Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 10 September 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		
Councillors:	Ron Batstone Jenny Hannaby David Hingley	Emma Garnett Paul-Austin Sargent Imade Edosomwan	
District Councillors:	Katharine Keats-Rohan Elizabeth Poskitt	Val Shaw Louise Upton	David Rogers
Co-Optees:	Sylvia Buckingham	Barbara Shaw	Dr Alan Cohen
Date of Next Meeting:	*26 November 2026*		

For more information about this Committee please contact:

Committee Officer: *Scrutiny Team / Health Scrutiny Officer*
Email: *Email: scrutiny@oxfordshire.gov.uk / omid.nouri@oxfordshire.gov.uk*

Martin Reeves OBE
Chief Executive

September 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 11 - 30)

To **APPROVE** the minutes of the meeting held on 11 June 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 7th September 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 31 - 48)

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

1. Director of Public Health Annual Report.
2. All-Age Autism Strategy.
3. Adult/Older Adult Mental Health.

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

6. **Chair's Update** (Pages 49 - 122)

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

Two reports containing Recommendations from the Committee were sent on behalf of the JHOSC as part of the following areas/items:

1. Dentistry Services in Oxfordshire.
2. South Central Ambulance Service CQC Improvement Journey.

These reports are attached to the agenda papers for this item.

A letter was submitted on behalf of the Committee to the Secretary of State for Health and Social Care, where the Committee requested that Government:

- **Reconsider the proposed abolition of Healthwatch** and explore whether its objectives could instead be achieved through reform of the existing model.

- **Protect the principle of independence** within future patient voice arrangements, allowing local areas to retain or commission independent organisations where appropriate.

- **Provide maximum local flexibility** so that health and care systems can design arrangements that reflect local circumstances and community needs.

The Committee received a response Letter from the Department of Health and Social Care. Both the letter submitted on behalf the JHOSC as well as the DHSC's response are attached to the agenda papers for this item.

The Committee received a Letter from the Thames Valley ICB with an update on delayed payments to Adult Social Care Providers. This Letter is attached to the agenda papers for this item.

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

7. Report of the Primary Care Access & Estates Working Group (Pages 123 - 222)

The purpose of this item is to receive the final report of the Oxfordshire Joint Health Overview Scrutiny Committee's Primary Care Access & Estates Working Group.

The Committee is **RECOMMENDED** to:

a) **RECEIVE** and **ENDORSE** the Joint Health Overview and Scrutiny Committee (JHOSC) primary care and estates working group report found in Annex 1.

b) **AGREE** to the recommendations outlined in the working group report and for these to be issued to the Thames Valley Integrated Care Board.

c) **AGREE** to share this report and its findings with the Secretary of State for Health and Social Care.

d) **AGREE** to share this report and its findings with the Oxfordshire Health and Wellbeing Board.

e) **AGREE** to **DELEGATE** to the Health Scrutiny Officer to arrange for this report to be graphically finalised, and for a graphical and accessible version of this report to be published in the November JHOSC public meeting.

f) **NOTE** the formal closure of the Joint Health Overview and Scrutiny Committee primary care and estates working group.

8. Urgent Emergency Care/System Pressures (Pages 223 - 256)

Lily O' Connor (Programme Director, Urgent & Emergency Care, Oxfordshire) has been invited to present a report on Urgent Emergency Care/System Pressures.

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

1. A General Urgent Emergency Care Update for HOSC (answering some specific themes raised by the Committee when commissioning this item).

2. Oxfordshire's Urgent Emergency Care Winter Plan.

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

9. Independent Patient Voice Update (Pages 257 - 266)

Ansaf Azhar (Director of Public Health, Oxfordshire County Council) and Carole Stow (Engagement & Consultation Manager, Oxfordshire County Council) have been invited to present an update on the ongoing work to explore the future of Independent Patient and Resident Voice in Oxfordshire. This is in light of government's plans to abolish the Healthwatch function.

The JHOSC will receive an update on the engagement work commissioned by the Health and Wellbeing Board's Patient Voice Working Group to explore what residents feel about the role and significance of an Independent Patient and Resident Voice.

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

10. Healthwatch Oxfordshire Update (Pages 267 - 276)

Veronica Barry (Executive Director of 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. Horton General Hospital Update (Pages 277 - 288)

Olivia Clymer (Director of Strategy & Partnerships, Oxford University Hospitals NHS Foundation Trust) has been invited to present a report with an update on the Horton General Hospital.

This item constitutes the first of two public meeting items that will be held on the Horton General Hospital (the second being scheduled for the JHOSC's November public meeting). This particular item will focus on the following themes:

- Strategic Role of the Hospital.
- Current Services delivered at the Horton.
- Access to Care and Patient Flows.
- Estate and Infrastructure.
- An update on the condition, capacity and utilisation of the Horton estate.
- The current estate constraints affecting service delivery.
- Quality Safety and Regulatory Assurance.

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 289 - 292)

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

13. **Actions and Recommendations Tracker** (Pages 293 - 302)

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, 11 June 2026 commencing at 10.02 am and finishing at 16:03.

Present:

Chair:	Councillor Jane Hanna OBE		
Deputy Chair:	City Councillor Louise Upton		
Councillors:	Ron Batstone	David Hingley	Paul-Austin Sargent
	Jenny Hannaby	Mark Lygo	Gavin McLauchlan
District Councillors:	Katharine Keats-Rohan		
	Elizabeth Poskitt		David Rogers
Co-Optees:	Sylvia Buckingham		
	Barbara Shaw		
	Dr Alan Cohen		

Officers in attendance:

- Dr Rustam Rea (Deputy Chief Medical Officer and Director of Clinical Improvement, OUH)
- Olivia Clymer (Director of Strategy and Partnerships, OUH)
- Caroline Armitage (Deputy Head of Clinical Governance, OUH)
- Julie Dandridge (Associate Director – Pharmacy, Optometry and Dentistry)
- Dan Leveson (Director for Places and Communities)
- Paul Jefferies (SCAS Divisional Director for Thames Valley)
- Andrew Battye (SCAS Head of Operations for Oxfordshire)
- Rob Bale (Chief Operating Officer Mental Health and Learning Disability, OH)
- Emma leaver (Chief Operating Officer Community Health Services, Dentistry & Primary Care, OH)
- Angie Fletcher (Deputy Chief Nurse, OH)
- Ian Bottomley (Deputy Director, Integrated Commissioning)

27/26 ELECTION OF CHAIR FOR THE 2026/27 COUNCIL YEAR
(Agenda No. 1)

The Health Scrutiny Officer opened the meeting and asked if there were any nominations for a Chair of the Committee for the 2026-2027 council year. Cllr Ron Batstone nominated Cllr Jane Hanna, and Cllr Paul-Austin Sargent seconded.

There being no other nominations, Cllr Jane Hanna was elected Chair of the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) for the 2026-2027 council year.

28/26 ELECTION OF DEPUTY-CHAIR FOR THE 2026/27 COUNCIL YEAR
(Agenda No. 2)

City Cllr Louise Upton was elected vice-chair of the Committee for the 2026-2027 council year.

29/26 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Apologies were received from Cllr Emma Garnett, with Cllr Gavin McLauchlan substituting. Apologies were also received from District Cllr Val Shaw.

30/26 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

Barbara Shaw declared she was a patient safety partner at Oxford University Hospitals NHS Foundation Trust (OUH) and Chair of Healthwatch Oxfordshire.

Sylvia Buckingham declared she was a patient safety partner at OUH and a member of Healthwatch Oxfordshire.

Cllr Jane Hanna declared she was a staff member at SUDEP Action.

31/26 MINUTES
(Agenda No. 5)

The minutes of the meeting held on 16 April 2026 were **APPROVED** as an accurate record.

32/26 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 6)

Cllr Andrew Crawford, speaking on behalf of Wantage Town Council, presented findings from a local survey on dentistry access. He reported that only a third of respondents had an NHS dentist, a third were private patients, and a third had no access at all. He highlighted significant barriers including long travel distances, lack of local provision, and increasing population growth in the area. He described

Wantage and Grove as a “dental desert” and called for more locally targeted NHS provision and better data on access at neighbourhood level.

Eddy McDowall, Chief Executive of the Oxfordshire Association of Care Providers, raised urgent concerns about unpaid continuing healthcare (CHC) invoices. He stated that providers were collectively owed tens of millions of pounds, with some invoices outstanding for years. He explained that this had caused severe financial strain, with some providers struggling to pay staff. He described the issue as a systemic failure linked to ICB finance processes and system changes, and urged the Committee to hold the ICB to account and push for immediate resolution and transparency.

Kristi McDonald addressed the Committee regarding epilepsy services and patient safety. She highlighted delays in accessing specialist care, stating that patients were waiting significantly longer than recommended standards. She raised concerns about the impact of Valproate policy restrictions, workforce capacity, and increasing epilepsy-related risks, including deaths in the region. She called for renewed scrutiny of previously agreed system actions, greater focus on patient safety, and stronger coordination across services, including emergency care, primary care, and mental health.

Roseanne Edwards spoke about the future of Horton General Hospital. She raised concerns about what she described as a long-term reduction in services, including maternity, surgery, and bed capacity, and the resulting pressures on Oxford hospitals. She emphasised the impact of population growth in the Banbury area and argued that retaining and expanding Horton services was essential. The Committee was urged to undertake a thorough review with local groups able to provide evidence to support this work.

33/26 JHOSC COOPTEE APPOINTMENT

(Agenda No. 7)

The Committee:

1. **NOTED** the requirement to fill one vacant co-opted post on the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) and the work undertaken to fill this post.

2. **AGREED** to Dr Alan Cohen’s appointment as a co-opted member of the JHOSC (subject to full completion and submission of a Register Of Interests form) for a period of two years from 10 September 2026.

34/26 INTERIM UPDATE REPORT FROM THE JHOSC PRIMARY CARE ACCESS AND ESTATES WORKING GROUP

(Agenda No. 8)

The Committee received a report from the Health Scrutiny Officer providing an interim update on the ongoing work and activities of the JHOSC Primary Care Access and Estates Working Group.

The Committee:

a) NOTED the Joint Health Overview and Scrutiny Committee (JHOSC) primary care and estates working group interim report.

b) AGREED to the appointment of District Cllr David Rogers.

c) AGREED to receive a final report with findings and recommendations from the working group in the September 2026 JHOSC meeting, so as to allow for:

- The final planned working group session to take place with representatives of the Thames Valley Integrated Care Board (ICB) on the use of digital tools and models in primary care services.

- Conducting site visits to GP practices in both rural and urban areas.

- Inclusion of further findings from the working group's inquiry on the national backdrop of General Practice, and on the case studies of the Great Western Park and Bicester Health Centre.

d) **AGREED** to share the final findings of the working group with the Secretary of State for Health and Social Care.

35/26 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 9)

The Committee received responses to its recommendations on:

1. Maternity Services.
2. Oxfordshire Learning Disability Plan.

The Committee **NOTED** the responses.

36/26 CHAIR'S UPDATE

(Agenda No. 10)

The Chair of the Committee, Cllr Hanna, provided the following updates:

1. A report was submitted to Oxfordshire system partners on behalf of the Committee with recommendations on Adult and Older Adult Mental Health Services. This report and the recommendations therein sought to address the concerns raised by the Full Council Motion on mental health.

2. Reports had also been submitted to Oxfordshire system partners on behalf of the Committee with recommendations on the All-Age Autism Strategy and on the Director of Public Health Annual Report.

3. A letter had been sent on behalf of the Committee to the Chief Executive of the Thames Valley Integrated Care Board (ICB) in relation to delayed

payments to adult social care providers for the provision of Continuing Health Care services (CHC).

4. The JHOSC primary care working group had held two further meetings with representatives of the Thames Valley ICB on 23rd April and 9th June to discuss GP estates and digital models respectively.

5. The Committee was alerted to proposed cuts to Gynaecology services.

6. The Committee was also alerted to proposed cuts to some aspects children's mental health services delivered by the NHS.

7. The government intended to proceed with its initial plans to abolish the Healthwatch function. The Health and Wellbeing Board Independent voice working group continued to work on exploring and designing a new independent patient voice function post Healthwatch abolition.

8. The Committee received concerns from members of the public in regard to potential tensions between the Oxford Eye Hospital and the Trust, and the potential implications this could be having on ophthalmology patients.

9. The Committee received a letter from Western Valley Parish Council for clarification on the current state of the Great Western Park GP project.

The Committee **AGREED** to:

1. Write to OUH seeking clarity on the decision and the reasoning behind it, and if any impact assessments had been undertaken.

2. Write to Oxford Health NHS Foundation Trust (OH) and the Thames Valley ICB in relation to proposed cuts to some aspects children's mental health services delivered by the NHS

3. Write to the Secretary of State for Health and Social Care to urge government to consider the implications of abolishing the Healthwatch function; and that if government intended to proceed with abolition, to enable local flexibility to allow local systems to produce any arrangements deemed fit to support patient voice.

4. Write to OUH to seek clarity around concerns heard from members of the public in regard to potential tensions between the Oxford Eye Hospital and the Trust, and the potential implications this could be having on ophthalmology patients.

5. Write to Western Valley Parish Council in response to their letter to the JHOSC seeking clarification on the current state of the Great Western Park GP project.

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

37/26 OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT

(Agenda No. 11)

Rustam Rea (Deputy Chief Medical Officer and Director of Clinical Improvement, Oxford University Hospitals NHS Foundation Trust); Olivia Clymer (Director of Strategy and Partnerships, Oxford University Hospitals NHS Foundation Trust), and Caroline Armitage (Deputy Head of Clinical Governance, Oxford University Hospitals NHS Foundation Trust) presented the OUH quality account for the year 2025-2026.

The Committee examined the Trust's implementation of the Patient Safety Incident Response Framework (PSIRF). The Deputy Chief Medical Officer and Director of Clinical Improvement explained that the Trust had used the Health Services Safety Investigations Body (HSSIB) investigation quality tool to assess the quality of investigations before and after implementation of PSIRF and had found significant improvement across all nine assessed domains.

The Committee raised a specific issue relating to learning from deaths and referred to a prevention of future deaths report from August 2025, asking whether this had been incorporated into the Trust's learning processes and how the Trust engaged with bereaved families where learning arose from a death. The Deputy Chief Medical Officer and Director of Clinical Improvement explained that both the Trust's hospital standardised mortality ratio and summary hospital-level mortality indicator were within expected or better-than-expected ranges, and that the number of prevention of future deaths notices received by the Trust had reduced in recent years. He attributed this partly to improvements in the quality of investigations and the evidence the Trust was able to present to coroners in relation to learning and action taken. The Trust would need to look back at the specific case referenced by the Chair, but where a death revealed learning, the Trust initiated a formal learning response and engaged with relatives to understand their concerns and insights.

Members asked whether bereaved families were informed about how learning had been embedded and whether there was any offer of co-production in such situations. Officers confirmed that the Trust actively involved families as part of its investigations into relevant deaths, used family liaison officers where appropriate, and sought to feed back on what had been learned and what had changed as a result.

The Committee asked why some quality priorities from the previous year had been carried forward and whether the factors that had prevented full delivery—such as workforce, digital or financial constraints—had now changed sufficiently to avoid repeated slippage. In response, the Deputy Chief Medical Officer and Director of Clinical Improvement explained that in a number of cases the original quality priority had broadened as the work developed. He gave the example of deterioration management, where the Trust had realised that its existing platform was not sufficiently robust and had therefore procured a new machine and new digital platform for recording and escalating deterioration. Similarly, medicines reconciliation had proved to be a much broader issue than originally anticipated, requiring improvement in interoperability between primary care, community services and hospital systems, and had now become part of a wider digital programme.

The Committee referred to examples in the report of digital innovation, including glucose monitoring work and ambient voice technology, and asked whether patient safety champions and co-production were embedded in that digital programme. The Deputy Chief Medical Officer and Director of Clinical Improvement explained that ambient voice technology had emerged from clinical services' desire for a more efficient and modern method of producing consultation notes and clinic letters. He described the concept as involving software listening to a consultation and then generating a letter or note which could then be checked and shared.

The Committee enquired as to what the Trust meant by the term co-production, observing that different organisations appeared to use it differently and that the Committee increasingly found itself hearing references to "co-production", "co-design" and "engagement" as if they were interchangeable. Officers responded that co-production began with understanding what patients and families wanted answered and what improvements they themselves wished to suggest, and that it was more appropriately understood as an ongoing process or active conversation rather than a single event. The Director of Strategy and Partnerships added that the Trust was keen to keep developing its confidence and examples of co-production, both in relation to care pathways and in the development of the Quality Account itself, including through open meetings and public engagement activity.

Members also raised concerns about the operation and version control of RESPeCT forms, particularly in situations where different versions of a patient's form existed at home and in hospital or where families were unclear whether changes to a patient's wishes had been reflected everywhere. The Deputy Chief Medical Officer and Director of Clinical Improvement described this as going to the heart of the absence of a fully shared digital care record, both locally and nationally. The issue had been raised with the Trust's Chief Digital Information Officer, and that the challenge was to preserve the strengths of the Trust's current RESPeCT and treatment escalation process while making it more shareable and updateable across organisational boundaries.

The Committee explored the Quality Account's work on health inequalities and learning disability provision, including the rollout of a reasonable adjustment flag and delivery of Oliver McGowan training. The Deputy Chief Medical Officer and Director of Clinical Improvement explained that one reason for bringing this as a quality priority the previous year had been to give greater visibility and coherence to a large body of work already happening across the Trust. A divisional nurse now led a monthly learning disability group, a number of services had compiled registers of patients with learning disabilities, and those patients were being identified and prioritised in advance of operations, diagnostics and other procedures so that reasonable adjustments—including different access arrangements, communication support, patient information materials and trusted people accompanying them—could be put in place before the patient arrived. This was an ongoing process rather than a completed programme.

The Committee enquired about national audits, noting that sections of the account referred to some audit participation rates and case ascertainment levels being below 100 per cent. The Deputy Chief Medical Officer and Director of Clinical Improvement confirmed that the Trust reviewed all national audit results, regardless of the extent of

participation, and stated that a meeting he was due to chair later that day was in fact focused on national audit outcomes.

Members returned to the quality accounts section on the discharge safety checklist and asked about current compliance levels, the interventions that had demonstrably reduced delayed discharge and length of stay, and how safety was being maintained around medication changes and patient understanding on discharge. The Deputy Chief Medical Officer and Director of Clinical Improvement said that this remained an ongoing quality priority. One of the most significant improvements had been the introduction of board rounds, which enabled teams to review all patients every day, identify who was likely to go home in the next few days, ensure that medications were reconciled and prepared in advance, and improve communication of discharge changes both digitally to primary and community care and directly to patients themselves.

Finally, the Committee asked about maternity services, noting that despite the considerable work undertaken and the recent improvement in the maternity rating from "requires improvement" to "good", the report still showed that maternity remained an area requiring further attention. The Deputy Chief Medical Officer and Director of Clinical Improvement said that the Committee would join the Trust in acknowledging the amount of work undertaken in maternity and the significance of the improved rating, which had also contributed to the Horton site being rated "good" overall. He explained that the next stage of work would focus not only on outcomes—where the Trust had seen some positive indicators—but particularly on patient experience, with a quality priority aimed at understanding and improving the experience of women and families in real time rather than only retrospectively.

The Committee:

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

b) **AGREED** to finalise the wording of the feedback subsequent to and outside the meeting, and to submit the feedback to the Trust prior to the publication date for the Quality Account at the end of June 2026.

38/26 DENTISTRY SERVICES IN OXFORDSHIRE
(Agenda No. 12)

Julie Dandridge (Associate Director – Pharmacy, Optometry and Dentistry, Thames Valley ICB) and Dan Leveson (Director for Places and Communities, Thames Valley ICB) were invited to present a report on dentistry services in Oxfordshire.

The Associate Director for Pharmacy, Optometry and Dentistry advised that since the previous scrutiny session in 2024, four new dental practices had opened across Oxfordshire, including in rural areas, and that the system had replaced more activity than had been lost following contract handbacks after the pandemic period. Additional urgent care capacity had been commissioned, with practices delivering thousands of additional urgent appointments in line with national policy objectives. She also highlighted the continuation of a flexible commissioning scheme, through which a significant number of vulnerable patients had accessed dental care, and

described the introduction of oral health promotion initiatives aimed at children, including early engagement in schools and nurseries.

The Committee referred to data within the report indicating that approximately 46.5 per cent of the population had seen an NHS dentist within the previous two years, compared with over 51 per cent before the pandemic. The Committee asked what trajectory the Integrated Care Board expected for recovery and what interventions would be required to close that gap. The Associate Director for Pharmacy, Optometry and Dentistry acknowledged that returning to pre-pandemic levels would be challenging, citing changes in public behaviour, growth in private provision, and workforce constraints. The reformed dental contract, including the requirement for a proportion of appointments to be made available for urgent care, was intended to improve access and reduce the number of practices closed to new patients. She also emphasised the importance of revising recall patterns in line with NICE guidance and strengthening public understanding of when and how to access dental care.

Members expressed concern that headline utilisation statistics did not capture unmet demand, particularly from individuals who had been unable to obtain NHS appointments at all. The Associate Director confirmed that there was currently no comprehensive dataset capturing unsuccessful attempts to access care, although proxy measures included complaints, Healthwatch intelligence, and 111 service contacts. It was noted that complaints relating to dentistry had reduced significantly in recent years, although Members cautioned that this might reflect reduced expectations rather than improved access.

The Committee explored urgent dental care pathways and their integration with NHS 111. Members raised concerns about the reliance on urgent care provision and the sustainability of delivering such care predominantly through general practice. The Associate Director explained that urgent care was provided through a combination of high-street practices, commissioned urgent care slots, and the community dental service, including some out-of-hours provision. However, the new contract had only recently been introduced and that it would take time to assess its impact on access patterns, including weekend demand.

Members also examined health inequalities and rural access, noting significant variation between districts, and highlighted data showing lower contract delivery rates and reduced access in areas such as Cherwell and the Vale of White Horse. In response, the Associate Director confirmed that variation existed and identified recruitment difficulties, geographic factors, and historic contract arrangements as key drivers. The Integrated Care Board was seeking to rebalance activity through commissioning decisions and to target additional provision to areas of highest unmet need. The Director of Public Health emphasised that rural inequalities required particular attention, noting that traditional deprivation measures did not always capture rural access issues.

The Committee sought further clarity on how population need was assessed and how future changes to local government structures might affect the availability of granular data. The Associate Director explained that data was currently assembled at district level but could be analysed at different geographic scales, including neighbourhood

level. The emerging neighbourhood health model would play a key role in identifying local need and shaping service provision going forward.

The Committee examined workforce challenges, particularly in recruiting dentists to underserved areas. The Associate Director explained that although financial incentives had been introduced to support recruitment, only a small number of practices had successfully recruited staff to date, reflecting wider workforce shortages. She referenced the lack of a dental school in the region as a structural challenge and noted ongoing discussions at regional level regarding training capacity.

