrs in the ED.
26. **Improve ambulance response times**: Reduce avoidable ambulances dispatches and conveyances and reduce ambulance handover delays.
27. **Improve and standardise care for those who require it on the same day**: optimising the urgent care offer to meet the needs of their local population, including the use of urgent treatment centres (UTCs)
28. **Reduce length of stay in hospital and ensure that people are cared for in the most appropriate setting**: Increasing the percentage of patients discharged by or on day 7 of their admission

Integrated Improvement programme

Neighbourhood model

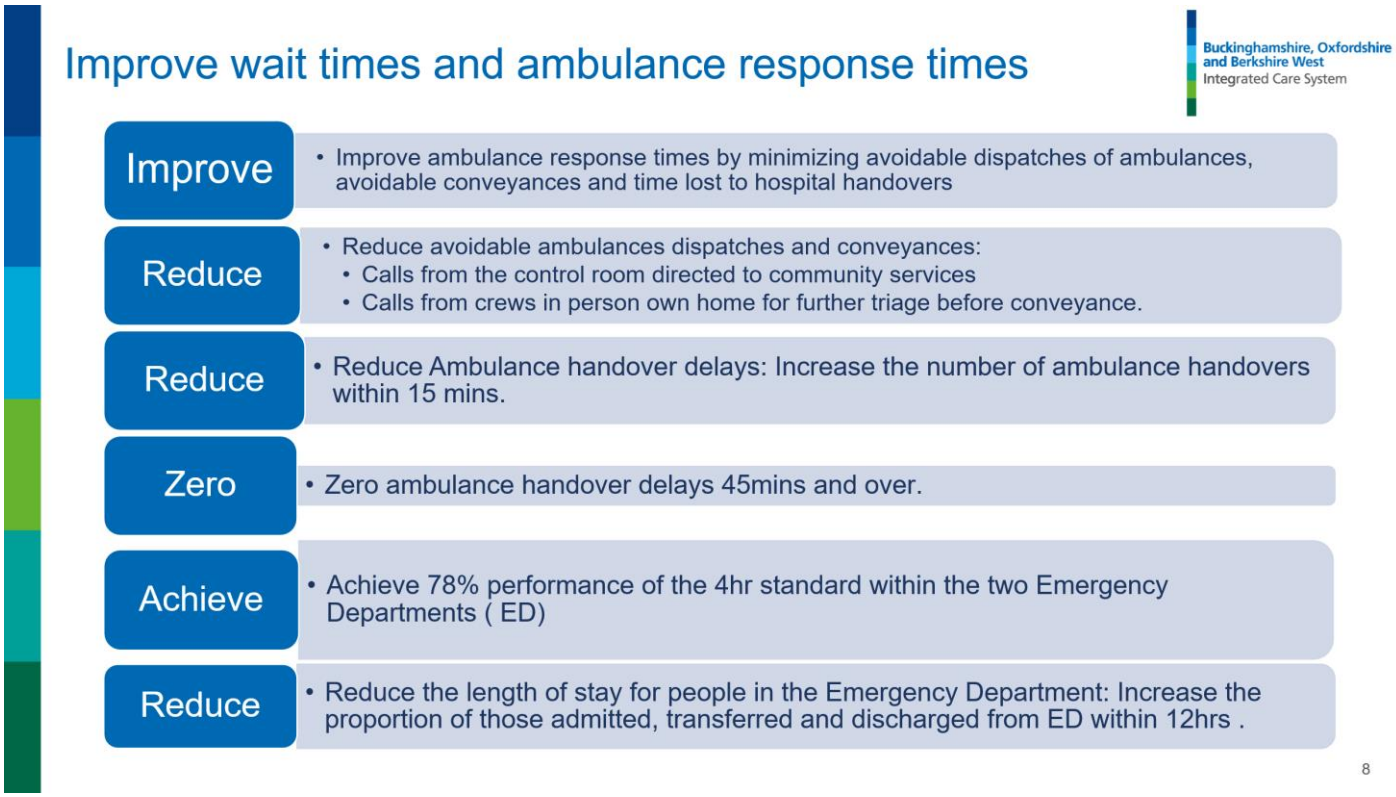
29. **Population health management (PHM)**: Capture the entire population at an individual level, while covering person-level demographics, medical conditions, service usage, cost of care, other clinical risk factors and wider determinants of health. Data to be used for forecasting resource required and to support integrated working with additional focus on those who are underrepresented e.g., those with Mental Health diagnosis, learning disability and autism.
30. **Neighbourhood multi-disciplinary teams (MDTs):** MDTs will deliver responsive care based on the individual's needs. MDTs are focussed on population cohorts with specific, complex needs.
31. **Integrated intermediate care** : To provide therapy led short-term rehabilitation and reablement services. Access will be directly from community or as part of discharge planning using a discharge to assess approach.
32. **Urgent neighbourhood services**: For people with escalating or acute health needs, systems should have a standardised and scaled urgent neighbourhood service, aligned and planned around local demand.

Urgent and Emergency Mental Health

Improving access to mental health crisis care

33. Provision of 24/7 crisis team through redesign of existing services (merger of night team and street triage)
34. New 24/7 police 136 and health professionals' advice line, reducing avoidable 136 / ED attendance
35. Expansion of crisis team capacity across Oxfordshire
36. All age, 24/7 mental health text service "SUNRISE"
37. Further refine opportunities for diversion from the Emergency Departments, including review of crisis alternatives such as safe havens.

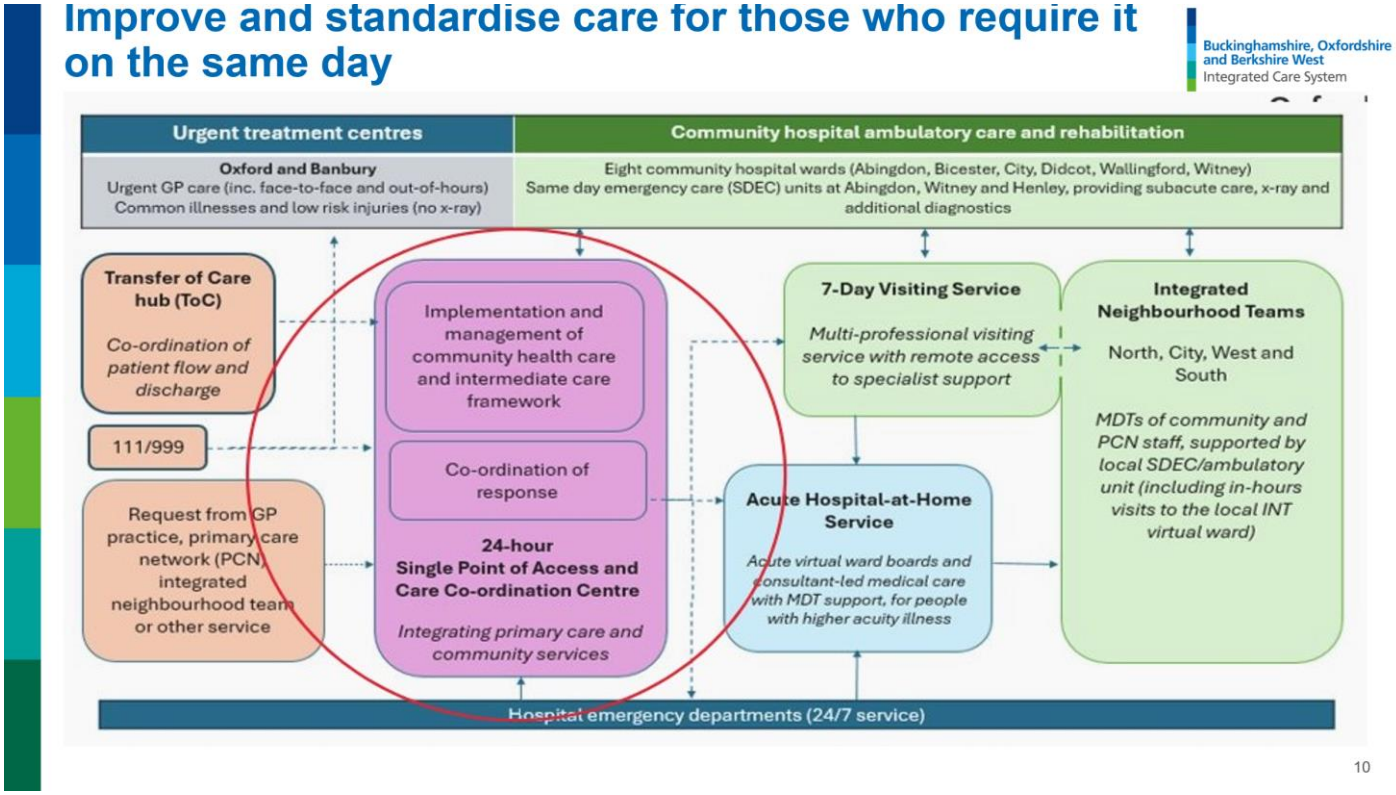
Reducing the length of time in Emergency Departments



Improve and standardise care for those who require it on the day

38. **Single Point of Access** to maximise referrals routes to all Same Day Emergency Units. Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.
39. Review how the various visiting services to see how capacity can be increased to meet the unmet demand. Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.
40. Increasing the proportion of patients seen, treated and discharged in 1 day or less using the principles of same day emergency care (SDEC), reduce variation across acute and community SDEC's
41. Optimising the urgent care offer to meet the needs of their local population, including the use of urgent treatment centers (UTCs) including Minor Injury Units (MIU's).
42. Improved home treatment provision with staff imbedded on inpatient wards
43. Embed new BCF schemes agreed for 24/25 (additional embedded housing workers).

Figure 1.8 Diagram of urgent care pathway through Single Point of Access



Reducing length of stay in hospital

44. Working across the NHS and local authority partners to reduce average length of discharge delay in line with the Better Care Fund (BCF).
45. Identify people at the earliest point during their hospital admission as to who will require support to return home.
46. Increasing the percentage of patients discharged by or on day 7 of their admission
47. Continue to increase the number of people returning directly to their own home. Introducing sustainable activity that will continue into the community to prevent falls and further deconditioning?
48. Assess people's needs in their own home, following discharge.
49. Develop plans with Neighbourhood teams to continue the holistic care of each person as an individual.

Future work and next steps

50. We will continue to develop the Oxfordshire integrated improvement programme to meet UEC system pressures for 2025/2026.

Your voice on health and care services

Report to the Oxfordshire Joint Health Overview Scrutiny Committee

5 June 2025

Table of Contents

1. Healthwatch Oxfordshire reports to external bodies

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

We attended Health and Wellbeing Board, Health Improvement Board, Children's Trust. 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, Population and Patient Experience Committee, and Prevention and Health Inequalities Committee.

2. Update since the last Health Overview Scrutiny Committee (HOSC) Meeting - 22 Jan 2025:

Healthwatch Oxfordshire reports published to date:

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.

- **What we heard about GPs in Oxfordshire** (May 2025) Summarising insight from 345 people between April 2024 - March 2025. Healthwatch Oxfordshire hears more about GP services than any other health or care service – and whilst new access systems have benefited some and improved aspects of access, others tell us they face significant barriers to navigating and reaching the support they need. There is still a sense that some of the systems can be inflexible and do not meet the needs of some of the more vulnerable and that better communication would support public understanding of changes taking place in the way GP services work. In a survey we ran asking for people's views on our priorities for 2025-26 GP access was a key issue for many people – this report highlights what we have heard on this theme over the last year.
- **What we heard about pharmacy** (Mar 2025) April 2024- March 2025. This report fed into the Oxfordshire Pharmaceutical Needs Assessment.
- **Your views on health and wellbeing in Wood Farm and Town Furze** (Feb 2025) as part of the community health profiles (part commissioned by Oxfordshire Public Health)

- **Hearing from Men in Oxfordshire** – (March 2025). Capturing voices of 167 men across Oxfordshire and their views on health and care. We heard about challenges including work pressure, lack of time, cost of living and stigma. Things supporting men to look after their health included being active, eating well, and support of friends, family and community. This was shared at Oxfordshire Men's Health Partnership.

To read more about the impact of all our reports see here: https://healthwatchoxfordshire.co.uk/impact/

In addition:

- We launched a new **video highlighting the great work by PPGs patient champions and practice managers** in patient involvement in GP practices across the county. See here: https://healthwatchoxfordshire.co.uk/our-work/our-videos/ and here https://youtu.be/OWyt_R7mNlo
- We supported Oxford Community Champions in production of **two videos** on the **role of GP receptionists**, and on **accessing interpreting and language support** – useful for all community groups and others. See here: https://healthwatchoxfordshire.co.uk/our-work/our-videos/ and here https://youtu.be/S2u6cSt7PHE
- Produced a **new leaflet** on supporting SEND children to look after their teeth: https://healthwatchoxfordshire.co.uk/news/new-leaflet-on-supporting-send-children-to-look-after-their-teeth/ following on from our work with community connectors looking at this topic. Available in printed form on request.

Enter and View Visits

Since the last meeting we made Enter and View visits to the following services:

- To three Connect Health sites in Bicester, Henley and Oxford
- Phoenix Ward Littlemore (see below)

We published the following **Enter and View** reports: (https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/) on visits to the following services:

- Phoenix Ward, Littlemore Mental Health Centre (May 2025)
- Hand and Plastic Injuries Clinic (April 2025)
- Freeland House Nursing Home, Freeland (March 2025).

- Ferendune Court Care Home, Faringdon (Feb 2025)
- Boots Pharmacy, Oxford City Centre (Feb 2025)

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

Webinars: Since the last meeting we have held four Public Webinars (Jan- March 146 people attended the webinars):

- January: GPs 'It's all about teamwork'
- February: 'Have your say on the future of the NHS'
- March: 'Mental wellbeing support for our children and young people'
- In March we held a closed webinar for PPGs linking with BOB ICB
- May 'Livewell in Oxfordshire' – with focus on prevention services and support.

To see our webinar programme, zoom links and recordings of all webinars: https://healthwatchoxfordshire.co.uk/news-and-events/patient-webinars/ All welcome.

Our **next webinar** will be:

- Tuesday 10th June 1 p.m. *'Let's talk about menopause'*. All welcome.

Our ongoing work:

- We published our priorities for the year 2025-6 here: https://healthwatchoxfordshire.co.uk/about-us/our-priorities/
- We published a summary of our Quarter 4 (Jan-March) activity here: https://healthwatchoxfordshire.co.uk/impact/activities-and-achievements/
- Ongoing face to face **outreach** to groups and events across the county, including hospital stands (we have been speaking to patients at Horton, NOC, JR and Churchill since last meeting), community groups and events e.g. Eid Extravaganza at Blackbird Leys, Wantage PPG led Wellbeing Day, libraries, Adderbury Coffee Morning among others. We also attend PPG meetings and support PPGs e.g. an NHS Change consultation with Benson and Millstream Practices in March. (Between Jan-March we spoke to 350 people during outreach.)

- We jointly presented with **community researchers** we supported from OX4 Food Crew and Oxford Community Action to share the research at Oxford's Marmalade Festival (Part of Skol world forum) on '*Feeding Oxford in a cost of living crisis*'
- Healthwatch Oxfordshire **Board Open Forum** (see here https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/) – took place on 22 May in Didcot Civic Centre, and combined with our team being 'out and about' on the streets in Didcot during the day to hear from members of the public. We heard about challenges to GP access, and concerns about rapid expansion of development with pressure on services.

3. Key issues we are hearing from the public:

Along with our themed research above, we hear from members of the public via phone, email, online feedback on services (see here for reviews and to leave a review https://healthwatchoxfordshire.co.uk/services), and when out and about. This enables us to pick up and raise with health and care providers and commissioners on emerging themes. Below is a brief insight into some of the themes we are hearing public on different issues.

- Challenges people experience in **making GP appointments (See details in GP report -link above)**

  "I rang my GP at 8am and by the time I got through at 8.18am there were no appointments left for the day so they told me to ring 111. I rang them and had to go through my history with them, and they said they would get me an appointment with my GP as they had some emergency slots they could allocate me to. Within five minutes I got a text message from my GP to say there were no appointments for me, so I rang 111 back and had to go through my story again and they said they would ring the GP back and check. They then came back on the call to say they had my surgery on the phone but they wouldn't confirm if I had an appointment or not, so we then ended up having a three-way call with my GP and 111. […] I then had to answer all the same questions for a third time and then they said someone would call me back in six hours."

  "My experience of the GP's, nurses and administrative staff at this practice has been universally excellent. But they are increasingly hidden behind an impenetrable piece of software called Engage-consult. I have just spent over an hour trying to make a routine, non-urgent appointment to have a nurse

check a mole, which has recently started to itch. Eventually I got through to a reception on the telephone, who explained that I can only keep trying Engage-consult. When I do that, I get a message saying there are no more appointments available for today. BUT I DON'T WANT AN APPOINTMENT FOR TODAY! It can be next month as far as I'm concerned."

"I struggle with my hearing and I cannot hear anyone on the phone. I have to go and visit the practice to book an appointment."

- **Social care**

  "Carers just don't have the time to care, they are stressed and under pressure. I never get the same carers as they are always leaving because of the stress of doing the job being under pressure for time, having to leave people".

- Difficulty **getting to appointments**, including people who are eligible for non-emergency patient transport but could not arrange the service to align with their appointment, and people who are not eligible but have been given appointments at some distance from where they live

- **Audiology** – people having challenges since drop-in clinic stopped running

  "My hearing aid stopped working and I followed the instructions to either mail my hearing aid with a wait of up to 2 weeks for repair or to email Adult Audiology. I emailed to ask if an appointment could be made as I did not want to be without them, as this would be very isolating and difficult for me - working full-time. After no response received [several days later] I phoned them. Phoning is not my preferred method of communication, as a hard of hearing person, but I can use the phone okay. […] I was advised the soonest appointment at the local Hospital to where I live would be end of May!! And so could I come to the JR on Saturday instead. Reluctantly I have agreed to this, but I cannot believe this can be the situation for our local area. It's just not good enough. I believe if you have age related hearing loss, you may be able to use a local provider (like Specsavers) but for any other hearing loss it's under the NHS."

- **ADHD:** Healthwatch England has recently published a report on ADHD, with some respondents giving feedback on support in Oxfordshire:

"I would like the NHS to look at more feedback from the ADHD community so that the way in which diagnoses are done reflect more adult experiences of this type of brain. We share more symptoms which should be recognised. The referral process should take into account and make reasonable adjustments for those with ADHD. For example filling in long boring forms and returning them expeditely is REALLY hard. And to do that more than once, as I have had to, is even worse. Trying to get information about waiting times or appointments is also really hard for someone with ADHD. Listening to people who say "oh, everyone seems to think they have ADHD these days" is really frustrating. Many of us have lived with this our whole lives without knowing about it - of course there is going to be a back log of people now coming forward"

"Support and empathy has been non-existent. Medication is constantly out of stock which exasperates the symptoms and creates more anxiety and stress"

- **Quality of care:** generally, once people are able to access the support they need, we hear that the care they receive from health professionals is good.

