Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 16 April 2026 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:	Councillor Jane Hanna OBE		
Deputy Chair:	District Councillor Dorothy Walker		
Councillors:	Ron Batstone	Judith Edwards	Emma Garnett
	Imade Edosomwan	Gareth Epps	Paul-Austin Sargent
District Councillors:	Katharine Keats-Rohan	Val Shaw	
	Elizabeth Poskitt	Louise Upton	
Co-Optees:	Sylvia Buckingham	Barbara Shaw	

Date of Next Meeting: *11 June 2026*

For more information about this Committee please contact:

Committee Officer: *Scrutiny Team*

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

Martin Reeves
Chief Executive

April 2026

What does this Committee review or scrutinise?

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

How can I have my say?

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

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes of the previous meeting (Pages 9 - 26)

To **APPROVE** the minutes of the meeting held on 29 January 2026 and to receive information arising from them.

4. 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.

Requests to speak must be submitted no later than 9am three working days before the meeting, i.e. Monday 13 April 2026.

Requests should be submitted to the Scrutiny Officer at omid.nouri@oxfordshire.gov.uk AND scrutiny@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.

5. Response to HOSC Recommendations (Pages 27 - 34)

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

1. Oxfordshire Neighbourhood Health Plan.
2. Adults Autism and ADHD Services

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

6. **Chair's Update** (Pages 35 - 56)

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

A request for information has been submitted on behalf of the Oxfordshire Joint Health Overview and Scrutiny Committee seeking assurance regarding the timeliness and oversight of Learning from Lives and Deaths of people with a learning disability and autistic people (LeDeR) reviews. The request was for a brief written update from the Integrated Care Board to the Committee covering:

1. Current performance against NHS England LeDeR Key Performance Indicators (including completion timescales) and the current backlog position.
2. Governance and accountability: where LeDeR sits in Oxfordshire/Thames Valley quality governance; and how learning/actions are tracked to completion.
3. Capacity and resilience of the LeDeR function (local area contact/reviewer capacity; Quality Assurance arrangements).
4. Recovery actions and milestones for bringing timeliness back on track (if applicable), and evidence of impact from learning.

The Buckinghamshire, Oxfordshire, and Berkshire West Joint Health Overview Scrutiny Committee (BOB JHOSC) convened its last meeting on 17 March 2026. Given the establishment of a new Thames Valley Integrated Care Board (ICB) with a new geography, a proposal will be submitted to all the local authorities within the new ICB boundaries to formally dissolve the BOB JHOSC and to establish a new Thames Valley JHOSC.

A letter was sent to the Chief Executive and Chair of Oxford University Hospitals NHS Foundation Trust on behalf of the Committee in relation to maternity services. The letter includes a request for clarification regarding errors in the data submitted in the report to the Committee on maternity services. This letter can be found in the agenda papers for this item.

A HOSC report containing recommendations on maternity services was submitted on behalf of the Committee to Oxford Health NHS Foundation Trust. This can be found in the agenda papers for this item.

Given that there remains one vacant cooptee post on the Committee, a formal recruitment exercise will be initiated, with the aim of recruiting a third co-optee member of the Committee by the next meeting in June.

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

7. Mental Health Motion from Council (Pages 57 - 58)

The purpose of this item is to address the Mental Health Motion passed by Oxfordshire County Council at its meeting on 9 December 2025. Oxfordshire County Council passed a motion requesting that the Health & Wellbeing Board (HWB) invite the Health Overview & Scrutiny Committee (JHOSC) to investigate and report on how mental health services provided by Oxford Health NHS Foundation Trust and wider system partners are addressing the rising prevalence and impact of poor mental health among adults and children in Oxfordshire.

The wording of the motion agreed was as follows:

"This Council being deeply concerned by the impact of poor mental health on adults and children in the County asks the Health and Wellbeing Board to request the Health Overview and Scrutiny Committee to investigate and report back to them and to the County Council on how Mental Health services provided by Oxford Health and other organisations are tackling this issue.

Such an investigation of issues needs to include addressing accessibility to services including:

- *Prevention*
- *Assessment*
- *Therapeutic support*
- *Medication*
- *Emergency intervention such as "sectioning"*
- *Inpatient beds*

How these issues impact on other public services such Community Safety, Public Health, Housing, Schools, Fire and Rescue and the Police also needs to be assessed and understood. Most of all poor mental health impacts on individuals, families, and communities around the County and this must be addressed.

Council requests that the outcome of the investigation be sent to the appropriate Secretaries of State."

The Oxfordshire Joint Health Overview Scrutiny Committee is **RECOMMENDED** to**:**

a) **NOTE** the request from the Health and Wellbeing Board for the Committee to undertake scrutiny of adults and childrens mental health services as outlined in the wording of the motion detailed in paragraph 3.

b) **AGREE** that the Committee will continue its scrutiny of adults and children's mental health as outlined in its work programme, and that it will report back within its annual report to Council, details of the adults and children's mental health scrutiny undertaken.

8. Adult and Older Adult Mental Health Services in Oxfordshire (Pages 59 - 110)

Dan Leveson (Director of Places and Communities, Thames Valley Integrated Care Board) and Rob Bale (Chief Operating Officer for Mental Health and Learning Disability, Oxford Health NHSFT) have been invited to present a report with an update on Adult and Older Adult Mental Health Services in Oxfordshire.

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

9. Update on the development of the All-Age Autism Strategy

Karen Fuller (Director of Adult Social Care, Oxfordshire County Council) has been invited to present a report on the ongoing development of an All-Age Autism Strategy for Oxfordshire.

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

PLEASE NOTE: The report for this item is to follow and will be published as an addenda.

10. Healthwatch Oxfordshire Update (Pages 111 - 122)

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.

11. Health Visitor Services in Oxfordshire (Pages 123 - 202)

Ansaf Azhar (Director of Public Health, Oxfordshire County Council) and Emma Leaver (Chief Operating Officer- Community Health Services, Dentistry & Primary Care, Oxford Health NHSFT) have been invited to present a report on Health Visitor Services in Oxfordshire.

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

12. Forward Work Plan (Pages 203 - 204)

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

13. **Actions and Recommendations Tracker** (Pages 205 - 210)

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.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 29 January 2026 commencing at 10.01 am and finishing at 3.30 pm.

Present:

Chair:	Councillor Jane Hanna OBE	
Deputy Chair:	District Councillor Dorothy Walker	
Councillors:	Ron Batstone	Gareth Epps
	Imade Edosomwan	Emma Garnett
District Councillors:	Katharine Keats-Rohan	Val Shaw
	Elizabeth Poskitt	Louise Upton
Co-Optees:	Barbara Shaw	

Officers:

Ansaf Azhar, Director of Public Health and Communities (Oxfordshire County Council)
Karen Fuller, Director of Adult Social Care (Oxfordshire County Council)
Alex Wheeler, Senior Joint Commissioning Officer
Bhavna Taank, Head of Joint Commissioning - Live Well
Clair Taylor, My Life My Choice Project Co-ordinator
Fiona Ruck, Health Improvement Practitioner
Kate Austin, Public Health Principal
Kumudu Perera, My Life My Choice Expert by Experience
Matthew Tait, BOB ICB Chief Delivery Officer
Professor Dr. Andrew Brent, Chief Medical Officer Oxford University Hospitals
Veronica Barry, Executive Director of Healthwatch Oxfordshire
Yvonne Christley, Chief Nurse Oxford University Hospitals NHS Foundation Trust
Omid Nouri, Health Scrutiny Officer

The Council considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and decided as set out below. Except insofar as otherwise specified, the reasons for the decisions are contained in the agenda and reports, copies of which are attached to the signed Minutes.

1/26 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Cllr Sargent, Cllr Edwards, and Sylvia Buckingham.

The Committee sent their best wishes to Cllr Sargent.

2/26 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Barbera Shaw declared her interest as the Chair of Healthwatch Oxfordshire.

Cllr Hanna declared her interest as an employee of SUDEP action.

3/26 MINUTES
(Agenda No. 3)

The Committee **APPROVED** the minutes of the meeting held on 20 November 2025 as a true and accurate record.

4/26 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

Roseanne Edwards (Banbury Guardian) urged the committee to address ongoing problems with maternity care at John Radcliffe Hospital and its impact on the Horton General Hospital. She claimed that a PowerPoint presentation was withheld from the Keep the Horton General group for nine months, which undermined their case. Roseanne argued that reported improvements did not solve space limitations, staff shortages, or high birth rates, and called for engagement on restoring two obstetric units in Oxfordshire.

Joan Stuart (Keep our NHS Public) warned of long-term risks to Oxford Eye Hospital, mainly due to profit-driven NHS-funded eye clinics. She explained that capping private sector profits could lead to a £45 million loss and withdrawal from cataract services. Fee cuts would impact NHS departments by ignoring their wider roles, while higher tariffs for complex surgeries might push private clinics to take over work now done by NHS hospitals, endangering future financial stability.

Emma Henrion (Keep our NHS Public) discussed concerns about the future of two NHS LIFT schemes in Oxford, with leases expiring in 2031. She explained that the ownership and accountability of these sites were unclear, as the company holding the leases lacked local health stakeholders. Emma warned that similar issues could arise with future health centres under public-private partnerships. She requested the Committee seek clarity from the ICB on site ownership, decision-making processes, and the ICB's relationship with the leaseholder.

5/26 RESPONSE TO HOSC RECOMMENDATIONS
(Agenda No. 5)

The Committee **NOTED** the responses to Committee recommendations on:

- Eyecare Services in Oxfordshire
- GP Access & Estates

The Committee expressed concern that the response to the Committee's recommendation on Eyecare services did not address the intended issue of tracking specific problems escalated to the Eye Hospital. They emphasised the need for a system to identify trends and sources of issues, particularly from private providers, for effective contract management.

6/26 JHOSC SUBSTANTIAL CHANGE WORKING GROUP UPDATE REPORT
(Agenda No. 6)

The Committee received an update on the JHOSC Substantial Change Working Group and its ongoing scrutiny of the project to redevelop Wantage Community Hospital.

The Chair updated the Committee on the substantial change working group, noting its ongoing scrutiny of the redevelopment project for Wantage Community Hospital. They explained that the hospital, serving a large local population, had been temporarily closed for many years, and the working group had identified local needs and inequalities. Progress had been made with building works underway, and the Chair recommended that the Committee supports the working group's continuation for another year and to appoint three new members to replace those who had left.

The Committee **NOTED, CONFIRMED,** and **AGREED** to the recommendations in the update.

7/26 CHAIR'S UPDATE
(Agenda No. 7)

The Chair provided a verbal update on the following issues since the previous OJHOSC meeting.

Cllr Garnett joined the meeting at this stage.

A detailed deep dive into children's emotional wellbeing and mental health services had already taken place in November, with further scrutiny on adult mental health, including transition issues, scheduled for April 2026. -dive into children's emotional wellbeing and mental health services had already taken place in November, with further scrutiny on adult mental health, including transition issues, scheduled for April

A report containing the Committee's recommendations on the Oxfordshire Neighbourhood Health Plan had been submitted to system partners.

Another report was submitted on behalf of the Committee containing recommendations to system partners on Children's Emotional Wellbeing and Mental Health.

The Committee was asked to **NOTE** the formal response received from the Department of Health and Social Care via Anneliese Dodds MP, regarding future arrangements for an independent patient voice after the imminent abolition of Healthwatch by government legislation.

The Chair also referenced a recent Oxfordshire County Council motion requesting scrutiny of both children's and adult mental health services.

An update was also given on interactions between the Chair and Health Scrutiny Officer with the Buckinghamshire, Oxfordshire, and Berkshire West Joint Health Overview Scrutiny Committee (BOB JHOSC) Vice Chair and the Buckinghamshire Council Scrutiny Manager as part of preparations for the establishment of a new Thames Valley JHOSC.

The Committee was also informed of a private meeting held with its members and with Oxford University Hospitals NHS Foundation Trust on 22 December 2025, to receive an update on maternity services.

Another meeting was also held between the Chair, the Health Scrutiny Officer, Dan Leveson, BOB ICB (Integrated Care Board) Director of Place and Communities, and Julie Dandridge, BOB ICB Associate Director for Primary Care, which had enabled concerns about primary care (including in Didcot) and local practice closures to be raised.

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

8/26 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2025/26

(Agenda No. 8)

Ansaf Azhar, Director of Public Health and Communities (Oxfordshire County Council), Kate Austin (Public Health Principal), and Fiona Ruck (Health Improvement Practitioner), were invited to present the Director of Public Health Annual Report.

The Committee received a presentation on the Director of Public Health's Annual Report, which took the form of an interactive web-based publication designed to make health information more engaging and accessible. The Public Health Principal and Health Improvement Practitioner demonstrated the platform's features, noting its use of bold visual design, clear navigation tiles and intentionally concise text to help users explore themes such as local data, lived experience, health inequalities and community voice. Offices highlighted that the new format builds on the direction set by the 2020 report, "Some Are More Equal Than Others", by showing progress in several areas of deprivation and showcasing community-led initiatives that have developed despite significant financial pressures across the system.

The Committee heard that the digital report incorporates videos, case studies, blogs and toolkits, including contributions from Professor Sir Michael Marmot and local

community health workers. These materials aimed to demonstrate the real-life impacts of health inequalities and highlight the positive outcomes achieved by communities themselves. Officers explained that the toolkit had been designed to help local groups access and interpret data at the most appropriate geographic level, and where possible at parish level, to support targeted action in both urban and rural contexts. They highlighted how the toolkit could provide granular detail at parish level, supporting tailored action in both rural and urban communities.

Officers discussed how the report and associated tools address the specific challenges faced by residents in affluent rural areas, where isolation, poor transport links and hidden deprivation can hinder access to services. They emphasised the importance of integrating local insight with the NHS ten-year plan to ensure that community experience influences future commissioning. The wide geography of the Thames Valley ICB was acknowledged as a further challenge, reinforcing the need for strong partnership working and a consistent focus on inequalities. The overarching intention of the new digital format is to foster dialogue, empower isolated individuals and enable community narratives to shape future public health priorities and service development. Importantly, they underlined the report's aim to foster dialogue, empower isolated individuals, and ensure community voices influence future health services and tangible health improvements.

Members sought clarity on the level of granularity available in the forthcoming toolkit and digital data platform. Officers explained that while users can already explore detailed data for the ten priority wards, equivalent parish-level information was not yet available county-wide due to national data limitations. Some indicators could be broken down more locally than others, and qualitative community insight was currently published for the fourteen areas where Community Insight Profiles had been completed. The long-term ambition was to extend this model across Oxfordshire, but data gaps, particularly in rural settings where small populations can mask need, prevented a fully consistent approach. Officers stressed that the new toolkit would support communities to undertake their own profiling, and demonstrations could be provided to any area wishing to use it.

Officers described how the initial focus on the ten most deprived wards had expanded as evidence of rural inequalities grew. Newer insight profiles already included areas outside the original list, such as Bicester-area communities and parts of West Oxfordshire. Rural deprivation, they noted, was complex to measure and often concealed within overall affluence, making mixed-method approaches essential. Work had therefore begun on a rural inequality dashboard that combined indicators such as transport access, housing and availability of services. This would support more precise identification of localised issues and guide tailored recommendations for market towns, villages and isolated communities. The long-term ambition was to extend the community insight model countywide, allowing tailored recommendations for market towns, villages and isolated communities.

The Committee explored how lived experience could be incorporated into the public health dashboard. Officers confirmed that including stories, videos and examples of community-led work was both feasible and desirable. Qualitative insight had always been central to the Community Insight Profiles, and Officers expect community-generated material to become increasingly important, particularly where

quantitative data remain inconsistent. The forthcoming toolkit was intended to support community groups in collecting, structuring and sharing their insights.

Discussion then turned to rural access to GP services. Officers acknowledged that limited transport, dispersed populations and reliance on voluntary schemes left many residents effectively cut off from primary care. The community insight work had already highlighted these barriers, and the rural inequality framework aimed to map them more systematically. Officers emphasised the importance of using public health evidence to shape broader decisions about housing, transport and place-shaping so that access to GPs becomes a proactive consideration rather than a reactive one. Innovation in rural areas, they said, would require stronger collaboration between councils, the NHS and local community groups.

Members asked how the Community Insight Profiles aligned with the NHS ten-year plan. Officers explained that the profiles were designed as a shared system resource rather than a standalone public health exercise. They already fed into neighbourhood-level planning and commissioning decisions led by the ICB, supporting a preventative approach that complemented clinical priorities. By embedding insight on wider determinants, the profiles helped to guide decisions about service locations, resource deployment and targeted interventions. Strong collaboration across the system was essential to retain this alignment.

Concerns were raised about whether the newly expanded Thames Valley ICB might dilute the focus on local inequalities. The BOB ICB Chief Delivery Officer outlined that senior leadership appointments had been confirmed and that staff consultation on organisational structures would begin in February, after which clearer operating models would be defined. He emphasised that the ICB remained committed to prevention and reducing inequalities, and highlighted successful joint programmes already under way, including Well Together and learning disability initiatives. Officers reiterated the importance of ensuring that the needs of rural and vulnerable communities continued to shape decision-making despite the larger geographic footprint.

Members also discussed how the community voice would continue to shape public health and wider system commissioning. Officers emphasised that community insight informed not only public health work but programmes such as school readiness and joint NHS–council evaluation projects. Stories, feedback and co-produced recommendations were expected to play a growing role in shaping prevention work and wider determinants of health across the system.

Officers noted that epilepsy, which affects about a quarter of people with learning disabilities, had been raised through recent LEADER findings. Further detailed information had been sought from health partners and fed through the Health and Wellbeing subgroup to inform ongoing planning.

Members sought reassurance on the accessibility of the new interactive website, particularly for people with visual impairments, limited digital literacy or unreliable internet connectivity. Officers confirmed that accessibility considerations would be built into the next development phase and that feedback would be passed to the communications team. Features such as text-to-speech and clearer navigation were

being explored, and the team was considering the publication of a technical report or alternative formats alongside the online version.

Finally, the Committee asked about monitoring progress against the report's recommendations. Officers explained that impacts would continue to be overseen through existing governance structures, primarily the Health and Wellbeing Board, with relevant issues returning to HOSC as appropriate. They emphasised that the report aims to shape long-term system priorities, so monitoring will focus on broader prevention and inequality outcomes rather than short-term activity measures.

The Committee **AGREED** to issue the following recommendations subject to minor amendments offline:

1. To embed Community Insight Profiles (CIP) into routine commissioning and service design, ensuring decisions explicitly reference CIP findings and community led priorities.

2. To ensure that neighbourhood working includes public health leadership and community voice structures. It is recommended that there is a systemwide roadmap for neighbourhood maturity, resourcing, and integration with the existing voluntary and community sector and council assets.

3. For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes, including Well Together and physical activity pathways.

4. To move Community Health Development Officer, Well Together roles and community led programmes onto multiyear funding cycles, given that short funding cycles undermine sustainability. It is recommended that there is a best value review and prioritisation of funding continuity to avoid regression of gains in areas with improving Index of Multiple Deprivation deciles.

5. To prioritise Oxfordshire-wide rural areas that are experiencing a regression on the Multiple Deprivation deciles of inequalities. It is recommended that the capability of rural communities is explored by the development of the Neighbourhood offer to Towns and parishes; and to give consideration for a contextualised offer to support an independent voice, local members, and to enhance community capabilities.

City Cllr Upton left the meeting at this stage.

9/26 OXFORDSHIRE LEARNING DISABILITY PLAN

(Agenda No. 9)

Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); Bhavna Taank (Head of Joint Commissioning - Live Well); Clair Taylor (My Life My Choice Project Co-ordinator); Kumudu Perera (My Life My Choice Expert by Experience); Alex Wheeler (Senior Joint Commissioning Officer); and Matthew Tait, (BOB ICB Chief Delivery Officer), were invited to present a report on the Oxfordshire Learning Disability Plan.

The Director of Adult Social Care highlighted the strong foundations of co-production that had shaped the plan and emphasised the positive atmosphere surrounding its development. She noted that the plan had recently been discussed at Cabinet, where its formal signing and subsequent media coverage had been warmly received, reflecting a strong endorsement of the work undertaken.

The Head of Joint Commissioning – Live Well and the My Life My Choice Expert by Experience then presented the Oxfordshire Learning Disability Plan in detail. They explained that the plan represented a ten-year, dynamic strategy that had been co-produced with people with learning disabilities, their families, carers and professionals across the system. Four central themes shaped the strategy: having a good life, health and wellbeing, a place to live, and homes not hospitals. These themes were supported by cross-cutting elements including transitions, workforce, technology and inclusion. They emphasised that the plan had been informed by extensive engagement involving more than 200 participants, whose contributions had centred on communication, access to activities and the importance of meaningful relationships.

The My Life My Choice Expert by Experience described the empowerment gained through the co-production process and illustrated how lived experience had helped frame the plan's priorities. The Officers explained that the plan aligned closely with both local frameworks and wider national policy.

The discussion moved into the structure of future reviews, and Officers explained that although the plan had originally been designed for formal reviews at three-, five- and seven-year points, this structure had been amended following feedback gathered through the World Café engagement event. People with learning disabilities had expressed a preference for an earlier review to ensure timely reflection and the ability to respond more dynamically to changing needs.

Officers confirmed that each review would draw on renewed engagement, likely employing a similar World Café-style format, ensuring that lived experience continued to guide the plan's evolution. Oversight of progress sat with the Learning Disability Improvement Board, which would assess whether developments in services, new data or emerging concerns required earlier revisions. They stressed that the plan had been deliberately structured as a dynamic document that any subgroup or partner could request to revisit if significant issues, changes in need or new evidence came to light.

Attention then turned to risk management, and Officers explained that oversight of risk sat with the Learning Disability Improvement Board, comprising health, social care, voluntary sector representatives and experts by experience. This structure provided continuous scrutiny and challenge. Officers added that the extensive co-production process itself helped to mitigate risks by ensuring that actions within the plan reflected real need and were grounded in lived experience rather than assumptions. Engagement mechanisms such as World Café events had been intentionally built into the plan's governance, helping to surface potential difficulties early and ensuring alignment with the priorities of people with learning disabilities. They emphasised that regular monitoring, open communication across partners and

the ability to trigger early adjustments formed essential components of long-term risk mitigation.

Consideration was then given to the measures that would be used to assess alignment with wider frameworks, such as the NHS Long Term Plan, the Oxfordshire Way and national learning-disability guidance. Officers explained that thematic subgroups would develop their own Key Performance Indicators (KPIs) linked to the "what needs to happen" section of the plan, ensuring clear metrics for progress and alignment. These KPIs would be reported to and overseen by the Learning Disability Improvement Board, which included experts by experience and system partners responsible for formal check-and-challenge. Officers added that governance and reporting arrangements would be refined further, recognising that various responsibilities sat with system partners beyond the Council and would require continued development and coordination.

Discussion then shifted to system-wide commitments, particularly in relation to the pact signed between Oxfordshire County Council and My Life My Choice. Officers confirmed that the Council took pride in having signed the pact, which contained practical commitments shaped directly through lived experience. These included promoting access to work, supporting good housing and facilitating independence. Some commitments, such as improving recruitment into social care, were already being advanced through joint work with advocacy groups. However, Officers recognised that wider system commitments, including those shared across health, social care and voluntary organisations, required further development. They highlighted the goal of strengthening integration between health and care and ensuring that commissioning decisions, service planning and housing alignment were conducted transparently and in line with the needs of people with learning disabilities.

The early priorities for addressing inequalities were then discussed in detail. Officers explained that the initial focus within the first one to three years would be on the most significant and well-evidenced inequalities disproportionately affecting people with learning disabilities. These included poorer access to healthcare, higher prevalence of co-existing conditions such as epilepsy and sensory impairments, and persistent barriers experienced by people from ethnic minority communities. They emphasised the importance of improving access to and quality of annual health checks, addressing disparities in life expectancy and tackling negative experiences within NHS settings. Subgroups had already begun examining data relating to dentistry, pain management, health checks and wider health inequalities to establish baseline measures. Officers confirmed that KPIs were being developed and would continue to evolve as new insights and lived-experience contributions emerged.

Plans to expand the number of "safe places" for people with learning disabilities were outlined. Officers clarified that the ambition related to the national Safe Places scheme and that the goal, though challenging, was to ensure that safe places were located within a five-minute walk for residents by December 2026. Some community support services and libraries already formed part of the scheme, and the "Having a Good Life" subgroup would lead further work to expand it. Although this subgroup was still developing its programme, Officers explained that they intended to work with district councils, community organisations and established networks such as dementia-friendly schemes to broaden coverage. They welcomed offers from

Members to help encourage local organisations to join the scheme, stating that community involvement was essential to its success.

Further discussion centred on annual health checks for people aged over 14 with a learning disability. Officers clarified that these checks were an NHS-commissioned responsibility delivered through GP practices and constituted an essential tool for improving health outcomes and preventing avoidable hospital admissions. It was acknowledged that uptake and quality varied considerably, both locally and nationally, underscoring the need for improvement. The Committee noted the importance of the checks as a bridge between health and social care, particularly given the vital supporting role often played by carers. Officers agreed that stronger integration at neighbourhood level would be required to improve the process and confirmed that they would seek further updates from health partners. They noted that epilepsy, affecting around one in five people with learning disabilities, had already been identified as an area requiring additional attention, and confirmed that updates would be brought into the Health and Wellbeing subgroup and future workplans.

System-wide collaboration was then explored further, with officers emphasising that the Learning Disability Plan had been developed jointly across health, social care and the voluntary sector. This collaborative approach created valuable opportunities to improve pathways such as annual health checks, early intervention and community support. Officers highlighted the role of joint commissioning teams, which operated across organisational boundaries and allowed for better alignment of priorities and monitoring. The Learning Disability Improvement Board would review progress, enabling system partners and experts by experience to challenge inconsistencies and identify any gaps in delivery. Officers reiterated that consistent improvement, particularly in areas such as epilepsy management or the avoidance of unnecessary hospital admissions, depended on strong, integrated governance, shared data and the sustained use of lived experience to inform decisions.

The plan's proposals for an information platform for activities and support groups were discussed next. Officers explained that the platform would be hosted through the Oxfordshire County Council website and the Live Well Oxfordshire portal, with layout, usability and content shaped by subgroup input. They described early findings showing that information across the county was scattered across multiple sources, and a key early task would be consolidating this into a clearer, more accessible system. Accessible design principles would guide the work, with lived-experience feedback central to refining its structure. A dedicated workstream had begun mapping out how information would be collected, validated and regularly refreshed. Officers mentioned that visual inclusivity indicators such as logos were being considered, although they emphasised the need to avoid unintentionally excluding groups who were not yet using such markers.

Employment support for adults with learning disabilities formed another major theme. Officers explained that the Oxfordshire Employment Service already supported many people with additional needs to secure and sustain employment. They also noted the launch of the national Connect to Work programme, which had gone live locally in January and aimed to help people with learning disabilities access employment and training opportunities. The importance of wellbeing and empowerment within employment pathways was highlighted, with advocacy groups such as My Life My

Choice providing workplace readiness, confidence-building and practical peer-led support. Officers confirmed that benefits advice and guidance formed routine parts of social care and advocacy support, helping individuals make informed decisions without fear of losing essential support.

Further emphasis was placed on ensuring that adults with learning disabilities felt genuinely empowered when seeking employment, particularly where employment might affect their benefits. Officers explained that empowerment formed a central principle of the plan and that a wide range of existing support, including workplace coaching, advocacy services and detailed benefits advice, helped to ensure people made informed, confident decisions. They described how advocacy organisations offered travel training, peer support and guidance tailored to individual needs, while social care teams regularly assisted with navigating the benefits system as part of transition planning. This approach was designed to ensure people felt supported and informed throughout their employment journey.

Training across the system was then considered, particularly the Oliver McGowan Mandatory Training. Officers explained that the training had become a statutory requirement and that monitoring mechanisms were being established across local organisations. The County Council had already begun delivering the training internally, while broader system-wide monitoring frameworks, especially those involving NHS and ICB governance, were still being clarified as part of the new operating model. Officers agreed to take away an action to produce a more detailed update and emphasised that robust oversight was essential, given that the training aimed to improve safety, communication and reasonable adjustments for people with learning disabilities.

There was also a discussion of supported living and risks relating to choice, continuity and quality. Officers explained that the Council and ICB had already undertaken significant work to strengthen the provider market, including establishing a specialist framework ensuring providers had the right expertise for varying levels of need. While acknowledging risks such as market fragility and the need for stable specialist provision, officers explained that current evidence did not support establishing a fully in-house service. The council lacked the infrastructure needed to directly deliver care services, and previous scoping had revealed substantial financial and operational barriers. Instead, resilience was being strengthened through mixed approaches, such as the council purchasing properties while external providers delivered care, enabling increased stability without requiring full in-house provision.

Finally, Officers outlined how assistive technology was being used to support adults with learning disabilities. They explained that assistive technology was already widely embedded in practice, forming part of the standard equipment offer. Tools such as movement sensors, bed sensors, medication reminders and devices like Alexa were routinely used to promote safety, support independence and strengthen the quality of assessments. Sufficient resources were available through the council's equipment budget, and use of technology was expanding across both learning-disability and dementia services. Officers noted that the technology market continued to evolve quickly and that a dedicated officer monitored developments and collaborated with Innovate Oxfordshire to explore emerging opportunities. Although no standalone

strategy existed, assistive technology was considered business as usual and an essential element of future service development.

The Committee **AGREED** to issue the following recommendations subject to minor amendments offline:

1. That partners at place consider an anniversary event to share progress and good practice.

2. For outcome measures to be developed on all due deliverables, and for this to be prepared for scrutiny by the JHOSC in 2027. It is recommended that there is a statement from all partners at place level on their roles and contributions to LD services, and on what has supported and hindered collaboration.

3. That people with Learning Disabilities, paid and unpaid carers, and health staff undertaking annual reviews, are empowered to improve the quality of annual reviews.

4. For there to be further engagement with people with Learning Disabilities/autism and epilepsy, and that relevant voluntary sector organisations (with their experts by lived experience) are engaged with in a timely way; with a view to understanding what they can contribute to communities of practice and prevention of avoidable and long admissions to hospital and early deaths.

The Committee adjourned for lunch at 12:45, and reconvened at 13:31

10/26 MATERNITY SERVICES

(Agenda No. 11)

Yvonne Christley (Chief Nurse, Oxford University Hospitals NHS Foundation Trust [OUH]) and Professor Dr. Andrew Brent (Chief Medical Officer, OUH), were invited to present the report containing an update on Maternity Services.

The Chair welcomed the Chief Nurse and Chief Medical Officer and invited the Committee to proceed directly to substantive discussion. Members sought clarity on whether the Trust had met families affected by maternity concerns and whether longstanding campaign groups had been meaningfully engaged, particularly in light of previous tensions. The officers reported that groups such as Keep the Horton General had engaged with the Trust at various times, including at listening events, although concerns had persisted about transparency and the handling of information shared by those groups.

The Committee reflected on the private meeting with OUH on 22 December 2025, which had enabled sensitive matters to be raised directly and had provided an opportunity to secure clearer commitments regarding transparency, responsiveness and future engagement. Members underlined the need for renewed dialogue among the Trust, campaigners and affected families, recognising the depth of feeling and the imperative to rebuild confidence.

Attention then turned to the potential for a fresh approach to engagement with campaign groups and the part that Healthwatch could have played as an independent bridge. The officers acknowledged the longstanding nature of concerns within local groups and recognised that earlier engagement had not always built confidence, partly due to misunderstandings and worries about the treatment of information. They supported a renewed, structured model of engagement that brought campaign groups and the Trust together more effectively. They agreed that Healthwatch's independence made it a valuable, community-facing partner, capable of both facilitating dialogue and offering challenge, particularly while national arrangements for patient-voice functions remained uncertain.

The financial environment formed a further line of inquiry. Members explored the implications of NHS tariff changes for maternity services, especially in the context of increasingly complex clinical presentations. The officers noted that national tariff adjustments had been affecting multiple clinical areas. As an illustration, ophthalmology had experienced reduced tariffs for routine activity contrasted with increases for complex procedures, a pattern they considered relevant to maternity. With workloads growing more complex and requiring greater staff time and specialist intervention, the officers questioned whether current tariffs adequately recognised rising acuity. The Trust had already raised these pressures and advocated for sustainable funding models that reflected the real cost of safe, high-quality maternity care. Members warned that tariff misalignment risked worsening workforce and capacity pressures, and the officers confirmed that the matter would remain a focus for continuing scrutiny.

The discussion moved to maternity safety outcomes, with reference to the historic spike in postpartum haemorrhage (PPH) and the measures that had subsequently driven improvement. The officers explained that the increase in PPH had been linked to several factors, including a more complex maternity population and service pressures that had undermined consistency of care. The Trust had conducted a detailed review to understand contributory causes and had implemented a targeted improvement plan. The most effective actions had included strengthening clinical guidelines, improving escalation pathways, enhancing staff training and focusing on the early identification and management of risk during labour and birth. These combined measures had produced a clear improvement in PPH rates and greater consistency in practice across teams, with continued monitoring to sustain progress and embed learning.

In parallel, members examined the newly launched Induction of Labour Improvement Initiative, introduced to address persistent delays. The officers stated that the initiative had been designed to streamline the induction pathway, reduce waiting times and improve outcomes for women needing medical initiation of labour. Although specific process changes were not detailed in the transcript, the officers advised that early signs already indicated reduced delays and better flow through the pathway. Monitoring had continued, with the Trust focused on embedding improvements to deliver safer and more timely inductions over the longer term.

Questions about minimising harm, maintaining safety and responding to shortfalls in outcomes led to further detail on governance. The officers reported that the Trust had strengthened clinical governance procedures through clearer guidelines, rapid

escalation routes and closer outcome monitoring. They added that incident reviews had been completed more quickly, making it possible to apply learning sooner. Complaints and concerns had been tracked for themes and fed into service-improvement discussions. The private OUH meeting in December had provided a forum to raise sensitive points directly and to reinforce expectations around transparency and responsiveness. Members stressed the need for consistent application of improvements and for a demonstrably responsive approach when things went wrong.

The Committee then considered the increase in concerns reported in September 2025, where communication, consent and postnatal care had emerged as dominant themes. The officers confirmed that the spike reflected a cluster of cases in which women and families felt communication had been unclear, consent processes had fallen short of expectations and postnatal support had been inconsistent. Each case had been reviewed, and the resulting learning had been routed through governance to identify and address weaknesses. Targeted work had subsequently reinforced staff training on communication, good practice in shared decision-making and appropriate postnatal follow-up. The officers stated that these themes continued to be monitored closely and that improvements were already being embedded through ongoing quality and safety work in maternity.

Members asked whether longstanding dissatisfaction might have contributed to the heightened reporting observed in September. The officers acknowledged that unresolved distress and breakdowns in communication could have influenced the pattern of concerns and emphasised that complaints were being reviewed individually, with attention to their emotional impact. Regarding the national requirement for independent review of 50% of baby deaths, the officers confirmed that the Trust was working towards compliance and that independent scrutiny formed part of established governance processes. The Committee reiterated the need for sensitive communication, clear support for complainants and sustained transparency in oversight.

Discussion of the complaints process continued. The officers accepted that earlier failings in communication had undermined trust and reported that work was underway to strengthen practice. They explained that each complaint was reviewed on its merits, that themes were captured and fed into governance and that learning informed improvements in communication, consent and postnatal care. The Committee underlined that confidence would only be rebuilt through consistent, timely responses, improved escalation and clearer explanations when outcomes fell short, and that visible follow-through would be essential.

A focus on inequalities prompted questions about how the Trust monitored experience across different groups and reached communities at greater risk. The officers stated that patient-experience feedback, complaint themes and incident reviews informed the understanding of variation in care and allowed earlier, more targeted responses. Strengthening the interface between hospital and community services had been prioritised as neighbourhood health models developed. Better communication, more consistent postnatal support and earlier identification of need were presented as critical to reducing inequalities and improving safety, and the

Committee stressed the importance of tracking lived experience alongside clinical outcomes.

Cllr Garnett left the meeting at this stage.

Historic learning was then revisited, with members requesting details from the 2023 maternity case reviews in Oxford. The officers reported that the dominant themes aligned with those already discussed: the quality of communication with families, the robustness of consent processes and the consistency of postnatal care. These same issues had been visible in the September 2025 increase in concerns, suggesting persistent underlying challenges. The officers confirmed that each 2023 case had been reviewed through governance processes and that learning had been fed back to clinical teams. Improvement efforts therefore continued to prioritise communication standards, shared decision-making and reliable follow-up after birth, with monitoring in place to ensure that learning translated into sustained change.

The Committee asked whether a specific risk cited in discussion was included in the NHS England Maternity Bundle and how national focus translated locally. The officers confirmed that the bundle did contain a section relating to this risk and stated that the Trust's governance incorporated these expectations into day-to-day practice. The bundle was used to guide monitoring, escalation and improvement, ensuring alignment between national standards and local delivery. Members also sought an update regarding women with epilepsy becoming pregnant. The officers noted the importance of this issue, particularly in the learning-disability population, undertook to obtain a clearer system-level update and confirmed that recent LEADER findings had highlighted epilepsy-related inequalities which would be fed back through the Health and Wellbeing subgroup.

Recent media reporting in the New Statesman and on Channel 4 News was acknowledged. The officers observed that the concerns described in those reports overlapped with issues already discussed: communication, consent and postnatal care. They reiterated that steps had been taken to strengthen governance, escalation and learning processes, and that improvement work was ongoing to address the highlighted areas. The private meeting with OUH on 22 December 2025 had enabled direct examination of sensitive matters and had provided reassurances about transparency and responsiveness. The Committee welcomed these clarifications as useful context for anyone who had viewed the coverage.

The conversation then turned to postpartum injuries and whether the BOB ICB was working toward a standardised approach. The officers recognised the significance of postpartum harm within maternity safety and explained that, while the transcript did not set out a single ICB-wide programme, approaches to perinatal risk and harm, such as postpartum haemorrhage and postnatal care, had been under active review through strengthened governance and shared learning. They added that clinical guidelines, escalation pathways and monitoring mechanisms were being improved locally and that collaboration across the BOB system formed part of the wider improvement agenda. Members reiterated the value of system-wide consistency, and the officers confirmed that cross-ICB alignment would remain a priority.

Workforce planning was examined in light of service pressures and the specific context of Oxfordshire. The officers acknowledged the scale of the challenge, citing rising clinical complexity and sustained demand. They described how workforce planning had been strengthened using national guidance, local activity data and learning from incident reviews, ensuring that staffing models reflected both acuity and capacity. The Trust was refining skill-mix, improving recruitment to specialist roles and focusing on the retention of experienced staff through support and training. The overarching aim was to deliver a flexible, evidence-based workforce aligned with neighbourhood-based care and ongoing maternity improvement work.

The future configuration of maternity services, particularly the longstanding debate about the Horton and the concentration of obstetric services at the John Radcliffe, was then revisited. The officers stated that current review work was aimed at ensuring services remained resilient, safe and capable of meeting future demand, but they did not indicate any imminent change to the configuration. When asked whether anything other than resources stood in the way of reopening obstetric services at the Horton, the officers explained that decisions of that scale depended on system-wide and national factors, including regulatory requirements, workforce sustainability and formal service-change processes. Previous evaluations had identified significant challenges, notably around staffing sustainability and clinical safety standards, which continued to act as major constraints. The Committee stressed the importance of transparent, ongoing review.

Technology's role in improving safety, communication and clinical effectiveness also formed part of the discussion. The officers stated that digital tools already supported monitoring, decision-making and information-sharing. They indicated that technological improvements were complementing broader maternity-improvement work, particularly in strengthening governance, escalation and learning, and were helping staff to respond more consistently when outcomes fell short. Digital solutions were also being used to streamline pathways such as induction of labour and to improve communication between hospital and community-based teams as neighbourhood health models developed. These tools supported more reliable follow-up and earlier identification of risk, contributing to safer postnatal care, even if no single initiative was presented as transformative.

To close, members asked about experiences at Chipping Norton, Wantage and in home-birth settings, noting that previous discussions had centred on the Horton and the John Radcliffe. The officers confirmed that women had given birth at those locations, as well as at home, although the report they submitted to the Committee did not provide detailed comparative data or outcomes. They emphasised that the broader improvement work, encompassing communication, consent, postnatal care and pathway development, applied across all birth settings, not only acute sites. Strengthening the interface from hospital to community, particularly through neighbourhood health models, had been intended to improve follow-up and ensure consistent support regardless of place of birth. Members welcomed the reassurance that community-based and home-birth services were included in ongoing work and reiterated the importance of monitoring experiences across all birth settings, not just obstetric units

The Committee **AGREED** to issue the following recommendations subject to minor amendments offline:

1. To implement a Trust wide maternity communication standard covering: timing, clarity and translation of information, as well as expectations during induction, labour and postnatal care.

2. For the Trust to produce a quarterly, public-facing learning report showing: complaint themes, patients' experience of the complaints process, actions taken, percentage achieved of involvement of independent reviewer in any baby death, and evidence of impact. This is to ensure transparency and restore confidence in maternity services.

3. For the Trust to produce an evaluation framework for: Equal Start Oxford's expansion to Didcot and Banbury, general support for asylum seekers and underserved groups, and translation and outreach programmes. It is recommended that such an evaluation framework should include uptake, impact on outcomes, and service user satisfaction.

4. For the Trust to plan and explain how the current national maternity tariff, demand modelling, and BirthRate Plus projections align with staffing expansion and staff burnout.

5. For the Trust to provide a written update on progress on the accepted JHOSC recommendation on epilepsy, and how it plans to align with the NHS England maternity bundle section on epilepsy.

11/26 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 10)

Veronica Barry, Executive Director of Healthwatch Oxfordshire, was invited to present an update from Healthwatch Oxfordshire.

The Executive Director provided an update on Healthwatch Oxfordshire's recent activities. She reported that Healthwatch had been monitoring issues with new systems, such as improved communication at the Key Medical Centre and ongoing concerns with Quora Health's MSK services, including appointment cancellations and travel difficulties.

Discharge processes, especially in rural areas, continued to be a focus, with follow-ups on previous recommendations. The Executive Director also highlighted increasing concerns about the new non-emergency transport service, noting that Healthwatch was collecting stories and would keep a close watch on developments. All Healthwatch reports and system responses were made available on their website.

A question was raised about whether the Healthwatch research guide addressed the role of towns and parishes in community research, suggesting these institutions would want to be involved when research teams engaged with local populations. Veronica Barry responded that the workshops had included community members in the design process and that the intention was for the report to be relevant to anyone

in Oxfordshire wishing to undertake research. The Neighbourhood Planning Alliance had also participated actively.

12/26 FORWARD WORK PLAN
(Agenda No. 12)

Members discussed and prioritised agenda topics for upcoming meetings. They agreed that the 16 April 2026 public meeting would focus on adult and older adult mental health, (including transitions). Consideration was also given to feature updates on neighbourhood health developments, on the South Central Ambulance Service, and on dentistry services in future HOSC meetings.

Members also considered adding items on dementia support, prostate cancer, cancer wait times, and rheumatology.

The Committee **NOTED** that the above items would be placed on a provisional list for future public meetings.

The Committee **AGREED** and emphasised the need to remain flexible, adapting the work programme as partner engagement and system developments evolved.

The Committee also **AGREED** to enable the Chair and Health Scrutiny Officer to make final amendments to the work plan offline.

13/26 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 13)

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

..... in the Chair

Date of signing .....

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: Neighbourhood Health Plan for Oxfordshire

Lead Cabinet Member(s) or Responsible Person:

- Dr Michelle Brennan, Chair Oxfordshire GP Leadership Group.
- Matthew Tait (Chief Delivery Officer, BOB ICB)
- Dan Leveson (BOB ICB Director of Places and Communities)
  Ansaf Azhar (Director of Public Health)

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

Deadline for response: Tuesday 24th February 2026.

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 clear governance arrangements to be developed for the Oxfordshire Neighbourhood Health Plan, including defined roles for the Health and Wellbeing Board, Place-Based Partnership, and Primary and Community Care Board. It is recommended that there is openness and transparency, as well as regular reporting to the JHOSC on the plan's development and delivery milestones.	Partially Accepted.	The Oxfordshire Primary and Community Care Board (PCCB) reporting to Oxfordshire's Place Based Partnership (PBP) and Health and Wellbeing Board (HWB) has now been established for 6 months with broad representation from health and care partners including those with lived experience. Oxfordshire PBP has reviewed and updated its Terms of Reference and these will be revisited (by September 2026) following the establishment of the Thames Valley ICB and associated operating model. NHS Neighbourhood health and care planning framework and any associated governance requirements is yet to be published, but Health and Wellbeing Boards (HWBs) may be responsible for leading and overseeing delivery which would be subject to legislative change. The PCCB is committed to reporting through OPPB and HWB and will work in an open and transparent manner regarding any future required governance changes. Partners welcome scrutiny from JHOSC as and when required but suggest that regular reporting on the neighbourhood health and care plan development and delivery is undertaken through the Place based governance that is now established.
2. To ensure that the Neighbourhood Health Plan aligns with other strategic initiatives (such as the Better Care Fund and the Health & Wellbeing Strategy, and the Oxfordshire Way), and to avoid duplication and fragmentation.	Accepted.	Oxfordshire PBP facilitates and co-ordinates health and care planning and strategic development activities at place level. This will ensure alignment and reduce duplication and fragmentation. The Oxfordshire Health, Education and Social Care (HESC) Joint Commissioning Team provide much of the capacity and leadership associated with the BCF and similar activities, this is overseen by the Joint Commissioning Executive.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

3. To prioritise investment in digital infrastructure, interoperability, and usability to enable data sharing and Population Health Management at neighbourhood level. It is recommended that system partners report on progress in implementing Population Health Management tools and Health Evaluation Units.	Partially Accepted.	Oxfordshire is committed to progressing digital and data driven approaches to improving health and social care provision to support alignment between Marmot Principles and the neighbourhood health and care plan. Investment opportunities will largely be shaped by National NHS Digital programmes and any local authority development. Oxfordshire has recently undertaken an engagement with the Health Economics Unit in an effort to improve culture, capacity and capability associated with population health management and evaluation. A steering group has been established to ensure further improvements are planned and sustained.
4. To ensure that the local patient voice and local voluntary sector input is at the heart of the development and delivery of the neighbourhood health plan for Oxfordshire. It is recommended that the role of the local member and Parish/Town Councils is also integral to this.	Accepted	Wide representation from a diverse range of stakeholders is integral to Neighbourhood Health and Care. The Primary and Community Care Board includes broad representation including those with lived experience as Board members alongside a networked approach to engage voluntary, community, faith and social enterprise sector. This will continue to evolve as the neighbourhood plan is formulated and moves into delivery. We are committed to broad representation and input throughout, building on trusted relationships and networks established through existing programmes such as Well Together. Since the JHOSC meeting in November, members of the P&CCB have since met with further Country, District and City Council colleagues to improve close working with local members and parish/town councils.

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: Adult Autism and ADHD Services

Lead Cabinet Member(s) or Responsible Person:

- Matthew Tait (BOB ICB Chief Delivery Officer).
- Niki Cartwright (Director of Delivery, MH, LD, SEND and community, BOB ICB).

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

Deadline for response: Monday 2nd February 2026.

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.
For the ICB to urgently review and increase the annual assessment capacity for both autism and ADHD services to better reflect current demand and reduce potentially unsafe waiting times.	Partially accepted	We are working with Oxford Healthcare Foundation Trust to implement the new service model for Adult ADHD services and to implement a delivery plan and a detailed timeline. This will include clearing waiting lists and developing a demand and capacity plan.
For the development of a detailed timeline (and potentially a resource plan) for clearing the existing waiting lists, including the 2,229 adults awaiting ADHD assessments.	Accepted	We are working with Oxford Healthcare Foundation Trust to implement the new service model for Adult ADHD services and to implement a delivery plan and a detailed timeline. This will include clearing waiting lists.
To undertake a formal review of Right to Choose (RtC) expenditure and its long-term viability, with options for integrating RtC providers into core commissioning.	Accepted	The ICB has reviewed its RtC expenditure and as part of thew new service model the aim is to integrate RtC provider into the service via the Single Point of Access.
For co-production to remain at the heart of the development of the All-Age Autism Strategy. It is recommended that there are clearly identified stakeholders to ensure that all complexities are represented.	Accepted	Co-production is, and will remain, central to the development and delivery of the All-Age Autism Strategy and its associated work programmes. The Autism Improvement Board will be co-chaired by an Expert by Experience to ensure autistic voices remain integral to implementation. Engagement is supported through an established, open-membership stakeholder group comprising representatives from local authorities, health partners, the voluntary sector, and Experts by Experience, including Oxford Health NHS FT, BOB ICB, Oxfordshire County Council, OXPCF, Autism Champions and OUH. Membership continues to expand as new organisations are identified and invited to participate.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		Wider community engagement remains a priority. The strategy was recently shaped through a co-produced event held on 4 December, attended by over 100 participants. The event demonstrated best practice in inclusive engagement and will inform the approach to future engagement activities. As set out in the strategy, we will continue to centre autistic voices by co-producing campaigns, events and communications that authentically represent a broad range of lived experiences. This aligns with one of the We Will statements in the strategy: ***Centre autistic voices and increase visibility by:***

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Letter from JHOSC Chair to Chief Executive and Chair of Oxford University Hospitals NHS Foundation Trust:

I am writing following correspondence we have recently received from families who have recently used the Trust's maternity services, including from the organisation called families failed by OUH.