Members queried how the Integrated Care Board defined vulnerable populations and how eligibility for the flexible commissioning scheme was determined. The Associate Director explained that the scheme was intended to support individuals facing barriers to access, including certain clinical groups and those with complex needs, and that it was flexible and evolving. She noted that the scheme had been adapted over time, with some groups removed where access had improved and others added where need had been identified, including individuals experiencing homelessness. Members suggested further groups for inclusion, including patients with epilepsy and those in institutional settings such as care homes and prisons.

The Committee also explored oral health as a wider public health issue, with Members emphasising the links between dental health and broader physical health outcomes, including cardiovascular disease, nutrition and cancer detection. The Associate Director acknowledged that this had not been fully articulated in the report and agreed that a broader framing of oral health would strengthen future reporting.

Significant discussion took place regarding water fluoridation. The Director of Public Health confirmed that the evidence base remained clear that fluoridation was the most effective population-level intervention to reduce tooth decay, particularly among children. However, he explained that implementation was complex, involving legal, logistical and public acceptability challenges, including coordination with water companies and neighbouring regions. Members queried why, given the strength of the evidence, progress had been so slow. The Director of Public Health reiterated that while the public health case was strong, delivery was constrained by regulatory processes and infrastructure considerations, and suggested that progressing the issue at a wider Thames Valley level might be more effective.

The Committee considered contract performance and reinvestment of underspends, noting that some practices had delivered below contractual activity thresholds. Members asked how recovered funds were being reinvested to improve access. The Associate Director explained that dental funding was ring-fenced and that underspends were reinvested into dentistry, including health promotion initiatives, services for vulnerable groups, and efforts to reduce secondary care waiting lists. Further, contract delivery reflected a complex interplay of workforce availability, patient demand and historic contract values, and the Integrated Care Board was seeking to rebalance provision to better reflect population need.

The Committee discussed the limitations of data available to commissioners, noting that unlike general practice, dental data was relatively restricted. The Associate

Director confirmed that the Integrated Care Board had limited visibility beyond activity data and urgent versus routine classification, which constrained strategic planning. Members emphasised the need for improved data in order to support effective scrutiny and commissioning decisions.

The issue of access to specialist dental care, particularly for children requiring general anaesthetic, was also raised. The Associate Director explained that such services were delivered through community dental services but depended on access to theatre capacity, which was shared with acute providers. She confirmed that waiting times for some patients remained a concern but stated that work was ongoing to prioritise cases and explore alternative provision, including use of independent sector capacity.

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

1. For system partners to pursue previously made requests to government by the JHOSC to support a local public consultation/engagement on fluoridating Oxfordshire's water supply. It is recommended that system partners work with any future combined authority at the Thames Valley level to further support this.

2. For the Thames Valley ICB to launch a review of the local impacts of changes being made to the dental contract. It is recommended that there is stakeholder involvement in this review, including the JHOSC.

3. For system partners to take collective action to reduce the effects of rural inequalities on poor dental outcomes and on access to NHS dentistry; and to develop data indicators at all District and Neighbourhood levels to provide visibility to population need and other/rural health inequalities affecting oral health and dentistry access. It is also recommended that strong measures are taken, including through public/stakeholder engagements, to tackle broader inequalities around oral health, including amongst vulnerable population groups.

4. For NHS dentistry underspends to be reinvested in the areas of worst dentistry access in Oxfordshire to improve oral health outcomes within the County.

5. For system partners to continue to support oral health promotion, using neighbourhood health planning at community level as an opportunity to pursue this. It is recommended that system partners utilise parish and town councils and schools, as well as grassroots community organisations, to support this work.

6. For the ICB to continue to engage with the Dentistry Deanery to support the case for a local dentistry school to be established urgently.

39/26 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 13)

Veronica Barry (Executive Director of Healthwatch Oxfordshire) presented the Healthwatch Oxfordshire update.

The Executive Director explained that the breadth of Healthwatch activity was reflected across many of the items already considered by the Committee and emphasised that Healthwatch sought to ensure that the experiences of residents were consistently fed into system decision-making. She confirmed that written responses had been submitted to both the Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust on their respective Quality Accounts, ensuring that patient voice informed those processes.

Healthwatch Oxfordshire had undertaken Enter and View visits to mental health inpatient settings, including wards at the Oxford Health NHS Foundation Trust, where patient experience aligned with themes discussed earlier in the meeting, particularly in relation to environments, access, and care pathways. Healthwatch Oxfordshire had also contributed to the Committee's primary care access work, having gathered feedback from a substantial number of residents over the previous year regarding GP access and patient experience.

The Executive Director of Healthwatch Oxfordshire then outlined recent community research activity, explaining that Healthwatch had increasingly adopted a "community researcher" model in order to reach groups that were typically under-represented in consultation processes. She described work undertaken with members of the older Chinese community, where a community researcher conducted in-depth interviews with Cantonese-speaking residents. This work had highlighted persistent barriers to care, particularly around access to interpreting services, understanding of NHS systems, and navigation of care pathways. It was reported that many residents continued to rely on family members, including children, to interpret healthcare conversations, indicating a continued gap in provision of appropriate language support.

The Committee also heard about partnership work with community organisations, including engagement with African and Caribbean women's groups to explore maternity experiences. This work built on previous engagement and had contributed to linking local community voices into wider system work, including national reviews. It was explained that further engagement events were planned to bring together community perspectives with system partners, including commissioners and providers.

The Executive Director of Healthwatch Oxfordshire highlighted the development of a community research "how-to" guide, co-produced with a wide range of grassroots organisations. She explained that the guide differed from traditional academic-focused resources, as it was designed to empower communities themselves to undertake research and articulate their experiences. The Committee noted that this represented an example of practical co-production and capacity-building within communities.

Members also heard about Healthwatch's rural outreach work, which had engaged extensively with residents across rural settlements using a combination of face-to-face engagement, focus groups and surveys. This work would feed into broader system strategies, including Marmot and population health programmes, and would provide further insight into the experiences of residents in rural areas, including access to services and transport challenges.

Members raised questions regarding the increasing use of artificial intelligence in complaints processes and its impact on provider organisations. It was responded that Healthwatch had been made aware by providers that some patients were now using AI tools to generate complaints. While this had the effect of enabling more people to raise concerns, it had also resulted in more complex and time-consuming complaint handling processes for providers.

The Committee also discussed how Healthwatch activity linked to wider system work on independent patient voice, noting its relevance to ongoing work by the Health and Wellbeing Board in developing future patient voice arrangements. Members reflected that Healthwatch's work demonstrated the breadth of ways in which patient voice could be expressed, including surveys, engagement events, complaints, and lived experience contributions.

The Committee **NOTED** the Healthwatch Oxfordshire update.

40/26 SOUTH CENTRAL AMBULANCE SERVICE CQC IMPROVEMENT JOURNEY UPDATE
(Agenda No. 14)

Paul Jefferies (South Central Ambulance Service [SCAS] Divisional Director for Thames Valley) and Andrew Battye (SCAS Head of Operations for Oxfordshire) were invited to present the SCAC Care Quality Commission (CQC) improvement journey update report.

The Committee enquired about the Trust's exit from the recovery support programme in January 2026 and the removal of the 2024 undertakings by the South East Regional Support Group in April 2026. The Divisional Director for Thames Valley explained that this had followed a period of close regional oversight in which the Trust was scrutinised primarily against three core areas: workforce, operational performance, and financial position. The Trust had achieved financial break-even in the previous financial year, had a formal recovery action plan in place for improving Category 2 response times towards the 18-minute target applicable to all ambulance services, and had embedded routine executive monitoring of operational, financial and workforce performance.

Members asked which issues identified by inspection remained most significant. The Divisional Director for Thames Valley responded that one of the main areas of ongoing work was medicines management, which had been identified by the CQC as requiring improvement in relation to storage, documentation and process reliability. He explained that the Trust had significantly developed its pharmacy team and had invested in a new site to support improved "make ready" processes and safer medicines management. He described the practical challenge of crews carrying a

range of medicines in different bags, including controlled drugs, and said that the Trust was introducing a new personal issue model for morphine management in Oxfordshire, which was due to go live the following week.

The Committee revisited its earlier recommendations on internal assurance, audit and governance. The Divisional Director for Thames Valley explained that the Trust had introduced a Performance Management Accountability Framework, under which each divisional director was required to provide formal monthly assurance to the executive team through internal scrutiny arrangements. He said that for Thames Valley this covered Oxfordshire, Buckinghamshire and Berkshire, each with sector leadership beneath him, including a Head of Operations and a Clinical Operations Manager. He explained that scrutiny included appraisal completion, personal development plans, statutory and mandatory training, and operational quality indicators such as hand hygiene, vehicle cleanliness and medicines management.

Members asked how patient and public voice influenced Board-level challenge. The Divisional Director for Thames Valley responded that public Board meetings did include lived experience input. He gave one recent example in which a team leader had attended the Board with members of the public involved in a cardiac arrest incident where a pregnant woman had been performing CPR on her husband before ambulance crews arrived and successfully resuscitated him. He explained that such accounts, whether of care that had gone exceptionally well or of care that had raised concerns, were used to inform learning and to bring patient experience directly into governance discussions, alongside the contribution of non-executive directors. When Healthwatch asked how the service systematically gathered and learned from patient feedback, the Divisional Director explained that the Trust had a dedicated patient experience team which coordinated all positive and negative feedback, allocated it to the relevant teams, and ensured that team leaders and clinical team educators investigated and responded.

The Committee explored the Trust's implementation of the Patient Safety Incident Response Framework. Members asked what had changed in practice since its introduction, what recurrent risks had been identified, what actions had followed, and what evidence existed that those actions had reduced harm. The Head of Operations for Oxfordshire explained that the principal initial change had been in the training and support given to staff and team leaders in understanding the new process for handling patient safety incidents. He said that patient safety incidents from the previous day were now reviewed every day by the patient safety team in order to identify harm or emerging concerns, and that there was now a much stronger culture of looking proactively for patient safety issues rather than reacting only after serious incidents had occurred.

Members asked about the expansion of the safeguarding team, including whether increased safeguarding capacity had improved the timeliness and quality of referrals and the feedback loops to crews. The Head of Operations for Oxfordshire explained that the Trust had previously had problems with safeguarding referrals because of a mismatch between paper and electronic systems, but that referrals were now made electronically through the patient record at the point of case closure. He said the system had been designed to prompt staff where a safeguarding issue had been identified but a referral had not yet been completed. He added that safeguarding

referrals, associated learning and performance were now reported monthly through the Board assurance framework.

The Committee examined the growing problem of violence and aggression towards staff. Members referred to similar concerns raised by OUH and asked whether the ambulance service was facing the same trend. The Head of Operations for Oxfordshire said that regrettably it was, and that the issue had not gone away but had worsened nationally and locally. He described the difficulty of distinguishing between aggression driven by illness and aggression that was deliberate, but stressed that no staff member deserved such abuse.

The discussion focused on workforce, particularly the report's statement that financial pressures and service realignment had led to a mismatch between clinical and non-clinical staff. The Head of Operations for Oxfordshire explained that the clinical workforce referred primarily to registered paramedics, while the non-clinical or clinical support workforce included Associate Ambulance Practitioners and Emergency Care Assistants. He said that, over the previous 18 months to two years, the Trust had deliberately invested in upskilling its own support workforce, with emergency care assistants progressing to associate practitioner roles and associate practitioners progressing through university routes to become paramedics. This had helped to reduce clinical vacancies in Oxfordshire, but had also left non-clinical vacancies which the Trust could not yet fully backfill.

The Committee scrutinised the Trust's 'Freedom to Speak Up' culture and psychological safety, and asked whether the increase in concerns being recorded indicated a genuinely safer speaking-up culture or continuing unresolved cultural problems. The Head of Operations for Oxfordshire acknowledged that it felt paradoxical to see rising numbers of concerns as positive, but said the increase suggested staff were becoming more comfortable raising issues. He explained that the organisation had invested heavily in the Freedom to Speak Up process, including local station-based champions, precisely so that staff did not have to raise issues only through line management and could speak to peers instead. He said the challenge was not only encouraging staff to speak up but also "listening up" and then following through, because if nothing changed the reporting would stop.

The Committee asked what the remaining causes of handover delay in Oxfordshire were and whether rising figures at the Horton General Hospital should be a concern. The Head of Operations for Oxfordshire replied that the main causes remained familiar system issues: acuity, seasonal or weather-related surges in demand, and the ability of acute hospitals to discharge patients safely into the community. He described ambulance arrivals as having a "tsunami effect", with several vehicles often arriving in quick succession from different parts of the county, thereby creating episodic pressure in emergency departments. He explained that the Trust also used the release to respond process at 45 minutes where hospitals could not offload patients promptly, transferring responsibility to the hospital so that crews could return to community demand. He said he was not overly concerned about the Horton figures, noting that they remained comparatively good against national standards and that although there had been a slight increase, it was much smaller than elsewhere and broadly linked to increased demand.

The Committee and Healthwatch Oxfordshire also explored the ambulance service's proactive work with high-intensity users and alternatives to conveyance. The Head of Operations for Oxfordshire explained that the service had a high-intensity user function which worked with social care and acute partners to identify better pathways for people who made repeated use of emergency services. He said the service actively encouraged safe non-conveyance, not as a matter of refusing transport but of identifying better alternative services.

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

1. For SCAS and the ICB to escalate the future pipeline issue with staff and challenges with non-availability of training placements.

2. For the Ambulance Service to strengthen opportunities for public and patient involvement. It is recommended that there is coproduction as part of shaping and monitoring the Trust's improvement journey.

3. For the Trust to ensure that "speaking up" is not merely encouraged or measured per se, but to evidence that actions are followed up and lessons are learned around the themes emerging through "speaking up".

4. To ensure that there is continued support for staff wellbeing. It is recommended that there are clear, measurable, and transparent outcomes frameworks to demonstrate success in supporting staff and in tackling burnout.

41/26 OXFORD HEALTH NHS FOUNDATION TRUST QUALITY ACCOUNT
(Agenda No. 15)

Rob Bale (Chief Operating Officer Mental Health and Learning Disability, Oxford Health NHS Foundation Trust [OH]); Emma Ieaver (Chief Operating Officer Community Health Services, Dentistry & Primary Care, OH); and Angie Fletcher (Deputy Chief Nurse, OH) have been invited to present the Oxford Health NHS Foundation Trust quality account for the year 2025-2026.

The Committee examined the outcome of the most recent Care Quality Commission (CQC) inspection of Child and Adolescent Mental Health Services (CAMHS) inpatient units, conducted in November 2025. The Deputy Chief Nurse explained that the inspection had identified a number of areas for improvement, including individualised care planning, the use and documentation of restrictive practice, and aspects of medication management. Many of the issues identified related not to the care delivered itself, but to the quality and consistency of documentation, particularly the lack of recorded evidence demonstrating the extent of de-escalation efforts undertaken by staff prior to incidents.

The Chief Operating Officer (Mental Health and Learning Disability Services) added that CAMHS inpatient provision served a much wider geography beyond Oxfordshire, including highly specialised services such as a national-level intensive care unit for young people. He emphasised the increasing complexity and acuity of patients, noting that young people now presented with higher levels of trauma, emotional dysregulation, and neurodivergent needs than had been typical in earlier years. This

complexity influenced both care delivery and the interpretation of incident data, particularly in relation to restrictive interventions.

Members examined the Trust's progress in reducing restrictive interventions, with particular focus on seclusion and prone restraint. The Deputy Chief Nurse reported that the Trust had succeeded in improving its measurement of seclusion by introducing metrics to record duration of seclusion, rather than simply the number of incidents. This allowed the Trust to better understand the extent to which patients' liberty was being restricted and to identify opportunities to reduce the length of seclusion episodes.

However, the Committee was advised that the Trust had not met its target for reducing prone restraint during the year. The Deputy Chief Nurse explained that this was not unexpected and reflected increasing patient complexity and risk behaviours, including incidents of self-harm and violence, often involving a small number of highly complex patients. The Trust had established a prone restraint taskforce, with all incidents subject to rapid review at senior level to identify learning and alternative approaches. Further targeted interventions had been introduced, including enhanced training, the introduction of alternative de-escalation equipment, and improved early identification of high-risk patients.

The Committee examined the Trust's priority relating to integration of physical and mental health care, particularly in light of evidence suggesting under-recording of physical health conditions among mental health patients. The Chief Operating Officer (Mental Health and Learning Disability Services) acknowledged that data quality challenges existed and that diagnosis coding was not always complete or consistent across systems. He emphasised that people with severe mental illness experienced significantly poorer physical health outcomes and reduced life expectancy compared to the general population, and that addressing this inequality was a key priority.
He outlined planned action through the establishment of an oversight group, improved integration of physical health teams within mental health services, and stronger collaboration with primary care.

The Committee considered the Trust's approach to learning from deaths, including the impact of national changes to the Learning from Deaths and LeDeR programmes. The Chief Operating Officer (Mental Health and Learning Disability Services) confirmed that all deaths were subject to internal review, irrespective of national programme changes, and that the Trust actively analysed trends and themes to identify areas for improvement. There had been some increase in the average age of death among people with learning disabilities, which indicated improvement in addressing physical health needs, though Members noted that significant national inequalities remained.

The Committee asked about engagement with bereaved families. Officers explained that families were actively invited to participate in investigations, including contributing to terms of reference, and were supported by family liaison officers. The Deputy Chief Nurse added that families were involved not only in investigations but also in subsequent improvement work, and that the Trust had employed patient safety partners to ensure that patient and family perspectives informed safety processes.

The Committee raised concerns regarding the number of suspected or confirmed suicides among patients and asked what changes had been implemented as a result of partnership working on suicide prevention. The Deputy Chief Nurse explained that the Trust had moved away from traditional “low, medium, high” risk stratification and towards a more individualised and dynamic assessment of risk, reflecting the complexity of suicide risk and the variability between individuals. The Trust had revised documentation, training and assessment tools accordingly. The Chief Operating Officer (Mental Health and Learning Disability Services) added that improvements had been made to safety planning, including co-production of safety plans with patients and, where appropriate, their families. He also described the expansion of access routes into support, including safe havens, mental health support lines, and digital services, designed to make support more accessible and less institutional. Members were advised that the Trust worked closely with public health partners to analyse suicide data and respond to emerging trends, including potential links to wider social or environmental factors.

The Committee scrutinised the Trust’s approach to co-production and patient voice, including the role of lived experience in governance and service design. The Chief Operating Officer (Mental Health and Learning Disability Services) acknowledged that while the Trust had a strong cohort of experts by experience, there remained a challenge in ensuring representation from harder-to-reach groups. The Trust was seeking to address this through neighbourhood-based approaches, improved use of population health data, and targeted engagement with specific communities. He gave examples of partnership working with voluntary sector organisations to reach groups such as traveller communities.

The Committee **AGREED** to:

a) Provide feedback on the Trust’s Quality Account.

b) Finalise the wording of the feedback subsequent to and outside this meeting, and to submit the feedback to the Trust prior to the publication date for the Quality Account at the end of June 2026.

42/26 FORWARD WORK PLAN
(Agenda No. 16)

The Committee **AGREED** to the items on the work plan for September, and that the November meeting should include items on Neighbourhood Health, Medicines Management, and Epilepsy Services.

The Committee also **AGREED** to **DELEGATE** to the Chair and Health Scrutiny Officer to make any necessary amendments to the work plan offline.

43/26 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 17)

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

..... in the Chair

Date of signing .....

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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

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

Issue: Director of Public Health Annual Report

Lead Cabinet Member(s) or Responsible Person:

- Ansaf Azhar- Director of Public Health, Oxfordshire County Council.
- Kate Austin- Public Health Principal, Oxfordshire County Council.
- Fiona Ruck- Health Improvement Practitioner, Oxfordshire County Council.

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

Deadline for response: Wednesday 8th July 2026.

Response to report:

The recommendations are broadly aligned with the direction of travel set out in the Director of Public Health Annual Report 2025/26 and current Partnerships and Inequalities work. The response below confirms where recommendations are accepted, where they are partially accepted due to current funding and system constraints, and the practical actions already underway or proposed.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. To embed CIPs into routine commissioning and service design, ensuring decisions explicitly reference CIP findings and community led priorities.	Accepted	The Community Insight Profiles are already being used in service design through the action plans developed for each profile area. These action plans translate the profile recommendations into local priorities and guide the work of multi-agency steering groups, including district and city councils, voluntary and community sector partners, health partners and, in some areas, residents. This means that CIP findings are already informing local delivery and partnership action in the areas where profiles have been completed. The proposed action is to scale up the use of CIPs across Oxfordshire by promoting the Community Insight Profile Development Toolkit as a legacy tool of the programme. The toolkit sets out the method for developing locally led profiles and action plans, enabling other areas of the county to use the same approach. Public Health will also continue to work with partners to expand and maintain the interactive dashboard and Oxfordshire Data Hub content so that local data and profile findings are easier to access and use in planning, service design and partnership decision-making. Timescale: ongoing through 2026/27, linked to toolkit rollout, dashboard updates and continued use of area action plans through local steering groups.
2. To ensure that neighbourhood working includes public health	Accepted	Public Health are already contributing to the development of neighbourhood working and has identified the Community Insight Profiles as a relevant evidence base for neighbourhood health. The

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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.		proposed action is to continue linking public health leadership, community insight, voluntary and community sector assets, and council assets into neighbourhood health planning as the model develops. A full systemwide roadmap will need to be developed with wider system partners, reflecting NHS, local government and voluntary sector roles. Timescale: ongoing through 2026/27, aligned with neighbourhood health and local government reorganisation work.
3. For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes, including Well Together and physical activity pathways.	Partially accepted	The Prevention and Health Inequalities Forum already provides a multi-agency forum for strategic oversight, shared learning and partner updates on prevention and health inequalities work. The Forum is not the sole governance route for these programmes, but it provides an important system-wide forum for sharing progress, identifying links between workstreams and supporting alignment across partners such as with community health and wellbeing roles and targeted support for inclusion health groups. This includes oversight of the ICB Prevention and Inequalities Fund programmes such as the (now concluded) Well Together programme and physical activity pathways. Wider publication of progress would need to be agreed through the Forum and aligned with existing reporting routes, including the Director of Public Health Annual Report, Oxfordshire Marmot Place work reporting and Health and Wellbeing Board governance. Timescale: during 2026/27, the Forum will agree the most appropriate route for sharing a consolidated annual update on relevant prevention and health inequalities programmes, using existing evaluation data, programme reporting and partner updates where available. Timescale: during 2026/27, the Forum will agree the most appropriate route for sharing a consolidated annual update on relevant prevention and health inequalities programmes, using

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		existing evaluation data, programme reporting and partner updates where available.
4. To move Community Health Development Officer, Well Together roles and community led programmes onto multi-year 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.	Partially accepted	The principle of longer-term funding for Community Health Development Officers and community-led programmes is supported. Current public sector funding constraints mean a commitment to multi-year funding cannot be confirmed through this response. The Well Together programme was supported through Thames Valley Integrated Care Board funding and is no longer funded as a continuing programme. This means any future community-led activity of this type would need to be considered through available funding routes, local priorities and wider system discussions rather than assumed as part of an existing programme. The proposed action is to use current evaluation, programme learning and evidence of impact from the Community Health Development Officer programme, Well Together and related community-led grant activity to inform future prioritisation and funding discussions. Any best value review would need to consider available budgets, statutory duties, evidence of impact, value for money and the risk of losing progress in communities where deprivation indicators have improved. Timescale: review and prioritisation discussions during 2026/27 as part of budget and commissioning planning.
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	Accepted	Rural inequalities scoping work is underway. Initial analysis identified 14 priority rural areas for engagement, informed by deprivation data and local intelligence. Engagement led by Healthwatch Oxfordshire and Community First Oxfordshire has gathered insight from residents and local organisations through surveys, focus groups and targeted outreach. Emerging findings include hidden deprivation, transport and connectivity barriers, housing pressures, cost of living issues, limited opportunities for young people, isolation, access to services and reliance on fragile

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

offer to support an independent voice, local members, and to enhance community capabilities.		local volunteer capacity. The final Rural Inequalities Scoping Report and associated data pack will be used to inform neighbourhood development, rural proofing and work with towns, parishes and community partners. The report will also be used to inform the work of partners through the system-wide Marmot Steering Group, with related actions and recommendations monitored through this group as part of the wider Marmot Place governance arrangements. Timescale: draft report review during summer 2026, presentation to the Marmot Steering Group by the end of July 2026, and recommendations informing Health and Wellbeing Board and wider system discussions from September 2026 onwards.