  "*Having fallen at home and called 111, they phoned back and they called an ambulance as I was still on the floor in pain. Paramedics carried out their tests and took me to A&E. The miracles were: no queue at A&E; straight to a cubicle, quick to Xray, diagnosis; empty bed in Trauma ward; slot available in theatre following day [weekend day]. So broken [bone] screwed together within 24 hours of falling. Can't fault anything. Thanks a million."*

  "I recently had nasty viral bug that led to an ongoing complication. I saw a very kind pharmacist the same day I first called, then a physician's associate who called in the GP. If I had had to wait for a GP appointment, I would have had to wait for longer. I was really impressed with the physician's associate system - the person I saw was knowledgeable, very professional and kind and was great on checking things with the GP. I would be really happy to use this system again."

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MARMOT PLACE- EMBEDDING MARMOT PRINCPLES IN OXFORDSHIRE

Report by Ansaf Azhar, Director of Public Health and Communities, Oxfordshire County Council.

Purpose of Paper

This paper provides an update to the Health Overview and Scrutiny Committee on the progress that has been made on Marmot Place programme of work, since agreement of the programme at the Health and Wellbeing Board in September 2024.

Executive Summary

1. The purpose of this paper is to update HOSC on the progress made so far in implementing the Marmot Place programme of work. The programme was agreed at Health and Wellbeing Board in September 2024. This paper provides information on the specific topic areas requested by HOSC.

2. The main drivers of health inequality are the wider determinants of health or what we increasingly refer to as the "building blocks" of health. On behalf of the wider Oxfordshire system, Oxfordshire County Council has been developing a two-year work-programme with Sir Michael Marmot's Institute of Health Equity (IHE) who are the leading international experts in approaches to addressing social determinants of health, to review our current activity and support more effective action going forward.

3. The Marmot programme aims to create a fairer and healthier Oxfordshire and has eight principles to enable areas to consider their approach through an inequalities lens. All principles are equally important, but in order to make early traction to address inequalities, Oxfordshire is initially focusing on three of these principles as below:

   (a) Give every child the best start in life
   (b) Create fair employment and good work for all
   (c) Ensure a healthy standard of living for all

4. To support these principles work has begun to:
   5.1 Identify gaps and draft recommendations around health equity in early years, with a focus on leadership and partnerships.
   5.2 Forge links with the Oxfordshire Inclusive Economy and Local businesses around social value, access to education and employment.

5.2 Understand rural inequalities in Oxfordshire beyond, the ten most deprived wards.
5.4 Explore implementation of a system to support GPs and other primary care colleagues identify patient needs through a health inequality lens.
5.5 Develop policy research projects focusing on inequalities through the Local Policy Lab, a new alliance between the University of Oxford, Oxford Brookes University and Oxfordshire County Council. This research will directly link back to the Marmot Place principles.

6. It is important to note that becoming a Marmot Place is not about stopping what we are already doing, but evaluating and building on existing work, measuring and tackling rural inequality, and utilising research to find innovative solutions.

Exempt Information

7. There is no exempt information contained in this report.

Overview of Oxfordshire as a Marmot Place

Specific goals and objectives for Oxfordshire becoming a Marmot Place.

8. The Institute of Health Equity defines a Marmot Place as a place that 'recognises that health and health inequalities are mostly shaped by the social determinants of health: the conditions in which people are born, grow, live, work and age, and takes action to improve health and reduce health inequalities.' A key aspect of a Marmot approach to tackling health inequalities is 'proportionate universalism', which means that there is a balance between universal services (open to all) and targeted services that reach those who need it most.

9. Becoming a Marmot Place cannot be achieved by one organisation in isolation, partners need to work together across the system to ensure that addressing inequalities is at the heart of everything that we do. Taking a proportionate universalism approach is one way for partners to achieve this.

10. The specific goals and objectives of Oxfordshire becoming a Marmot Place are outlined below:

10.1 Provide high-quality evidence based external review of the range of activities happening in Oxfordshire to tackle health inequality and inform potential gaps.
10.2 Act as a glue to bring together all activities to tackle health and social inequalities across Oxfordshire.
10.3 Enable us to measure rural inequality and take effective actions.
10.4 Mobilise our policy research function to find innovative solutions to tackling health inequality and help secure external funding for future work.

Aligning the goals of Oxfordshire as a Marmot Place with broader health and prevention agendas nationally and locally.

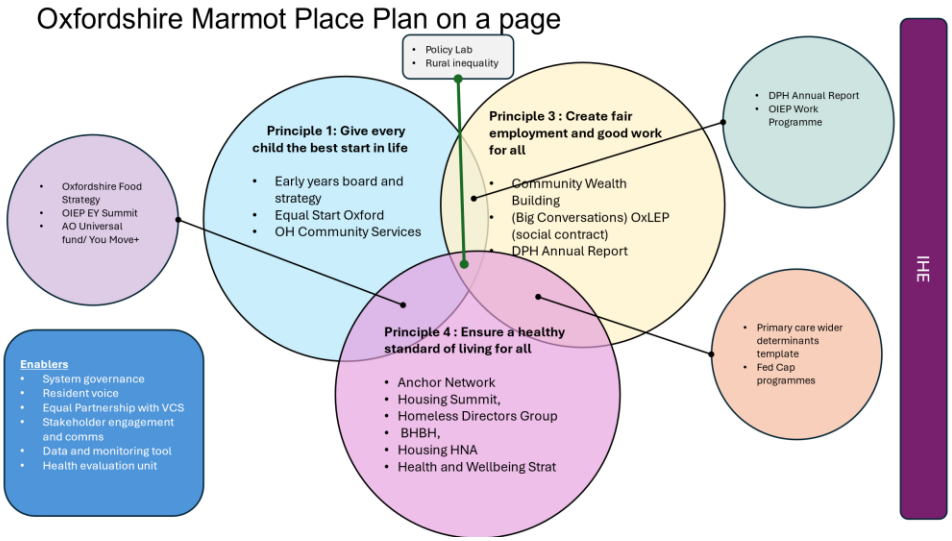
11. System partners in Oxfordshire are already active in delivering a range of projects and programmes that seek to address inequalities in Oxfordshire. Some of these programmes address a particular building block of health (such as housing or employment) or a particular health behaviour (such as physical inactivity or tobacco use). Others are broader taking an asset-based community development approach (including the Community Profiles, Brighter Futures in Banbury, Well Together Programme, Oxfordshire Food Strategy and the Oxfordshire Way prevention programme), considering all the local assets that contribute to the health of its residents.

12. The aim of the Marmot Place partnership is not to duplicate any of these existing programmes but to bring an inequalities lens to everything we do. The Marmot approach provides an overall strategic and evidence-based framework that brings these different strands of work together. It aims to ensure there is a common methodology underpinned by the Marmot Principles that exists across all programmes of work.

13. The proposed Marmot Place partnership builds on the Oxfordshire Health and Wellbeing Strategy which identified action on health inequalities as one of the three cross cutting principles that spans across all priority areas for action. The Strategy's 10 priorities span across four thematic areas- the first three being stages of the life course, with the fourth the Building Blocks of Health. This final theme describes the social determinants of health that are the structural drivers of much of the inequality we see locally.

14. Various areas in the country have now partnered with Institute of Health Equity to become a Marmot Place. Oxfordshire has some specific features which make Oxfordshire stand out as a unique Marmot Place. These include the increasingly close working with the Universities in Oxford, taking place-based approaches to research and wellbeing, and the combination of the rural and city communities.

15. This plan on a page demonstrates how the workstreams of the Marmot Place programme complement each other and link to other areas of work in the county:



Key stakeholders involved in the planning and implementation of Oxfordshire as a Marmot Place.

16. The Oxfordshire Marmot Place Steering Group brings together strong local leadership across the Oxfordshire System to maximise the positive impact of the Marmot work in Oxfordshire. The Steering Group sits as a time limited subgroup of the Prevention and Health Inequalities Forum (PHIF).

17. The PHIF aims to reduce avoidable and unfair differences in health outcome among residents of Oxfordshire. To achieve this, it brings together key leaders from the health system in Oxfordshire to ensure primary, secondary and tertiary prevention initiatives are effective and to move forward new initiatives and collaboration where there are gaps. The forum uses the Core 20 plus 5 framework to help structure its work but will also prioritise focus on issues specific to the Oxfordshire context. Through the PHIF, the Marmot Place Steering Group reports into the Place-Based-Partnership and Health and Wellbeing Boards in Oxfordshire. This will be in place for the duration of the two-year partnership between the Oxfordshire System and the Institute of Health Equity (IHE) at University College London.

18. Its aim is to ensure the work-programme is of relevance to all system partners and therefore maximises the extent to which the work supports the system to go further and faster in tackling the avoidable and unfair differences in health and wellbeing that we see between different population groups locally.

19. The steering group aims to:

    19.1 Ensure system wide engagement in the Marmot Place initiative
    19.2 Provide local insight and intelligence to inform focus and priorities of the work programme
    19.3 Ensure the voice and perspective of diverse communities in Oxfordshire feed into the Marmot Place work, especially from those seldom heard

19.4 Review outputs/ products/ documents from Institute of Health Equity to check they will meet local priorities and have the desired local impact

20. Membership of the Steering Group is as follows

(a) Oxfordshire County Council
(b) Oxford University Hospital NHS Trust
(d) District Councils
(e) NHS Integrated Care Board (ICB)
(f) Primary Care
(g) Oxford Health
(h) Voluntary and Community Sector organisations
(i) Healthwatch Oxfordshire
(j) Oxfordshire Inclusive Economy Partnership
(k) Start Well System
(m) Institute of Health Equity at University College London

21. In addition to the steering group a Marmot Advisory Board, made up of senior system leaders, meets two to three times per year and is chaired by Sir Michael Marmot and gives strategic oversight to the overall work. Membership of this group includes:

(a) Institute of Health Equity at University College London
(b) Oxfordshire County Council
(c) District Councils
(d) Political representation
(e) NHS Integrated Care Board (ICB)
(f) NHS Providers
(g) Primary Care
(h) Voluntary and Community Sector
(i) Faith Sector
(j) Business
(k) Inclusive Economy
(l) Primary/ Secondary Education
(m) Further Education
(n) Higher Education

Arrangements for Leadership of Oxfordshire as a Marmot Place

Priority Principles

22. Further to a systemwide prioritisation exercise which reviewed the eight Marmot principles (as detailed in the diagram below) alongside the health and wellbeing strategy, it was agreed that Oxfordshire would initially focus efforts on the following three principles:

22.1 **Principle 1: Give every child the best start in life**: Ensuring that children have equal opportunities for health and development, regardless of their background or circumstances.

22.2 **Principle 3: Create fair employment and good work for all:** Focusing on good working conditions, job security, and fair wages.

22.3 **Principle 4: Ensure a healthy standard of living for all**: Addressing economic disparities and providing access to essential resources such as housing, food, & healthcare.

23. To support these principles several workstreams are emerging:

24. **Early Years** – starting on early years, work is under way to identify gaps and draft recommendations around health equity in early years, considering leadership and partnerships. This work is progressing with the Institute of Health Equity and within existing children's partnership meeting structures.

25. **Local economy -** Links being forged with Oxfordshire Inclusive Economy partnership to consider social value and access to education and employment. Work has also started to consider how we can engage with local businesses and industry to adopt a Marmot place approach.

26. **Rural Inequalities -** In January 2025 the Rural Inequalities Working Group put out a call for data and perspectives on access to healthcare, social or other services, employment, and infrastructure in rural areas. 43 responses were received from a range of organisations and sources. This included data from organisations working in rural areas, reports of previous work, personal experience accounts from residents, and feedback from Primary Care Network Directors/ Social Prescribers and charities.

27. Between March and May 2025, the data was collated to identify areas of inequalities in rural Oxfordshire alongside the development of a rural inequalities' dashboard, to be used by district councils to decide on areas for further community engagement. During June-October 2025, the group plan to launch community engagement in the form of focus groups to discuss rural challenges and potential solutions.

28. **Primary Care –** Exploring implementation of a system to support GPs and other primary care colleagues identify patient needs through a health

inequality lens. Utilising successful approaches from other Marmot places, the aims are to improve awareness of current and ongoing work in this area, improve and streamline access to relevant resources and (if required) increase referral to necessary Voluntary Community Organisation provision. Work will consider how to make that onward "referral" / signposting / reporting of it. Effective engagement required to ensure successful coordination and implementation.

29. **Policy Lab -** The University of Oxford and Oxford Brookes University will play a pivotal role in establishing Oxfordshire as a Marmot Place. They will leverage their academic expertise and research capabilities to guide actions aimed at reducing health inequalities through their Policy Lab partnership with Oxfordshire County Council, initiated in 2024.

30. In 2025, the Policy Lab successfully recruited 14 Fellows to support six research projects aligned with the Marmot principles. These Fellows have commenced collaboration with Policy Officers and their Academic Advisers to design and implement these initiatives. Additionally, three Chief Scientific Advisors will be appointed to provide ongoing strategic research leadership and evidence-based guidance within key Marmot priority policy areas over the next three years.

How system partners will be assessing the social determinants of health locally.

31. It will be important for system partners to assess the social determinants of health locally, as part of the Marmot Place programme. This will be achieved through:

    31.1 Defining evidence-based actions for health equity, based on insight captured from Phase 1 of the Marmot Place programme.
    31.2 Reviewing what activities/workstreams we should stop, what we should start, and which activities we should carry on.
    31.3 Considering what action is required to address any identified inequality.

32. Partners will undertake research and evaluation to:

    33.1 Develop a framework for the evaluation of new or existing programmes that aim to improve health equity.

    33.2 Work with the Oxfordshire “Local Policy Lab” and the local research partnership to develop an approach to researching new and innovative ways to address the building blocks of health and reduce health inequality.

33. The outputs from the Marmot Place programme are expected to include:

    34.1 IHE involvement in mapping activity across Oxfordshire and disseminate the findings from Phase 1.

34.2 Working in partnership with the Policy Lab to develop a health equity framework for evaluation and other accountability tools.

34.3 Developing a monitoring tool.

34.4 Defining new approaches which can reduce inequalities in Oxfordshire.

Measuring if the Marmot Place programme has made a difference.

34. Partners will work together to determine how far Oxfordshire has come in tackling health inequalities through monitoring and evaluation. This will include the development of a monitoring tool that can be used to track progress against improving health equity in Oxfordshire. In doing so, partners will be able to ensure work streams contribute to existing outcomes such as the framework of the local Health and Wellbeing Strategy. There will be system wide support for the implementation and oversight of the actions to improve health equity.

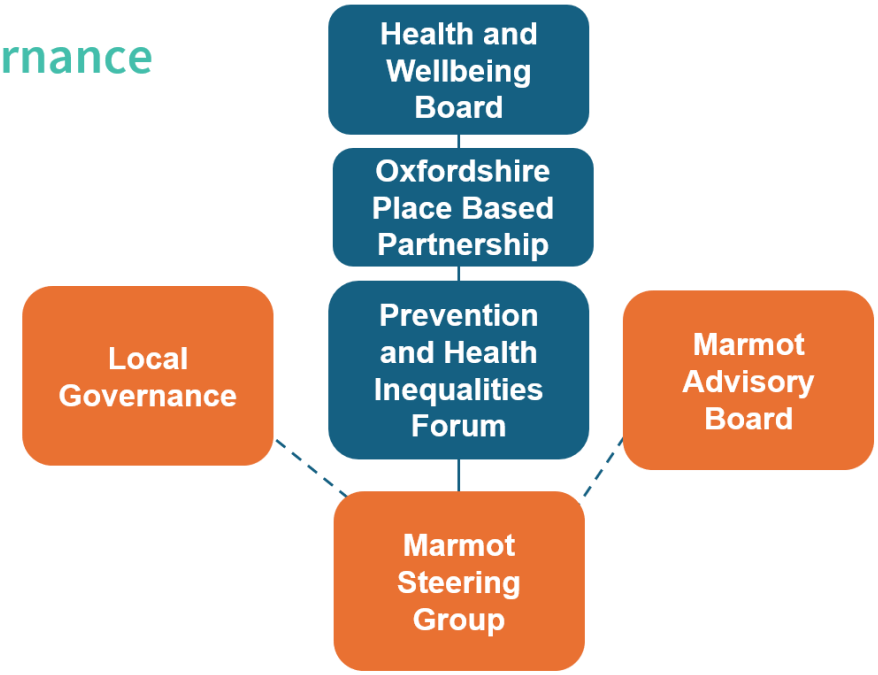
How the government's devolution plans may impact the work around Oxfordshire becoming a Marmot Place.

35. Until we know more about the plans for devolution we will continue to develop Oxfordshire as a Marmot Place. If our footprint changes, we will review the situation and bring in any new areas that we are joined with to become part of the Marmot place.

How accountability and transparency will remain at the heart of the Marmot Place initiative.

36. There is a clear governance structure in place with multi partner accountability at a senior level through the Oxfordshire Marmot Place Advisory Board. There is a reporting mechanism in place that feeds into other existing governance structures to ensure join up across the Oxfordshire system.

Governance



Corporate Policies and Priorities

37. The Marmot Place programme supports the below priorities from the Oxfordshire County Council Corporate Plan 2023-25

38.1 Tackle inequalities in Oxfordshire – through Principle 4: Ensure a healthy standard of living for all: Addressing economic disparities and providing access to essential resources such as housing, food, & healthcare.

38.2 Prioritise the health and wellbeing of residents - through Principle 4: Ensure a healthy standard of living for all: Addressing economic disparities and providing access to essential resources such as housing, food, & healthcare.

38.3 Create opportunities for children and young people to reach their full potential – through Principle 1: Give every child the best start in life: Ensuring that children have equal opportunities for health and development, regardless of their background or circumstances.

38.4 Work with local businesses and partners for environmental, economic and social benefit – through Principle 3: Create fair employment and good work for all: Focusing on good working conditions, job security, and fair wages.

Financial Implications

The financial implications section should be completed by a member of the finance service

38. The approved core costs of the Marmot Place programme have been detailed below for information:

Payments to University College London, Institute of Health Equity.

Financial year	Payment amount
2024/25	£90,275
2025/26	£51,300
Total	£141,575

39. The funds for payment to the University College London, Institute of Health Equity are allocated from within the Oxfordshire County Council Public Health Wider Determinants budget. The payment includes covering the costs of Institute of Health Equity staff time working on the Oxfordshire Marmot Place programme. There will also be some project costs associated with individual workstreams as they develop through the programme.

Comments checked by:

Emma Percival, Assistant Finance Business Partner,
emma.percival@oxfordshire.gov.uk (Finance)

Legal Implications

The legal implications section should be completed by a member of the legal service

40. The funding above is below threshold for procurement legislation, so that does not apply. However, the funding will need to comply with the Council's Contract Procedure Rules. Any subsequent agreement for the funding that needs to be put in place between the parties will also need legal support on the negotiation, drafting and completion of that agreement.