The Committee has now received and noted the points raised in their correspondence. In order to ensure accuracy and fairness in how this matter is understood and considered, the Committee would be grateful if the Trust could confirm and, where necessary, clarify some of the points raised in their correspondence with us.

In particular, we would welcome confirmation of the Trust's position on the following matters:

- *Whether the Trust accepts that there are data inaccuracies in the report it has submitted to the Committee for its maternity item at its meeting on 29 January 2026 (and if clarity could be provided on those data inaccuracies and assurance that all data inaccuracies in the paper have now been brought to the attention of the Committee).*
- *That the Trust understands the impact on families of data inaccuracies and on the JHOSC ("This not only underestimates the immense patient safety issues present in OUH maternity services, but erases my daughter's death as well as the other babies who died during 2023").*
- *Whether the Trust can expand on it's narrative of the mortality statistics for the death of babies in 2023 (combined perinatal, neonatal and stillbirth) and provide that in writing. The concern of families is that they show higher than average deaths for OUH compared with other tertiary units and that this is a trend since 2017. Specifically it is stated that the stillbirth rate is over 5% in 2023 and therefore the highest of any tertiary unit in the UK whereas the OUH analysis shared with the committee is that it is 'slightly above the peer average (by 0.18%)'. Please clarify what hospitals are included in determining peer average and why as there is a concern that the comparison ought only to be with other tertiary units.*
- *The Trust's understanding of the engagement that has taken place to date with affected families and campaign representatives, including the nature and timing of that engagement.*
- *Any relevant actions, reviews, or remedial steps that the Trust considers directly relevant to the matters raised by affected families.*
- *Whether there are any additional contextual points the Trust believes the Committee should be aware of when considering the issues raised.*

The purpose of this request is simply to ensure that the Committee has a clear and accurate understanding of the Trust's position in relation to the matters raised.

As I am sure you understand the impact of data inaccuracy for families. I am attaching an account we received from one bereaved family whose baby death was omitted from the OUH report because it was part of the 2023 statistics. This also provides a lived experience account of the process in the aftermath of their bereavement and identifies quality concerns. Whilst it is clearly beyond JHOSC jurisdiction to investigate individual accounts, we have secured the permission of this family to share this account with you confidentially at the highest level of the trust and ask what assurance you are able to give the Committee that all actions are being taken to ensure good practice in the investigation and resolution of complaints and that there will be consideration and action to sensitively reach out to this family. I am also attaching our recommendations from the January Scrutiny as our recommendation to complaints is pertinent to this.

We would be grateful if your response could be provided in writing so that it may be shared with Committee members for consideration. Thank you for your cooperation with us on this matter, and we look forward to your response.

Please see below some further extracts from Alice and Pedro Topping's correspondences with the Committee since the January public meeting:

- *OUH said in their internal PMRT report that there were no issues in my care, yet the external investigation showed a catalogue of failures and made 5 safety recommendations all that are considered contributory to the "outcome".*
- *OUH still refuse to update the PMRT, so our daughter isn't even officially down as a preventable death, despite staff knowing my care was a "disaster" and that they "totally failed" me (their words, not mine). We were told the OUH legal team were blocking it being changed. Reputation should not be put ahead of honesty. We have also been left nearly 2 and a half years without a response to our PMRT questions and feedback.*
- *The Trust changed local guidance in response to our daughter's preventable death, the external investigation and the formal complaint we made, but did not inform us of those changes. We have been left to find out ourselves through research, the external investigation and other people*

Best wishes

Cllr Jane Hanna (Chair, Oxfordshire Joint Health Overview Scrutiny Committee)

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

Maternity Services in Oxfordshire

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

Report to:
- Yvonne Christley (Chief Nurse, Oxford University Hospitals NHS Foundation Trust).
- Professor Dr. Andrew Brent (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on maternity services in Oxfordshire during its public meeting on 29 January 2026.

2. The Committee would like to thank Yvonne Christley (Chief Nurse, Oxford University Hospitals NHS Foundation Trust [OUH]) and Professor Dr. Andrew Brent (Chief Medical Officer, OUH); for attending the meeting and answering questions from the Committee.

3. The topic of maternity services is of significant interest and concern to the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the acute provider Trust to ensure that maternity patients receive the professional and empathetic support that they require. The Committee is also aware of rising challenges with maternity services on both a local and national scale.

4. PLEASE NOTE: Since the committee scrutinised this item, we were informed by Oxford Health NHS Foundation Trust that there were some errors in the data provided in the report submitted to the Committee. The Chair has acted with advice from the Health scrutiny officer and has written the Chief Executive and Chair of the Trust, seeking additional written clarifications and responses which will be reported and considered by the Committee as part of the Chair's update item in the Committee's public meeting on 16 April 2026.

5. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:

   - Trends in birth injuries and trauma.

   - Perinatal and stillbirth mortality and how OUH compares with peer Trusts.

   - An update on the October 2025 CQC maternity inspection, including: any immediate actions taken.

- Details on workforce planning (including staffing levels, how demand modelling is used, and how safety improvements are balanced against staff wellbeing and burnout).

- Patient experience, complaints, and communication (including how women and families are: communicated with during care, supported when things go wrong, kept informed in accessible formats and languages).

- Details on the engagement with families and community voices.

SUMMARY

6. During the 29 January 2026 meeting, the Committee sought clarity on whether the Trust had met families affected by maternity concerns and whether longstanding campaign groups had been meaningfully engaged, particularly in light of previous tensions and disputes with families. The officers reported that groups such as Keep the Horton General had engaged with the Trust at various times, including at listening events, although concerns had persisted about transparency.

7. Attention then turned to the potential for a fresh approach to engagement with campaign groups and the part that Healthwatch could have played as an independent bridge. The officers acknowledged the longstanding nature of concerns within local groups and recognised that earlier engagement in their view had not always built confidence, partly due to misunderstandings and worries about the treatment of information. They supported a renewed, structured model of engagement that brought campaign groups and the Trust together more effectively. They agreed that Healthwatch's independence made it a valuable, community-facing partner, capable of both facilitating dialogue and offering challenge, particularly while national arrangements for patient-voice functions remained uncertain.

8. The financial environment formed a further line of inquiry. Members explored the implications of NHS tariff changes for maternity services, especially in the context of increasingly complex clinical presentations. The officers noted that national tariff adjustments had been affecting multiple clinical areas. With workloads growing more complex and requiring greater staff time and specialist intervention, the officers questioned whether current tariffs adequately recognised rising acuity especially with the significant change in the average age of motherhood The Trust had already raised these pressures and advocated for sustainable funding models that reflected the real cost of safe, high-quality maternity care. Members warned that tariff misalignment risked worsening workforce and capacity pressures, and the officers confirmed that the matter would remain a focus for continuing escalation ? scrutiny.

9. The discussion moved to maternity safety outcomes, with reference to the historic spike in postpartum haemorrhage (PPH) and the measures taken to address maternal safety. . The officers explained that the increase in PPH had been linked to several factors, including a more complex maternity population

and service pressures that had undermined consistency of care. The Trust had conducted a detailed review to understand contributory causes and had implemented a targeted improvement plan. The most effective actions had included strengthening clinical guidelines, improving escalation pathways, enhancing staff training and focusing on the early identification and management of risk during labour and birth. These combined measures had produced a clear improvement in PPH rates and greater consistency in practice across teams, with continued monitoring to sustain progress and embed learning.

10. Members examined the newly launched Induction of Labour Improvement Initiative, introduced to address persistent delays for women. The officers stated that the initiative had been designed to streamline the induction pathway, reduce waiting times and improve outcomes for women needing medical initiation of labour.

11. Questions about minimising harm, maintaining safety and responding to shortfalls in outcomes led to further questions on the detail on governance. The officers reported that the Trust had strengthened clinical governance procedures through clearer guidelines, rapid escalation routes and closer outcome monitoring. They added that incident reviews had been completed more quickly, making it possible to apply learning sooner. Complaints and concerns had been tracked for themes and fed into service-improvement discussions.

12. Members asked whether longstanding dissatisfaction of families might have contributed to the heightened reporting of complaints observed in September. The officers acknowledged that unresolved distress and breakdowns in communication could have influenced the pattern of concerns and emphasised that complaints were being reviewed individually, with attention to their emotional impact. Regarding the national requirement for independent review of 50% of baby deaths, the officers confirmed that the Trust was working towards compliance and that independent scrutiny formed part of established governance processes. The Committee reiterated the need for clear support for complainants, sensitive communication, and sustained transparency in oversight.

13. Discussion of the complaints process continued. The officers accepted that earlier failings in communication had undermined trust and reported that work was underway to strengthen practice. They explained that each complaint was reviewed on its merits, that themes were captured and fed into governance and that learning informed improvements in communication, consent and postnatal care. The Committee underlined that confidence would only be rebuilt through consistent, timely responses, improved escalation and clearer explanations when outcomes fell short, and that visible follow-through would be essential.

KEY POINTS OF OBSERVATION:

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

Trust-wide maternity communication standard: Effective communication is not an adjunct to safe maternity care; it is a core clinical intervention that underpins informed consent, patient safety, experience, equity, and trust. The report submitted for this item shows a service that is making measurable progress in clinical outcomes and workforce stability, yet continues to face challenges in patient experience and complaints.

Complaints to the Trust have risen since September 2025, with the most common themes being communication, consent and postnatal care. These are not isolated issues but recurring signals across multiple feedback channels, including complaints, listening events and patient experience data. The Trust has acknowledged these themes and initiated improvement work through mechanisms such as the Triangulation and Learning Committee (TALC), enhanced postnatal ward arrangements and the Perinatal Improvement Programme. However, these initiatives, while valuable, operate largely as responsive interventions rather than as part of a single, coherent communication framework that sets clear expectations for staff and service users across the entire maternity pathway.

The OUH report also highlights specific clinical areas—such as induction of labour—where complexity, delays and uncertainty can heighten anxiety and increase the risk of dissatisfaction or harm if communication is inconsistent or poorly timed. Although the Trust reports improvements in induction delays, national evidence shows that induction remains an area where women frequently report inadequate information and a lack of understanding about what will happen and when. Without a Trust-wide standard, communication quality risks varying between teams, sites and individual clinicians, undermining both safety and confidence.

National regulators have repeatedly identified communication as a central weakness in maternity services across England. The Care Quality Commission's National Review of Maternity Services (2022–2024) found that poor communication was one of the most common themes arising from inspections and patient feedback, particularly for women with protected characteristics under the Equality Act. The CQC reported that many women were not given timely, clear or sufficient information to make informed decisions, especially during labour and postnatal care, and that communication failures were a frequent driver of formal complaints and traumatic experiences[1].

[1] https://www.cqc.org.uk/publications/maternity-services-2022-2024/communication

Importantly, the CQC has emphasised that communication problems are not confined to individual interactions but reflect system design. Women repeatedly described feeling uninformed about what was happening to them, uncertain about delays, and unable to access staff when they were worried—experiences that are magnified during induction, labour and the immediate postnatal period. The regulator's findings strongly support the case for formal communication standards that define what information should be given, when, and in what form, rather than relying on informal practice or individual judgement.

A Trust-wide communication standard is also a critical tool for addressing maternity inequalities. Both national data and academic research show that women who face language barriers, cultural differences or lower health literacy experience poorer outcomes and higher levels of dissatisfaction. The CQC has warned that communication failures disproportionately affect women from ethnic minority backgrounds and those who do not speak English fluently, undermining informed consent and safe care.

Academic evidence reinforces this. A 2025 qualitative analysis of maternity incident reports published in *BMJ Open Quality* found that communication failures were a leading contributor to severe maternal morbidity and that these failures disproportionately affected Black women. The study highlighted omissions, lack of shared understanding and unclear responsibilities as recurring problems, concluding that improving communication quality is essential to reducing inequities and preventable harm. Similarly, broader reviews of maternal care consistently link clear, empathetic communication to improved maternal satisfaction, reduced anxiety and better health outcomes[2].

The OUH report for this item describes positive initiatives such as translated antenatal classes and targeted support for vulnerable groups through programmes like Equal Start Oxford. However, without a Trust-wide standard, such efforts risk remaining fragmented. A formal standard would embed translation, interpreter use and culturally appropriate communication as routine expectations rather than optional enhancements, aligning with the NHS Accessible Information Standard and equality duties.

Induction of labour, labour itself and the postnatal period are phases where uncertainty is highest and communication demands are greatest. Evidence from a large UK postnatal survey published in *BMJ Open* found that many women undergoing induction felt poorly informed about what to expect, experienced significant anxiety, and reported that delays and changes were not adequately explained. The authors concluded that inadequate information and unclear expectations were central

[2] https://bmjopenquality.bmj.com/content/14/1/e003112

contributors to negative experiences, even where clinical care was otherwise appropriate[3].

National survey data from the CQC echoes this pattern. While overall communication during antenatal care has improved, communication during labour and especially postnatal care continues to score more poorly, with a notable minority of women reporting that they were not given information about options, were left alone when worried, or did not know who to contact for help after discharge. These findings underline the need for standards that specify not only *what* information should be shared, but *when* it should be provided and *how* expectations should be managed across transitions of care[4].

Furthermore, other NHS trusts have begun to formalise communication as part of their maternity strategies. Trusts such as West Suffolk and North Tees and Hartlepool explicitly frame personalised, accessible information and clear communication as strategic priorities, co-produced with Maternity Voices Partnerships. While these strategies vary in scope, they demonstrate a growing recognition that communication requires system-level standards rather than ad hoc initiatives.

At a national level, NHS England's Maternal Care Bundle and the Royal College of Obstetricians and Gynaecologists' *Standards for Maternity Care* both emphasise consistency, clarity and equity in care delivery, including communication. Although these frameworks do not prescribe local communication scripts, they strongly support the principle that variation in information provision contributes to unequal outcomes and undermines safety[5].

A Trust-wide maternity communication standard would not remove clinical judgement or reduce compassionate care to a checklist. Rather, it would provide a shared baseline that ensures every woman and birthing person in Oxfordshire can expect timely, understandable communication and appropriately translated information for those that need this, regardless of where or by whom they are cared for. It would support staff by clarifying expectations, reduce variation across sites and teams, and provide a framework against which improvement can be measured.

From a governance perspective, such a standard also strengthens accountability. Communication failures are frequently cited in serious incidents, complaints and litigation. By setting clear expectations, the Trust can better demonstrate learning, assurance and compliance with national guidance, while providing the JHOSC and the public with clearer lines of sight over progress.

[3] [bmjopen.bmj.com]
[4] [cqc.org.uk], [cqc.org.uk]
[5] [england.nhs.uk], [rcog.org.uk]

The JHOSC recommendation to implement a Trust-wide maternity communication standard is therefore well-founded, proportionate and evidence-based. It responds directly to local patient experience data from Oxfordshire, aligns with national regulatory concerns, and is strongly supported by academic research linking communication quality to safety, equity and outcomes. In a maternity system under sustained national scrutiny, such a standard represents not an additional burden, but a necessary foundation for safe, respectful and equitable care.

Recommendation 1: *To implement a Trust wide maternity communication standard covering: listening, timing, clarity and translation of information, as well as expectations during induction, labour and postnatal care.*

Public reporting on complaints and patient experience: Public confidence in maternity services is shaped not only by clinical outcomes, but by how health systems listen, learn and respond when things go wrong. The report submitted to the Committee for this item acknowledges a rise in complaints relating to maternity services since September 2025, with dominant themes including communication, consent and postnatal care. The report describes the Trust's internal mechanisms for learning, including the Triangulation and Learning Committee (TALC), which reviews complaints, patient feedback, incidents and legal claims to identify themes and drive improvement. While this demonstrates a commitment to learning, the report also makes clear that much of this learning currently remains internal to the organisation, with limited visibility for complainants, service users and the wider public.

Evidence from listening events held in December 2025, attended by families, campaign groups and staff, further indicates that families are not only seeking reassurance that issues are recognised, but want to understand what has changed as a result of raising concerns. In this context, a public-facing learning report would provide a structured and transparent means of closing the feedback loop between families and the Trust, reinforcing that complaints are treated as a source of improvement rather than defensiveness.

National regulators have repeatedly emphasised that poor handling of complaints and inadequate communication with families following adverse events are systemic weaknesses in maternity services. The Care Quality Commission's National Review of Maternity Services in England 2022–2024 found that while most trusts had mechanisms for incident reporting and learning, many families did not feel listened to or informed about what had changed as a result of raising concerns, particularly following baby deaths or serious harm[6]. There was no evidence that OUH had any system or procedure to address this locally.

The CQC's dedicated analysis of communication in maternity services highlights that complaints about communication are among the most

[6] https://www.cqc.org.uk/publications/maternity-services-2022-2024

common issues raised nationally and that failure to respond transparently can compound trauma and erode trust[7]. Importantly, the regulator stresses that learning must be visible and demonstrable, not simply recorded internally.

This expectation aligns closely with what the Committee is recommending. A quarterly learning report would allow OUH to show how complaints themes are identified, how families experience the complaints process, and how learning translates into service change over time.

Moreover, the CQC's Focus on Maternity section within the State of Care 2024/25 report reinforces that meaningful engagement with families and robust, independent review processes are essential to improving safety and preventing recurrence[8]. By publishing data on independent reviewer involvement, OUH would provide a clear and measurable indicator of assurance, demonstrating alignment with national expectations and best practice.

Furthermore, several NHS organisations have begun to recognise the importance of public learning in maternity care. For example, Trusts such as West Suffolk NHS Foundation Trust explicitly commit in their maternity strategies to publishing learning from patient feedback and complaints as part of building confidence and co-production with families[9]. Similarly, improvement frameworks supported by The King's Fund emphasise that safety improvement in maternity services depends on openness, shared learning and visible feedback to service users [10]. While approaches vary, these examples demonstrate a growing national recognition that transparency is not optional but integral to safe maternity systems.

Academic literature also strongly supports the link between transparent learning processes and improved patient trust and outcomes. Research published in *BMJ Open Quality* analysing maternity incident reports found that communication failures and inadequate learning responses were key contributors to severe maternal morbidity and that families' trust was significantly affected by how organisations responded after harm occurred[11].

Broader reviews of patient complaints handling in healthcare show that when organisations openly report themes, actions and outcomes, complaints decrease over time and patient satisfaction improves. Studies on continuity and informational transparency in postnatal care, such as those published in the European Journal of Public Health, further

[7] https://www.cqc.org.uk/publications/maternity-services-2022-2024/communication
[8] https://www.cqc.org.uk/publications/major-report/state-care/2024-2025/focus/maternity
[9] https://www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Strategy/Our-maternity-and-neonatal-strategy.pdf
[10] https://assets.kingsfund.org.uk/f/256914/x/027ccc6bcf/improving_safety_maternity_toolkit_communication.pdf
[11] https://bmjopenquality.bmj.com/content/14/1/e003112

highlight that clear communication about changes and follow-up enhances confidence and reduces anxiety for families[12].

It is of significant concern that national official reports show there have been 31 recommendations to improve mental health and support services, but that maternal death rates from suicide are now 74% higher than in 2019 in the UK. Whilst a rare outcome and with a complexity of risk factors associated, it is important to be cognisant that a recent large observational study found the risk of suicide and postpartum depression is significantly higher for women who feel they were treated inadequately during childbirth (Martinez-Galliano, Risk of suicide and postpartum depression in women who feel they were treated inadequately during childbirth, Women and Birth Vol 38, Issue One). Any maternity complaints process needs to be fully cognisant of the importance of supporting maternal well-being through the process and analysing the experiences of the process by the complainants.

Importantly, the evidence suggests that learning reports are most effective when they go beyond description and include evidence of impact, such as changes in practice, reductions in repeat complaints, or improvements in patient experience metrics.

The proposed quarterly frequency that the Committee is recommending strikes an appropriate balance between responsiveness and rigour. It allows trends to be identified without overwhelming staff, while providing families and the public with regular assurance that learning is ongoing. Making the report public reinforces accountability and supports the Trust's wider Patient Experience and Engagement Strategy.

Crucially, such reporting would not be about attributing blame. Rather, it would demonstrate a mature safety culture in which complaints, baby deaths and adverse experiences are treated as opportunities for improvement, consistent with national patient safety principles and the NHS Constitution's commitment to openness.

Therefore, the Committee's recommendation for OUH to produce a quarterly, public-facing learning report on maternity complaints, patient experience, independent review involvement and impact is firmly grounded in local evidence, national regulatory expectations and academic research. In a maternity system where public confidence has been repeatedly tested, transparency is not an additional requirement but a foundational one. By adopting this recommendation, OUH would take a significant step towards rebuilding trust, strengthening learning and demonstrating leadership in maternity safety and accountability.

Recommendation 2: *For the Trust to produce a quarterly, public-facing learning report showing: complaint themes, patients' experience of the complaints process, actions taken, percentage achieved of involvement of independent reviewer in any baby death,*

[12] https://academic.oup.com/eurpub/article/30/4/749/5497816.

and evidence of impact. This is to ensure transparency and restore confidence in maternity services.

Evaluation framework: Reducing inequalities in maternity care requires more than good intentions and innovative programmes; it requires robust, transparent evaluation to ensure that interventions are effective, equitable and sustainable. The report submitted to the Committee for this item describes significant progress in addressing maternity inequalities through targeted initiatives. Chief among these is Equal Start Oxford, a community-led programme developed in partnership with local organisations to support women and birthing people from minoritised ethnic and migrant communities, particularly in East Oxford. The report highlights tailored antenatal education, outreach to the East Timorese community, translation support and collaboration with voluntary sector partners as key components of this work. The Trust also outlines its intention to expand this approach to Didcot and Banbury, recognising similar patterns of deprivation and unmet need.

Equal Start Oxford itself is well documented as a place-based intervention designed to address barriers in access, experience and outcomes for women from diverse migrant communities[13]. However, while these initiatives are widely regarded as positive, the OUH report provides limited detail on how success will be measured as the programme scales. In the absence of a structured evaluation framework, there is a risk that expansion decisions are driven by anecdotal success rather than demonstrable impact, and that learning is not systematically captured or shared.

National evidence shows that maternity inequalities are persistent, complex and deeply rooted in social determinants of health. Systemic biases have been a consistent finding of MBRRACE reports on maternal deaths with a 50 percent rise in the UK's maternal death rate between 2013 and 2023. Underserved groups include socio-economically disadvantaged women; ethnic minority groups (black women are nearly three times more likely to die) and women with health inequalities (women with physical and mental health conditions).

The *National Maternity and Perinatal Audit inequalities report* demonstrates clear disparities in outcomes by ethnicity and deprivation, underlining the need for targeted interventions and continuous monitoring[14]. NHS England's *Equity and Equality Guidance for Local Maternity Systems* explicitly calls on systems to co-produce interventions with communities and to evaluate their impact using meaningful data on access, experience and outcomes[15].

[13] https://www.flosoxford.org.uk/equalstart/; https://researchequity.phc.ox.ac.uk/Projects/equal-start-oxford

[14] https://maternityaudit.org.uk/FilesUploaded/RCOG_Inequalities%20Report_Lay_Summary.pdf

[15] https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

Without formal evaluation, well-designed programmes risk becoming vulnerable to funding cuts, policy shifts or scepticism about their value. A structured framework allows Trusts to demonstrate that resources directed at underserved groups are not only ethically justified but also effective in improving outcomes and reducing long-term demand on services.

Moreover, other NHS systems and community-based maternity programmes increasingly recognise evaluation as integral to addressing inequalities. NHS England's Maternity and Neonatal Equalities Dashboard has been developed specifically to make disparities visible and support monitoring of progress over time[16]. At a local level, evaluations of community connector models, such as those reported in Kent, demonstrate how structured evaluation can inform refinement and scaling of equity-focused interventions[17].

Academic reviews of large-scale maternity improvement programmes published in *BMJ Quality & Safety* highlight that many initiatives fail to demonstrate impact precisely because evaluation is weak or absent, limiting learning and sustainability[18]. These findings underscore the importance of embedding evaluation from the outset, particularly when programmes are expanded geographically.

Furthermore, the Committee is also recommending that the evaluation framework include uptake, impact on outcomes and service user satisfaction. This reflects a comprehensive and proportionate approach. Uptake data indicates whether programmes are reaching intended populations; outcome measures demonstrate whether they are making a tangible difference; and satisfaction data captures the qualitative dimensions of dignity, trust and cultural safety that are central to maternity care. Public health research consistently shows that community-based and outreach interventions are most effective when communities perceive them as relevant, respectful and responsive[19].

The need for evaluation is particularly acute for maternity support provided to asylum seekers and refugees, who face well-documented barriers to accessing timely and appropriate care. A systematic review published in *BMJ Open* found that immigrant and asylum-seeking women in the UK are more likely to book late for antenatal care and experience poorer outcomes, driven by language barriers, lack of system knowledge and fear linked to immigration status[20]. Reports by *Doctors of the World UK* similarly highlight delayed access, poor maternal mental health outcomes and inconsistent support for migrant women[21].

[16] https://digital.nhs.uk/dashboards/maternity-and-neonatal-equalities-dashboard
[17] https://www.involvekent.org.uk/wp-content/uploads/2025/05/Maternity-Inequalities-Report-FINAL_compress.pdf
[18] https://qualitysafety.bmj.com/content/qhc/early/2023/11/28/bmjqs-2023-016606.full.pdf
[19] https://www.ssph-journal.org/journals/international-journal-of-public-health/articles/10.3389/ijph.2023.1605239/full
[20] https://bmjopen.bmj.com/content/9/12/e029478
[21] https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/06/Maternity-care-report.pdf

Specialist maternity services for migrant women, such as those evaluated at King's College Hospital, show high levels of user satisfaction but also underline the importance of capturing service user experience to understand gaps beyond clinical care[22]. These findings reinforce the importance of evaluation frameworks that include service user satisfaction alongside uptake and outcomes, ensuring that interventions respond to lived experience rather than solely clinical metrics.

Furthermore, the Royal College of Obstetricians and Gynaecologists' standards on cross-cultural communication and language support emphasise that interpretation and culturally safe communication must be routinely evaluated to ensure they are effective and trusted by service users[23]. An evaluation framework that tracks uptake of translated services, changes in engagement and outcomes, and user satisfaction would allow OUH to move beyond counting provision towards understanding real-world impact.

In essence, the recommendation for OUH to develop a formal evaluation framework for Equal Start Oxford's expansion, asylum seeker support and translation and outreach programmes is firmly grounded in local evidence, national guidance and academic research. As Oxfordshire seeks to reduce entrenched maternity inequalities, evaluation is not an administrative burden but a vital enabler of learning, accountability and improvement. By adopting a framework that systematically assesses uptake, outcomes and service user satisfaction, OUH can ensure that innovation translates into measurable progress and that equity remains central to maternity care across the county.

Recommendation 3: *For the Trust to produce an evaluation framework for: Equal Start Oxford's expansion to Didcot and Banbury, general support for asylum seekers and underserved groups, and translation and outreach programmes. It is recommended that such an evaluation framework should include uptake, impact on outcomes, and service user satisfaction.*

Relationship between maternity tariffs, demand modelling, and BirthRate Plus projections with staffing expansion and burnout: Safe, high-quality maternity care depends on a delicate alignment between funding mechanisms, realistic demand modelling and sustainable workforce planning. The report submitted to the Committee for this item presents a picture of a service that has invested significantly in its workforce. The Trust reports a surplus of midwifery whole-time equivalents against its planned establishment and ongoing recruitment to build further resilience. At the same time, the report acknowledges the intensity of maternity work, the complexity of the caseload and the

[22] https://www.britishjournalofmidwifery.com/content/research/a-service-evaluation-of-a-specialist-migrant-maternity-service-from-the-users-perspective
[23] https://www.rcog.org.uk/media/l1ypcshk/cross-cultural-communication-and-language-support-standards-for-maternity-care-and-womens-health.pdf

importance of staff wellbeing initiatives, including psychological support and professional advocacy. This juxtaposition—numerical workforce strength alongside persistent concern about pressure—raises an important question for scrutiny: how do staffing decisions relate to the funding and activity assumptions that underpin them?

Without a clear explanation of how staffing expansion is supported by tariff income and demand forecasts, it becomes difficult for non-executive oversight bodies, staff and the public to understand whether workforce growth is sustainable or whether it risks creating hidden pressures elsewhere in the system.

The Committee understands that maternity services in England are funded through the NHS Payment Scheme, which replaced the National Tariff in 2023. Maternity prices are largely activity-based, covering antenatal, intrapartum and postnatal care, and are informed by national cost modelling and policy adjustments[24]. NHS England's development of the maternity formula for 2025/26 allocations explicitly recognises that maternity activity is complex, unpredictable and influenced by population characteristics, deprivation and clinical acuity[25].

However, national bodies and professional organisations have repeatedly noted that the tariff does not always fully reflect the true cost of rising complexity in maternity, safeguarding responsibilities and non-clinical workload borne by maternity staff. This creates a risk that Trusts expand staffing to meet safety expectations without a commensurate increase in sustainable income, placing pressure on budgets and, indirectly, on staff through efficiency demands. Explaining how OUH reconciles tariff income with workforce expansion is therefore essential for transparency and assurance.

Demand modelling in maternity must go beyond headline birth numbers. While national birth rates have fluctuated, multiple analyses show that clinical complexity, social vulnerability and acuity per birth have increased, requiring more staff time per woman and baby. The **National** Audit Office's modelling of maternity services demonstrated that changes in demand characteristics, rather than volume alone, can significantly affect workforce requirements and service pressure[26].

Contemporary NHS planning approaches, such as those used by The Strategy Unit, emphasise collaborative modelling that incorporates population growth, deprivation, clinical risk and service configuration rather than simple activity counts[27]. Other systems, including North East London, have published demand and capacity reviews explicitly linking

[24] https://www.england.nhs.uk/long-read/25-26-nhsps-annex-d-prices-and-cost-adjustments/.
[25] https://www.england.nhs.uk/wp-content/uploads/2025/06/PRN01693_i-development-of-the-maternity-formula-for-2025-26-allocations.pdf
[26] https://www.nao.org.uk/wp-content/uploads/2013/11/Modelling-of-maternity-services-in-England.pdf
[27] https://www.strategyunitwm.nhs.uk/our-work?f%5B0%5D=topic%3A278

population projections, workforce modelling and service redesign to ensure sustainability[28].

Against this backdrop, the JHOSC recommendation seeks assurance that OUH's staffing plans are grounded in similarly sophisticated demand modelling, and that the assumptions underpinning recruitment are explicit and that they can be subject to scrutiny.

Birthrate Plus remains the nationally endorsed tool for midwifery workforce planning and is recommended by NICE and the Royal College of Midwives as the basis for establishing safe staffing levels[29]. The methodology uses local activity, case mix and models of care to calculate recommended establishments and is widely used across the NHS.

However, an independent review of the Birthrate Plus methodology published in 2026 highlighted that while the tool is robust, it must be interpreted in the context of rising acuity, expanded non-clinical responsibilities and workforce wellbeing considerations[30]. The review cautioned against treating Birthrate Plus outputs as a complete solution to workforce sustainability, emphasising the importance of professional judgement and transparency in how results are applied.

This is particularly relevant to the Committee's recommendation. Publishing Birthrate Plus projections without explaining how they interact with funding constraints and burnout risks can create a false sense of assurance. Conversely, openly describing how OUH uses Birthrate Plus alongside demand modelling and financial planning would demonstrate mature workforce governance.

A growing body of academic evidence also shows that staffing levels alone do not protect against burnout if workload intensity, recovery time and organisational pressures remain unaddressed. A large UK survey published in Midwifery found high levels of burnout and stress among midwives, with staffing shortfalls and lack of recovery time strongly associated with poorer emotional wellbeing and intentions to leave the profession[31].

Research from the University of Bath, funded by the NIHR, similarly identified workload, staffing pressure and organisational demands as key drivers of stress and attrition among midwives, noting that recruitment

[28] https://northeastlondon.icb.nhs.uk/wp-content/uploads/2024/07/Best-start-in-life-shaping-future-maternity-neonatal-services-summary-July-2024.pdf
[29] https://www.rcm.org.uk/wp-content/uploads/2025/02/birthrate-plus-what-it-is-and-why-you-should-be-using-it.pdf; https://www.nice.org.uk/guidance/ng4/resources/birthrate-plus-workforce-planning-methodology-and-birthrate-plus-intrapartum-acuity-tool-pdf-3300074199493
[30] https://birthrateplus.co.uk/wp-content/uploads/2026/01/Birthrate-Plus-Methodology-Review-REPORT.pdf
[31] https://researchprofiles.herts.ac.uk/en/publications/the-importance-of-recovery-and-staffing-on-midwives-emotional-wel/

without systemic change risks perpetuating burnout[32]. The UK WHELM study, commissioned by the Royal College of Midwives, further demonstrated that emotional distress and poor working conditions are closely linked to workforce sustainability and patient safety[33].

These findings underscore why scrutiny bodies increasingly expect trusts to explain not only how many staff they employ, but why those numbers are appropriate given funding, demand and wellbeing considerations.

The JHOSC's recommendation does not seek to challenge OUH's commitment to workforce investment. Rather, it calls for a clear narrative that connects tariff income, demand forecasts, Birthrate Plus outputs and burnout mitigation strategies. Such an explanation would allow stakeholders to understand whether staffing expansion is financially sustainable, whether demand modelling adequately reflects complexity, and how workforce planning contributes to reducing burnout rather than simply absorbing pressure.

Other NHS trusts, such as Sheffield Teaching Hospitals, routinely publish board papers linking Birthrate Plus assessments, funding decisions and risk management, providing a useful model for transparency[34].

In essence, the recommendation that OUH plan and explain how the national maternity tariff, demand modelling and Birthrate Plus projections align with staffing expansion and staff burnout is firmly grounded in national policy, financial reality and workforce evidence. In a service where demand is complex, funding is constrained and staff wellbeing is under sustained pressure, transparency is essential to maintaining confidence and ensuring sustainable improvement. By articulating this alignment clearly, OUH can demonstrate responsible stewardship of public resources, commitment to staff wellbeing and a robust approach to safe maternity care in Oxfordshire.

Recommendation 4: *For the Trust to plan and explain how the current national maternity tariff, demand modelling, and BirthRate Plus projections align with staffing expansion and staff burnout.*

Previous JHOSC recommendations on epilepsy and maternity: Epilepsy remains one of the most significant medical causes of maternal mortality in the United Kingdom, despite being a condition for which much of the risk is potentially preventable through timely, specialist and coordinated care. There has been a near doubling of maternal deaths in this population since 2015 with MBBRACE recognising system bias and

[32] https://www.bath.ac.uk/announcements/midwife-stress-research-reveals-what-creates-most-stress-for-midwives-and-the-best-interventions/
[33] https://www.rcm.org.uk/wp-content/uploads/2024/06/work-health-and-emotional-lives-of-midwives-in-the-united-kingdom-the-uk-whelm-study.pdf
[34] https://www.sth.nhs.uk/clientfiles/File/Ciii%20-%20Midwifery%20Workforce%20Current%20Position%20and%20Future%20State%20Proposal%20BoD%2026_09_2023.pdf

recommending specialist risk assessment and communication. The Oxfordshire Joint Health Overview and Scrutiny Committee's recommendation that Oxford University Hospitals NHS Foundation Trust (OUH) provide a written update on progress against the previously accepted JHOSC recommendation on epilepsy (January 2025), and explain how it will align with the NHS England Maternal Care Bundle element on epilepsy in pregnancy that was published last Autumn is therefore rooted in both local accountability and national patient-safety priorities.

The report submitted to the Committee for this item focuses primarily on trends in birth outcomes, patient experience, workforce and inequality initiatives. While it outlines a range of improvement programmes and partnerships, it contains limited explicit detail on epilepsy-specific pathways, learning or progress against earlier scrutiny recommendations. In the context of a condition associated with rare but catastrophic outcomes, the absence of a visible update does not imply inaction, but it does create an assurance gap for scrutiny bodies and the public.

The Committee had previously made recommendations relating to epilepsy, recognising national evidence that epilepsy-related maternal deaths frequently involve missed opportunities for pre-conception counselling, early specialist review, medication optimisation and postnatal safety planning. The recommendations included increasing the epilepsy workforce and co-production on mitigating harms. A written update would therefore allow the Committee to understand what has changed in practice since the recommendation was accepted, what remains outstanding, and how learning is being embedded across maternity, neurology and primary care services.

In January 2026, NHS England published The Maternal Care Bundle, establishing a national baseline for reducing maternal mortality and morbidity across five clinical areas, one of which is epilepsy in pregnancy[35]. The inclusion of epilepsy reflects long-standing findings from MBRRACE-UK that epilepsy, particularly sudden unexpected death in epilepsy (SUDEP), is a recurrent cause of maternal death, often linked to fragmented care, lack of specialist input and inadequate postnatal planning.

The epilepsy element of the Maternal Care Bundle emphasises early identification of women with epilepsy, timely referral to specialist epilepsy services, coordinated obstetric-neurology care, clear intrapartum and postnatal plans, and robust communication across services. NHS England has been explicit that Trusts are expected to assess their current practice against the bundle and implement system-level changes where gaps are identified[36].

[35] https://www.england.nhs.uk/long-read/the-maternal-care-bundle
[36] https://www.nhsbmenetwork.org.uk/wp-content/uploads/2026/01/NHS-England-The-Maternal-Care-Bundle.pdf

In this context, the JHOSC's recommendation is not merely about reporting, but about alignment with a new national safety framework that now sets clear expectations for providers.

Independent safety investigations reinforce the importance of transparency and follow-up. The Maternity and Neonatal Safety Improvement Programme (MNSI) has published safety spotlights highlighting repeated themes in epilepsy-related maternal deaths, including lack of contraception counselling including lack of person-centred communication on risk of SUDEP, missed opportunities for medication review and optimisation, and insufficient postnatal follow-up[37]. These investigations consistently stress that learning must be demonstrable and shared, rather than remaining implicit within organisations.

Providing a written update to the Committee would allow OUH to demonstrate how national learning is being translated into local practice, including whether epilepsy-related incidents or near misses have been reviewed, and how findings have informed service changes.

Moreover, academic literature consistently shows that women with epilepsy face substantially higher risks in pregnancy, particularly when seizures are poorly controlled or specialist care is delayed. A large systematic review and meta-analysis published in *PLOS Medicine* found that epileptic seizures during pregnancy are associated with increased risks of preterm birth, low birth weight and perinatal complications, with socioeconomic factors influencing seizure control[38]. Research published in *NIHR Open Research* further demonstrates that women with severe or uncontrolled epilepsy are at particularly high risk and should be prioritised for early specialist review and multidisciplinary planning[39].

Qualitative research also highlights that women with epilepsy often experience fragmented care and uncertainty about who is responsible for their management during pregnancy and the postnatal period. A 2025 systematic review in *Seizure: European Journal of Epilepsy* emphasises the importance of clear pathways, continuity and communication to improve both safety and experience[40].

These findings underline why scrutiny bodies increasingly expect providers not only to state that guidance exists, but to demonstrate progress in implementing it.

A written update to JHOSC would serve several critical functions. First, it would provide assurance that the Trust has acted on an accepted scrutiny recommendations, respecting the accountability relationship

[37] https://www.mnsi.org.uk/news/maternal-care-bundle-safety-spotlights/).
[38] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004580
[39] https://openresearch.nihr.ac.uk/articles/4-53
[40] https://www.seizure-journal.com/article/S1059-1311(25)00279-1/fulltext

between the NHS and local democratic oversight. Second, it would allow OUH to set out explicitly how its current epilepsy pathways align with the Maternal Care Bundle, including any gaps, risks or planned improvements. Third, it would support transparency for service users who gave evidence to the committee, many of whom are acutely aware of national safety concerns relating to epilepsy in pregnancy.

Recommendation 5: *For the Trust to provide a written update on progress on the accepted JHOSC recommendation on epilepsy within 28 days, and how it plans to align with the NHS England maternity bundle section on epilepsy.*

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 n consultations.

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

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

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

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Judith Edwards
Councillor Gareth Epps
Councillor Emma Garnett
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
City Councillor Louise Upton
Barbara Shaw
Sylvia Buckingham

Annex 1 – Scrutiny Response Pro Forma

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

April 2026

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Oxfordshire Joint Health Overview Scrutiny Committee (HOSC)
16 April 2026

Oxfordshire County Councill Motion on Mental Health

Report by Director of Legal and Governance and Monitoring Officer

RECOMMENDATION

1. The Oxfordshire Joint Health Overview Scrutiny Committee is **RECOMMENDED** to**:**

   a) **NOTE** the request from the Health and Wellbeing Board for the Committee to undertake scrutiny of adults and childrens mental health services as outlined in the wording of the motion detailed in paragraph 3.
   b) **AGREE** that the Committee will continue its scrutiny of adults and children's mental health as outlined in its work programme, and that it will report back within its annual report to Council, details of the adults and children's mental health scrutiny undertaken

Executive Summary

2. At its meeting on 9 December 2025, Oxfordshire County Council passed a motion requesting that the Health & Wellbeing Board (HWB) invite the Health Overview & Scrutiny Committee (HOSC) to investigate and report on how mental health services provided by Oxford Health NHS Foundation Trust and wider system partners are addressing the rising prevalence and impact of poor mental health among adults and children in Oxfordshire.

3. The wording of the motion agreed was as follows:

   "This Council being deeply concerned by the impact of poor mental health on adults and children in the County asks the Health and Wellbeing Board to request the Health Overview and Scrutiny Committee to investigate and report back to them and to the County Council on how Mental Health services provided by Oxford Health and other organisations are tackling this issue.

   Such an investigation of issues needs to include addressing accessibility to services including:

   - *Prevention*
   - *Assessment*
   - *Therapeutic support*
   - *Medication*
   - *Emergency intervention such as "sectioning"*

- *Inpatient beds*

How these issues impact on other public services such Community Safety, Public Health, Housing, Schools, Fire and Rescue and the Police also needs to be assessed and understood. Most of all poor mental health impacts on individuals, families, and communities around the County and this must be addressed.

Council requests that the outcome of the investigation be sent to the appropriate Secretaries of State."

4. This report recommends that the Committee notes this request and responds to full council via the HOSC annual report.

Financial Implications

5. There are no direct financial implications arising from this report.

Comments checked by: Drew Hodgson- Strategic Finance Business Partner – Resources, FRCS and TDCE

Legal Implications

6. Under Part 6.1B s11.of Oxfordshire County Council's Constitution, the Health Overview and Scrutiny Committee 'may hold enquiries and investigations'.

7. Responsibility for establishing these enquiries and investigations is, under Part 6.1B s. 6 'as they may determine'. A request from the Health and Wellbeing Board does not automatically mean such a request will be granted.

Comments by:

Jay Akbar
Head of Legal & Governance

Anita Bradley
Director of Legal and Governance and Monitoring Officer.

Report Author/ Contact Officer: Dr Omid Nouri (Health Scrutiny Officer)

April 2026.

Meeting	Health and Social Care Overview and Scrutiny Committee (HOSC)
Date of Meeting	Thursday 16th April 2026
Title	Adult and Older Adult Mental Health in Oxfordshire
Date of Report	1st April 2026
Version	1
Author(s)	Oxford Health NHS Foundation Trust (OHFT) Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Oxfordshire County Council (OCC)

1. Executive Summary

Oxfordshire has made significant progress in strengthening adult and older adult mental health services by shifting care earlier, closer to home and working in more integrated ways across the system.

Community provision has expanded through Keystone Hubs, embedded mental health practitioners in primary care and new early-intervention services, improving access and supporting prevention for people with severe mental illness, eating disorders and those at risk of crisis. Long-standing partnership with the voluntary, community and social enterprise sector remains a clear strength, with peer workers and experts by experience embedded across services and a new long-term outcomes-focused commissioning approach reinforcing co-production.

Crisis pathways are continuing to improve through the 24/7 NHS 111 Mental Health Helpline, Safe Havens in Oxford and Banbury, and the development of a consistent countywide Crisis Resolution and Home Treatment model, offering more alternatives to hospital. Despite sustained demand pressures, inpatient flow is improving, with reducing lengths of stay and a marked reduction in inappropriate out-of-area placements, supported by stronger discharge planning and joint working with the local authority.

A key development is the planned reintroduction of Assertive Outreach and Intensive Case Management, providing intensive, multi-agency support for people with severe mental illness who struggle to engage with standard services, representing an important step forward in safety, continuity of care and outcomes across Oxfordshire.

2. Introduction

This briefing paper provides an overview of adult and older adult mental health provision in Oxfordshire in response to the following points requested by the Oxfordshire Scrutiny Officer:

- Community-based prevention and early intervention, including neighbourhood and voluntary sector support.
- Access to community mental health and crisis alternatives
- Work to reduce escalation to acute services
- Crisis response pathways (including NHS 111, crisis teams, Safe Havens and liaison services).
- Response times, demand trends and performance.

- Work with partners (including Right Care, Right Person) to ensure people access the right support first time.
- Current demand for acute and older adult mental health beds
- Use of out-of-area placements and actions to reduce these
- Length of stay, discharge pathways and step-down provision
- Workforce and operational pressures affecting bed availability
- Update on the Warneford Park redevelopment
- How estate plans will improve quality, safety and local capacity over time

Additional Insight to be provided in the report

1. Transitions from children's to adult mental health services.
2. Medication management (How prescribing decisions are made person-centred, and how recent prescribing restrictions (e.g., valproate) are managed for people with bipolar disorder or epilepsy with mental health co-morbidities).
3. Details on any system level KPIs around SMI as well as any local system-level KPIs on mental health services more broadly.
4. Insights into the community dimension/aspect of out of area placements.
5. How people with complex needs/comorbidities are supported by the system.

3. Avoiding Crisis: Early help and community response

3.1 Community-based prevention and early intervention, including neighbourhood and voluntary sector support.

Keystone Hubs

8 Hubs in Oxon (7 bases - Abingdon, Wantage, Witney/Chipping Norton, Banbury, Cowley Road Oxford, Kidlington). Established 2023/4 as part of Community Mental Health Framework initiative to bridge gap between primary and secondary mental health care and in conjunction with Voluntary Community and Social Enterprise (VCSE). Aim to benefit three patient groups and address health inequality in the areas of Eating Disorders, Personality Disorder and people with severe and enduing psychotic illnesses. 'Health on the high street' accessibility in Abingdon, Wantage, Banbury, Oxford, Kidlington.

Additional Role Reimbursement Scheme (ARRS) workers

12 workers based across Oxfordshire working into Primary Care Networks (PCN's). Mental health practitioners fully embedded in GP practices providing primary care MH assessment and intervention. Not all PCNs (of which there are 21) have chosen to have Mental Health ARRS workers.

Oxfordshire Talking Therapies (OTT)

For people with depression and/or anxiety who may also have comorbid Long-term physical health conditions (Long Term Condition pathways: cardiac conditions, chronic/post viral fatigue, diabetes, irritable bowel syndrome (IBS), Long COVID, menopause symptoms, and respiratory diseases). NICE recommended, evidence-based psychological therapies at the appropriate dose. Stepped care with appropriately trained and supervised workforce using routine clinical outcome measure. Integrated employment advice service. Self-referral; GP referral.

Mental Health Helpline (NHS 111, select mental health)

Self-referral. 24/7 helpline operated by qualified and experienced mental health clinicians. Embedded within NHS 111/999 (SCAS). Mental health triage, advice and information; and onward referral to all other parts of the MH services. Covers Oxon and Bucks.