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Issue: All-Age Autism Strategy

Lead Cabinet Member(s) or Responsible Person:

- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council).
- Ian Bottomley (Deputy Director, Integrated Commissioning).
- Bhavna Taank (Head of Joint Commissioning [Life Course] – Live Well)
- Dan Leveson (Director for Places and Communities- Thames Valley ICB).

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

Deadline for response: Thursday 2nd July 2026.

Response to report:

This is a draft response and could be subject to changes as required ahead of the deadline to respond of the 2nd of July

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. That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including: how partner organisations are held to account for delivery of agreed actions; how under performance or delay will be escalated; and how assurance will be reported to the Health and Wellbeing Board and shared with scrutiny.	Accepted	The role, authority and escalation mechanisms of the Autism Improvement Board (please be aware that the name of this board may change but the function will stay the same) will be clearly set out through the Board's TOR. The TOR are being co-designed with the Board as part of the year 1 project plan. The current working documents describe the Board's main forum for strategic oversight of autism improvement. The Board is co-chaired by the Head of Joint Commissioning (Live Well) and an expert by experience. There are thematic task and finish groups supporting development and delivery of the strategy which report into the board. The year 1 project plan will review and refine the Board's TOR and: • Define escalation routes from the sub-groups into the Board and/or within partner organisations • Establish reporting templates into the Board • Establish formal progress updates to the Board. Health and Wellbeing board will be asked in July to hold system wide responsibility for development and delivery of the Strategy with the Director of Adult Services, OCC as the SRO. Reports on progress will be received by the Board and any issues with performance or delay escalated to the DASS on behalf of the Health

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		and Wellbeing Board. Board updates will be shared with nominated senior officers in partner organisations.
2. That co production principles are explicitly embedded in delivery, not only strategy development, including: a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities, sequencing actions and reviewing progress within the implementation plan; and clarity on how lived experience feedback will directly influence commissioning, service redesign and system decisions.	Accepted	Co-Design will be embedded in the development of the strategy and in its implementation, delivery, review and improvement. Whilst there have been pockets of Co-production due to the statutory nature of the strategy and elements of delivery this is a co-designed process. The strategy has set out within it that Autistic people, parent carers and experts by experience will continue to shape, guide and influence the work. The year 1 project plan will translate this into delivery through membership of experts by experience in the workstream, task and finish groups and co-design of the priorities, design and implementation approach for each workstream. The Autism Improvement Board is designed to ensure representation of people with lived experience of autism at system level, and TOR for task and finish groups emphasise that lived experience should inform priority-setting, sequencing of actions, performance review and continuous improvement. This provides a route for lived experience feedback to influence commissioning, service redesign and wider system decisions rather than being limited to strategy development alone.
3. That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope; the balance between new investment and reconfiguration of existing resources;	Partly Accepted	Financial modelling of the costs and impact of the Strategy is only partly developed at this stage. The assumption of system partners is set out in the Strategy that there are no direct new financial commitments attached to adoption of the Strategy itself and that costs of delivery should be met from within the existing pooled budget between the council and the ICB. The development of the Strategy has identified that some priority areas may create resource implications over time, for example

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

and the affordability and sustainability of priority commitments.		around digital information infrastructure, training, and strengthened specialist support for autistic individuals. These areas will need further development within the implementation plan and, if they require new investment will need to be funded from savings identified elsewhere. The year 1 project plan takes a pragmatic approach by focusing first on governance, baselines, pathway mapping, data, and targeted improvement work, which should allow the system to clarify which actions can be delivered through reconfiguration of existing resources and where future business cases should be developed to identify resource requirements and where these might be found. The final implementation plan will make explicit which budgets and contracts are in scope, where existing resources might be aligned to the aims of the Strategy, and where there are affordability and sustainability issues that need to be resolved as part of the implementation.
4. For a clear outcomes and performance framework to be developed. It is recommended that any outcomes and performance frameworks include diagnostic waiting times and access to support while waiting; consistency and effectiveness of reasonable adjustments across services; experiences of transitions; and lived experience and qualitative outcomes, not solely access metrics.	Accepted	An outcome and performance framework will be co-designed within the year 1 project plan. A draft document includes commitments to: • Confirm baseline indicators and data sources • Develop a year 1 milestones implementation dashboard • Agree a reporting cycle • Create a baseline reporting templates for sub-groups The draft document provides a framework for further development through co-design that goes beyond simple activity reporting. In line with concerns raised by HOSC and reflecting evidence set out in the Strategy and SCIE report, the framework will include:

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		• Diagnostic waiting times • Use of support while waiting • Assessment of consistency and effectiveness of reasonable adjustments across services • Experience of transition between children's and adult pathways and across services • Lived experience and qualitative outcomes alongside quantitative access measures. The draft implementation document also emphasises the use of feedback and data together to shape year two priorities, which support a more meaningful and improvement-focused framework.
5. For system partners to work toward the development a children's version of the Autism Strategy.	Accepted	Work is already moving in this direction. The Strategy is described throughout as all-age and jointly owned across adults' and children's services, with children's partners involved in development and delivery. The latest draft year 1 implementation plan goes further by including a specific action to create a children-friendly version of the Autism Strategy, led through children's colleagues, alongside production of a more accessible all-age version. This means the recommendation for system partners to work toward a children's version is consistent with current implementation planning and can be reflected as an active commitment within the final document rather than a future aspiration only.

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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

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

Issue: Adult and Older Adult Mental Health Services

Lead Cabinet Member(s) or Responsible Person:

- Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust).
- Dan Leveson (Director for Places and Communities, Thames Valley ICB).
- Sarah Bellars (Chief Nurse, Thames Valley ICB).
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council)

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

Deadline for response: Tuesday 30th June 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. That system partners treat equity of access as a core performance objective, with explicit action taken where neighbourhood-level variation is identified, including: addressing gaps in crisis alternatives and Safe Haven coverage, and ensuring that any neighbourhood-based models benefit rural and more deprived communities as effectively as urban areas.	**Accepted** We accept this recommendation. Oxford Health and VCSE agree that equity of access should be treated as a core performance objective across adult mental health services, particularly as demand is rising, service use varies across pathways, and current crisis alternatives are not yet consistently distributed across the county. Current service development already includes neighbourhood working, Keystone Hubs, mental health practitioners embedded in primary care, Safe Havens in Oxford and Banbury, and a review of crisis alternatives to improve accessibility and equity across Oxfordshire.	1. We will review current service provision to identify unwarranted variation in access, experience and outcomes across localities, including access to crisis alternatives. 2. We will take proportionate action to address any identified gaps, with particular focus on rural access, transport barriers, digital exclusion and deprivation. 3. We will ensure that existing service models are clearly articulated and understood across the system, including how current pathways support equitable access. **Key Improvements** • Removes implication of **new neighbourhood expansion** • Refocuses on **variation and optimisation of what exists**
2. That system partners treat co-production as a core performance objective for design, development and delivery neighbourhood mental health centres. It is recommended that there is an inclusion of local councils, local	**Partially Accepted** We partially accept this recommendation. Oxfordshire already has a strong foundation of partnership with the VCSE sector, embedded peer workers and experts by experience, and a 10-year outcomes-focused recommissioning approach through the Mental Health Outcomes Improvement Programme. We agree that co-production should be	1. We will ensure that neighbourhood-level work programmes include a clear route for local place-based engagement, including with communities experiencing poorer access or outcomes, and with groups representing minoritised communities. Oxford Health has already begun work with Oxfordshire Community Action to strengthen culturally responsive access; this will be built into future planning. 2. We will include co-production as an explicit criterion in service development and commissioning discussions, including the recommissioning of VCSE mental health provision.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

members and local voluntary sector working with lived experience families at any neighbourhood level included in the work programme.	strengthened further and treated as a core expectation in the design, development and delivery of neighbourhood mental health models with relevant people involved as necessary. This may not include everyone as listed but will be dependent on the work being completed.	**Proposed measures of success** • Agreed co-production framework in place. • Evidence of lived experience, VCSE and local authority participation in neighbourhood design groups. • Service changes demonstrably informed by local feedback and lived experience.
3. That access standards for adult community mental health services are applied in a clinically meaningful way. It is recommended that there are clear safeguards to ensure that: early contact does not displace therapeutic continuity, that data definitions are consistent across teams, and that performance management reinforces quality and outcomes, not just speed of access.	**Accepted** We accept this recommendation. Oxfordshire supports access standards but agrees that performance management must support clinically meaningful care, therapeutic continuity and good outcomes, rather than incentivising speed alone.	1. We will review how adult community mental health access standards are currently applied across teams, including the definition of "meaningful contact", and agree consistent operational guidance. 2. We will ensure that performance discussions include continuity of care, outcomes and service quality, not solely first contact times. This will be reflected in local assurance processes. 3. We will undertake a data consistency exercise across adult and older adult services to reduce variation in recording practice and improve confidence in reported performance. **Proposed measures of success** • Standardised definitions and guidance agreed across teams. • Performance reporting includes access and outcomes. • Improved assurance on data quality and comparability.
4. For collaboration amongst system partners to identify what is needed locally for the implementation of the new government guidance on key workers/named worker for personalised care	**Partially Accepted** We partially accept this recommendation. Oxfordshire agrees that implementation of both named/key worker arrangements and PCREF must be delivered collaboratively across partners, with clarity about what is required locally, how roles will work in practice, and how equity and anti-racist improvement are	1. There is a programme of work already in place to define what local implementation of named/key worker arrangements should look like in Oxfordshire adult mental health services. 2. We will map where named/key worker functions already exist in current services, including community mental health teams, crisis pathways, transitions work and social care interfaces, and identify gaps. 3. There is a PCREF board in place which is run in collaboration with the directorate EDI and feeds into the Trustwide PCREF board.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

and on implementation of the Patient and Carer Race Equality Framework. (PCREF)	embedded in service delivery. The current breadth of multi-agency mental health provision in Oxfordshire makes this system-level approach essential.	4. We will ensure that implementation proposals identify workforce, training, governance and data requirements, and include lived experience and carer input. **Proposed measures of success** • Agreed local model for named/key worker implementation. • PCREF delivery plan in place with system partner involvement. • Evidence of involvement from service users, carers and VCSE partners.
5. For collaboration amongst system partners on reducing/preventing out of area placements to include independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient. It is also recommended that there is a review that includes patients, families, and the voluntary sector to determine whether community placements are working well as a safe and conducive home setting protective against worst outcomes.	**Partially Accepted** We partially accept this recommendation. Oxfordshire has already reduced inappropriate out of area placements (OAP) and bed days, uses weekly OAP rapid reviews, regular discharge escalation calls, face-to-face reviews and director-level scrutiny of OAP decisions. However, we agree that further work is needed to sustain this, strengthen independent review, and ensure patient, family and voluntary sector views inform decisions about long-term placements and community alternatives.	1. We will strengthen the current OAP review process so that patient and family views are routinely sought and documented, alongside clinical, social care and discharge considerations. 2. We will work with social care, commissioners and VCSE partners to review whether community placements and supported housing are achieving safe, stable and recovery-oriented outcomes, particularly where there are concerns about institutional dependence or repeated crises. Oxfordshire's supported housing pathway, floating support and social care review processes provide an important basis for this work. 3. We will continue the current focus on repatriation, discharge planning and least restrictive alternatives, including Crisis Resolution Home Treatment Team (CRHTT) input, weekly escalation processes and system review of barriers such as housing and step-down capacity. **Proposed measures of success** • Continued reduction in inappropriate OAP bed days. • Evidence that patient/family input informs long-term placement decisions.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

6. For any performance targets for access to physical health checks for mentally ill patients to be met. It is recommended that there are timely and regular physical health checks for those with comorbidities, and to also include a check-up of their long-term conditions.	**Accept** We accept this recommendation. We recognise the importance of improving performance against physical health check targets for people with mental illness, particularly those with severe mental illness and co-morbid long-term conditions. Oxfordshire already has a Physical Health in Severe Mental Illness Team and a Talking Therapies offer for people with long-term physical conditions, but further action is needed to improve delivery and consistency	1. We will review current local performance on physical health checks for people with severe mental illness, including variation by service/team, and agree a focused improvement plan. 2. We will strengthen coordination between community mental health teams, primary care and the Physical Health in Severe Mental Illness Team to improve completion of checks and follow-up for co-morbidities. 3. We will ensure that physical health reviews include not just screening but appropriate attention to existing long-term conditions, medication effects, and ongoing monitoring needs. 4. We will consider targeted outreach for people who are least likely to engage, including those supported through assertive approaches, supported housing, complex needs pathways or severe self-neglect concerns. **Proposed measures of success** • Improvement trajectory agreed for SMI physical health check performance. • Improved integration of physical and mental health monitoring. • Clear follow-up for long-term condition management.
7. For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a co-produced community mental health centre in every community; for mental health investment to be placed on a statutory footing; and for there to be support for expansion of s75 agreements for pooled budgets or other clear mechanisms and levers for the local integration and shared ownership	**Partially Accepted** We partially accept this recommendation. The Oxfordshire system recognises that local transformation depends not only on local partnership working but also on clear national strategy, durable investment, effective integration mechanisms and stability for the voluntary sector. Current Oxfordshire progress such as neighbourhood working, VCSE recommissioning, s75 partnership arrangements and community transformation has been enabled by collaboration but is still affected by wider funding and policy constraints.	1. We will discuss, through relevant Oxfordshire and wider system governance, a shared system position on national support required for community mental health transformation, including neighbourhood/community mental health centres, investment stability and the role of the Modern Service Framework. 2. We will continue to maximise local use of s75 and integrated arrangements to support shared ownership of outcomes across health and social care. Oxfordshire already has an s75 arrangement with integrated social work provision embedded in adult mental health services. 3. We will continue the 10-year outcomes-focused recommissioning approach with VCSE partners and use this learning to inform future commissioning discussions about stability and sustainability. 4. We will articulate, through system partnership routes, where national policy clarity or levers would most help local delivery, particularly around multi-year funding, workforce support and integrated commissioning. **Proposed measures of success** • Shared system position developed through partnership governance. • Continued effective use of pooled/integrated arrangements locally.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

needed. It is recommended that local system partners call for national support to move to multi-year funding for commissioning of the voluntary sector, and that there be clear timely arrangements for the delivery of the Modern Service Framework for mental health.		• Stronger alignment between commissioning, VCSE provision and neighbourhood delivery.
8. For collaboration among system partners to ensure that transitions from children's to adults mental health services are as smooth and supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions.	**Accepted** We accept this recommendation. Oxfordshire agrees that transitions must be smoother, more supportive and led by patient need. Work is already underway through the 18–25 Transitions Mental Health Outcomes Improvement Programme, including a review of pathways, mapping services, gap analysis, service-user feedback, and work on transitions from out of area placements. A cross-commissioner and County Council group is also in place for children and young people with more complex needs who may be at risk of out of area accommodation.	1. We will continue and complete the current 18–25 transitions programme, ensuring that it produces clear improvement actions for Oxfordshire services and families. 2. We will use this work to improve joint planning between CAMHS and adult services, including for young people with severe mental illness, complex needs and those at risk of out of area placements. 3. We will ensure that experts by experience, families and VCSE partners remain part of transition improvement work, as already established in the programme's project group arrangements. 4. We will seek to strengthen continuity, information sharing and preparedness for transition, including the use of named professionals where appropriate and better visibility of the adult offer before transfer. **Proposed measures of success** • Delivery of actions from the 18–25 transitions programme. • Improved experience of transition reported by young people and families. • Better joint oversight of higher-risk transition cohorts.

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

Dentistry Services in Oxfordshire

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

Report to:
- Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire, Thames Valley ICB)
- Dan Leveson (Director for Places and Communities, Thames Valley ICB).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on the current state of dentistry services in Oxfordshire in its public meeting on 11 June 2026.

2. The Committee would like to thank Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire, Thames Valley ICB) and Dan Leveson (Director for Places and Communities- Thames Valley ICB) for attending the meeting and answering questions from the Committee.

3. The topic of dentistry services is of significant interest and concern to the JHOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the Thames Valley Integrated Care Board (ICB) to improve access to NHS dentistry services throughout the County.

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

   - Progress update against the Committee's previous recommendations on dentistry services.
   - The current position on access to NHS dentistry in Oxfordshire.
   - How access varies geographically within the county**,** including rural/urban differences where known.
   - Details of any local flexibilities available to the ICB in relation to dentistry commissioning and how these have been used in Oxfordshire since April 2024; including any reinvestment of underspends.
   - Whether decisions have been taken to target resources at areas or groups with the greatest need, and on what basis.
   - Any action being taken locally to improve children's oral health, especially among deprived communities;
   - How the ICB is working with local authorities and schools to support prevention, rather than relying solely on treatment-based solutions.
   - Details on workforce recruitment and retention in NHS dentistry services**.**

- How information about NHS dentistry access is communicated to Oxfordshire residents.

SUMMARY

5. During the 11 June 2026 meeting, the Strategic Lead for Primary Care advised that since the previous scrutiny session in 2024, four new dental practices had opened across Oxfordshire, including in rural areas, and that the system had replaced more activity than had been lost following contract handbacks after the pandemic period. Additional urgent care capacity had been commissioned, with practices delivering thousands of additional urgent appointments in line with national policy objectives.

6. The discussion highlighted the continuation of a flexible commissioning scheme, through which a significant number of vulnerable patients had accessed dental care. There was also an introduction of oral health promotion initiatives aimed at children, including early engagement in schools and nurseries.

7. The Committee queried what trajectory the Integrated Care Board expected for recovery and what interventions would be required to close that gap. The Strategic Lead for Primary Care acknowledged that returning to pre-pandemic levels would be challenging, citing changes in public behaviour, growth in private provision, and workforce constraints. The reformed dental contract, including the requirement for a proportion of appointments to be made available for urgent care, was intended to improve access and reduce the number of practices closed to new patients.

8. The Committee explored urgent dental care pathways and their integration with NHS 111. Members raised concerns about the reliance on urgent care provision and the sustainability of delivering such care predominantly through general practice. It was explained that urgent care was provided through a combination of high-street practices, commissioned urgent care slots, and the community dental service, including some out-of-hours provision. However, the new contract had only recently been introduced and it would take time to assess its impact on access patterns, including weekend demand.

9. Members also examined health inequalities and rural access, noting significant variation between districts, and highlighted data showing lower contract delivery rates and reduced access in areas such as Cherwell and the Vale of White Horse. In response, the Strategic Lead for Primary Care confirmed that variation existed and identified recruitment difficulties, geographic factors, and historic contract arrangements as key drivers. The Integrated Care Board was seeking to rebalance activity through commissioning decisions and to target additional provision to areas of highest unmet need.

10. The Committee examined workforce challenges, particularly in recruiting dentists to underserved areas. It was responded that although financial incentives had been introduced to support recruitment, only a small number of practices had successfully recruited staff to date, reflecting wider workforce

shortages. Reference was made to the lack of a dental school in the region as a structural challenge and how there were ongoing discussions at the regional level regarding training capacity.

11. Significant discussion took place regarding water fluoridation. The Director of Public Health confirmed that the evidence base remained clear that fluoridation was the most effective population-level intervention to reduce tooth decay, particularly among children. However, he explained that implementation was complex, involving legal, logistical and public acceptability challenges, including coordination with water companies and neighbouring regions.

12. The Committee discussed the limitations of data available to commissioners, noting that unlike general practice, dental data was relatively restricted. The Associate Director confirmed that the Integrated Care Board had limited visibility beyond activity data and urgent versus routine classification, which constrained strategic planning. Members emphasised the need for improved data in order to support effective scrutiny and commissioning decisions.

KEY POINTS OF OBSERVATION:

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

Supporting Public Engagement on Water Fluoridation as Part of a Long-Term Strategy to Improve Oral Health in Oxfordshire: In recommending that system partners continue to pursue previous requests to Government for a local public consultation and engagement exercise on the fluoridation of Oxfordshire's water supply, and that opportunities to work with any future Thames Valley Combined Authority should also be explored, the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) sought to emphasise the importance of prevention within the wider oral health agenda. The recommendation was not intended as an endorsement of fluoridation itself, nor as a proposal to bypass public debate. Rather, it reflected the Committee's view that Oxfordshire residents should be afforded the opportunity to engage with the substantial body of evidence surrounding one of the most significant population-level oral health interventions currently available and to participate in an informed discussion about its potential role within the county's future public health strategy[1].

The Committee reached this position following consideration of the report submitted as part of this item which highlighted both the progress and the continuing challenges associated with NHS dentistry across Oxfordshire and the wider Thames Valley area. Although access to NHS dental services has improved considerably since the pandemic, the

[1] [post.parliament.uk]

report demonstrated that access levels remain below those achieved prior to 2020. Across the Buckinghamshire, Oxfordshire and Berkshire West system, approximately 46% of the population had attended an NHS dental service within the previous two years by March 2026, compared to more than 51% before the pandemic. The report also outlined continuing challenges relating to workforce shortages, treatment backlogs, population growth, recruitment difficulties in rural areas and persistent inequalities in access to care. These challenges continue despite substantial local investment, the opening of new practices, targeted commissioning programmes, urgent care initiatives and major reforms to the national dental contract.

The Committee therefore recognised that while improvements to NHS dental services remain essential, improvements to treatment services alone are unlikely to be sufficient to address the underlying causes of poor oral health or to significantly reduce future demand for dental treatment. The report submitted to the Committee repeatedly highlighted the growing importance of prevention as a central principle underpinning future dental commissioning arrangements. This is reflected through the Children's Oral Health Improvement Programme, the expansion of supervised toothbrushing schemes, the introduction of new prevention-focused elements within the national dental contract and the wider ambition of the Thames Valley ICB to improve population health outcomes and reduce inequalities. Water fluoridation sits firmly within this preventative agenda.