41. When using public health grants, local authorities must consider reducing inequalities in health between people in their area.

Comments checked by:

Gareth Hale, Senior Solicitor and Team Leader, Contracts and Conveyancing
Gareth.hale@oxfordshire.gov.uk

Staff Implications

42. Oxfordshire County Council officers are working on the delivery and implementation of the Marmot Place programme alongside colleagues from partner organisations.

Equality and Inclusion Implications

43. This project will actively seek to improve healthy equity and the health and wellbeing of inclusion groups. A formal Equality Impact Assessment is not required.

Sustainability Implications

44. There are no sustainability implications associated with this report.

Risk Management

45. A detailed risk assessment is not required for this work. Oversight and input on the work programme will be provided by the Health and Wellbeing Board.

Consultations

46. Public Consultation is not required for this proposal, however meaningful engagement and joint work between organisations on the Health and Wellbeing Board and communities themselves lies at the heart of what will make this work successful.

NAME Ansaf Azhar, Director of Public Health and Communities, Oxfordshire County Council.

Annex: Nil

Background papers: Nil

Contact Officer: Kate Holburn, Interim Deputy Director of Public Health, Oxfordshire County Council
kate.holburn@oxfordshire.gov.uk

May 2025

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Oxford Health
NHS Foundation Trust

Oxford Health NHS Foundation Trust

Quality Account 2024/25

Contents

Part 1: Statement on Quality

Part 1: Statement form our Chief Executive

Oxford Health NHS Foundation Trust

Welcome to the Oxford Health NHS Foundation Trust 2024/25 Quality Account.

The information within the Quality Account brings an overview and summary of the successes and challenges we have experienced over the year whilst working towards achieving the quality priorities that we set ourselves to deliver during 2024/25 to improve the care and services we provide.

The report contains further detail about the nine areas we identified as quality priorities for the trust, and I am pleased to say that we have made progress in each priority area, with particular improvement in the following areas:

We exceeded the targets that we set ourselves to improve patient safety in inpatient care. Over 95% of people who were in our inpatient care that includes, community hospitals, mental health and forensic wards were assessed using a tool called NEWS2 that allows early identification of deterioration in patients physical health. This allows nursing staff to quickly identify and respond to any emerging concerns which can be critical in preventing serious health problems and saving lives.

We also exceed the reduction we aimed for regarding the use of restrictive practice in our mental health inpatient services. We focused on the reduction of use of prone (face or chest down) position during the year and further built upon the consistent reduction over the previous four years. Whilst we are pleased with our progress, we are committed to caring for people using the least restrictive options, to support this we have been more ambitious with our aims for this priority area for the next year.

The year also saw the embedding of the Patients and Carers Race Equality Framework (PCREF) as priority area for the trust. The framework exists to eliminate the unacceptable racial disparity in the Access, Experience and Outcomes of Black, Asian, and minority ethnic communities and significantly improve their trust and confidence in our services, our progress in this area is detailed in part 3 of the report. Alongside this we have also appointed an Anti-Racist Programme Lead to support our commitment to being an anti-racism organisation. We acknowledge that racial discrimination exists and that this has a profound impact across the NHS and in our own organisation and in the communities that we serve. We are working to remove systemic racial discrimination and to improve the experience of our staff and all who use our services.

continued on next slide

Part 1: Statement form our Chief Executive cont.

Oxford Health NHS Foundation Trust

Continuous improvement is at the heart of our organisation not only to respond to the changing nature of healthcare, but to ensure that we are meeting the health and wellbeing needs of our local communities. It is crucial that we work together with patients, their families, and carers to do this and most importantly, how we listen, respond, learn, and grow together. The report includes how we are approaching this and reports on progress made over the year to embed this as a fundamental across the trust.

Alongside successes, our biggest challenge throughout the year has continued to be meeting the demand for our services across all areas of the trust, colleagues' responsiveness and "can do" attitude has seen some incredibly innovative developments that have enabled us to continue to deliver high quality care and services, that are accessible to the people who need them. However, we remain concerned about our capacity to meet demand in a timely manner. Nonetheless, we have shared some highlights of successes in this area within part 2 of the report

As always, our achievements and ability to support those in need of our services are thanks to my dedicated colleagues. I would like to extend heartfelt gratitude on behalf of the trust Board to all colleagues for all their hard work and resilience during a challenging year. The incredible efforts of our Oxford Health team in caring for our service users, their families, and carers make me immensely proud.

I hope you enjoy reading about the progress we've made over the past year. I'm confident that we will continue to improve and develop our services to ensure they are not only timely but also provide high quality local care as close to home as possible.

To the best of my knowledge the information contained in this report is an accurate representation of the year's events.

Grant Macdonald - Chief Executive

Part 1: Introduction to our Quality Account 2024/25

Oxford Health NHS Foundation Trust

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS.

This definition sets out three dimensions to quality, which must be present in order to provide high quality services:

- ✓ **clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- ✓ **safety** – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety
- ✓ **patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

Our 2024/25 Quality Account looks back on the progress we have made over the past year to achieve our goals. The report also looks forward to the year ahead (2025/26) and identifies our priority areas for improvement and how we hope to achieve these.

Throughout the document we have used the terms patients, families, and carers to mean any person who has used or been involved with our services now or may be in the future.

The Quality Account should be read alongside the trust 2024/25 Annual Report that gives an overview of trust activity, summarises performance during the year and provides background information about its performance, business model and governance arrangements. The 2024/25 Annual Report can be found here: Insert Link when available

If you require any further information about the Quality Account please contact our Patient Advice and Liaison Service: pals@oxfordhealth.nhs.uk

Part 1: Our vision and values

Oxford Health NHS Foundation Trust

Our vision is that no matter who you are or where you are, you will tell us that you receive:

"Outstanding care delivered by an outstanding team".

The Trust works towards its vision through its values – **Caring, Safe, and Excellent**:

Caring

- Privacy and dignity is at the heart of our care.
- We treat people with respect and compassion.
- We listen to what people tell us and act upon what they say.

Safe

- Our services will be delivered to the highest standards of safety.
- All services will be provided within a safe environment for patients and staff.
- We will support our patients and staff with effective systems and processes.

Excellent

- We aspire to be excellent and innovative in all we do.
- We aim to provide the best services and continually improve.
- We will recognise and reward those who deliver excellence.

Part 1: Our Trust Strategy

Oxford Health NHS Foundation Trust

Five year strategy 2021-2026

The Trust strategy sets out Oxford Health's mission, vision, values and strategic objectives for the next five years (2021-2026). The purpose of the strategy is to act as a guide for future activity and planning across the Trust, and collaborations with other health and care organisations, to improve the overall health of local people.

The strategy is grouped into four strategic themes – Quality, People, Sustainability, and Research & Education. Each strategic objective has been worked into a set of key focus areas which seek to describe the objective in more detail and provide a framework for further activity and planning.

Read our 2021-2026 strategy

- Accessible Summary (pdf)
- One page summary (pdf)
- Full version (pdf)

Part 1: Our services

Oxford Health NHS Foundation Trust

Oxford Health is one of the largest NHS trusts in the country providing community health, mental health and specialised health services for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset.

Community health services

In Oxfordshire we are the main provider of community health services and deliver these in a range of community and inpatient settings, including eight community hospitals.

Mental health services

Our mental health teams provide a range of specialist healthcare in the community and from inpatient settings across the geographic areas of:

- Milton Keynes
- Buckinghamshire
- Oxfordshire
- Wiltshire
- Swindon
- Bath and North East Somerset (BaNES)
- Specialist health services

Our services are delivered at community bases, hospitals, clinics and in people's homes. We focus on delivering care as close to home as possible. In everything we do, we strive to be caring, safe and excellent.

Overall, our services are rated as "good" by the Care Quality Commission (CQC)

To find out more about our trust and the services we provide visit our website: www.oxfordhealth.nhs.uk

Part 1: Our services

We lead three NHS Provider Collaboratives, these are regional partnerships that provide specialised mental health services for patients, forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire and from Wales.

To find out more about NHS-led Provider Collaboratives visit: https://youtu.be/V4J0FX_Ifk4

The collaboratives we lead on are:

- The Thames Valley & Wessex Adult Secure Provider Collaborative, known as the For Me Provider Collaborative
- Thames Valley Children and Adolescent Mental Health inpatient services, Tier 4 Provider Collaborative
- HOPE (Healthy Outcomes for People with Eating disorders) Adult Eating Disorder Provider Collaborative

We are leading partners in:

- Buckinghamshire, Oxfordshire, Berkshire West (BOB) Mental Health Provider Collaborative with Berkshire Healthcare NHS Foundation Trust in partnership with BOB Integrated Care Board to improve the quality and efficiency of patient care across the neighbouring localities.

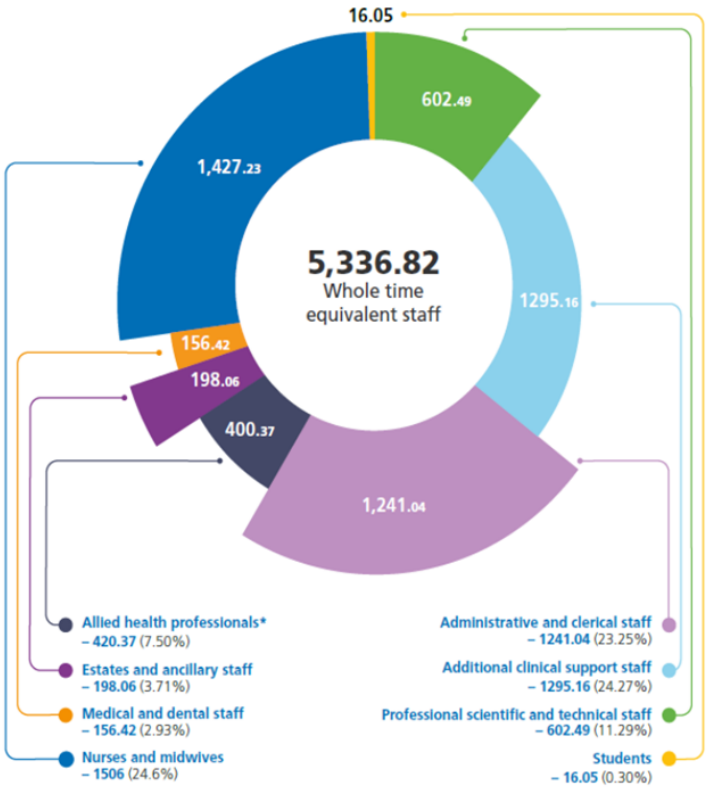
- Thames Valley Community Dental Services Partnership, a collaboration between Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Central and Northwest London NHS Foundation Trust. We provide specialist dental care for children, young people and adults with additional and complex needs who require specialised care that cannot be provided by the general dental service.

Part 1: Our people

We employ around **6,500 staff** who work across **150 Trust sites** and provide services to a population of **2.5 million people.**

Professions at Oxford Health

Oxford Health has some 6,920 people, or 5,336.82 whole time equivalent staff, made up as follows:



The launch of the National People Promise in 20/21 has given NHS Trusts a renewed drive to create a wellness culture for all. Providing the tools to help shift from a reactive response to staff wellbeing, to one that is proactive and preventative, truly embedded within our culture.

To make the People Promise a reality, we have tools available to us to ensure that our interventions are evidence based and truly making a difference to staff. The following slides outline how we support our staff

Part 1: Staff support and Wellbeing

Oxford Health NHS Foundation Trust

Staff support and wellbeing

As we continue our journey of developing a Wellness Culture within our Organisational Family, we are leading with a series of cultural changes; including the implementation of a **Restorative, Just & Learning culture**, underpinned by **Civility & Respect** including a focus on **Kindness into Action**.

We want Oxford Health to be a great place to work and thrive and we are committed to listening to what our staff tell us about their experience of working with Oxford Health. We will now continue our journey to continue to create a positive culture of civility and respect, supporting all colleagues in their Wellbeing, and enabling them to speak up in confidence, raising concerns, as well as developing managers at all levels to have a supportive, inclusive, and compassionate approach.

We have invested in the Restorative Just and Learning Culture (RJLC) culture change programme, promoting a psychological safe environment to better support staff when things go wrong and to encourage learning from incidents.

We have seen the difference this approach has made in other organizations.
By implementing these principles, we are transforming our culture in Oxford Health striving for a culture of kindness, patient safety and fairness.

WELLBEING MATTERS

Part 1: Staff support and Wellbeing

Oxford Health NHS Foundation Trust

Staff support and wellbeing

Looking after your emotional wellbeing

Improving your physical wellbeing

Living a healthy lifestyle

Commitment to career progression and opportunities

Fully supporting the OHFT family

A flexible approach to daily work life

Financial Support for Staff!

Your area leads to wellbeing

We have a range of offers for staff support and wellbeing, that includes our Employee Assistance Programme (EAP).

Oxford Health's 24/7 staff helpline is fully operational offering compassionate support for our people whatever challenges they face.

WELLBEING MATTERS

Part 1: Staff support and Wellbeing

Staff support and wellbeing

During the year our Chief Nurse has introduced two new programmes of work aimed to support staff in the workplace by reducing harm to staff and increasing our offer of post incident support.

Staff Sexual Safety

As an organisation we have signed the NHS England first ever sexual safety charter. By signing this charter, we have committed to reducing and eliminating any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and have a programme of work to support the ten core principles and actions to help achieve this.

Reducing staff experience of Violence and Aggression in the workplace

As employers we must ensure that all staff feel safe, supported and empowered to report incidents of violence and abuse and feel confident that action will be taken to keep them and others safe. We have created a programme of work that that includes defining and monitoring issues, identifying why violence occurs, developing and testing approaches, and supporting widespread adoption of effective initiatives.

We have also progressed our offer of TRiM - trauma risk management as post incident support, This is in addition to the existing support and learning options, including Post Incident Psychological Support (PIPS), further information about this is in Part 3.

Part 1: CQC

Oxford Health NHS Foundation Trust

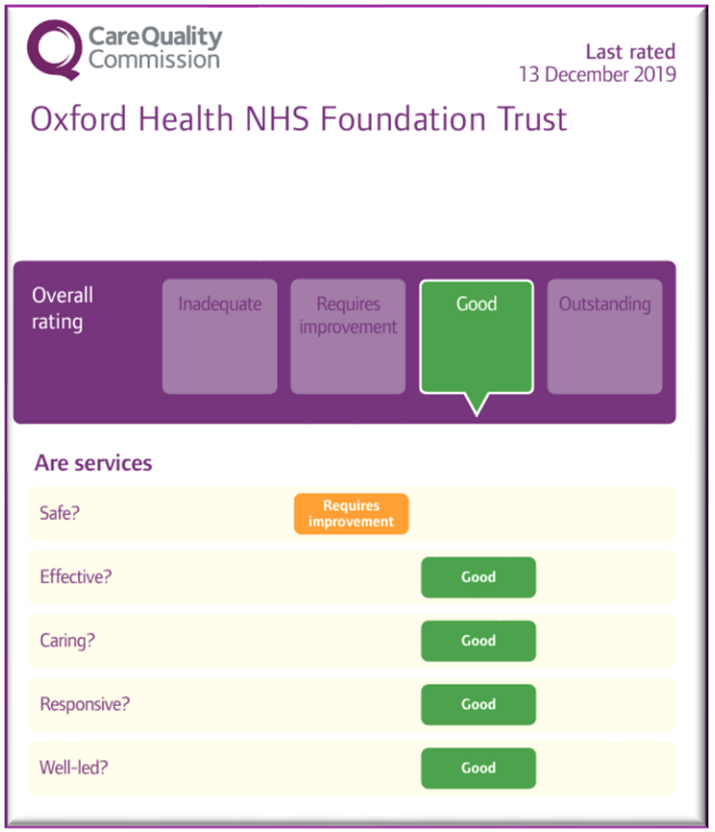
The CQC's new approach to assessment

The CQC continue to roll out the new assessment framework as part of their regulatory approach. The new assessment framework retains the 5 key questions, are services:

- ✓ **safe**
- ✓ **effective**
- ✓ **caring**
- ✓ **responsive to people's needs**
- ✓ **well-led**

The CQC will assess services against quality statements. These have replaced the key lines of enquiry (KLOEs), prompts and ratings characteristics. Assessments may be responsive (in response to information of concern) or planned.

To find out more about the changes visit: [Assessment - Care Quality Commission]



The CQC last assessed Trust services as **Good** at 13th December 2019.

During November 2024 the CQC assessed trust forensic inpatient services applying the new assessment framework. We are currently awaiting formal feedback and the outcome of the assessment that will inform the re-rating of the services assessed.

Patients and colleagues involved in the assessment process gave positive feedback regarding the experience and as a trust we have shared the learning from the inspection experience in a range of ways across the trust to support colleagues to understand the process.

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

More Keystone Mental Health & Wellbeing Hubs opened their doors during 2024!

Adults experiencing mental health challenges are able to draw on support from the Keystone Mental Health & Wellbeing Hub Oxford thanks to NHS mental health professionals, Peers Support workers who have their own experience of mental health challenges, services which help people to remain in work or find employment and third-sector mental health services, in order to thrive among friends, family and their community. The hub is also linked to their local GP surgeries.

Wantage, Kidlington, Cowley & Chipping Norton saw the opening of the hubs in response to people saying that they would like to see specialist care available at local level via their GP surgery, and improved communication between GPs and mental health services. This builds upon the hubs already open in Banbury Abingdon.

Part 1: Summary of successes!

The HSJ Award for the ‘Best Pharmaceutical Partnership with the NHS was described by the organisers as ‘improving accurate, early diagnosis of Alzheimer’s Disease’.

The partnership is delivering work to improve early and more precise diagnosis of Alzheimer’s Disease, with an emphasis on developments in Mental Health Trusts.

Dementias Platform UK and Lilly UK collaborated on this together with 4 NHS Trusts enrolled from the DPUK Trials Delivery Framework:

- Oxford Health NHS Foundation Trust
- Greater Manchester Mental Health Foundation Trust
- University Hospitals Sussex Foundation Trust
- Sheffield Teaching Hospital Foundation Trust

It is an ambitious national collaborative pilot involving Lilly UK, Dementias Platform UK, and the NHS trusts, seeking to deliver earlier and more precise Alzheimer’s Disease diagnoses.

Its further goal is to understand the costs and benefits in order to establish a framework for services across the NHS. Organisers believe that this transformative project has the potential to revolutionise the diagnostic landscape of AD in the UK, thereby improving outcomes for patients.

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

Family, friends and carers handbook launched

Oxford Health launched a new Carers Handbook for anyone who cares for or supports someone receiving care and treatment from our adult and older adult mental health services.
The 'Family, friends and carers handbook' has been created by mental health carers and the trust Carers Lead.

It has been designed to give an overview of what to expect from the Trust. It provides information and support that is available to those caring for others.

Why is it needed?
Carers must remember that their health and wellbeing is as important as the welfare of the person they care for. It is easy to feel alone and isolated, but help is available.