Early Intervention in Psychosis Service (EIS)
Service for people experiencing a first episode of psychosis offering up to 3 years of focussed and evidence-based care and treatment with the aim of reducing the likelihood of future relapse and recurrence of psychosis and improving outcomes for people who have experienced psychosis for the first time.

At Risk Mental State Service (ARMS)
New service (2025/6) working with people aged 14+ who are presenting to services with signs and symptoms suggestive of possible future risk for developing a psychotic illness. Assessment and prevention intervention. Onward referral to EIS as required.

Neighbourhoods
As part of the NHS 10-year plan, NHS, Local Authority Social Care, Primary Care and VCSE operating in collaboration in defined geographies and targeting health inequalities of specified population / patient groups. Mental health services (all age) have been fully connected into neighbourhood developments in Oxfordshire and working with Oxford Health Foundation Trust (OHFT) Community Services Directorate on an integrated Oxford Health offer into Neighbourhoods.

First Episode Rapid Early Intervention for Eating Disorders (FREED)
Based within the Community Adult Eating Disorders team, FREED offers early intervention to people aged 16 – 25 who have had an eating disorder for 3 years or less. It provides rapid specialised treatment intervention to this population paying particular attention to the challenges that young people face during these critical years of their lives and aiming to reduce or reverse the changes to brain, body and behaviour caused by eating disorders.

VCSE
Adult mental health provision in Oxfordshire has benefitted from partnership working with the voluntary, community & social enterprise (VCSE) sector for many years, with arrangements having been formalised in 2015. The OHFT-led 'Mental Health Outcomes Improvement Programme' is currently recommissioning VCSE provision for the next ten years. At present OHFT has range of arrangements in place with the following organisations:

VCSE organisations	Contracted provision
Oxfordshire Mind	Support ranging from wellbeing to supported accommodation, to crisis care
Response	Specialist mental health accommodation, care & support
Sweda	Eating disorder support
Elmore	Support for people with complex needs
Restore	Supporting people with recovery, training & employment
Bridewell	Horticultural therapy to support recovery
Root and Branch	Horticultural therapy to support recovery
Connections	Floating Support, Hospital discharge support workers

In addition to the specific services they deliver, these organisations embed peer workers and experts by experience across a wide range of teams. These roles are deliberately positioned within services to ensure that lived experience directly shapes how care is designed, delivered and improved. Embedded peer workers bring together professional expertise, personal insight and system knowledge, creating meaningful added value for both service users and clinical teams. This includes, for example, peer workers based within inpatient settings who support people to prepare for discharge and rebuild confidence in returning to home life, as well as those embedded within adult community mental health teams, where lived experience informs day-to-day practice and

service development. OHFT has also begun collaborative work with Oxfordshire Community Action to strengthen access to community mental health provision for minoritised communities, with experts by experience playing a key role in shaping culturally responsive approaches.

As a system leader, OHFT is committed to sharing its vision for adult mental health services and driving improvement through co-production and system-wide collaboration. During 2025/26, OHFT convened a series of multi-agency events designed to bring together practitioners, VCSE partners and people with lived experience to collectively reflect, learn and improve practice across the system. Experts by experience and peer workers were integral to the design and delivery of each event, ensuring that lived experience perspectives informed discussion, challenge and solution-building. Topics included working effectively together across the mental health system, supporting people experiencing self-neglect, applying system thinking to enable people to move on to independent living and sustain tenancies, and strengthening joint working to support people with eating disorders.

The Mental Health Outcomes Improvement Programme is founded on partnership and co-production, with the explicit aim of improving outcomes and quality across accommodation, care and support, community mental health services and urgent care pathways. OHFT is working in close collaboration with the VCSE, Thames Valley ICB, Oxfordshire County Council and, critically, people with lived experience to design, deliver and evaluate this programme. Experts by experience and peer workers are embedded throughout the programme, ensuring that improvement activity remains grounded in what matters most to people who use services and that change is informed by real-world experience at every stage.

3.2 Access to community mental health and crisis alternatives

Alongside community mental health services described above, Oxfordshire provides a range of crisis alternatives designed to offer support outside of hospital or statutory services.

Safe Haven services in Oxford and Banbury, delivered in partnership with Oxfordshire Mind, provide out of hours mental health crisis support in a safe and non-clinical environment. These services offer drop-in support, emotional wellbeing guidance and short-term crisis support for people experiencing distress who may otherwise attend emergency departments. Safe Havens play an important role in the urgent care pathway by providing an alternative setting for people who require immediate support but do not require a clinical crisis response.

Work is currently underway across Oxfordshire to review the range and effectiveness of crisis alternatives provided across the system, including those delivered by the voluntary sector. This work aims to ensure services are accessible, equitable across the county and aligned to the developing urgent mental health care pathway. The review is considering opportunities to expand crisis alternatives and improve integration with NHS urgent care services, ensuring people can access the most appropriate support at the earliest opportunity.

3.3 Work to reduce escalation to acute services

Reducing unnecessary escalation to emergency departments and inpatient services remains a key priority across Oxfordshire's urgent mental health pathway.

Voluntary sector partners including Oxfordshire Mind are working with statutory sector partners in a system wide workstream. This is currently reviewing the range of crisis alternatives delivered, with the aim of ensuring the right support is available earlier in a person's crisis. This includes considering how services can better support individuals whose needs may not require a clinical crisis intervention, but who would benefit from timely emotional and practical support.

In parallel, Oxford Health is progressing the development of a 24/7 countywide Crisis Resolution and Home Treatment Team (CRHTT) model to ensure consistent access to urgent mental health assessment and intensive

home treatment across Oxfordshire. This expansion aims to reduce the need for hospital admission by providing timely crisis assessment and treatment in people's homes wherever clinically appropriate.

In addition, the mental health text support service will transition to an in-house model from April, improving integration with existing urgent mental health services and enabling better coordination of support across the crisis pathway.

4. Access to crisis care

4.1 Crisis response pathways (including NHS 111, crisis teams, Safe Havens and liaison services).

Oxfordshire operates a multi-agency urgent mental health pathway designed to ensure people in crisis can access the right level of support quickly.

NHS 111 Mental Health Helpline

The Oxfordshire and Buckinghamshire Mental Health Helpline is available 24 hours a day through NHS 111 using the mental health option. The service is staffed by experienced mental health clinicians who provide triage, advice, risk assessment and referral into appropriate services across the mental health system. The helpline acts as a key entry point to urgent mental health support and helps ensure people are directed to the most appropriate service first time.

Crisis Resolution and Home Treatment Teams (CRHTT)

Adult and CAMHS Crisis Resolution and Home Treatment Teams provide rapid assessment and intensive home treatment for people experiencing acute mental health crises that might otherwise require hospital admission. The teams operate 24/7 and provide short term intensive support in the community, including psychiatric assessment, medication management and therapeutic interventions. Their role is to stabilise crises while enabling people to remain safely at home wherever possible. Work is underway to further develop the adult CRHTT model to deliver full countywide coverage, ensuring equitable access to crisis support across Oxfordshire.

Safe Haven services

Safe Havens in Oxford and Banbury provide an alternative to hospital attendance for individuals experiencing emotional distress or crisis. Delivered by the voluntary sector, they offer informal, supportive environments where individuals can access immediate support, information and guidance.

Emergency Department psychiatry services

Mental health services operate within acute hospitals across Oxfordshire, including the John Radcliffe and Horton hospitals. These teams provide specialist mental health assessment and intervention for patients attending emergency departments or who have mental health needs. The service works closely with emergency department teams, acute clinicians and community mental health services to ensure patients receive appropriate care and follow up.

4.2 Response times, demand trends and performance.

Demand for mental health services across Oxfordshire has continued to increase across both community and urgent care pathways over the past year.

Referrals to adult community mental health services, including psychological therapies, community mental health teams, eating disorder services, complex needs services and perinatal services, have increased significantly. Monthly referrals rose from between around 500 and 640 earlier in the year to over 1,200 referrals per month in the latter part of the reporting period, reflecting both increased demand and improved access through community mental health pathways.

Referrals to older adult community mental health services, including community mental health teams and memory services, have remained relatively stable across the period, typically ranging between around 290 and 376 referrals per month.

Demand across the urgent mental health care pathway remains consistently high. Referrals to urgent mental health services ranged between approximately 1,300 and 1,750 referrals per month. These figures represent the total number of referrals entering the urgent care pathway, including referrals to Crisis Resolution and Home Treatment Teams (CRHTT), the Emergency Department Psychiatric Service (EDPS) and the Mental Health Helpline.

The Oxfordshire Mental Health Helpline, delivered through NHS 111 in partnership with South Central Ambulance Service, continues to provide an important entry point to urgent mental health support. The data presented relates to Oxfordshire residents supported by the service rather than the total number of calls received, as the helpline also supports Buckinghamshire. During the reporting period the service supported between approximately 256 and 457 Oxfordshire residents per month, providing clinical advice, triage and onward referral into the urgent mental health pathway where required.

Referrals to Primary Care Mental Health Teams remained relatively consistent throughout the year at around 500 to 600 referrals per month. CAMHS referrals fluctuated between approximately 536 and 949 per month, reflecting seasonal variation commonly seen within children and young people's mental health services.

Emergency Department Psychiatric Service (EDPS) demand also remained high, with monthly referrals ranging from 158 to 334 during the reporting period and an average of approximately 274 referrals per month. Between 76% and 94% of patients were seen within one hour, against a local target of 95%, demonstrating the continued responsiveness of liaison mental health services within busy emergency department environments.

4.3 Work with partners (including Right Care, Right Person) to ensure people access the right support first time.

Oxfordshire partners have worked collaboratively to support the implementation of the Right Care, Right Person (RCRP) approach across the Thames Valley. Oxford Health NHS Foundation Trust co chaired system wide implementation meetings during the early stages of rollout, bringing together partners including Thames Valley Police, South Central Ambulance Service, local authorities and voluntary sector organisations.

These meetings supported the development of shared operational pathways, escalation processes and communication arrangements to ensure people experiencing mental health distress are directed to the most appropriate service.

As the approach has matured and become embedded within routine system working, dedicated RCRP implementation meetings have now concluded. Oversight and ongoing development of the approach is now incorporated into existing governance structures, including the monthly Partnerships in Practice forum, ensuring continued multi agency collaboration and system oversight

5. Inpatient capacity and flow

5.1 Current demand for acute and older adult mental health beds

Demand for acute adult beds has fluctuated in recent months. Our approach is to admit patients locally wherever possible, with Out of Area Placements (OAP) used only when demand exceeds local capacity. Historically, higher demand for male acute wards meant that a small number of male patients required placement out of area; however, this pattern shifted in February, when increased demand for female acute beds led to limited use of female OAPs for the first time in around six months. At the same time, demand for male older adult beds reduced, enabling the local older adult male ward to support and safely admit a number of working-age adults, helping to maintain care closer to home. Demand for older adult female beds has remained relatively stable, and

local admissions have largely been achieved, with occasional mutual aid support from Buckinghamshire. Reducing reliance on OAPs remains a priority due to the impact on patient experience, continuity of care and outcomes, and ongoing work is focused on strengthening local capacity and flow to support this.

Bed request/admissions by gender/age:

	Dec 2025	Jan 2026	Feb 2026
AWA female	22	22	26
AWA Male	23	16	24
OA Female	6	9	4
OA Male	8	2	4

5.2 Use of out-of-area placements and actions to reduce these

Out of Area Placements (OAPs) occur when a patient is admitted to an inpatient mental health bed outside their local NHS Trust area. An inappropriate OAP is defined as an out of area admission that takes place for non-clinical reasons, most commonly due to the unavailability of a suitable local bed, rather than because the patient requires highly specialist care that cannot be provided locally.

Oxon no longer have blocked booked beds and therefore all acute admissions to Out of Area Placements (OAPS) are considered 'inappropriate OAPs'. There were no new admissions to OAPS in January 2026, however demand for beds increased in February resulting in OAP admissions – current position as of 18/03/2026 – 3 female, 1 male inappropriate OAPS.

Inappropriate OAP bed days:

Dec 2025 – 144 days

Jan 2026 – 142 days

Feb 2026 – 59 bed days

Female Psychiatric Intensive Care Unit's (PICU) are considered 'appropriate OAPS' as we have no local provision for female PICU. Current position is 3 female PICU's – 1 for step down to local acute ward this week (as of 18/03/2026)

Appropriate OAP bed days:

Dec 2025 - 65 days

Jan 2026 - 62 days

Feb 2026 - 56 days

Actions being taken to reduce OAPs:

1) Weekly OAP rapid review – led by patient flow, attended by community teams, crisis team and social care
2) Repatriation of OAPS when feasible (without leading to other OAPS going out)
3) 3 x weekly escalation calls to review all delayed discharges, identify discharges and consider alternative options to admission ensuring all least restrictive options to admission have been explored and exhausted
4) Regular face to face reviews of patients in OAPS – generally around once per fortnight – led by patient flow with support from community/crisis teams where possible
5) High threshold for authorisation to refer to OAPS – director level in hours, head on call out of hours.

6) Use of HBPOS when capacity allows if it is clear that this will be short term until a bed is available weighing up the restrictions of a HBPOS vs an OAP.
7) Input from CRHTT at earliest opportunity to facilitate discharge from OAPS/local inpatient wards to facilitate discharge.

5.3 Length of stay, discharge pathways and step-down provision

Length of stay is gradually reducing, with a number of long-stay patients moving on to appropriate placements or completing their treatment, improving both patient experience and outcomes. A weekly length-of-stay review meeting has been established for the past six months, focusing on patients in hospital for over 60 days. These reviews ensure there is a clear, patient-centred treatment and discharge pathway, with active identification and escalation of clinical, social and system barriers that may be prolonging admission. This approach supports timely recovery, reduces the risk of institutionalisation, and helps patients move on when clinically appropriate.

Average LOS for AWA beds:

Dec 2025 – 72 days

Jan 2026 – 70 days

Feb 2026 – 62 days

Average LOS for OA beds:

Dec 2025 – 61 days

Jan 2026 – 53 days

Feb 2026 – 48 days

Discharge pathways:

Data on discharge pathways is currently captured for patients who are formally declared clinically ready for discharge. In Oxfordshire, this is supported through close joint system working with Oxfordshire County Council, the ICB and other partners to maximise the use of step-down provision as a key enabler of timely and safe discharge. The Oxfordshire Better Care Fund has (since 2024) funded additional capacity to support discharge including discharge capacity in adults and older adults services and the Oxford City-led Oxfordshire Homelessness and Health Inclusion team (OHHI). Step-down accommodation is a highly valuable shared resource, particularly for people experiencing homelessness or awaiting accommodation to become habitable and reflects a coordinated health and local authority response to discharge barriers. The step-down houses in Oxford and Banbury delivered as part of OHHI also enable continued access to CRHTT support, allowing integrated health and social care input to stabilise and sustain discharge into temporary accommodation.

Barriers to safe and effective discharge from acute mental health beds are discussed and supported by the Oxfordshire system in a dedicated weekly escalation call. Oxfordshire has sought to establish the same focus and processes to support people ready to leave mental health beds as we apply to other acute hospitals.

5.4 Workforce and operational pressures affecting bed availability

The main pressures have related to estates issues, including the need for repairs following significant wear and tear to the ward environment, such as damage to fire doors and bedroom doors. At times, this has temporarily reduced bed capacity while essential works are completed. Over the past year, this has most notably affected the two male wards and Ashurst.

It remains extremely uncommon for admissions to be paused or delayed due to workforce availability. Where this has occurred, it has been in response to periods of particularly high clinical acuity requiring enhanced levels of care to maintain safety and quality. Any decisions of this nature are agreed at directorate level (Clinical Director, Head of Service and Service Director) and are subject to daily review. Overall, vacancy rates and staffing levels across the wards are good, with established processes in place to flex staffing in response to changes in patient acuity.

6. Mental Health estate

6.1 Update on the Warneford Park redevelopment

Warneford Hospital is the oldest inpatient unit still in use across the NHS and the building is no longer a suitable environment in which to be providing modern mental health care.

In partnership with the University of Oxford and a local benefactor, we have developed plans to transform the site into a major mental health campus, and in the summer we submitted a detailed planning application to Oxford City Council. Whilst we await the outcome of our application, we are working hard to secure government funding for the new hospital.

At the heart of our plans is a brand-new hospital, which will focus on providing modern inpatient facilities. This will have an enormously positive impact on the quality of mental health care we can provide: better mental healthcare facilities and innovative new integrated models of care will transform outcomes and significantly improve the experience of that care for people living in Oxfordshire.

Our plans also include a major research facility and the establishment of a new post-graduate college focusing on medical sciences, bio-engineering and related disciplines. In combination, the proposals would provide a world-class research campus in Oxford that will aim to tackle some of the most important issues in brain and mental health, by discovering new forms of treatment and therapies. Bringing together science and clinical care on one site will see the benefits from mental health research translated directly into clinical practice, with the new hospital allowing for the growth of these innovative treatments.

6.2 How estate plans will improve quality, safety and local capacity over time

- Improved mental health facilities and environment for patients, visitors and staff - the new hospital will focus on providing modern inpatient facilities, with a strong emphasis on patient wellness and therapeutic spaces that connect with nature.
- Better mental healthcare facilities and innovative new integrated models of care will transform outcomes and significantly improve the experience of that care for people living in Oxfordshire.
- High quality facilities will be available for these groups of patients. Including all en-suite facilities to improve privacy and dignity which meets with CQC regulatory standards. In addition, multiple areas for other activities will be available on site. The new hospital will help to create a positive therapeutic atmosphere through the provision of areas to socialise and enable the development of a sense of "community" and quiet areas for reflection. Further benefits are natural light and access to outdoor space. The therapeutic environment will support recovery and this, with the community transformation plans, reduce average length of stay which provides increased capacity for admission, less out of area admissions and more people able to receive a service closer to their home.
- Crisis team hub will be located on the hospital site. Crisis team Hub will ensure effective oversight and clinical input in HBPOS and community teams to ensure patient flow. Services delivered on a single campus to ensures maximum focus of care delivery, fewer transitions through easier access of community/inpatient MDT; and smoother pathways for patients. Improved space and environment with particular attention to

incorporation of evidence-based technology to ensure safe observations of patients, anti-ligature fixtures and fittings, low impact flooring are in place as standard. Staffing levels that allow for high quality care delivery and intervention.

- Mental health and brain research has lagged behind other areas of healthcare and so there is much more we can do to develop and improve therapies and treatments for the future and create the best environment for new scientific break-throughs – helping to better prevent, diagnose, and treat mental illness early. We're developing a range of new treatments, such as Virtual Reality therapy, as well as trialling drugs that have been shown to be effective in treating difficult-to-treat depression and helping to revolutionise dementia diagnosis through blood tests. Our proposals would provide a world-class research campus in Oxford that will aim to tackle some of the most important issues in brain and mental health, by discovering new forms of treatment and therapies.
- The co-location of clinical staff with academic and commercial research teams in a purpose-built campus means that mental health research can be translated directly into clinical practice, with the new hospital allowing for the growth of these innovative treatments.
- We have carried out a bed modelling exercise as part of our planning for the new hospital to ensure it meets future demands, which has resulting in an increase in the number of beds being planned. However, we also expect the benefits of a new purpose-built facility, with a greater focus on treatment and recovery, to reduce the average length of stay of our inpatients.
- As a result of patients spending less time in hospital, improved capacity would support the ability to meet the current and future population need. The hospital is being designed so that we can flex up if required.

OHFT's estate plan sets out how the built environment will support better care delivery now and in the future. By aligning buildings, infrastructure and digital capability with clinical and service priorities across Oxfordshire and Buckinghamshire, our estate plan will play a direct role in improving **quality**, **safety** and **local capacity**.

1. Improving quality of care

Over time, estates plans improve care quality by ensuring facilities are fit for modern clinical practice and patient needs.

Better clinical environments: Investment in modern, well-designed spaces supports dignity, privacy and therapeutic outcomes (e.g. single rooms, improved mental health environments, accessible outpatient facilities).

Support for new models of care Estates plans enable a shift from hospital-centric care to community-based and integrated services, including:

- Community/neighbourhood hubs
- ambulatory and day-case facilities
- co-located health, social care and voluntary services

This improves continuity of care and patient experience.

Digital-enabled estates Upgraded infrastructure (power, data, Wi-Fi) supports digital transformation, telemedicine, electronic patient records and diagnostic technologies, improving clinical effectiveness and responsiveness.

2. Improving safety and compliance

A core purpose of NHS estates planning is to reduce risk to patients, staff and the organisation. This reduces the likelihood of adverse incidents, enforcement action or service disruption.

Targeted estates investment to address priority and high-risk issues. This investment focuses on mitigating identified risks and strengthening the safety and resilience of the estate, delivering improvements in:

- fire safety
- infection prevention and control
- electrical and medical gas safety

- structural integrity

Compliance with statutory and regulatory standards Estates plans support compliance with:

- Health Technical Memoranda (HTMs)
- Health Building Notes (HBNs)
- CQC safety and environment standards

Resilient and reliable infrastructure. Planned upgrades to plant, utilities and resilience measures (e.g. power redundancy, flood mitigation) reduce unplanned downtime and clinical risk.

3. Increasing local capacity and flexibility

Estates plans help ensure the NHS can meet rising and changing demand within local systems. This reduces pressure on acute sites and supports care closer to home.

Optimising use of existing estate. Through rationalisation, refurbishment and repurposing, trusts can:

- release under-used or poor-quality space
- reinvest in priority services
- improve operational efficiency

Targeted capacity expansion. New or expanded facilities are aligned to population need and service demand, supporting:

- growth in outpatient and diagnostic capacity
- same-day emergency care
- mental health and community services

System-wide planning. Estates strategies increasingly align with Integrated Care System (ICS) priorities, enabling shared use of assets, joint developments and better coverage of local need.

4. Supporting workforce and sustainability

Over the longer term, estates plans also underpin workforce stability and environmental goals.

Attracting and retaining staff. High-quality, safe and well-designed workplaces improve staff wellbeing, productivity and retention.

Net zero and running cost reduction. Investment in energy efficiency and low-carbon technologies reduces emissions, lowers revenue costs and improves long-term affordability.

7. Additional Insights

7.1 Transitions from children's to adult mental health services.

18 – 25 transitions Mental Health Outcomes Improvement Programme started in December 2025, with an objective to review the current process for transitioning young people from CAMHS to adult services, complete a full scoping exercise to review all services available for people aged 18-25 across the community in Oxfordshire, improve the transitions process for young people and their families when transferred to adult mental health services, and improve the offer for young people with Severe Mental Illness (SMI) and their families in the partnership

18-25 Transitions project group meetings have representatives from across services, including experts by experience (who have recent experience of transitions) and VCSE organisations. Phase 1 task and finish groups underway, focusing on Mapping of services, Gap analysis, Feedback from Services and users of services, and Transitions from out of area placements

Oxford Health was also invited to the Corporate Parenting Panel in January 2026, where there was a presentation on services available post 18, for people experiencing mental health issues.

A working group has been established across commissioners and County Council and OH to develop a better understanding and pathways for more children and young people who have more complex needs and who might be at higher risk of being placed in out of area accommodation. This group will develop the practice and commissioning intentions to improve transition for this group.

7.2 Medication management (How prescribing decisions are made person-centred, and how recent prescribing restrictions (e.g., valproate) are managed for people with bipolar disorder or epilepsy with mental health co-morbidities).

Medication management within Oxford Health is underpinned by a strong commitment to person-centred care, shared decision-making, and safe, evidence-based prescribing. Prescribing decisions are made collaboratively between the prescriber and the individual, taking into account clinical need, diagnosis, co-morbid physical and mental health conditions, previous treatment response, personal preferences, and wider social circumstances. This approach is explicitly supported within the Trust's Medicines Management Policy and Prescribing Policy which emphasise prescriber accountability, informed consent, and the involvement of service users in decisions about their treatment wherever possible.

Medication management is delivered through a person-centred, shared decision-making approach, with prescribing decisions tailored to individual clinical need, co-morbid mental and physical health conditions, treatment history, and personal circumstances. For people with bipolar disorder or epilepsy with mental health co-morbidities, clinicians carefully balance symptom control, safety, and quality of life, supported by regular specialist review. In some cases, valproate remains the most clinically effective option for maintaining mood stability or seizure control; however, its use is always considered alongside current MHRA safety requirements and NICE guidance. Where prescribed, this is underpinned by clear risk–benefit discussions, documented informed consent, and ongoing review to ensure treatment remains appropriate, safe, and aligned with national regulatory expectations.

7.3 Details on any system level KPIs around SMI as well as any local system-level KPIs on mental health services more broadly.

Please see appendix A for full KPI details.

Talking Therapies – Summary Dashboard

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	687	Jul-25	746			685
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	.	Jul-25	7.40%		N/A	7.42%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	>=67%	Jul-25	64.10%			67.11%
National	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	>=75%	Jul-25	99.60%			99.69%
National	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	>=95%	Jul-25	100%			99.96%
National	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	<=10%	Jul-25	6.30%			3.91%
National NOF	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	>=48%	Jul-25	43.90%			50.59%
National	Meet and maintain at least 50% Talking Therapies recovery rate - Oxfordshire	>=50%	Jul-25	50.40%			53.72%
National	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	>=50%	Jul-25	43.20%			48.90%
National	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire	>=50%	Jul-25	53.60%			55.22%

Adult and Older Adult Community – Summary Dashboard

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire	>=6737	Jul-25	9330		.	7764
National	4 week wait (28 days) standard (interim metric - two contacts within pathway)- Oxfordshire	>=36% National average	Jul-25	84.87%			67.74%
National	Improve access to perinatal mental health services - Oxfordshire (rolling 12 months)	>=501	Jul-25	567		.	490
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	>=60%	Jul-25	92.86%			88.29%
National	Number of people accessing Individual Placement Support (IPS) - Oxfordshire (rolling 12 months)	>=400	Jul-25	419		.	353
National	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	>=63%	Jul-25	63.70%	N/A	N/A	62.77%

Urgent Care – Summary Dashboard

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire	>=6737	Jul-25	9330		.	7764
National	4 week wait (28 days) standard (interim metric - two contacts within pathway)- Oxfordshire	>=36% National average	Jul-25	84.87%			67.74%
National	Improve access to perinatal mental health services - Oxfordshire (rolling 12 months)	>=501	Jul-25	567		.	490
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	>=60%	Jul-25	92.86%			88.29%
National	Number of people accessing Individual Placement Support (IPS) - Oxfordshire (rolling 12 months)	>=400	Jul-25	419		.	353
National	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	>=63%	Jul-25	63.70%	N/A	N/A	62.77%

7.4 Insights into the community dimension/aspect of out of area placements.

There is a s75 agreement between Oxford Health NHS Foundation Trust and Oxfordshire County Council. Social Workers are an integral part of the integrated mental health teams to deliver statutory social care duties across community and inpatient settings. The s75 agreement supports a seamless coordination between health and social care for people with mental health conditions which reduces fragmentation in service delivery. There are 42 WTE Social Work professionals fully integrated into adult mental health provision.

Mental health Social Workers work across a variety of settings in community, forensic and early intervention services. The inpatient Social Work team is a vital service to support safe, effective and timely discharge from hospital. The mental health social workers provide statutory social care assessments and reviews of care and support plans, investigate safeguarding concerns, assess under the Mental capacity Act and, will at times need to make decisions on behalf of people with severe mental health conditions in their best interests. Crucially, mental health social workers provide expertise in law, safeguarding and community support services to colleagues in their integrated teams, promoting a rights based social perspective and providing direct 1:1 support and interventions to meet needs.

Not all the people being supported by mental health social work meet the criteria for secondary mental health services. A small number of people are managed under a 'best fit' policy. These cases are commonly characterised by the person having a primary diagnosis of autism with no co-occurring mental health diagnosis but severely high risk behaviours.

Insights into the community dimension

The majority of people supported by mental health social work are eligible for Section 117 after-care. This places a joint statutory responsibility on the Integrated Care Board and the local authority to arrange and fund care and support that helps individuals remain well, prevents relapse, and reduces the risk of readmission to hospital. For people eligible under Section 117, care and support is planned and delivered within this framework, ensuring a coordinated health and social care approach. Alongside this, the social work team also undertakes Care Act assessments where appropriate, to identify and meet wider care and support needs.

Many people with mental health conditions are supported in their own homes by integrated mental health services. For some people, floating support services provided by Connections Support and Elmore is needed to support with connecting to wider community services and to provide support with practical issues such as housing and finances.

Some people require supplementary support by way of a care and support package to meet their s.117 after-care or Care Act needs. There are 242 people receiving a care and support package. In the main, the packages are to support medication adherence, maintaining the home environment and support with social inclusion.

For those people who require more intensive support following a hospital admission or who are still in recovery or moving towards independence, the Oxfordshire Mental Health Partnership offers a range of supported housing throughout Oxfordshire which is currently provided by Oxfordshire Mind and Response Organisation. The supported housing offer ranges from 24-hour 7 day a week support to transitional and unstaffed housing where people are more independent but require lower-level support.

Number of people in Oxfordshire Mental Health Partnership supported housing	
Oxfordshire Mind	87
Response Organisation	214

In two of the highest levels of supported housing (Rowan House and Morrell Crescent), we have been required to provide additional care and support packages to a total of 69 hours a week.

Whilst we aim to meet peoples care and support needs in the most least restrictive way possible, there are 19 people whose needs cannot be met in their own homes or in the Oxfordshire mental health supported pathway. These are called spot placements. There are a range of individual reasons for this including where the person is autistic and has no co-occurring mental health diagnosis or, because the person has a complex range of needs due to the interaction between their mental and physical health and the risks to self cannot be safely managed in the community. There are 7 people residing in care homes or supported living placements in Oxfordshire whose care plans amount to a deprivation of liberty (DOLS), either already authorised or currently undergoing the authorisation process.

Safeguarding

Safeguarding is a key area of mental health social work practice. Mental health social work commitment to preventing and addressing abuse and neglect is a key performance indicator. We manage safeguarding concerns in line with Oxfordshire County Council processes and contribute to the council's meaningful measures meetings to ensure robust oversight and governance into safeguarding concerns.

Since March 2025, mental health social work has completed 85 safeguarding enquiries

Whilst safeguarding concerns are varied, self-neglect, including hoarding is a countywide and national issue and the most common safeguarding concern we see for people living with mental health conditions. Within the domain of self-neglect, we routinely manage concerns related to inability to manage personal care, home environment, finances and physical health care. In recognition of this, mental health social work has developed

resources and provided presentations to support integrated mental health teams and our supported living providers to identify, and report concerns for self-neglect.

Out of Area Social Care Placements

There are currently a total of 20 people residing in out of area social care placements that are being case managed by a s.75 mental health social worker.

This number has been much reduced over the course of the last 24 months, supported by statutory social care reviews and the s.75 mental health social work 'better outcomes' process which provides monthly senior social work oversight. The 'better outcomes' process was developed in response to the growing number of people being placed out of county. This was problematic for many reasons: we had little evidence of people being supported towards independence and recovery in these placements and/or there were concerns about the quality and safety of the provisions and apprehension about over and under provision of care. We have acknowledged the harms that can come from removing people from their family and local networks and disconnection from the integrated mental health team: it can lead to a situation where there is reliance on mental health services who does not know the person, and the person does not know the service in the area where they are living.. We recognise that our ability to effectively monitor, and safeguard people placed outside of Oxfordshire is at times hampered by distance and our capacity to be responsive in crisis situations remains a concern.

However, most of the people who are currently placed in out of county social care placements have resided outside of Oxfordshire for many years – in some cases for more than 10 years. These people are settled and at this point a move would be destabilising, and so we have decided that for some, their placement is meeting their needs and is a safe and effective provision.

Over the last 12 months, we have placed 3 people outside of Oxfordshire due to lack of suitable social care provision in county. The reasons are varied – unable to live in Oxfordshire due to Ministry of Justice conditions, one person with a combination of complex mental health, an acquired brain injury and a forensic history and another who has been unsuccessfully supported in Oxfordshire in a range of support provisions and whose mental health and co-occurring drug use has led to significant safeguarding concerns.

7.5 How people with complex needs/comorbidities are supported by the system.

Adult Mental Health Teams (AMHT)
Multidisciplinary teams (Psychiatry, Psychology, Social Work, Occupational Therapy, Nursing, support workers, peer support workers, embedded VCSE workers, admin) based across Oxfordshire assessing and treating people (agreed 18-65) with acute, severe and enduring mental health needs. Adult mental health teams re integrated health and social care provision (s75 arrangement in place with the Local Authority for delegated social care and Social Work function inc s117 MHA and Care Act eligible needs). Full range of bio-psycho-social intervention is provided. Core function covers all diagnoses including dual diagnoses (autism/SMI and substance misuse/SMI). Referral response times – routine 28 days, urgent 7 days, very urgent 24hrs – waits all within national average and target. Access to inpatient care.

Older Adult Community Mental Health Teams (OA CMHT)
Multidisciplinary teams (Psychiatry, Psychology, Occupational Therapy, Nursing, support workers, peer support workers, admin) based across Oxfordshire assessing and treating people aged 65+ with acute, severe and enduring mental health needs. Integrated memory clinic and dementia diagnostic service. Full range of bio-psycho-social intervention is provided. Referral response times – routine 28 days, urgent 7 days, very urgent 24hrs – waits all within national average and target except for access to memory clinic where we have significant waits. Access to inpatient care.

Multiagency working including statutory safeguarding approaches

High frequency use of multiagency partnership approaches to meeting patient need involving social care, probation, police, acute Trust, ambulance service, housing, homelessness, substance misuse services and VCSE partners. Criminal justice interface also includes MAPPA, MARAC and MHTRs. Safeguarding approaches also include MARM and MEAM.

Complex Needs Service
Highly specialist service for people with personality disorder. Offers a range of psychotherapeutic intervention for people with personality disorder whose needs have not or cannot be met in other parts of service provision. Individual and group-based intervention including Therapeutic Community (TC) approach.

Crisis Resolution Home Treatment (CRHT) Team – as detailed elsewhere

Community Adult Eating Disorders Team
Specialist community eating disorder service working with all eating disorder diagnoses of all severity and all ages 18+. Full range of psychological intervention. Enhanced medical monitoring for high-risk eating disorder presentations. Access in inpatient care.

Perinatal Mental Health Team and Maternal Mental Health Service (MMHS)
Specialist mental health service providing assessment and treatment for women with moderate to severe mental health difficulties during pregnancy and up to 1-year post-birth, otherwise known as the 'perinatal period'. The service aims to improve access to treatment and achieve improved outcomes for women and their families. The MMHS along with embedded VCSE worker provides support to women who are experiencing emotional distress related to their maternity experience, for example severe pregnancy related anxiety, phobia of giving birth or trauma related to past birthing experience.

Physical Health in Severe Mental Illness Team
Physical health assessment, intervention and health promotion targeting to people with severe and enduring mental illness in particular where they may find it hard to engage with physical health care services or require assertive approaches to engagement.

Forensic community mental health team
Referrals are received from custody / inpatient environments with a focus on offending in the context of mental disorder. Our teams are fully multidisciplinary. The service provides specialist assessment, treatment and risk management for those involved in the criminal justice system that pose a high risk to others or themselves. Community teams across the Thames Valley: the service aims to safely rehabilitate individuals (many of who are subject to ongoing MoJ restrictions) into the community who have been in secure forensic inpatient services through recovery focussed interventions, mental health treatment and maintenance and risk management. Forensic provision also includes Inpatient Services, Prison Mental Health Service and IIRMS (Intensive Intervention and Risk Management Service).

Assertive Outreach Team (AOT) / Intensive Case Management (ICM) developments
Along with many other Mental Health Trusts, OHFT took the difficult decision to end its specialist AOT provision about 10 years ago. Following the murders perpetrated by Valdo Calocane in Nottinghamshire in 2023 and the subsequent enquiries that have taken place, the need for implementation of AOT/ICM approaches has been highlighted.

The Oxfordshire Assertive Outreach model is designed to provide intensive, flexible, and proactive community-based support for people with severe mental illness who experience significant difficulty engaging with standard community mental health services. The model focuses on a relatively small, clearly defined cohort with high levels of complexity, offering high-frequency contact, continuity of care, and assertive engagement delivered by a dedicated multidisciplinary team. It is aligned to national NHS priorities and fidelity principles, with the aim of improving engagement, reducing avoidable crisis presentations and hospital admissions, and supporting

individuals to remain safely in the community through coordinated, person-centred care and strong partnership working across the wider system.

NHSE has required all Mental Health Trusts to participate in self-assessment against key service standards for people with severe mental illness who struggle to be effectively and safely engaged and treated by core mental health services. In Oxfordshire, we have developed plans to deliver an AOT for Oxford City and implement ICM within our county AMHTs with strong links between the two to ensure good fidelity to the required clinical model. This will meet the needs of approximately 120 patients in Oxfordshire who fulfil the criteria for this enhanced level of service provision. We plan to use Mental Health Investment Standard (MHIS) new investment to commence this is FY26/27.

System / strategic connectivity; partnership working

We are involved in multiple forums where service coordination, planning and commissioning occurs for people with comorbidities and complex care needs, for example:

- Oxfordshire Health Inclusion Partnership
- Oxfordshire Mental Health Partnership (OMHP) management group
- Countywide Homelessness Steering Group
- Prevention of Homelessness Directors Group
- Urgent Care Delivery Group
- Urgent and Emergency Care Board
- Mental Health Partnerships in Practice forum
- Thames Valley Police Mental Health Strategic Partnership Group
- Oxfordshire Health Inequalities
- Suicide Multi-Agency Group
- BCF planning / oversight group
- Criminal Justice Mental Health Panel
- Oxfordshire Safeguarding Adults Board
- Thames Valley MAPPA operational and governance meetings
- Multiagency Family Hubs Program Board
- Combatting Drugs Partnership

Appendices

Appendix A – 02.a Oxfordshire Performance and Assurance Oversight Board Report March 2026

Appendix B - HOSC Glossary

Oxfordshire Performance and Assurance Oversight Board Report:

March 2026

Quality

People

Sustainability

Research

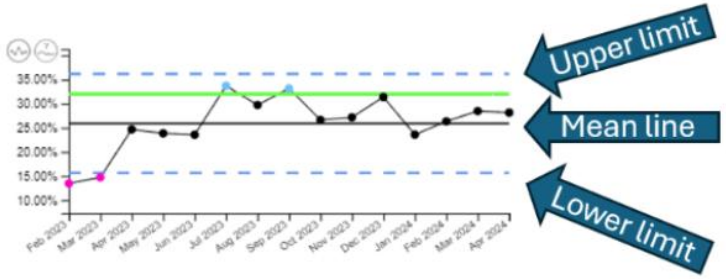
Oxford Health NHS Foundation Trust

Guide to the Performance Report

The below legends explain Variation and Assurance icons and Statistical Process Charts (SPCs) used throughout this IPR.

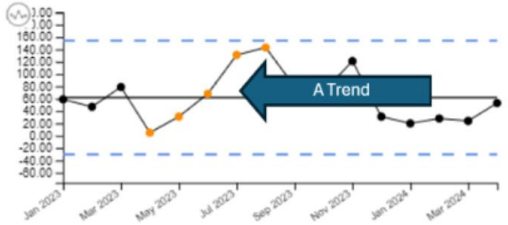
Statistical Process Charts (SPC) is an analytical technique that plots data over time. Such charts help identify variation i.e. what is 'different' and what is the 'norm'. Using these charts can help understand where focus might be needed to make a difference.

The SPC chart has three lines on it: central line (mean line; black) is the average of data and blue are upper and lower control limits. If data points are within the control limits, it indicates that the activity is within normal range. If the data points are outside of these control units, it indicates that the activity is out of control.

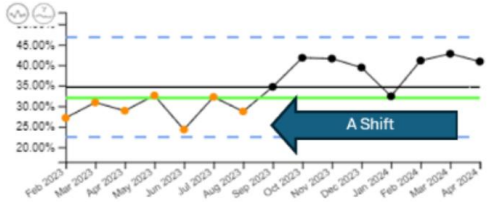


Green is the metric target line – only added to those graphs where target is applicable. Data points highlighted in pink are noted to be statistically different from the rest of the points (outside of the upper and lower control limits).

A Trend is defined as five or more consecutive data points all going up or all going down – orange indicates a deteriorating trend and blue indicates an improving trend.



A Shift is defined as seven or more consecutive data points all above or all below the centre (mean) line. Orange indicates a deteriorating shift and blue indicates an improving shift



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: orange indicates concerning **special cause variation** requiring action; blue indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: Blue indicates that you would consistently expect to achieve a target. Orange indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Guide to the Performance Report – interpreting the Data Quality Indicators (for clinical metrics)

The indicator provides an effective visual aid to quickly provide analysis of the collection, review and quality of the clinical data associated with a group of metrics. Group of metrics are rated against the three domains described below and overall assessment (red, amber, green) is provided by adding relevant icons on top of each summary clinical dashboard throughout the IPR. Narrative describing any identified concerns with regards to Data Quality are added in the Cover sheet accompanying the Integrated Performance Report.

Due to the aggregated nature of the data quality reporting, only issues of significance (impacting most metrics in a group or significantly impacting a single metric) will be taken into consideration.

Symbol	Domain	Definition
S	Sign off and Review	Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	Is the required data available and up to date at the point of reporting? Are all the required data values captured and available at the point of reporting?
P	Process and System	Is there a process to assess the validity of reported data using business logic rules? Is data collected in a structured format using an appropriate digital system?

Rating	Definition
	Yes
	Partly
	No

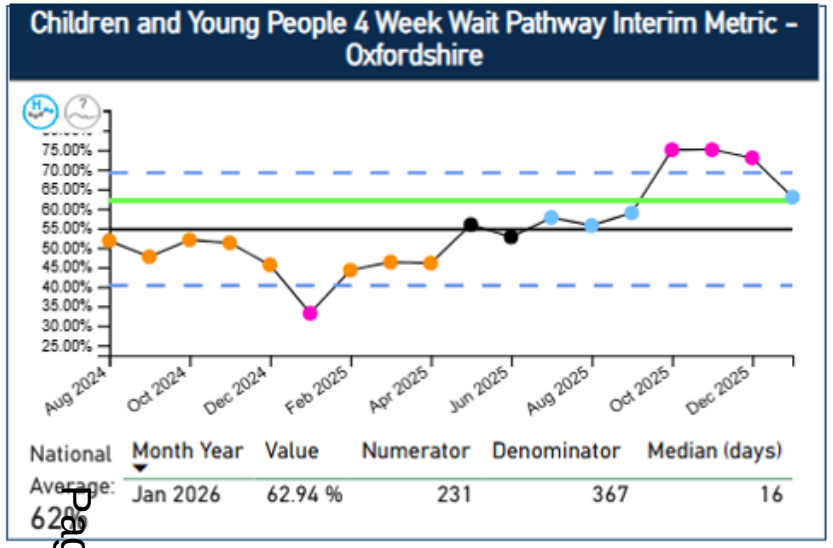
Clinical performance (National and Local Mental Health Standards)

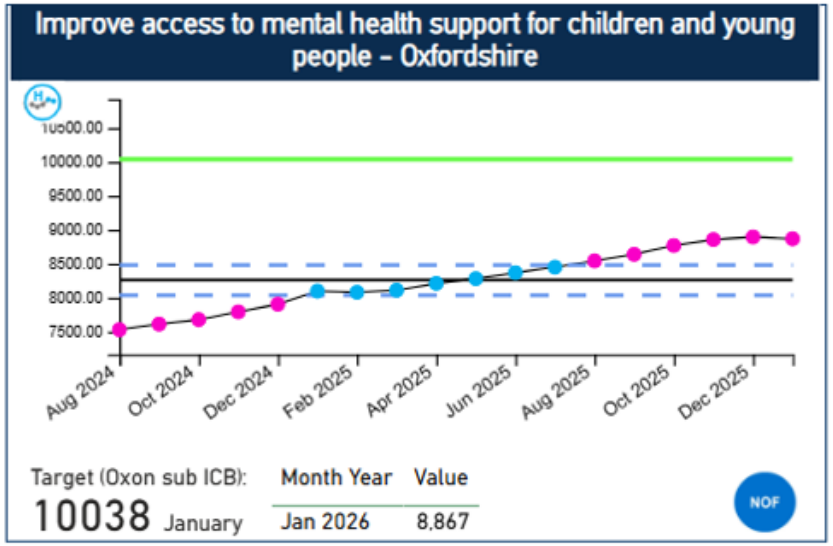
January 2026 data unless indicated otherwise

Oxford Health NHS Foundation Trust

Mental Health Services – Children and Adolescent Mental Health Services - summary

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National NOF (scored)	Improve access to mental health support for children and young people - Oxfordshire	>=10038	Jan-26	8867		.	8260
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Oxfordshire	>=62% National average	Jan-26	62.94%			54.70%
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	>=95%	Jan-26	67.86%			91.20%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire (rolling 3 months position)	>=95%	Jan-26	100%			95.19%





Summary & actions

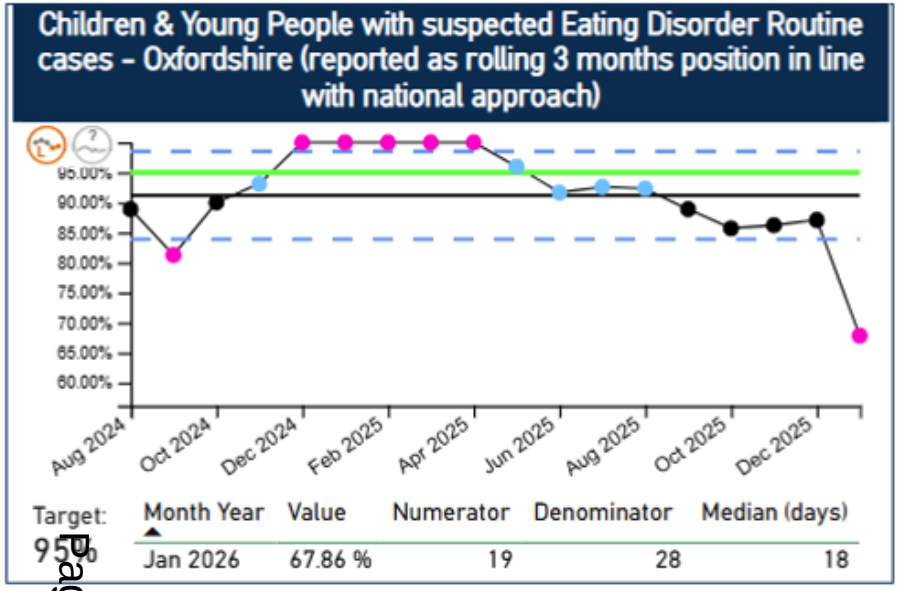
This is an interim metric, which measures one meaningful contact* within a pathway within the four (4) week period. Following on from the national 4 week wait pilots and the clinically led review of mental health standards, new non-urgent waiting time standards are being introduced for Child and Adolescent Mental Health Services (CAMHS). There is currently no set national target, and the Trust is baselining against the national average position. Whilst the Making Data Count algorithm is not flagging these metrics as requiring attention, due to their strategic importance they are being flagged in the report.

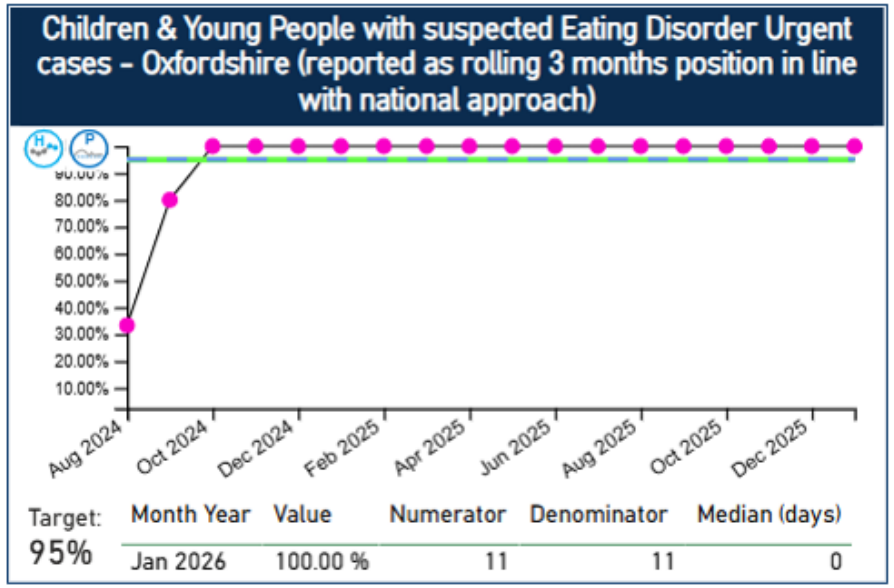
Oxfordshire CAMHS have exceeded the national 4 week wait average in January 2026 with 62.94%

Oxfordshire CAMHS did not meet the access target for January 2026. The variance against plan reflects the fact that the agreed trajectories were predicted on the implementation of a revised rotational Mental Health Support Teams (MHST) delivery model during the current financial year. However, such model was deemed to be inappropriate for the local population and therefore not implemented resulting in a lower access trajectory than planned. Current Oxford Health's MHST delivery model emphasises stable school portfolios with scheduled presence, aiming for continuity and relationship-based delivery. Additionally, Activity from AnDY (Anxiety and Depression in Young People) Research Clinic has not been included as it is recorded on a separate system and reported through a different dataset. As of December 2025, AnDY activity accounted for 185 patients accessing (January data not yet available due to reporting lag). System-wide CAMHS access target has been met; target for next financial year will be rebased collectively within the System.