From a public health perspective, fluoridation is distinct from many other oral health interventions because its benefits are delivered automatically across the whole population without requiring individuals to seek care, register with a dentist, pay for treatment or actively change their behaviour. This characteristic is particularly important in a context where access to NHS dentistry remains challenging for many residents. The Parliamentary Office of Science and Technology's comprehensive review of the evidence in 2024 concluded that there remains strong scientific evidence demonstrating that water fluoridation improves dental health outcomes and reduces levels of tooth decay. The review further noted that dental disease remains one of the most common preventable health conditions affecting children across England and remains a significant contributor to avoidable hospital admissions and wider health inequalities[2].

For the Committee, one of the most compelling aspects of the fluoridation debate relates to inequality. Throughout its work on health services, the JHOSC has consistently highlighted the need to address unequal outcomes experienced by different communities. Oral health is no exception. Nationally, children living in more deprived communities continue to experience significantly higher rates of tooth decay, are more likely to require hospital treatment and are less likely to enjoy good oral

[2] [post.parliament.uk], [researchbr...liament.uk]

health throughout adulthood. These inequalities often begin early in life and can persist for decades. The Government's 2026 Water Fluoridation Health Monitoring Report found that the benefits associated with fluoridated water supplies were particularly apparent amongst children living in more deprived communities, with evidence demonstrating reductions in tooth decay and related treatment requirements. Importantly, the report found no evidence of adverse impacts on children's cognitive development and no convincing evidence of wider health harms associated with fluoridation schemes operating within regulated parameters[3].

The Committee was also mindful that England already possesses decades of practical experience of fluoridation from which lessons can be drawn. Around six million people currently receive fluoridated water supplies, including large populations within the West Midlands, parts of the North East and other areas of England. These schemes provide a substantial evidence base regarding implementation, operation, governance arrangements, monitoring requirements and public health outcomes. Indeed, Government guidance continues to identify fluoridation as one of several evidence-based interventions capable of improving oral health alongside supervised toothbrushing, fluoride varnish programmes and wider preventative measures. The recommendation therefore reflected a belief that Oxfordshire residents should have the opportunity to understand the experiences and evidence emerging from these areas when considering whether fluoridation may have a role to play locally[4].

The economic dimension of the issue is also relevant. The dentistry report submitted to the Committee described substantial efforts by the Integrated Care Board to increase capacity, recover lost activity, improve urgent care provision, recruit additional dentists and commission new dental practices. These interventions represent significant investment and are likely to remain necessary for the foreseeable future. However, there is increasing evidence that prevention can contribute to reducing future treatment requirements and associated costs. The University of Manchester's LOTUS study, one of the largest studies of water fluoridation ever undertaken, examined the experience of approximately 17.8 million adults and adolescents over a ten-year period. The study found that people receiving optimally fluoridated water experienced fewer invasive dental treatments, lower NHS treatment costs and lower patient charges than those living in non-fluoridated areas. The researchers concluded that fluoridation remained cost-effective and generated savings over time through avoided treatment activity. While fluoridation is clearly not a substitute for accessible dental services, the findings suggest that it may contribute to a more sustainable oral healthcare system when combined with other preventative interventions[5].

[3] Water fluoridation: health monitoring report for England 2026 - GOV.UK
[4] [gov.uk], [acmedsci.ac.uk], [post.parliament.uk]
[5] [sites.manc...ster.ac.uk], [acmedsci.ac.uk]

Importantly, the Committee's recommendation recognises the constitutional and legislative context in which fluoridation decisions are now made. Under the Health and Care Act 2022, responsibility for introducing, varying or terminating water fluoridation schemes rests with the Secretary of State for Health and Social Care rather than local authorities. The dentistry report submitted to the Committee noted that the Integrated Care Board itself does not possess the statutory authority to initiate fluoridation consultations. However, the report also acknowledged that officers were aware of the potential oral health benefits associated with fluoridation and its capacity to contribute towards the reduction of oral health inequalities. The Committee therefore concluded that it remained entirely appropriate for local system partners, public health organisations and elected representatives to continue advocating for a public consultation process that would enable local views to be gathered and considered by Government.

The reference to future collaboration with any Thames Valley Combined Authority reflects the broader changes occurring across local government and NHS structures. The establishment of the Thames Valley ICB has already created a more strategic footprint for healthcare planning, whilst Local Government Reorganisation and devolution proposals may lead to the creation of new regional governance arrangements in the future. Given that water fluoridation schemes often operate across large geographical areas and require coordination between public health bodies, water companies, local authorities and central government, any future Combined Authority could provide an important mechanism through which evidence gathering, public engagement and health improvement initiatives may be coordinated at scale. This would be particularly relevant where population health challenges extend beyond individual county boundaries.

Ultimately, the Committee's recommendation reflects a wider principle that has consistently underpinned its scrutiny of healthcare services: that prevention should receive the same level of attention as treatment. Considerable progress is being made to restore and improve NHS dentistry across Oxfordshire, but the scale of current and future demand means that preventative measures will be increasingly important if improvements in oral health are to be sustained. Water fluoridation remains one of the most extensively researched oral health interventions available internationally. While reasonable debate continues regarding its application, the Committee considered that the evidence base is sufficiently significant to justify a formal programme of public consultation and engagement. Supporting that conversation would allow Oxfordshire residents to make informed judgements about a proposal that could have long-term implications for oral health, health inequalities and the sustainability of dental services across the county for generations to come.

Recommendation 1: *For system partners to pursue previously made requests to government by the JHOSC to support a local public consultation/engagement on fluoridating Oxfordshire's water supply. It is recommended that system partners work with any future combined authority at the Thames Valley level to further support this.*

Reviewing the local Impact of NHS Dental Contract Reforms: The Committee welcomes evidence of improvements in NHS dental activity, the opening of new practices, increased urgent care provision and investment in preventative initiatives, but remains mindful that significant challenges continue to affect residents seeking NHS dental care. It was against this backdrop that the Committee recommended that the Thames Valley ICB launch a formal review of the local impacts of the changes being introduced through the reformed NHS dental contract and that this review should involve key stakeholders, including the JHOSC itself.

This recommendation reflects the Committee's view that the reforms currently being implemented are of such significance that they should be subject to structured local evaluation. The report presented to the Committee for this item explicitly noted that the changes being introduced from April and June 2026 represent the most substantial reforms to NHS dentistry since the introduction of the national dental contract in 2006. These changes include new urgent care payment arrangements, mandatory urgent care activity levels, complex care pathways for patients with higher levels of need, enhanced support for preventative interventions, funded quality improvement programmes and new approaches to workforce development. Given the scale of these reforms, the Committee considered it both reasonable and necessary that their impact should be assessed locally rather than relying solely upon national performance reporting.

The rationale for undertaking such a review begins with the long-standing challenges that have characterised NHS dentistry nationally. For many years, concerns have been raised regarding the sustainability of the NHS dental contract and the extent to which it has supported access to care. Successive parliamentary inquiries, professional bodies and health policy organisations have highlighted concerns regarding recruitment and retention, difficulties in securing NHS dental appointments, and questions about whether the Unit of Dental Activity (UDA) system appropriately rewards practices for treating patients with complex oral health needs. The House of Commons Health and Social Care Committee's report on NHS dentistry concluded that the existing arrangements had contributed to widespread access challenges and called for substantial reform of the contractual framework[6].

Similarly, the National Audit Office observed that, despite significant expenditure on NHS dentistry, many patients continued to experience difficulties accessing services and that fundamental reform would be necessary if long-term improvements were to be achieved. Its analysis

[6] https://committees.parliament.uk/publications/40571/documents/197217/default/

highlighted the gap between demand for NHS dental services and available capacity, emphasising the importance of ensuring that contractual arrangements incentivise the right outcomes[7].

The national reforms introduced during 2026 are intended to address many of these concerns. NHS England's new Quality and Payment Reform programme introduces the most extensive package of changes since the creation of the current contract model. These reforms seek to create stronger incentives for practices to provide urgent care, encourage preventative dentistry, improve the management of patients with significant oral health needs and support quality improvement activities[8].

However, whilst the ambitions behind the reforms are welcome, the Committee recognised that successful implementation cannot be assumed. National policies often produce different outcomes depending upon local circumstances, and Oxfordshire presents a distinctive environment in which to assess these changes. The county contains rapidly growing areas such as Didcot, Bicester and parts of the Science Vale, alongside more rural communities where access challenges can be particularly acute. Workforce pressures, demographic changes and patterns of deprivation vary considerably across the county. Consequently, a policy that appears successful nationally may not necessarily produce the same outcomes in every locality.

The Committee was particularly interested in understanding whether the reforms achieve one of their primary objectives: improving access to NHS dental care. The report submitted to the Committee demonstrated that progress has already been made. Across the former Buckinghamshire, Oxfordshire and Berkshire West footprint, the number of residents accessing NHS dental services increased substantially between 2022 and 2026. Nevertheless, access levels remain below those achieved before the pandemic. The report further acknowledged that many residents still struggle to obtain routine NHS dental appointments and that demand continues to exceed available capacity in some areas.

A local review would therefore provide an opportunity to determine whether the contractual reforms are translating into meaningful improvements for Thames Valley residents. This evaluation should not be limited to headline activity levels. It should examine whether more people are able to secure appointments, whether waiting times are reducing, whether residents are travelling shorter distances for care, and whether communities previously identified as underserved are experiencing tangible improvements in access.

[7] https://www.nao.org.uk/reports/progress-in-improving-nhs-dentistry/

[8] https://www.england.nhs.uk/long-read/nhs-dentistry-quality-and-payment-reforms-contractual-guidance/

The Committee also considered the importance of examining whether the reforms are delivering positive outcomes for vulnerable groups and helping to reduce oral health inequalities. The Thames Valley ICB has already established several initiatives aimed at improving access for populations who often experience significant barriers to dental care, including looked-after children, refugees and asylum seekers, people with learning disabilities, pregnant women, residents of care homes and other vulnerable groups. The JHOSC is keen to ensure that the new contractual arrangements strengthen rather than undermine this work.

This focus on inequalities is consistent with broader national policy. The Government's prevention strategy for oral health, *Delivering Better Oral Health*, emphasises that dental disease is largely preventable and highlights the importance of targeted interventions to address inequalities experienced by disadvantaged communities[9]. The Committee further recognised that workforce sustainability will be central to determining whether the reforms are ultimately successful. The Thames Valley ICB report highlighted the use of Golden Hello schemes, recruitment incentives and other workforce support measures designed to attract dentists to harder-to-recruit areas. Yet workforce shortages remain one of the most significant barriers to increasing NHS dental capacity. The reformed contract aims to improve the attractiveness of NHS practice by better recognising the complexity of patient care and improving remuneration arrangements. A structured review would allow the ICB to assess whether these intended workforce benefits are being realised and whether recruitment and retention challenges are beginning to ease.

The Committee was equally interested in the preventative aspirations underpinning the reforms. One of the principal criticisms of the previous contract was that it placed insufficient emphasis on prevention and incentivised activity rather than outcomes. The reforms seek to address this by supporting interventions such as fluoride varnish applications, quality improvement programmes and care pathways designed to improve oral health over time. This aligns with broader national evidence demonstrating that prevention represents one of the most cost-effective approaches to improving oral health outcomes.

The Committee therefore considered it essential that a review should assess not only activity levels but also evidence relating to prevention. The review should seek to understand whether preventative interventions are being delivered more consistently, whether practices are engaging with quality improvement programmes and whether there are early indications of improvements in oral health outcomes amongst children and adults.

[9] https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention

Importantly, the JHOSC recommendation emphasised the need for stakeholder involvement throughout the review process. The Committee recognises that quantitative performance measures alone would be insufficient to understand the full impact of the reforms. Patients, providers, local authorities, Healthwatch organisations, public health experts and community representatives all possess valuable insights that should inform any evaluation.

The involvement of the JHOSC itself is particularly important. As the statutory scrutiny body responsible for examining health services affecting Oxfordshire residents, the Committee has an established role in holding system partners to account and representing the interests of local communities. Participation within the review would help ensure transparency, provide democratic oversight and strengthen public confidence in the process and its conclusions.

Ultimately, this JHOSC recommendation reflects a straightforward but important principle: major reforms should be accompanied by robust evaluation. The Thames Valley ICB has inherited responsibility for implementing the most significant package of changes to NHS dentistry in two decades. It has also inherited responsibility for ensuring that these changes deliver meaningful benefits for residents. By undertaking a structured review involving a broad range of stakeholders, the ICB would place itself in a stronger position to identify successes, address emerging challenges and ensure that future commissioning decisions are informed by local evidence rather than national assumptions.

For these reasons, the Committee concluded that a formal review of the local impact of dental contract reform is both necessary and proportionate. Such a review would support accountability, strengthen partnership working, ensure that the experiences of patients and providers are properly understood and, ultimately, help maximise the likelihood that the reforms deliver lasting improvements in access, quality, prevention and oral health outcomes across Oxfordshire and the wider Thames Valley system.

Recommendation 2: *For the Thames Valley ICB to launch a review of the local impacts of changes being made to the dental contract. It is recommended that there is stakeholder involvement in this review, including the JHOSC.*

***Addressing Rural and Wider Oral Health Inequalities in Oxfordshire*:** Whilst the Committee welcomes evidence of improvements in NHS dental activity, increased urgent care provision, the opening of new dental practices and targeted initiatives for vulnerable groups, it remains concerned that significant inequalities continue to affect both oral health outcomes and access to NHS dentistry across the county. It was for this reason that the Committee recommended that system partners take collective action to reduce the effects of rural inequalities on poor dental outcomes and access to NHS dentistry, develop robust data indicators at District and Neighbourhood level to improve visibility of local

population need, and strengthen action to address broader inequalities affecting vulnerable groups and disadvantaged communities.

The recommendation reflects a long-standing concern of the Committee that access to healthcare services cannot be viewed solely through the lens of overall service performance. Whilst improvements are clearly being made across Thames Valley, the Committee recognised that some communities continue to face significantly greater barriers to accessing NHS dentistry than others. Rural communities, in particular, often experience a combination of challenges including workforce shortages, limited public transport, longer travel times, dispersed populations and reduced availability of NHS providers. These issues are not unique to Oxfordshire, but they are highly relevant to a county containing extensive rural areas across West Oxfordshire, the Vale of White Horse, South Oxfordshire and parts of Cherwell.

The report received by the Committee for this item highlighted examples of progress in addressing access challenges. Four new dental practices had opened within Oxfordshire since the previous scrutiny item, including in Chipping Norton, Witney, Milton and Faringdon, all locations serving significant rural populations. Commissioners had also succeeded in replacing more activity than had been lost following contract handbacks after the pandemic and had introduced a range of initiatives aimed at expanding urgent care and improving access for vulnerable groups. The Committee welcomes these developments and recognises the considerable work undertaken by the Integrated Care Board. However, the Committee also noted that approximately 46 per cent of the population had attended an NHS dentist within the previous two years, compared with over 51 per cent before the pandemic. This demonstrates that, despite progress, significant unmet need remains.

The Committee was particularly mindful that access challenges are often more severe in rural communities. National research increasingly demonstrates that geographical inequalities play a significant role in determining whether people are able to secure NHS dental care. A neighbourhood-level study published in the *European Journal of Public Health* found substantial spatial disparities in NHS dental accessibility across England and concluded that both deprivation and rurality are important determinants of access. The research identified significant differences in the availability of NHS dental provision between urban and rural communities and highlighted how the closure of even a single practice can have major consequences for local accessibility in rural areas[10]. Similarly, analysis undertaken by the Local Government Association identified persistent "dental deserts" across England and found that rural communities are significantly more likely to have lower levels of NHS dental provision. The research highlighted the uneven distribution of NHS practices and warned that poor access risks worsening broader health inequalities[11].

[10] Spatial disparities in access to NHS dentistry: a neighbourhood-level analysis in England.
[11] Persistent dental deserts risk deprived and rural communities being left behind.

There is also evidence that oral health inequalities extend far beyond geography alone. Poor oral health is strongly associated with deprivation, social exclusion and vulnerability. The Office for Health Improvement and Disparities' review *Inequalities in Oral Health in England* concluded that oral health inequalities remain a significant public health challenge throughout England and affect communities across the life course. The report highlights substantial inequalities by socioeconomic status, deprivation, geographic location and vulnerable group status. It further notes that groups including homeless people, looked-after children, travellers, prisoners and people experiencing social exclusion often experience considerably poorer oral health whilst simultaneously facing the greatest difficulties in accessing dental services[12].

These findings closely align with evidence presented within the Thames Valley ICB report to the JHOSC, which highlighted that local flexible commissioning programmes had specifically targeted groups known to experience barriers to care, including looked-after children, refugees, asylum seekers, pregnant women, residents of care homes and people with learning disabilities. The continuation of these programmes demonstrates that inequalities within oral health are already apparent locally and require targeted intervention. The Committee welcomed these initiatives but felt there was a need to go further by developing a more comprehensive understanding of where unmet need exists and how it varies between communities.

A key element of the recommendation therefore relates to data. The absence of consistently available oral health and dentistry access indicators at District, locality and Neighbourhood level limits the ability of the system to identify where intervention is most required. This concern is not new. During previous scrutiny of dentistry provision in 2023, the Committee recommended the creation of a baseline dentistry dataset that could be used to understand patterns of oral health, deprivation, service utilisation and access across Oxfordshire. It was argued that improved data would allow commissioners and partners to better identify disparities, target resources more effectively and monitor whether interventions were achieving their intended impact.

This recommendation is arguably even more relevant in the context of the NHS's growing emphasis on neighbourhood health planning. National policy increasingly seeks to understand population health needs at a much more granular level than traditional county-wide metrics allow. The NHS 10-Year Health Plan and the development of neighbourhood models of care place considerable emphasis on understanding local variation and targeting resources where they will have the greatest impact. Without comprehensive local indicators relating to dental attendance, oral health outcomes, workforce availability, deprivation and vulnerable populations, there is a risk that communities with the greatest need remain hidden within aggregate county-wide statistics.

[12] Inequalities in Oral Health in England.

The Committee also considered the importance of public and stakeholder engagement in tackling oral health inequalities. Good oral health is shaped by a wide range of factors extending well beyond dental treatment alone. Educational attainment, income, housing conditions, health literacy, dietary habits, community infrastructure and access to preventative services all influence oral health outcomes. For this reason, reducing inequalities requires collective action involving local authorities, NHS organisations, schools, parish councils, voluntary organisations, community groups and residents themselves.

There are positive examples of such approaches elsewhere in the country. The supervised toothbrushing programmes introduced in parts of the North West, the Greater Manchester oral health improvement initiatives, and targeted community engagement programmes undertaken in areas of the North East have demonstrated the benefits of combining preventative interventions with local community engagement. Similarly, national guidance contained within *Delivering Better Oral Health* emphasises the value of community-based prevention programmes and targeted interventions aimed at populations experiencing the greatest levels of disadvantage[13].

The Committee recognises that Thames Valley ICB has already made progress in this area through its Children's Oral Health Improvement Programme, support for supervised toothbrushing initiatives and targeted commissioning arrangements. However, the scale of oral health inequalities across Oxfordshire warrants a more coordinated system-wide response which places reducing inequalities at the centre of future planning and commissioning decisions.

Ultimately, this recommendation reflects the belief that improving overall access to NHS dentistry, whilst important, is not sufficient on its own. A service can improve at aggregate level whilst continuing to leave behind particular communities, rural areas and vulnerable groups. The Committee therefore concluded that system partners should adopt a more sophisticated and targeted approach to understanding and addressing oral health inequalities. This requires better local intelligence, stronger data, greater visibility of need at neighbourhood level and meaningful engagement with the communities most affected by poor oral health outcomes.

The recommendation is therefore both preventative and strategic in nature. It seeks to ensure that future improvements in NHS dentistry are distributed fairly across Oxfordshire and that the benefits of investment are experienced not only by the average resident, but also by those communities that have historically experienced the greatest challenges in accessing dental care. By combining improved data, place-based planning, targeted interventions and meaningful stakeholder engagement, system partners can place themselves in a significantly

[13] Delivering Better Oral Health: An Evidence-Based Toolkit for Prevention.

stronger position to reduce oral health inequalities and improve outcomes for all residents across Oxfordshire's urban, rural and vulnerable populations.

Recommendation 3: *For system partners to take collective action to reduce the effects of rural inequalities on poor dental outcomes and on access to NHS dentistry; and to develop data indicators at all District and Neighbourhood levels to provide visibility to population need and other/rural health inequalities affecting oral health and dentistry access. It is also recommended that strong measures are taken, including through public/stakeholder engagements, to tackle broader inequalities around oral health, including amongst vulnerable population groups.*

Reinvesting NHS Dentistry Underspends into Areas of Greatest Need in Oxfordshire: The Committee has examined evidence regarding improvements in urgent dental provision, ongoing workforce challenges, inequalities in access to care, children's oral health initiatives and future developments in NHS dental commissioning. Whilst the JHOSC welcomes evidence that some improvements had been achieved since its previous review of dentistry services in 2024, it remains concerned that significant inequalities in access to NHS dentistry persist across Oxfordshire. In response to the evidence presented, the Committee recommended that NHS dentistry underspends should be reinvested into those areas experiencing the worst dentistry access in order to improve oral health outcomes across the County. This recommendation reflects broader national policy objectives, established public health principles, academic evidence regarding health inequalities, and growing concerns about the sustainability of NHS dental services nationally. It is a recommendation rooted in the principle that resources intended for dentistry should remain focused on improving dentistry services and should be directed towards those communities where unmet need is greatest.

This recommendation emerges against the backdrop of one of the most significant access crises in the history of NHS dentistry. Despite dentistry being a core component of the NHS since its foundation in 1948, access to NHS dental services has deteriorated significantly over the past decade. The House of Commons Health and Social Care Committee concluded in its *report on NHS Dentistry* that access to NHS dentistry had become one of the most frequently raised concerns by members of the public and described the system as being in need of fundamental reform. The Committee noted widespread concerns about geographical inequalities, workforce shortages and the inability of existing arrangements to meet patient demand[14].

National evidence demonstrates that difficulties accessing NHS dentistry are not simply an inconvenience but constitute a significant public health challenge. The World Health Organization's Global Oral Health Status Report 2022, estimates that oral diseases affect approximately 3.5 billion

[14] https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/964/report.html.

people worldwide and identifies oral health as an essential component of overall health and wellbeing. The report highlights clear associations between poor oral health and wider health inequalities, emphasising that disadvantaged populations consistently experience poorer oral health outcomes than more affluent groups[15].