The handbook contains lots of useful guidance about the support they can access. This includes help both from Oxford Health and in their local community.

Andy, a carer who helped produce the handbook, said:

"As a carer, I became involved with the creation of the Carers Handbook, as it can be so hard to have your voice heard in a big organisation. To be able to shape a positive change for future carers was very important to me."

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

Ruby Ward, achieve accreditation with the Quality Network for Working Age Mental Health Services (QNWA)

Ruby Ward, based at the Whiteleaf Centre for women who have acute mental health needs, was accredited by the Quality Network for Inpatient Working Age Mental Health Services (QNWA). This network aims to support and engage wards in quality improvement through a supportive network and peer-review process.

The accreditation recognises the good practice and high-quality care provided on the ward. The network adopts a multi-disciplinary approach to quality improvement, with a key component of the work being the sharing of best practice through the facilitation of peer-review visits.

Additionally, the ward met over 90% of the sustainability principles standards and has been awarded a Sustainable Service Accreditation Certificate in recognition of this achievement.

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

QNWA QUALITY NETWORK FOR INPATIENT WORKING AGE MENTAL HEALTH SERVICES

Part 1: Summary of successes!

Oxford Health retained its two-star Triangle of Care accreditation for another year!

The Triangle of Care (ToC) is a framework for working together to support recovery, promote safety and maintain wellbeing of people using mental health services and their carers.

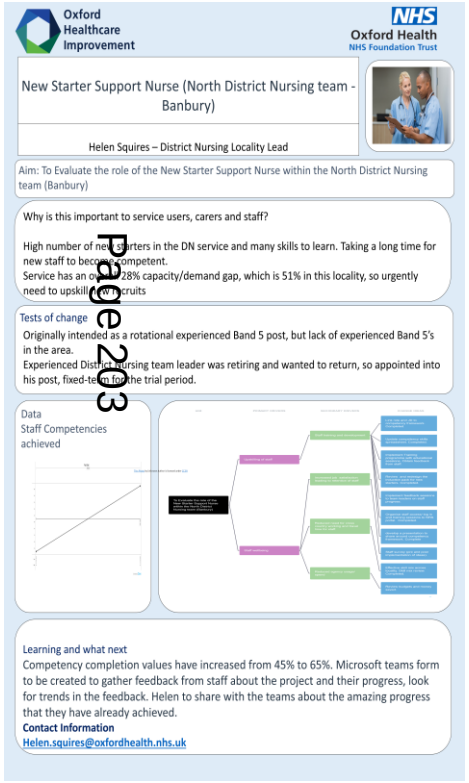
Oxford Health NHS Foundation Trust began delivery of the Triangle of Care in 2018, achieving a two-star accreditation (the maximum an organisation can achieve for mental health services). It has been able to retain the two-star accreditation by providing annual reports to demonstrate the progress being made, Triangle of Care annual report for 2024

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

District Nursing –Quality Improvement (QI) Pioneers!

The District Nursing Service won the inspiring teams award for Quality Improvement work completed and that continues to maximise capacity, manage demand and improve outcomes in a very challenged setting due to a notable mismatch between capacity and demand. The below posters demonstrate some of the areas the teams have focused on to support improvement across the service.



Oxford Healthcare Improvement

NHS Oxford Health NHS Foundation Trust

New Starter Support Nurse (North District Nursing team - Banbury)

Helen Squires – District Nursing Locality Lead

Aim: To Evaluate the role of the New Starter Support Nurse within the North District Nursing team (Banbury)

Why is this important to service users, carers and staff?

High number of new starters in the DN service and many skills to learn. Taking a long time for new staff to become competent.
Service has an ongoing 28% capacity/demand gap, which is 51% in this locality, so urgently need to upskill recruits

Tests of change

Originally intended as a rotational experienced Band 5 post, but lack of experienced Band 5's in the area.
Experienced District Nursing team leader was retiring and wanted to return, so appointed into his post, fixed-term for the trial period.

Data

Staff Competencies achieved

Learning and what next

Competency completion values have increased from 45% to 65%. Microsoft teams form to be created to gather feedback from staff about the project and their progress, look for trends in the feedback. Helen to share with the teams about the amazing progress that they have already achieved.

Contact Information

Helen.squires@oxfordhealth.nhs.uk

Oxford Healthcare Improvement

NHS Oxford Health NHS Foundation Trust

Reducing MSK injury in District Nursing staff

Emily Bishop, Harriett Carroll and Emma Woods

Aim

To reduce MSK injuries in District Nursing staff when completing leg ulcer care.

Why is this important to service users and staff?

- Staff safety and wellbeing during dressing changes
- Enhanced patient comfort during dressing changes
- Reducing sickness related to MSK injuries and maxmising workforce available

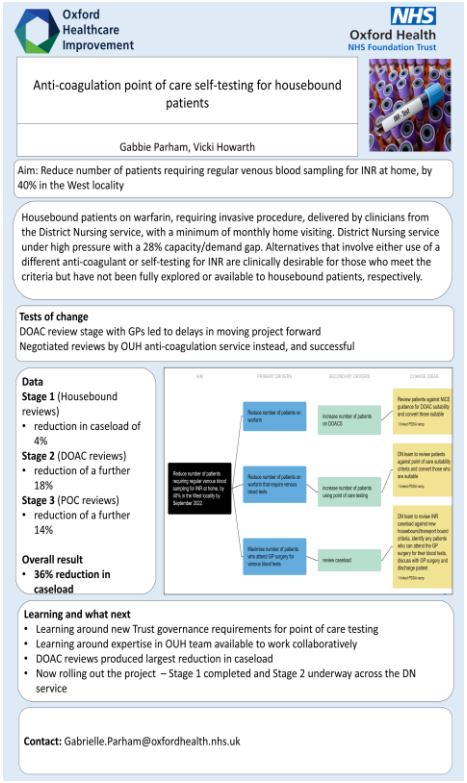
Tests of change

- Various staff and patient aids and equipment were trialled and evaluated in phase 1 – not found to be helpful for leg care. However may be helpful for podiatry service.

Learning and what next

Phase 2 trial of different aids and equipment, following learning during phase 1 trial around feedback about equipment that was initially trialled.

Contact Information: Emily.bishop@oxfordhealth.nhs.uk



Oxford Healthcare Improvement

NHS Oxford Health NHS Foundation Trust

Anti-coagulation point of care self-testing for housebound patients

Gabbie Parham, Vicki Howarth

Aim: Reduce number of patients requiring regular venous blood sampling for INR at home, by 40% in the West locality

Housebound patients on warfarin, requiring invasive procedure, delivered by clinicians from the District Nursing service, with a minimum of monthly home visiting. District Nursing service under high pressure with a 28% capacity/demand gap. Alternatives that involve either use of a different anti-coagulant or self-testing for INR are clinically desirable for those who meet the criteria but have not been fully explored or available to housebound patients, respectively.

Tests of change

DOAC review stage with GPs led to delays in moving project forward
Negotiated reviews by OUH anti-coagulation service instead, and successful

Data

Stage 1 (Housebound reviews)
- reduction in caseload of 4%

Stage 2 (DOAC reviews)
- reduction of a further 18%

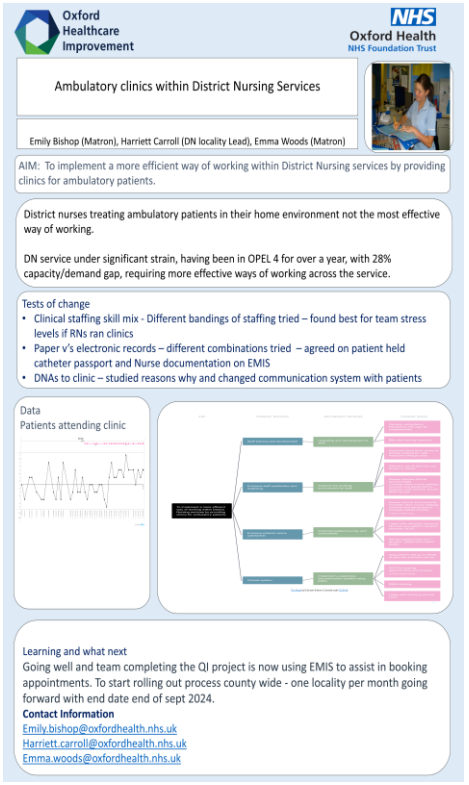
Stage 3 (POC reviews)
- reduction of a further 14%

Overall result
- **36% reduction in caseload**

Learning and what next

- Learning around new Trust governance requirements for point of care testing
- Learning around expertise in OUH team available to work collaboratively
- DOAC reviews produced largest reduction in caseload
- Now rolling out the project – Stage 1 completed and Stage 2 underway across the DN service

Contact: Gabrielle.Parham@oxfordhealth.nhs.uk



Oxford Healthcare Improvement

NHS Oxford Health NHS Foundation Trust

Ambulatory clinics within District Nursing Services

Emily Bishop (Matron), Harriett Carroll (DN locality Lead), Emma Woods (Matron)

AIM: To implement a more efficient way of working within District Nursing services by providing clinics for ambulatory patients.

District nurses treating ambulatory patients in their home environment not the most effective way of working.

DN service under significant strain, having been in OPEL 4 for over a year, with 28% capacity/demand gap, requiring more effective ways of working across the service.

Tests of change

- Clinical staffing skill mix - Different bandings of staffing tried – found best for team stress levels if RNs ran clinics
- Paper v's electronic records – different combinations tried – agreed on patient held catheter passport and Nurse documentation on EMIS
- DNAs to clinic – studied reasons why and changed communication system with patients

Data

Patients attending clinic

Learning and what next

Going well and team completing the QI project is now using EMIS to assist in booking appointments. To start rolling out process county wide - one locality per month going forward with end date end of sept 2024.

Contact Information

Emily.bishop@oxfordhealth.nhs.uk
Harriett.carroll@oxfordhealth.nhs.uk
Emma.woods@oxfordhealth.nhs.uk

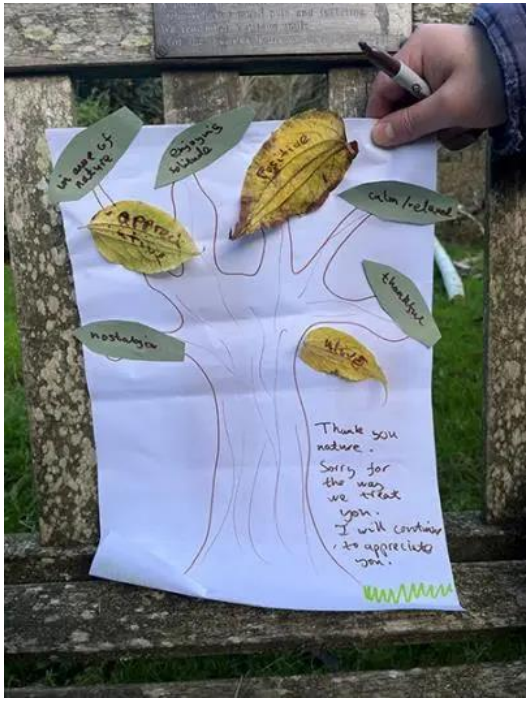
Part 1: Summary of successes!

NatureWell – inpatient forensic services

Forensic colleagues have embraced the outdoors to bring Nature Based Approaches (NBA) into the Forensic Inpatient settings.
Forensic inpatient environments have the particular challenge that access to the natural world is exceptionally limited, due to the individual's risk and legal status. NatureWell is an accredited programme which gives participants the skills to deliver NBAs designed to encourage health and wellbeing outcomes, using the five pathways to nature connectedness proposed by the University of Derby's Nature Connectedness Research Group.

NatureWell highlights to date

- 11 colleagues from Kennet Ward are trained in NatureWell
- Formal and informal nature-based interventions are run on the ward and a rolling Nature Connection group takes place once a week.
- An initial evaluation of staff perspectives has been submitted for publication and evidences potential benefits for both relational security and trauma informed approaches.
- An article coproduced by Oxford Health colleague and a patient who completed the Nature Well Programme has been published by The Psychologist journal:



Next steps

- A rolling train the trainer programme in licencing agreement with the Natural Academy who own the NatureWell model
- Plans to train two cohorts in 2025/2026 rolling out the training to the other wards
- Evaluation planned in partnership with the University of Derby (who have a leading Nature Connectedness research department). This evaluation will focus on service user voice.
- Ambitions to initiate and develop projects alongside our Green Spaces Coordinator to improve our outside green spaces

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

Lucy's Room opens – inspirational idea to meaningful music space

Lucy received care through Oxford Health's adult mental health teams and missed having a space to play and make music during that time. Following her passing, Lucy's family wanted to create the space she had been missing for other patients to benefit from in the future. The appeal was created in 2018 and along with donations from the Oxford Health Charity and Oxford Health NHS Foundation Trust, Lucy's family fundraised to take the idea to reality.

The room takes pride of place at Warneford Hospital – bringing a much-needed space for adult mental health patients on both the wards and with community teams to benefit from music therapy – providing an escape to love music, be imaginative, feel free, and perhaps discover a new talent.

Patients contributed ideas and views on how Lucy's Room can have the most positive impact for them through focus groups and consultation sessions hosted by the Activity Coordinators, Oxford Health Arts Partnership and wider ward teams. The modern room has an outside green space with seating, whilst inside offers a welcoming atmosphere with comfortable sofas, bean bags, and a collection of instruments.

Trust Chair David Walker and Lucy's mother Lesley officially opened the new, beautiful space surrounded by Lucy's loved ones and those involved in the project.

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

Smiles all round at 10th annual Have a Go Festival

This year's event marked a decade of providing people with a learning disability the chance overcome some of the barriers they can experience when taking part in sports

Sunshine and smiles were in abundance at the 10th annual Have a Go Festival.

About 180 people took the chance to "Have a Go" at several sporting activities including cycling, archery, football, dancing and cricket at Horspath Athletics Track in Oxford.

The pleasant weather lent itself to a great day of fun, socialising and activity for adults with learning disabilities who travelled from across Oxfordshire to enjoy the sports day.

This year's event marked a decade of providing people with learning disabilities the chance to try out a range of activities and overcome some of the barriers they can experience when it comes to taking part in sports.

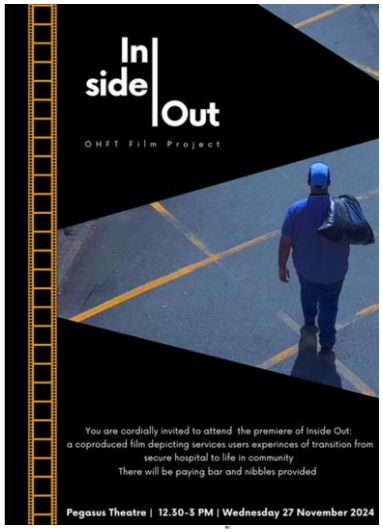
The event was hosted by the Learning Disability Service at Oxford Health NHS Foundation Trust and Active Oxfordshire. Organisations who made the event possible include MOLA, the new Family and Community Partner for Oxford United and Oxford United in the Community, and Cyclability, who provide cycling opportunities primarily for adults with the aim of making cycling inclusive, so it really is for all people.

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

InsideOut: service users experience of forensic services

InsideOut: a film depicting the service user's experience of discharge from forensic inpatient ward to the community



On 27th November 2024, the much-anticipated premiere of the film InsideOut marked the culmination of an extraordinary collaboration between service users, experts-by-experience, and staff from the Forensic Recovery College and the Specialist Community Forensic Team.

The film offers a deeply moving exploration of one of the most challenging transitions in forensic mental health: the journey from inpatient care to life in the community. Through the stories of three fictional characters, InsideOut vividly portrays the fears, hopes, and realities faced by individuals leaving the safety of long-term inpatient wards to rejoin a world full of both promise and unpredictability.

Claire Macgregor, Sarah Shanahan & Petr Neckar

The idea for the co-produced film was born in August 2023, when the Specialist Community Forensic Team envisioned using storytelling as a way to support service users during discharge. Creative workshops provided the foundation for the film, where service users courageously shared their experiences, shaping the film's themes and narratives. Unique activities, such as creating papier-mâché heads of fictional characters were used as tools to facilitate service users exploring the complex emotions tied to transition.

Part 1: Summary of successes!

Oxford Health NHS Foundation Trust

Embracing technology to improve patient care!

During the year we have successfully implemented our e-Obs rollout within our mental health and forensic inpatient wards. E-Obs supports the recognition and timely escalation of deteriorating patients as well as guiding clinicians decision making – a significant development to increase patient safety and timely care and treatments.

e-Obs Rollout

eObs (electronic observations) is an electronic patient record (web application) system that is to be used by clinical and medical staff for recording physical health observations and assessments at point of contact on a handheld mobile device (iPad). eObs is fully integrated with Rio and seamlessly makes all data immediately available in the patient's Rio electronic record.

Inpatient ward staff who normally record the below physical health assessments on paper will be required to record them into eObs using an iPad.

- Capillary, Blood, Glucose & Ketone Monitoring
- Neuro Observations & Glasgow Coma Scale (GCS)
- Malnutrition Universal Screening Tool (MUST)
- NEWS2
- Sepsis Screening Tool

Oxford Health
NHS Foundation Trust

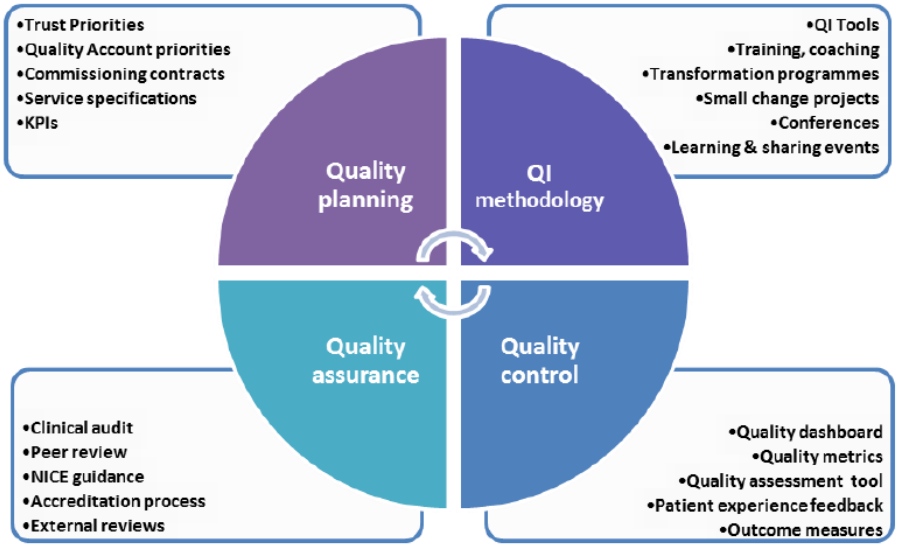
Part 2: Priorities for improvement and statements of assurance

Part 2: Quality Management System

Oxford Health NHS Foundation Trust

Quality Management System

By utilising a Quality Management System a range of factors are included to ensure a continual cycle of improvement is in place that is supported using a QI approach:



Oxford Healthcare improvement (OHI) Team continue to be the corporate support for teams and services across the trust to embed a Quality Improvement approach to improve safety, experience, effectiveness and outcomes for patients, carers and trust colleagues.