**Meaningful contact is one that informs assessment and intervention, that is related to the identified/coded problem and is intended to assess or change feelings, thoughts, behaviour, or physical/bodily state. This may involve advice, support, or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment. These may be delivered through direct or indirect work where there is a referral*

Mental Health Services – Child and Adolescent Mental Health Services





Summary

These metrics measure routine and urgent referrals seen within 28 & 7 days where the referral reason is "Eating Disorders" and the age of patient is between 0 – 18 years. For the attended first appointment to count in the national waiting times, it must be outcomed and an appropriate SNOMED* intervention recorded. All providers are measured on a rolling 3-month position, so January 2026 performance includes November, December 2025 and January 2026 performance. Patients who choose to be seen outside of the timeframe will still be counted as a breach. Eating Disorders referrals are not in scope of the Children and Young people (CYP) four (4) week wait measure.

For routine referrals, one (1) breach occurred in November due to patient choice, two (2) in December – one (1) due to patient choice and one (1) patient due to a combination of delays with interpreter service and patient choice and six (6) in January 2026 (three (3) due to capacity (patients seen on days 40, 41 and 50) and three (3) due to patient choice). The target for urgent referrals to be seen within 7 days continues to be exceed.

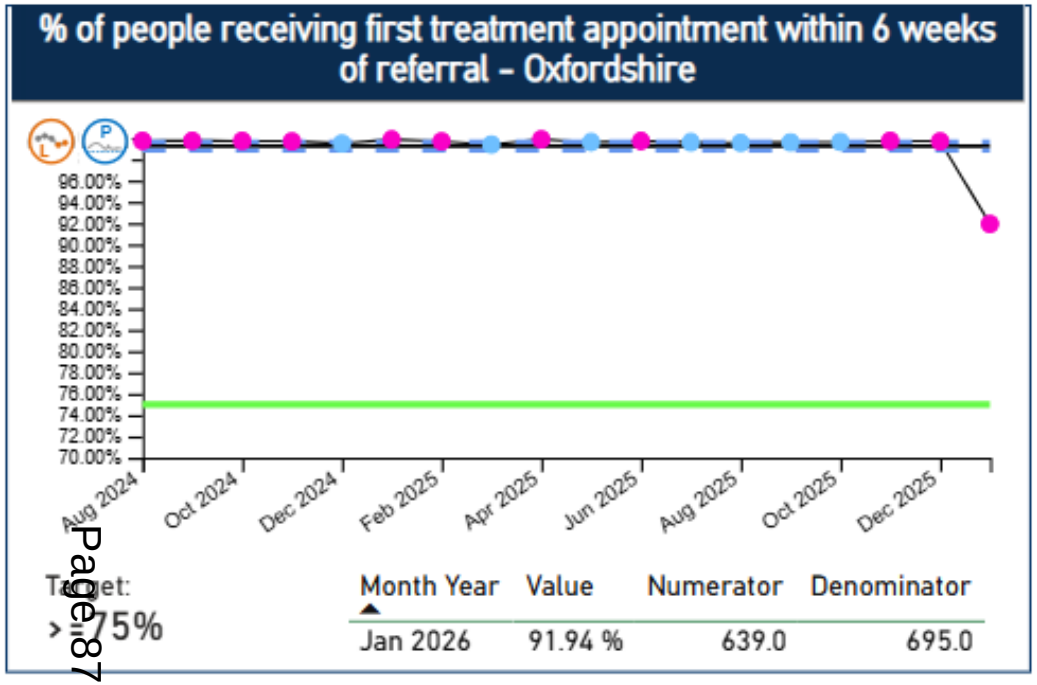
Actions

- Continuation of Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement.
- Review of capacity in each of the Eating Disorders teams to improve forward planning and pre-empt demand peaks. Strengthen communication, so team can act rapidly when activity increases.

Mental Health Services – Talking Therapies – Summary

Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	>=687	Jan-26	695			689
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	.	Jan-26	5.46%	L	n/a	7.23%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	>=68%	Jan-26	67.48%			67.80%
National	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	>=75%	Jan-26	91.94%	L	P	99.23%
National	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	>=95%	Jan-26	100%	H	P	99.96%
National	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	<=10%	Jan-26	7.29%		P	5.75%
National NOF(contextual)	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	>=50%	Jan-26	48.42%			50.73%
National	Meet and maintain at least 52% Talking Therapies recovery rate - Oxfordshire	>=52%	Jan-26	51.88%			54.21%
National	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	>=50%	Jan-26	44.34%			48.21%
National	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire	>=50%	Jan-26	51.97%			55.32%

Mental Health Services – Talking Therapies



Summary and Actions

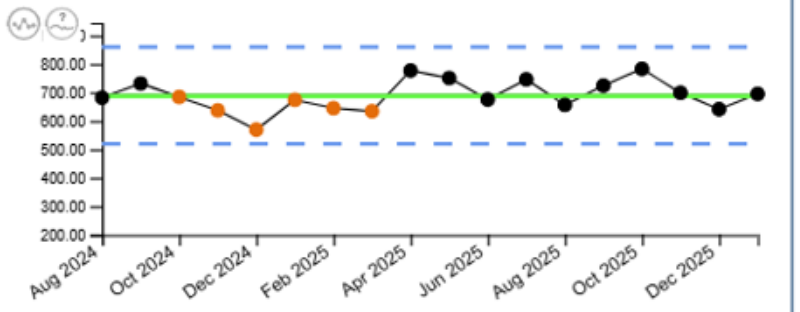
This metric measures the proportion of patients receiving first treatment appointment within 6 weeks of referral. The national expectation is that more than 75% of patients should be offered first treatment appointment within 6 weeks of referral. Lowering proportion could indicate that the service capacity is not aligned with demand.

The service is currently performing well above the target. Due to consistent performance at near 100%, the upper and lower control limits of the statistical range are at very close proximity resulting in Making Data Count algorithm highlighting even the slightest variation. January 2026 was the first month to show a slight breach of the lower control limit, triggering a review of contributory factors.

No systemic risk has been identified at this stage.

Mental Health Services – Talking Therapies

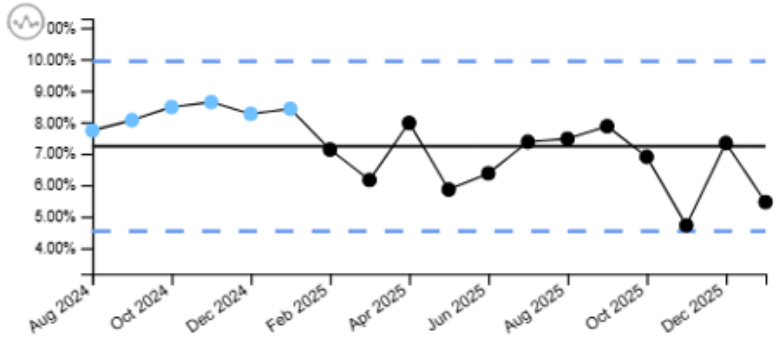
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Oxfordshire



Target:
>=437 in month

Month Year	Value
Jan 2026	695.0

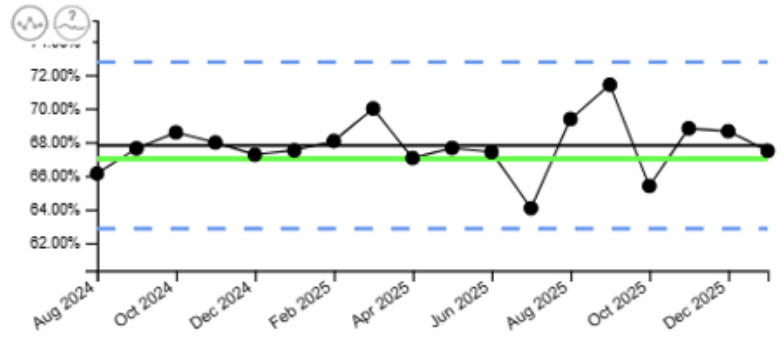
% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire



Target:
baseline

Month Year	Value
Jan 2026	5.46 %

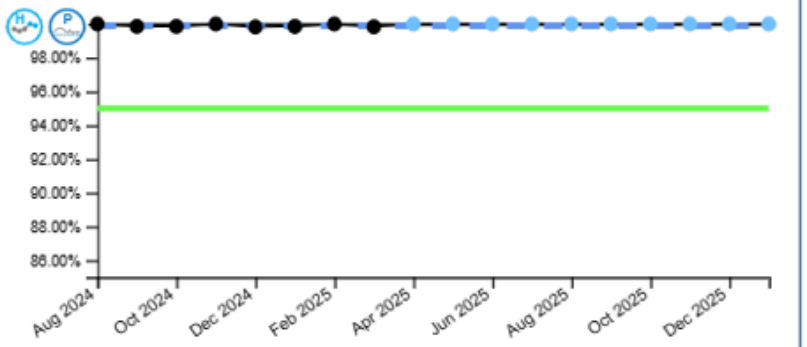
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Oxfordshire



Target:
>=68%

Month Year	Value	Numerator	Denominator
Jan 2026	67.48 %	469.0	695.0

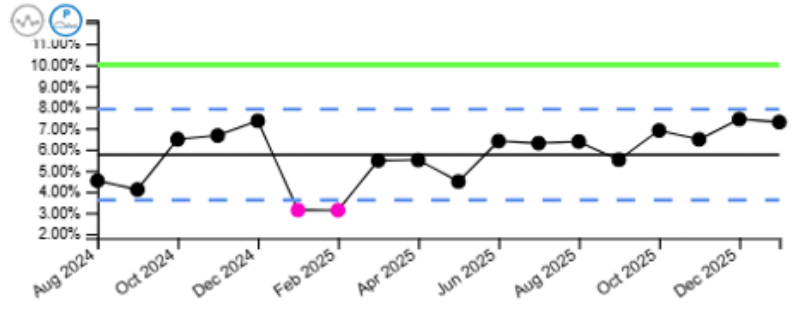
% of people receiving first appointment within 18 weeks of referral - Oxfordshire



Target:
>=95%

Month Year	Value	Numerator	Denominator
Jan 2026	100.00 %	695.0	695.0

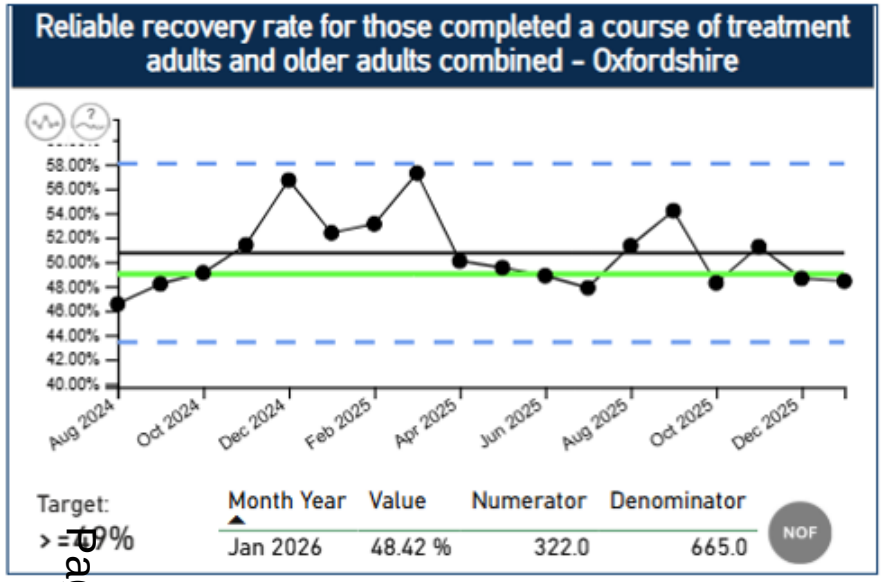
Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting no more than 90 days between treatments) - Oxfordshire

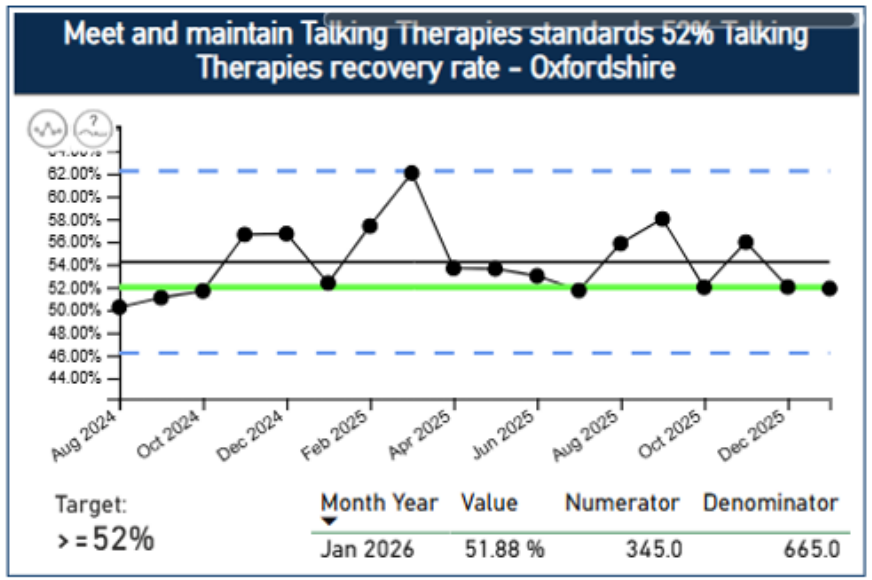


Target:
<=10%

Month Year	Value	Numerator	Denominator
Jan 2026	7.29 %	71.0	974.0

Mental Health Services – Talking Therapies



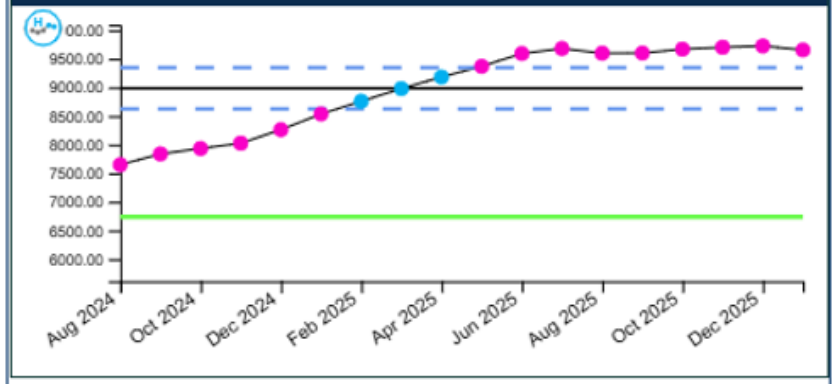


Mental Health Services – Adult and Older Adult Community - summary

Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National NOF(contextual)	Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire	>=6737	Jan-26	9654		.	8985
National	4 week wait (28 days) standard (interim metric - two contacts within pathway)- Oxfordshire	>=36% National average	Jan-26	66.78%			63.13%
National	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Oxfordshire)	>=60%	Q3	44.69%	.	.	38.34%
National	Improve access to perinatal mental health services - Oxfordshire (rolling 12 months)	>=501	Jan-26	624		.	533
National	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	>=60%	Jan-26	100%			95.14%
National	Number of people accessing Individual Placement Support (IPS) - Oxfordshire (rolling 12 months)	>=430	Jan-26	550		.	425
National	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	>=63%	Dec-26	64.90%	.	.	63.65%

Mental Health Services – Adult & Older Adult Community

Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire

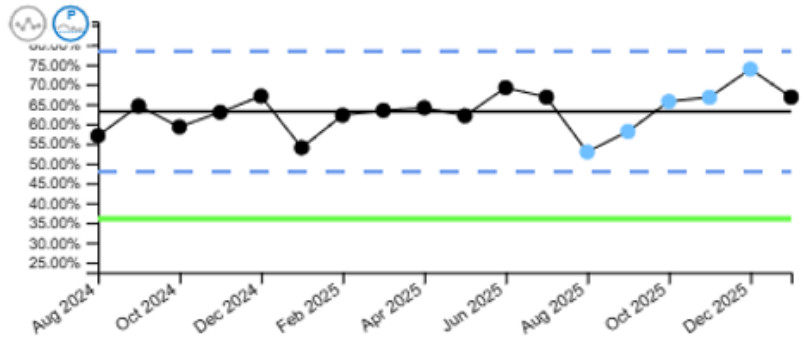


Target (Oxon sub ICB):
average of 6737 a month

Month Year	Value
Jan 2026	9,654

NOF

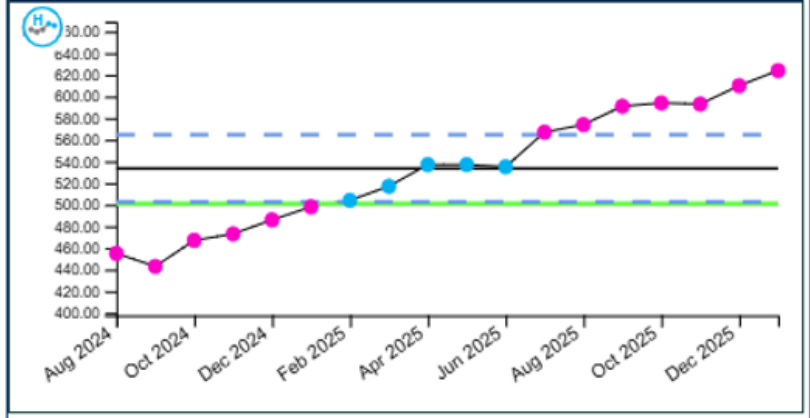
Community Mental Health 4 Week Wait Pathway interim metric - Oxfordshire



National Average: >=36%

Month Year	Value	Numerator	Denominator	Median (days)
Jan 2026	66.78 %	386	578	19

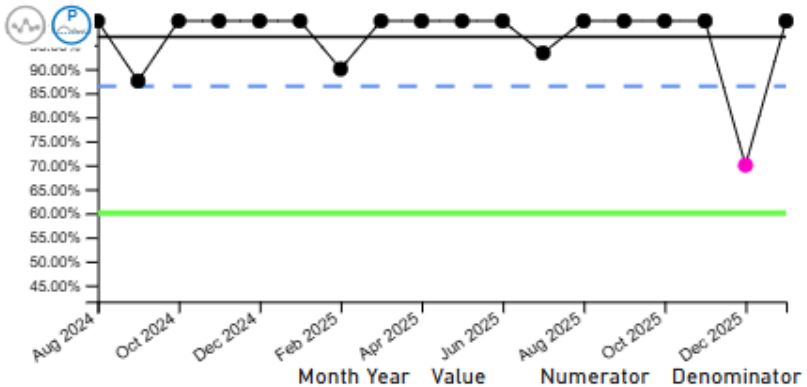
Improve access to Perinatal mental health services - Oxfordshire



Target (Oxon sub ICB):
average of 501 a month

Month Year	Value
Jan 2026	624

Early Intervention in Psychosis Waits (% of people with first episode of psychosis treated within 2 weeks of referral) - Oxfordshire



>=60%

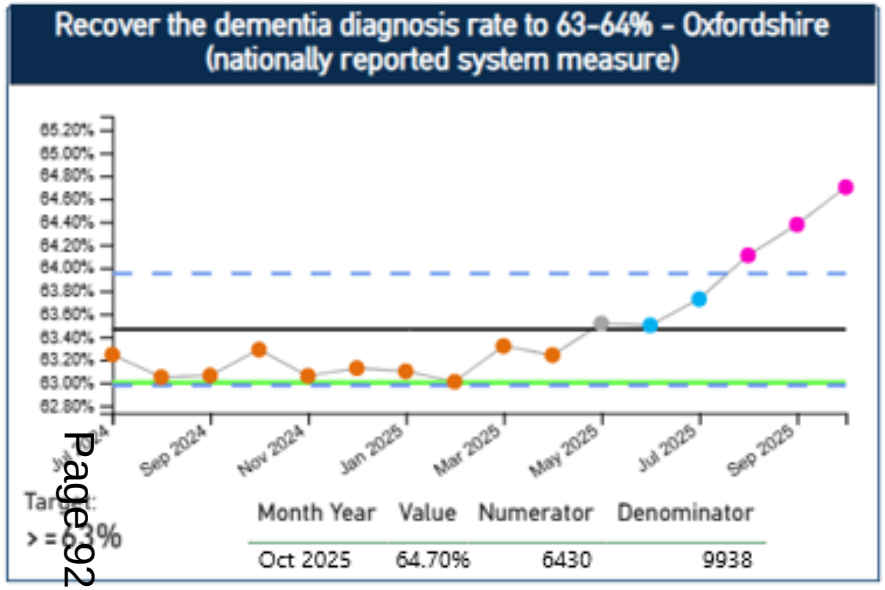
Month Year	Value	Numerator	Denominator
Jan 2026	100.00 %	3	3

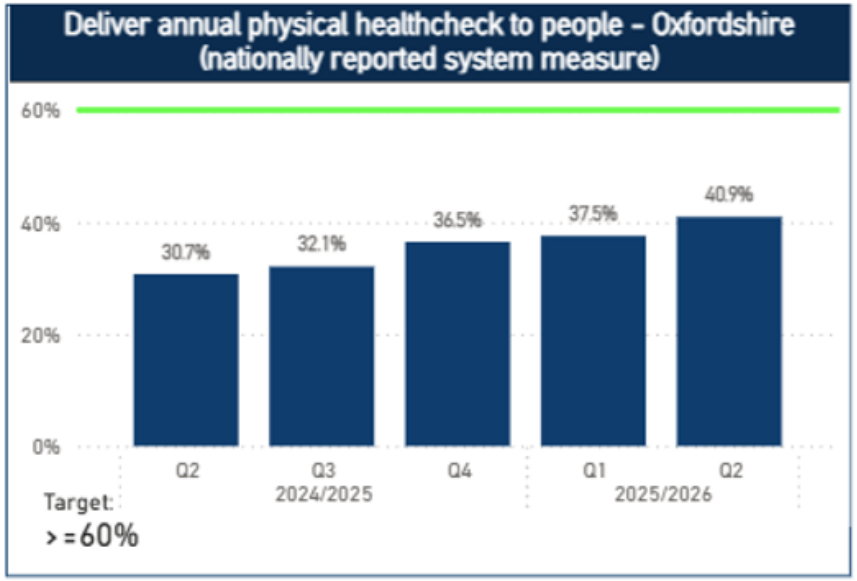
Number of people accessing Individual Placement Support (IPS) - Oxfordshire

Target (Oxon sub ICB):
430

Month Year	Value
Jan 2026	550

Mental Health Services – Adult & Older Adult Community



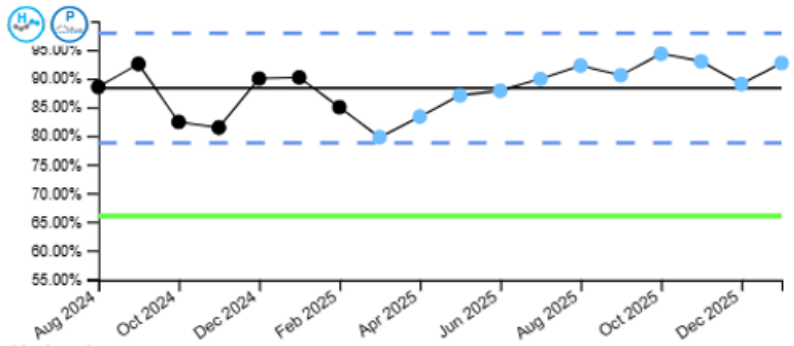


Mental Health Services – Urgent Care - summary

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	>=66% National average	Jan-26	92.69%			88.33%
National	Response from Mental Health Psychiatric Liaison within 24 hours - Oxfordshire	>=81% National average	Jan-26	100%			97.50%
National	Response from Mental Health Crisis Service within 4 hours (Very Urgent) – Oxfordshire	>=61% National average	Jan-26	100%			48.15%
National NOF (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) – Oxfordshire	>=58% National average	Jan-26	85.19%			64.05%

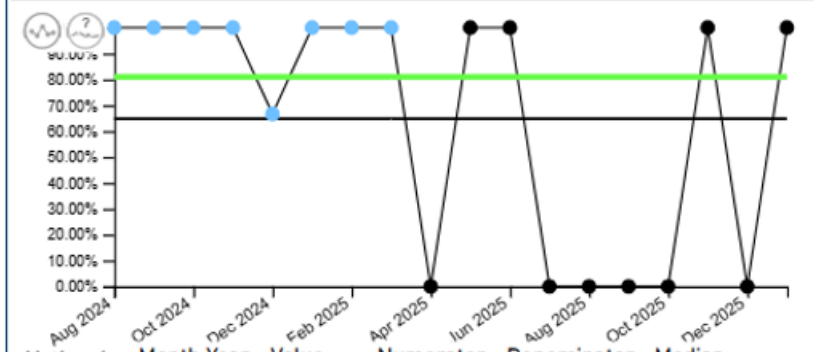
Mental Health Services – Urgent Care

Response from Mental Health Psychiatric Liaison Service within 1 hour - Oxfordshire



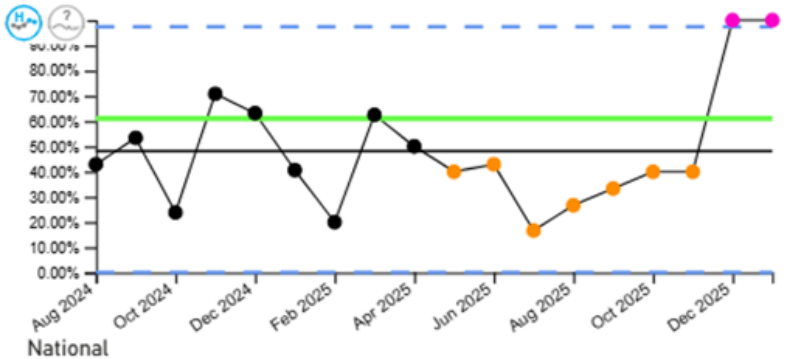
National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=92%	Jan 2026	92.69 %	241	260	0

Response from Mental Health Psychiatric Liaison Service within 24 hour - Oxfordshire



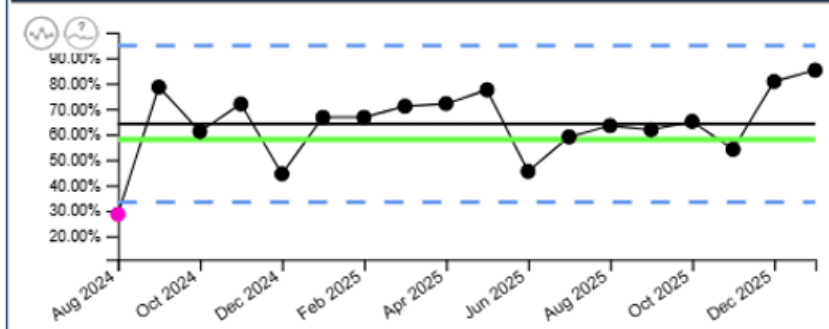
National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=81%	Jan 2026	100.00 %	1	1	2

Response from Mental Health Crisis Service within 4 hours (very urgent) - Oxfordshire



National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=61%	Jan 2026	100.00 %	3	3	1

Response from Mental Health Crisis Service within 24 hours (urgent) - Oxfordshire



National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=58%	Jan 2026	85.19 %	23	27	20

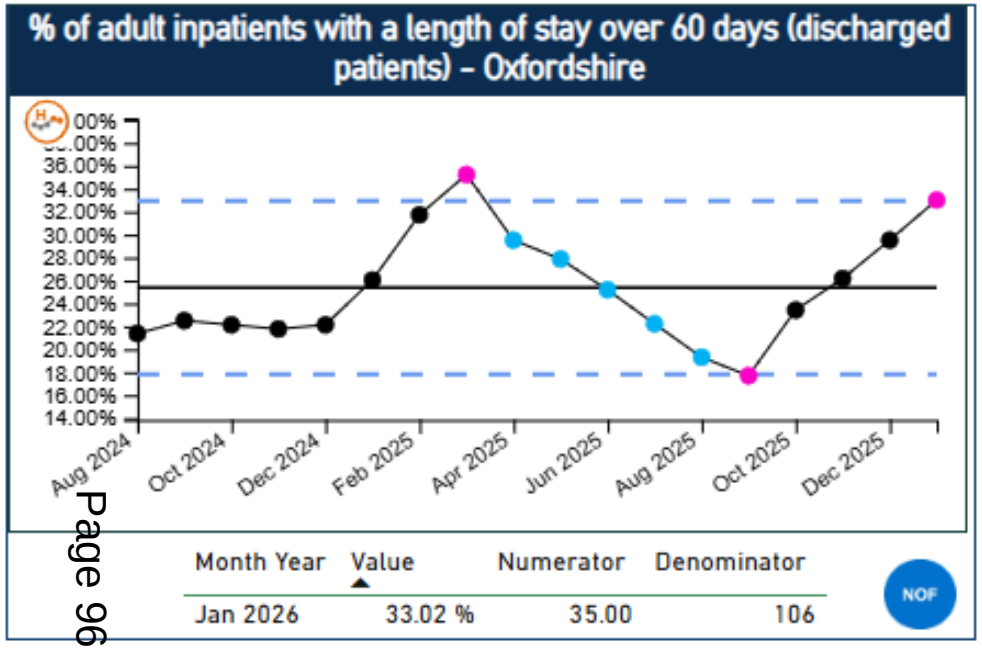
NOF

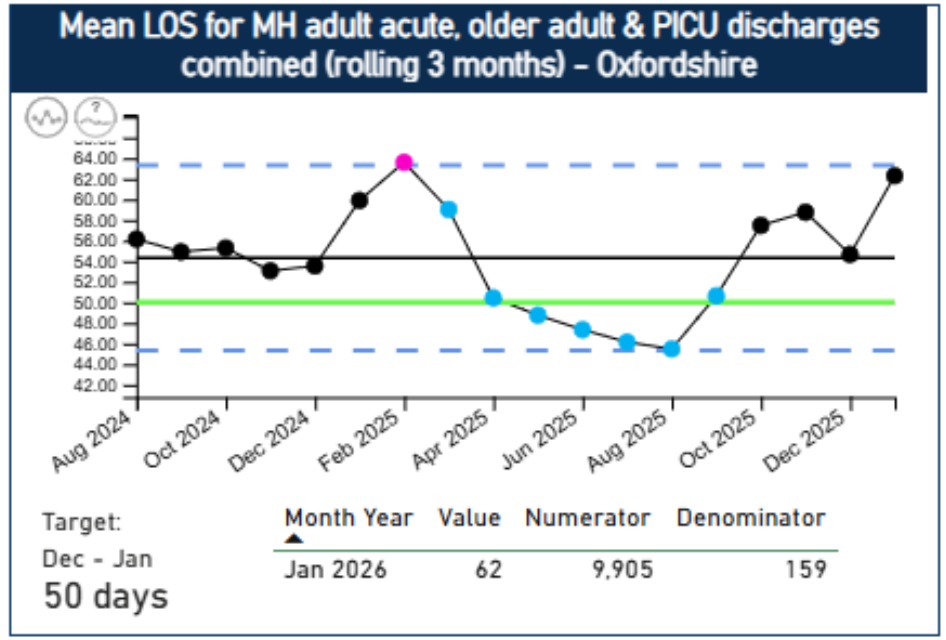
Mental Health Services – Acute/Inpatients (Adults and Older Adults) – summary

S T P

Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - rolling quarter- Adult (acute & Psychiatric Intensive Care Units) - Oxfordshire	<=12% National average	Jan-26	17%		F	17.52%
National	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - rolling quarter - Older Adult - Oxfordshire	<=12% National average	Jan-26	19%		?	13.98%
National	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined; rolling 3 months) - Oxfordshire	<=50	Jan-26	62		?	54
National NOF (scored)	Percentage of adult inpatients with a length of stay over 60 days (discharged patients) - Oxfordshire	.	Jan-26	33.02%	H	n/a	25.38%
National NOF (contextual)	Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) - Oxfordshire	.	Jan-26	19.44%		n/a	22.36%
National	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	>=80%	Jan-26	93.20%		?	92.50%
National	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	>=80%	Jan-26	100%		P	97.26%
Local	% adult acute readmission within 30 days for mental health - Oxfordshire	.	Jan-26	2%		n/a	5.75%
Local	% older adult readmission within 30 days for mental health - Oxfordshire	.	Jan-26	7%		n/a	3.41%
Local	Average number of clinically ready for discharge patients per day - Oxfordshire	.	Jan-26	4.9		n/a	7
National	Inappropriate adult acute mental health out of area placements - snapshot last day month - Oxfordshire	2	Jan-26	0		?	3.44
National	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire		Jan-26	0	L	.	0
National	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire		Jan-26	0		.	0
National	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	.	Jan-26	136		n/a	103.44
Local	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	.	Jan-26	0	L	n/a	0.89
Local	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	.	Jan-26	0		n/a	0

Mental Health Services – Acute/Inpatients (Adults and Older Adults)





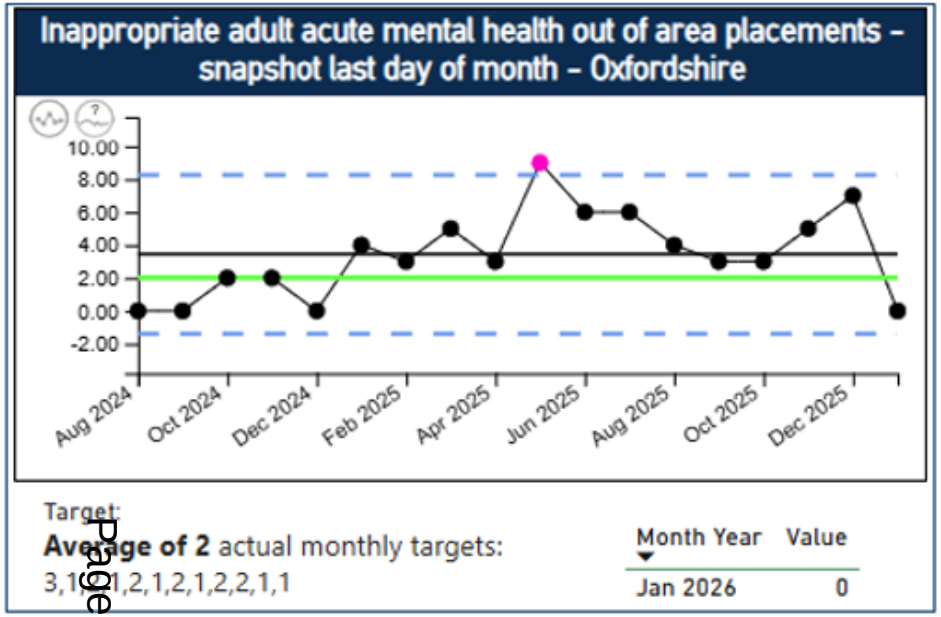
Summary and Actions

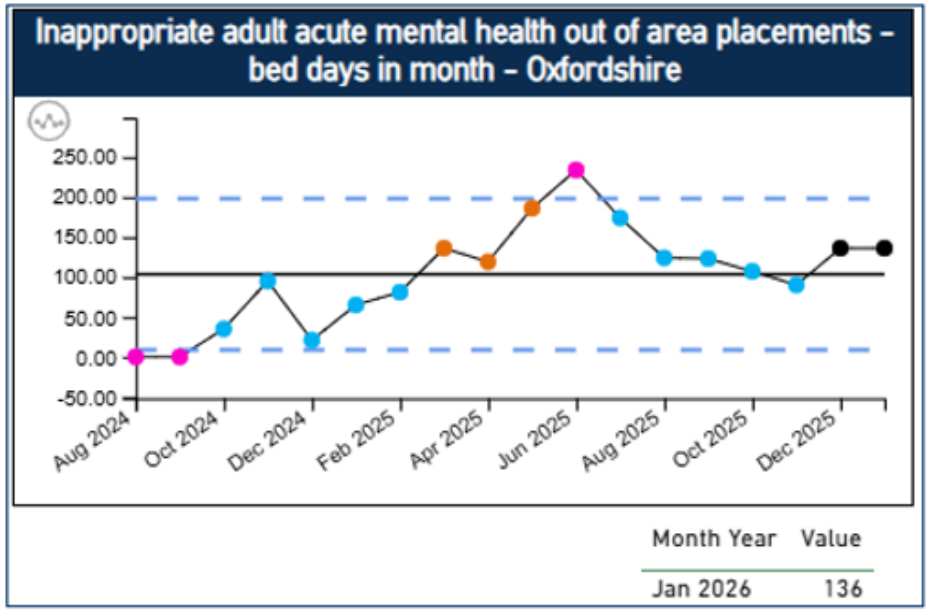
Current performance shows a further increase in the proportion of adult inpatients with a length of stay over 60 days, reaching 33.02% in Oxfordshire in January 2026, alongside elevated combined mean length of stay across adult acute, older adult, and PICU pathways.

These trends are driven by both acuity of patients (meaning that extended length of stay was appropriate) and delays in discharging clinically ready-for-discharge (CRFD) patients. Delays primarily linked to challenges in securing timely onward placements or suitable accommodation for patients who are clinically ready for discharge. Some delays are short and resolved quickly once placement arrangements progress, while others are more complex where individuals require accommodation that is not easily sourced within existing pathways.

Actions underway include close joint work between inpatient services and the EHR team to develop a CRFD form within Rio, which will replace manual recording and enable accurate in-month reporting of actual bed days and numbers of patients affected. This improvement, expected to begin reporting from quarter 4 or early next financial year, will strengthen operational oversight and allow more targeted interventions to reduce avoidable delays.

Mental Health Services – Acute / Inpatients





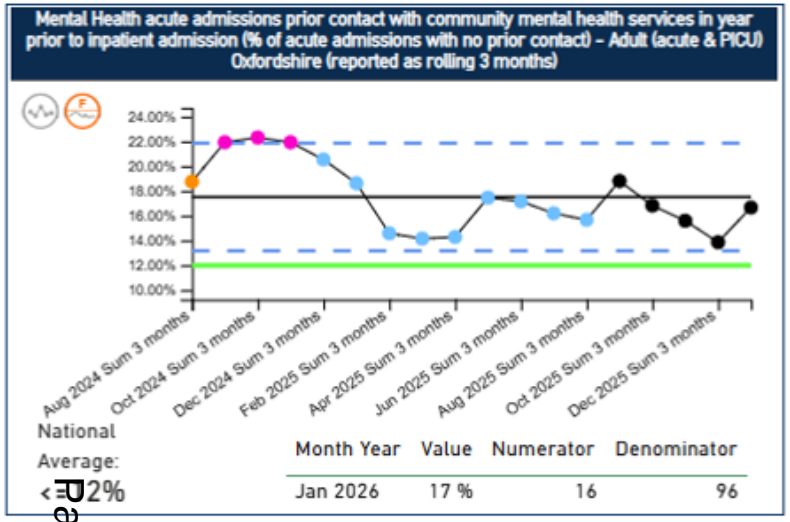
Summary and Actions

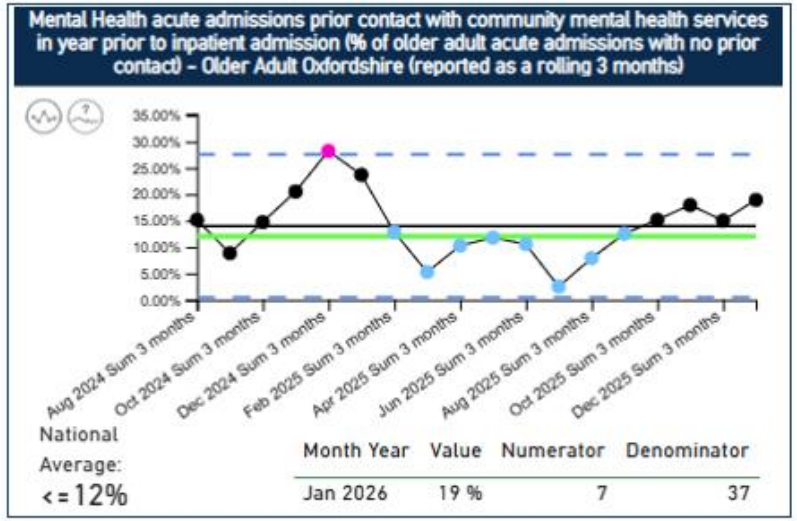
An inappropriate Out of Area Placement (OAP) refers to the situation where a patient is admitted to an inpatient unit that is outside of the local NHS trust area, not close to their home or community support network due to non-clinical reasons (e.g. lack of appropriate local inpatient beds). Majority OAPs admitted are out of hours due to no available local adult mental health beds and no options available to create local capacity (urgency of admission warrants OAP admission to manage risks).
In January 2026, adult acute inappropriate out of area placements bed days remain elevated with 136 bed days, however, number of inappropriate out of area placements was 0 at the end of the month.

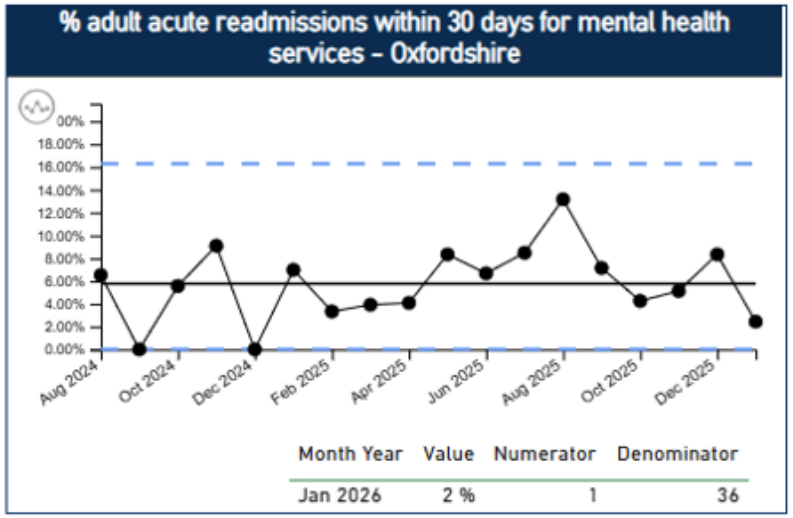
Actions:

- Implemented a high threshold for authorising OAPs (must be approved by senior manager or Director)
- Face to face reviews with Crisis Resolution and Home Treatment Team every 2 – 4 weeks to ensure quality of care and support facilitation of early discharge where clinically appropriate.
- Optimisation of bed usage by end of March 2026.
- Enhanced admission purpose and patient journey documentation and tracking task and finish project was concluded in January 2025. Achievements include the implementation and first stage evaluation of a purpose of admission form, a Patient Flow data dashboard on internal Trust Online Business Intelligence (TOBI) app, and greater oversight on the causes of Length of Stay and the use of Out of Area Placements.

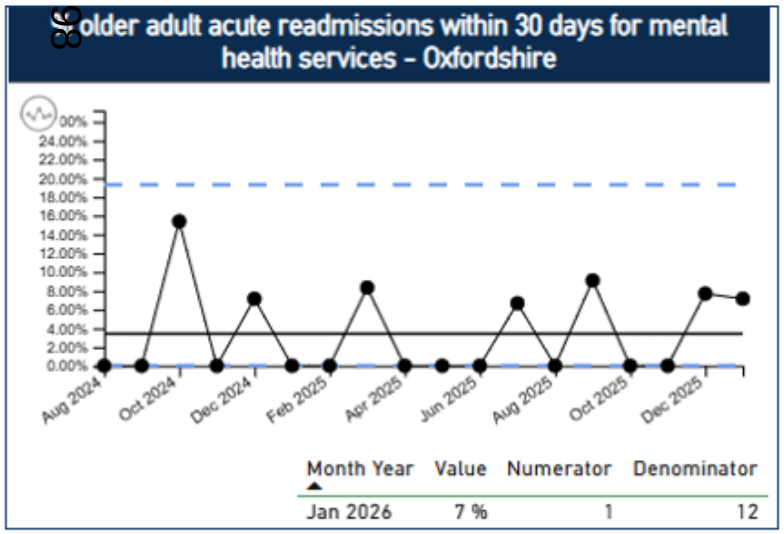
Mental Health Services – Acute / Inpatients

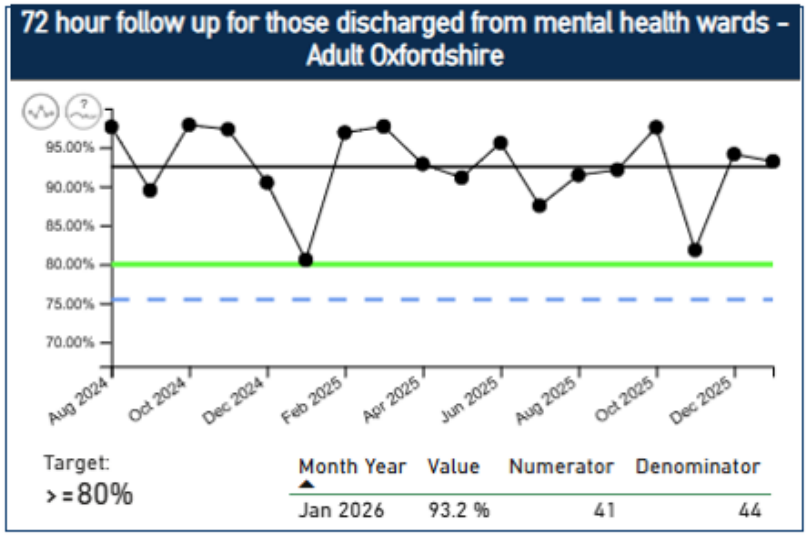


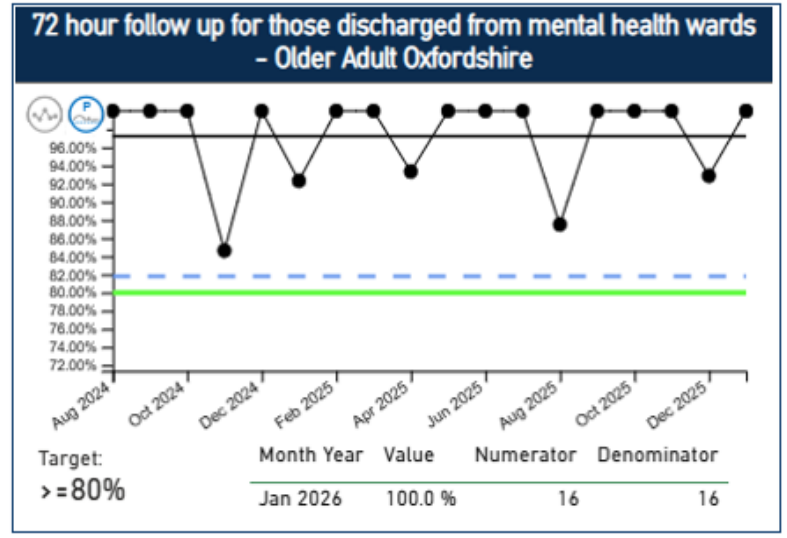




Narrative is not provided for the percentage of adult acute admissions with no prior contact (rolling quarter) as regular audits have not identified any addressable themes that would support improvement to date.