These findings are highly relevant to Oxfordshire. Whilst the county is often regarded as relatively affluent, significant inequalities exist both between and within communities. The evidence presented to the JHOSC highlighted continuing concerns regarding workforce recruitment, geographical access, rural provision and the distribution of services throughout the county. Although improvements had been reported in some areas of urgent access and patient activity, the Committee heard that ensuring equitable access to NHS dentistry remains a substantial challenge.

One of the strongest justifications for the Committee's recommendation lies in the contradiction that exists between significant unmet patient demand and continuing underspends within NHS dentistry budgets. Across England, NHS dental budgets have repeatedly been underspent despite widespread reports of patients being unable to secure routine NHS appointments. The National Audit Office's investigation into the government's dental recovery programme found that hundreds of millions of pounds allocated for NHS dentistry have remained unspent in recent years. Importantly, these underspends were not caused by a lack of public demand. Rather, they reflected workforce shortages, recruitment challenges, contractual limitations and difficulties delivering commissioned activity[16].

Similarly, the British Dental Association has consistently argued that dental funding should be protected and reinvested into dental services wherever possible. The Association has reported significant levels of underspend across England whilst simultaneously highlighting record levels of unmet patient need[17].

The existence of underspends under such circumstances raises important questions about equity and public accountability. If dental funding was originally allocated to improve access to care, and if substantial populations remain unable to access NHS dentistry, there is a compelling argument that any unspent funding should remain within dental services rather than being diverted elsewhere. Therefore, reinvestment offers a practical mechanism to ensure that public resources continue serving their intended purpose.

This recommendation is also firmly grounded in the principles of health inequality reduction. The landmark Marmot Review, *Fair Society, Healthy*

[15] https://www.who.int/publications/i/item/9789240061484
[16] https://www.nao.org.uk/reports/investigation-into-the-nhs-dental-recovery-plan/,
[17] https://bda.org/news-centre/latest-news-articles/pages/Millions-meant-for-patients-going-unspent-as-government-fails-to-save-NHS-dentistry.aspx.

Lives, introduced the concept of "proportionate universalism". This principle argues that whilst services should be available universally, additional resources should be directed towards those communities experiencing the greatest levels of need. The review concluded that reducing health inequalities requires deliberate action to address unequal distributions of health, wealth and access to services.

Applied to dentistry, this principle suggests that additional investment should not necessarily be distributed equally across all communities. Rather, it should be directed towards areas where residents experience the greatest barriers to care and the worst oral health outcomes. Such an approach would allow Oxfordshire to maximise the impact of any available resources by targeting interventions towards those populations most likely to benefit.

Furthermore, academic literature strongly supports this position. Research published in the *British Dental Journal* has repeatedly demonstrated clear associations between deprivation, rurality and poor dental access[18]. Studies have consistently found that populations living in disadvantaged or geographically isolated communities experience higher rates of untreated tooth decay, lower utilisation of preventative services and greater difficulties securing NHS appointments. Similar findings have been reported by research published in the *Community Dentistry and Oral Epidemiology journal*[19].

The Committee's recommendation is further reinforced by evidence demonstrating the significant economic value of preventative oral healthcare. Poor oral health creates substantial costs for individuals, healthcare systems and wider society. Research published in the *Journal of Dental Research* has repeatedly shown that preventive dental interventions generate long-term savings by reducing the need for more costly restorative and emergency treatment[20]. Similarly, evidence reviewed by the Office for Health Improvement and Disparities has demonstrated that investments in oral health promotion programmes frequently deliver substantial returns through reductions in disease burden and hospital admissions[21].

Perhaps nowhere is the importance of prevention more evident than in children's oral health. Dental decay remains one of the leading causes of hospital admissions among young children for procedures performed under general anaesthetic. NHS England has repeatedly highlighted the need to improve preventative oral health services and reduce inequalities in childhood dental disease[22]. Improving access to NHS dentistry in underserved communities would support earlier intervention, greater

[18] https://www.nature.com/bdj/,
[19] https://onlinelibrary.wiley.com/journal/16000528
[20] https://journals.sagepub.com/home/jdr
[21] https://www.gov.uk/government/collections/oral-health
[22] https://www.england.nhs.uk/long-read/nhs-dentistry-and-oral-health-update/.

uptake of preventative care and ultimately improved oral health outcomes for future generations.

Examples from elsewhere in England also demonstrate the value of targeted investment. The Government's Dentistry Recovery Plan introduced targeted "golden hello" recruitment incentives, mobile dental initiatives and enhanced commissioning arrangements specifically aimed at areas experiencing the worst access problems. The policy explicitly recognised that some communities face disproportionately severe challenges and therefore require disproportionately greater support[23]. This philosophy mirrors approaches taken elsewhere across healthcare and public health policy. Whether addressing health inequalities, primary care workforce shortages, or access to preventative services, policymakers increasingly accept that targeted investment often delivers greater improvements than uniform investment. Reinvesting dentistry underspends into those parts of Oxfordshire experiencing the poorest access would therefore be entirely consistent with established national policy approaches.

Ultimately, the recommendation made by the JHOSC reflects a straightforward but important principle: where dentistry funding cannot initially be utilised as intended, it should remain within dentistry and be redirected towards those communities experiencing the greatest unmet need. The evidence considered by the Committee demonstrated that significant challenges remain regarding access to NHS dentistry, workforce sustainability, rural provision and health inequalities across Oxfordshire.

In this context, reinvesting dentistry underspends into underserved communities represents not merely a sensible financial decision but an important commitment to equity, prevention and population health improvement. It is a recommendation that aligns with national policy objectives, reflects the findings of leading academic research, is supported by public health evidence, and offers a practical mechanism through which oral health outcomes can be improved for those Oxfordshire residents who currently face the greatest barriers to accessing NHS dental care.

Recommendation 4: *For NHS dentistry underspends to be reinvested in the areas of worst dentistry access in Oxfordshire to improve oral health outcomes within the County.*

Supporting Oral Health Promotion Through Neighbourhood Health Planning and Community Partnerships: The Committee welcomes evidence of improvements in urgent dental access, expanded commissioning initiatives, children's oral health programmes and efforts to increase workforce recruitment. However, improving NHS dental services alone would not be sufficient to address the underlying causes

[23] Faster, Simpler and Fairer: Our Plan to Recover and Reform NHS Dentistry.

of poor oral health across the county. Consequently, the Committee recommended that system partners should continue to support oral health promotion, using neighbourhood health planning at community level as an opportunity to pursue this work, and that parish and town councils, schools and grassroots community organisations should be utilised to support these efforts. This recommendation reflects a growing consensus across public health, healthcare policy and academic research that lasting improvements in oral health require prevention, community engagement and action on the wider determinants of health, rather than reliance upon clinical treatment alone. The recommendation is particularly relevant at a time when the NHS is increasingly seeking to shift from a model focused primarily on treatment towards one centred on prevention, population health management and neighbourhood-based care.

The recommendation is fundamentally rooted in the understanding that oral health is not merely a dental issue but a significant public health issue that affects wider health, wellbeing and life chances. The World Health Organization's Global Oral Health Status Report 2022 notes that oral diseases affect approximately 3.5 billion people worldwide and remain among the most common non-communicable diseases globally. The report highlights that oral diseases share many of the same risk factors as cardiovascular disease, diabetes, obesity, respiratory disease and certain cancers, including unhealthy diets, tobacco use, harmful alcohol consumption and socioeconomic disadvantage[24].

The importance of prevention has also been emphasised repeatedly within national policy. The Government's *Faster, Simpler and Fairer: Our Plan to Recover and Reform NHS Dentistry* explicitly identifies prevention and oral health improvement as central components of long-term dentistry reform. The policy recognises that improving access to treatment alone will not be sufficient to narrow oral health inequalities and that greater emphasis must be placed on preventative approaches, community engagement and early intervention[25].

The evidence presented to the Committee for this item demonstrated that system partners are already supporting children's oral health programmes and undertaking targeted commissioning initiatives designed to improve access amongst groups facing the greatest barriers to care. However, the Committee recognised that oral health outcomes are profoundly shaped by factors that sit outside the formal healthcare system. These include educational attainment, health literacy, dietary habits, deprivation, housing conditions, social isolation and broader community circumstances. Consequently, improving oral health requires action across entire communities rather than solely within dental surgeries.

A particularly important aspect of the recommendation concerns the use of neighbourhood health planning as a vehicle for oral health

[24] https://www.who.int/publications/i/item/9789240061484.

[25] Our Plan to Recover and Reform NHS Dentistry.

improvement. This reflects broader national policy developments within the NHS. The NHS Long Term Plan established a clear ambition to strengthen place-based and neighbourhood-level approaches to improving population health[26]. More recently, NHS England's emerging neighbourhood health service model has placed increasing emphasis on partnership working between healthcare providers, local authorities, schools, voluntary organisations and local communities[27].

The rationale for this approach is well-established within academic literature. Research consistently demonstrates that health interventions are more effective when delivered within communities and shaped by local relationships. A substantial body of evidence published in journals such as *Social Science & Medicine* and *BMC Public Health* has shown that community-based health promotion programmes can improve health literacy, increase uptake of preventative services and reduce health inequalities. In oral health specifically, research published within the *Community Dentistry and Oral Epidemiology journal* has repeatedly demonstrated that community-level interventions are most successful when local stakeholders play an active role in programme design and delivery[28].

The Committee's specific reference to parish and town councils reflects the important role that local democratic institutions can play in supporting health improvement. Parish and town councils are often amongst the most trusted and accessible local institutions within communities. Their detailed understanding of local circumstances enables them to identify community needs, promote health initiatives, facilitate engagement opportunities and support local campaigns. Whilst parish councils have not traditionally been viewed as healthcare partners, increasing emphasis has been placed nationally upon utilising community assets to improve health outcomes. The Local Government Association has highlighted the growing importance of local councils in supporting preventative health interventions through its publication *Prevention in Action*[29].

Moreover, schools represent another crucial component of the Committee's recommendation. The importance of school-based oral health interventions is strongly supported by academic evidence. Research published in the *British Dental Journal* and the *Journal of Public Health Dentistry* has shown that school-based oral health education programmes can significantly improve oral hygiene behaviours, increase knowledge regarding healthy diets, and reduce levels of dental decay amongst children. Schools provide an unparalleled opportunity to reach children and families at an early stage, thereby supporting lifelong oral health habits. The significance of this work is underscored by continuing concerns regarding childhood oral health

[26] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[27] https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-2026/.
[28] https://onlinelibrary.wiley.com/journal/16000528
[29] https://www.local.gov.uk/topics/social-care-health-and-integration/public-health/prevention

nationally. Data published by the Office for Health Improvement and Disparities demonstrates that tooth decay remains one of the leading causes of hospital admissions amongst young children[30]. The Committee therefore recognised that schools provide a natural platform through which oral health promotion activities can be embedded into wider programmes concerned with healthy lifestyles, nutrition and wellbeing.

There are also numerous examples from elsewhere in England demonstrating the effectiveness of community-based oral health promotion. Greater Manchester's Starting Well programme has successfully worked with schools, communities and dental practices to improve access and oral health outcomes among children living in deprived communities[31]. Similarly, supervised toothbrushing schemes operating across several local authority areas, including programmes supported in Yorkshire and the North East, have demonstrated measurable reductions in dental decay amongst participating children. These initiatives have frequently relied upon partnerships between schools, community organisations and healthcare providers.

The recommendation's emphasis on grassroots community organisations is equally important. Community groups often have relationships with residents who may be less likely to engage with traditional public services. This includes disadvantaged populations, minority ethnic communities, vulnerable adults and individuals experiencing social exclusion. Evidence from public health research has repeatedly shown that trusted local organisations can be highly effective in promoting healthy behaviours and supporting healthcare engagement. The King's Fund has highlighted the importance of harnessing the strengths of community assets within preventative health programmes, as outlined in its work on population health and community-centred approaches[32].

This recommendation being made by the JHOSC is also consistent with wider policy developments concerning integrated care systems. A core objective of integrated care is to address the social, economic and environmental factors that influence health outcomes. The Health and Care Act 2022 strengthened requirements for integrated care systems to improve population health, tackle inequalities and work collaboratively with local partners. Promoting oral health through neighbourhood planning and community partnerships directly supports these objectives by bringing together healthcare organisations, local authorities, education providers and community groups around a shared public health goal.

Ultimately, the recommendation made by the JHOSC reflects a recognition that improving oral health outcomes requires a whole-system and whole-community response. While access to NHS dental services

[30] https://www.gov.uk/government/collections/oral-health
[31] https://www.england.nhs.uk/long-read/starting-well-core/
[32] //www.kingsfund.org.uk/publications/population-health-systems

remains critically important, long-term improvements in oral health will only be achieved through sustained investment in prevention, health promotion and community engagement. The evidence considered by the Committee demonstrated that positive work is already taking place across Oxfordshire, including children's oral health initiatives and outreach programmes. However, the Committee concluded that these efforts should be strengthened further through neighbourhood health planning and deeper collaboration with parish and town councils, schools and grassroots organisations.

Such an approach aligns with national NHS policy, public health best practice, academic evidence and the broader ambitions of integrated care. Most importantly, it offers an opportunity to improve oral health outcomes before problems develop, reduce inequalities between communities, strengthen local resilience and ensure that oral health becomes a shared responsibility across the whole system rather than solely the responsibility of dental services. By embedding oral health promotion within neighbourhood-level planning and community partnerships, Oxfordshire would be well positioned to develop a preventative, community-centred model of oral health improvement capable of delivering lasting benefits for residents across the county.

Recommendation 5: *For system partners to continue to support oral health promotion, using neighbourhood health planning at community level as an opportunity to pursue this. It is recommended that system partners utilise parish and town councils and schools, as well as grassroots community organisations, to support this work.*

Supporting the Establishment of a Local Dental School: The Committee remains concerned about the long-term sustainability of the dental workforce and the continuing difficulties many residents experience in accessing NHS dental services. In response to these concerns, the Committee recommended that the Thames Valley Integrated Care Board (ICB) should continue to engage with the Dentistry Deanery to support the case for a local dentistry school to be established as a matter of urgency. This recommendation reflects a growing recognition that the workforce challenges facing NHS dentistry are structural rather than temporary and that sustainable solutions will require long-term investment in professional education, training infrastructure and workforce development. The recommendation is not simply about increasing the number of dentists; rather, it is about creating a resilient local workforce pipeline capable of supporting the future oral health needs of Oxfordshire and the wider Thames Valley region.

The starting point for understanding this recommendation is the national workforce crisis currently affecting NHS dentistry. Over the past decade, concerns regarding workforce shortages have become increasingly prominent within national health policy discussions. The House of Commons Health and Social Care Committee concluded in its report *NHS Dentistry* that workforce shortages represented one of the most significant barriers to improving access to NHS dental services and

highlighted growing concerns regarding recruitment and retention across many parts of England[33].

Similarly, NHS England's Long Term Workforce Plan identified dentistry as one of several healthcare professions where training capacity would need to increase significantly if workforce demand was to be met over the coming decades. The plan acknowledged that demographic growth, increasing healthcare demand and changing patient expectations require substantial expansion of professional training pathways[34]. The recommendation made by the JHOSC aligns closely with these national objectives by recognising that workforce shortages cannot be solved solely through short-term recruitment initiatives and instead require investment in local education infrastructure.

The evidence presented to the Committee for this item highlighted that workforce recruitment remains a challenge in parts of Oxfordshire despite initiatives including incentive schemes and targeted commissioning approaches. The JHOSC explored issues relating to recruitment difficulties, workforce sustainability and persistent challenges in ensuring adequate provision across all parts of the county. These concerns were particularly notable in relation to certain rural and underserved communities where recruiting NHS dentists has historically proved more difficult.

A substantial body of academic evidence suggests that the location of professional training has a significant influence upon where clinicians ultimately choose to practise. Research published in the *journal Medical Education* has consistently demonstrated that healthcare professionals frequently establish careers in regions where they undertake their education and postgraduate training[35]. Similar findings have been identified in dentistry. Research published in the *British Dental Journal* has shown that dental graduates often remain within the geographic areas in which they have trained, particularly when high-quality clinical placements and postgraduate opportunities are available locally[36].

This relationship between education and workforce retention has become a major consideration in healthcare workforce planning across the United Kingdom. Health Education England, prior to its integration into NHS England, repeatedly emphasised the importance of developing regional educational infrastructure to support local workforce needs. The rationale is straightforward: if a region lacks a dental school, students frequently leave the area to pursue education elsewhere and may subsequently establish careers in those regions after graduation. Conversely, regions with strong educational and training institutions are often better positioned to recruit and retain healthcare professionals over the long term.

[33] https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/964/report.html
[34] https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan/,
[35] https://onlinelibrary.wiley.com/journal/13652923,
[36] https://www.nature.com/bdj

For Oxfordshire and the wider Thames Valley area, this issue is particularly significant. The region contains one of the fastest-growing populations in England and has experienced substantial housing growth across communities including Didcot, Bicester, Witney and other parts of the county. Population growth inevitably increases demand for healthcare services, including dentistry. The Office for National Statistics has consistently projected continuing population growth across much of southern England, creating additional demand pressures upon healthcare systems[37].

At the same time, the Thames Valley region remains one of the few larger population centres in England without its own established dental school. This contrasts with other parts of the country where dental schools play a crucial role in supporting local healthcare economies. For example, the University of Plymouth Peninsula Dental School was explicitly established with the objective of addressing regional workforce challenges and improving access to dental services across Devon and Cornwall[38].

The Plymouth example is particularly relevant because it demonstrates how a dental school can contribute not only to workforce supply but also to patient care. The Peninsula Dental School operates teaching clinics that provide care to local communities whilst students undertake supervised clinical training. Academic evaluations of the model have suggested that it has contributed to increasing local workforce capacity and improving access to services in areas historically affected by workforce shortages. Research examining the impact of the school has been published through the *British Dental Journal*[39]. Similarly, the establishment of the University of Central Lancashire School of Dentistry in Preston was motivated in part by concerns regarding workforce supply in the North West of England[40]. These examples demonstrate that educational institutions are increasingly being viewed as strategic tools for addressing regional healthcare workforce challenges.

The Committee's recommendation is also supported by evidence concerning the economic and social benefits generated by health education institutions. Universities and professional schools frequently act as anchors for innovation, research, economic development and community engagement. Dental schools support clinical research, facilitate partnerships between healthcare providers and academic institutions, and create opportunities for workforce development across multiple professional groups, including dental therapists, hygienists, nurses and technicians. The General Dental Council's publication *Shaping the Dental Team* highlights the increasingly multidisciplinary

[37]https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections

[38] https://www.plymouth.ac.uk/schools/peninsula-dental-school

[39] https://www.nature.com/bdj

[40] https://www.uclan.ac.uk/schools/medicine-and-dentistry

nature of modern dentistry and the need for integrated educational pathways that support the entire dental workforce[41].

Furthermore, this recommendation being issued by the Committee also aligns with the government's broader ambitions regarding preventative healthcare and neighbourhood-based services. Modern dental schools increasingly emphasise community dentistry, public health and outreach work as part of their educational programmes. The World Health Organization's *Global Oral Health Status Report* advocates stronger links between oral health services, public health interventions and academic institutions. By establishing a dental school within the Thames Valley region, opportunities could be created for students to support community-based oral health initiatives, undertake placements in underserved areas and contribute to neighbourhood-level prevention programmes.

In addition, a local dental school could strengthen research capacity relating to oral health inequalities. Oxfordshire contains world-leading academic institutions and health research infrastructure. A dental school could complement existing healthcare research activity and contribute to evidence-based approaches for addressing inequalities in access, improving prevention and supporting innovation within NHS dentistry. The National Institute for Health and Care Research has increasingly emphasised the importance of applied research partnerships between academia and healthcare providers[42].

Hence, the recommendation made by the JHOSC recognises that many of the challenges facing NHS dentistry cannot be resolved through short-term interventions alone. Whilst recruitment incentives, contract reform and targeted commissioning initiatives all have an important role to play, sustainable access to NHS dental services will ultimately depend upon the development of a strong and resilient workforce pipeline. The evidence considered by the Committee highlighted continuing concerns regarding recruitment, workforce sustainability and equitable access to care across Oxfordshire.

In this context, continuing to engage with the Dentistry Deanery and other relevant partners to support the establishment of a local dental school represents a strategic and forward-looking response. Such an institution would have the potential to strengthen workforce recruitment and retention, increase regional training capacity, support community dentistry, improve access to care, enhance research and innovation, and contribute to the long-term sustainability of NHS dentistry across Oxfordshire and the wider Thames Valley. The recommendation is therefore firmly grounded in workforce evidence, national health policy, academic research and the Committee's broader objective of securing equitable and sustainable dental services for future generations.

[41] https://www.gdc-uk.org/docs/default-source/quality-assurance/shaping-the-dental-team.pdf
[42] https://www.nihr.ac.uk

Recommendation 6: *For the ICB to continue to engage with the Dentistry Deanery to support the case for a local dentistry school to be established urgently.*

Legal Implications

14. 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.

15. 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'.

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

Annex 1 – Scrutiny Response Pro Forma

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September 2026

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

South Central Ambulance Service CQC Improvement Journey

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

Report to:
- Paul Jefferies (SCAS Divisional Director for Thames Valley)
- Andrew Battye (SCAS Head of Operations for Oxfordshire)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report with an update on the South Central Ambulance Service (SCAS). Particular attention was paid to the Trust's Care Quality Commission (CQC) improvement journey.

2. The Committee would like to thank Paul Jefferies (SCAS Divisional Director for Thames Valley) and Andrew Battye (SCAS Head of Operations for Oxfordshire) for attending the meeting and answering questions from the Committee.

3. The topic of the ambulance service and its journey in addressing concerns raised by the CQC is of significant interest and concern to the JHOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by SCAS to improve its services in ways that adhere to CQC standards.

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

   - Confirmation of whether any regulatory conditions, warning notices, or external oversight arrangements remain in place and what is required to exit them.

   - The overall structure of the CQC improvement programme, including key workstreams and priorities.

   - How learning from inspections and assurance visits is translated into operational change rather than standalone action plans.

   - Performance indicators that demonstrate whether changes are actually improving patient experience and safety (for example response performance, call handling, handover delays, and medicines management where highlighted by CQC).

   - How SCAS assures itself that improvements are sustained, not just short-term compliance responses.

- What is the current strategy for meeting demand without the need for private providers.

- Progress on staff recruitment, retention, training and appraisal, including whether staff feel supported to deliver high-quality care.

- Actions taken to strengthen speaking-up culture, leadership visibility and staff engagement.

- How staff wellbeing is being protected in the context of operational pressures.

- How improvement depends on, or is constrained by, system-wide factors such as hospital handover delays; and what joint work is taking place with ICBs and acute trusts in Oxfordshire to address these issues.

SUMMARY

5. During the 11 June 2026 meeting, the Committee discussed which issues identified by inspection remained most significant. The Divisional Director for Thames Valley explained that one of the main areas of ongoing work was medicines management, which had been identified by the CQC as requiring improvement in relation to storage, documentation and process reliability. The Trust had significantly developed its pharmacy team and had invested in a new site to support improved “make ready” processes and safer medicines management.