The team provide training and support for quality improvement projects, enable collaboration, sharing of outcomes and horizon scanning for future projects, with the aim that improvements to patient care are always co-produced with patients and their families.

Part 2: Quality Improvement (QI)

Oxford Health NHS Foundation Trust

Areas of QI focus 2024/25

- Reducing restrictive practice mental health services
- District Nursing Improvement Programme
- Coproduction – Experience and Involvement training programme
- Patient safety Incident Response Framework (PSIRF) learning and improving from incidents.
- Sustainable Healthcare
- Culture of Care – Mental Health & Learning Disability Inpatient Transformation Programme

Embedding of QI culture across the trust has continued to thrive, examples throughout this report demonstrate the cultural shift and importance placed on continuously improving by trust colleagues. Our QI approach aligns with the trust priority areas supporting not only patient and carer experience and safety but also promoting staff care and wellbeing.

Next year QI features as one of the Trust Quality priority areas to strengthen coproduction as a fundamental of improvement

Part 2: Quality Priorities 2024/25

Oxford Health NHS Foundation Trust

We identified the following 3 broad quality priorities for 2024/25 based upon safe and effective care and patient and carer experience.

Each priority area had key objectives with identified targets for achievement with associated key milestones and measures to demonstrate progress over the year. The Trust's Quality Committee will monitor progress against the objective milestones quarterly. The below shows the overarching priorities and key objectives that support the Trust's 5-year Strategy 2021-2026, the following slides will detail progress in each area.

Safe Care: We will consistently deliver safe care, with a reduction in avoidable in-service harm

- To improve in-patients' safety
- To provide timely access to care and effectively monitor patients and minimise harm when waits occur.
- To address health inequalities
- To have a safe and learning culture
- To support staff wellbeing and build resilience

Effective care: We will deliver effective services to ensure care is planned and delivered around the needs of the patient

- To build our capability to measure
- To improve the physical healthcare to people with a serious mental illness

Patient and Carer Experience: We will consistently improve on the experience of those using our services

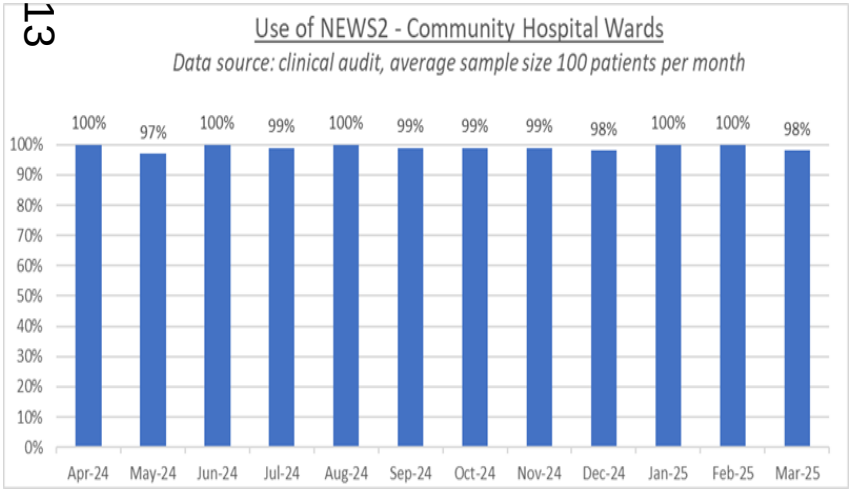
- End of Life Care
- To improve the physical healthcare to people with a serious mental illness

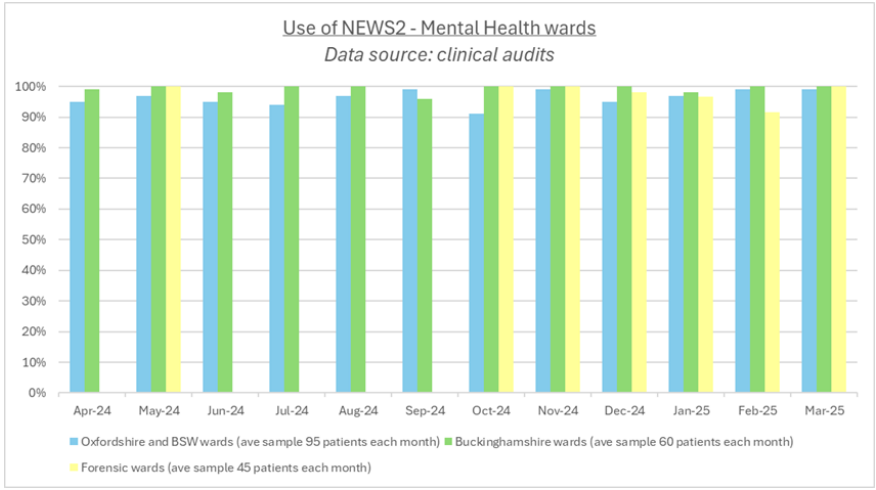
Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative
Use of NEWS2, 95% completion across all inpatient wards	Achieved	The clinical audit results show NEWS2 has been well embedded across all inpatient wards achieving our internal target. NEWS2 training has been integrated into the physical health skills training for registered and unregistered staff. The performance by month is shown in the charts below. The next stage of the work has started on recognising and responding to the soft signs of a patient physically deteriorating. Related to this the Trust is about to roll out mandatory sepsis training across the Trust.



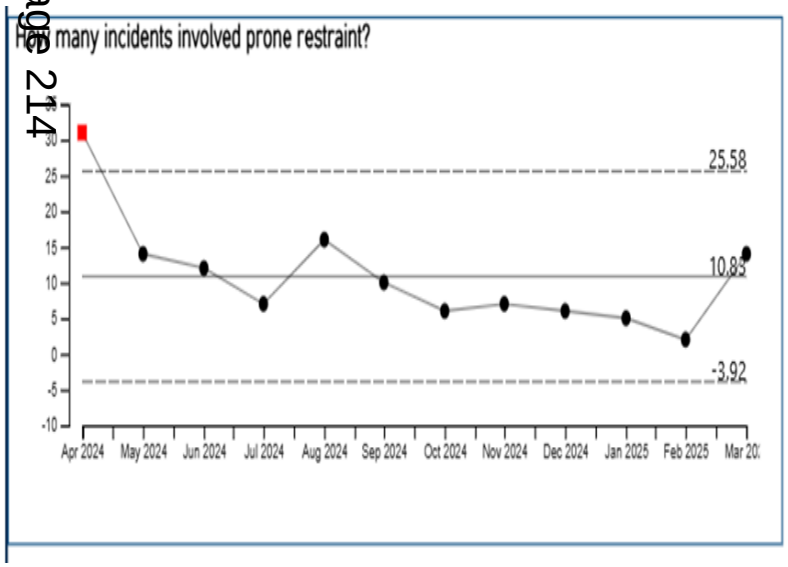


Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative
Reduction in prone episodes by 30% over 3 years	Achieved	This year prone restraint has reduced by over 30% from 2023/24. There were 209 uses in 2023/24 and 130 uses in 2024/25. The reduction has been overview Quality Improvement (QI) work across all mental health wards. The below gives an over view of the QI work streams.



- **Prone reviews / Leadership in practice** each use of the prone position is reviewed locally for reflection and learning.
- **Roll out of Safety Pods** in all wards reducing the need for the prone position by enabling restraint in a dignified, safe and compassionate way
- **Roll out of alternative injection site training** to enable alternatives to the gluteal muscle and the need for the prone position.
- **Competency self-certification** to maintain competence of IM Injection administration with additional training available when needed.
- **Patient leaflets** to explain and inform choice of for alternative injection sites
- **Safety Pod training** within trust Positive Engagement and Caring Environments training
- **Medicines Management guidance** outlining the medications, doses and licensed injection sites
- **EPMA & Prescription charts** were adapted to include the requirement to specify the injection site at the point of prescribing.

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative
Timely access to care: reduction in waits in mental health services (focus on where there are national waiting time targets)	CAMHS generic, adult and older adult mental health services – significant progress/partial achievement CAMHS NDC pathway – not achieved	**CAMHS** The national access targets for CAMHS in Buckinghamshire, Oxfordshire, Bath & North East Somerset, Swindon and Wiltshire have been met in 2024/25. The targets are set on a number of children being seen each month. Unfortunately, we do have children waiting to be seen as demand for our services and different treatments exceed capacity. We measure how we are doing by looking at children waiting for more than 4 weeks. The number of children waiting reduced in 2024/25 apart from those waiting for the neurodevelopment care pathway. **Adults and Older People** We measure how we are doing by looking at adults waiting more than 4 weeks. The number of adults waiting has reduced in Buckinghamshire and Oxfordshire in 2024/25 and is better than the national average, although we do still have adults waiting for assessment and treatment. Access to perinatal services, mental health crisis services and psychiatric liaison services has been generally good and better than the national average access rates. Access and recovery rates for Talking Therapies in Buckinghamshire and Oxfordshire are above the national targets, and access to Early Intervention in Psychosis within 2 weeks has improved and is above the national target. The number of adults accessing the Individual Placement and Support employment and job retention service has increased. For full details against each waiting target and our performance see the published Trust board papers here Board Papers | Oxford Health NHS Foundation Trust the waiting information is within the integrated performance report.

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative
Address health inequalities relating to race through roll out of the Patients and Carers Race Equality Framework (PCREF)	Achieved	The Trust has made a commitment to implement the Patients and Carers Race Equality Framework and other mechanisms for advancing health equalities. A programme structure has been developed to lead the implementation. Achievements in initial 6 months of implementing the framework include: • Setting up a leadership structure and workstreams; developing policy, reviewing workforce plans are in line with anti-racist principals, improving data capture on ethnicity and access to services and developing patient/carer feedback mechanisms. Encouragingly, commissioners from 3 of our Local Authority areas have committed to focusing their complaints advocacy contracts on improving rates of feedback from people from ethically and culturally diverse communities • Engagement with voluntary, community & social enterprise (VCSE) organisations about interest, capacity and commitment to PCREF at 'Place' level. Some organisations have engaged enthusiastically but for most there is a limitation due to capacity and funding. Some groups have been unable to commit their valuable time without this. As their independent scrutiny is essential for the next phase of PCREF, the programme leads have committed to co-designing a proposal for a funded solution to this. • Launching 'Go 90' campaign, aimed at increasing recording of patient ethnicity data collection to 90% across the Trust. Current levels for mental health services 81%, an improvement from the baseline at 78%. • Developing a series of metrics to measure the progress of the programme this is nearly complete and will report quarterly and externally on our work under PCREF.

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative
Develop safety culture through how we respond and learn from patient safety incidents (part of embedding the Patient Safety Incident Response Framework)	Achieved	The Trust transitioned to working under PSIRF from December 2023. The workplan we set for 2024/25 has been delivered – key highlights are listed below **2024 staff survey results n=3,666, 53%** Four key patient safety culture questions – all improved in 2024 from 2023 and above the national average scores. • 19a treat those involved in an incident fairly 70.2% • 19b encouraged to report incidents 91.9% • 19c take action from incidents 76.6% • 19d received feedback about changes from incidents 68.9%

PSIRF workplan and achievements in 2024/25

- 50 incidents declared under PSIRP, 11 safety areas and 8 different learning responses (14 PSII and 7 thematic reviews)
- Reviewed 1st year of PSIRP and agreed changes. ICB approved and formal sign off at System Quality Meeting .
- SEIPs (Systems Engineering Initiative for Patient Safety) methodology used for all PSIRP cases.
- Reviews are being completed timelier, PSII being completed and signed off 19 days quicker.
- 183 incident learning huddles completed, additional 45 huddles this year. 49 huddle included an external organisation.
- 2024 national staff survey results for the second year running demonstrate the improvements made in developing the patient safety culture. Local staff feedback has been positive with helpful comments to continually amend our processes.
- Employed two Patient Safety Partners that worked with us around PSIRF and implementing safety initiatives. The partners created and embedded a process to ask patients/families for feedback following completion of a PSIRF review. We have strengthened how we share learning, for example introducing 6-weekly patient safety webinars open to all staff and also how we develop safety actions working more closely with OHI to take a QI perspective to change.
- Started testing an approach to review the impact of the actions we have taken.

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative
Support staff wellbeing and build resilience; develop and evaluate mechanisms such as Trauma Risk Management approach (TRiM), Post Incident Psychological Support Service (PIPS) and Staff Psychology Service	Achieved	Work to develop, embed, and integrate pathways for supporting staff wellbeing and to provide evidence based and consistent support following traumatic experiences in the workplace. This includes: Continued rollout of TRiM (Trauma Risk Management – an evidence-based model for peer-to-peer support and screening following exposure to trauma) - New leadership structure aligned to Health & Wellbeing with continuing clinical oversight and central project resource - Refresh/review of TRiM practitioners trained in first wave and creation of a new TRiM ambassador role - TRiM practitioner training to be supported as a core L&D offer - Continued support of dedicated roles and time in Forensic Directorate with discussions around operational ownership and support in wider MH services. - Development of new communications and promotional materials to boost awareness and uptake Continued support of REACT training (an evidence-based model for staff training to promote positive wellbeing conversations including addressing risk) - New cohort of trained trainers identified in partnership with Learning & Development - REACT training to be added to core L&D OTR system and promoted as part of managers toolkit – complementing existing procedural offer with a more relational training. Will also be available to other staff.

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently deliver safe care with a reduction in avoidable in-service harm

Quality Priority	Progress RAG Rating	Progress Narrative continued from previous slide
Support staff wellbeing and build resilience; develop and evaluate mechanisms such as Trauma Risk Management approach (TRiM), Post Incident Psychological Support Service (PIPS) and Staff Psychology Service	Achieved	Continued support of Post Incident Psychological Support (PIPS) as a supportive intervention to teams after difficult or traumatic incidents. Offer continues to be led by Spiritual and Pastoral Care team with staff across disciplines volunteering to receive training and deliver sessions Work (as also described below) to link TRiM and PIPS support as part of an overall complementary offer Continued development of Staff Psychology Service as part of Occupational Health provision. Service has welcomed new Consultant leadership and is now securely embedded as a core part of the Occupational Health service Service offers individual confidential consultation and advice to staff as well as evidence based treatment for trauma where this relates to a work based incident including Cognitive Behavioural Therapy and EMDR (Eye Movement Desensitisation & Reprocessing). Service is working on a wider more proactive offer including MBCT (Mindfulness based Cognitive Therapy) groups for staff and a new 'GTEP' group offering group based EMDR. Work to coordinate the offer and make it more accessible Consultant Clinical Psychologist in Occupational Health has initiated work to further coordinate and align the above offers with the aim of developing a clear and simple map of support to ensure a more joined up response for staff.

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Delivering effective services to ensure care is planned and delivered around the needs of the patient

Quality Priority	Progress RAG Rating	Progress Narrative
To build our capability to measure and capture outcomes for patients accessing mental health services across the Trust	Achieved	We set up a workstream to roll out and start embedding patient reported outcomes (PROMs: DIALOG, Re-Qol-10, Goal-based Outcomes) and collaborative care planning in community mental health services across the Trust. We did a 3-phase rollout after an initial pilot running from July 2024 to 18th March 2025. In each phase a number of teams had enhanced support for 2 months prior to launch. Full roll out was achieved in March 2025.Capability to do this has been developed through training, strong engagement of experts by experience and developing a purpose-built software platform (True Colours) to capture outcomes. **Adults and Older People mental health services** Since rollout from July 2024-18th March 2025: ✓1,374 patients have had at least one patient reported outcome measure ✓556 have had a paired PROM ✓507 have a co-produced care plan Based upon current caseload 10% of patients have at least one PROM measure. **Children and Adolescent mental health services** Since launch of True Colours in November 2024: ✓2,261 patients have had at least one patient reported outcome measure ✓1,635 patients have had a paired PROM ✓412 have multiple goal-based outcomes set (similar to a co-produced care plan). Based upon current caseload 6% of patients have at least one PROM measure.

Part 3: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Delivering effective services to ensure care is planned and delivered around the needs of the patient

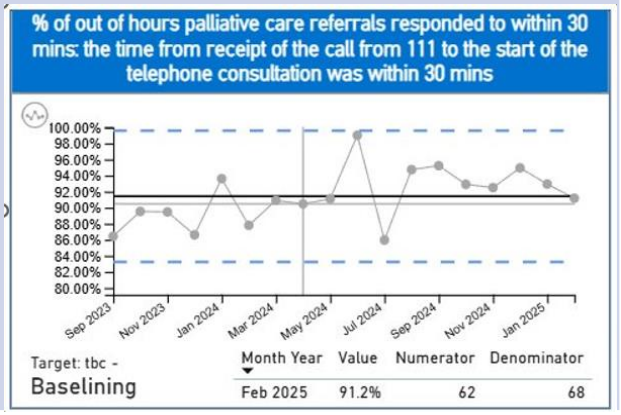
Quality Priority	Progress RAG Rating	Progress Narrative
To improve the physical healthcare to people with a serious mental illness (key focus- use of Lester tool and screening smoking status for inpatients)	Significant progress/ partial achievement	During the year we have set up an Integrated Health Strategy Group to include all trust services and provide a better interface for physical health and mental health. Across mental health services a range of ways are in place to support the physical health needs of patients with mental health needs such as physical health clinics, locally based physical health champions, physical health outreach workers and a newly created physical health team in Buckinghamshire. These offers review and assess the physical health needs of those with SMI and include advise and guidance including smoking cessation and lifestyle advice. Following review of the current offer from our Tobacco Dependacy Team the trust is currently coordinating work to take forward to cover both the use of smoking and nicotine replacement therapies such as vaping and how we can support cessation. Physical Health The Cardiometabolic Assessment (CMA) form on Rio includes elements of the Lester Tool and is to be completed every six months for inpatients and annually for community patients as part of routine PH health checks and is now audited as part of the Core Clinical Standards Audit, undertaken by matrons, below is a table showing audit compliance across the trust.