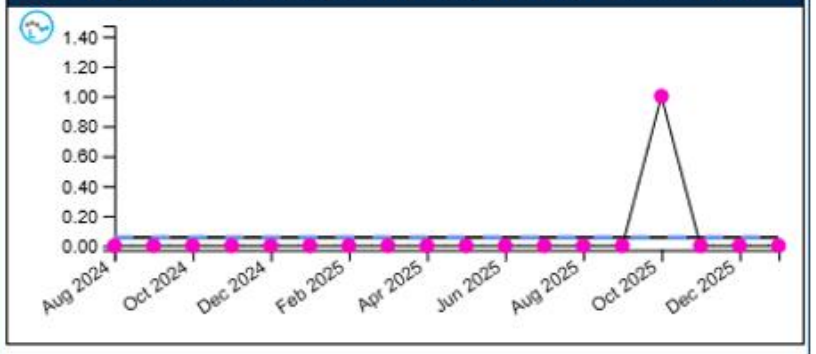






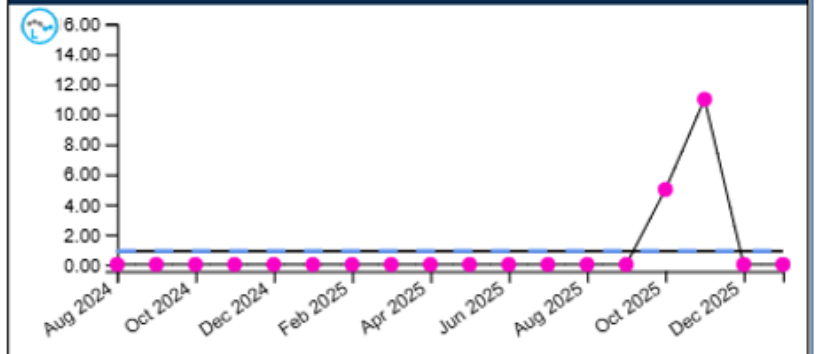
Mental Health Services – Acute / Inpatients

Inappropriate Psychiatric Intensive Care Unit mental health out of area placements – snapshot last day of month – Oxfordshire



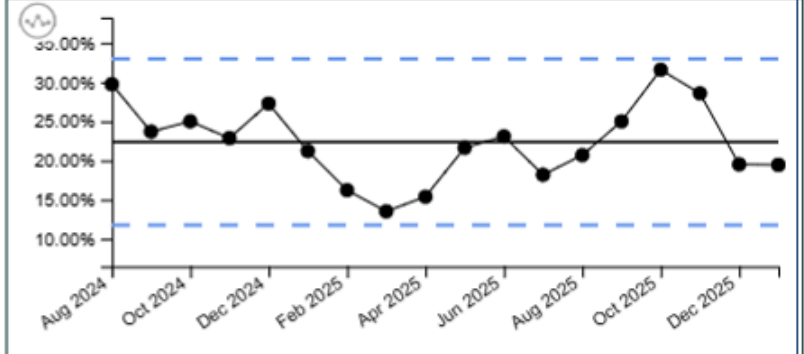
Month Year	Value
Jan 2026	0

Inappropriate Psychiatric Intensive Care Unit mental health out of area placements – bed days in month – Oxfordshire



Month Year	Value
Jan 2026	0

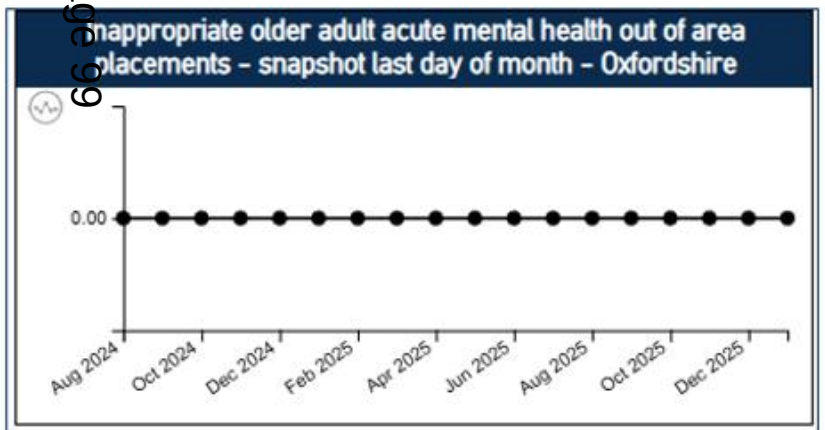
% of older adult inpatients with a length of stay over 90 days (discharged patients) – Oxfordshire



Month Year	Value	Numerator	Denominator
Jan 2026	19.44 %	7.00	36

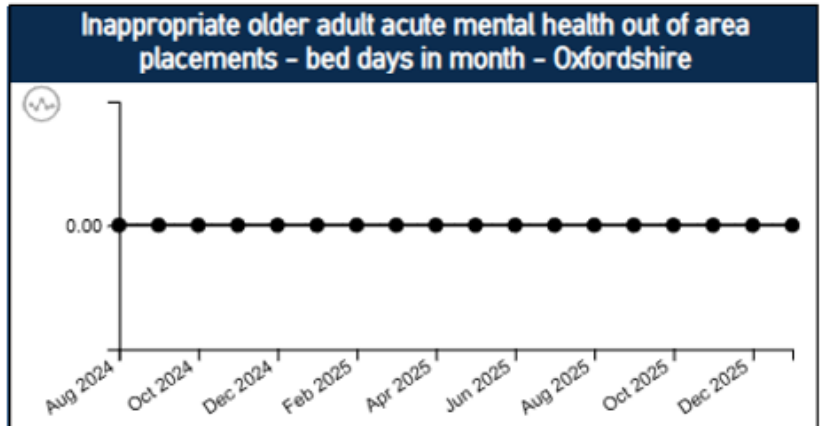
NOF

Inappropriate older adult acute mental health out of area placements – snapshot last day of month – Oxfordshire



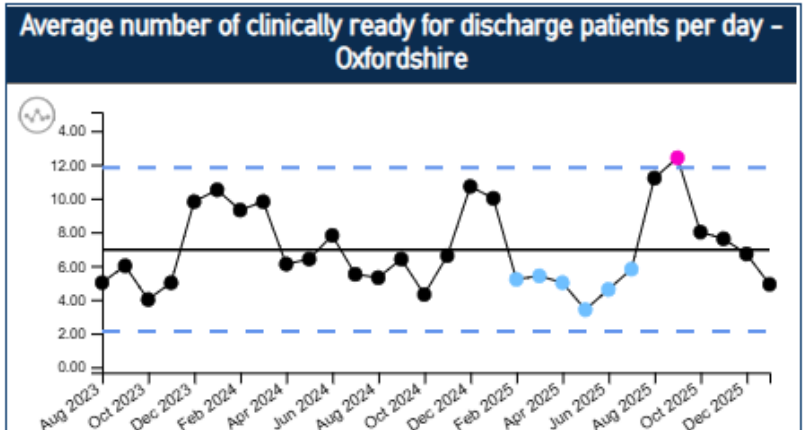
Month Year	Value
Jan 2026	0

Inappropriate older adult acute mental health out of area placements – bed days in month – Oxfordshire



Month Year	Value
Jan 2026	0

Average number of clinically ready for discharge patients per day – Oxfordshire



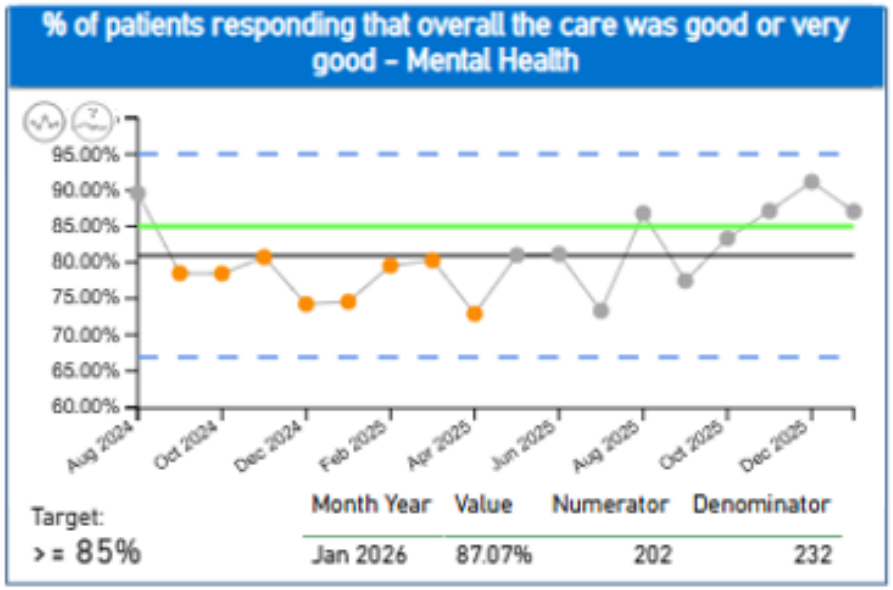
Month Year	Value
Jan 2026	4.9

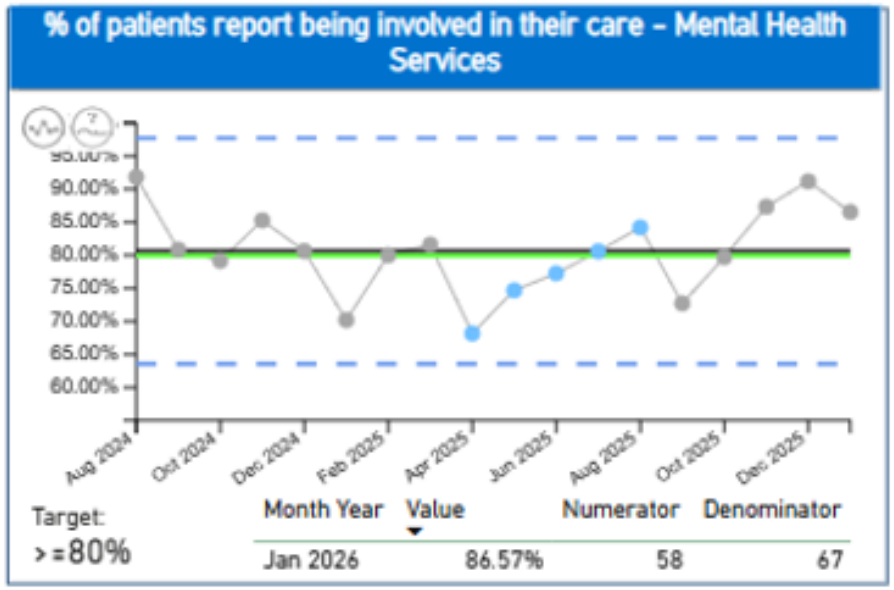
Other Mental Health reporting (including activity)

January 2026 data unless indicated otherwise

Oxford Health NHS Foundation Trust

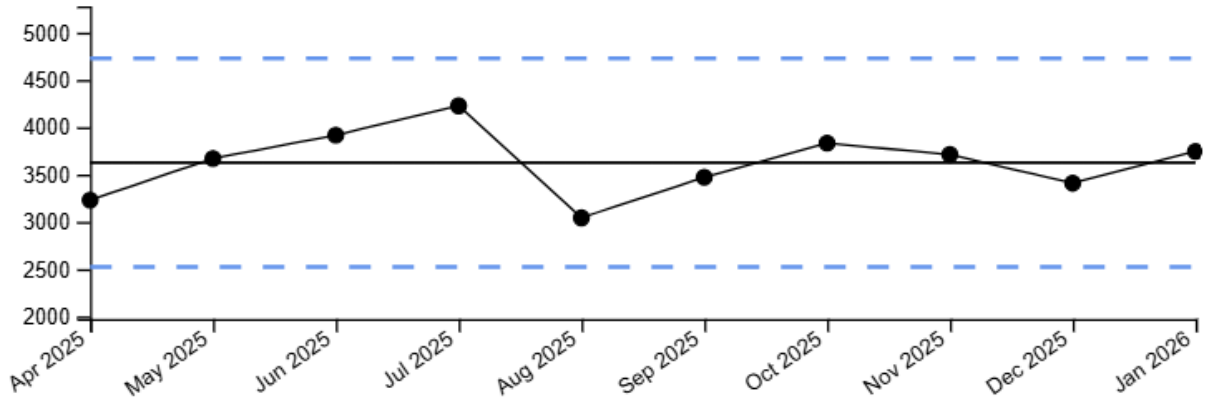
Mental Health services – Patient Feedback





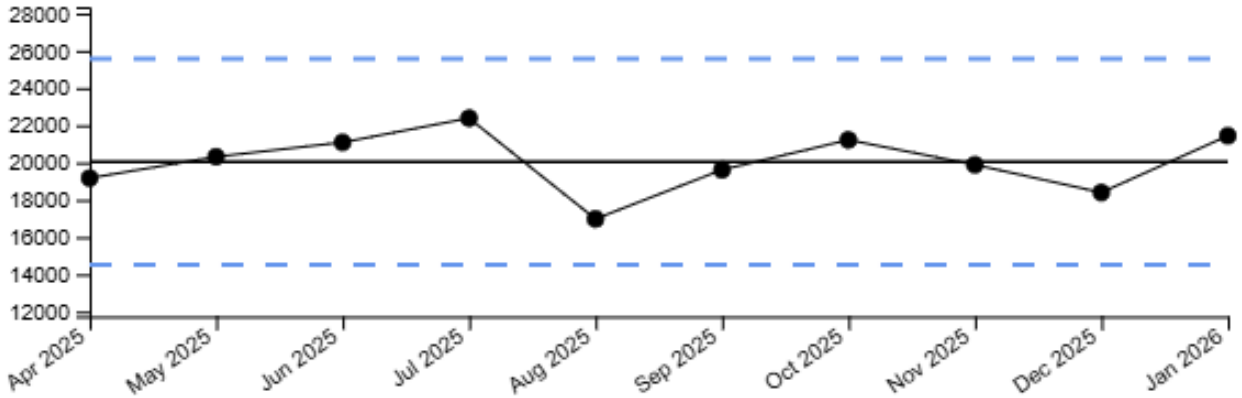
Mental Health services – Activity - Referrals

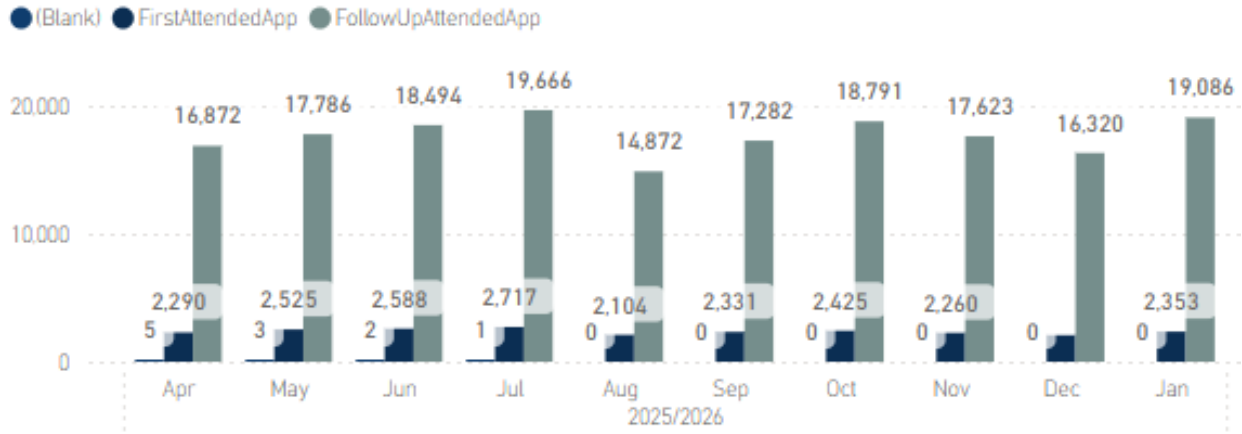
Directorate	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
⊟ Oxfordshire & BSW Mental Health Directorate	3,230	3,670	3,916	4,227	3,043	3,471	3,832	3,711	3,409	3,745
⊞ Adult - CMHT	284	317	322	407	310	392	418	406	343	355
⊞ Adult - Complex Needs	37	40	42	56	39	29	43	44	38	36
⊞ Adult - Crisis/Outreach	323	279	272	292	242	236	271	355	339	400
⊞ Adult - Eating Disorders	45	32	30	42	43	24	51	44	48	45
⊞ Adult - EIS	25	32	37	42	29	35	31	41	26	37
⊞ Adult - Homeless pathway	6	11	7	6	3	4	8	6	10	1
⊞ Adult - IPS	29	49	43	49	32	39	40	20	10	40
⊞ Adult - Neuro		1	1	2	2	1	1	1	4	
⊞ Adult - Other	23	10	3	13	8	8	10	9	8	4
⊞ Adult - PCMHT	572	666	817	973	538	611	624	598	607	630
⊞ Adult - Perinatal	60	58	59	77	62	61	56	69	42	59
⊞ Adult - Psychiatric Liaison	147	214	277	297	275	288	316	281	255	309
⊞ Adult - Psychological Therapies	46	76	80	63	55	48	67	66	73	67
⊞ Adult - SPA/Triage	560	613	567	578	508	522	569	547	479	548
⊞ CAMHS - Eating Disorders	11	8	13	13	11	11	15	14	12	10
⊞ CAMHS - Getting Advice (SPA)	255	317	323	327	126	247	330	284	302	302
⊞ CAMHS - Getting Help	45	84	64	41	57	117	56	46	55	76
⊞ CAMHS - Getting More Help	118	98	152	112	90	105	137	128	94	147
⊞ CAMHS - Getting Risk Support (Crisis/Outreach)	32	39	46	47	26	25	42	36	33	39
⊞ CAMHS - Learning Disabilities	6	14	12	16	10	14	11	13	13	13
⊞ CAMHS - Neuro Diversity (ASD/ADHD assessments)	148	204	152	149	135	147	145	139	106	84
⊞ CAMHS - Other	76	100	124	107	82	90	116	107	103	108
⊞ CAMHS - Other - MHST	76	81	101	101	29	63	143	116	89	83
⊞ Older Adult - CMHT	154	169	199	224	177	188	164	177	186	197
⊞ Older Adult - Memory Service	152	158	173	193	154	166	168	164	134	155
Total	3,230	3,670	3,916	4,227	3,043	3,471	3,832	3,711	3,409	3,745



Mental Health services – Activity – Attended Appointments

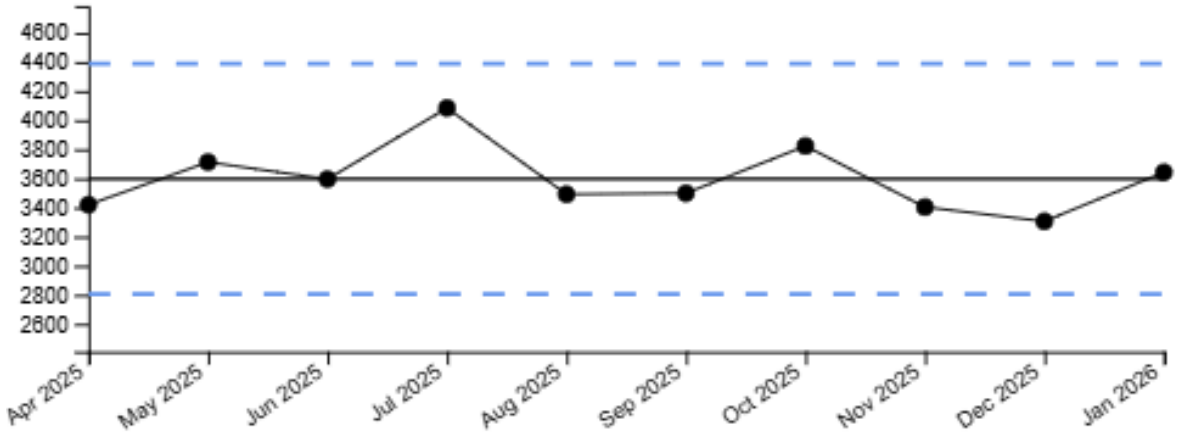
Directorate	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Oxfordshire & BSW Mental Health Directorate	19,167	20,314	21,084	22,384	16,976	19,613	21,216	19,883	18,395	21,439
Adult - CMHT	3,384	3,564	3,701	4,242	3,565	3,972	4,373	4,011	3,962	4,539
Adult - Complex Needs	362	350	468	420	305	583	552	503	422	636
Adult - Crisis/Outreach	932	886	967	861	969	956	825	946	812	797
Adult - Eating Disorders	276	277	224	224	258	275	283	286	331	319
Adult - EIS	594	612	610	598	527	554	620	519	476	712
Adult - Homeless pathway	44	31	30	47	32	23	31	20	17	29
Adult - IPS	207	247	267	290	252	230	271	242	148	216
Adult - Neuro	38	27	23	36	38	66	66	66	50	58
Adult - Other	17	20	22	25	15	15	21	20	12	29
Adult - PCMHT	3,220	3,264	3,089	3,196	1,487	1,716	1,736	1,869	1,575	1,886
Adult - Perinatal	272	274	297	349	336	367	385	372	366	391
Adult - Psychiatric Liaison	178	236	293	371	321	384	501	404	332	387
Adult - Psychological Therapies	565	748	832	872	575	684	713	679	580	766
Adult - SPA/Triage	421	459	369	374	281	288	319	294	259	312
CAMHS - Eating Disorders	324	291	294	329	230	255	336	302	289	294
CAMHS - Getting Advice (SPA)	133	122	137	140	132	165	173	125	124	158
CAMHS - Getting Help	625	886	773	672	488	730	918	767	522	777
CAMHS - Getting More Help	1,914	2,258	2,365	2,523	1,727	2,163	2,125	2,047	1,798	2,098
CAMHS - Getting Risk Support (Crisis/Outreach)	525	418	547	553	564	531	543	453	430	477
CAMHS - Learning Disabilities	341	290	298	346	223	334	431	378	379	417
CAMHS - Neuro Diversity (ASD/ADHD assessments)	706	703	846	852	570	743	871	843	903	805
CAMHS - Other	513	572	648	745	531	738	908	788	683	760
CAMHS - Other - MHST	421	590	747	706	429	647	786	907	697	1,003
Older Adult - CMHT	2,675	2,666	2,684	3,073	2,532	2,634	2,781	2,528	2,750	2,958
Older Adult - Memory Service	480	523	553	540	589	560	648	514	478	615
Total	19,167	20,314	21,084	22,384	16,976	19,613	21,216	19,883	18,395	21,439





Mental Health services – Activity - Discharges

Directorate	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
⊟ Oxfordshire & BSW Mental Health Directorate	3,419	3,712	3,595	4,084	3,491	3,498	3,823	3,403	3,305	3,642
⊞ Adult - CMHT	250	283	347	385	303	360	466	325	345	322
⊞ Adult - Complex Needs	32	52	56	63	45	36	33	42	47	41
⊞ Adult - Crisis/Outreach	310	263	270	281	237	232	274	325	298	310
⊞ Adult - Eating Disorders	35	50	46	42	25	32	31	19	41	28
⊞ Adult - EIS	29	27	39	38	46	30	27	37	33	25
⊞ Adult - Homeless pathway	2	2	7	9	13	4	8	3	4	6
⊞ Adult - IPS	44	39	37	41	41	22	40	49	36	41
⊞ Adult - Neuro	28	15	34	13	26	92	13	39	27	14
⊞ Adult - Other	29	17	6	5	10	4	15	9	6	6
⊞ Adult - PCMHT	523	583	645	867	528	625	586	610	548	573
⊞ Adult - Perinatal	56	56	47	71	71	53	61	48	70	71
⊞ Adult - Psychiatric Liaison	155	216	274	295	275	289	321	285	255	309
⊞ Adult - Psychological Therapies	67	59	66	74	61	80	78	54	65	47
⊞ Adult - SPA/Triage	558	609	568	588	504	514	579	534	451	582
⊞ CAMHS - Eating Disorders	13	7	15	18	13	12	12	5	7	14
⊞ CAMHS - Getting Advice (SPA)	336	468	221	232	470	183	246	181	176	148
⊞ CAMHS - Getting Help	94	83	77	113	75	50	45	38	68	190
⊞ CAMHS - Getting More Help	171	125	167	185	111	142	134	135	107	158
⊞ CAMHS - Getting Risk Support (Crisis/Outreach)	32	33	36	33	26	36	35	32	28	37
⊞ CAMHS - Learning Disabilities	18	10	2	12	8	16	17	3	15	20
⊞ CAMHS - Neuro Diversity (ASD/ADHD assessments)	109	127	116	132	96	154	216	140	163	153
⊞ CAMHS - Other	110	124	93	112	116	103	117	88	100	97
⊞ CAMHS - Other - MHST	94	101	91	114	55	75	64	60	95	114
⊞ Older Adult - CMHT	166	177	148	204	181	190	237	186	178	185
⊞ Older Adult - Memory Service	158	186	187	157	155	164	168	156	142	151
Total	3,419	3,712	3,595	4,084	3,491	3,498	3,823	3,403	3,305	3,642



Appendices

Glossary of metrics (in continuous development)

Area	Metric	Definition	Why is it important?
Mental Health Services	**Improve access to mental health support for children and young people**	This metric tracks the number of children and young people (CYP) aged under 18 who have accessed NHS-funded mental health services within a rolling 12-month period. Derived from the NHS Long Term Plan access standard for CYP mental health.	Improved access ensures that CYP with emerging mental health needs receive early support, reducing the risk of escalation to crisis. Early intervention supports better educational outcomes, family wellbeing, and long-term recovery.
	Four (4) week wait for mental health support for children and young people	Percentage of referrals to community-based mental health services for CYP who receive their first meaningful treatment within 4 weeks. This is an NHS England access standard under development nationally.	Timely intervention is critical in preventing deterioration of mental health in CYP. A shorter wait reduces distress and avoids escalation to emergency or inpatient care, improving long-term outcomes.
	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - children and young people	The proportion of routine referrals for suspected eating disorders in CYP who begin a National Institute for Health and Care Excellence (NICE)-concordant treatment pathway within 4 weeks. This is part of the Access and Waiting Time Standard for Eating Disorders.	Eating disorders have some of the highest mortality rates of all mental illnesses. Early treatment improves recovery rates and physical health outcomes, reducing the need for inpatient admission.
	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - children and young people	The proportion of urgent referrals for eating disorders in CYP starting NICE-concordant treatment within 7 days. Monitored as part of the Eating Disorder Access & Waiting Time standard.	In urgent cases, rapid intervention prevents physical deterioration and supports better psychological recovery. Delays in urgent care can lead to life-threatening complications and increased family distress.
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression	Total number of patients (aged 18+) who complete a course of treatment in NHS Talking Therapies (formerly IAPT) services.	Higher treatment completion suggests improved service access, engagement, and continuity. For patients, it reflects successful navigation of therapy and greater opportunity for symptom relief.
	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over)	The proportion of total IAPT therapy completers who are aged 65 or above. Tracked nationally to monitor equitable access for older adults.	Older adults are historically underrepresented in psychological therapy. Improving this rate supports healthy ageing, reduces loneliness, and improves independence in later life.
	Reliable improvement rate for those completed a course of treatment adult and older adults combined	Percentage of people who show reliable improvement (defined as statistically significant positive change on two validated clinical outcome measures such as PHQ-9 and GAD-7) after completing NHS Talking Therapies treatment.	This is a core quality indicator for psychological therapy. It provides assurance that patients are receiving interventions that lead to real, measurable improvements in mental health.
	% of people receiving first treatment appointment within 6 weeks of referral	The proportion of patients referred to NHS Talking Therapies who begin treatment within 6 weeks.	Timely access improves therapeutic outcomes and helps prevent worsening of conditions. For patients, shorter waits reduce uncertainty and support early symptom relief.
	% of people receiving first treatment appointment within 18 weeks of referral	Proportion of referrals to NHS Talking Therapies seen within 18 weeks of referral.	Ensures that the vast majority of patients are not left waiting for care. It reflects service responsiveness and commitment to recovery-focused care.
	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments)	This metric measures the proportion of patients who wait over 90 days between their first and second Talking Therapies appointments. The standard is that less than 10% should wait this long.	Long gaps between sessions disrupt therapeutic progress and risk disengagement. Maintaining momentum between sessions supports better recovery and improves the patient's therapeutic experience.
	Reliable recovery rate for those completed a course of treatment adults and older adults combined	Percentage of people who move from "caseness" (clinical levels of distress) to non-clinical levels on validated measures (PHQ-9, GAD-7) after completing NHS Talking Therapies.	Reliable recovery provides assurance that treatment not only improves symptoms but brings patients back to a state of wellbeing. For the patient, it reflects meaningful mental health restoration and improved daily functioning.

Glossary of metrics (in continuous development)

Area	Metric	Definition	Why is it important?
Mental Health Services	**Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined**	Proportion of people from ethnically diverse backgrounds who achieve recovery following treatment in NHS Talking Therapies.	Highlights equity of outcome across diverse populations. Ensures that services are culturally responsive and that all patients, regardless of background, achieve good outcomes.
	Recovery rate for White British - complete a course of treatment, adult and older adult combined	Proportion of White British individuals achieving recovery after completing NHS Talking Therapies. Used for benchmarking against ECDC outcomes.	Provides comparative insight to address potential inequalities and improve service delivery for all groups. Helps ensure all patients are receiving effective, evidence-based care.
	Improve access for Adults and Older Adults to support by community mental health services	Tracks access to communitu mental health services,aligned with the NHS Long Term Plan Community Mental Health Framework.	Supports early intervention, continuity of care, and integrated multi-agency support. For patients, this enables better support in the community, reducing hospital admissions and promoting recovery.
	4 week wait (28 days) standard (interim metric – two contacts within pathway)	Percentage of referrals to community mental health services receiving two meaningful contacts within 28 days. A developing standard aligned with new access ambitions from NHS England.	Reduces delays in treatment initiation for people with serious mental illness. Improves patient experience and helps prevent deterioration, crisis escalation, and unnecessary admissions.
	Deliver annual physical health checks to people with Severe Mental Illness	Proportion of people on the SMI register receiving a comprehensive physical health check annually (covering blood pressure, BMI, cholesterol, blood glucose, smoking, alcohol). National standard from NHS England and NICE guidance.	People with SMI have significantly reduced life expectancy due to preventable physical health conditions. Regular checks improve early detection and promote parity between physical and mental healthcare.
	Improve access to perinatal mental health services	Monitors access to specialist perinatal mental health care for women experiencing moderate to severe mental illness during and after pregnancy. Part of NHS Long Term Plan targets.	Untreated perinatal mental illness can have long-term consequences for mother, infant, and family wellbeing. Early specialist care supports maternal recovery and healthy child development.
	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	Proportion of people aged 14–65 referred to Early Intervention in Psychosis (EIP) services who start treatment within two weeks and receive a full NICE-concordant care package. National access and quality standard.	Early intervention is associated with reduced relapse, improved functioning, and long-term recovery. Timely care in psychosis can prevent deterioration and reduce hospital stays.
	Number of people accessing Individual Placement Support (IPS)	Number of adults with Serious Mental Illness supported by IPS services, which offer personalised, evidence-based support to help people find and sustain paid employment. NHS England expansion target.	Employment is a key determinant of recovery and quality of life. IPS improves social inclusion, financial independence, and psychological wellbeing.
	Recover dementia diagnosis rate	Percentage of people aged 65+ estimated to have dementia who have a formal diagnosis recorded in primary care. National ambition: 66.7%.	Early diagnosis enables access to support, treatment, and care planning. For patients and carers, it supports independence, safety, and better management of the condition.

Glossary of metrics (in continuous development)

Area	Metric	Definition	Why is it important?
Mental Health Services	**Response from Mental Health Psychiatric Liaison within 1 hour**	Percentage of referrals from A&E or acute medical wards seen by psychiatric liaison within 1 hour. Derived from NHS England's "Core 24" liaison psychiatry standards.	Rapid mental health assessments reduce emergency department wait times and help ensure safe, effective treatment planning. Patients in crisis benefit from immediate care to reduce risk and distress.
	Response from Mental Health Psychiatric Liaison within 24 hours	Percentage of all mental health referrals to liaison services in acute settings that are seen within 24 hours. Required under national liaison psychiatry models.	Timely mental health input during hospital admissions reduces unnecessary stays, improves holistic care, and supports faster recovery for patients with coexisting physical and mental health needs.
	Response from Mental Health Crisis Service within 4 hours (Very Urgent)	Proportion of 'very urgent' referrals to Crisis Resolution and Home Treatment Teams (CRHTT) that are responded to within 4 hours. Part of NHS Mental Health Crisis Care Concordat.	Swift response during acute mental health crises reduces the risk of harm, unnecessary detention under the Mental Health Act, and hospital admission. Patients feel safer and more supported.
	Response from Mental Health Crisis Service within 24 hours (Urgent)	Percentage of urgent crisis referrals responded to within 24 hours by CRHTTs. NHS England standard for community-based urgent care.	Ensures timely, appropriate care during periods of acute need. Prevents deterioration and supports people to stay in their homes and communities.
	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission	Proportion of patients admitted to an inpatient mental health ward who had no community mental health contact in the preceding 12 months.	Lack of prior engagement may suggest missed opportunities for prevention. For patients, this highlights the need for improved outreach and integrated care pathways.
	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined; rolling 3 months)	Average number of inpatient days for patients discharged from acute adult, older adult, or PICU services, measured on a 3-month rolling basis.	Ensures patients are in hospital only as long as needed. Long stays may indicate delayed discharges; short stays must still allow for recovery. Balanced stays improve patient outcomes.
	72 hour follow up for those discharged from mental health wards	Percentage of patients discharged from mental health inpatient care who receive follow-up contact (face-to-face or phone) within 72 hours. A national quality standard (NHS England/NICE).	The first 72 hours post-discharge is a high-risk period for suicide and relapse. Timely contact supports safety and smooth reintegration into the community.
	Inappropriate Out of Area Placements (mental health inpatients)	Number of patients placed in inpatient beds outside their local area due to bed unavailability (excluding specialist placements).	Out-of-area placements disrupt continuity of care, isolate patients from family, and delay discharge. Reducing them improves quality, equality, and patient dignity.
	% adult acute readmission within 30 days for mental health	Proportion of adult patients discharged from acute mental health care who are readmitted within 30 days. A quality metric for post-discharge planning.	High readmission rates may signal poor follow-up support or premature discharge. Patients benefit from coordinated, recovery-focused care that reduces the need for readmission.
	Average number of clinically ready for discharge patients per day	Average daily count of inpatients who are medically fit for discharge but remain due to delays in arranging ongoing care.	Blocked discharges reduce hospital efficiency and increase stress for patients. Timely discharge helps recovery and frees capacity for others in need.

Glossary

Acronym	Full Term	Description (as used in this report)
AOT	Assertive Outreach Team	Specialist community mental health service providing intensive, proactive support for people with severe mental illness who struggle to engage with standard services.
AMHT	Adult Mental Health Team	Multidisciplinary community teams providing assessment and treatment for adults aged 18–65 with severe and enduring mental illness.
ARMS	At Risk Mental State Service	Early intervention service for people aged 14+ at risk of developing psychosis, offering assessment and preventative interventions.
ARRS	Additional Roles Reimbursement Scheme	National primary care scheme funding additional roles, including mental health practitioners embedded within GP practices and PCNs.
AWA	Adult Working Age	Refers to inpatient mental health beds and services for adults of working age.
BCF	Better Care Fund	Pooled NHS and local authority funding supporting integrated health and social care, including discharge and step-down provision.
BOB ICB	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Statutory NHS body responsible for planning and commissioning healthcare services across the BOB system.
CAMHS	Children and Adolescent Mental Health Services	Specialist mental health services for children and young people, including transition pathways to adult services.
CQC	Care Quality Commission	Independent regulator of health and social care services in England, setting safety and environment standards.
CRHT / CRHTT	Crisis Resolution and Home Treatment (Team)	24/7 community-based crisis services providing rapid assessment and intensive home treatment as an alternative to hospital admission.
DOLS	Deprivation of Liberty Safeguards	Legal framework protecting people who lack capacity and are deprived of their liberty in care settings.
EDPS	Emergency Department Psychiatric Service	Mental health liaison services operating within acute hospital emergency departments.
EIS	Early Intervention in Psychosis Service	Specialist service providing up to three years of treatment for people experiencing a first episode of psychosis.
FREED	First Episode Rapid Early Intervention for Eating Disorders	Early intervention programme for people aged 16–25 with a recent onset eating disorder.
HBPOS	Home Based Place of Safety	Short-term alternative to hospital admission used during mental health crises when appropriate.
HBN	Health Building Note	National guidance on the planning and design of healthcare buildings.
HOSC	Health and Social Care Overview and Scrutiny Committee	Oxfordshire County Council committee responsible for scrutinising health and social care services.
HTM	Health Technical Memorandum	National standards providing guidance on healthcare building engineering and safety systems.
IBS	Irritable Bowel Syndrome	Long-term physical health condition referenced within Talking Therapies pathways.
ICB	Integrated Care Board	NHS statutory body responsible for system-level commissioning and planning.

ICM	Intensive Case Management	Enhanced care coordination approach for people with severe mental illness and high levels of complexity.
ICS	Integrated Care System	Partnership of NHS, local authorities and other organisations working together to improve population health.
LOS	Length of Stay	Duration of inpatient admission, monitored as part of patient flow and capacity management.
MAPPA	Multi-Agency Public Protection Arrangements	Multi-agency framework for managing individuals who pose a serious risk of harm to others.
MARAC	Multi-Agency Risk Assessment Conference	Multi-agency meetings focused on safeguarding individuals at high risk of harm.
MARM	Multi-Agency Risk Management	Collaborative safeguarding approach for people with complex risk profiles.
MEAM	Making Every Adult Matter	Multi-agency approach supporting people with multiple and complex needs.
MH	Mental Health	General abbreviation used throughout the report.
MHIS	Mental Health Investment Standard	NHS funding requirement to increase mental health investment in line with overall NHS growth.
MHRA	Medicines and Healthcare products Regulatory Agency	UK regulator responsible for medicines safety, including valproate restrictions.
MMHS	Maternal Mental Health Service	Service supporting women experiencing mental health difficulties related to pregnancy and childbirth.
MoJ	Ministry of Justice	UK government department referenced in relation to forensic and legal restrictions.
NDC	Neurodevelopmental Conditions	Term referenced in performance and waiting time contexts (e.g. autism, ADHD).
NHS	National Health Service	Publicly funded healthcare system in England.
OA / OA CMHT	Older Adult / Older Adult Community Mental Health Team	Community mental health services for people aged 65+.
OAP / OAPS	Out of Area Placement(s)	Inpatient admissions outside the local NHS trust area due to capacity or specialist need.
OCC	Oxfordshire County Council	Local authority partner for social care, safeguarding and public health.
OHHI	Oxfordshire Homelessness and Health Inclusion	Partnership providing step-down and discharge support for people experiencing homelessness.
OHFT	Oxford Health NHS Foundation Trust	NHS provider organisation delivering mental health and community health services.
OMHP	Oxfordshire Mental Health Partnership	System partnership coordinating mental health services across Oxfordshire.
OTT	Oxfordshire Talking Therapies	NHS psychological therapies service for people with depression, anxiety and long-term conditions.
PCN	Primary Care Network	Groups of GP practices working together with community and mental health services.
PICU	Psychiatric Intensive Care Unit	Specialist inpatient units for patients requiring intensive psychiatric care.
RCRP	Right Care, Right Person	National approach ensuring people in mental health crisis receive support from the most appropriate agency.
SCAS	South Central Ambulance Service	Regional ambulance service supporting NHS 111 and urgent care pathways.

SMI	Severe Mental Illness	Term used to describe conditions such as schizophrenia, bipolar disorder and psychosis.
s.75 / S75	Section 75 Agreement	Legal agreement enabling pooled budgets and integrated health and social care provision.
TC	Therapeutic Community	Structured psychological treatment model used within complex needs services.
VCSE	Voluntary, Community and Social Enterprise	Sector delivering commissioned mental health support and crisis alternatives.
WTE	Whole Time Equivalent	Staffing measure indicating full-time equivalent workforce capacity.

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Healthwatch Oxfordshire
Your voice on health and care services

Report to the Oxfordshire Joint Health Overview and Scrutiny Committee

April 2026

Table of Contents

1. Healthwatch Oxfordshire reports to external bodies

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

We attend and report to Health and Wellbeing Board (Mar 2026) and Health Improvement Board (Feb 2026).

We also attend Children's Trust Board, Oxfordshire Place Based Partnership, Oxfordshire Adult Safeguarding Board and Oxfordshire Neighbourhood Health and Marmot Oxfordshire, Military Civilian Partnership meetings. We bring insight into committees at Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level (now Thames Valley Integrated Care Board). We collaborate with the Healthwatch at Place across the ICB to share what we are hearing.

We published two letters: https://healthwatchoxfordshire.co.uk/correspondence

- Healthwatch Oxfordshire response to Local Government Reorganisation in Oxfordshire (Government consultation)
- Thames Valley Healthwatch joint response to Thames Valley Integrated Care Board Operating Model 2026-7.

2. Update since the last Health Overview Scrutiny Committee (HOSC) Meeting Jan 2026

Healthwatch Oxfordshire reports

All this years' reports, along with summaries, and responses from providers and commissioners, to date can be seen here: www.healthwatchoxfordshire.co.uk/reports-hub

- **"Your feedback about Cora Health – January 2025 to January 2026"** Summarises what we have heard about Cora Health from 90 people via our Feedback Centre, information and advice service, and through face-to-face outreach around the county. We heard some positive feedback about timely and effective care. However, unfortunately most people told us about challenges experienced in getting support from Cora Health, including poor communication, unclear information, trouble making convenient appointments, long waits, cancelled appointments and problems with referrals. We have made a series of recommendations for improvements

based on what we have heard and people's suggestions, and received responses from BOB ICB and Cora Health

- **Community research:**
  "What we heard about cancer and access to healthcare" – community research with Sunrise Multicultural Centre, who wanted to understand the experiences of some of the communities they support in Banbury Neithrop and Ruscote, especially South Asian women. Including what barriers people face to getting a timely diagnosis and what would support people to find and get help.

Snapshot reports on:

- **Men in Faringdon** - as part of the 30 Chats in 30 Days initiative.
- **What you told us about mental health services** – summary of themes from feedback from over 100 people (see below).

All reports are available in **easy read**, and word format. We follow up responses to recommendations again after six months.

To read more about the **impact** of all our work and reports, and how we make a difference along with commissioner and provider responses and agreed actions, see here: www.healthwatchoxfordshire.co.uk/our-impact

See a snapshot of our work in March https://healthwatchoxfordshire.co.uk/latest-news/2026/04/a-snapshot-of-our-work-in-march

We have also continued to support **community research** with grassroots communities, including:

- **Black Women in Maternity** group in Oxford to carry out research and feed into the national Amos Review
- **Chinese Community** views of elders.
- Contributing to Oxfordshire Community Research Network (OCRN)
- Final design of Community Research 'how to guide' developed with community members from grassroots groups (Publication shortly).

Enter and View Visits

We have statutory powers under the Health and Social Care Act 2012 to make **Enter and View** visits to publicly funded local health and social care services. The aim of these visits is to identify what works well and what could be improved to make

people's experiences better. Since the last meeting we made Enter and View visits to the following services:

- Katharine House Hospice
- Ashurst Ward – Psychiatric Intensive Care Unit – Littlemore Hospital.

We published **Enter and View reports** based on our observations from visits to the following services:

- St Leonard's Ward – Wallingford Community Hospital.

All published Enter and View reports with recommendations to, and responses and actions from providers are available here:
www.healthwatchoxfordshire.co.uk/enter-and-view-reports

Healthwatch Oxfordshire Webinars

Since the last meeting we held one public webinar: To see our webinar programme, zoom links and **recordings of all past webinars**:
www.healthwatchoxfordshire.co.uk/our-webinars

- **Tuesday 17th March 2026**, on Oxfordshire's work on addressing health inequalities, as a 'Marmot Place' with speakers representing some of the work with communities taking place attended by 58 people
- **Our next webinar is on Tuesday April 14th 1-2 p.m. giving people a chance to feed into Oxford Health strategy 2026-31.** All welcome. Joining details on our website.

Forthcoming reports include:

- A focus on hearing from people about views on **end of life care**, www.healthwatchoxfordshire.co.uk/have-your-say/complete-a-survey with an online survey supplemented by focused outreach. Working alongside Oxfordshire Palliative Care network and others
- Rural insights from 14 **rural areas** (Deddington, Cropredy, Heyford, Yarnton, Chipping Norton, Charlbury, Long Hanborough, Freeland, Chalgrove, Sonning Common, Faringdon, Stanford in the Vale, Shrivenham and Watchfield) for Oxfordshire County Council as part of the Marmot focus on health inequalities. We worked in partnership with Community First Oxfordshire and ran a survey outreach and focus groups. A final draft report will be presented to public health in June

- Summary of what we have heard about **GP services** – for HOSC working group.

Note: Publication of some reports will be after May 7th due to **Purdah guidance** from Healthwatch England on local elections.

3. What we are hearing from the public

Along with our themed research above, we hear from members of the public via phone, email, our advice and signposting, and online feedback on services (for reviews and to leave a review. see www.healthwatchoxfordshire.co.uk/services).
We also hold conversations when out and about on the street, in community settings, at hospital stands, with patient and VCS groups and services, and events like Oxford Eid Extravaganza. This enables us to raise what we are hearing, including emerging themes, with health and care providers and commissioners.

Ongoing themes

We continue to pick up on more general themes including dentistry access, GP access and waiting times, communication and admin challenges. We continue to support people in understanding the changing landscape of the Integrated Care Board and health service planning
https://healthwatchoxfordshire.co.uk/understanding-health-and-care

We hear from people who are navigating complaints and feedback to ICB and providers – often facing delayed responses, and with all the changes taking place, remain concerned that issues are being managed in a timely way, and lessons learned.

Mental Health Services

We visited a range of services to hear about mental health services, including Keystone Hubs in Banbury, Chipping Norton, Abingdon, spoke to men in Faringdon, and outreach at community settings. We also visited Memory Clinics to speak to people about dementia services and support. We also heard about mental health in our rural engagement, and end of life insight gathering.

Feedback on support for Dementia:

- Importance of community groups and support such as choirs, coffee mornings

- Support for carers. Difficulty accessing and affording respite care
- Confusion around different dementia services and support pathways
- Sense that services are helpful but there's only so much they can do

"A volunteer comes once a month and takes her to the market which is wonderful because it gives her other company, she doesn't have to just be with me all the time. A paid carer has a different energy. It would be great to have more volunteers, even just to have coffee."

"One of the problems with dementia care is that you're entirely on your own. There's a need for a single point of contact. Because I'm a nerd, I'd be the one saying to the group, "If you need help with this thing, you need to speak to this person, this is the phone number…" The argument is always, "we will support you", but what they actually mean is, "We'll give you a list of websites and phone numbers". You can google 'memory café' – but it doesn't get you away from the care – it's support, but not relief"

"In terms of actual support, there were craft groups in the village who would look after her for an hour or two while I did the shopping. And Shared Lives could take her for a weekend – before x got that bad, I could book a weekend once a month with them. Support means being relieved of responsibility. But respite care was difficult to find, and expensive."

"I get confused by all the agencies. We recently had a carers assessment which was very useful – we don't qualify for government money but they had good advice."

"She was discharged from the memory clinic – they were very helpful but for now there's not much they can continue. Then they referred her to Occupational Therapist and physio – it feels like help would be there if we needed it but there's not been any major need."

What you told us about using mental health services

healthwatch Oxfordshire

In 2025 we heard from more than 100 people about their experiences of seeking support for their mental health. People contacted us by phone, email, our online Feedback Centre, and spoke to us when we were out and about.

We also visited the Keystone Hubs across the county, and carried out two Enter and View visits to Littlemore and Warneford Hospitals. People we spoke to had experience of a range of services, including Talking Therapies, CAMHS, Adult Mental Health Teams, Keystone Hubs and voluntary sector support like MIND, Restore and the Samaritans.

We will publish a longer report about what people told us, but here is a summary of some of the themes we heard, which include:

Helpful and compassionate help when people found the right support for them...

Challenges and long waiting times in finding support...

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Some told us about the things that support mental wellbeing, including exercise, being with friends and family, hobbies and connecting with nature...

We also heard about things that cause stress and affect people's mental wellbeing, including accessing a GP as first point, impact of poor health, loneliness and isolation, rural access challenges, money and work worries, and wider national and global uncertainty...

> Walking the dog gives me a purpose to get out which does my mental health good as I suffer from anxiety.