6. The Committee revisited its earlier recommendations on internal assurance, audit and governance. The Divisional Director for Thames Valley explained that the Trust had introduced a Performance Management Accountability Framework, under which each divisional director was required to provide formal monthly assurance to the executive team through internal scrutiny arrangements. For Thames Valley, this covered Oxfordshire, Buckinghamshire and Berkshire, each with sector leadership beneath him, including a Head of Operations and a Clinical Operations Manager. He explained that scrutiny included appraisal completion, personal development plans, statutory and mandatory training, and operational quality indicators such as hand hygiene, vehicle cleanliness and medicines management.

7. The Committee explored the Trust’s implementation of the Patient Safety Incident Response Framework. Members asked what had changed in practice since its introduction, what recurrent risks had been identified, what actions had followed, and what evidence existed that those actions had reduced harm. The Head of Operations for Oxfordshire explained that the principal initial change had been in the training and support given to staff and team leaders in understanding the new process for handling patient safety incidents. Patient safety incidents from the previous day were now reviewed every day by the patient safety team in order to identify harm or emerging concerns, and that

there was now a much stronger culture of looking proactively for patient safety issues rather than reacting only after serious incidents had occurred.

8. The Committee examined the growing problem of violence and aggression towards staff. Members referred to similar concerns raised by Oxford University Hospitals NHS Foundation Trust (OUH) and asked whether the ambulance service was facing the same trend. The Head of Operations for Oxfordshire said that regrettably it was, and that the issue had not gone away but had worsened nationally and locally. He described the difficulty of distinguishing between aggression driven by illness and aggression that was deliberate, but stressed that no staff member deserved such abuse.

9. The discussion focused on workforce, particularly the report's statement that financial pressures and service realignment had led to a mismatch between clinical and non-clinical staff. The Head of Operations for Oxfordshire explained that the clinical workforce referred primarily to registered paramedics, while the non-clinical or clinical support workforce included Associate Ambulance Practitioners and Emergency Care Assistants.

10. The Committee scrutinised the Trust's 'Freedom to Speak Up' culture and psychological safety, and asked whether the increase in concerns being recorded indicated a genuinely safer speaking-up culture or continuing unresolved cultural problems. The Head of Operations for Oxfordshire acknowledged that it felt paradoxical to see rising numbers of concerns as positive, but said the increase suggested staff were becoming more comfortable raising issues. The organisation had invested heavily in the Freedom to Speak Up process, including local station-based champions, precisely so that staff did not have to raise issues only through line management and could speak to peers instead. The challenge was not only encouraging staff to speak up but also "listening up" and then following through, because if nothing changed the reporting would stop.

11. The Committee asked what the remaining causes of handover delay in Oxfordshire were and whether rising figures at the Horton General Hospital should be a concern. The Head of Operations for Oxfordshire replied that the main causes remained familiar system issues: acuity, seasonal or weather-related surges in demand, and the ability of acute hospitals to discharge patients safely into the community. The ambulance arrivals as having a "tsunami effect", with several vehicles often arriving in quick succession from different parts of the county, thereby creating episodic pressure in emergency departments.

KEY POINTS OF OBSERVATION:

12. This section highlights four key observations and points that the Committee has in relation to SCAS's CQC improvement journey. These four key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

For SCAS and the ICB to escalate the future pipeline issue with staff and challenges with non-availability of training placements: The Committee's recommendation that South Central Ambulance Service (SCAS) and the Integrated Care Board (ICB) should escalate concerns regarding the future workforce pipeline and the increasing challenges associated with the availability of training placements is a strategically important recommendation that goes beyond the immediate issues which often dominate discussions about ambulance performance. While ambulance response times, hospital handover delays and service demand are frequently the most visible indicators of system pressure, the ability of ambulance services to recruit, train and retain sufficient numbers of staff remains one of the most important determinants of long-term service sustainability. Without a reliable pipeline of future paramedics, technicians, emergency care assistants and clinical support staff, there is a significant risk that improvements achieved through SCAS's wider quality improvement programme could become increasingly difficult to sustain over time.

Evidence presented in the report by SCAS to the Committee demonstrates that this issue is already emerging. The report explained that financial pressures across the NHS had resulted in a recruitment freeze and that onboarding activity had become largely driven by establishment constraints rather than longer-term workforce planning. The report notes that SCAS is "acutely aware of the impact of not recruiting new graduates this year, particularly in relation to our engagement with students and our partnership with Oxford Brookes University." It further acknowledges that the current recruitment pause may create future difficulties because the organisation will eventually need to rebuild its candidate pipeline after a prolonged period of reduced intake. The report additionally highlights the loss of Patient Transport Services as reducing a valuable route through which staff historically progressed into Emergency Care Assistant roles and subsequently into registered clinical practice. These observations demonstrate that SCAS itself recognises the emergence of a workforce pipeline risk that extends beyond immediate staffing levels.

The significance of this issue lies in the nature of ambulance workforce development itself. Unlike some professions where new staff can be recruited and become productive relatively quickly, paramedic education requires a lengthy period of investment. Undergraduate paramedic programmes typically require three years of higher education followed by structured consolidation and preceptorship arrangements before staff become confident autonomous practitioners. Consequently, decisions taken today regarding recruitment, student support and placement provision may not be fully felt in workforce supply figures for several years. Once a gap emerges in the pipeline, it can take a prolonged period to rectify. This means that workforce planning in ambulance services must necessarily be proactive rather than reactive.

National workforce policy increasingly recognises the importance of this challenge. NHS England's Long Term Workforce Plan identifies workforce supply as one of the most significant risks facing the NHS and explicitly links future service sustainability to the expansion of education, training and placement opportunities. The Plan argues that workforce shortages have become one of the principal constraints on service improvement and states that increasing workforce numbers will require significant growth in student training opportunities, clinical placements and educator capacity[1]. The accompanying detailed workforce strategy further highlights that increasing recruitment alone will be insufficient if health systems are unable to provide the practical learning environments necessary to support expanding student cohorts[2].

This issue is particularly relevant for ambulance services because the scope of paramedic practice has evolved significantly over the last decade. Paramedics increasingly work not only within emergency response functions but also within primary care, urgent community response services, virtual wards, integrated neighbourhood teams and specialist practitioner roles. NHS England's Paramedics Workforce Programme recognises that the future workforce requires a broader clinical skillset and greater exposure to diverse care environments. This evolution has increased the importance of providing high-quality placements across multiple parts of the health and care system rather than relying solely upon traditional ambulance-based training experiences[3].

A particular concern is that increasing training places at universities does not automatically translate into future workforce growth. Students can only qualify if they are able to undertake supervised clinical placements. NHS England has repeatedly identified placement availability as one of the major barriers to workforce expansion across a range of clinical professions. Guidance produced through the national Allied Health Professions placement expansion programme highlights that placement capacity has historically acted as a limiting factor on workforce growth and that competition for placements has intensified as health systems seek to expand workforce supply[4].

The College of Paramedics has similarly emphasised the importance of placement capacity in determining future workforce sustainability. During the development of the profession's updated education framework, the College identified difficulties in securing sustainable placement opportunities across the wider health and care system as a significant national challenge. Increasing student numbers across multiple healthcare professions has generated growing competition for clinical

[1] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/,
[2] https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/,
[3] https://www.hee.nhs.uk/our-work/paramedics
[4] https://www.hee.nhs.uk/our-work/allied-health-professions/increase-capacity and https://www.hee.nhs.uk/our-work/allied-health-professions/increase-capacity/practice-placements-challenges-solutions

placements and increased pressure upon practitioners who serve as practice educators. The College has further highlighted concerns regarding the alignment between student numbers, placement opportunities and eventual employment pathways for newly qualified staff[5].

There are examples from elsewhere in England which illustrate the potential consequences of inadequate workforce pipeline planning. Several ambulance trusts experienced significant recruitment difficulties following the COVID-19 pandemic despite substantial growth in demand. The North East Ambulance Service, East of England Ambulance Service and South Western Ambulance Service all developed targeted workforce strategies to improve relationships with universities and increase placement opportunities after identifying risks associated with future workforce supply. Similarly, Health Education England's placement expansion work has drawn upon successful initiatives in regions such as Yorkshire and the Humber, where integrated approaches involving universities, ambulance trusts, community services and Integrated Care Systems were used to increase placement capacity and create sustainable learner pathways. Such examples demonstrate that workforce pipeline issues require coordinated system-wide action rather than relying upon individual organisations acting alone.

The academic literature strongly supports the Committee's concerns. Research published in journals including *BMC Health Services Research, Human Resources for Health* and the *International Journal of Practice-Based Learning in Health and Social Care* consistently identifies placement availability as one of the principal constraints upon healthcare workforce expansion. Studies have found that universities often possess capacity to educate larger numbers of students but are restricted by the availability of clinical learning environments and appropriately trained supervisors. Researchers have further highlighted a self-reinforcing cycle whereby workforce shortages reduce an organisation's ability to support students, which in turn contributes to future workforce shortages. This challenge has been identified across nursing, allied health professions and paramedic education[6].

The recommendation being made by the JHOSC also directly supports SCAS's wider CQC improvement journey. One of the concerns identified during previous inspections related to staff support, professional development and clinical oversight. Since then, SCAS has invested significantly in leadership development, staff wellbeing, Freedom to Speak Up processes, safeguarding capacity, patient safety improvement and cultural change. The report submitted to JHOSC details a substantial programme of organisational development designed to improve both staff experience and patient care. However, sustaining those

[5]https://collegeofparamedics.co.uk/COP/ProfessionalDevelopment/Developing%20a%20New%20Paramedic%20Curriculum.aspx,
[6] https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-022-03799-8

improvements ultimately depends upon having a sufficient supply of staff entering the organisation over the coming years. If workforce pipeline challenges are not addressed, future shortages could place renewed pressure upon supervision arrangements, training opportunities, staff wellbeing and service resilience.

Importantly, this challenge cannot be resolved by SCAS acting alone. The inclusion of the ICB within the recommendation is significant because Integrated Care Boards possess a system leadership role that extends beyond the boundaries of individual trusts. Training placements are provided across a wide range of organisations, including ambulance services, acute hospitals, community providers, mental health providers, primary care and voluntary sector partners. The ability to create sufficient placement opportunities therefore depends upon coordinated action across the entire health and care system. Integrated Care Boards are uniquely positioned to identify constraints, convene partners and advocate nationally where local barriers require intervention at regional or national level.

In essence, this recommendation made by the Committee is therefore both prudent and forward-looking. While SCAS currently benefits from comparatively favourable staffing levels within Oxfordshire, its own report identifies emerging risks relating to graduate recruitment, workforce succession planning and future placement availability. These risks have been recognised nationally through NHS workforce policy, by professional bodies such as the College of Paramedics and within academic research examining healthcare workforce sustainability. Escalating the workforce pipeline issue now represents a preventative intervention designed to protect future service resilience rather than a response to an immediate crisis. By drawing attention to workforce supply and placement capacity at this stage, the Committee is seeking to ensure that the considerable progress achieved through SCAS's improvement journey can be sustained, strengthened and built upon in the years ahead.

Recommendation 1: *For South Central Ambulance Service and the Thames Valley Integrated Care Board to escalate the future pipeline issue with staff and challenges with the non-availability of training placements.*

Strengthening public and patient involvement, and ensuring co-production forms part of shaping and monitoring SCAS's improvement journey: The Committee's recommendation that SCAS should strengthen opportunities for public and patient involvement and that co-production should form part of shaping and monitoring the Trust's improvement journey reflects an increasingly important principle within the modern healthcare improvement: sustainable organisational improvement is most effective when it is designed and monitored not only by professionals and regulators but also by the people who use services. While the CQC, NHS England and Trust Boards all have essential roles in assuring quality and safety, patients, carers and communities offer a

unique perspective on the real-world impact of services that cannot be replicated through performance metrics, inspections or governance processes alone.

The recommendation is particularly relevant in the context of SCAS's ongoing improvement journey following its previous CQC ratings of "Requires Improvement". The report submitted to the Committee for this item demonstrates that SCAS has undertaken substantial work to address the concerns raised by regulators, including improvements in safeguarding, medicines management, patient safety, leadership development, staff wellbeing, Freedom to Speak Up processes and organisational culture. The Trust has also exited the NHS Recovery Support Programme, successfully had several undertakings removed and established extensive governance arrangements to monitor progress. These are significant achievements and indicate meaningful organisational commitment to improvement. However, much of the evidence presented focuses on internal measures of success, governance arrangements and organisational processes. While these are necessary elements of improvement, they do not alone demonstrate whether patients and communities experience those changes positively or whether services are evolving in ways that reflect the priorities of local people.

Co-production provides a mechanism through which this gap can be addressed. The term co-production refers to service users, carers and communities working in equal partnership with professionals to design, deliver and evaluate services. NHS England has increasingly promoted co-production as a core principle of healthcare transformation, arguing that healthcare services achieve better outcomes and greater public confidence when people are actively involved in decisions affecting them. NHS England's guidance on working in partnership with people and communities emphasises that involvement should move beyond consultation and towards meaningful collaboration in decision-making and service improvement[7].

This principle is particularly important for ambulance services. Unlike many NHS services, ambulance trusts interact with patients during some of the most stressful, urgent and vulnerable moments of their lives. Performance indicators such as response times, hospital handovers and non-conveyance rates are important, but they do not fully capture patient experience. For example, patients may judge the quality of care according to communication, reassurance, dignity, involvement in decision-making and confidence in clinical assessments. Carers may identify barriers affecting vulnerable individuals that are not visible through routine performance data. Communities may identify inequalities in access or outcomes that are not immediately apparent through organisational reporting. Public involvement therefore provides

[7] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance

intelligence that complements traditional performance measures and supports more comprehensive improvement.

The argument for co-production is strongly supported by national policy. The Health and Care Act 2022 placed significant emphasis on involving patients and communities in the planning, commissioning and evaluation of health services. The legislation reinforced existing duties contained within Section 242 of the NHS Act 2006, requiring NHS organisations to involve service users in the planning and development of services. Guidance published by NHS England identifies engagement with communities as one of the fundamental components of system improvement and highlights the importance of co-production in developing effective and sustainable healthcare services[8].

Academic evidence similarly demonstrates the value of co-production in the healthcare improvement. A landmark review published in the *British Medical Journal* argued that healthcare systems achieve better outcomes when patients are treated as partners in improvement rather than passive recipients of care. The authors concluded that patient involvement improves service quality, strengthens safety cultures and leads to more effective service redesign[9]. Similarly, research published in *BMC Health Services Research* found that healthcare organisations using co-production approaches often experienced improvements in service quality, service responsiveness and organisational learning[10].

Further evidence comes from research undertaken by the National Institute for Health and Care Research (NIHR). The NIHR has consistently found that services designed with patients, rather than solely for patients, are more likely to identify unmet needs, reduce inequalities and achieve sustainable improvements. Their work on patient and public involvement highlights that lived experience provides a distinct type of expertise that complements professional knowledge[11].

Importantly, there are examples from elsewhere in the ambulance sector that demonstrate how public and patient involvement can strengthen organisational improvement. The London Ambulance Service established a Patient and Public Advisory Group which advises on strategic priorities, service redesign and equality initiatives. The Trust has reported that direct engagement with patients and carers has influenced decisions regarding accessibility, communication and experiences of urgent and emergency care[12].

Similarly, East Midlands Ambulance Service has developed a Patient Participation Group and community engagement structures that contribute to strategic planning and service evaluation. Through these

[8] at https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/
[9] https://www.bmj.com/content/359/bmj.j3453
[10] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4247-6.
[11] NIHR Patient and Public Involvement Resources.
[12] https://www.londonambulance.nhs.uk/about-us/involving-patients-and-the-public

mechanisms, patients have provided feedback on service accessibility, communication standards and ambulance service experiences, helping shape organisational improvement activity[13].

North East Ambulance Service has also adopted extensive community engagement approaches, including engagement with seldom-heard groups, carers and voluntary sector organisations. This work recognises that ambulance services frequently interact with populations who may otherwise be underrepresented within traditional engagement processes, including people experiencing homelessness, individuals with learning disabilities and those living in rural communities[14].

The recommendation being made by the Committee is also consistent with broader themes emerging from SCAS's own improvement work. The report submitted to the Committee describes extensive efforts to improve organisational culture, psychological safety and the ability of staff to raise concerns. SCAS highlights the strengthening of Freedom to Speak Up arrangements, the creation of champion networks and efforts to ensure that colleagues feel heard and valued. The Trust rightly recognises that listening to staff and responding to concerns are fundamental components of organisational improvement. The same principle logically extends to patients and communities. If listening to staff is essential for creating a learning organisation, listening to patients should be equally important for understanding whether services are meeting the needs of those who use them.

Co-production could also strengthen the monitoring of SCAS's improvement journey. Traditional organisational metrics often focus on what can be measured quantitatively, such as response times, staffing numbers, incident rates and compliance indicators. While these measures are important, they cannot fully explain whether improvements are translating into better experiences for patients and families. Involving patients, carers and community representatives in improvement oversight groups, quality committees or specific workstreams would allow the Trust to test whether improvements identified internally are producing meaningful external benefits. This would strengthen assurance for both regulators and local scrutiny bodies by demonstrating that progress is being validated not only by organisational self-assessment but also by those receiving services.

There is also a strong public accountability argument. Ambulance trusts are publicly funded organisations delivering services on behalf of local communities. Involving the public in shaping and scrutinising improvement programmes can strengthen transparency, trust and legitimacy. This is particularly important following periods of regulatory intervention or organisational challenge. International evidence suggests that organisations recovering from quality concerns often rebuild public confidence more effectively when service users are visibly involved in

[13] https://www.emas.nhs.uk/get-involved/patient-participation-group/.
[14] https://www.neas.nhs.uk/get-involved.aspx

monitoring progress and helping shape solutions. A comprehensive review published in *Health Expectations* found that meaningful patient involvement can improve trust, accountability and organisational legitimacy[15].

Ultimately, the Committee's recommendation reflects an increasingly accepted understanding that healthcare improvement should not be something that is done to patients but something that is done with patients. SCAS has demonstrated significant commitment to improving governance, culture, workforce development and patient safety, and these achievements should be recognised. However, the next stage of the improvement journey should ensure that patients, carers and communities play a more active role in shaping priorities, evaluating progress and identifying opportunities for further development. Strengthening public involvement and embedding co-production within the Trust's improvement programme would align with national NHS policy, academic evidence, and good practice from ambulance services across England. Most importantly, it would help ensure that improvements are judged not solely by organisational processes or regulatory assessments but by the experiences and outcomes of the people whom the service exists to serve.

Recommendation 2: *For the Ambulance Service to strengthen opportunities for public and patient involvement. It is recommended that there is coproduction as part of shaping and monitoring the Trust's improvement journey.*

To ensure that "speaking up" is not merely encouraged or measured per se, but to evidence that actions are followed up and lessons are learned around the themes emerging through "speaking up": The Committee's recommendation that SCAS should ensure that "speaking up" is not merely encouraged or measured, but that actions are demonstrably followed through and lessons are learned from the themes emerging through speaking up, reflects an important principle of effective organisational improvement. While encouraging staff to raise concerns is an essential component of a healthy organisational culture, evidence from healthcare regulation, national policy, organisational psychology and patient safety research consistently demonstrates that the true measure of a successful speaking-up culture is not how many concerns are raised, but what an organisation does with those concerns once they have been heard. A culture in which staff are actively encouraged to speak up but do not subsequently see meaningful action can ultimately become less safe than one where concerns are not raised at all, because repeated failures to respond may create cynicism, disengagement and loss of trust in leadership.

This recommendation is particularly relevant in the context of SCAS's ongoing Care Quality Commission (CQC) improvement journey. The

[15] https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12640

report submitted to the Committee highlighted the substantial progress that the Trust has made since the CQC identified concerns relating to governance, leadership, clinical oversight and organisational culture. The report describes a significant programme of cultural improvement, including the development of a network of Freedom to Speak Up (FTSU) Champions, more than 800 conversations with staff, a 99% compliance rate for FTSU e-learning, and a 26% increase in concerns being recorded. The Trust states that these developments have improved its ability to "listen up" as well as encouraging colleagues to speak up. At the same time, however, the report acknowledges that there has been an increase in anonymous concerns and that significant themes continue to include bullying and harassment, behavioural concerns, psychological safety and sexual safety. The report further recognises that building a psychologically safe culture remains a continuing improvement priority rather than a completed task.

Importantly, during the Committee's discussion, the Head of Operations for Oxfordshire explicitly recognised that encouraging staff to raise concerns is only part of the challenge. He noted that the real challenge is "listening up" and ensuring that concerns result in meaningful follow-through, because if staff perceive that nothing changes, they will eventually stop reporting concerns. This observation goes to the heart of why the Committee made this recommendation. The success of Freedom to Speak Up arrangements cannot be judged purely by activity measures such as the number of champions trained, training compliance rates or the volume of concerns reported. Those indicators may show that mechanisms exist, but they do not demonstrate that the organisation is learning from concerns, addressing the issues identified, or improving outcomes for staff and patients.

The national Freedom to Speak Up framework itself supports this interpretation. The original *Freedom to Speak Up Review*, led by Sir Robert Francis QC and published in 2015, argued that organisations should not simply focus on creating channels for reporting concerns but should actively demonstrate that concerns lead to visible change. The review stressed that staff must have confidence that raising concerns will result in action and that organisations should routinely communicate the lessons learned and improvements made following concerns being raised. The report warned that where employees see little evidence of organisational response, confidence in speaking-up systems rapidly deteriorates[16].

Subsequent NHS England guidance has reinforced this position. The National Guardian's Office, which oversees Freedom to Speak Up arrangements across the NHS, repeatedly emphasises that organisations should move beyond measuring speaking-up activity and instead demonstrate organisational learning. Its guidance highlights that boards should ask not merely how many concerns have been raised, but

[16]https://webarchive.nationalarchives.gov.uk/ukgwa/20150218150343/http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

what themes are emerging, what actions have been taken, whether those actions have improved culture and whether staff can see evidence of change. The National Guardian's Office stresses that visible learning and feedback are essential components of maintaining trust in speaking-up processes[17].

The Committee's recommendation is also strongly supported by patient safety literature. Modern patient safety thinking increasingly recognises that healthcare organisations are complex adaptive systems in which frontline staff often identify risks long before those risks become visible through formal performance metrics or serious incidents. Professor Amy Edmondson's influential work on psychological safety, published in journals such as *Administrative Science Quarterly* and subsequently developed through her book The Fearless Organization, demonstrates that high-performing organisations are characterised not simply by people speaking up, but by leaders responding constructively to concerns. Edmondson found that organisations learn most effectively when staff feel safe to identify problems and when leaders treat concerns as opportunities for improvement rather than criticism[18].

Similarly, research published in *BMJ Quality & Safety* has consistently shown that effective incident reporting and speaking-up systems depend on visible organisational learning. Studies have demonstrated that staff are significantly more likely to report concerns when they believe that reporting leads to meaningful action, whereas under-reporting becomes more common when employees perceive that concerns disappear into bureaucratic processes without producing tangible change[19].