Core clinical standards audit	Jul-Sep 2024	Oct-Dec 2024	Jan-Mar 2025
Q8. Are relevant physical health needs accurately documented, up-to-date and addressed in the Care Plan?	67.30%	78.30%	80.70%
Q10. When did the patient last have a physical health review? (include, where appropriate, cardiometabolic check)	62.60%	68.10%	65.90%

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently improve on the experience of those using our services

Quality Priority	Progress RAG Rating	Progress Narrative
Improve end of life care (early recognition, timeliness of F2F response times and advanced care planning)	Achieved	During 2024-25 The Palliative and End of Life Task and Finish Group has made progress against five workstreams in support of the strategy; anticipatory and palliative care, care on the last day of life, staff education, development of resources with the help of bereaved families. Data from the audits in 2024-25 provide assurance that care at end of life is being delivered in line with the national priorities for End-of-Life Care, although we need to keep focusing on ensuring every patient as a personalised care plan. There has also been a significant improvement related to documenting evidence that patients spiritual, social communication and emotional and psychological needs are being better addressed on the community hospital wards. The Trust is an active partner in the roll out of the national ReSPECT process across the region. Training sessions on the use of the ReSPECT tool and related processes were held in February 2025 and we are aiming to launch a digital tool in the summer. An End-of-Life Response telephone line for out of hours has been established. The service aims to respond within 30 minutes to calls from 111 or a healthcare professional 

Part 2: Review of Quality Priority progress 2024/25

Oxford Health NHS Foundation Trust

Priority area: Consistently improve on the experience of those using our services

Quality Priority	Progress RAG Rating	Progress Narrative
Working with families (embedding the Triangle of Care standards across the Trust)	significant progress/ partial achievement	The Trust's current Friends, Family and Carers Strategy is being reviewed and whilst this happens the current Strategy has been extended to October 2025. We remain aligned to the national Triangle of Care standards and regularly use the self-assessment tool to support clinical teams to improve how they involve and work with carers and family members. The Trust's mental health services have retained our 2-star Triangle of Care accreditation which involves an annual external assessment. We have a Trust Carers lead as well as carer champions across a number of clinical teams. Work has continued to grow the carer champion role across services, with many of our mental health inpatient and community mental health teams now having an active role within the team. The role is responsible to advocate for carers, raise awareness and support the team to engage with carers. We have carers awareness e-learning and also deliver interactive sessions with clinical teams. No. of staff who completed the Carer Awareness training Apr 23 – Mar 24 50 staff completed Apr 24 – Mar 25 69 staff completed Carers workshops continue to be offered to carers/family members to provide education and support to any carer on specific mental health conditions.

Part 2: Quality Priorities 2025/26

Following review of our progress during 2024/25 we have chosen to focus our priority areas on five specific areas for 2025/26, these areas are key indicators of quality across the trust. Where previous indicators are not included these continue to be monitored by our Integrated Performance report, Quality Dashboard and local governance groups. A copy of our Board papers that include these reports can be found here

Priority Area	Detail	Aim	Measures	Trust area involved
Reducing restrictive practice	To continue to reduce the use of restrictive practice and care for patients using the least restrictive way possible.	To build upon previous years progress to reduce the use of prone restraint and seclusion.	Using 2024/25 data as baseline: • 25% reduction of prone restraint • 20% reduction in use of seclusion • Establish a baseline measurement of seclusion duration.	MH & Forensic inpatient wards
Implementing PSIRF and creating a learning culture	To continue to develop the embedding of PSIRF across the trust with a focus to support continuous improvement of safety cultures, systems and behaviours.	To embed patient safety incident response within a wider system of improvement that supports cultural shift towards systematic patient safety management	Achievement of the PSIRF priority area metrics for 2025/26.	Whole trust services
Involving patients and their families	Patients, carers and families are at the core of all we do. We aim to progress and develop ways to work together to learn from experience and improve trust services.	To have a framework for co-production developed and in place.	Evidence of framework and monitoring of embedding and performance	Whole trust services
Embedding continuous quality improvement.	To continue to develop the Quality Improvement (QI) culture across the trust to enhance patient care, safety and satisfaction.	To improve progression of QI project activity demonstrating a culture of improvement. To embed coproduction as an improvement fundamental.	Total number of QI projects registered on Life QI defined by those that are active and those stalled. % of QI projects involving patients/ carers	Whole trust services
Address inequalities in the delivery of healthcare	To better achieve health equality, reliable data is required that supports the identification of potential areas of inequality across the trust to drive improvement.	Reliable and meaningful data is recorded and provides the trust with meaningful insights to focus antiracism interventions..	90% of patients having a meaningful ethnicity recorded.	Whole trust services

Part 2: Monitoring our performance

Oxford Health NHS Foundation Trust

Performance Reports

The Integrated Performance Report (IPR) provides the Board of Directors with an integrated view of the strategic domains of Operational Performance, Quality and People. It has been re-designed for an improved alignment with Trust strategic ambitions, national and local reporting performance requirements. The report continues to be developed further to provide a comprehensive and reassuring oversight of Trust performance measures. The report continues to be developed further to provide a comprehensive and reassuring oversight of Trust performance measures.

The IPR is fed by directorate data that is monitored and reviewed robustly at a local level to understanding performance metrics and inform improvement and appropriate early escalation where necessary.

(1) Delivery of the NHS National Oversight Framework (NOF) The Trust continues to perform well against the reportable targeted NOF metrics with the exception of Inappropriate Out of Area Placement (OAP) adult acute bed days and staff sickness rate. We have robust oversight and monitoring processes for these metrics and performance part 2 of this report detail the work we are undertaking to respond to these challenges.

The Trust has 40 strategic metrics to track performance against set strategic objectives and ambitions. The annual position is expected to be reported in May 2025.

Detailed performance data and the annual strategic measures reporting can be found within the trust public board papers here

Oxford Health
NHS Foundation Trust

Part 3: Key Dimensions of Quality

Part 3: Clinical Audit

Oxford Health NHS Foundation Trust

Clinical Audit - a tool for improvement

Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust takes actions to improve the care provided.

Clinical Audit activity forms part of the trusts wider Quality Management System aimed to support inform learning, improvement and to ensure the trust can demonstrate that it is meeting regulatory, commissioning, contractual and legal requirements in relation to the quality and safety of the services provided.

In 2023-24 we participated fully in 15 national audits. Alongside these we carried out 51 locally identified clinical audits. Updates for the national audits we participate in can be found in appendix 1 of this report.

10 national audits

124 locally managed clinical audits.

The clinical audit plan 2025/26 has been developed by the corporate audit team in coordination and collaboration with the directorate governance leads and clinical teams. The plan has been developed to balance directorate/service level audits with national and trust wide priorities.

Summary of the Results appendix 1 of this report.

Part 3: Implementing the Patient Safety Incident Response Framework

Oxford Health NHS Foundation Trust

National aims of PSIRF

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1.Compassionate engagement and involvement of those affected by patient safety incidents

2.Application of a range of system-based approached to learning from patient safety incidents

3.Considered and proportionate responses to patient safety incidents

4.Supportive oversight focused on strengthening response system functioning and improvement

Our vision and outcomes

The vision for the next phase of the programme is to achieve a patient safety culture where staff report all incidents, there is openness to identify learning and make changes, and we can demonstrate the impact of this.

This will lead to the following positive outcomes:

- Increase in patient incidents reported with a decrease in moderate and severe harm incidents.
- Improved feedback from staff and patients/families affected by incidents about their experience.
- Increase in use of alternative learning response approaches, to enable tailored and richer learning.
- Improved timeliness of learning responses against expected timescales.

Programme Objectives

Objective 1

Improve how we Respond to Patient Safety Incidents by developing our learning responses and safety culture.

Objective 2

Improve how we Share Learning through developing the mechanisms we use to cascade learning and developing better ways to capture and use 'work done' versus 'work imagined' to equally learn from how our teams are adapting and providing good care.

Objective 3

Improve how we Make Sustainable Changes by evolving how we create safety actions and monitor the impact of changes for more complex actions.

Key deliverables 2024/25

- Implement changes to improve Incident Learning Huddles.
- Implement new patient safety training.
- Develop the role of Patient Safety Partners (people with lived experience working with us).
- Continue improvement work on duty of candour for all moderate harm incidents.
- Grow capability to use a range of learning response techniques.
- Build on how we share learning both areas for improvement and positive practice.
- Strengthen the development and monitoring of safety actions.

Part 3: Patient Safety

Oxford Health NHS Foundation Trust

Incident analysis

In the financial year 2024-25 there were 50 incidents declared under our Patient Safety Incident Response Plan (PSIRP), summarised in table 2. Covering 12 of the safety areas we prioritised (8 local safety areas and 4 national safety areas). The incidents go across our different clinical directorates. The majority of cases identified have been in relation to access to care and treatment.

Table 2. Incidents identified under our PSIRP 2024-25

	Type of Learning Response									
Safety Area	**AI**	**Extended-ILH**	**ILH**	**IRR**	**LeDeR - ILH**	**PSII**	**Thematic review**	**ToC**	**Obs visit**	**Grand Total**
Assess care/treatment		1	10	1		2	3		2	19
Child death with concerns about care (national area)		1								1
Custody death (national area)			1	1		1				3
Emergent themes		2				2	3			7
Internal joint working	1	3	2			1	1			8
Involving families						1				1
Leder with concerns about care (national area)					1	1				2
MH detained Death			1			3				4
MHHR/DARDR (national area)						2				2
Risk formulation/safety planning						1				1
Pressure Ulcer										0
Cross organisational reviews		2								2
Grand Total	**1**	**9**	**14**	**2**	**1**	**14**	**7**	**0**	**2**	**50**

For the 50 cases we have used 8 different types of learning responses demonstrating a more considered and proportionate approach and effective use of resources. We have been able to identify and start learning from incidents quicker, with 38 out of 50 reviews completed. The different learning responses we have used include; thematic reviews, incident learning huddles, observational audits, system reviews, in-depth patient safety incident investigations, and appreciative inquiry.
For each review we use a systems factor methodology (SEIPS = Systems Engineering Initiative for Patient Safety) to better understand what happened ('work done') and why, against what we think or expect should happen ('work imagined') so that the learning we identify and the safety actions we take address the real issue(s).

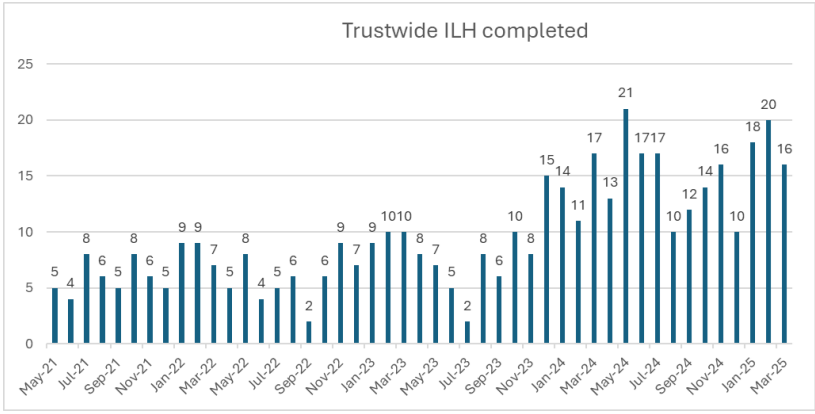
Part 3: Patient Safety

Oxford Health NHS Foundation Trust

Incident Analysis

We use incident learning huddles as an initial learning response where there has been significant harm to a patient, or we believe there is a potential for great learning. Huddles help us to understand more about incidents, to ensure support is in place for those affected, to identify immediate learning and to clarify if incidents require further exploration/learning response as detailed in our Patient Safety Incident Response Plan (PSIRP).

Since we started Incident Learning Huddles, we have completed 138 in 2023/24 and 183 in 2024/25. This is 45 more huddles this year compared to last year. In 2024/25, 49 of the huddles (27%) included an external organisation to help maximise our understanding of an incident and to share learning across organisations.



The key learning and actions are shared in a number of ways and through a series of forums.

- monthly learning summarises from each review are shared directly and discussed with team/ward managers at monthly governance meetings
- written learning summarises are posted on the staff intranet 03 March Learning from Incidents Summary.docx
- 6-weekly patient safety webinars are held themed around our key areas for learning (all recordings are here Patient Safety Webinars with the next on 12th May 2025)
- the outcomes from reviews are shared in each Quality Improvement hub in the clinical directorates
- sharing themes with learning advisory leads to bring into regular staff training

In the last 6 months the overall priority areas for learning and change across patient safety reviews are;

- How we manage/oversee the modifications and risks when demand exceeds capacity in a service
- Sharing information and engaging with family members
- Joint working and communication with external agencies (GPs, care homes, police, private providers)
- Communication between OHFT services
- Quality of clinical documentation – risk assessments/formulations, capacity assessments, care plans, NEWS2

Part 3: Learning from Deaths

Oxford Health NHS Foundation Trust

The Trust takes our role and responsibilities very seriously around reviewing, learning and taking appropriate actions after a death. The Trust's learning from deaths process reviews all patients against a national database to ensure we identify all deaths, including patients under our care at the time of their death and those who die within 12 months of their last contact to help identify any themes or trends.

The deaths of all patients under our care at the time they die are screened by at least two senior clinicians and this decides on whether a further review of care is required. The majority of deaths are expected but where there is a specific trigger or a patient comes from a particular vulnerable group (as identified in our policy) we then review these deaths further. The level of review required will depend on various criteria such as age, the setting they die in and the circumstances surrounding their death.

We always complete a mortality review for all patients who are aged under 18, if they had a learning disability, a diagnosis of autism, died on a mental health ward, died whilst detained under the Mental Health Act, or died after we suspected they took their own life by suicide.

We also submit information to the following national confidential enquiries to support national learning:

- Learning disabilities and autistic people mortality review programme
- National child mortality database
- National confidential inquiry into suicide and homicide

The following slide gives an overview of our review of mortality data and trends

Part 3: Learning from Deaths

Oxford Health NHS Foundation Trust

Overall similar pattern over time for number of deaths. Average 511 deaths per month. Above average numbers of deaths in Q3 of 24/25 and Q4 of 24/25 which falls in the period of excess winter deaths, mirrors national trend with an even split between males (49%) and females (51%).

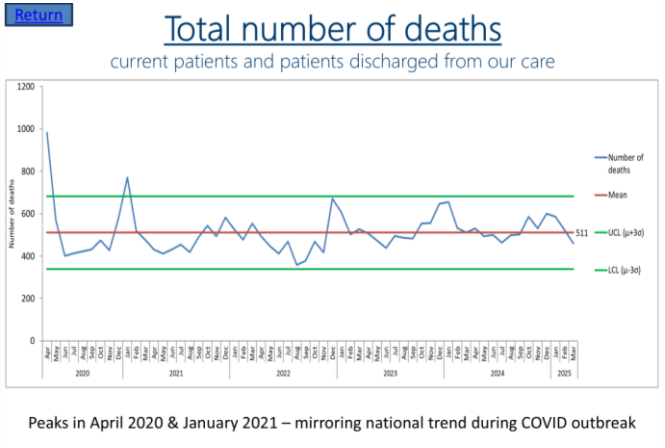
There are Data Quality limitations with looking at ethnicity, however where it is captured the ethnicity picture for deaths mirrors the patient caseload and the census data in each county, with most deaths for people from a white ethnic background.

Compared to total deaths in England and Wales (ONS) – similar pattern over time, slightly lower levels of deaths in Q4.

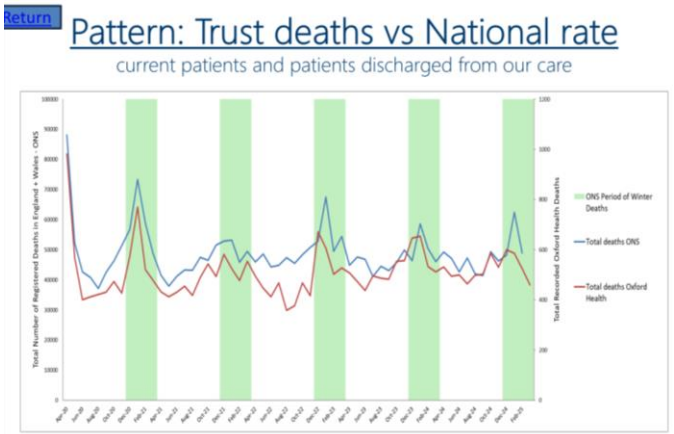
Majority of deaths are for patients last seen by services in the Community Directorate such as District Nursing. Most deaths are for patients aged 75-89 and then 90+. Small increase for patients aged 75-89 since April 2023

Most deaths are for patients open to services at the time they have died (76%, 389 deaths a month). We also regularly review and look at data for discharged patients in last 12 month. No significant changes over the last 5 years.

There have been 49 confirmed/suspected suicides for open and discharged patients in the last 12 months, of which 29 were open at the time to mental health services. Higher number of male suspected suicides (32 males/17 females). In Q4 there were 10 confirmed or suspected suicides, 6 with open referrals to a mental health service. Lower number of deaths by month between Feb 24 – March 2025 (average of 4 per month compared with an average of 5 per month previously).



Peaks in April 2020 & January 2021 – mirroring national trend during COVID outbreak



Part 3: Learning from deaths

Actions Taken in response to themes

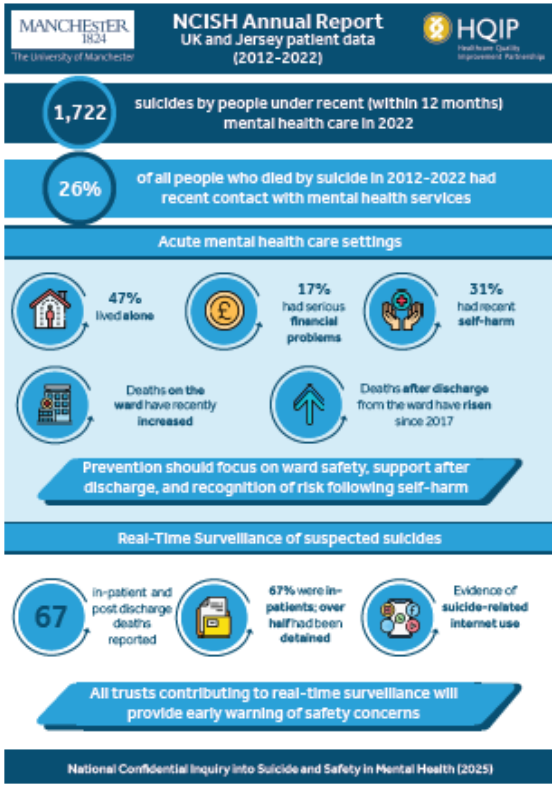
- Developing how we involve and work with families about their loved ones care. In mental health services we are using the national Triangle of Care standards from the Carers Trust to guide the work.
- Working on communication between OHFT teams and single points of access.
- Learning disability deaths; Work is in progress around lung health, bowel and bladder LD pathway and use of health passports. As well as work the ICS are leading on for NHS Core 20 PLUS5.
- Continued work around early recognition and responding to soft signs of sepsis and physical deterioration (inpatient and community teams). Trust is rolling out eLearning on sepsis for all clinical staff.
- Improving the quality of clinical documentation and how easy it is for staff to use our electronic patient record systems. There has been a lot of work in the last 12 months to improve the link to the Thames Valley shared care record from within Trust systems to improve joint working.
- Developing mechanisms for reviewing deaths for patients who were on a waiting list for a service who had not yet been seen e.g. Community Heart Failure, Urgent Community Response, Podiatry.
- End of life care pathway:
  - Work is in progress for children to improve access to expert advice on specialist medications and more in-reach to improve coordination of support on discharge from the acute hospital.
  - A response telephone line for out of hours has been established. The service aims to respond within 30 minutes to calls from 111 or a healthcare professional. We are receiving 60+ calls a month and responding to 90%+ of these within 30 mins.