> Faith, friends and family

> Activities, hobbies, connecting with others, nature walks, and star gazing.

> Decreasing physical health reduces ability to exercise - knock-on effect on mental health.

> Work, cost of living, rising crime... I feel scared walking around Oxford.

Some people told us about the need for more culturally appropriate, accessible and tailored support:

> More Asian agencies to help people who struggle with mental health.

> Better access to mental health services for teenagers and young people.

> Nothing for men... especially around mental health, trying to find things for my generation, especially when retired, is difficult, especially mental health.

For information and support

- See the **Live Well Oxfordshire** website **https://livewell.oxfordshire.gov.uk** for details of organisations and activities to help you stay healthy and well
- See the Oxford Health website **https://oxfordhealth.nhs.uk/support-advice/what-to-do-in-an-emergency** for details of mental health support in an emergency, including contacting **NHS 111** to access the 24/7 Mental Health Helpline
- The **Oxfordshire Mind** website **www.oxfordshiremind.org.uk** also gives details of local support and services, including the Oxfordshire Mind Guide

Please get in touch with us if you have a question about local health services or would like to tell us about your experience of using a service.

You can call us on 01865 520520 or email hello@healthwatchoxfordshire.co.uk

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HEARING FROM MEN IN FARINGDON

healthwatch Oxfordshire

In November 2025, we held short, meaningful conversations with men in support of the Oxfordshire Men's Health Partnership's annual 30 Chats in 30 Days Initiative.

Men's health is a growing area of focus for health and care services, recognising that men have a shorter life expectancy than women, and are more likely to die prematurely from coronary heart disease or by suicide. Men, especially those of working age, are less likely than women to seek help with their physical and mental health, and are often 'seldom heard' by services.

This year, we visited Faringdon, where we had conversations on the street with 30 men, including local residents, those who work in Faringdon or were visiting to use local services. We asked:

- What helps them to be healthy and well and what makes this hard
- What their experiences of using health and care services is like
- What would make a difference to support men to be healthy

"It's really important that men talk more about mental health and wellbeing"

What men told us

What helps you stay healthy and well?

- ✓ Keeping active and spending time outdoors – including gardening or walks in the countryside with a dog or a walking group
- ✓ Trying to eat well – with support from initiatives like Slimming World
- ✓ Spending time with family and friends and trying to reduce 'screen time'
- ✓ Helpful and kind health and care professionals, and effective services

Faringdon's a nice place to live and there are nice areas around.

I do a lot of keep fit and do this with other people - sometimes I help to signpost people who haven't got computers to activities they would like to do but don't know about. I find the information for them.

The NHS have done me a lot of favours lately - I'd had joint pain for several months, but an injection put me back on the straight. I'm glad it worked because they don't work for everyone. My lovely boss said, "You need to sort it out," and signed me off for a few weeks. Then the GP practice did all the health checks on me - they sorted me out, blood pressure and cholesterol.

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What makes it hard to stay healthy and well?
✗ Work and family pressures
✗ Struggles with digital technology
✗ Cost of living – such as rent, exercise classes and healthy food
✗ Decline of local amenities and services, reducing opportunities to socialise and access to health and care services such as podiatry
✗ Lack of transport to bigger towns and cities, including to attend healthcare appointments
✗ Difficulty making a GP appointment
✗ Long waits at local pharmacies
✗ A lack of NHS dentists in the area
✗ Stigma and stereotypes around seeking help
A lot of people in Faringdon are struggling, you can judge by the size of the food bank (at council office), and Faringdon larder as well...
Men have a large element of stiff upper lip, and you don't want to show weakness...
It is very difficult to see the doctors at White Horse Medical Practice. They should have more appointments.
Getting to the JR is a nightmare, it's two buses and takes about two hours... not great if you are not feeling well.
There were 15 pubs, but now only three that work really, you don't have to drink to use them, but it's a good place to meet friends and positive for mental health.
I have to have a significant thing wrong with me before I go, as I think am I wasting the doctor's time?
What would support you to stay healthy and well?
✓ An environmental and gardening space for people of all ages
✓ Keep fit sessions in community spaces
✓ More activities for young people
✓ Better information about help, support and activities – including for those who are not online
✓ PSA tests or better screening for cancer in men
They do need to make more people aware of what is out there... the social prescriber goes to the community café every six weeks, but you often only hear about things if you are proactive...
Before COVID I used to play walking football, but when COVID came it all stopped and hasn't ever got going again. Would be good if there were more activities like that for people to do. People tell you to go to the gym but the weight I am I could hurt myself, I might go if there if there was someone there to talk me through what I could do and how to things without hurting myself.
My advice is to try and connect with others and if not try and set something up yourself...
Perhaps the council could organise some sessions in a village hall for keep fit, nothing involving heavy weights just some circuits or similar - would be an opportunity to get out and to meet people. Would have to be at a minimal cost or even free to be able to afford it.
We will share what we heard with key health service providers, commissioners and decision-makers in Oxfordshire.
Many thanks to the men in Faringdon who shared their experiences with us
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South Central Ambulance Services:

Some feedback comments received via our advice and signposting on calling NHS 111.

"After waiting for hours to be called back I called to let them know my symptoms are worsening. Had the rudest, most dismissive man on the phone who bullied me while I was feeling very vulnerable. He asked me the same question over and over again … He made an already terrible situation much worse and left me in tears having still not accessed medical help. He literally had zero compassion or empathy and shouldn't be allowed to deal with sick and vulnerable people."

"Husband was really unwell; he was given a choice whether to go to hospital or not. Was phrased in a "we can take you, but you'll probably be okay at home". He ended up in ICU three days later!"

"Absolutely abysmal service. I was deep in crisis, crying after self-harm, in complete despair and hadn't slept for 2 nights. I speak to someone at 111 who was good telling me someone would call me back. Well, the person who called me back was absolutely useless. They went through some checklist of anodyne questions and didn't enquire as to my background or details about my condition at all. They told me to go to the job centre. They offered no help at all. And anything they did offer I had already tried about a million years ago. They assumed I was stupid, and they made me feel even worse for contacting them."

Health Overview Scrutiny Committee

16th April 2025

Healthy Children and Young Person's Public Health Service – focus on babies and young children

Report by Ansaf Azhar

Executive Summary

1. This report provides the committee with an update on the Health Visiting and Family Nurse Partnership elements of the Healthy Child Public Health Service. This service is commissioned by Public Health in Oxfordshire County Council and delivered by Oxford Health NHS Foundation Trust. The integrated contract commenced on 1st April 2024.

2. This report and Annex 1 will provide an overview of the commissioned service and provide information on mandated reviews, digital systems, safeguarding, feedback from parents, quality assurance, workforce and system collaboration.

Giving Every Child the Best Start in Life

3. The first 1,001 days of life – from conception to a child's second birthday – are a critical period that shapes lifelong health, wellbeing and opportunity. During this time, rapid brain and physical development occurs, and early experiences strongly influence emotional security, learning, behaviour and future health outcomes. Evidence consistently shows that adversity in these early years, such as poverty, parental mental ill health or insecure attachment, can have lasting impacts across the life course, while positive early support can build resilience and reduce inequalities before they become entrenched.

4. Public health has a central role in prevention and early intervention during the 1,001 critical days, working across the system to ensure that babies and families receive the right support at the right time.

5. The Healthy Child Programme (HCP) is the cornerstone of this approach, providing a universal framework of evidence-based assessments, screening, health promotion and support for all families, with additional targeted input for those with greater needs.

6. Health visiting services are fundamental to delivery of the HCP, offering trusted, relationship-based support to families, identifying concerns early, promoting child development and parental wellbeing, and acting as a key connector to wider services.

7. This approach aligns closely with the Marmot principles, particularly the need to "give every child the best start in life" as the most effective way to reduce health inequalities. By focusing on universal provision, proportionate targeting, and the wider social determinants of health, public health and health visiting services help to narrow gaps in outcomes related to deprivation, ethnicity, disability and vulnerability.

8. Investment in the early years is therefore both a moral and economic imperative: it improves outcomes for children and families, reduces future demand on health and care services, and supports sustainable, preventative public services. A strong, integrated early years system is essential to ensuring that all babies and children have the best possible start in life.

Institute of Health Visiting Report 2025

9. The Institute of Health Visiting (iHV) is an independent charity, professional body and centre of excellence for health visiting – established to strengthen the quality and consistency of health visiting for the benefit of all babies, children, families and communities.

10. In their national annual survey[1], members reported that being part of an organisation that acts as a "voice" for health visiting, to influence policy, was the most important reason for being a member of the iHV. In 2024, 1,392 practitioners completed the survey between 9 September and 4 November 2024. The survey findings are presented in four themed sections
    - Health Visitors want to deliver a good service to all families and support the Government's ambition to create the 'healthiest generation of children ever'.
    - There are big differences in the level of health visiting support between the different countries in the UK and among local authorities in England. Families receive good levels of support in some areas, and barely any support in other areas.
    - Health Visiting workforce matters, across all four UK nations, practitioners reported a decrease in health visitor numbers
    - Strengthening health visiting: train new health visitors, attract people who have left back into health visiting, reform through good leadership, commissioning models, prevention and value health visiting

Issues being faced by families in the UK

11. The iHV annual survey reported the top issues being faced by families across the UK and these can be grouped into four categories
    - Physical and mental health: preterm or sick babies, baby/child physical health problems, parent carer perinatal mental health problems, breastfeeding, substance use and or alcohol use

[1] https://ihv.org.uk/wp-content/uploads/2025/01/State_of_Health_Visiting_Report_2024_FINAL_VERSION_22.01.25_compressed.pdf

- Child development and safeguarding: poverty, domestic abuse, child subject to child protection plan, child subject to child in need plan
- Referral and support needs: connecting families to other services, infants with disabilities or complex conditions
- Growth and nutrition concerns: child behaviour, baby/child development concerns, families seeking support as they are worried their child is unwell, growth concerns, underweight, parent/carer physical health problems.

Commissioning arrangements for Health Visiting Services

12. The Local Authorities (Public Health Functions and Entry to Premises by Local Health Watch Representatives) Regulations 2013[2] (as amended by the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015[3]) prescribe steps local authorities must take in exercising their public health functions, including arranging for public health services for children and young people aged 0 to 19.

13. These regulations include the requirement for local authorities to provide, or secure the provision of, universal ages 0 to 5 health and development reviews for eligible people at the following points in time. Oxfordshire has commissioned these services, and they must be offered to a:
    - woman who is more than 28 weeks' pregnant (referred to as the 'antenatal health and development review')
    - child who is between 1 day and 2 weeks old (referred to as the 'new birth health and development review')
    - child who is 6 to 8 weeks old (referred to as the '6-to-8-week health and development review')
    - child who is 9 to 15 months old (referred to as the '12-month health and development review')
    - child who is 24 to 30 months old (referred to as the '2-to-2-and-a-half-year health and development review')

14. In addition to the statutory duties, commissioners must deliver the Healthy Child Programme. The guidance for this programme was updated and published on 6th February 2026 by Department for Health and Social Care. This major public health programme is a national framework for improving the health and wellbeing of babies, children and young people aged 0-19 years of age. It sets out evidence- based approaches to prevention, early intervention, and family support, supporting the governments ambition of raising the healthiest ever generation of children.

15. The Healthy Child Programme underpins statutory responsibilities for local authorities and health services, and aligns with the 10 Year Health Plan for

[2] https://www.legislation.gov.uk/uksi/2013/351/contents/made
[3] https://www.legislation.gov.uk/uksi/2015/921/made

England: fit for the future[4]. The commissioning and delivery of the programme supports the aims of the plan by:

- promoting equity and access: services reach all families, with targeted proportionate support for those most in need
- integration across services: joined up working across health, education and social care
- evidence-based practice: interventions supported by research and clinical standards

16. The Healthy Child Programme[5] identifies priority high-impact areas for 0-19 years. The framework for 0-5's prioritises

- The transition to parenthood
- Maternal and family mental health
- Breastfeeding
- Healthy Weight and nutrition
- Health literacy, managing minor illnesses and reducing accidents
- Healthy, well and ready to learn

17. There are also National Institute of Health and Care Clinical Excellence guidelines which describe how new babies and mothers and families should be supported from a clinical perspective. Example guidance includes maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years[6] and antenatal and postnatal mental health: clinical management and service guidance[7]. Commissioners utilise these national clinical guidance when developing local services.

18. Commissioning these services occurs within local public health teams and is overseen by the Director of Public Health for the area. Commissioning follows a cycle of activity that is determined locally and based upon procurement rules set out nationally.

19. Local authorities retain accountability for the quality and outcomes of commissioned services, ensuring contracts meet statutory requirements and oversight via Directors of Public Health.

20. Provider organisations for all activities must adhere to all relevant legal and clinical requirements, including being registered with the Care Quality Commission (CQC) for the appropriate regulated activity, as described under section 10 of the Health and Social Care Act 2008. It is expected that delivering the Healthy Child Programme will involve undertaking a regulated activity and therefore providers should be registered with CQC.

21. Public health nurses (health visitors, family nurses, community nurses and their appropriate team members) must adhere to legal requirements

[4] https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
[5] https://www.gov.uk/government/publications/healthy-child-programme-high-impact-area-framework/high-impact-areas-for-health-visiting-ages-0-to-5
[6] https://www.nice.org.uk/guidance/ng247
[7] https://www.nice.org.uk/guidance/cg192/chapter/Recommendations#recognising-mental-health-problems-in-pregnancy-and-the-postnatal-period-and-referral

for professional registration and revalidation. This should be in line with revalidation requirements for practice issued by the Nursing and Midwifery Council (NMC).

Public Health Commissioning and Contractual Arrangements

22. Oxfordshire County Council Public Health Directorate commission the service and Oxford Health NHS Foundation Trust are the provider organisation.

23. This is an integrated service and consists of the following service areas
    - Health Visiting (0-8 years)
    - Family Nurse Partnership (first time young mothers <19 years or <21 years if care leavers)
    - Vision Screening (reception year)
    - National Child Measurement Programme (reception year and year 6)
    - School Health Nursing (primary and secondary schools)
    - College Nursing (further education colleges)
    - Protective Behaviours (secondary schools)

24. Oxfordshire's contract for 0-19 Public Health Nursing Integrated Service is £12.5m per year. Over the lifetime of the contract this represents £87m spend. The funding for this service is from the public health ring fenced grant.

25. The contract started on 1st April 2024 and ends 31st March 2031. This is a 5 years + 2 years contract.

Oxfordshire Population

26. Oxfordshire has an estimated population of around 39,731 children aged 0–4[8], based on the latest ONS mid-year population estimates. This cohort represents approximately 5–6% of the county's population and forms the core population for delivery of the Healthy Child Programme.

27. In 2024, Oxfordshire had 7,153 live births. 1,801 in Cherwell, 1,440 in Oxford, 1,412 in South Oxfordshire, 1,486 in Vale of White Horse and 1,014 in West Oxfordshire.

28. There are approximately 1,775 babies and children eligible for each of their mandated health and development reviews per quarter.

29. Service demand does not fall in line with population size, as complexity and vulnerability have increased despite smaller cohorts.

National reporting requirements Health Visiting and Family Nurse Partnership (FNP)

[8] Population - UTLA | Oxfordshire | Report Builder for ArcGIS

30. Indicators are set nationally by government and are reported quarterly[9]. The metrics reported include the 5 mandated elements of the service. These 5 mandated elements also contain information about health outcomes as described in the Public Health Outcomes Framework.

31. Exact numbers of completed mandated health visitor reviews for Oxfordshire are published in the national Health Visitor Service Delivery Metrics data tables[10] (April 2024–March 2025). These tables provide the denominators, numerators and coverage percentages for each mandated review and are the authoritative source used for national and local performance monitoring.

32. In addition to coverage of health and development reviews, health visiting services report child development outcomes that feed into national datasets and public reporting. The Ages and Stages Questionnaire (ASQ3) developmental outcomes at 2–2½ years report the percentage of young children who are at or above expected level in: communication, gross motor, fine motor, problem solving, personal social skills. These indicators are published annually and used nationally to assess early child development.

33. The Department of Health and Social Care (via the Office of the Chief Public Health Nurse) publishes national-level FNP programme information, mainly through annual national FNP reviews, commissioning and programme guidance. These publications include aggregate programme data, not individual or Local Authority level performance tables.

34. The number of health and development reviews that family nurse practitioners undertake are included in the total number of reviews reported by the health visiting service.

35. Local authorities submit their data through a website operated by the Local Government Association. The data collection is based on the local authority of residence of each child. Data for children resident in any local authority who have moved in after they received a review while resident in another local authority must be included.

36. Health Visiting providers are also required to submit quarterly data to NHS England's community services data set[11] (CSDS).

Local Performance and Oversight

37. The Oxfordshire County Council contract requires Oxford Health NHS Foundation Trust to report on the mandated healthy and development review performance as well as locally defined key performance indicators, qualitative information and case studies. Public Health commissioners also visit and

[9] https://www.gov.uk/government/publications/childrens-public-health-0-to-5-years-national-reporting/interim-data-submission-for-the-universal-health-visiting-service-2025-to-2026
[10] https://www.gov.uk/government/statistics/health-visitor-service-delivery-data-for-2024-to-2025
[11] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/community-services-data-set

observe the workforce during visits to families' homes and community venues and utilise these observation visits for service improvement.

Antenatal Review

38. During the antenatal period, midwives and doctors who specialise in pregnancy and birth provide care and support. Midwives can provide antenatal care from before 10 weeks. The maternity service then notify GP's and health visitors of the pregnancy.

39. Babies and families are typically handed over from midwifery to the health visiting and family nurse service around 10 days of age. This transition is part of the continuity of care provided by midwifery and health visiting services, ensuring that the baby's health and development are monitored by trained professionals. For some families the midwives will be involved for longer.

40. The Health Visiting service works in partnership with midwives, specialist medical care teams and social care teams for targeted and specialist antenatal support. The health visitors completed 571 antenatal reviews from 1st April 2025 – 31st December 2025.

New Birth Visits

41. During 2024/2025 the service completed 5,865 new birth visits within 14 days which represents 81.5% of the eligible population. The locally set target for year 2 of the contract is 90% and the latest year to date performance for visits within 14 days is 80.9%. More detailed information is available in Oxford Health's report, section 3.

42. This increases to 6,796 within 30 days which is 94.4% of new babies. The locally set target for year 2 of the contract is 95% and the latest year to date performance for visits within 30 days is 94.5%. More detailed information is available in Oxford Health's report, section 3.

43. Reasons for delayed reviews include parental choice, baby in special care/paediatric intensive care, baby born early, late notification, delay due to providing continuity of care from same health visitor professional.

6-8 week reviews

44. At 6-8 weeks the GP practice will offer a postnatal check to ask about health and wellbeing and ensure good recovery after the birth. The health of the baby is also checked.

45. Alongside the GP check, the health visiting service provide a health and development review. During 2024/2025 the service completed 5,825 reviews within 6-8 weeks which represents 81.2% of the eligible population.

46. The locally set target for year 2 of the contract is 93% and the latest year to date performance is 87%. More detailed information is available in Oxford Health's report, section 3.

12-month health and development reviews

47. During 2024/2025 the service completed 6,031 12-month health and development reviews before the child's 1st birthday. This represents 82.4% of the eligible population.

48. The locally set target for year 2 of the contract is 90% and the latest year to date performance is 90.25%. More detailed information is available in Oxford Health's report, section 3.

49. Reasons for no review include parents returning to work, unable to contact the family, client choice; still chasing by offering follow up appointment following Did Not Attend.

2-2.5 year reviews

50. During 2024/2025 the service completed 6,155 2-2.5-year reviews. This represents 83% of the eligible population.

51. The locally set target for year 2 of the contract is 90% and the latest year to date performance is 81%. More detailed information is available in Oxford Health's report, section 3.

52. Reasons for no review include return of parents to work, unable to contact; client choice; still chasing by offering follow up appointment following Did Not Attend.

53. More detail about the mandated health and development reviews and performance is provided within the Oxford Health report. The service has explained how factors such as timeliness, locality variation and service improvement actions have been identified and addressed to improve engagement with families.

Use of National and Local Thresholds for Assurance

54. National thresholds for health visitor performance can be useful as high level parameters as they provide consistency and visibility of common metrics (mandated reviews) and can help ensure that there is a universal offer of support for all babies, children and their families. They also provide accountability at a local authority level and can indicate service delivery issues at a population level.

55. They also protect universalism and the public health prevention approach especially during periods of system pressures. They prevent the risk of service provision drifting towards a purely targeted model, undermining prevention and early identification.

56. National thresholds do not however take into account contextual indicators. National thresholds rarely adjust for deprivation, safeguarding prevalence, perinatal mental health need, transient populations, housing insecurity or migration.

57. A completed visit to a family in a low need area is not equivalent to one in a high complexity context. Need and complexity are not evenly distributed throughout Oxfordshire. Also, when families move home address into Oxfordshire from another area it could impact on the health visitor service knowing about the family as they are reliant on transfer in notifications from the NHS system (maternity, primary care).

58. The national thresholds are monitoring reviews completed within a specific time period. If a review is 1 day outside the time period, it will not count in the reporting window. Clinical judgement and continuity of professional supporting a family may mean that a health and development review is delayed if it's in the best interests of the child. Oxford Health do provide additional data on the total number of reviews completed (in and out of the reporting window) to provide assurances that children are being seen.

59. Parental choice is a factor that impacts on performance, a health and development review may be scheduled but cancelled at the last minute by the family which means it can miss the time window. It does not necessarily mean that there is poor performance from the provider. This would be the same for all local authorities reviewing performance from their 0-5 public health service.

60. Additional assurances are sought by commissioners in contract meetings. Contextual discussions consider for example safeguarding, areas of deprivation, vacancy factors. Commissioners also receive information on parental experience, feedback from system partners, timeliness of follow up, staff retention and sickness and evidence of early help escalation.

61. Locally commissioners use thresholds as an early warning system and a trigger for support, quality improvement, or peer learning. It provides the basis for honest conversations with the service and system partners.

Corporate Policies and Priorities

62. This public health service supports the vision, values, objectives and strategic priorities in the County Council's Corporate Plan by giving children the best start in life and increasing the number of children who reach a good level of development by the age of 5 years. It also links with the roll out of a network of Family Hubs.

63. The Best Start Family Hubs and Healthy Babies guidance[12] from the Department for Education and Department for Health and Social Care states

12 https://assets.publishing.service.gov.uk/media/693063ec375aee4a15ee8b65/Best_Start_Family_Hubs_and_Healthy_Babies___Preparing_for_implementation_in_2026.pdf

that all local authorities publish their local Best Start in Life Plan[13]. This focuses on ensuring the healthy development of babies and children through locally tailored approaches focused on prevention. The public health nursing service is a key partner to improve outcomes for babies, children and their families.

64. Education Scrutiny Committee[14] recently scrutinised three interconnected strands of work: the Best Start in Life plan, Early Years sufficiency, and improving the Good Level of Development (GLD) at age five. Although the Council performed above national averages overall, outcomes for children from deprived backgrounds remained significantly lower. The Cabinet Member for Children and Young People emphasised that national targets were not sufficient to close this gap, and the Council had therefore adopted more ambitious local objectives.

65. Children's Trust are scrutinising the good level of development ambition set by national government for Oxfordshire. The government's strategy for improving child development and meeting the ambition that 75% of 5-year-olds in England have a good level of development by 2028.

Financial Implications

66. Funding for Public Health comes from a ring-fenced grant for the Department of Health and Social Care to be used exclusively for public health activity. The 2026/2027 settlement for Oxfordshire is £41,980,812. There are no new or additional financial implications to deliver this mandated function.

67. Comments checked by

Stephen Rowles
Strategic Finance Business Partner
stephen.rowles@oxfordshire.gov.uk

Legal Implications

68. There are no legal implications to the content of the report at this stage. Legal colleagues have been engaged to ensure compliance with the Contract Procurement Regulations in respect of the commissioning of the Healthy Children and Young Person's Public Health Service.

Comments Checked by

Jayne Pringle
Principal Solicitor – Contracts
Jayne.pringle@oxfordshire.gov.uk

[13] https://www.oxfordshire.gov.uk/sites/default/files/file/children-and-families/oxfordshirebeststartinlifeplan.pdf
[14] https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=1223&MId=7857&Ver=4

Staff Implications

69. There are no new or additional staff implications regarding the content of this report.

Equality & Inclusion Implications

70. Delivery of the Healthy Child Programme is a key mechanism through which Oxfordshire County Council addresses health inequalities in line with the Marmot principles, particularly by giving every child the best start in life. The programme's universal, non-stigmatising offer supports early identification of need and proportionate support for families experiencing disadvantage, including those affected by poverty, parental mental health difficulties, safeguarding concerns or barriers to access.

71. However, workforce pressures and rising complexity of need present an equity risk if capacity constraints reduce continuity of care or targeted, inclusive support for families with the greatest need. Sustaining equitable delivery therefore requires continued focus on proportionate universalism, culturally responsive practice and strong partnership working across local communities and the early help system to avoid widening inequalities in Oxfordshire.

Sustainability Implications

72. There are no sustainability implications associated with this report.

Risk Management

73. Delivery of the mandated reviews and the healthy child programme in Oxfordshire identifies workforce capacity, rising complexity of need, and variation in service delivery as key risks to the sustainability of health visiting services.

74. Locally, while Oxford Health NHS Foundation Trust continues to deliver the core elements of the Healthy Child Programme and maintains strong performance against mandated contacts, this is being achieved within a context of ongoing workforce pressure, increasing acuity of family need and growing demand related to perinatal mental health, safeguarding concerns below statutory thresholds, and wider social vulnerability.

75. As with the national picture, there is a risk that sustained staffing pressures and high caseloads reduce capacity for continuity of care and preventative, relationship-based practice.

76. Oxford Health NHS Foundation Trust continues to mitigate these risks through active workforce management, skill-mix optimisation, balancing universal and targeted prioritisation of support to families with the highest levels of need, while maintaining focus on delivery of mandated contacts.

77. Oxford Health NHS Foundation Trust works closely with commissioners and system partners to align the service model with Best Start in Life priorities, strengthen integration with maternity, primary care and early help services, and support early identification and escalation of need. Ongoing performance monitoring, quality improvement activity and workforce planning are in place to support service resilience and to sustain safe delivery within available resources.

Consultations

78. Public consultation was completed as part of the commissioning process to specify the requirements for service delivery. Improvements continue to be made based on engagement and feedback from families, key stakeholders, parents or carers, and where possible young children.

NAME
Ansaf Azhar, Director of Public Health and Communities

Annex:	Annex 1 – Oxford Health NHS Foundation Trust Public Health Nursing Service Report
Background papers:	NIL
Contact Officer:	Donna Husband Head of Public Health Programmes, Start Well Donna.husband@oxfordshire.gov.uk

April 2026

Oxfordshire Health Visiting & 0–5 Public Health Service (part of the New integrated child and young persons 0-19 integrated public health service) – Provider Report for HOSC (April 2026)

Prepared by: **Mark Chambers – Head of Children & Young People's Services**

Provider: **Oxford Health NHS Foundation Trust**

HOSC Public Meeting: **16 April 2026**

CONTENTS

1. INTRODUCTION AND PURPOSE

This report provides Oxford Health's written response to the HOSC themes relating to **Health Visiting and the 0–5 Public Health Service**, within Oxfordshire's integrated **0–19 Healthy Child and Young Person Public Health Service**. It focuses on (1) what the service delivers, (2) current performance and trends, (3) the quality and safeguarding arrangements that underpin delivery, (4) workforce capacity and sustainability, and (5) system collaboration and improvement actions.

The service model described in this report reflects the integrated 0–19 contract awarded in 2023 and the subsequent phased implementation across 2024, including the establishment of 11 integrated locality teams and a centrally based **Single Point of Access (SPA)**.

2. OVERVIEW OF THE NEW SERVICE MODEL (BREADTH OF SUPPORT)

Oxfordshire's current model is an **integrated 0–19 Public Health Nursing Service**, bringing together previously separate services—**Health Visiting (HV), School Health Nursing (SHN), and Family Nurse Partnership (FNP)**—into a single pathway, supported through the SPA. The service launch began on 1 April 2024 and reached full integration with SHN by September 2024, including the additional elements of Vision Screening and Protective Behaviours programmes.

2.0 HOW THE NEW SERVICE MODEL OPERATES IN PRACTICE

The integrated 0–19 Public Health Nursing Service in Oxfordshire functions through a coordinated pathway that begins with the Single Point of Access (SPA). Families and professionals can access support via the SPA via email or telephone call, which then provides initial triage and signposting, ensuring that needs are rapidly identified and directed to the most appropriate locality team or specialist service. Families can also access support and advice via the Chat Health confidential messaging service, offering a convenient digital route to communicate directly with health visitors and school nurses (described in further detail below).

Eleven locality teams operate across the county, each comprising Health Visitors, School Health Nurses, Family Nurses, and support staff, allowing for seamless transitions between universal, targeted, and specialist provision according to the child or family's needs. A map of the locality boundaries is described in Figure 1.

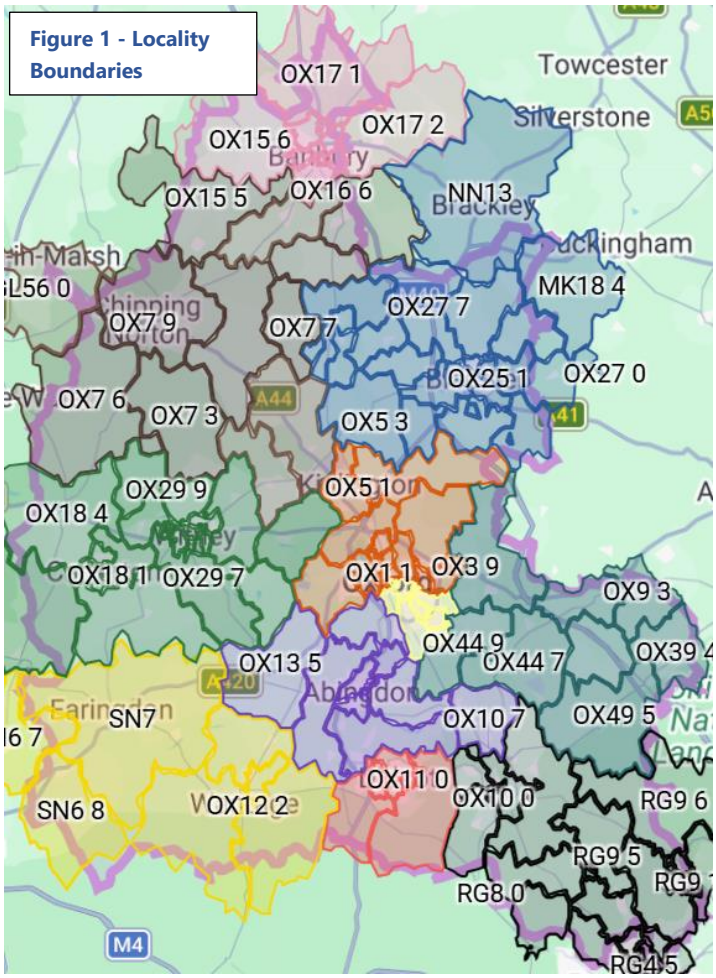


Figure 1 - Locality Boundaries

Routine contacts are scheduled as per the Healthy Child Programme, but the model's flexibility enables families to receive additional support through targeted Episodes of Care when specific concerns arise, such as sleep or behaviour issues (described in more detail below).

These episodes involve assessment, intervention, and—if needed—referral to wider services, promoting a holistic "Think Family" approach. The service utilises both face-to-face and virtual formats, adapting delivery to the family's circumstances and preferences while maintaining safety and quality standards. Close collaboration between locality teams and specialist practitioners ensures that pathways for complex needs (such as perinatal mental health or safeguarding) are robust, and escalation protocols are clear and responsive.

Regular multidisciplinary meetings within locality teams facilitate information sharing and joint decision-making, supporting integrated care planning and safeguarding. Workforce development is embedded in practice, with ongoing training and supervision to sustain professional expertise and service quality. Feedback from families and professionals is routinely captured and used to inform service improvement, ensuring the model remains responsive and effective in meeting the diverse needs of Oxfordshire's children and families.

2.1 ESTATES AND GEOGRAPHICAL DELIVERY OF THE SERVICE

The Oxfordshire 0–19 Public Health Nursing Service is delivered through a well-established network of community-based premises across the county, enabling local, accessible delivery while supporting countywide consistency. As the largest community services provider in Oxfordshire, Oxford Health utilises a combination of freehold and leasehold NHS premises, alongside co-located community settings, to deliver services within each of the 11 integrated localities. This includes clinical bases, protected space within secondary schools and colleges for school-aged pathways, and the use of GP practices and other community health settings where appropriate.

Importantly, families are not restricted to accessing services solely within their immediate local area. Contacts, clinics and group activity can be delivered across any suitable setting countywide, enabling flexibility, choice and continuity where this best meets family need or preference. This approach supports equitable access, reduces barriers linked to geography or travel, and allows the service to respond pragmatically to availability, capacity and individual circumstances.

The service also works in partnership with local authority and NHS partners through the One Public Estate approach, enabling flexible use of shared buildings such as Family Hubs, community centres, leisure centres and schools, particularly for group delivery and health promotion activity. This blended estate model allows services to be delivered close to where families live, supports outreach and group work, and enables the service to respond to population growth, housing developments and changing patterns of need.

However, it is important to recognise that community estates are subject to multiple competing system demands, including pressures from other health services, local authority functions and wider public use. As a result, 0–19 services are not always the priority user within shared premises, requiring ongoing negotiation, flexibility and adaptation to ensure continuity of delivery. Estate usage is therefore kept under regular review to ensure suitability, accessibility and value for money, while

maintaining the flexibility required to adapt to changing system pressures and future service need.

2.2 MANDATED CONTACTS, UNIVERSAL OFFER, AND ESCALATION BY NEED

Within Health Visiting, the service provides the mandated/core Healthy Child Programme contacts and a wider offer of targeted and specialist interventions where vulnerabilities are identified, aligned to a "Think Family" approach. The broader 0–19 service is delivered through a skill mix workforce with a range of contact formats ranging from face-to-face, virtual, groups and drop-in sessions used where safe and appropriate.

The Healthy Child Programme mandates a series of universal contacts for all families with children aged 0–5 years. These include:

- Targeted antenatal contact: Support and information for expectant parents, focusing on health, wellbeing, and preparation for parenthood.
- New birth visit (10–14 days): Assessment of the newborn and support for parents, including feeding, bonding, and safety.
- 6–8 week review: Monitoring infant development, maternal emotional health, and parental adjustment.
- 1 year review: Evaluation of growth, nutrition, development, and immunisations, alongside parental support.
- 2–2½ year review: Focused on the child's physical, emotional, and social development, school readiness, and early identification of additional needs.
- New 4 year universal review: Introduced as part of the integrated 0–19 model, this contact offers a universal assessment for children approaching school entry. It aims to review health, development, and wellbeing, reinforce school readiness, and identify any emerging needs or vulnerabilities, ensuring timely support and referral where appropriate.

In addition to these mandated contacts, Health Visiting teams facilitate group sessions for parents and carers, which may include:

- Infant feeding groups: Providing support and advice on breastfeeding, bottle feeding, and weaning.
- Baby Well drop in Clinics: Offering routine health checks, growth monitoring, and advice for infants, ensuring early identification of health issues and supporting parents with guidance on infant care.

- ‘Marvellous Me’ Groups: These health promotion groups specially target additional suggested HCP contacts points at 3-4 months, 6 months, 18 months and 3 years, providing sessions designed to boost children’s confidence, self-esteem, and emotional wellbeing, using age-appropriate activities and interactive play.

Where vulnerabilities are identified—such as concerns regarding safeguarding, parental mental health, or child development—the service provides targeted and specialist interventions, either individually or in groups, to address the specific needs of families. All contacts are delivered flexibly depending on family preference, safety, and appropriateness, ensuring accessibility and responsiveness across Oxfordshire’s diverse communities.

2.3 EPISODES OF CARE (TARGETED INTERVENTIONS DELIVERED THROUGH SKILL MIX)

A central component of the Oxfordshire 0–19 Public Health Nursing Service is the structured delivery of Episodes of Care. These episodes offer families defined, evidence-based packages of support, designed to address specific needs and facilitate early intervention. Each Episode of Care follows a clear protocol as outlined in the service standard operating procedure, encompassing assessment, intervention, and—when necessary—onward referral, all linked to integrated care pathways. Delivered through both the 0–5 and the broader 0–19 pathways, these time-limited episodes provide consistent advice and enable escalation to targeted or specialist support within locality teams, ensuring a coordinated and responsive approach.

The following Episodes of Care for early years are offered by the service:

- Sleep support
- Toileting support
- Behaviour management
- Social interaction and play
- Nutrition, healthy weight and infant feeding
- Early speech, language, and communication support (social communication and language)
- Child / Parent attachment
- Home safety & accident prevention
- Early childhood illnesses prevention and management
- SEND support

A review of 146 episodes of care in one month showed sleep (1), then speech/language/communication (2), behaviour (3), toileting (4), and nutrition (5) as the most requested interventions, and that many requests came via parental self-referral through ChatHealth (See section 4.2).

2.4 SPECIALIST HEALTH VISITING ROLES AND ENHANCED PRACTICE

The service model features a variety of specialist roles that support and strengthen universal HV and SHN provision in key priority areas. These roles offer countywide leadership for pathway development, promote effective collaboration across agencies, and provide workforce training across the 0-19 Public Health Service. Specialist Lead Practitioners also deliver clinical expertise for complex cases, contribute to service improvement, and ensure best practice is implemented in their areas. In addition, specialist support is provided via the two stand-alone Senior Lead Practitioners in Infant Feeding and Perinatal Infant Mental Health. This support can be offered through group sessions or direct 1:1 interventions, ensuring tailored guidance and care for families and children who require it. This integrated approach embeds specialist knowledge in daily practice, maintaining strong links with both universal and targeted services, and enhancing quality, consistency, and outcomes throughout early years and school-aged pathways.

Some Specialist Lead Practitioners also hold the role of Locality Team Leader, combining specialist leadership with operational management responsibility for a defined locality. In addition, Senior Lead Practitioners may take on the role of Clinical Education Lead, contributing to the development and delivery of clinical education and training across the service. Therefore, a Senior Lead Practitioner can operate as a standalone specialist, also serve as a Locality Team Leader, or fulfil the responsibilities of a Clinical Education Lead, depending on the needs of the service and their individual expertise. This blended model provides both depth of expertise and strong local oversight, supporting safe, effective and responsive services for children and families across Oxfordshire.

The current Specialist Lead Practitioner roles within the service are each linked to a healthy child programme high impact area and include three stand-alone roles of Perinatal, Infant and Family Mental Health; Infant Feeding, Healthy Weight and Nutrition and SEND plus the following joint roles:

- Maternity and Care Of Next Infant (extra support for families who have previously experienced the sudden or unexpected death of a baby).
- School Readiness
- Neglect and Early Years Safeguarding
- Early Help and 0–19 Supervision
- Minor Illness, Emergency Department (ED) and Minor Injury Units (MIU)
- Healthy Lifestyles and PSHE
- Sexual Health (including contraception prescribing)
- Education Safeguarding and Attendance
- Mental Health Support Teams (MHSTs) and CAMHS interface
- Protective Behaviours and Substance Misuse
- Transition to Adulthood
- Clinical Triage and ChatHealth
- Digitalisation (EMIS)
- Website, Communications and Digital Engagement
- Co-production and Patient Experience
- Domestic Violence and Abuse (DVA)

Together, these roles strengthen clinical governance, support workforce capability, and ensure that evidence-based interventions are delivered consistently across the county, while enabling timely escalation and specialist support where additional need is identified.

2.5 FAMILY NURSE PARTNERSHIP (FNP)

FNP is embedded within the integrated model and provides an intensive, evidence-based programme for eligible young parents. FNP is an evidence-based, preventative programme designed to support young first-time mothers, aged 19 or under (or 21 and under if a care leaver), from early pregnancy through to their child's second birthday. The programme aims to improve maternal health, child development, and family self-sufficiency by providing regular, structured home visits from specially trained family nurses. These visits cover a range of topics including health, parenting, and personal development, fostering strong relationships and empowering young parents to make informed choices.

FNP operates under a national licence, which requires participating organisations to adhere to strict fidelity criteria, including staff training, programme delivery standards, and data collection protocols. Only qualified nurses who have completed

accredited FNP training are permitted to deliver the programme, ensuring consistency and quality. Additionally, services must maintain compliance with the licence, participate in national evaluations, and submit regular data returns to monitor outcomes and maintain programme integrity.

As part of the new service model a new, integrated young parent pathway has been implemented within the Service to ensure early identification, continuity and proportionate support for young parents from pregnancy through the early years.

The pathway operates alongside, and is closely aligned with, FNP, with Family Nurses providing specialist oversight, clinical leadership and expertise in supporting young parents with complex or multiple needs. Eligible young first-time parents are offered the evidence-based FNP programme, while those who do not meet FNP criteria or who graduate from the FNP programme are supported through the wider young parent pathway by locality Health Visiting teams.

Family Nurses play a central role in advising on pathway thresholds, contributing to multidisciplinary decision-making, supporting safe transitions between FNP and universal services, and providing consultation and supervision to locality practitioners. This approach ensures that all young parents in Oxfordshire receive a consistent, equitable and needs-led offer, with intensive support targeted where it will have the greatest impact, while maintaining continuity of care as families' needs change over time.

2.6 PARTNERSHIP WITH HOME-START – STRENGTHENING EARLY HELP AND COMMUNITY REACH

As part of the integrated 0–19 Public Health Nursing Service, Oxford Health holds a formal contractual partnership with **Home-Start**, a national charitable organisation that provides volunteer-led peer support to families with young children under 5. This partnership is a key component of the service's early help and prevention offer, complementing statutory health visiting and public health nursing provision.

Home-Start volunteers offer practical, emotional and non-judgemental peer support, typically through regular weekly contact, which may include home visits or community-based support. This frequency and continuity of support provides an offer that would not be possible through statutory services alone and enables families to build confidence, routines and resilience over time. Volunteers are carefully

recruited, trained and supported by Home-Start, and work alongside Health Visitors rather than replacing professional input.

Referrals into Home-Start are made through Health Visiting teams, ensuring that families are identified early and supported through a coordinated and proportionate pathway.

This partnership offers several important benefits within the Oxfordshire model:

- **Peer support that builds trust and engagement**
  Evidence from national and international studies demonstrates that peer support can be as effective as, and for some families more effective than, professional-only support in building trusting relationships, improving engagement and supporting positive outcomes, particularly for families experiencing isolation, low confidence or early vulnerability. Shared lived experience enables volunteers to connect with families in a way that reduces stigma and supports honest, open conversations.
- **Extending reach into communities**
  Home-Start's volunteer model enables support to be offered to families who may be less likely to engage with formal services, including those experiencing social isolation or practical barriers to access. This extends the reach of the 0–19 service beyond traditional clinical contacts and helps address inequalities in access.
- **Strengthening prevention and early intervention**
  Regular, relationship-based peer support helps prevent escalation of need by addressing issues early, supporting parental confidence and coping, and reinforcing key health and developmental messages. This reduces pressure on targeted and specialist health visiting capacity and supports families before concerns become more complex.
- **Enhancing outcomes through complementary support**
  Home-Start does not replace statutory services. Instead, volunteers work alongside Health Visitors to reinforce advice around parenting, routines, child development and emotional wellbeing. This layered approach strengthens outcomes through consistent, trusted relationships while ensuring that clinical oversight and escalation remain in place where required.
- **Supporting proportionate universalism**
  The availability of a voluntary-sector peer support offer enables Health Visiting teams to provide a graduated response, ensuring families receive the right

level of support at the right time, without over-medicalising need or defaulting to statutory intervention where this is not required.

- **Strengthening system collaboration**
  The partnership reflects a strong and mature relationship between the NHS and the voluntary and community sector, supporting shared ownership of early years outcomes and contributing to a more sustainable, system-wide approach to supporting families.

Illustrating impact: family and professional perspectives

The impact of the Home-Start partnership is evidenced not only through activity and outcome reporting, but also through direct feedback from families and professionals working within the integrated 0–19 pathway. These perspectives provide qualitative assurance of the value of structured, regular peer support alongside statutory public health nursing.

Family experience

Feedback captured within Home-Start annual reporting highlights the difference that sustained, relationship-based peer support can make for families experiencing vulnerability, isolation or low confidence. One parent described the impact of the support as follows:

> *"Having someone come regularly who understood what it was like, without judgement, helped me feel more confident as a parent. The support helped me get back on my feet, build routines, and feel less alone. It made a real difference to our family."*

Professional and system impact

From a professional perspective, Home-Start's contribution is recognised as strengthening early help pathways and supporting families with increasing complexity, complementing health visiting input. In contract review correspondence, Home-Start's Chief Executive highlighted the impact of the partnership with Oxford Health, noting:

> *"The security of the contract has enabled us to plan longer-term, increase capacity and take on more complex cases. Working closely with health visiting teams has improved referral quality and helped ensure families receive the right support earlier."*

Together, these perspectives reinforce the role of Home-Start as a trusted voluntary sector partner within the Oxfordshire 0–19 service model. By providing consistent,

non-judgemental peer support alongside professional public health nursing, the partnership enhances engagement, strengthens prevention and helps reduce escalation into more intensive statutory services.

Overall, the Home-Start partnership is a valued and integral part of the Oxfordshire 0–19 service model. By combining professional public health nursing with structured, regular peer support, the service is able to increase reach, build trust with families, and improve outcomes through a preventative, strengths-based approach aligned with national evidence and local need.

2.7 WORKFORCE SUSTAINABILITY AND DEVELOPMENT

Oxford Health is committed to ensuring workforce sustainability through a robust strategy of growing its own talent, underpinned by structured induction, ongoing development, and clear pathways for career progression. This approach not only maintains service continuity but also enhances the capability and morale of the workforce, ensuring that evidence-based interventions are delivered consistently across the county.

The organisation offers an extensive career progression framework that supports all staff bands, fostering professional growth from entry-level roles through to specialist positions. Staff are encouraged to pursue further qualifications and development opportunities, with dedicated sponsorship pathways available for those seeking to advance into Specialist Community Public Health Nursing (SCPHN), particularly within Health Visiting. This framework includes mentorship, regular appraisals, and tailored learning plans, ensuring that every team member has access to the resources and guidance required to progress in their career.

To become a qualified health visitor, practitioners must obtain the SCPHN qualification, which is recognised nationally as the essential credential for this role. Oxford Health actively sponsors eligible staff to undertake this qualification, typically recruiting candidates from its existing pool of community public health nurses.

During the SCPHN training period, staff are employed by the Trust, maintaining continuity of income and service engagement while developing their skills. Throughout the SCPHN training, trainees benefit from a comprehensive support structure designed to maximise their learning and success. Clinical Education Leads provide hands-on supervision, guidance, and feedback in practice settings, ensuring

trainees can apply theoretical knowledge effectively and safely. Academic support is delivered in partnership with local universities, most notably Oxford Brookes University and Bucks New University, where trainees receive expert tuition, access to research resources, and opportunities for academic enrichment. This dual support system ensures that trainees are well-equipped both academically and clinically to meet the demands of modern health visiting.

By investing in internal recruitment and supporting existing staff to achieve the SCPHN qualification, Oxford Health ensures a steady supply of new health visitors. This 'grow your own' model reduces reliance on external recruitment, promotes organisational loyalty, and facilitates the development of a highly skilled, locally embedded workforce. As a result, the Trust is able to maintain workforce stability and deliver high-quality, needs-led services to children and families in Oxfordshire. This is also evidenced by the level of vacancy currently within the service which stands at 0.77% (1.77twe) as of March 2026.

3. MANDATED REVIEWS – PERFORMANCE OVERVIEW, LOCALITY VARIATION AND IMPROVEMENT ACTIONS

This section summarises Oxfordshire's performance against mandated Healthy Child Programme contacts and associated follow-up activity. It presents (1) **timeliness and trends** over the year to date, (2) **locality variation** to identify places/groups with lower coverage or poorer outcomes, and (3) the **impact of targeted actions** (including SPA booking changes, outreach, and place-based approaches) and what has changed as a result. Performance is monitored through near real-time dashboards and commissioner reporting, with learning and improvement actions overseen through operational and clinical governance routes.