The themes identified within SCAS's own report submitted to the Committee further strengthen the Committee's argument. The Trust reports that bullying, harassment, psychological safety and sexual safety remain among the most significant categories of concerns being raised by staff. These are not isolated operational issues but indicators of underlying organisational culture. The existence of recurring themes means that the organisation now possesses valuable intelligence about where cultural challenges remain. The key question therefore becomes whether those themes are informing systemic interventions. It is not enough to know that concerns relate to bullying or psychological safety; the organisation must be able to demonstrate how information from those concerns is influencing leadership development, workforce policies, investigations, behavioural expectations, performance management and organisational culture programmes.

There are noteworthy examples elsewhere in the NHS where organisations have attempted to embed this learning approach. Mersey Care NHS Foundation Trust, often recognised nationally for its work on psychological safety and organisational learning, publishes examples

[17] https://nationalguardian.org.uk/.
[18] https://www.hbs.edu/faculty/Pages/profile.aspx?facId=6451
[19] available through https://qualitysafety.bmj.com

showing how staff concerns have resulted in specific policy changes, leadership interventions and service improvements. Rather than reporting only the number of concerns raised, the Trust focuses on demonstrating what changed because staff spoke up[20].

Similarly, University Hospitals Birmingham NHS Foundation Trust has sought to strengthen confidence in Freedom to Speak Up arrangements through regular "You Said, We Did" reporting. This approach explicitly links themes raised by staff to actions implemented by the organisation and aims to ensure that employees can observe the practical consequences of speaking up. Such approaches help convert speaking-up activity into organisational learning and reinforce trust in reporting mechanisms[21].

The recommendation being made by the Committee is especially important because SCAS is moving from a period of regulatory recovery into a phase of longer-term organisational maturity. The report submitted to the Committee for this item notes that the Trust has now exited the NHS Recovery Support Programme and has had several undertakings removed. These are significant achievements. However, the Trust itself acknowledges that further improvement is required and that the Board remains focused on continuing the improvement journey. Sustained improvement depends upon developing learning systems capable of identifying and responding to emerging risks before they become major problems. Freedom to Speak Up represents one of the most powerful sources of organisational intelligence available to any healthcare provider. Staff are uniquely positioned to identify barriers to safe care, weaknesses in governance, leadership challenges and cultural concerns. The value of FTSU therefore lies not in the act of speaking up itself but in the organisation's ability to convert that information into improvement.

Ultimately, the Committee's recommendation reflects a mature and evidence-based understanding of organisational culture. SCAS has clearly invested substantial effort in encouraging staff to speak up through champion networks, training programmes, leadership development initiatives and cultural improvement work. Those achievements should be recognised. However, the next stage of the Trust's cultural development should focus on demonstrating the impact of Freedom to Speak Up activity. This means evidencing how concerns are analysed, how themes are identified, how actions are implemented, how lessons are shared across the organisation and how leaders can demonstrate that staff voices directly influence change. Such an approach would align with the recommendations of the Francis Review, the expectations of the National Guardian's Office, NHS policy on organisational learning, and a substantial body of academic research on psychological safety and patient safety. Most importantly, it would help ensure that speaking up becomes not merely a measure of

[20] https://www.merseycare.nhs.uk/
[21] https://www.uhb.nhs.uk/

organisational activity, but a mechanism for continuous learning, safer care and lasting cultural improvement.

Recommendation 3: *For the Trust to ensure that "speaking up" is not merely encouraged or measured per se, but to evidence that actions are followed up and lessons are learned around the themes emerging through "speaking up".*

To support staff wellbeing and develop clear, measurable and transparent outcomes frameworks to demonstrate success in supporting staff and tackling burnout: The Committee's recommendation that SCAS should continue to support staff wellbeing and develop clear, measurable and transparent outcomes frameworks to demonstrate success in supporting staff and tackling burnout reflects a growing recognition across the NHS that staff wellbeing is not merely a workforce issue but a fundamental component of patient safety, service quality and organisational sustainability. The Committee welcomed the extensive work undertaken by SCAS as part of its CQC improvement journey and recognised the significant investment that has been made in culture change, staff support and organisational development. However, the Committee considered that it is no longer sufficient simply to demonstrate that wellbeing initiatives are being implemented. There must also be clear evidence that these initiatives are delivering measurable improvements in staff experience, reducing burnout and ultimately contributing to safer and more sustainable services.

The report submitted by SCAS to the Committee demonstrates that considerable progress has been made in strengthening support for staff. The Trust reported major developments across its Freedom to Speak Up arrangements, leadership development programmes, mental health support services, Occupational Health provision and organisational culture improvement work. The report notes that SCAS has strengthened its Freedom to Speak Up network, achieved 99% compliance with associated training, introduced culture champions, established leadership forums, implemented new leadership development programmes and secured a £250,000 wellbeing grant to strengthen support for learners and new recruits. The Trust has also expanded Mental Health First Aid provision, strengthened Trauma Risk Management support, developed a suicide prevention steering group and invested in programmes designed to create psychologically safe working environments. The Committee recognised these initiatives as positive and welcomed the continued commitment shown by the organisation towards staff wellbeing.

However, the report simultaneously highlights why continued attention is required. SCAS acknowledges that, despite progress in some areas, results from the NHS Staff Survey demonstrated that morale and burnout scores remained below the national average and that both organisational trust and staff engagement had declined. The Trust explicitly identified reducing the gap between local trust and organisational trust as a continuing challenge. These findings are significant because they

suggest that while substantial effort is being invested in wellbeing initiatives, the impact of these interventions cannot yet be viewed as fully realised. The Committee therefore concluded that the next stage of the improvement journey should focus not only upon delivering wellbeing initiatives but also upon demonstrating whether those initiatives are achieving their intended outcomes.

This recommendation being made by the JHOSC is consistent with wider national policy. NHS England's People Promise recognises staff wellbeing as a strategic priority and emphasises that NHS organisations should create environments where staff feel safe, supported, valued and able to thrive. The People Promise explicitly links staff wellbeing to patient experience, staff retention, productivity and quality of care. NHS England further argues that wellbeing programmes should be supported by robust metrics and meaningful evaluation rather than focusing solely on activity measures such as attendance at training or participation in wellbeing events[22].

The evidence linking staff wellbeing to patient outcomes is now substantial. One of the most influential reviews in this area was undertaken by Professor Michael West and Dame Denise Coia for NHS England, published as *Caring for Doctors, Caring for Patients*. The review concluded that the wellbeing of healthcare staff directly influences the quality and safety of patient care and argued that organisations have a responsibility to create environments in which staff can flourish. The review found that staff experiencing burnout are more likely to demonstrate reduced engagement, increased sickness absence, lower job satisfaction and a greater likelihood of making mistakes[23].

Academic research provides further support for the Committee's recommendation. A major systematic review published in *The Lancet* identified burnout among healthcare professionals as a significant threat to patient safety, workforce retention and organisational effectiveness. The study found consistent associations between burnout and higher rates of patient safety incidents, reduced professionalism and poorer quality of care[24]. Similarly, research published in *BMJ Open* found that ambulance staff experience some of the highest levels of occupational stress within the NHS due to exposure to trauma, shift working, high workloads and emotionally demanding situations. This research highlighted the importance of organisational support mechanisms in reducing burnout and promoting resilience[25].

The ambulance sector faces particular challenges that make staff wellbeing especially important. Ambulance clinicians routinely encounter traumatic incidents, death, serious injury, distressed families and highly

[22] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/supporting-our-nhs-people/people-promise
[23] https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf
[24] The Lancet: Interventions to Reduce Burnout Among Physicians
[25] https://bmjopen.bmj.com/content/12/3/e050965

pressured operational environments. They often work long shifts, experience unpredictable workloads and face the challenges associated with hospital handover delays and increasing demand. Research published in the *British Paramedic Journal* has shown that paramedics experience high rates of occupational stress, emotional exhaustion and psychological distress compared with many other professional groups[26].

Importantly, many NHS organisations have moved towards outcome-based wellbeing frameworks rather than relying solely on descriptions of wellbeing initiatives. For example, Northumbria Healthcare NHS Foundation Trust has developed a comprehensive workforce wellbeing strategy accompanied by quantitative measures relating to sickness absence, staff survey results, workforce retention and wellbeing service utilisation[27]. Similarly, Mersey Care NHS Foundation Trust has established a wellbeing framework that uses measurable indicators alongside qualitative feedback to assess whether wellbeing investments are genuinely improving staff experience[28].

Within the ambulance sector, London Ambulance Service has increasingly integrated workforce wellbeing metrics into its People Strategy, monitoring indicators such as sickness absence, retention, staff survey responses, psychological support uptake and workforce engagement measures. The rationale for this approach is that leadership teams require objective evidence to determine whether interventions are producing meaningful improvements rather than simply demonstrating activity[29].

The Committee's recommendation is therefore not a criticism of the work already undertaken by SCAS but rather reflects the view that the Trust has now reached a stage in its improvement journey where demonstrating impact is as important as demonstrating commitment. The report identifies a wide range of positive initiatives, including wellbeing conversations training, occupational health improvements, mental health support programmes, leadership development and culture change interventions. These initiatives should continue to be supported and expanded where necessary. However, the Committee considered that it should be possible to evidence whether those initiatives are leading to measurable improvements in areas such as sickness absence, turnover rates, retention, burnout indicators, NHS Staff Survey results, engagement scores, psychological safety measures and workforce stability. Such information would provide a more robust basis for understanding whether interventions are succeeding and would strengthen assurance for staff, regulators, governors and local scrutiny bodies.

[26] British Paramedic Journal: Occupational Stress and Paramedic Wellbeing
[27] https://www.northumbria.nhs.uk/about-us/our-strategy
[28] https://www.merseycare.nhs.uk/about-us/our-values-and-strategy
[29] https://www.londonambulance.nhs.uk/about-us/our-strategy

There is also an important transparency argument underpinning the recommendation. Healthcare organisations frequently report the activities they undertake to support wellbeing but comparatively few publish comprehensive assessments of whether those activities have improved outcomes. Transparent reporting of wellbeing measures can help strengthen trust between staff and leaders by demonstrating that wellbeing is being treated as an organisational outcome rather than a promotional initiative. It would also support learning across the wider NHS, enabling other organisations to understand which interventions are having the greatest impact.

Ultimately, the Committee concluded that staff wellbeing must remain central to SCAS's continued improvement journey. The evidence presented demonstrates that SCAS has invested significantly in supporting its workforce and has implemented a substantial programme of cultural and organisational development. Nevertheless, the persistence of concerns relating to morale, organisational trust and burnout demonstrates that this work remains unfinished. National policy, academic evidence and experience across the NHS all show that staff wellbeing is intrinsically linked to patient safety, workforce retention and organisational performance. The Committee therefore considered it appropriate to recommend that SCAS not only continues its investment in staff wellbeing but also develops clear, measurable and transparent outcomes frameworks capable of demonstrating whether those investments are delivering meaningful improvements for staff and, ultimately, for the patients they serve.

Recommendation 4: *To ensure that there is continued support for staff wellbeing. It is recommended that there are clear, measurable, and transparent outcomes frameworks to demonstrate success in supporting staff and in tackling burnout.*

Legal Implications

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

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

15. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the Committee may require a response from the responsible person to

whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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

September 2026

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OXFORDSHIRE COUNTY COUNCIL

Cllr J Hanna OBE

Chair, Oxfordshire Health Overview and Scrutiny Committee

18 August 2026

Dear Secretary of State for Health & Social Care,

Subject: Future of Healthwatch and the Need to Preserve an Independent Patient and Resident Voice

I am writing on behalf of the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) to express our concern regarding the Government's proposed abolition of Healthwatch England and the network of local Healthwatch organisations. The Committee urges the Government to reconsider the implications of this proposal and, should it proceed, to ensure that local systems are afforded the greatest possible flexibility to develop arrangements that preserve an independent, locally rooted patient and resident voice.

The Committee recognises the Government's ambition to strengthen patient and public voice within health and care decision-making and understands the rationale for ensuring feedback is more closely connected to those responsible for commissioning and delivering services. However, we remain concerned that abolishing Healthwatch without a clear independent replacement risks weakening rather than strengthening the ability of patients, carers and residents to influence decisions about health and care services.

In Oxfordshire, we have consistently recognised the value of a local independent patient voice function. The ability of residents to provide feedback through an organisation that is visibly separate from providers and commissioners is fundamental to public confidence. Independence is not a peripheral feature of the current model; it is the reason many people feel able to raise concerns, challenge decisions and share experiences openly. This is particularly important for those who face barriers to engagement, have lost confidence in services, or belong to seldom-heard communities. The local Healthwatch has a standard item on our agenda of every local scrutiny meeting and we work closely with Healthwatch Oxfordshire in-between our public meetings. This helps bring together a vital independent lived experience perspective of critical issues across our local population, and their reports are part of the evidence we use for the local scrutiny function.

The Committee notes that the Local Government Association has recently warned that transferring patient voice responsibilities into organisations responsible for delivering or commissioning services risks those organisations being perceived as "marking their own homework". The LGA has further highlighted the risk of fragmentation, duplication and weakened accountability if an independent local patient voice is removed without a clear alternative.

Similarly, research undertaken by The King's Fund into the future of patient voice found that Healthwatch's independence was central to its credibility with communities and enabled it to raise issues that the health and care system might otherwise overlook. The report highlighted the value of trusted local relationships, particularly with people experiencing health inequalities and those less likely to engage directly with statutory organisations. Importantly, it concluded that any future arrangements should retain independence from government and service providers and continue to provide a trusted mechanism capable of "speaking truth to power".

The Government's own equality impact assessment also acknowledges that some people are more likely to share feedback with an independent organisation than with bodies responsible for delivering or commissioning their care. It recognises that the loss of an independent patient voice function may create challenges for some communities and that trust in new arrangements will need to be established over time.

For these reasons, the Committee believes there remains a strong case for reconsidering the abolition of Healthwatch. Whilst the current model is capable of improvement, we believe reform and strengthening of an independent local patient voice function would better protect public confidence, accountability and meaningful engagement than its removal. We recognise that there is duplication between the national Healthwatch and National voices, but that this duplication does not exist at a local level.

At the same time, we recognise that the Government may decide to proceed with its proposed reforms. If so, the Committee strongly urges that the legislation and accompanying guidance provide maximum local flexibility. Local systems should be able to determine the arrangements that best meet the needs of their communities, including the ability to retain or commission independent organisations where this is considered the most effective means of ensuring that patient and resident voices are heard.
This point is particularly important in Oxfordshire. Following a County Council motion and JHOSC recommendations, the Oxfordshire Health and Wellbeing Board has already established a multi-agency Independent Patient Voice Working Group involving key system partners to explore what a future independent patient voice function could look like locally should Healthwatch be abolished. The group has been tasked with considering potential models, overseeing public engagement, and identifying the key principles that should underpin any future arrangements.

Those discussions have consistently identified independence, trust, credibility, meaningful influence, and strong relationships with communities as essential characteristics of any future patient voice function. The purpose of this work is not simply to create a replacement for Healthwatch, but to ensure that Oxfordshire retains a trusted mechanism through which residents can influence health and care services and hold organisations to account.

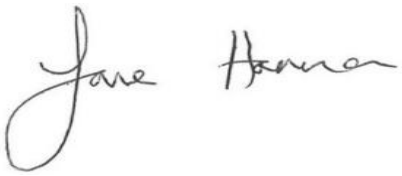
The Committee therefore urges the Government to:

1. **Reconsider the proposed abolition of Healthwatch** and explore whether the objectives of strengthening patient and public voice could be achieved through reform of the existing independent model rather than abolition of local Healthwatch.
2. **Protect the principle of independence** within any future patient voice arrangements so that local areas may retain or commission independent organisations where appropriate.

3. **Provide maximum local flexibility** for health and care systems to design arrangements that reflect local circumstances, existing partnerships and community needs.

The Committee firmly believes that an independent patient and resident voice is an essential component of an accountable, person-centred and continuously improving health and care system. Whatever national reforms are pursued, we urge the Government to ensure that the principles of independence, trust and local accountability are not lost. Oxfordshire's partners are already working constructively to explore future arrangements, and we believe that local flexibility will be critical to the success of that work.
We would be grateful for your consideration of these concerns and three requests as well as clarification as to how the Government intends to safeguard independent patient and resident voice if Healthwatch is abolished.

Yours sincerely,



Cllr Jane Hanna OBE

Chair, Oxfordshire Joint Health Overview Scrutiny Committee

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Department of Health & Social Care

From the Ministerial Correspondence and Public Enquiries Unit

39 Victoria Street
London
SW1H 0EU

Our ref: DE-1716582

31 July 2026

Dear Councillor Hanna,

Thank you for your correspondence of 3 July to the former Secretary of State for Health and Social Care about the future of patient voice in Oxfordshire with the closure of Healthwatch. I have been asked to reply.

I appreciate your concerns regarding the importance of independent patient and resident voice.

The Government aims to ensure that patients, carers or their representatives, and anyone who draws on care and support services, has a say in the services that matter to them. Integrated Care Boards (ICBs) and local authorities (LAs) already have responsibilities to involve the public in shaping services. Currently, there are too many different routes through which feedback is gathered, and too often that means people's experiences do not have the influence they should. The Government is therefore making accountability clearer.

Subject to parliamentary passage of the Health Bill, the Government is making it explicit that accountability for listening to local people, and acting on what they say, sits with ICBs and LAs. And where support is needed to make that work, the Government aims to work alongside ICBS and LAs to help them deliver it well. The Government is not being prescriptive about how the feedback is gathered. However, ICBs and LAs will be accountable for acting on the feedback provided. This cuts through duplication, ends confusion, and makes it much clearer to patients and service users who is accountable for listening to them, and acting on what they say.

ICBs and LAs will be represented on health and wellbeing boards. It is at this point that the more integrated joined up approach to the provision of health and care services comes together – allowing LAs and ICBs to share insights, confront challenges, and take action to improve services locally.

At national level, the Government is bringing patient voice into the Department, through a new Patient Experience Directorate, where it can drive real change. The Department aims to focus on groups less likely to engage. Guidance published by the Department aims to make it clear that ICBs and LAs should ensure that the steps they take to involve local people include those experiencing health inequalities, those who do not have access to digital platforms, those who are less proficient with technology, and people for whom English is a second language. This will ensure that services provided will benefit all people in the area. This marks a decisive step change in how the Government listens to and acts on patient experience in shaping national policy. It puts patient experience at the heart of national policymaking.

The priority of the Government's reforms around patient and public voice is not to maintain the current independent structures, but to strengthen the patient and public voice by bringing it closer to decision-makers, so what people say cannot be ignored and has a more direct impact on services. The Patient Experience Directorate in the Department of Health and Social Care seeks to be transparent, visible and influential in a way that better drives change.

To support this, the Government is developing a new, more sophisticated patient voice intelligence system. It will go beyond current feedback mechanisms, bringing together both qualitative and quantitative data on patient experience, providing a much richer, more complete picture of how services are performing. Information will be made more accessible and visible, including being available in places and formats people are more likely to encounter and use in their day-to-day interactions with the NHS. Overall, this aims to make it much clearer how the NHS is performing on patient experience, strengthening accountability across the system.

I hope this reply is helpful.

Yours sincerely,

Correspondence Officer
Ministerial Correspondence and Public Enquiries
Department of Health and Social Care

NHS
Thames Valley

Councillor Jane Hanna OBE
Chair, Oxfordshire Joint Health Overview & Scrutiny Committee
Oxfordshire County Council
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New Road
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OX1 1ND

Thames Valley ICB offices
First Floor
Unipart House
Garsington Road
Cowley
Oxford
OX4 2PG

3rd July 2026

Dear Councillor Hanna,

Re: Continuing Healthcare (CHC) and Adult & Community Care Commissioning (AACC) Invoice Payments

Thank you for your recent correspondence regarding delays to Continuing Healthcare (CHC) and Adult & Community Care Commissioning (AACC) invoice payments and for the Committee's continued interest in this important issue.

I fully recognise the concern that these delays have caused amongst providers and the wider health and care system. Timely payment is fundamental to maintaining confidence across our supply chain and to ensuring that organisations delivering essential care services are able to operate sustainably.

This continues to be a major operational priority for NHS Thames Valley Integrated Care Board. We have implemented a dedicated recovery programme, supported by NHS England and Shared Business Services, to both address the current backlog and establish longer-term resilience within our financial processes.

A number of actions have now been implemented, including:

- Deployment of additional finance capacity to validate and process invoices.
- More frequent payment runs to increase payment throughput.
- Changes to final authorisation processes to improve the speed of invoice approval whilst maintaining appropriate financial controls.
- Dedicated programme management bringing together senior leaders from NHS Thames Valley ICB, NHS England regional and national teams and Shared Business Services to oversee both immediate recovery and long-term system sustainability.

Governance arrangements have also been strengthened. Progress is reviewed weekly by the Executive Team, whilst the Chief Financial Officer maintains daily oversight of the recovery programme to ensure issues are escalated and resolved as quickly as possible.

Whilst there remains more work to do, we are seeing measurable progress. Within the Continuing Healthcare and Learning Disability/Mental Health Aftercare cohort, outstanding invoices have reduced by 25% in the last month alone. These figures include duplicate and disputed invoices and therefore do not represent invoices requiring payment in every case.

Alongside reducing the backlog, we recognise that rebuilding provider confidence requires open and transparent communication. Since the Committee last met, we have written to providers via the local Care Associations, responded to media enquiries and participated in local radio interviews to explain the actions being taken and provide regular updates on progress.

We remain particularly concerned to ensure that no provider experiences service disruption or business failure because of delayed payments. A dedicated supplier query and escalation process remains in place, enabling providers experiencing significant financial pressure to contact us directly so that individual circumstances can be reviewed urgently and, where appropriate, interim payment arrangements considered whilst invoices continue through validation.

Although significant progress has been made, we fully acknowledge that the position is not yet where it needs to be. Clearing the remaining backlog and restoring normal payment performance remains one of our highest operational priorities, and we will continue to provide regular updates on progress to providers, partner organisations and the Committee.

Thank you for your continued interest and scrutiny of this important issue.

Yours sincerely,

Sam Burrows
Chief System Development & Engagement Officer
NHS Thames Valley Integrated Care Board

On behalf of
Dr Nick Broughton
Chief Executive
NHS Thames Valley Integrated Care Board

CC
Dr Priya Singh, Chair, NHS Thames Valley Integrated Care Board
Dr Nick Broughton, CEO, NHS Thames Valley Integrated Care Board

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

10 SEPTEMBER 2026

Report of the Joint Health Overview and Scrutiny Committee Primary Care Access and Estates Working Group

Report by Director of Law and Governance and Monitoring Officer

RECOMMENDATIONS

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

a) **RECEIVE** and **ENDORSE** the Joint Health Overview and Scrutiny Committee (JHOSC) primary care and estates Working Group report found in Annex 1.

b) **AGREE** to the recommendations outlined in the Working Group report and for these to be issued to the Thames Valley Integrated Care Board.

c) **AGREE** to share this report and its findings with the Secretary of State for Health and Social Care.

d) **AGREE** to share this report and its findings with the Oxfordshire Health and Wellbeing Board.

e) **AGREE** to **DELEGATE** to the Health Scrutiny Officer to arrange for this report to be graphically finalised, and for a graphical and accessible version of this report to be published in the November JHOSC public meeting.

f) **NOTE** the formal closure of the Joint Health Overview and Scrutiny Committee primary care access and estates Working Group.