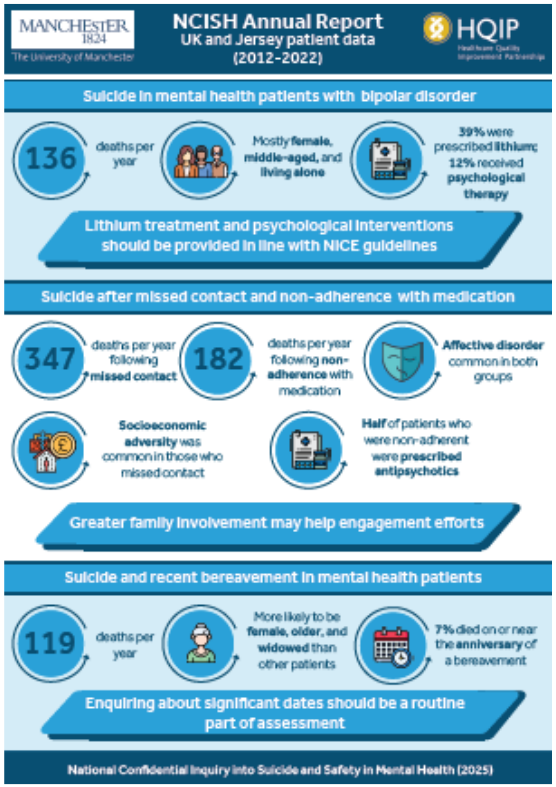
Part 3: Learning from Deaths

Suicide Prevention

We are currently refreshing a self-assessment against the National Confidential Inquiry into Suicide and Safety in Mental Health(NCISH) 10 ways to safer care with clinicians to identify the next areas of focus. Previous work has been on;

- Minimizing ligatures in inpatient environments
- Developing mental health services/resources to improve access for people in a crisis
- Developing single points of access into services
- Embedding risk formulation
- Embedding safety planning carried out with patients/families.





Patient Experience

Oxford Health NHS Foundation Trust

Complaints, Concerns and Compliments

As of 1 April 2024 the Trust introduced the new NHS Complaints Standards.

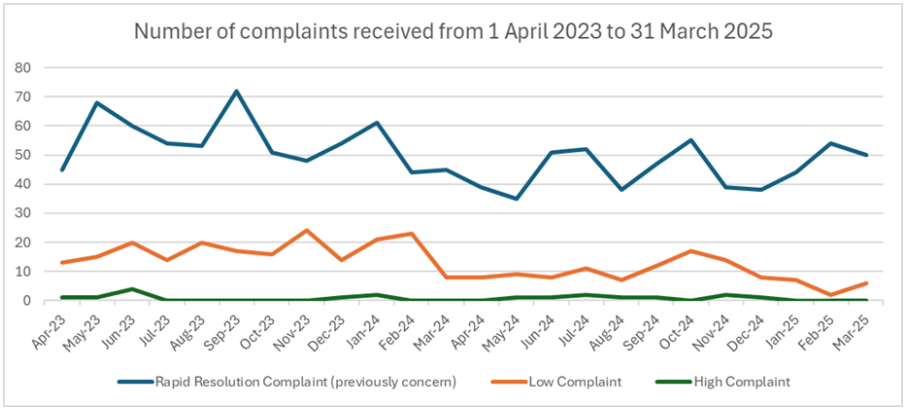
The Complaint Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service. They have a strong focus on:

- Early resolution by empowered and well-trained people.
- All staff, particularly senior staff, regularly reviewing what learning can be taken from complaints.
- How all staff, particularly senior staff, should use this learning to improve services.

The new standards encourage organisations to focus on the early resolution of complaints and as such have changed the language used and the way we approach and categorise complaints to promote early resolution:

- Pre-1 April 2024 categories: Formal Complaints and Concerns.
- Post 1 April 2024 categories: Rapid Resolution, Low-Level Complaints, High-Level complaints.

In 2024-25, Oxford Health NHS Foundation Trust (OHFT) received a total of 629 complaints which is a decrease from the previous year of 887.



✓ 100% of low/high level complaints were acknowledged within three working days.

✓ 100% of low/high level complaints were responded to within a timescale agreed and communicated with the complainant. This includes complaints with an extension to the timescale.

Patient Experience

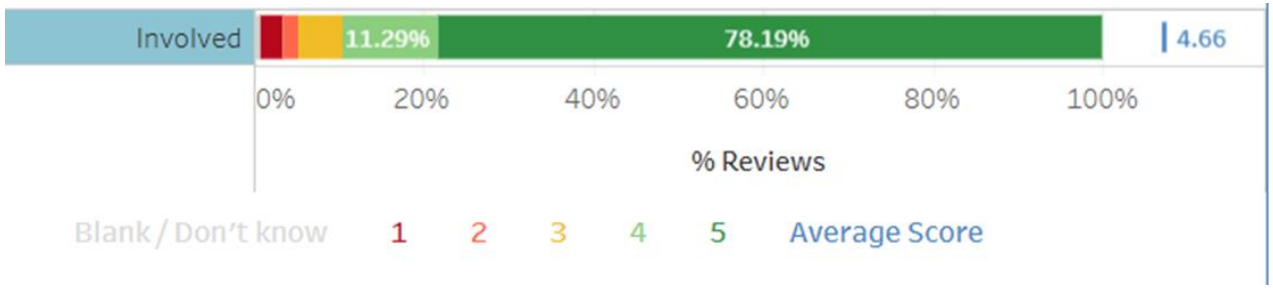
Oxford Health NHS Foundation Trust

Feedback from patients and Carers

We have a mechanism for collecting feedback. 15, 526 reviews were received on I Want Great Care (IWGC) over the 12-month period with 3,105 of those coming from self-identified friends, family members and carers.

89% of that group said they felt very or well involved in their loved ones care. The feedback allows people to tell us what went well and what can be improve. In addition, we have a database of carers who have said they want to work with us to help make quality improvements.

The below graphs show the responses across the organisation from parents, carers and friends who answered the question “were you involved as much as you wanted to be in your loved ones care?” between April 2024 -March 2025



Themes from IWGC qualitative data

Themes emerging from the “what could be improved?” qualitative feedback from self identified friends, family members and carers:

Waiting used in 305 reviews,

Information used in 150 reviews,

Support used in 123 reviews,

Communication used in 106 reviews.

Part 3: National Survey Outcomes

Oxford Health NHS Foundation Trust

National Survey Adult and Older Adult Community Mental Health Patient Survey 2024

The Care Quality Commission (CQC) undertakes an annual community mental health survey, which asks people who use NHS community mental health services in England about their experiences of care.

Out of the 35 scored areas the trust scored 6 questions in the top 20% range of organisations surveyed, 24 scores in the intermediate-60% and 5 in the bottom-20%. The trust is revieing the results of the survey in further detail to understand where improvement efforts may be directed and share the good practice identified.

Top & Bottom Five Scores

This section of the report summarises your organisation's highest and lowest scoring results for the current year across the entire survey.

Top 5 Questions	Score
Q26. Thinking about the last time you received therapy, did you have enough privacy to talk comfortably?	8.19
Q13. Did your NHS mental health team treat you with care and compassion?	8.09
Q40. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	7.92
Q07. Was the support offered appropriate for your mental health needs?	7.80
Q15. To what extent did your NHS mental health team involve you in agreeing your care plan?	7.75

Bottom 5 Questions	Score
Q33d. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for… Cost of living	1.12
Q33c. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for… Financial advice or benefits	1.76
Q33b. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for… Finding or keeping work	2.28
Q41. Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	2.62
Q32. In the last 12 months, has your NHS mental health team supported you with your physical health needs?	4.16

Part 3: Statement of Directors responsibilities in respect of the Quality Account

Oxford Health NHS Foundation Trust

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out by NHS England, available here NHS England » Quality Accounts requirements
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2024 to March 2025
- papers relating to quality reported to the Board over the period April 2024 to March 2025
- feedback from commissioners dated
- feedback from governors dated
- feedback from local Healthwatch organisations dated
- feedback from Overview and Scrutiny Committees dated
- The Trust's annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009

Part 3: Statement of Directors responsibilities in respect of the Quality Account

Oxford Health NHS Foundation Trust

- The 2024 national patient survey
- The 2024 national staff survey
- The Head of Internal Audit's annual opinion of the Trust's control environment
- Any CQC inspection reports
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

DATE- David Walker, Chairman DATE**– Grant MacDonald , Chief Executive(TBC)**

Oxford Health
NHS Foundation Trust

Appendices

Appendix 1: National Clinical Audit summary
Appendix 2: Commissioners feedback
Appendix 3: Council of Governors feedback
Appendix 4: Health watch feedback
Appendix 5: Oxfordshire Joint Health Overview & Scrutiny Committee feedback

Appendix 1: National Clinical Audit updates

Clinical Audit	Summary
National Respiratory Audit Programme (NRAP): Pulmonary rehabilitation	100% of eligible patients submitted so far. Deadline 8th August 2025 for 2024/25 data. Key Successes • Successful recruitment growing the team. • More groups are being held – more capacity across the county helping to reduce waiting times. • Currently conducting a service improvement project to improve waiting time. • The DNA rates have reduced this year from 35% in 2023-24 to 18% in the first half of 2024-25. Key Concerns • Equity of provision across the county - some areas are waiting longer than others. • Enhancing engagement of ethnic minorities within pulmonary rehabilitation has been a concern. • New recruits are currently on yearly contracts which may affect ability to continue groups once it ends. • Yet to achieved accreditation from Royal college of physicians (RCP) but working towards.
National Audit of Diabetes Footcare (NDFA)	Deadline expected July 2025 for 2024/25 data. A Quality Improvement project using national audit submission as a measure is ongoing and has seen an improvement in the number of submissions. **Key Successes** • Huge improvement from last year on numbers of audits been completed. • The NHS digital access has been updated and more relevant staff now have access to update information. • SINBAD Score used in 100% of cases every quarter. **Key Concerns** • Staffing levels within podiatry could impact the number of completed audit forms. **Action** • New audit lead has been inducted and actively seeking further NDFA champions within the department to assist with the project.

Appendix 1: National Clinical Audit Updates

NHS Oxford Health

Clinical Audit	Summary
National Audit of Care at the End of Life (NACEL)	Overall compliance April-December 2024:

	Compliance	Number of patient deaths
April 2024	91.9%	5
May 2024	88.0%	3
June 2024	88.3%	5
July 2024	92.2%	4
August 2024	100.0%	3
September 2024	93.8%	4
October 2024	88.2%	5
November 2024	95.7%	2
December 2024	78.2%	10

From January 2025, the NACEL audit tool changed and the NACEL mental Health Spotlight audit was also launched (although no eligible deaths have yet occurred from the mental health wards).

	Compliance	Number of patient deaths
April 2024	96.2%	5
May 2024	97.6%	4
June 2024	95.9%	7

It has been recognised that there has been a lot of work done by the trust to develop the information and resources available to patients, families and carers, which staff can access on the End-of-Life page.
There is good collaborative working between the MDT on wards to ensure that patients who have been identified as approaching the end of life are included in their care planning and decision making.
There has been improvement in the review of nutrition and hydration options in the last days of life.

Key Concerns

It has been identified that there is room for improvement with Advanced care planning.

Recommendations

There is more work to be done around developing End-of-Life champions so that Advanced Care plan discussions can take place with patients and families sooner and are not reliant on the Advanced nurse practitioner or End of Life nurse.
N.B. The trust collects additional data on patients which are not submitted to the national audit.
Due to low numbers of eligible patients' compliance is easily skewed.
There is a wider transformation workstream overseen by the End of Life Steering Group.

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
National Audit of Inpatient Falls (NAIF)	It has been identified that the Oxford Health was not being allocated cases to audit. This was due to how falls resulting in fracture were attributed to occurring on an inpatient unit on the Hip Fracture Database. The Clinical Audit and NICE Manager was liaising with Oxford University Hospitals (OUH) new audit manager to resolve. The audit team have been reviewing falls for 2024/25 and linking with OUH to ensure eligible cases were audited, however numbers remain small. From January 2025, NAIF expanded to collect information from patients who sustain any fracture, spinal or head injury as a result of an inpatient fall and allowed participating organisations to identify patients who are eligible for audit data collection. Monthly falls reports are being reviewed and eligible cases audited.
Prescribing Observatory for Mental Health (POMH-UK) - Rapid Tranquillisation (RT)	This audit was from the 2023/24 Quality accounts list with a deadline of 30th April 2024. 83 patients were audited from 16 wards across the Trust. - Post-RT, a debrief with a nurse and doctor is required to assess harm and emotional impact and to be offered a supportive debrief with staff, an advocate, or a carer. As an action plan, debriefs will be made mandatory at closure, involving working with the Ulysses team to implement a mandatory functionality. - Within a week of RT, care plans should include triggers or early warning signs. Trigger warnings will be added to de-escalation plans to support clearer documentation, to improve compliance in this area. - Hourly physical, mental and behavioural observations are currently logged on NEWS2 sheets and not in care notes. The news EObs system, will record all observations including attempts, refusals etc., which will be pulled directly inro RiO. A snapshot audit is planned for June to test this data integration to improve compliance in future audits. - The treatment target for this audit includes - Oral medication should be offered before IM/IV options for behavioural disturbance. For action plan to this – this will be covered as part of the de-escalation plan and learning from incident forms. Trust practices, offering oral medication as first choice, but it's often not recorded in care notes, incident forms may better reflect this practice.

Appendix 1: National Clinical Audit Updates

Oxford Health NHS Foundation Trust

Clinical Audit	Summary
Prescribing Observatory for Mental Health (POMH-UK) - The use of melatonin (21a)	170 patients were audited from 20 teams/wards across the Trust. The audit results closely similar to previous round of the audit. The action plans from 2023 are still valid and will be reviewed with fresh focus. - Evidence-based, non-pharmacological interventions should be attempted before prescribing melatonin. For samples with "No documentation" may indicate poor or inconsistent record-keeping rather than a lack of intervention. A guideline and standard proforma, including sleep hygiene advice and a tick box for documentation, would help ensure better consistency and proper recording in Rio. - For the standard, that the target symptoms for melatonin treatment should be documented. The figures for 2024 are similar to those in 2023, indicating room for improvement. As an improvement recommendation, this could be supported by incorporating these expectations into a trust guideline and using a proforma to aid consistent documentation in Rio. - A licensed melatonin preparation should be prescribed. Clinicians must ensure adherence to these updates and discontinue Circadin MR prescriptions as per recent changes. - The updated trust guidance to include clear instructions to ensure off-label use is explained to patients and carers; and documented. To ensure compliance with documentation, a tick box in the proforma can be copied into Rio. The Choice and Medication leaflet or the Medicines for Children leaflet will be provided, and these links could be included in the trust guideline. - The efficacy and safety/tolerability of melatonin to be reviewed within three months of starting and also the need for continued melatonin treatment should be reviewed annually, considering efficacy and side effects. The results highlight the ongoing need for clear trust guidance and expectations, particularly regarding how these reviews are documented.

Appendix 1: National Clinical Audit Updates

Oxford Health NHS Foundation Trust

Clinical Audit	Summary
Prescribing Observatory for Mental Health (POMH-UK) - Opioid medications in mental health services (24a)	20 patients were audited from 11 wards across the Trust. POMH have yet to publish the report with the results for the Trust.
Core National Diabetes Audit (NDA) – Education Element	National deadline for 2024/25 is currently not yet released (09/04/2024). The audit collects data on diabetic patients. There are multiple audits which track a patients diabetes management to form a wider registry of diabetic care in England and Wales. Oxford Health only provides structured education to Type 2 diabetic patients and enters this data into the audit. For the 2023/24 year, 1236 patients were offered structured education, of which 757 attended. This gives an attendance rate of 61%. Data is currently being collated ready for upload to the national audit.
National Clinical Audit of Psychosis (NCAP) (EIP)	The national audit is trialling using data from the Mental Health Services Data Set (MHSDS). The trust did not participate in the trial in 2023/24 due to ongoing work with RiO and populating the MHSDS following the systems outage. Nationally this is expected to run in 2024/25 and the trust has provided our data identifiers. It has been noted that the trial in 2023/24 did experience a number of issues. The bespoke audit focused on effective treatment, physical monitoring (against an approved Lester Tool), and whether outcome assessments were undertaken. The work is ongoing with introduction of outcome measure tools in the True Colours rollout. A live spreadsheet, color-coded by intervention status (red for out of date, amber for about to expire, green for in date), has been implemented to give immediate support in documenting these measures. Supervisors review and update this monthly during supervision. The spreadsheet helps identify missing measures, ensuring each patient has at least two sets, typically updated every six months in line with care plan reviews. To improve efficiency in providing CBTp, allocation meetings for CBTp will be held more frequently. A review will be conducted on the current number of sessions provided to assess if they can be reduced.

Appendix 1: National Clinical Audit Updates

Oxford Health NHS Foundation Trust

Clinical Audit	Summary
Sentinel Stroke National Audit programme (SSNAP)	SSNAP provides two data sets: • 'Patient centred' attributes the results to every team which treated the patient at any point in their care. This recognises that the stroke care pathway usually involves many teams treating the patient at different points. This holistic approach is aimed at encouraging teams to work closely together to ensure consistency of care. It is patient centred, because it describes the care and outcomes from the patient perspective, regardless of which team treated the patient. • 'Team centred' attributes the results to the team considered to be most appropriate to assign the responsibility for the measure to. Whilst the patient centred holistic approach identifies that teams along the pathway need to work closely together to ensure that patients get consistently high quality of care, it is also recognised that it is useful to provide results on a team centred basis so that teams can see the results for the interventions delivered. SSNAP assigns grading based on a score determined by percentage compliance for key indicators under each domain in the audit, which is then readjusted using case ascertainment and audit process compliance. These are then used to calculate the overall grades. Further guidance and how key indicators are calculated is available on the SSNAP website. For simplicity the following key can be used as a guide for compliance A to E: A = ≥80 | B = 70 to 79 | C = 60 to 69 | D = 50 to 59 | E = ≤49 Overall SSNAP level for 2024/25 was rated B for both patient centred and team centred measures for Quarters 1 and 2. Changes to the reporting mean that no score has been given for Quarter 3 (Quarter 4 data deadline has not yet passed). Case ascertainment/Audit compliance has remained rated A (90%+) across Quarters 1 and 2. Key points from specific domains are: • Occupational Therapy and Physiotherapy domains remain rated A. • Standards by Discharge and Discharge Process rated C. This is affected by patients not being able to access Early Supported Discharge or specialist community rehabilitation team on discharge. • MDT working is rated D.