3.1 PERFORMANCE AND TRENDS

Table 1 below provides the headline position for key mandated contacts. Oxfordshire continues to deliver strong overall coverage, with the most significant improvement opportunity being achievement of the *tighter mandated windows* (particularly NBV within 14 days and the 6–8 week review within the 42–56 day window).

Table 1 - Headlines of Mandated Contacts

Contact / measure	Q3 2025/26 position	Target	Trend / Year to date position	Locality ranges in performance (Q3 2025/26)
New Birth Visit (NBV) within 14 days	**82.24%** (1486/1807 babies)	90%	**Improving**: 79.8% (Q1) → 81.0% (Q2) → 81.8% (Q3); YTD **80.9%** (4330/5354)	75% → 92%
NBV within 30 days	**94.96%** (1716/1807 babies)	95%	YTD **94.5%** (5064/5354) – consistently high coverage	90% → 95%
6–8 week review (42–56 day window)	**84.52%** (1518/1796 babies)	93%	Stable with improving timeliness; YTD approx. **87%**	78% → 92%
Breastfeeding prevalence at 6–8 weeks	**62.53%** (1123/1796 babies)	60%	Stable and above target across year; YTD above target	N/A (countywide metric)
12-month review by 12 months	**86.57%** (1566/1809 children)	90%	Improving when extended window of 15 months applied; YTD **90.25%** (1657/1836)	83% → 91%
2–2½ year review (within 691–914 days)	**81.20%** (1529/1883 children)	90%	Locality variation is the key driver for targeted improvement. YTD **81.0%**	76% → 89%

The tables below show the performance of each of the universal contacts, providing a detailed breakdown of how well the service is meeting its key targets across different review periods. These tables include data on the new birth review, the 6–8 week review, the 1-year review, the 2-year review, and the 4-year review.

For each stage, the tables display both the percentage of reviews completed within the recommended timeframe and the actual number of cases achieved versus the total eligible population. This enables a clear assessment of progress towards annual targets and facilitates the identification of areas requiring focused improvement.

The data also illustrates where performance is close to or exceeds set targets, as well as where there are shortfalls. For instance, the 12-month review by 12 months achieved 86.7% completion in Q3, slightly below the 90% target, but improved to 90.25% when extended to 15 months. Similarly, the 2–2½ year review reached 81.70% against a 90% target.

Table 2 - New Birth Review Performance

New Birth Review	(Blank) Current Qtr. % completed within 8-14d	(Blank) Current Qtr. % completed within 8-30d	90.0 % 8-14d 95.0 % 8-30d Qtr. Target Yr2	(Blank) Current Qtr. % completed within quarter

Financial Year	Total completed within 8-14d	% completed within 8-14d	Total completed within 15-30d	% completed within 15-30d	Total completed within 8-30d	% completed within 8-30d	No. of children 30d within quarter	Total completed before 8d	Total completed after 30d	Total completed within quarter	Total declined	Total DNA	Total no review	Total completed after 30d after quarter end
2025/2026	4,330	80.9 %	734	13.7 %	5,064	94.6 %	5,354	2	48	5,114	103	89	26	22
Q1	1,413	79.8 %	268	15.1 %	1,681	95.0 %	1,770		19	1,700	26	23	14	7
Q2	1,425	81.0 %	232	13.2 %	1,657	94.1 %	1,760	1	10	1,668	43	29	10	10
Q3	1,492	81.8 %	234	12.8 %	1,726	94.6 %	1,824	1	19	1,746	34	37	2	5
Total	4,330	80.9 %	734	13.7 %	5,064	94.6 %	5,354	2	48	5,114	103	89	26	22

Table 3 - 6-8 Week Performance

6-8wk Review	84.5 % Current Qtr. % completed within 42-56d	93.0 % Qtr. Target Yr2	91.2 % Current Qtr. % completed within quarter

Financial Year	% of 6-8wk reviews completed: Total completed within 42-56d	% completed within 42-56d	No. of children 56d within quarter	Total completed before 42d	Total completed after 56d	Total completed within quarter	Total declined	Total DNA	Total no review	Total completed after 56d after quarter end
2025/2026	4,393	83.7 %	5,248	118	329	4,840	157	134	73	44
Q1	1,425	83.2 %	1,712	41	117	1,583	47	33	36	13
Q2	1,458	83.0 %	1,757	45	113	1,616	51	44	28	18
Q3	1,510	84.9 %	1,779	32	99	1,641	59	57	9	13
Total	4,393	83.7 %	5,248	118	329	4,840	157	134	73	44

Table 4 - 1yr Review Performance

1yr Review	(Blank) Current Qtr. % completed within 270-366d	90.0 % Qtr. Target Yr2	(Blank) Current Qtr. % completed within quarter

Financial Year	Percentage of 12-month development reviews completed by the time the child turned 12 month: Total completed within 270-366d	% completed within 270-366d	No. of children 366 days within quarter	Total completed before 270d	Total completed after 366d	Total completed within quarter	Total declined	Total DNA	Total no review	Total completed after quarter end
2025/2026	4,595	84.4 %	5,445	6	287	4,888	165	243	65	84
Q1	1,540	84.2 %	1,830	4	88	1,632	57	91	27	23
Q2	1,494	82.3 %	1,815	2	121	1,617	57	85	21	35
Q3	1,561	86.7 %	1,800		78	1,639	51	67	17	26
Total	4,595	84.4 %	5,445	6	287	4,888	165	243	65	84

Table 5 - 2yr Review Performance

2yr Review	(Blank) Current Qtr. % completed within 691–914d	90.0 % Qtr. Target Yr2	(Blank) Current Qtr. % completed within quarter

Percentage of 2 to 2 1/2 year reviews completed

Financial Year	Total completed within 691–914d	% completed within 691–914d	No. of children 914d within quarter	Total completed before 691d	Total completed after 914d	Total completed within quarter	Total DNA	Total declined	Total no review	Total completed after quarter end
2025/2026	4,479	81.0 %	5,531	4	225	4,708	406	259	94	64
Q1	1,531	82.1 %	1,864	3	81	1,615	100	86	45	18
Q2	1,422	79.0 %	1,799		95	1,517	149	85	22	26
Q3	1,526	81.7 %	1,868	1	49	1,576	157	88	27	20
Total	4,479	81.0 %	5,531	4	225	4,708	406	259	94	64

Table 6 - 4yr Review Performance

4yr Review	(Blank) Current Qtr. % completed F2F	(Blank) Current Qtr. % completed records review	70.0 % Completed records reviews Qtr. Target

No. of 4yr old children who have had a school readiness transition review

Financial Year	Total completed F2F	% F2F completed	Total completed school readiness transition review	% completed school readiness transition review	No. of children 50m within quarter
2025/2026	2,425	40.3 %	5,536	92.1 %	6,011
Q1	615	32.0 %	1,724	89.6 %	1,924
Q2	760	38.1 %	1,879	94.1 %	1,996
Q3	1,050	50.2 %	1,933	92.4 %	2,091
Total	2,425	40.3 %	5,536	92.1 %	6,011

To support scrutiny, a summary of **variation in localities** for each mandated contact is provided below.

New Birth Visit (NBV) within 14 days

- Best performing localities: achieved approximately 89-90% NBV completion within 14 days in Q3.
- Lowest performing localities: recorded completion rates in the region of 62-75% within the 14-day window.
- Despite this variation, NBV completion within 30 days remained consistently high across all localities, with all localities above 90%, and several exceeding 95%.

6–8 week review (42–56 day window)

- Best performing localities: achieved around 92-93% completion within the mandated window.
- Lowest performing localities: were in the range of 68-79% within the 42–56 day window.
- Locality variation reflects differences in parental choice, Did Not attend/ Was Not Brought, and workforce availability rather than completion of the review overall, which is higher when measured outside the strict window.

12-month review (by 12 months)

- Best performing localities: achieved over 93% completion by 12 months.

- Lowest performing localities: recorded completion rates of approximately 78-85% by 12 months.
- When the reporting window is extended to 15 months, all localities exceed 90%, demonstrating that the issue relates primarily to timing rather than access or engagement.

2–2½ year review (within 691–914 days)

- Best performing localities: achieved approximately 86-88% completion within the mandated window.
- Lowest performing localities: recorded completion rates of around 73–78%.
- This review shows the greatest locality variation and is therefore the main focus of targeted improvement activity described below in Section 3.3. This metric is particularly influenced by factors such as the return of mothers to work and other availability constraints, which can impact attendance and timely completion of reviews as further described below.

4-year universal review

- This is a new contact introduced as part of the new integrated 0–19 model.
- Best performing localities: are already achieving over 97% completion of school-readiness transition reviews.
- Lowest performing localities: are in the range of 85%.
- Performance is improving quarter-on-quarter as the pathway becomes fully established across all localities but overall performance remains high.

Non-Mandated Activity

Across Q1–Q3 2025/26, the service recorded 121,958 attended contacts, of which 93,734 were face-to-face, 22,104 telephone, 4,726 email and 1,396 video. In Q3 alone, there were 42,280 attended contacts (32,547 face-to-face; 7,907 telephone; 1,340 email; 486 video). This demonstrates that, alongside mandated reviews, the service is delivering substantial volume of ongoing follow-up contacts and support (Table 7).

Table 7 - Number and Type of Contacts by the service. *NB this is the whole 0-19 service not just that of 0-5 ages.*

Back to report | NUMBER OF ATTENDED CONTACTS

Financial Year	Consultation via video consultation	E-mail consultation	Face to face consultation	Other consultation medium used	Telephone consultation	Total
2025/2026	1,396	4,724	93,734	0	22,104	121,958
Q1	474	1,773	30,628	0	7,843	40,718
Q2	436	1,611	30,559	0	6,354	38,960
Q3	486	1,340	32,547	0	7,907	42,280
Total	1,396	4,724	93,734	0	22,104	121,958

Caseload profile and implications for demand and capacity

Table 8 below summarises the current caseload profile for children aged 0–4 years within the Oxfordshire 0–19 Public Health Nursing Service. The majority of children are supported at a **universal level**, with a smaller but significant proportion requiring **targeted** or **specialist** input based on identified need. This distribution reflects a proportionate universalism model, where support is escalated according to vulnerability and complexity rather than applied uniformly.

At Q3 2025/26, approximately 80% of the 0–4 caseload is supported at a universal level, with around 14–15% receiving targeted support and approximately 5–6% receiving specialist support. Universal support includes delivery of the mandated Healthy Child Programme contacts and routine health promotion activity for children and families without identified additional needs which includes weekly well-baby drop-in clinics available in all localities. Demand at this level is primarily driven by population size and birth rates and is relatively predictable.

Families move from universal to **targeted support** where vulnerabilities or emerging concerns are identified through routine contacts, assessment or self-referral. Targeted support is typically delivered through **time-limited Episodes of Care**, as described above. While targeted cases represent a smaller proportion of the overall caseload, they generate **disproportionately higher contact activity**, requiring additional visits, follow-up and coordination, and therefore have a greater impact on workforce capacity.

A smaller proportion of children are supported at a **specialist** level, reflecting more complex, enduring or multi-agency needs, including safeguarding, significant developmental concerns, long-term conditions or SEND. All specialist intervention or support is delivered by a health visitor and cannot be undertaken by skill mix staff, although cases may also be escalated to Specialist Lead Practitioners where additional expertise is required. Specialist input often involves enhanced clinical oversight, multidisciplinary working and liaison with partner agencies, and may be delivered by Senior Lead Practitioners or practitioners with further specialist training. Although numerically limited, specialist cases are resource-intensive and contribute significantly to demand on practitioner time and system coordination.

Movement between levels of support is dynamic and needs-led. Families may step up from universal to targeted or specialist support as needs emerge, and step back down following effective intervention. This fluidity is central to the service model but

creates variability in demand that is not fully visible when considering headline caseload numbers alone. Periods with a higher proportion of targeted and specialist cases can therefore place additional pressure on capacity, even where overall caseload size remains stable.

Overall, the caseload profile in Table 8 provides important context for interpreting performance and capacity. High volumes of targeted and specialist work increase contact intensity and practitioner workload, which in turn can affect the timeliness of universal contacts in specific localities or periods. Understanding this balance is critical to workforce planning, performance interpretation and the targeted improvement actions described elsewhere in Section 3.

able 8 - Caseload Numbers by Level of Service

Back to report | NUMBER OF CASELOAD RECORDED AS UNIVERSAL; TARGETED; SPECIALIST IN 0-4 YEARS

Financial Year	Universal	% Universal	Targeted	% Targeted	Specialist	% Specialist	Denominator - Caseload
2025/2026	89,333	80.0 %	16,060	14.4 %	6,289	5.6 %	111,682
Q1	29,825	80.0 %	5,281	14.2 %	2,195	5.9 %	37,301
Q2	29,800	80.0 %	5,377	14.4 %	2,078	5.6 %	37,255
Q3	29,708	80.0 %	5,402	14.6 %	2,016	5.4 %	37,126
Total	89,333	80.0 %	16,060	14.4 %	6,289	5.6 %	111,682

3.2 FACTORS AFFECTING TARGET ACHIEVEMENT AND INTERPRETATION OF PERFORMANCE

The performance data presented in **Table 1-6 above** should be interpreted alongside an understanding of how national measures are defined, locally agreed reporting arrangements with commissioners, and the operational realities of delivering community-based services at scale. Together, these factors explain why some mandated targets are not consistently achieved despite high overall coverage and improving trends.

National time-window measures versus locally agreed quarterly reporting

As shown in **Table 1**, Oxfordshire performs strongly against broader completion measures (for example, New Birth Visits within 30 days) while performance against tighter national windows (such as NBV within 14 days and 6–8 week reviews within the 42–56 day window) remains below target.

National KPIs measure delivery strictly within defined day ranges, whereas local reporting agreed with commissioners considers performance **across the whole quarter**, recognising that families may choose appointments just outside the

mandated window while still receiving timely and clinically appropriate care. This explains the visible gap in Table 1 between "within window" performance and overall completion, and is a recurring theme discussed through Contract Review Meetings.

Impact of parental choice, declines, Did Not attend/ Was Not Brought and practitioner consistency

Variation observed in **locality performance** is partly driven by parental choice, including families declining reviews or requesting appointments outside mandated windows due to work commitments, family circumstances or personal preference this is particularly relevant for the 2-2.5yr review.

For the New Birth Visit (NBV), several factors contribute to visits falling outside the national timeframe. For example, some families may still be under the care of the midwife, with the health visitor visit intentionally deferred until midwifery discharge to avoid duplication and ensure a smooth transition of care. Additionally, there are cases where the baby remains in hospital for an extended period following birth—such as admissions to neonatal units—meaning the NBV cannot take place at home within the prescribed window. Occasionally, families may temporarily relocate to stay with relatives or move out of area for additional support during the early postnatal period, making it impractical to deliver the NBV within the original timeframes. These scenarios, alongside individual family choices and practitioner consistency considerations, collectively influence service performance against mandated targets.

Did Not Attend (DNA) rates and declines also disproportionately affect reported performance. These factors sit largely outside the provider's direct control but materially reduce the percentages shown in the performance tables. This is why some localities with otherwise strong engagement show lower headline KPI performance, despite high levels of contact activity overall.

In addition, practitioner consistency is a significant but often underemphasised factor influencing whether reviews are completed within target timeframes. In some instances, the service may intentionally prioritise continuity of practitioner—such as waiting for a part-time health visitor who already knows the family and carried out the antenatal contact—to deliver the New Birth Visit, even if this means missing the strict KPI window, particularly this would be the case for families under the specialist level of service.

The relationship and trust built through consistent practitioner involvement is considered to have a greater long-term benefit for family outcomes than rigidly meeting a reporting metric. This approach reflects the service's commitment to meaningful engagement and high-quality care, recognising that the value of practitioner-family continuity may outweigh the short-term impact on headline performance figures.

Workforce capacity, Locality variation and access factors

Locality variation and access factors, demonstrate that performance across Oxfordshire is not uniform. These differences stem from a blend of population characteristics, geography, transport and access issues, and variations in service configuration, rather than any single systemic problem. The proactive use of these variations enables targeted locality improvement plans, focusing action where performance is lowest instead of applying a uniform response. In this way, the locality performance data used internally serves as diagnostic tools to inform improvement.

Further, certain localities have experienced staffing pressures due to maternity leave and long-term sickness—factors not always visible when considering headline vacancy rates alone. Such pressures significantly impact the ability to meet targets, as teams that appear fully staffed on paper may still face operational challenges if key personnel are absent for extended periods. Recognising these subtleties is essential for understanding the true capacity and resource limitations in each locality, ensuring that improvement plans address the root causes of performance variation.

As well as long term, short-term workforce capacity pressures, including sickness absence and staff turnover, can affect the timeliness of service delivery in specific areas. Additionally, performance data in Tables 1–6 is sensitive to the timing of recording and coding: if a review is completed but not fully documented within the reporting period, this can temporarily suppress performance figures. Such factors are within the provider's control and are actively addressed through ongoing operational and administrative improvement efforts.

Deep dive into "no review" cases – explaining the residual gap

To support interpretation of the locality variation shown in Tables 2–6, a focused deep-dive analysis was undertaken in Q3 2025/26 for the **2–2½ year review**. This review was selected to better understand the drivers behind the residual gap between overall completion and achievement within the mandated national window

as it is also an Oxfordshire target of improvement as part of the national good level of development government standard.

The deep dive examined all cases recorded as **"no review"** at the point of extraction and categorised the reasons for non-completion, distinguishing between factors **within the provider's control** and those **outside the provider's control**. This analysis provides important context for understanding both the scale of improvement potential and the realistic limits of performance improvement based on provider action alone.

Key findings from the analysis were as follows:

- **Total 'no review' cases identified:** 58 cases (3% of 1,883 reviews due).
- **Factors not within Oxford Health's control:**
    - 31 cases (approximately 1.64% of reviews due).
    - These primarily related to parental choice, families declining the review, repeated DNAs, or child/family sickness.
- **Factors within the provider's control:**
    - 27 cases (approximately 1.4% of reviews due).
    - These related mainly to administrative or capacity-related issues, such as booking delays or recording lag.
- **Quantified improvement potential:**
    - If all cases within the provider's control had been completed within the mandated window, Q3 performance would have increased from **81.70% to 82.63%**.
- **Interpretation:**
    - Even full resolution of all 'within gift' cases would result in a **modest overall uplift**, demonstrating that DNAs, declines and parental choice have a disproportionate impact on headline KPI performance.

This analysis reinforces that locality variation and under-achievement against the national window are not driven by systemic access failure, but by a combination of timing, family choice and a relatively small number of administratively resolvable cases. It also supports the service's proportionate improvement approach, focusing effort where it can have the greatest impact without over-medicalising families who have actively chosen not to engage.

3.3 DATA DRIVEN IMPROVEMENT AND IMPACT

Performance improvement within the Oxfordshire 0–19 Public Health Nursing Service is driven through a structured, data-led approach that combines countywide operational changes with targeted locality-level actions. The performance tables and locality breakdowns presented in Sections 3.1 and 3.2 are actively used as improvement tools rather than solely as reporting outputs, enabling the service to prioritise action where variation is greatest and to monitor the impact of changes over time.

Countywide improvement actions

The most significant countywide action to improve timeliness of mandated contacts has been the introduction of **SPA-led booking** for key reviews, including New Birth Visits, implemented from January 2026. This change was informed directly by performance data showing slippage against tighter national time windows despite high overall completion rates (as illustrated in Table 1). Centralised booking through SPA has improved consistency of offer, reduced variation in booking practice between localities, and strengthened oversight of appointments approaching the mandated window. Early data shows a continued upward trend in NBV delivery within 14 days, supporting the direction of travel seen across Q1–Q3.

In parallel, the service has strengthened **reminder and communication processes**, including increased use of AccuRx messaging (see section 4.4) and clearer appointment information, to reduce avoidable DNAs. These actions directly respond to the themes identified in the deep-dive analysis of "no review" cases and are intended to improve the figures presented in both the headline and locality-level tables.

Locality-specific improvement actions

Locality variation shown in Section 3.2 is used to trigger **local improvement plans**, which are reviewed through operational management and shared with commissioners via Contract Review Meetings. Rather than applying uniform solutions, locality teams are supported to tailor actions based on their specific population, geography and access challenges. Examples of locality-level actions include adjustments to clinic configuration, targeted follow-up of missed appointments, and flexible use of outreach approaches where clinic attendance is a barrier. These actions are designed to address the lower-performing localities identified in the tables, while sustaining performance in areas already performing well.

Focus on access, engagement and equity

Performance data is triangulated with service-user feedback and access insight to ensure improvement actions address underlying barriers rather than solely focusing on numerical targets. Feedback reviewed has informed changes such as improving clarity of appointment information, reviewing clinic locations where travel or parking is a barrier, and reinforcing messaging that families can attend alternative local clinics where appropriate. These actions support equitable access and are particularly relevant to localities where DNAs or declines contribute disproportionately to lower KPI performance.

Targeted follow-up of declines and DNAs

The Q3 deep-dive analysis of "no review" cases has provided a clearer understanding of which elements of under-performance are within the provider's control and which are not. This analysis has directly informed improvement actions, including prioritising earlier contact with families who initially decline or do not attend, refining escalation routes within SPA, and strengthening administrative oversight of follow-up activity. While the analysis demonstrates that resolving all "within gift" cases would result in a modest overall improvement, it has enabled the service to focus effort proportionately and avoid unintended consequences, such as over-medicalising families who have actively chosen to decline contact.

Monitoring impact and sustaining improvement

The impact of improvement actions is monitored through routine performance dashboards, locality reviews and Contract Review Meetings, ensuring that changes are tracked against the same measures presented in this report. This creates a clear feedback loop between data, action and oversight. Where improvement is demonstrated, actions are embedded as standard practice; where variation persists, further targeted intervention is considered. This approach ensures that the service continues to improve performance against national standards while maintaining a family-centred, proportionate model of care.

4. DIGITAL – HOW DIGITAL SUPPORTS SERVICE DELIVERY

4.1 DIGITAL PRINCIPLE: "SUPPORTING, NOT REPLACING" FACE-TO-FACE

Digital technology is increasingly utilised within the Oxfordshire 0–19 Public Health Nursing Service to enhance access, timeliness and consistency across service delivery. However, it remains fundamental that digital tools are designed to support—rather

than replace—the provision of face-to-face care. This guiding principle ensures that families continue to benefit from direct clinical interaction, with digital solutions complementing and expanding rather than substituting the traditional healthcare model.

The service's activity profile for Q3 25/26 demonstrates that face-to-face consultations continue to be the predominant method, accounting for 77.74% of all recorded contacts, whilst telephone consultations represent 18.91%, email 2.18%, and video 1.17%. These figures highlight the sustained prioritisation of in-person engagement, particularly for clinically mandated reviews, where direct assessment and support are essential.

The commissioned model is purposefully structured to allow a blend of delivery methods, ensuring flexibility and responsiveness to varying needs where it is considered both good and safe practice. Digital channels are harnessed to facilitate administrative efficiency, rapid communication, and improved reliability, such as through appointment reminders and information sharing.

At the same time, the service continually reviews feedback and performance data to ensure that digital approaches do not inadvertently create barriers or diminish the quality of clinical care. By maintaining a strategic balance between digital and face-to-face modalities, the service is able to optimise accessibility and consistency for families, while upholding the clinical standards and personalised support that underpin its model of care.

4.2 CHATHEALTH / PARENTLINE – RAPID ACCESS AND REDUCED BARRIERS

ChatHealth is an innovative digital messaging platform designed to provide families and young people across Oxfordshire with confidential access to timely health advice and support. The system allows users to communicate directly with Public Health Nursing staff via secure text messaging, facilitating early intervention and seamless escalation into face-to-face care pathways when necessary.
One of the key advantages of ChatHealth is its flexibility: messages can be sent at any time, 24/7, making it highly accessible for users regardless of their schedules. The service aims to respond to all messages within one working day, ensuring that timely support is provided. By offering a discreet and accessible means of engagement,

ChatHealth helps to remove barriers around seeking support, particularly for sensitive topics or when attending clinics in person may be challenging. The platform features clearly defined governance and quality assurance processes, including automated response messages, staff notifications, and robust authentication protocols, ensuring both the safety and reliability of communications. ChatHealth is available across a variety of age groups, supporting Parentline 0–5, as well as dedicated channels for children aged 5–11 and 11–19, thus catering to the distinct needs of different populations.

Figure 2 - Visual overview of ChatHealth Process

During Q3 25/26, ChatHealth facilitated a substantial volume of engagement, with 15,125 messages received through Parentline 0–5, 397 for the 5–11 age group, and 444 for the 11–19 channel. These figures are summarised in Table 9, which provides a detailed breakdown of ChatHealth activity and highlights the key role the platform plays in extending rapid access to advice, support, and feedback from families and young people throughout Oxfordshire.

Table 9 - Chat Health Messages Received

Financial Year	Number of messages received through digital platform Chat Health			
	a. Number of messages received through digital platform Chat Health for 0-5 years	b. Number of messages received through digital platform Chat Health for 5-11 years	c. Number of messages received through digital platform Chat Health for 11-19 years	Total
⊟ **2025/2026**	46,208	1,416	970	48,594
Q1	15,637	518	282	16,437
Q2	15,446	501	244	16,191
Q3	15,125	397	444	15,966
Total	46,208	1,416	970	48,594

Analysis of Q3 Parentline 0–4 activity confirms that the top three reasons for messages sent were appointment queries, constipation, and general development. These themes underline the service's role as a trusted first point of contact for parents seeking advice on both routine and more specific health concerns. Chat Health 0–4 Parentline continues to be the most widely accessed service of its kind across NHS Trusts nationwide, demonstrating its value in supporting families with young children.

Oxfordshire data demonstrates that the 0–4 and 5–11 Parentlines, as well as the 11–19 ChatHealth line, have all maintained performance levels consistently above the national average. This sustained high usage across all age groups highlights the platforms' growing relevance and effectiveness in addressing the evolving needs of parents, adolescents, and young people—offering timely support, reassurance, and expert advice when it is needed most. National benchmarking further underscores this success: using the ChatHealth standard metric of conversations per 100,000 service users (Oct 2024–Aug 2025), Oxfordshire's 0–4 Parentline averages 25.90 compared to the national average of 7.19 (over 3.6 times higher).

The 5–11 Parentline averages 0.801, nearly 2.7 times the national figure of 0.299, while the 11–19 service averages 0.462 compared to the national average of 0.267 (1.7 times higher). These results are consistent with local reporting which confirms that Oxfordshire's 0–4 Parentline is the most widely accessed ChatHealth service nationwide, and that the county's ChatHealth offer continues to outperform national averages across both the Parentline and young people's services.

In recognition of its innovative approach, the Oxford Health Chat Health team was nominated among the top three nationally for a digital innovation award in the past year. This accolade highlights the team's commitment to excellence and ongoing leadership in the development of accessible, responsive digital health solutions for families and young people.

The service is actively strengthening ChatHealth governance and quality assurance. Provider drafting describes ChatHealth away days and associated work to improve standard operating procedures and celebrate achievements (including recognition of the ChatHealth team). From a patient safety perspective, a formal ChatHealth clinical safety case describes inbuilt safety features including automated “bounce back” messages in and out of hours, staff notifications, unique staff logins and multi-factor authentication, with clear signposting to urgent services when the service is closed.

4.3 WEBSITE AND DIGITAL INFORMATION – IMPROVING HEALTH LITERACY AND SELF-MANAGEMENT

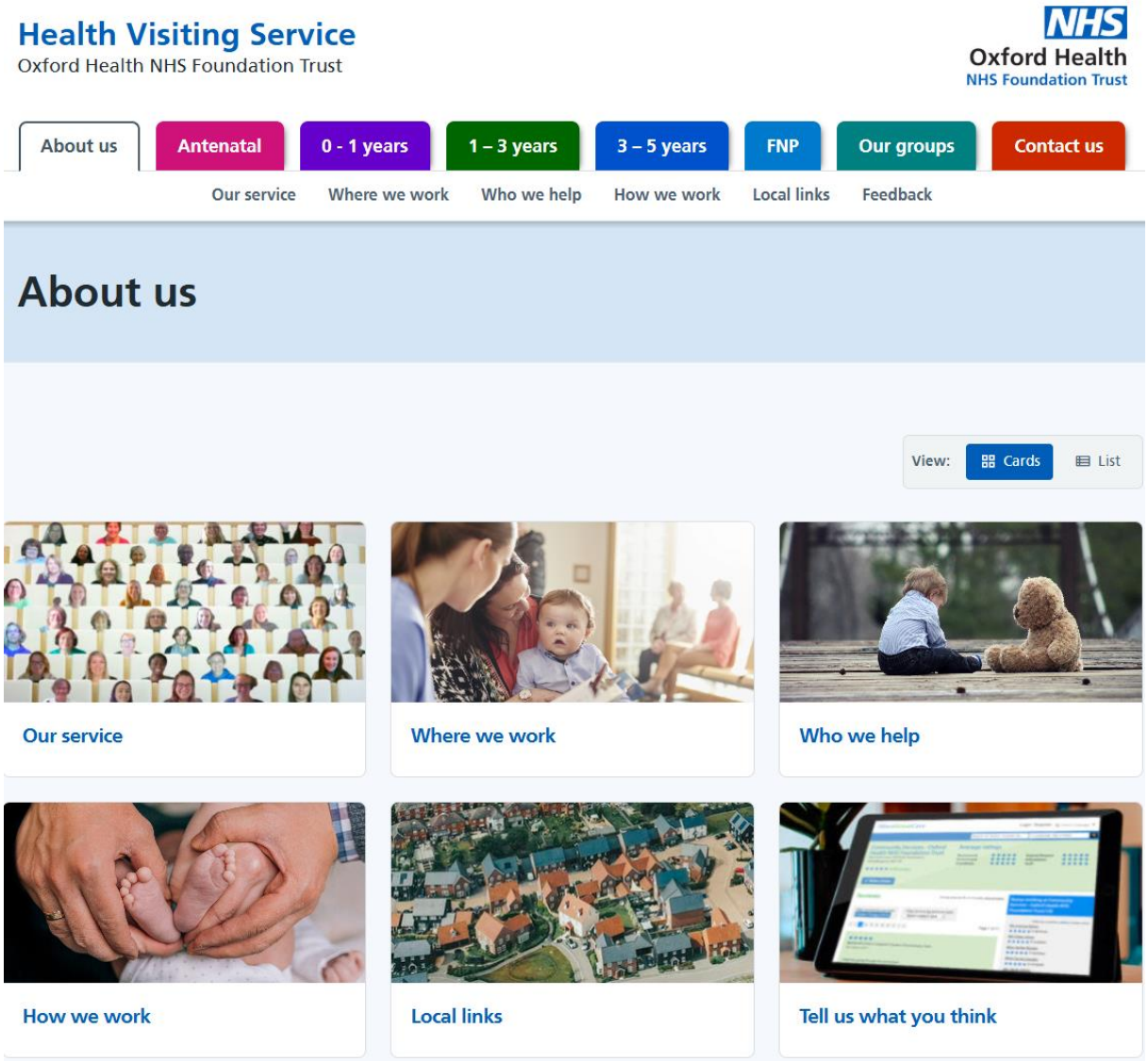
The Oxfordshire 0–19 website serves as a comprehensive digital hub, offering families and professionals a wide range of evidence-based resources and clear signposting to support health and wellbeing across childhood and adolescence. The site’s Health Visiting section, in particular, has been prioritised for update to ensure that parents and carers of young children can easily access reliable advice on topics such as child development, feeding, sleep, and common health concerns. Regularly updated with the latest guidance, the section provides downloadable leaflets, interactive tools, and practical tips, enabling users to make informed decisions about their children's care.

Usage data for the website underscores its growing importance and reach: since January 2025, the Health Visiting pages have attracted 48,600 unique visitors—a substantial 40% increase compared to the previous period—while overall page views have soared by 48% to 136,000. These figures indicate not only heightened awareness and engagement with the service, but also confirm that families are turning to the site as a trusted first point of contact for health information and support. The rise in visitors and page views suggests successful efforts in promoting the website and improving its accessibility.

Recent enhancements to the site have further bolstered its usability and inclusivity. Multilingual functionality enables users who speak languages other than English to access key information, supporting Oxfordshire’s diverse population. Improved mobile usability ensures that families can engage with the service on smartphones and tablets, reflecting modern digital behaviours and reducing barriers to access. Together, these advancements demonstrate a proactive commitment to digital inclusion and health literacy, ensuring that all families—regardless of background or device preference—can benefit from reliable, accessible health resources online.

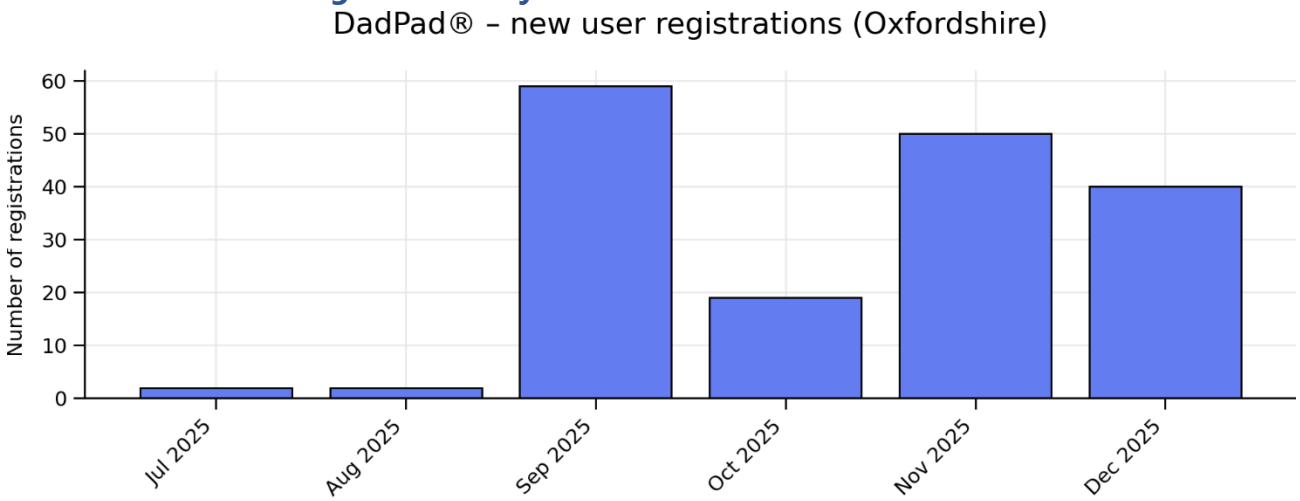
To ensure families have access to trustworthy information, the Oxfordshire 0–19 website provides direct links to national, reputable sources of health advice, such as the NHS website. In addition, the site is integrated with the Healthier Together platform, which offers evidence-based guidance specifically tailored for parents, carers, and young people of Oxfordshire. These partnerships and signposts reinforce the website's role as a gateway to reliable, up-to-date information, supporting families in making well-informed decisions about their health and wellbeing.

Figure 3 - Screenshot of the Website Homepage



The service also promotes father-inclusive digital support through **DadPad®**. Oxfordshire dashboard data shows 63 new registrations in Q3 2025 (Jul–Sep) and 109 in Q4 2025 (Oct–Dec) — 172 registrations across the two quarters — demonstrating growing utilisation of father-focused support.

Table 10 - DadPad Registrations by Month



The service's optimisation workstreams also recognise that digital content must be clear and accessible, with ongoing work to improve navigation and to strengthen how the service is described to families and professional stakeholders.

4.4 ACCURX AND APPOINTMENT COMMUNICATION – REDUCING ADMIN BURDEN AND IMPROVING RELIABILITY

AccuRx is a digital communication platform that is extensively utilised across the Oxfordshire 0–19 service to streamline appointment management and enhance the reliability of contact with families. Through the Single Point of Access, AccuRx facilitates the sending of appointment notifications, reminders, and clinician messages directly to parents and carers, making it easier for them to keep track of upcoming appointments and key information. All communications sent via AccuRx are seamlessly uploaded into EMIS (the Trust's electronic records system), ensuring that records are comprehensive and up to date, which supports continuity of care and robust documentation practices.

The system incorporates well-defined opt-in and opt-out procedures, allowing families to exercise choice over how they receive digital communications. This approach respects individual preferences and supports data protection requirements. Furthermore, there is a planned development to introduce further feedback mechanisms following appointments, enabling families to share their experiences and helping the service to continually improve its provision.

By automating routine appointment communications and facilitating secure clinician messaging, AccuRx significantly reduces administrative workload, minimises missed appointments, and improves overall service efficiency. Its integration with EMIS ensures that all interactions are accurately recorded, supporting audit capabilities and safeguarding. In addition, AccuRx enhances accessibility and engagement by providing timely, clear, and direct communication, enabling families to feel informed and supported throughout their care journey. These improvements ultimately contribute to better health outcomes and a more responsive, patient-centred service.

4.5 EMIS, TEMPLATES, DASHBOARDS AND SYSTEM INTEGRATION

EMIS is the core clinical record system used across the Oxfordshire 0–19 Public Health Nursing Service and plays a central role in enabling safe, efficient and optimised service delivery. The system supports consistent recording, clinical decision-making, safeguarding assurance and performance management across universal, targeted and specialist pathways.

Optimised service delivery through structured EMIS templates

Standardised EMIS templates are used across the service for mandated Healthy Child Programme contacts, safeguarding activity, Episodes of Care and outcome recording. These templates support practitioners to capture key information consistently at the point of care, reducing unwarranted variation in documentation and ensuring that clinical assessments, professional judgement and actions are clearly recorded. The use of structured templates improves data quality, supports audit and learning, and enables timely escalation where concerns are identified. Importantly, it also reduces duplication, supports skill-mix working, and ensures that information follows the child and family seamlessly as they move between levels of service or across the 0–19 pathway.

Access to the full GP record within EMIS

EMIS enables practitioners to view the full GP record directly within the clinical system, supporting safe, informed and joined-up care. Access to GP records allows Health Visitors, School Health Nurses and Family Nurses to understand the wider health context for children and families, including relevant medical history, long-term conditions, medications and recent primary care contacts.

This integration supports more effective clinical decision-making, reduces the need for families to repeat information, and strengthens collaboration between community

public health services and primary care. It is particularly important for safeguarding, complex needs and continuity of care.

Importantly, the integration with the GP record is reciprocal: not only can public health nursing practitioners access GP-held information, but GPs are also able to view relevant entries and updates made by the 0–19 service within EMIS. This two-way visibility ensures that both community and primary care professionals are kept fully informed, enabling truly joined-up and coordinated care for children and families.

To support understanding of the practical impact of EMIS integration on frontline delivery, the following anonymised feedback reflects themes consistently raised by practitioners through supervision, training sessions and service optimisation work:

> *"Having access to the full GP record within EMIS has made a real difference to how safely and confidently we work. We no longer rely on families repeating their story, and we can see medications, recent GP contacts and safeguarding flags immediately. It has reduced duplication, improved the quality of our assessments and helped us make clearer, quicker decisions about next steps for families."*

TOBI dashboards and performance oversight

TOBI (Trust Online Business Intelligence) provides near real-time dashboards that draw directly from EMIS data, enabling comprehensive oversight of service activity and performance. TOBI dashboards are used to monitor mandated review timeliness, caseload profiles, Episodes of Care, locality variation and commissioner-specific reporting requirements.

These dashboards support operational teams and senior leaders to identify emerging trends, understand variation, and target improvement action where it will have the greatest impact. The integration between EMIS and TOBI ensures transparency, supports routine governance and Contract Review Meetings, and enables the service to move from retrospective reporting to proactive, data-driven management.

Together, EMIS and TOBI form an integrated digital backbone for the Oxfordshire 0–19 Public Health Nursing Service. They support high-quality clinical practice, effective safeguarding, efficient use of workforce capacity and robust performance management, while enabling commissioners and the provider to share a consistent, trusted view of activity and outcomes across the system.

4.7 NEXT STEPS IN DIGITAL DEVELOPMENT

The Oxfordshire 0–19 Public Health Nursing Service will continue to develop its digital offer in a planned, proportionate and evidence-led way, aligned to clinical safety, information governance. A key underpinning of future digital development is a commitment to **co-production**, ensuring that digital solutions are shaped with families, young people and practitioners, rather than imposed upon them.

Co-production as a core design principle

Future digital developments will be informed through co-production with parents, carers and young people, alongside frontline practitioners. Feedback and insight gathered through ChatHealth, service-user feedback mechanisms, engagement events and routine governance forums will be used to test, refine and prioritise digital changes. This approach ensures that digital tools are accessible, inclusive and responsive to real-world need, and that they support trusted relationships rather than creating additional barriers to engagement.

Proactive digital communication and health promotion

Planned developments include extending the use of digital channels for proactive health promotion messaging, building on existing AccuRx and ChatHealth infrastructure. This includes the planned introduction of batch health-promotion messages from Spring 2026, targeted at key Healthy Child Programme milestones and seasonal priorities. Content will be co-produced where appropriate and clinically signed off, reinforcing evidence-based advice, signposting families to support, and reducing avoidable demand by providing timely and consistent information at scale. All messaging will operate within clear governance, with opt-out arrangements and safeguards to ensure communications remain proportionate and appropriate.

Strengthening digital engagement and reach

The service is also developing additional family-facing digital engagement routes, including a planned CYP 0–19 social media presence from Summer 2026. This work is intended to improve reach to families who may not routinely engage through traditional service routes, particularly around early years development, emotional wellbeing and school readiness. Content development will be informed through co-production and professional oversight, with clear moderation processes, safeguarding escalation routes and Trust governance in place to ensure safe and responsible use.

Continued optimisation of digital access routes

Ongoing work will continue to optimise existing digital access routes, including ChatHealth, AccuRx and the 0–19 website, ensuring information is clear, consistent and easy to navigate across platforms. Co-produced feedback from families and young people will be used to refine digital content, improve clarity around access routes, and reduce duplication or unnecessary contact. Digital developments will complement SPA processes, supporting earlier triage, clearer signposting and smoother transitions between universal, targeted and specialist pathways.

Data, oversight and continuous improvement

All digital developments will be supported by robust monitoring through EMIS and TOBI dashboards, enabling the service to track usage, understand variation and assess the impact of digital activity on access, demand and workforce capacity. Learning from implementation will be routinely reviewed through governance routes and used to refine digital approaches over time, ensuring continuous improvement. Together, these planned developments reflect a measured, co-produced and sustainable approach to digital innovation. They aim to strengthen prevention and early help, improve equity of access, and support staff to deliver high-quality care efficiently—while ensuring that digital tools enhance professional judgement, relational practice and partnership with families and young people.

5. SAFEGUARDING – NATIONAL GUIDANCE AND CURRENT OXFORDSHIRE PRACTICE

5.1 NATIONAL GUIDANCE AND POLICY CONTEXT

Safeguarding practice within the Oxfordshire 0–19 Public Health Nursing Service is underpinned by a clear and robust framework of **national statutory guidance, professional policy positions and local safeguarding arrangements**, ensuring that practice is lawful, consistent, proportionate and child-centred.

At a national level, safeguarding practice is governed by ***Working Together (2023)*** the statutory guidance that sets out how organisations and agencies must work together to help, support and protect children. This guidance places a clear expectation on health services, local authorities and police to work collaboratively, to share information appropriately, and to ensure that safeguarding responses are timely, proportionate and focused on the needs of the child. It also emphasises the importance of early help, multi-agency decision-making and clear accountability for

safeguarding arrangements. Practice within the Oxfordshire 0–19 service is aligned to this guidance, including expectations for attendance and contribution to strategy discussions, child protection conferences and multi-agency planning, where there is an identified health need.

Safeguarding practice is further informed by the Children Act 1989 and Children Act 2004, which establish statutory duties for agencies to safeguard and promote the welfare of children, and by the Healthy Child Programme (HCP), which embeds safeguarding as a core thread across universal, targeted and specialist public health nursing practice. The HCP reinforces the principle of proportionate universalism, ensuring that all children receive a universal offer, with additional support provided where vulnerability or risk is identified.

In recognition of the increasing complexity of safeguarding demand nationally, Oxfordshire's approach is also aligned to the Joint Policy Position: *The Safeguarding Role of Public Health 0–19 Services*[1] (November 2024), published by the Institute of Health Visiting (iHV), the School and Public Health Nurses Association (SAPHNA) and the Association of Directors of Public Health (ADPH).

This policy position provides important clarity on the role of Health Visitors and School Health Nurses in safeguarding, emphasising that safeguarding is a core responsibility of 0–19 services, but must be delivered in a way that does not displace their wider public health and preventative function. The position statement reinforces the principle that the "best placed practitioner" should contribute to safeguarding activity, and that health professionals should not default into roles where there is no identified health need.

At a local level, safeguarding practice operates within the arrangements of the Oxfordshire Safeguarding Children Partnership (OSCP), which brings together the local authority, health and police as statutory safeguarding partners. Local multi-agency procedures, thresholds and escalation routes are set through OSCP guidance and are embedded within Oxfordshire 0–19 service Standard Operating Procedures. These arrangements ensure consistency in how concerns are identified, escalated and managed, and provide assurance that safeguarding practice is aligned across agencies.

[1] The-Safeguarding-Role-of-Public-Health-0-19-services-FINAL-VERSION-28.10.24.pdf

Within Oxford Health NHS Foundation Trust, safeguarding practice is further underpinned by Trust-wide safeguarding children policies and supporting procedures, which set out expectations for information sharing, documentation, supervision, training and escalation. These policies are operationalised locally through 0–19 service SOPs, including safeguarding triage processes, SPA workflows and clear expectations for recording and professional accountability.

Together, these national and local policies and guidance provide a strong and coherent framework for safeguarding practice in Oxfordshire. They support a model that is child-centred, proportionate and multi-agency, balancing statutory safeguarding responsibilities with the delivery of effective public health and early intervention services, and providing clear assurance to partners and scrutiny bodies that safeguarding practice is both robust and evidence-based.

5.2 CURRENT PRACTICE: OPTIMISING ROLES, BALANCE, AND DEMAND MANAGEMENT

Safeguarding practice within the Oxfordshire 0–19 Public Health Nursing Service is delivered in a way that is safe, proportionate and focused on identified health need, in line with national guidance and local safeguarding arrangements. A key principle underpinning current practice is the allocation of the "best placed practitioner", ensuring that safeguarding activity is undertaken by the professional with the most relevant and current involvement with the child and family.

Safeguarding representation is determined through structured decision-making that considers the nature of the safeguarding concern, the child's health needs and the level of recent service involvement. Where there is an identified health need, a 0–19 practitioner contributes actively to multi-agency safeguarding processes, including strategy discussions, child protection conferences and core groups. Where there is no recent health involvement and no unmet health need, the service provides a standardised written response to multi-agency meetings, clearly setting out the rationale for non-attendance and the route for re-engagement should health needs be identified. This approach ensures statutory safeguarding responsibilities are met while avoiding unnecessary duplication of professional input.

Safeguarding demand and its impact on service capacity are explicitly recognised through the 0–19 risk register and governance processes. Increasing safeguarding

workload is acknowledged as having the potential to impact both universal service delivery and workforce wellbeing, particularly where health involvement does not add value to outcomes for the child. To support proportionate and consistent decision-making, the service maintains a safeguarding escalation log, which is used to record and track issues arising from multi-agency safeguarding processes that create operational risk or inefficiency.

The escalation log captures themes such as late or missing notifications of meetings, changes to meeting times without notice, absence of minutes or outcomes following meetings, and repeated follow-up required by health teams to obtain essential information. These issues are reviewed regularly through 0–19 safeguarding oversight arrangements and escalated where appropriate via senior operational and system-level forums. This provides a clear audit trail, supports constructive challenge within the partnership, and enables the service to highlight where safeguarding processes are impacting disproportionately on frontline capacity.

In parallel, the service operates regular 0–19 safeguarding oversight meetings to review requests for representation, agree the most appropriate practitioner to attend, and ensure safeguarding activity is allocated transparently and equitably across locality teams. The use of both the escalation log and structured oversight meetings enables safeguarding demand to be actively managed rather than absorbed informally by individual practitioners or teams.

This approach is consistent with the Joint Policy Position on the Safeguarding Role of Public Health 0–19 Services, which emphasises that health professionals should not default into safeguarding roles where there is no identified health contribution, and that public health nursing capacity must be protected to sustain prevention and early intervention. By applying these principles in practice, the Oxfordshire 0–19 service seeks to balance its statutory safeguarding duties with its wider public health role, ensuring that safeguarding activity is purposeful, proportionate and focused on improving outcomes for children and families, while maintaining transparency about system pressures and partnership dependencies.