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
Serious Hazards of Transfusion (SHOT)	National registry for incidents involving blood transfusion. Oxford Health participate via Oxford University Hospitals. 9 incidents were recorded in 2024/25. Incidents were investigated as per trust patient safety processes. 2 incidents related to blood units being sent to the wrong EMU; 2 incidents related to blood units being left behind; 1 incident related to incomplete details on crossmatch request form; 1 incident related to no request card attached to the sample; 1 incident related to the scanner being unable to scan the product code on the blood bag; 1 incident related to blood fridge tachograph not recording temperature as not inserted properly; 1 incident related to incorrect wristband being placed in patient. A local blood transfusion audit is undertaken regularly to provide assurance of practice against standards.
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide (NCISH)	The trust participates in the programme. As of 09/04/2024, 98 patients have been identified as eligible for deaths between 1st April 2019 and 31st March 2025, of which: • 78 (80%) have been completed, • 3 (3%) have been abandoned as agreed by NCISH, • 16 (16%) are overdue, and • 1 (1%) are in progress and have not passed the due by date.

Appendix 2: Commissioner feedback

Oxford Health NHS Foundation Trust

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Appendix 3: Council of Governor feedback

Oxford Health NHS Foundation Trust

Appendix 4: Healthwatch feedback

Appendix 5: Oxfordshire Joint Health Overview & Scrutiny Committee feedback

Oxford Health NHS Foundation Trust

OXFORDSHIRE COUNTY COUNCIL

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Work Programme 2025/26
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair TBC | Dr Omid Nouri, Health Scrutiny Officer, omid.nouri@oxfordshire.gov.uk

COMMITTEE BUSINESS

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
5 June 2025				
NHS Reforms Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update on and discuss the recent and ongoing NHS reforms. These reforms include the government's plans to integrate NHS England into the Department of Health and Social Care, and to further reduce Integrated Care Board running costs.	Overview and Scrutiny	
System Pressures Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report on pressures within the Oxfordshire Health and Care System.	Overview and Scrutiny	
Oxfordshire as a Marmot Place	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on Oxfordshire becoming a Marmot Place	Overview and Scrutiny	
Oxford Health NHS Foundation Trust Quality Account	Prioritise the Health and Wellbeing of Residents.	To receive and discuss Oxford Health NHS Foundation Trust's Quality Account for the year 2024-2025, with a view to provide written feedback on this to the Trust.	Overview and Scrutiny	

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
11 September 2025				
Children's Emotional Wellbeing and Mental Health Strategy	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from system partners with an update on the delivery of the Children's Emotional Wellbeing and Mental Health Strategy.	Overview and Scrutiny	
Oxfordshire Learning Disability Plan	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from Oxfordshire County Council and its partners on the Oxfordshire Learning Disability Plan	Overview and Scrutiny	
NHS Adult Learning Disabilities, Autism and ADHD Services	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from the NHS on services for Adults with Learning Disabilities, Autism, and ADHD.	Overview and Scrutiny	
20 November 2025				
CAMHS Services Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report providing an update on the current state of the CAMHS service for Oxfordshire residents.	Overview and Scrutiny	
School Nurses Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents	To receive a report from Oxford Health NHS Foundation Trust with an update on the role and activities of School Nurses in Oxfordshire.	Scrutiny	
South Central Ambulance Service Performance Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents	To receive a report from South Central Ambulance Service on the current state of Oxfordshire's Ambulance services; to include insights into the Trust's CQC improvement journey.	Overview and Scrutiny	

Recommendation Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair TBC | Omid Nouri, Health Scrutiny Officer, omid.nouri@Oxfordshire.gov.uk

The action and recommendation tracker enables the Committee to monitor progress against agreed actions and recommendations. The tracker is updated with the actions and recommendations agreed at each meeting. Once an action or recommendation has been completed or fully implemented, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker.

KEY	Report due	With Cabinet / NHS	Complete

Recommendations:

Meeting date	Item	Recommendation	Lead	Update/response
21-Nov-24	Oxfordshire Healthy Weight	1. To explore support to local businesses supplying food in the takeaway market to provide healthier offers that meets both business and health needs. It is recommended that effective measures are adopted to address the concerns of local takeaway businesses about losing business in the event of switching to healthier food products	Derys Pragnell	**Partially Accepted** (See item 7)
21-Nov-24	Oxfordshire Healthy Weight	2. To support food banks and larders in providing healthier food options; and for there to be further liaison and cooperation between the County Councils' Public Health Team and food larders and banks. It is recommended that there is further celebration of the role of volunteers and voluntary sector organisations in this regard.	Derys Pragnell	**Partially Accepted** (See item 7)
21-Nov-24	Oxfordshire Healthy Weight	3. For the development of clear and measurable KPIs so as to evaluate the impacts and progress of the work to promote healthy weight.	Derys Pragnell	**Accepted** (See item 7)

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
21-Nov-24	Oxfordshire Healthy Weight	4. For there to be clear communications as soon as possible with residents as to the benefits and risks associated with obesity medications, especially for anyone who has not been encouraged to lose weight by their GP and is considering buying weight loss drugs privately or online without medical supervision.	Derys Pragnell	**Rejected** (See item 7)
21-Nov-24	Oxfordshire Healthy Weight	5. For there to be clear mapping and identification of individuals with comorbidities. It is crucial that there is ongoing coproduction of healthy weight services that would include input from those with comorbidities or from vulnerable population groups.	Derys Pragnell	**Partially Accepted** (See item 7)
21-Nov-24	Oxfordshire Healthy Weight	6. For system partners to work collaboratively to promote greater physical activity amongst residents of all ages. It is recommended that consideration is given to launching a public event to celebrate good practice in schools around promoting eating well and moving well. This could help to raise awareness of the importance of healthy eating and physical activity for all children.	Derys Pragnell	**Accepted** (See item 7)
30-Jan-25	BOB ICB Operating Model Update	1. For the ICB's Executive Sponsor for Oxfordshire and the Director for Places and Communities to meet with the HOSC chair and Health Scrutiny Officer, as well as to meet with local MPs (as part of the national offer for facilitation), to initiate proper engagement with Oxfordshire Place. It is recommended that clear indicators are developed which demonstrate the levels of engagement being undertaken between the ICB and key stakeholders in Oxfordshire Place.	Matthew Tait; Dan Leveson	**Accepted** (See item 7)

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
30-Jan-25	Health and Wellbeing Strategy Outcomes Framework	1. To support sustainable funding in the Oxfordshire County Council budget for early years readiness for school.	Cllr Leffman; Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	**Partially Accepted** (See item 7)
30-Jan-25	Health and Wellbeing Strategy Outcomes Framework	2. To ensure that rural geographies in Oxfordshire are also at the heart of implementing the priorities and actions of the Health & Wellbeing Strategy.	Cllr Leffman; Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	**Accepted** (See item 7)
30-Jan-25	Support for People Leaving Hospital	1. To explore support to local businesses supplying food in the takeaway market to provide healthier offers that meets both business and health needs. It is recommended that effective measures are adopted to address the concerns of local takeaway businesses about losing business in the event of switching to healthier food products.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	**Partially Accepted** (See item 7)
30-Jan-25	Support for People Leaving Hospital	2. To support food banks and in providing healthier food options; and for there to be further liaison and cooperation between the County Councils' Public Health Team and food larders and banks. It is recommended that there is further celebration of the role of volunteers and voluntary sector organisations in this regard.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	**Partially Accepted** (See item 7)
30-Jan-25	Support for People Leaving Hospital	3. For the development of clear and measurable KPIs so as to evaluate the impacts and progress of the work to promote healthy weight.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	**Accepted** (See item 7)

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
30-Jan-25	Support for People Leaving Hospital	4. For there to be clear communications as soon as possible with residents as to the benefits and risks associated with obesity medications, especially for anyone who has not been encouraged to lose weight by their GP and is considering buying weight loss drugs privately or online without medical supervision.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	**Rejected** (See item 7)
30-Jan-25	Support for People Leaving Hospital	5. For there to be clear mapping and identification of individuals with comorbidities. It is crucial that there is ongoing coproduction of healthy weight services that would include input from those with comorbidities or from vulnerable population groups.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	**Partially Accepted** (See item 7)
30-Jan-25	Support for People Leaving Hospital	6. For system partners to work collaboratively to promote greater physical activity amongst residents of all ages. It is recommended that consideration is given to launching a public event to celebrate good practice in schools around promoting eating well and moving well. This could help to raise awareness of the importance of healthy eating and physical activity for all children.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	**Accepted** (See item 7)
30-Jan-25	Oxford Health NHS Foundation Trust People Plan	1. To work toward reducing reliance on agency staff where possible. It is recommended that processes are in place to ensure that the quality of care provided by agency staff is appropriate and up to standard so as to ensure consistency in the quality of care for patients.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	**Accepted** (See item 7)
30-Jan-25	Oxford Health NHS Foundation Trust People Plan	2. To create a positive and supportive work environment for staff, and to foster an environment and processes where staff can easily make complaints or express legitimate grievances.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	**Accepted** (See item 7)

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
30-Jan-25	Oxford Health NHS Foundation Trust People Plan	3. To harness the use of technology to create a better and more efficient working environment for staff. It is also recommended that the Trust takes steps to avert the prospects of future IT outages inasmuch as possible, and to provide evidence of this.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	**Accepted** (See item 7)
30-Jan-25	Oxford Health NHS Foundation Trust People Plan	4. To work with system partners to campaign for an Oxford salary weighting.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	**Rejected** (See item 7)
06-Mar-25	Director of Public Health Annual Report	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.	Ansaf Azhar; Donna Husband; Frances Burnett	**Partially Accepted** (See item 7)
06-Mar-25	Director of Public Health Annual Report	2. For clarity to be provided on who will have responsibility for implementing each of the recommendations being made in the DPH annual report.	Ansaf Azhar; Donna Husband; Frances Burnett	**Partially Accepted** (See item 7)
06-Mar-25	Director of Public Health 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.	Ansaf Azhar; Donna Husband; Frances Burnett	**Accepted** (See item 7)
06-Mar-25	Musculoskeletal Services in Oxfordshire	1. To address variances around the county, with a view to residents being able to access local MSK services more swiftly.	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	**With NHS**
06-Mar-25	Musculoskeletal Services in Oxfordshire	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.	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	**With NHS**
06-Mar-25	Musculoskeletal Services in Oxfordshire	3. For efforts to be made to create improvements to pelvic health outcomes. It is recommended that there is engagement with the Pelvic Partnership around support for those who are waiting for support.	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	**With NHS**

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
06-Mar-25	Cancer Services in Oxfordshire	1. For further detail to be shared on outcomes across different cancer types, and how that compares nationally and regionally.	Matthew Tait; Felicity Taylor; Andy Peniket	**With NHS**
06-Mar-25	Cancer Services in Oxfordshire	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.	Matthew Tait; Felicity Taylor; Andy Peniket	**With NHS**
06-Mar-25	Cancer Services in Oxfordshire	3. For Oxford University Hospitals NHS Foundation Trust to collaborate with the Oxfordshire County Council's Public Health team on awareness campaigns with communities with low take-ups of cancer screening.	Matthew Tait; Felicity Taylor; Andy Peniket	**With NHS**
06-Mar-25	Audiology Services in Oxfordshire	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. It is recommended that further resourcing is sought to tackle waiting lists and prioritisation, particularly around Community Diagnostic Centres.	Matthew Tait; Neil Flint; Phil Gomersall	**With NHS**
06-Mar-25	Audiology Services in Oxfordshire	2. For improvements to be made around communications with the wider public to increase awareness of available support from audiology services.	Matthew Tait; Neil Flint; Phil Gomersall	**With NHS**
06-Mar-25	Audiology Services in Oxfordshire	3. That Community Audiology is brought onto the same Electronic Patient Record system as the rest of Oxford University Hospitals NHS Foundation Trust.	Matthew Tait; Neil Flint; Phil Gomersall	**With NHS**

Action Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair TBC | Omid Nouri, Health Scrutiny Officer, omid.nouri@Oxfordshire.gov.uk

The action and recommendation tracker enables the Committee to monitor progress against agreed actions and recommendations. The tracker is updated with the actions and recommendations agreed at each meeting. Once an action or recommendation has been completed or fully implemented, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker.

KEY	Delayed	In Progress	Complete

Actions:

Meeting date	Item	Action	Lead	Update/response
No outstanding action items				

Recommendation Update Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair TBC | Omid Nouri, Health Scrutiny Officer, omid.nouri@ocfordshire.gov.uk

The recommendation update tracker enables the Committee to monitor progress accepted recommendations. The tracker is updated with recommendations accepted by Cabinet or NHS. Once a recommendation has been updated, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker. If the recommendation will be update in the form of a separate item, it will be shaded yellow.

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	1. To work on developing explicit and comprehensive navigation tools for improving communication and referral for services at the neighbourhood level and within communities. It is recommended that piloting such navigation tools in specific communities may be a point of consideration.	CM Children and Young People	Progress update to be provided
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	2. To ensure adequate co-production with children and their families as part of continuing efforts to deliver the strategy, including considerations of how children and families can be placed at the heart of commissioning. It is also recommended for an early review with the users of the digital offer once this becomes available; to include testing with neurodivergent children and other children known to be at higher risk of mental ill health.	CM Children and Young People	Progress update to be provided
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	3. To continue to explore and secure specific and sustainable sources of funding for the Strategy to be effectively delivered in the long run.	CM Children and Young People	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	4. 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.	CM Children and Young People	Progress update to be provided
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	5. 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.	CM Children and Young People	Progress update to be provided
06-Jul-24	GP Provision	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.	Julie Dandridge; Dan Leveson	Progress update to be provided
06-Jul-24	GP Provision	2. To continue to work on Prevention of medical and long-term conditions besides cardiovascular disease.	Julie Dandridge; Dan Leveson	Progress update to be provided
06-Jul-24	GP Provision	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.	Julie Dandridge; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
06-Jul-24	GP Provision	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.	Julie Dandridge; Dan Leveson	Progress update to be provided
06-Jul-24	GP Provision	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.	Julie Dandridge; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	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.	Hugh O'Keefe; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	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.	Hugh O'Keefe; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	4. For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.	Hugh O'Keefe; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	1. To ensure that carers receive the necessary guidance as well as support in being able to maximise the support they provide to palliative care patients.	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	2. To secure sustainable sources of funding and resources for the RIPEL project, as well as Palliative Care Services more broadly.	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	3. To secure additional and sufficient resourcing and support for palliative transport services. It is recommended that transport services for palliative care patients are organised in a manner that avoids delay and distress for patients.	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	1. To ensure that adult eating disorder services are personalised in a manner that takes the unique needs and experiences of each individual patient. it is recommended that this service is coproduced with adults with eating disorders as much as possible.	Rachel Corser; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	2. To take adequate measures to tackle loneliness amongst older adults, and to make every effort to reach out to older adults (with lived experience) and to include them in the designing of older adult mental health services. It is recommended that there is liaison with the Oxfordshire Mental Health Partnership to explore avenues to improve coproduction here.	Rachel Corser; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	3. To ensure that patient history is effectively communicated and shared amongst professionals/organisations providing mental health support, and to avert the prospects of patients being or feeling bounced between various mental health services.	Rachel Corser; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	4. That voluntary sector stakeholder organisations who work in Oxfordshire on suicide prevention are invited to register with a VSO suicide prevention stakeholder register. It is also recommended that there is adequate resource, engagement, and a collaborative system inclusive of the VSO registered stakeholders to tackle suicide.	Rachel Corser; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	5. That there is collaborative system work to develop KPIs on serious mental health to maximise the impact of the existing resource available across Oxfordshire, with a view to prevention and to increase the support available to people and families in distress. It is recommended that there is engagement with the local authority and Region on KPIs relating to patients residing in long-term inpatient settings away from their families.	Rachel Corser; Dan Leveson	Progress update to be provided
26-Nov-24	Medicine Shortages	1. To ensure that policies are in place to recognise and identify patients with cliff-edge conditions, and to ensure that mitigations are in place to reduce the risk of harm to these patients in the event of supply disruptions.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
26-Nov-24	Medicine Shortages	2. To ensure effective communication, coordination, and transparency within and between the local and national levels to help mitigate risks associated with medicine shortages.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
26-Nov-24	Medicine Shortages	3. To work on reducing any prospect of additional excessive workloads on both clinical and administrative staff in the event of medicine shortages, and to provide meaningful support for staff as well as additional resource if need be for the purposes of tackling any additional demand/burdens.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
26-Nov-24	Medicine Shortages	4. To continue to improve sharing of information and transparency, including through a potential digital local database, for helping professionals to easily identify where supply issues exist.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
26-Nov-24	Medicine Shortages	5. To work on improving communication and coproduction with patients and involving those with cliff-edge or long-term conditions, regarding the pharmacy services and the availability of medicines (including through the use of frequently asked questions). It is also recommended that patients are signposted to any support that could be available from pharmacy services and the voluntary sector.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
16-Dec-24	Epilepsy Services Update	1. For the ICB and Oxford University Hospitals NHSFT to: a. Give priority to patient safety for people with epilepsy and their families in Oxfordshire, and to the welfare of the Oxfordshire epilepsy team, and to set out how that priority will be addressed through their governance and management at a board level. The governance and management of these priorities should also be inclusive of people with lived experience and their charity representatives, as well as their concerns regarding tailored and balanced communications and the use of existing empowerment tools. b. To secure further funding and resource for epilepsy services.	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided
16-Dec-24	Epilepsy Services Update	2. For NHSE Region to give support to the ICB and Oxford University Hospitals NHS Foundation Trust to help achieve the above prioritisations.	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
16-Dec-24	Epilepsy Services Update	3. For OCC Cabinet: For Oxfordshire County Council Cabinet members and senior officers responsible for education and residential care for children and adults with Learning Disabilities and/or autism (who are affected by patient safety concerns), to consider the likely impacts of the valproate policy for the local authority commissioning arrangements and the provision of residential care and out of county placements.	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	1. To ensure that maternity staff receive ongoing training around improving OUHFT Maternity Services. It is recommended that staff are also trained in patient-centred care.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	2. To continue to improve the support for the welfare and wellbeing of maternity staff in the context of improving OUHFT Maternity Services. It is especially crucial that staff are not subjected to undue negative pressure due to their working in maternal services or as part of efforts to improve OUHFT Maternity Services.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	3. To develop a maternity trauma care pathway for ongoing support for mothers (and their partners) to include those who have experienced difficult births, complications, premature babies, and still births and bereavement. It is recommended that this is undertaken in co-production with voluntary organisations that work with families experiencing trauma and who include experts with lived experience. It is crucial to be proactive in reaching out to such patients and their partners in this regard.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	4. To establish robust processes through which to monitor and evaluate the effectiveness of measures aimed at improving OUHFT Maternity Services.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
06-Mar-25	OUHFT Maternity Services in Oxfordshire	5. To ensure that coproduction remains at the heart of the design as well as the improvements of OUHFT Maternity Services. It is also recommended for collaboration amongst relevant system partners, to explore the opportunity for coproduction work to maximise the potential of health checks for supporting women who have given birth, with a view to improve their physical and mental wellbeing and that of their families in the long run.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	6. For there to be clear communication with patients, including in indigenous languages for those who may not be fluent in English.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided

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