5.3 SAFEGUARDING PROCESSES: SPA TRIAGE, URGENT TIMEFRAMES AND CONSISTENT RECORDING

A dedicated safeguarding process standard operating procedure sets out how safeguarding communications are triaged through a separate safeguarding inbox,

prioritising Strategy Meetings and Initial Child Protection Conferences due to short timescales, requiring urgent forwarding to locality and Locality Team Leaders, and requiring documentation of actions in EMIS. This standard operating procedure also covers Red multi-agency safeguarding hub (MASH) referrals, uploading of outcomes/minutes, and escalation routes.

This provides assurance that safeguarding work is supported by structured administrative controls, escalation pathways and consistent recording expectations (rather than being dependent on informal processes).

5.4 TRAINING, SUPERVISION AND SAFEGUARDING COMPETENCE

Safeguarding competence is supported through training and supervision structures which are described in more detail below under the quality section.

6. SURVEYS / INSIGHT

6.1 SERVICE USER INSIGHT (SURVEYS, COMPLAINTS, COMPLIMENTS)

The Oxfordshire 0–19 Public Health Nursing Service gathers service-user insight through a range of structured and routine mechanisms, including **IWantGreatCare (IWGC)**, ChatHealth feedback, Microsoft Forms used following group sessions and targeted interventions, and direct feedback gathered during clinical contacts. These sources are triangulated with performance and safety data and reviewed through established governance arrangements to ensure that learning is translated into service improvement.

IWantGreatCare (IWGC) feedback and themes

IWGC feedback demonstrates consistently positive experiences of care across the 0–19 service. During the most recent reporting period of February 2026, **77 IWGC responses were received** (including Family Nurse Partnership), with the **overwhelming majority rated positively**. Only **three responses scored 2 or below**, relating to non-attendance at an appointment and delays in re-booking; these were reviewed and followed up locally by locality team leaders.

Qualitative feedback highlights strong themes around reassurance, professional relationships and feeling listened to. Illustrative examples include:

"I was so worried about my little boy, but no-one was listening. Then a health visitor walked through my door. It was like an angel had arrived. She listened, she knew our family, the history and my own difficulties. I immediately felt reassured."

"I want to thank my health visitor for the amazing support she gave me. She made me feel truly heard and understood at every visit and every tip she gave made a difference."

"The appointment was very relaxed and the health visitor very friendly – she put both me and my child at ease."

Feedback also reflects the value families place on group-based and preventative support:

"We really enjoyed the group development review. It was lovely to see my child play and interact with other children his age."

"The early days course was so informative, delivered in a relaxing environment and a good opportunity for networking with other new mums going through similar things."

'You Said, We Did' – learning and improvement

Where feedback has identified areas for improvement, this has been addressed through a structured **'You Said, We Did'** approach, providing transparency about actions taken. Examples include:

You said: "The appointment felt like a tick-box exercise, the person did not really engage with my child and the questionnaires were not properly explained."
We did: Reviewed Ages and Stages Questionnaire practice with Community Public Health Associate leads, introduced retraining and strengthened supervision to improve the quality and consistency of reviews.

You said: "We have always felt supported when coming to lunchbox, but the room where we weigh our baby is small and often there is someone else there."
We did: Relocated the drop-in clinic to a venue with more space, enabling greater privacy and improved opportunities for 1:1 discussion.

Where actions cannot be taken immediately, this is communicated transparently, with rationale recorded and reviewed through governance routes.

Complaints and concerns

Formal complaints relating to the 0–19 service remain very low. Between 1 April 2025 and 31 December 2025, the service recorded 1 formal complaint. Complaints within the Oxfordshire 0–19 Public Health Nursing Service are managed in line with the NHS Complaint Standards, which promote proportionate, timely responses and early resolution wherever possible. Concerns raised by families are categorised according to complexity and risk, with clear expectations for response timeframes.

Under this framework, concerns are handled as follows:

- **Rapid Resolution Concern**
  Concerns that can be resolved quickly through explanation, reassurance or immediate action are managed as rapid resolutions. These are typically responded to and closed within 3 working days, often through direct contact with the practitioner or locality team leader. This approach supports timely reassurance and prevents unnecessary escalation.

- **Early Resolution Concern**
  Where a concern requires some additional review or coordination but does not meet the threshold for a formal investigation, it is managed through early resolution. Early resolution responses are normally completed within 10 working days, with a focus on understanding the concern, providing a clear explanation and agreeing any immediate actions.

- **Formal Complaint**
  A concern is managed as a formal complaint where issues are more complex, involve multiple elements of care, or where early resolution has not been possible.
  Formal complaints are acknowledged promptly and responded to within an agreed timeframe, typically up to 25 working days, with extensions agreed with the complainant where required.

This structured approach ensures that concerns are addressed proportionately and compassionately, with the majority resolved quickly and close to the point of care. It also reflects national expectations that complaint handling should focus on learning

and improvement, rather than defaulting to lengthy investigative processes where these add little value.

Learning from all concerns and complaints—regardless of category—is reviewed alongside other sources of service user insight, including feedback, compliments and incident themes. This ensures that issues identified through complaints contribute to service improvement, while maintaining transparency and assurance for families and system partners.

Accolades and compliments

Positive experience is also reflected through formal accolades and compliments. In Q3 alone, the service received 23 accolades, including 12 recognising the wider 0–19 service and 11 relating specifically to the Family Nurse Partnership. These accolades consistently highlight compassion, professionalism and the impact of sustained support for families.

Examples of accolade feedback include:

- Praise for practitioners who "went above and beyond" to support families during challenging periods.
- Recognition of staff who provided calm, clear advice that helped parents feel confident and supported.
- Positive feedback about group sessions that increased parental confidence and peer support.

ChatHealth feedback

ChatHealth feedback provides additional insight into user experience across the 0–4 Parentline, 5–11 Parentline and 11–19 services. Feedback consistently highlights:

- Speed and reliability of responses
- Clear, reassuring advice
- Feeling listened to and supported, particularly for sensitive or anxiety-provoking concerns

Service users frequently describe ChatHealth as convenient and accessible, valuing the ability to seek advice discreetly and receive timely guidance that supports decision-making and, where needed, escalation into face-to-face care.

Overall assurance

Taken together, IWGC feedback, low complaint levels, high numbers of accolades and

positive ChatHealth experience provide strong assurance that families experience the Oxfordshire 0–19 Public Health Nursing Service as **supportive, responsive and professionally delivered**. Service-user insight is routinely reviewed at service and Children and Young People Senior Management Team level and is used to inform service development, reinforce good practice and support workforce recognition, demonstrating a culture of continuous learning and improvement.

6.2 WORKFORCE SURVEY / STAFF INSIGHT

Staff insight for the Oxfordshire 0–19 Public Health Nursing Service is gathered primarily through the **NHS Staff Survey**, supplemented by structured local engagement and listening activity. Together, these sources provide a rounded view of workforce experience, morale and engagement, and are used alongside workforce, quality and performance data to inform leadership focus and service improvement.

Staff survey overview and context

The March 2026 staff survey comparison for the 0–19 service demonstrates a mixed but improving picture. Across many domains, responses show positive movement compared to the previous year, reflecting increased stability following the major service reconfiguration and the embedding of the integrated 0–19 model. Staff continue to report a strong sense of purpose in their work, with consistently high scores relating to making a difference to children, young people and families, and positive relationships within teams. However, the data also highlights ongoing pressures associated with workload, pace of change and capacity, which are consistent with national findings across community services and with the wider context described elsewhere in this report.

Key themes from the staff survey

Engagement and commitment

Staff report high levels of enthusiasm for their roles and strong attachment to their teams. Many indicators relating to pride in work, teamwork and respect between colleagues show improvement year-on-year, suggesting that the integrated locality model has strengthened day-to-day team relationships and peer support.

Leadership and line management

Responses relating to immediate line managers are generally positive, particularly in relation to approachability, care for staff wellbeing and openness to challenge. This

aligns with the leadership visibility and locality-based management arrangements, including increased senior clinical presence in teams and regular engagement forums.

Workload and capacity

As reflected elsewhere in this paper, workload pressure remains a key challenge. Survey responses relating to staffing levels, time pressures and ability to meet conflicting demands remain lower than organisational averages. These findings reinforce the narrative that performance and workforce wellbeing are influenced not only by establishment numbers, but by caseload complexity, safeguarding demand and targeted work, which place disproportionate pressure on clinical time.

Wellbeing and fatigue

While there has been some improvement in measures relating to work–life balance and support for flexible working, indicators associated with emotional exhaustion and fatigue remain an area of concern. These findings are consistent with the period of sustained change and demand experienced over the past 12–18 months and are reflected in the workforce risks outlined later in this report.

Speaking up and safety culture

The majority of staff report feeling able to raise concerns and that colleagues treat one another with respect. However, confidence that concerns will always be addressed remains an area for continued focus. This aligns with the service's use of multiple feedback and escalation routes, including Freedom to Speak Up, listening events and direct leadership engagement.

Staff engagement and listening activity

The staff survey results are not considered in isolation, the service has invested significantly in workforce engagement and co-production, particularly during and following the implementation of the new integrated model.

Key engagement activity has included:

- A formal staff consultation and restructure process during 2023–24, supporting transition to the new locality model.
- A large-scale listening event in July 2025, with strong attendance and structured feedback on workload, systems and ways of working.
- Ongoing locality-based engagement, including leadership attendance at team meetings, open Q&A sessions and direct access to senior leaders.

- Use of **"you said, we did"** approaches to feedback, ensuring that staff input is visibly reflected in service changes and optimisation workstreams.

Feedback from these engagement activities has directly informed the **0–19 Service Optimisation Plan**, including priorities around workload management, role clarity, digital optimisation and workforce wellbeing. Staff representatives are embedded within the optimisation governance structure, ensuring that workforce voices continue to shape service development.

Overall assurance

Taken together, the staff survey data and wider engagement activity provide assurance that:

- Staff remain highly committed to the purpose and values of the 0–19 service.
- The integrated model has strengthened team working and professional relationships.
- Workforce pressures are recognised, understood and being actively addressed through targeted improvement and engagement.
- There is a clear line of sight between staff feedback, leadership action and service development.

This triangulated approach supports a learning culture and underpins the service's commitment to sustaining a resilient, engaged and supported workforce while continuing to deliver high-quality care to children, young people and families across Oxfordshire.

7. QUALITY ASSURANCE

7.1 OVERVIEW OF THE QUALITY ASSURANCE FRAMEWORK

Quality assurance within the Oxfordshire 0–19 Public Health Nursing Service is delivered through a layered and integrated framework that provides ongoing oversight of safety, effectiveness, experience and workforce practice. Assurance activity operates at three interconnected levels:

1. Day-to-day operational controls, embedded in service Standard Operating Procedures
2. Routine review and learning, through supervision, audit, incident review and performance oversight; and

3. Formal governance and escalation, through Trust quality structures and system-level forums.

This framework ensures that quality and safety are actively monitored throughout the year, enabling early identification of risk, timely intervention and continuous improvement, rather than relying solely on retrospective assurance.

7.2 SUPERVISION MODEL AND SAFEGUARDING SUPERVISION

Clinical, managerial and safeguarding supervision within the Oxfordshire 0–19 Public Health Nursing Service is delivered in line with the Trust Supervision Policy and the 0–19 Supervision Standard Operating Procedure, which define clear minimum frequency, format and accountability requirements. Supervision is delivered through a combination of scheduled supervision and live supervision, providing both planned reflective space and real-time professional oversight.

Managerial and clinical supervision (scheduled)

- All staff receive managerial supervision at least every 8 weeks, focusing on workload management, wellbeing, performance, and professional development.
- All clinically registered staff receive clinical supervision at least every 8 weeks, delivered separately from managerial supervision. Clinical supervision provides structured reflective discussion on clinical decision-making, safeguarding, professional judgement and complex cases, supporting safe, consistent practice across localities.

Safeguarding supervision

All staff participate in regular safeguarding supervision, delivered through a structured group model as set out in the 0–19 Supervision SOP. These supervision groups are facilitated by safeguarding named nurses, who are part of the Trust safeguarding team, ensuring expert guidance and consistency in safeguarding practice.

The safeguarding supervision model has been strengthened during the current financial year, including:

- defined supervision cycles,
- capped group sizes to enable meaningful discussion and challenge,
- senior clinical oversight to ensure consistency across localities, and

- explicit linkage to individual Safeguarding Passports, supporting ongoing competence assurance.

Safeguarding supervision provides focused review of complex cases, multi-agency decision-making and learning from practice and is a key mechanism for identifying emerging risk and supporting proportionate, defensible safeguarding practice.

Live supervision (in-practice oversight)

In addition to scheduled supervision, the service makes active use of live supervision, which provides real-time clinical oversight and support during day-to-day practice. Live supervision is embedded within service SOPs and is used to support safe decision-making at the point of care. Live supervision can also take the form of observed practice, where senior clinicians or team leaders directly observe practitioners as they carry out clinical duties. This enables immediate feedback, practical guidance, and reinforcement of best practice in real-world scenarios.

Live supervision operates through:

- immediate access to senior clinicians, Locality Team Leaders or Specialist Lead Practitioners for case discussion,
- real-time advice and challenge during safeguarding triage, complex assessments or escalation decisions,
- support for practitioners during contacts or follow-up activity where professional judgement is required,
- prompt guidance on thresholds, documentation and next steps in line with policy,
- direct observation of practice, allowing supervisors to provide immediate feedback and support within the clinical environment.

This approach ensures that practitioners are not making complex or high-risk decisions in isolation, particularly in relation to safeguarding, escalation, or multi-agency working. Live supervision complements scheduled supervision by providing timely support, reducing risk and reinforcing consistent practice.

Enhanced supervision for specialist roles

Staff working in high-intensity or specialist roles, including the Family Nurse Partnership, receive additional specialist and psychological supervision, in line with national programme requirements and Trust expectations. This reflects the complexity and emotional demands of the work and provides additional assurance around practitioner wellbeing and safe practice.

Governance and assurance

Supervision arrangements, including frequency, uptake and themes arising from both scheduled and live supervision, are monitored through operational governance routes. Learning from supervision informs training priorities, audit focus and service improvement actions, ensuring that frontline learning feeds directly into the wider quality assurance framework.

Taken together, the combination of scheduled supervision, safeguarding supervision and live supervision provides strong assurance that staff are supported, risks are identified early, and clinical and safeguarding practice is consistently reviewed and strengthened in line with Trust policy.

7.3 AUDIT PROGRAMME – COMPLETED ACTIVITY AND FORWARD PLAN

Audit is a central component of the service's quality assurance approach and is used to provide assurance on practice quality, pathway compliance and safeguarding standards.

During the current financial year to date, audit activity has included (but not limited to):

- Safeguarding case file audits, reviewing identification, escalation, documentation quality and multi-agency working;
- Casefile audits as part of the SEND and Joint Targeted Area Inspection Child Sexual Abuse in the Family Environment Inspections;
- Pathway and documentation audits, focusing on mandated contacts and Episodes of Care;
- Targeted audits initiated in response to themes emerging from incidents, complaints or performance review.
- Ongoing temperature monitoring audits to ensure safe practice and compliance.
- Regular breastfeeding practice audits undertaken as part of our Baby Friendly Initiative (BFI) accreditation, supporting best practice and standards in infant feeding.

Findings from completed audits have been reviewed through service governance, shared with locality teams and translated into clear actions, including updates to guidance, targeted training and changes to local processes. Where audit findings

indicate potential risk, actions are tracked to completion through Trust quality governance arrangements.

The audit programme for the forthcoming year has now been finalised and builds on learning from audits already completed this year. It continues to prioritise:

- safeguarding practice,
- quality and consistency of recording,
- adherence to agreed clinical pathways, and
- areas of known system risk.
- continuation of temperature monitoring and breastfeeding practice audits to underpin safe care and maintain BFI standards.

This ensures continuity between retrospective learning and forward assurance.

7.4 INCIDENT REPORTING, THEMES AND LEARNING (FINANCIAL YEAR TO DATE)

Patient safety incidents within the Oxfordshire 0–19 Public Health Nursing Service are reported and managed in line with the Trust Incident Reporting Policy and the Patient Safety Incident Response Framework (PSIRF). Incident data is reviewed routinely through the Children and Young People Management Team, Service Management Team (SMT) quality reporting and Trust governance routes to ensure that learning is identified and acted upon in a timely and proportionate way.

Incident reporting volume and profile (2025/26 year to date)

During the current financial year to date, incident reporting volumes within the 0–19 service have remained low and stable, with incidents predominantly assessed as low-level and low-harm. Recent safety metric reporting shows that:

- incident reporting fluctuates month-to-month in line with service activity,
- there have been no Serious Incidents recorded during the year to date, and
- the majority of incidents relate to process, communication or documentation issues rather than direct harm.

For example, service data shows 14 incidents reported in December 2025, representing a reduction compared to the preceding month. Similar patterns have been seen across other months, with no upward trend in severity or harm.

Incident themes and learning

Themes identified through incident review during the year to date include:

- communication and information-sharing challenges, often at service interfaces with partner agencies,
- documentation or recording issues within clinical systems,
- coordination or timing issues linked to multi-agency working,
- isolated estates or environmental issues.

These themes are consistent with those identified through complaints, audit and staff feedback, and are therefore considered within a triangulated quality assurance approach rather than in isolation.

Application of PSIRF and just culture principles

The service now operates fully within the **Patient Safety Incident Response Framework (PSIRF)**, which represents a shift away from a one-size-fits-all investigation model towards a **proportionate, learning-focused approach**. Under PSIRF:

- not all incidents trigger formal investigation,
- the response is tailored to the level of risk, harm and learning potential, and
- the emphasis is on understanding what happened and why, rather than attributing blame.

Low-level incidents are typically reviewed through local management review, learning huddles or team discussion, while higher-risk incidents would be escalated through Trust patient safety routes using structured review methodologies where required.

How learning is embedded in practice

Learning from incidents is embedded through:

- learning huddles and team meetings, where themes and examples are discussed,
- updates to SOPs, templates or guidance where system issues are identified,
- targeted supervision or support for individuals or teams where appropriate,
- escalation of system-level issues through governance where learning requires wider action.

This approach ensures that incident reporting contributes directly to service improvement and risk reduction, rather than becoming a purely administrative process.

Assurance and oversight

Incident trends and themes are reviewed alongside audit findings, complaints and safeguarding intelligence to provide a rounded view of risk and quality. Where recurring themes are identified, these are escalated through governance and inform priorities for audit, training or service improvement.

Overall, the incident profile for the current financial year to date provides assurance that:

- incident reporting is being used appropriately,
- there is a strong learning culture aligned to PSIRF principles, and
- safety risks are identified early and managed proportionately in line with Trust policy.

7.5 SAFEGUARDING PROCESSES AND MULTI-AGENCY INTERFACE

Safeguarding quality assurance within the Oxfordshire 0–19 Public Health Nursing Service is underpinned by a clear set of Trust policies, service Standard Operating Procedures and local multi-agency safeguarding arrangements, which describe exactly how safeguarding concerns are identified, assessed, recorded and escalated in practice.

Identification, thresholds and recording

- All safeguarding concerns identified by practitioners are recorded on the clinical record within EMIS, using standardised safeguarding templates, regardless of whether the concern meets the threshold for referral to Children's Social Care.
- Where concerns do not meet statutory thresholds, the rationale for decision-making is clearly documented, ensuring transparency and continuity of care.
- Practice is aligned to the Oxfordshire Safeguarding Children Partnership (OSCP) threshold of need guidance, supporting consistent, proportionate decision-making and appropriate use of early help, targeted or statutory pathways.

Triage and escalation through SPA

- All incoming safeguarding communications are triaged through a dedicated safeguarding inbox within the Single Point of Access, in line with the safeguarding process SOP.

- Defined criteria are used to prioritise urgent activity, including strategy discussions, Initial Child Protection Conferences (ICPCs) and urgent safeguarding reviews.
- Standard operating procedures set out:
    - expected response timeframes,
    - escalation routes to senior clinicians and managers,
    - documentation standards within EMIS, and
    - processes for following up outcomes and minutes from multi-agency meetings.

This ensures safeguarding activity is managed consistently and does not rely on informal processes or individual practitioner judgement alone.

Use of local multi-agency protocols Safeguarding practice is informed by specific OSCP-approved protocols, which are embedded within training, supervision and SOPs. These include:

- the Protocol for the Management of Bruising in Pre-Mobile Babies and Children, which requires urgent assessment and escalation for any bruising in children who are not independently mobile, and
- the Guidance on Bruising in Independently Mobile Children and Young People, which supports proportionate assessment and decision-making based on developmental stage, presentation and context.

These protocols provide a shared, evidence-based framework across health, social care and partner agencies, supporting consistent responses and reducing variation in practice.

Safeguarding escalation log and system assurance

- The service maintains a safeguarding escalation log, which records system-level issues arising from multi-agency safeguarding processes, such as late notifications of meetings, changes to arrangements without notice, or missing documentation.
- This log is reviewed through safeguarding oversight meetings and escalated through Trust and partnership routes where required.
- The escalation log provides an audit trail, supports constructive system challenge, and ensures that operational risks arising from safeguarding processes are visible and managed.

Governance and assurance

- Safeguarding activity, themes and pressures are reviewed through routine governance routes alongside incident, audit and supervision intelligence.
- This enables safeguarding demand to be actively managed, learning to be identified and acted upon, and assurance to be provided that safeguarding practice is consistent, proportionate and aligned to both Trust policy and OSCP guidance.

Taken together, these arrangements provide assurance that safeguarding within the 0–19 service is robust, well-governed and fully integrated with local multi-agency safeguarding systems, while maintaining clear clinical oversight and accountability.

7.6 EXTERNAL ASSURANCE AND INSPECTION PREPAREDNESS

The Oxfordshire 0–19 Public Health Nursing Service maintains ongoing readiness for external scrutiny, accreditation and inspection, with assurance activity embedded within routine practice rather than treated as a standalone exercise.

CQC self-assessment and action planning

The service has completed CQC self-assessments aligned to the CQC quality statements, with associated action plans in place. These self-assessments are used to:

- identify areas of strength and improvement,
- track actions through service and Trust governance routes, and
- ensure that evidence remains current and reflective of day-to-day practice.

Progress against CQC action plans is monitored through established governance structures, providing assurance that learning is acted upon and improvements are sustained.

External accreditation and recognised standards

The Oxfordshire 0–19 Public Health Nursing Service is accredited by the Baby Friendly Initiative (BFI), reflecting its commitment to internationally recognised standards for infant feeding, parent-infant relationships and safeguarding. This accreditation demonstrates that the service has met rigorous criteria and consistently applies best practice, further strengthening its external assurance alongside other recognised standards.

Embedding these standards within clinical pathways, training and supervision provides an additional layer of external assurance and supports consistency, quality and improved outcomes for babies and families.

Recent Oxfordshire inspection activity and assurance

In 2026, the service has actively participated in both a SEND inspection and a Joint Targeted Area Inspection (JTAI) focusing on Child Sexual Abuse in the Family Environment (CSAFE). As part of these inspection processes:

- service leads and frontline practitioners were interviewed directly by inspectors, providing evidence of leadership oversight, clinical decision-making and operational practice;
- the service completed and submitted case file audits, demonstrating the quality of recording, safeguarding assessment and professional judgement;
- practitioners and leaders participated in multi-agency case tracking meetings with inspectors, evidencing how the service works collaboratively with partners to safeguard children and support families.

This level of engagement provides assurance that safeguarding and quality assurance arrangements are not only documented but are actively understood and applied in practice by staff at all levels of the service.

Embedding inspection and accreditation learning

Learning from inspection activity and external accreditation standards is reviewed through service and Trust governance routes and informs:

- audit priorities,
- supervision focus,
- training and development activity, and
- service improvement actions.

This ensures that external scrutiny and accreditation contribute to continuous improvement, rather than being treated as one-off or compliance-only exercises.

Overall assurance

The combination of routine CQC self-assessment, action planning, alignment to external accreditation standards such as BFI, and recent active participation in SEND and Joint Targeted Area Inspection focusing on Child Sexual Abuse in the Family Environment inspections provides strong assurance that the Oxfordshire 0–19 Public Health Nursing Service is:

- inspection-ready,

- quality-focused and evidence-informed,
- transparent in its practice,
- engaged in multi-agency safeguarding systems, and
- committed to learning and continuous improvement.

7.7 TRAINING, COMPETENCE AND COMPLIANCE ASSURANCE

Training and professional development within the Oxfordshire 0–19 Public Health Nursing Service are structured to ensure that staff are competent, confident and appropriately skilled to deliver safe, effective and evidence-based care across universal, targeted and specialist pathways. Training assurance operates across three levels: statutory and mandatory training, enhanced role-specific training, and ongoing professional development, with clear governance oversight.

Statutory and mandatory training

All staff are required to complete Trust-mandated statutory and mandatory training, including safeguarding level 3 for children and adults, information governance, basic life support, and other core requirements, in line with Trust policy. Compliance is monitored through routine reporting and reviewed through service and directorate governance routes. Where gaps are identified, actions are agreed with managers and followed up through supervision and performance processes.

Enhanced and role-specific training

In addition to mandatory training, the service delivers and commissions a wide range of enhanced role-specific training, reflecting the complexity of 0–19 public health nursing practice. This includes, but is not limited to:

- **Solihull Approach** training to support evidence-based practice in parent–infant relationships, emotional wellbeing and behaviour;
- Infant feeding and breastfeeding support training, aligned to national guidance and local pathways, to ensure consistent, high-quality support for families;
- safeguarding-focused training linked to specific risks and pathways, informed by OSCP guidance and learning from audits and incidents;
- training linked to specialist roles and pathways, delivered or supported by Specialist Lead Practitioners and Clinical Education Leads.
- All Health Visitors are trained in NSPCC Graded Care Pathway 2 assessments, which helps professionals measure the quality of care provided by a parent or

carer, ensuring consistent, developmentally informed assessment and decision-making across the service.

External training and professional development

The service supports ongoing professional development through access to external training and qualifications, including the use of Learning Beyond Registration (LBR) funding where appropriate. This enables staff to undertake accredited courses or specialist training that supports service priorities, succession planning and workforce sustainability. Access to external training is agreed through managerial processes and aligned to service need.

Monitoring, governance and assurance

Training compliance and professional development are monitored through a triangulated assurance approach, including:

- routine training compliance reporting through Trust systems;
- discussion and review of training needs and competence within supervision, including safeguarding supervision;
- incorporation of training and development objectives within Personal Development Reviews (PDRs);
- oversight through service and directorate governance forums, where themes from training, audit and incident learning are reviewed together.

Learning from audits, incidents, complaints and external inspections informs training priorities, ensuring that education and development activity remains responsive to emerging risks and service need, rather than static or compliance-driven alone.

Overall assurance

Taken together, the combination of mandatory training, enhanced role-specific education, access to external development opportunities and robust governance oversight provides assurance that the 0–19 workforce is appropriately trained, supported and competent to deliver safe, high-quality care. This structured approach supports workforce capability, underpins safeguarding assurance and contributes directly to improved outcomes for children, young people and families.

8. WORKFORCE

8.1 WORKFORCE OVERVIEW AND STRUCTURE

The Oxfordshire 0–19 Public Health Nursing Service is delivered by a large, multidisciplinary workforce, structured to support delivery of universal, targeted and specialist interventions across the county. The workforce includes Health Visitors, School Health Nurses, Family Nurses, Community Public Health Nurses, Community Public Health Associates, specialist practitioners and administrative staff, operating within integrated locality teams and a centrally based Single Point of Access.
The service is led through a clear clinical and operational leadership structure, with senior clinical leadership, operational management and professional leads providing oversight across health visiting, school nursing and Family Nurse Partnership pathways. Locality Team Leaders, Specialist Lead Practitioners and Clinical Education Leads (CELs) provide day-to-day operational management, clinical leadership and workforce development within and across localities, ensuring consistency of practice and appropriate escalation.

This structure supports both strong local leadership and county-wide standardisation, embedding specialist expertise within frontline delivery while maintaining clear lines of accountability.

8.2 SKILL MIX AND WORKFORCE DEPLOYMENT

The service operates a skill-mix workforce model, enabling high-volume delivery of the universal Healthy Child Programme alongside targeted and specialist support for families with additional or complex needs. Registered practitioners retain accountability for assessment, safeguarding and clinical decision-making, while Community Public Health Nurses and Associates support delivery of defined elements of care under clear delegation and supervision arrangements.

This approach supports efficient use of professional capacity, but also means that caseload complexity, safeguarding activity and targeted Episodes of Care have a disproportionate impact on workload and capacity. Workforce planning therefore considers not only headcount and whole-time equivalents but also caseload profile, safeguarding demand and service user need.

8.3 WORKFORCE METRICS AND MANAGEMENT OVERSIGHT

Workforce metrics for the Oxfordshire 0–19 Public Health Nursing Service are monitored through routine Trust governance arrangements, providing clear oversight of workforce capacity, stability and risk. These metrics are reviewed regularly through the Children and Young People Senior Management Team (CYP SMT), escalated through directorate performance and quality boards, and reported to Executive Board level where required.

The workforce metrics presented below are drawn from the Trust's operational management dataset and therefore exclude NHS Agenda for Change Band 8a and above roles, which are overseen through separate senior leadership reporting. The data reflects the frontline workforce delivering services day-to-day.

Current workforce position and performance against Trust targets (as of February 2026)

- **Substantive headcount: 288 staff**
- **Whole Time Equivalent (WTE): 226.1 WTE**
- **Vacancy rate: 0.77% (1.8 WTE vacancies)**
  Trust target: <5%
  → Significantly better than target, indicating a stable workforce and effective recruitment.
- **Agency usage: £0.00 (0%)**
  Trust expectation: minimal / zero agency use
  → Target met, supporting continuity of care and cost control.
- **Bank usage: 0.41% (0.77% of WTE)**
  Trust target: <5%
  → Well within target, demonstrating controlled use of temporary staffing.
- **Turnover (monthly): 9.57%**
  Trust target: <14%
  → Within target, though monitored closely due to the size and complexity of the workforce.
- **Early turnover: 9.07%**
  Trust target: <14%
  → Within target, indicating improving retention during early employment.
- **Sickness absence (current month): 4.20%**
  Trust target: <4.5%

→ Within target, with fluctuations managed through local absence management processes.

- **BAME representation: 8.0%**
  → Monitored through Trust equality, diversity and inclusion reporting and informs ongoing workforce development activity.

Trend and stability overview

Trend data over the past 12 months shows:

- **Sustained vacancy levels below Trust thresholds**, with vacancy WTE continuing to reduce;
- **Consistently low bank usage**, remaining well below Trust tolerance;
- **No reliance on agency staffing**;
- **Turnover and early turnover maintained within Trust targets**, with locality-level monitoring to identify emerging risk;
- **Sickness absence fluctuating month-to-month**, but remaining within Trust expectations for community services.

Governance and assurance

Workforce performance against Trust targets is triangulated with:

- staff survey feedback,
- caseload complexity and safeguarding demand,
- incident and quality intelligence, and
- locality management insight.

This triangulated approach enables **early identification of workforce risk**, supports targeted management action, and ensures that workforce performance remains aligned with Trust expectations. Where indicators approach or exceed tolerance, issues are escalated through Trust governance routes to ensure timely oversight and mitigation.

8.4 WORKFORCE WELLBEING, ENGAGEMENT AND LISTENING

Workforce wellbeing and engagement within the Oxfordshire 0–19 Public Health Nursing Service are monitored through a combination of quantitative and qualitative intelligence, including NHS Staff Survey results, structured engagement activity, supervision and routine management oversight. This information is reviewed alongside workforce metrics, quality data and caseload complexity to inform leadership focus and service improvement.

Staff feedback highlights a workforce that remains highly committed to the purpose and values of the service, with strong pride in supporting children, young people and families. Team relationships are generally positive, and staff report valuing visible leadership and locality-based management arrangements. These strengths support resilience and continuity of care across the service.

At the same time, staff feedback consistently identifies workload pressure, pace of change and emotional fatigue as ongoing challenges. These themes are consistent with national trends across community services and reflect the complexity of safeguarding demand, targeted work and the scale of service transformation delivered over recent years. These pressures are explicitly recognised within workforce planning and optimisation activity described elsewhere in this section.

The service places strong emphasis on listening to and engaging with staff, using a range of mechanisms to ensure workforce voices inform decision-making. This includes:

- locality-based team meetings with leadership presence;
- structured listening and engagement events;
- open Q&A sessions with senior leaders; and
- visible **"you said, we did"** approaches to feedback.

Feedback gathered through these routes has directly informed service development priorities, including workload distribution, digital optimisation, supervision models and workforce support arrangements. Engagement is treated as an ongoing process rather than a one-off exercise, with learning routinely fed back to teams and reflected in service improvement plans.

Together, this approach provides assurance that workforce wellbeing and engagement are actively monitored, understood and addressed, and that staff experience and insight are used to shape how the service continues to develop and improve.

8.5 WORKFORCE RISKS AND ASSURANCE

The service recognises ongoing workforce risks, including:

- workload pressure linked to safeguarding demand and targeted work;
- sickness absence and emotional fatigue;

- recruitment challenges in some registered and specialist roles.

These risks are actively managed through workforce planning, recruitment activity, supervision, wellbeing support and escalation through Trust governance routes.

8.6 WORKFORCE OPTIMISATION, DEMAND AND CAPACITY REVIEW

Alongside routine workforce monitoring and governance oversight, the service is undertaking a structured programme of workforce optimisation to ensure that the staffing model continues to align with demand following implementation of the new integrated 0–19 service model.

As a first stage, a Time in Motion study has recently been completed across the service. This work provides a detailed understanding of how staff time is currently being spent across universal, targeted and specialist activity, including direct clinical contacts, safeguarding activity, administrative tasks and indirect care. The study establishes a robust baseline of real-world activity and variation across localities and roles and is currently in the process of being analysed.

The Time in Motion study forms the initial phase of a wider demand and capacity review, which will:

- assess whether the current skill mix and staffing distribution appropriately reflects population need and service demand;
- identify variation in workload and activity across localities;
- support evidence-based decisions about the right balance of registered, non-registered and specialist roles in different parts of the county; and
- inform future workforce planning, recruitment and development priorities.

This work is being taken forward as part of the service's broader optimisation plan and is overseen through established governance arrangements, including the CYP Programme Board and directorate transformation board. Findings will be triangulated with workforce metrics, caseload data, safeguarding demand and staff feedback to ensure that changes are proportionate, transparent and focused on maintaining service quality and workforce wellbeing.

The purpose of this work is not to reduce capacity, but to ensure that the configuration of the workforce matches demand, supports safe and effective practice, and is sustainable over time as population need and service delivery models continue to evolve.

8.7 OVERALL WORKFORCE ASSURANCE

Taken together, the workforce structure, skill-mix model, routine performance metrics and governance oversight provide assurance that:

- workforce capacity and risk are actively monitored and managed;
- leadership structures support safe, consistent practice;
- staff engagement and wellbeing are recognised and addressed; and
- workforce intelligence informs decision-making at service, directorate and executive levels.

. In addition, robust assurance arrangements are in place to ensure that all staff working within the Oxfordshire 0–19 Public Health Nursing Service meet required employment, registration and safeguarding standards. All staff in regulated roles are subject to Disclosure and Barring Service (DBS) checks at the appropriate level prior to appointment, with ongoing oversight through Trust employment processes. Professional registration for regulated staff (including Nursing and Midwifery Council registration) is verified at appointment and monitored on an ongoing basis, including confirmation of revalidation in line with national professional requirements.

Compliance with DBS and professional registration requirements is overseen through Trust-wide workforce systems, routine management checks and internal assurance processes. Any concerns relating to registration status, safeguarding suitability or professional practice are escalated promptly through established HR, safeguarding and clinical governance routes.

These arrangements provide assurance that the workforce delivering the 0–19 service is appropriately vetted, professionally registered and safe to practise, and that safeguarding considerations are embedded within workforce governance alongside quality, supervision and training oversight. This supports the delivery of a sustainable, high-quality 0–19 Public Health Nursing Service across Oxfordshire

9. SYSTEM COLLABORATION

9.1 HOW THE SERVICE WORKS WITH SYSTEM PARTNERS

The Oxfordshire 0–19 Public Health Nursing Service operates as a core system partner, working collaboratively with health, local authority, education, justice and voluntary and community sector (VCS) organisations to improve outcomes for children, young people and families. Partnership working is integral to the service model and underpins delivery of early help, safeguarding, SEND support and population health improvement across the county.

The integrated 0–19 design, including locality teams and a central Single Point of Access, enables consistent engagement with partners while maintaining clear accountability for health-led contributions. Collaboration occurs at strategic, operational and frontline levels, ensuring alignment between system priorities and day-to-day practice.

At an operational level, the service works closely with a wide range of partners, including:

- **maternity and community midwifery services**, ensuring effective antenatal and postnatal pathways and smooth transitions of care;
- **GPs and primary care teams**, supporting shared information, continuity and joined-up management of health needs;
- **children's social care and early help services**, including regular interface with MASH and early help teams;
- **education and early years providers**, supporting prevention, school readiness and early identification of need;
- **CAMHS, Mental Health Support Teams and specialist perinatal services**, ensuring appropriate escalation and continuity;
- **voluntary and community sector organisations**, extending reach and supporting engagement with families.

Regular multi-agency meetings at locality level support shared understanding of need, coordinated planning and timely escalation where required. Health Visitors and School Health Nurses act as **key system connectors**, supporting information sharing, joint planning and continuity for families.

The SPA plays a central role in operational collaboration, providing a **consistent access point for professionals**, supporting triage, and ensuring referrals are directed appropriately across health and partner services.

9.2 STRATEGIC SYSTEM LEADERSHIP AND GOVERNANCE

The service provides active leadership and professional input across a wide range of multi-agency governance boards and programmes, ensuring that public health nursing expertise, safeguarding insight and health intelligence inform system decision-making. This includes representation on:

- the **Family Hubs Programme Board**, supporting delivery of the Start for Life agenda and ensuring health visiting and school nursing are fully embedded within the wider family support offer;
- the **Families First Programme**, aligning early help pathways and supporting coordinated, whole-family responses;
- the **Early Years Board**, contributing to system-wide priorities around school readiness, child development and prevention;
- the **Early Help and Early Intervention Board**, supporting shared thresholds, escalation routes and proportionate responses to emerging need;
- the **Neglect Strategy Group**, contributing health expertise to the development and oversight of the countywide neglect strategy;
- **Neglect Practitioner Forums**, supporting consistent practice, shared learning and multi-agency understanding at a frontline level;
- **SEND improvement governance**, including participation across all SEND improvement theme groups;
- the **SEND Assurance and Improvement Board (SAIB)**, providing health assurance and supporting oversight of SEND improvement activity;
- the **PAUSE Programme Board**, contributing health insight to intensive work with families experiencing recurrent care proceedings;
- the **Youth Justice Board**, supporting joined-up responses for children and young people involved with the youth justice system.

Through these forums, the service helps shape strategy, supports assurance activity, and ensures that health visiting and school nursing perspectives are fully integrated into system planning and improvement. In addition, Specialist Lead Practitioners participate in systemwide meetings relevant to their areas of expertise, such as those focused on attendance in education, supporting coordinated approaches in their

specialist fields, and contributing to wider multi-agency planning and improvement activities.

9.3 SAFEGUARDING AND MULTI-AGENCY WORKING

Safeguarding is a central element of system collaboration. The service works closely with **children's social care, multi-agency safeguarding hub, police and partner agencies**, contributing to strategy discussions, child protection conferences, core groups and multi-agency planning where there is an identified health need.

Clear thresholds, agreed through the Oxfordshire Safeguarding Children Partnership (OSCP), support consistent decision-making across agencies. The service's safeguarding escalation processes and oversight arrangements ensure that partnership challenges—such as late notifications, changes to meeting arrangements or missing information—are identified, recorded and escalated appropriately, supporting continuous system improvement.

9.5 COLLABORATION WITH THE VOLUNTARY AND COMMUNITY SECTOR

Partnership with the voluntary and community sector is a key strength of the Oxfordshire model. Alongside statutory partners, the service works with VCS organisations to:

- extend reach into communities,
- improve engagement with families,
- support prevention and early intervention.

These partnerships complement statutory provision and enable a **graduated, strengths-based response**, aligned with proportionate universalism. Clear governance arrangements ensure that VCS partnerships align with safeguarding standards, pathways and outcome monitoring.

9.6 IMPACT OF SYSTEM COLLABORATION

Effective system collaboration supports:

- earlier identification of need and timely intervention;
- reduced duplication and clearer pathways for families;
- shared ownership of safeguarding, neglect and early help;
- stronger coordination across health, education, social care and justice;
- improved assurance and inspection readiness at system level.

By maintaining strong relationships, clear governance and consistent operational processes, the Oxfordshire 0–19 Public Health Nursing Service acts as a **reliable, accountable and influential system partner**, contributing to improved outcomes for children, young people and families across the county.

10. CONCLUSION AND ASSURANCE

This report has set out how the Oxfordshire 0–19 Public Health Nursing Service operates, the breadth of support it provides to children, young people and families, and the systems in place to ensure safe, effective and high-quality delivery. It has described service performance against mandated contacts, the reasons for variation where targets are not consistently met, and the actions being taken to improve timeliness while maintaining a family-centred, proportionate approach.

The report has also provided assurance on quality and safeguarding arrangements, including supervision, audit, incident learning and inspection readiness, demonstrating that risks are actively identified, managed and escalated through established Trust governance structures. Recent inspection activity, alongside routine self-assessment and external assurance processes, provides further confidence that safeguarding and quality assurance arrangements are embedded in day-to-day practice.

Workforce capacity, wellbeing and sustainability remain a critical enabler of service delivery. The service has a stable workforce performing well against Trust workforce targets, supported by strong leadership, structured supervision, ongoing training and active engagement with staff. At the same time, the service recognises the ongoing pressures created by safeguarding demand, caseload complexity and the scale of the integrated model. Work underway as part of the optimisation plan, including the Time in Motion study and subsequent demand and capacity review, provides a robust, evidence-based approach to ensuring the workforce configuration continues to match population need.

Finally, the report has demonstrated the service's role as a core system partner, working collaboratively across health, local authority, education, justice and the voluntary and community sector. Through strong operational interfaces and active participation in strategic governance, the service contributes to shared system priorities around early help, safeguarding, SEND improvement and prevention.

Taken together, the information presented provides assurance that the Oxfordshire 0–19 Public Health Nursing Service is:

- delivering a comprehensive and proportionate offer to families;
- performing strongly overall, with targeted action where improvement is needed;
- operating within robust quality, safeguarding and governance frameworks;
- maintaining a stable and supported workforce; and
- working effectively with system partners to improve outcomes for children and young people.

The service remains committed to continuous improvement, transparency and partnership working, and will continue to use data, feedback and system learning to strengthen delivery and outcomes across Oxfordshire.

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Work Programme 2025/26
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna | Dr Omid Nouri, Health Scrutiny Officer, omid.nouri@oxfordshire.gov.uk

COMMITTEE BUSINESS

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
16 April 2026				
Adult and Older Adult Mental Health Services	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from Oxfordshire system partners on Adult and Older Adult Mental Health Services. This is a routine update on HOSC's previously issued recommendations for this item, and a response to the Council Motion requesting HOSC to investigate Mental Health Services.	Overview and Scrutiny	Dan Leveson (BOB ICB) Ansaf Azhar Matthew Tait (BOB ICB)
All-Age Autism Strategy	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from Karen Fuller (on behalf of Oxfordshire system partners) on the development of the All-Age Autism Strategy. This is to provide opportunity for scrutiny and recommendations on the strategy prior to its sign off at the Health and Wellbeing Board in July 2026.	Overview and Scrutiny	Karen Fuller Ian Bottomley Matthew Tait (BOB ICB)
Health Visitors Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on Health Visitor Services in Oxfordshire	Overview and Scrutiny	Ansaf Azhar

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
11 June 2026				
South Central Ambulance Service Performance Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from SCAS on its CQC improvement journey and on its performance in Oxfordshire more broadly.	Overview and Scrutiny	David Eltringham (SCAS CEO)
Dentistry Services in Oxfordshire	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from the NHS Integrated Care Board on developments around improving NHS dentistry access and contracts.	Overview and Scrutiny	Hugh O Keefe (BOB ICB)
Oxford Health NHSFT Quality Account	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive the draft of the Trust's Quality Account for this year, with a view to provide feedback to the Trust that will be published in the final version of its Quality Account at the end of June 2026.	Overview and Scrutiny	Sam Shepherd (Oxford Health NHSFT)
Oxford University Hospitals NHSFT Quality Account	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive the draft of the Trust's Quality Account for this year, with a view to provide feedback to the Trust that will be published in the final version of its Quality Account at the end of June 2026.	Overview and Scrutiny	Olivia Clymer (Oxford University Hospitals NHSFT)

Recommendation Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | 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
11-Sept-25	Adults Autism and ADHD Strategy	1. For the ICB to urgently review and increase the annual assessment capacity for both autism and ADHD services to better reflect current demand and reduce potentially unsafe waiting times.	Matthew Tait; Niki cartwright	**Partially Accepted** See agenda item 5
		2. For the development of a detailed timeline (and potentially a resource plan) for clearing the existing waiting lists, including the 2,229 adults awaiting ADHD assessments.		**Accepted** See agenda item 5
		3. To undertake a formal review of Right to Choose (RtC) expenditure and its long-term viability, with options for integrating RtC providers into core commissioning.		**Accepted** See agenda item 5
		4. For co-production to remain at the heart of the development of the All-Age Autism Strategy. It is recommended that there are clearly identified stakeholders to ensure that all complexities are represented.		**Accepted** See agenda item 5

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
20-Nov-25	Neighbourhood health Plan for Oxfordshire	1. For clear governance arrangements to be developed for the Oxfordshire Neighbourhood Health Plan, including defined roles for the Health and Wellbeing Board, Place-Based Partnership, and Primary and Community Care Board. It is recommended that there is openness and transparency, as well as regular reporting to the JHOSC on the plan's development and delivery milestones.	Michelle Brennan; Matthew Tait	**Partially Accepted** See agenda item 5
		2. To ensure that the Neighbourhood Health Plan aligns with other strategic initiatives (such as the Better Care Fund and the Health & Wellbeing Strategy, and the Oxfordshire Way), and to avoid duplication and fragmentation.		**Accepted** See agenda item 5
		3. To prioritise investment in digital infrastructure, interoperability, and usability to enable data sharing and Population Health Management at neighbourhood level. It is recommended that system partners report on progress in implementing Population Health Management tools and Health Evaluation Units.		**Partially Accepted** See agenda item 5
		4. To ensure that the local patient voice and local voluntary sector input is at the heart of the development and delivery of the neighbourhood health plan for Oxfordshire. It is recommended that the role of the local member and Parish/Town Councils is also integral to this.		**Accepted** See agenda item 5

Action Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Omid Nouri, Health Scrutiny Officer, omid.nouri@Oxfordshire.gov.uk

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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 Cllr Jane Hanna OBE | 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	Item	Lead	Update
06-Jul-24	GP Provision	Julie Dandridge; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	Hugh O'Keefe; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	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	Rachel Corser; Dan Leveson	See agenda item 8
26-Nov-24	Medicine Shortages	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
16-Dec-24	Epilepsy Services Update	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date	Item	Lead	Update
06-Mar-25	OUHFT Maternity Services in Oxfordshire	Yvonne Christley; Rachel Corser; Dan Leveson	Update in January meeting
05-Jun-25	Oxfordshire Healthy Weight	Derys Pragnell	Progress update to be provided
05-Jun-25	BOB ICB Operating Model Update	Matthew Tait; Dan Leveson	Update in January meeting
05-Jun-25	Health and Wellbeing Strategy Outcomes Framework	Cllr Leffman; Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
05-Jun-25	Oxford Health NHS Foundation Trust People Plan	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	Progress update to be provided
11-Sept-25	Musculoskeletal Services in Oxfordshire	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	Progress update to be provided
11-Sept-25	Cancer Services in Oxfordshire	Matthew Tait; Felicity Taylor; Andy Peniket	Progress update to be provided
11-Sept-25	Audiology Services in Oxfordshire	Matthew Tait; Neil Flint; Phil Gomersall	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date	Item	Lead	Update
11-Sept-25	Oxfordshire System Pressures	Dan Leveson; Lily O'Connor; Karen Fuller	Progress update to be provided