Executive Summary:

2. This report introduces the Committee to the work, findings and recommendations of the JHOSC Primary Care Access and Estates Working Group (Annex 1).

3. The Working Group was established to support the Committee's scrutiny of primary care access and the condition, capacity and suitability of the primary care estate across Oxfordshire, including how system partners are responding to pressures in access and premises and what plans are in place for improvement.

4. The report in Annex 1 sets out the key themes emerging from the working group's work, and its findings and recommendations for the Committee to consider.

5. The Committee is asked to receive and note the Working Group's update report and to consider the findings and recommendations within Annex 1. The Committee is also asked to allow the Working Group members to conduct two further planned site visits (on behalf of the wider Committee) to Bicester Health Centre and Newbury Street Practice.

Background and work undertaken:

6. The JHOSC Primary Care Access and Estates Working Group was established by the Committee to undertake detailed work on issues relating to access to general practice and primary care estates, and to report back to the Committee with findings and recommendations.

7. The Working Group's remit includes understanding the current position on access (including variation across localities and groups of patients), reviewing the capacity and condition of primary care premises, and considering the plans of system partners to improve access and address estates constraints. The group has gathered evidence through engagement with relevant NHS partners and by reviewing available performance and estates information.

8. Since its formation, the Working Group has continued its programme of evidence-gathering and discussion on primary care access and estates, supported by officers.

9. The report in Annex 1 contains some key findings of the Working Group and summarises the key themes emerging from the Group's work, including issues raised in relation to access routes and patient experience, and the constraints and opportunities associated with the primary care estate.

10. Annex 1 also sets out the Working Group's recommendations on GP services and estates matters for the Committee to consider and submit to the Thames Valley Integrated Care Board.

Sharing findings of the inquiry with the Health and Wellbeing Board

11. As indicated above, it is also important that the Working Group's report and findings are shared with the Oxfordshire Health and Wellbeing Board, on the basis that the evidence considered by the group points to significant and interrelated challenges within primary care and general practice services. These include pressures around access, capacity, patient experience, premises constraints and the ability of services to respond consistently to population growth and changing patterns of need. These issues are not simply operational matters for individual practices or for the Integrated Care Board in isolation; they are central to the wider place-based planning of health, care and prevention in Oxfordshire.

12. This is particularly important in the context of neighbourhood health planning. National policy is clear that neighbourhood health is intended to shift care closer to home, improve access, strengthen prevention and support more integrated

working between the NHS, local government, social care and wider partners. The Government's Neighbourhood Health Framework defines the roles of Integrated Care Boards, local authorities, Health and Wellbeing Boards and other partners in the development and implementation of neighbourhood health services.

13. The Local Government Association has also highlighted that Health and Wellbeing Boards have a critical role in leading the development of neighbourhood health plans through local evidence, partner alignment and coordinated action. It is therefore appropriate for the Committee to ensure that the Working Group's scrutiny findings are brought formally to the attention of the Oxfordshire Health and Wellbeing Board, so that the challenges identified in relation to GP access and the primary care estate can inform neighbourhood-level planning at the point when that planning is being developed, rather than being considered separately or retrospectively.

14. Sharing the report with the Board would also help ensure that neighbourhood health planning in Oxfordshire is grounded in the experience of residents, the evidence gathered through health scrutiny, and the practical constraints facing primary care, particularly where estates, workforce, digital access and service integration will affect the feasibility of delivering more care closer to home.

Sharing findings of the inquiry with the Secretary of State for Health and Social Care:

15. It is also appropriate and timely for the findings of the Working Group's inquiry, together with the recommendations being made to the Thames Valley Integrated Care Board, to be shared with the Secretary of State for Health and Social Care. The issues considered by the Working Group are local in their evidence base, but they speak directly to national questions about the future sustainability, accessibility and configuration of primary care.

16. The Group heard evidence of significant and persistent pressures within general practice and primary care services, including pressures on access, workforce, digital routes into care, estates capacity, premises suitability, population growth and the ability of primary care to support a wider shift of activity out of acute hospitals and into community-based settings. These are precisely the kinds of issues which the Government's current programme of health and care reform is seeking to address. The 10 Year Health Plan for England sets out a national direction based on three major shifts: from hospital to community, from analogue to digital, and from sickness to prevention.

17. The Government's Neighbourhood Health Framework and subsequent NHS England guidance also make clear that neighbourhood health is expected to be a central mechanism for delivering more integrated, preventative and accessible care closer to home, and that Integrated Care Boards, local authorities, Health and Wellbeing Boards and other system partners will need to work together to develop local neighbourhood health plans and delivery models.

18. In that context, the Committee's findings are likely to be of wider relevance because they show how national ambitions around neighbourhood health, community-based care and strategic commissioning will depend in practice on the capacity, condition and resilience of local primary care infrastructure. Sharing the report with the Secretary of State would therefore provide locally gathered scrutiny evidence at a point when national policy is actively being translated into implementation guidance, commissioning reform and estate planning. It would help demonstrate that the success of national reforms will depend not only on new models of care, but also on whether existing general practice and primary care services have the premises, workforce, digital systems, investment routes and commissioning support needed to fulfil the expanded role being envisaged for them. It would also enable the Secretary of State to consider the Committee's recommendations as part of the broader national conversation about the future of primary care, the development of neighbourhood health centres, the strategic commissioning role of ICBs, and the practical conditions required to make the shift from hospital to community meaningful for residents.

Legal implications:

19. The establishment of this Working Group has been undertaken pursuant to Part 6.1B of Oxfordshire County Council's Constitution which states that: 'Appointments to such Working Groups will be made by the Committee, ensuring political balance as far as possible. Such panels will exist for a fixed period, on the expiry of which they shall cease to exist.'

20. There are no other direct legal implications arising from this report relating to the existence of this Working Group or its interim report and recommendations to the wider Committee.

    Legal Comments:
    Jay Akbar – Head of Legal & Governance

Financial implications:

21. There are no direct financial implications arising from the existence of this Working Group or its report and recommendations to the wider Committee.

    Comments checked by:
    Bick Nguyen-McBride
    Finance Business Parter
    bick.nguyen-mcbride@oxfordshire.gov.uk

Anita Bradley
Director of Law and Governance and Monitoring Officer

Annex 1: Report of the Oxfordshire JHOSC Primary Care Access and Estates Working Group.

Please note: The Report of the Working Group has its own set of annexes labelled A-E.

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

September 2026

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Report of the JHOSC Primary Care Access and Estates Working Group

Working Group Membership: Cllr Jane Hanna (Chair), City Cllr Louise Upton, Cllr Gareth Epps (until appointed to Cabinet in May 2026), Cllr Paul-Austin Sargent, Cllr Ron Batstone, District Cllr Katherine Keats-Rohan. District Cllr David Rogers.

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

Report to:

- Nick Broughton- Chief Executive, Thames Valley ICB.
- Julie Dandridge- Strategic Lead for Primary Care for Oxfordshire.
- Daniel Leveson- Director of Places & Communities, Thames Valley Integrated Care Board.

Report Contents:

EXECUTIVE SUMMARY:

1. The Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) established the Primary Care Access and Estates Working Group following its scrutiny of GP services in September 2025, where members identified significant concerns relating to GP access, workforce sustainability, primary care estate constraints and the impact of housing growth on local services. The Working Group was tasked with undertaking a detailed review of the structural factors affecting general practice across Oxfordshire and developing evidence-based recommendations for the Thames Valley Integrated Care Board (ICB).

2. The Working Group report follows on continued scrutiny sessions since a previous workshop in October 2022 Agenda for Oxfordshire Joint Health Overview & Scrutiny Committee on Thursday, 24 November 2022, 10.00 am | Oxfordshire County Council which led to recommendations and action to tackle long-standing concerns resulting in:

   - The creation of a dedicated GP estates role within the Integrated Care Board (ICB).
   - Didcot Great Western Park being prioritised for ICB capital funding for a new GP estate.
   - Formal correspondence from the Committee to the Secretary of State for Health and Social Care, calling for primary care estate to be delivered ahead of major housing developments in Oxfordshire, alongside action on national workforce shortages.

3. A formal scrutiny item in September 2025 clearly identified the need for a 2026 inquiry to examine serious ongoing concerns about general practice through multiple lenses, including workforce, estates, patient experience, planning policy, infrastructure delivery and national NHS reforms. Evidence was gathered through a series of dedicated sessions with the Thames Valley ICB, the Buckinghamshire, Oxfordshire and Berkshire West Local Medical Committee (LMC), Healthwatch Oxfordshire, South Oxfordshire and Vale of White Horse District Council officers, and practising clinicians. The Working Group also reviewed extensive datasets covering GP appointment activity, patient list growth, workforce trends, patient survey results for every GP Practice in Oxfordshire. National policy and academic literature were also consulted. Three case studies of Didcot, Bicester and Wallingford were examined to properly understand the structural issues underpinning vital provision of GP estate.

   Summary of the Inquiry's Main Findings:

   - **Sustained and increased demand -** Oxfordshire's primary care system is experiencing sustained and increasing demand that is structural rather than temporary. Most practices are working very hard at exceptionally high levels of appointments. The structural problem is that public need and demand is outstripping the available service leading to patients experiencing insufficient or inequitable access.

- **Complex causes of demand -** Growth in demand for primary care is being driven by multiple interconnected factors including: housing and population growth, ageing demographics, increasing multimorbidity, rising mental health needs, greater public expectations, service shifts from hospitals into communities, and broader societal change all creating increasing complexity. GP services cannot be understood through appointment numbers alone. Access is shaped by the interaction between workforce capacity, workload intensity, primary care estate provision, patient demographics, digital exclusion, continuity of care and wider NHS system pressures. Crucially, the evidence suggests that no single intervention will be sufficient to address these pressures; rather, a coordinated and integrated response will be required if general practice is to continue meeting the needs of Oxfordshire's growing and changing population.

- **Structural imbalances and access pressures -** Structural imbalance and access pressures are unevenly distributed. This problem is most acute in areas of rural Oxfordshire that have experienced the highest housing growth and population increases or populations with additional access barriers. Patient experience evidence examined by the Working Group further highlighted substantial inequalities with people experiencing particular challenges in accessing timely care in communities that have and are experiencing rapid housing growth, rural communities and digitally excluded residents. The Working Group concluded that reducing inequalities in access should be a central objective of any future improvement programme.

- **Limited resilience -** GP practices are operating close to their limits; with little headroom to absorb additional demand, service change or workforce attrition. This helps explain why relatively small disruptions— such as staff absence, delayed estate development, or interface failures elsewhere in the system—can have disproportionate effects on patient access.

- **Workforce sustainability -** The inquiry also identified that while Oxfordshire has benefited from the growth of multidisciplinary primary care teams, increases in full-time equivalent GP capacity have not matched growth in demand. There are good examples of innovations that had improved access and reduced complaints. One practice however, had also changed to a limited liability organisation and indicated that any further pressures would require them to consider private practice. The evidence demonstrated that increasing workload intensity, pressures on continuity of care, and difficulties retaining experienced clinicians represent very real and significant short, medium and long-term risks for the future of general practice.

- **Administrative workload burden on GPs -** A recurring theme throughout the review was the impact of avoidable workload and administrative burden on general practice. Evidence from the Local Medical Committee (LMC), NHS partners, and national studies demonstrated that a significant proportion of GP capacity continues to be consumed by system-generated work originating elsewhere within the NHS. The Working Group concluded that reducing avoidable workload is critical if meaningful impact is to be achieved. Evidence from the Group's site visits was that there would be value in local leaders across

acute and primary care working on opportunities to rationalise and create efficiency through improved collaboration on avoidable workload. This was an important finding from the site visit to Hedena Health in Oxford City.

- **Constrained and outdated premises -** The Working Group found that across Oxfordshire, constrained or outdated premises are limiting practices' ability to recruit additional staff, expand services, and deliver new models of care; and that this emerged as the most critical concern of all. Workforce growth, appointment delivery, and service transformation are all constrained by the availability, suitability and timing of primary care infrastructure. Estate provision has failed to keep pace with population growth, changing models of care, and access pressures. The problem is acutely urgent across rural Oxfordshire, which has and is experiencing high housing and population growth.

- **Challenges generated by national restrictions -** The national context is crucial to understanding the range of funding, legislative and policy restrictions within which local leaders are able to operate to make improvements The Working Group's review suggests that many national contractual reforms are directionally positive and consistent with broader policy objectives around integration, prevention and multidisciplinary care. However, the Working Group found that contractual reform alone cannot resolve underlying pressures relating to workforce sustainability, estates capacity, housing growth, continuity of care and workload intensity. Whilst the Working Group found good practice supporting transformation and improvements to neighbourhood health (including tackling social determinants of health and prevention), funding was short-term and was restricted to a minority of GP practices. The future of general practice will depend not only on the contents of the national contract itself, but on how effectively local systems can be supported to be able to translate those contractual reforms into meaningful improvements for both patients and clinicians.

- **Limitations of planning legislation and policy on estate provision -** The Working Group found that the existing national framework for estates provision through planning legislation and policy is not fit for purpose. It is unable to deliver timely estate, constituting a major barrier to patient registration and critical workforce recruitment for primary care. Local leaders need urgent support in tackling the serious delays in providing necessary estate in the communities that have experienced high growth. Future planning for housing growth needs to align with reforms that make provision of health and care infrastructure and services happen at the same time as communities grow.

Case Studies

4. To explore these challenges in greater depth, the Working Group undertook detailed case study reviews of three major primary care estate projects:

- ***Great Western Park, Didcot*** examined the consequences of large-scale housing development occurring ahead of healthcare infrastructure delivery. The case study demonstrated how population growth can outpace primary care capacity and highlighted the complexity and longstanding challenges associated with funding,

planning and delivering new health infrastructure. It also demonstrated the severe impacts of this on the local population and primary care workforce. The Working Group concluded that Great Western Park illustrates the imperative of aligning healthcare delivery with housing growth from the outset. It reinforces the need for national and local changes to support earlier and more structured engagement between healthcare commissioners, planning authorities, developers and central government. Many of the challenges encountered at Great Western Park could have been mitigated through stronger strategic alignment between housing delivery, infrastructure planning and healthcare funding arrangements.

- ***Bicester Health Centre*** examined the impact of rapid population growth on existing primary care facilities and demonstrated how estate constraints can limit workforce expansion and appointment capacity. The Working Group found that the project illustrates the direct relationship between estate capacity and patient access, particularly in fast-growing communities. The quality, size and functionality of primary care premises directly influence how many patients can be seen, how quickly they can be seen, and which services can be provided locally.

- ***Wallingford Medical Practice*** focused on the long-term challenge of future-proofing healthcare infrastructure generally. The evidence demonstrated that incremental estate expansion can eventually become insufficient, requiring more fundamental redevelopment solutions. The case study highlighted how demographic change, population growth and changing models of care are creating pressures that many existing practices were never originally designed to accommodate. This case study raises an important question for the wider health system: how many other practices across Oxfordshire may currently be operating from buildings that were designed for healthcare models of the 1980s and 1990s rather than the needs of the 2030s? The Wallingford case study also illustrates a future model where health infrastructure needs are considered as early as possible in local strategic and growth planning; and where GP practices can play a leading role; and where the layer of developer profit is removed or reduced. Could local systems be freed up by national reform to the renting system to bring it in line with the requirements of modern and sustainable general practice?

5. Funding for housing growth is secured currently through local housing development through s106 and sometimes with CIL (Community Infrastructure Levy) development funding. There is significant funding that is ringfenced at district level for the NHS to use for health estate, but the Working Group found severe barriers that prevent that funding being spent in a timely way and in line with the promises held out to local communities at the time of housing developments. This has been a very long-standing concern of the Committee, with previous developments like Wantage and Grove taking 12 years to materialise. The three case studies examined by the Working Group clearly illustrated that estate provision is not timely, resulting in higher cost and severe pressures on local practices and populations for many years. It is vital that the new wider Thames Valley ICB invest, as a priority, in capacity to support the necessary working with local partners so that builds can be completed sooner. It is also vital that national government and all policy makers make changes with a view to the local NHS, planning authorities, and general practice being able to deliver timely access to General practice; and with it plans for neighbourhood health.

6. Taken together, these three case studies provided powerful evidence that access, workforce sustainability, infrastructure planning and housing growth are fundamentally interconnected and that where there is systemic failure in timely delivery the real-life impacts on the population are profound. They also reinforced the Working Group's conclusion that primary care estate planning must urgently improve and become more proactive if future growth is to be supported effectively.

7. There is currently no financially viable mechanism for delivering the GP estate in a timely way. The Working Group found that local planners do engage with the ICB right from the start, but even when the need for estate and land is available there is a funding gap under the current model. The current funding system using developer contributions does not align with the reality of modern primary care. Modern premises standards and complex staffing requirements contributes to GP estate costing considerably more to build, operate, maintain and staff than in the past. Section 106 developer contributions are not sufficient to meet the costs to a private developer to satisfy requirements and to generate profit for commercial viability. Even with local CIL funding, it is rarely enough and not timely for residents. At best there are very significant delays due to the valuation and rent methodology applied by the District Valuation Service and the availability of local NHS capital and revenue funding. The Wallingford site visit identified an alternative model which we would urge the ICB and all policy makers to consider and engage with.

   Recommendations:

8. Following its review, the Working Group makes the following recommendations to the Thames Valley Integrated Care Board:

   Recommendation 1

   For the Integrated Care Board to adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. It is also recommended that variation between localities and communities at a neighbourhood level is supported in this process. The ICB needs to prioritise enhancing its own capacity to work with local authorities and communities to expand capacity of primary care services in light of increases in demand.

   Recommendation 2

   For active steps to be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system, in order to protect clinical capacity and improve patient access. It is recommended that there is collaboration with local General Practice leaders (as well as patient representative bodies) to explore ways to reduce excessive administrative non-clinical work for qualified GPs; that there is national escalation when this excessive work is owed to national constraints; and that there is a local workshop between local partners to explore opportunities to identify efficiencies from improving shared understanding of administrative pressures and how these might be reduced.

Recommendation 3

That the Integrated Care Board ensures that workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs, rather than focusing solely on staffing numbers.

Recommendation 4

That the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. It is recommended that local patient voices and the scrutiny function have meaningful input into the design and commissioning of GP services.

Recommendation 5

That the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, and ensures that the planning, delivery and expansion of primary care infrastructure in Oxfordshire is proactively aligned with population growth and housing development. It is recommended that there is early/structured engagement with local planning authorities and developers; and a timely delivery of adequate, fit-for-purpose primary care facilities as communities expand, rather than responding retrospectively once access pressures have already emerged.

Overall Conclusion:

9. The Working Group concluded that Oxfordshire's primary care challenges are not primarily the result of insufficient effort or activity within general practice. Rather, they are the product of increasing demand, workforce pressures, system-generated workload, infrastructure constraints, and a lack of alignment between health service planning and population growth. Sustainable improvements in access will therefore require coordinated action across the NHS, local government, planning authorities and wider system partners. National reform is urgently needed to provide a financially viable mechanism for delivering GP estate in a timely way and to help communities in parts of rural Oxfordshire that have experienced large housing growth without timely GP estate. The Group's recommendations are intended to support that shift and provide a framework through which Oxfordshire can maintain resilient, accessible and sustainable primary care services in the face of continued growth and increasing demand.

10. At the time of writing this report, the Working Group had conducted site visits to two GP practices in Oxfordshire; Hedena Health Centre in Oxford City, and Wallingford Medical Practice. Special thanks goes to these two practices for hosting the Group and for their engagement with this inquiry. The visits provide significant opportunity for the Group to understand first hand how GP services operate in both urban and rural areas respectively, and what some of the challenges are in this context. The findings and recommendations found throughout this report have been partly

shaped by what the Working Group had learnt through their experience at these two site visits.

INTRODUCTION AND OVERVIEW

11. Long-standing issues of concern with GP services in Oxfordshire have received regular scrutiny by the JHOSC over the past few years. The Committee held a primary care Workshop on 17 October 2022 which examined demand, capacity, and activity in General Practice, alongside primary care estate development and availability. (Please see link to the agenda of the November 2022 JHOSC meeting which contains a report of the findings of this workshop as well as an annex detailing the number of patients registered per GP practice in Oxfordshire from 2014-2022: Agenda for Oxfordshire Joint Health Overview & Scrutiny Committee on Thursday, 24 November 2022, 10.00 am | Oxfordshire County Council).

12. This topic also received significant attention in a deep-dive of JHOSC scrutiny of GP services in 2023 which resulted in:

- The creation of a dedicated GP estates role within the Integrated Care Board (ICB).
- Didcot Great Western Park being prioritised for ICB capital funding for a new GP estate.
- Formal correspondence from the Committee to the Secretary of State for Health and Social Care, calling for primary care estate to be delivered ahead of major housing developments in Oxfordshire, alongside action on national workforce shortages.

13. The Primary Care Access and Estates Working Group was established by the Oxfordshire Joint Health Overview and Scrutiny Committee following its public meeting on 11 September 2025. At that meeting, the Committee considered the increasing pressures facing general practice in Oxfordshire and agreed that a more detailed examination of the systemic issues affecting primary care delivery was required. The GP Access and Estates scrutiny held in the JHOSC's September 2025 public meeting highlighted significant variation in access, challenges in recruiting and retaining staff, and delays to major estate projects such as Didcot Great Western Park and Bicester Health Centre.

14. In the context of this item in September, the Committee identified the following system-wide concerns:

- Access to GP appointments varies significantly across Oxfordshire.
- Workforce pressures, including difficulties recruiting GPs, nurses and administrative staff.
- Delays to key estate projects are limiting service expansion.
- Estate constraints are preventing practices from increasing capacity even when workforce funding is available.
- Areas experiencing large housing growth face the greatest pressure on GP buildings.
- The above dynamics are having significant impacts on residents and on professionals working in primary care.

15. During the September 2025 meeting, the Committee recommended for there to be:

- Stronger engagement between the ICB and local planning authorities.
- Clearer ownership of estate strategy at local, place level.
- Assurance that estate constraints will not undermine commitments on access, workforce resilience or neighbourhood-based models of care.

16. The ICB responded to and accepted the JHOSC's recommendations, noting constraints relating to national capital funding, policy and regulatory frameworks. The Committee therefore agreed that these issues require continued and intensive scrutiny. Case studies needed to be central to this (e.g. Didcot Great Western Park), where regular updates on progress such as the most recent appointment of a developer and the start of building works continue to be crucial to the Committee as well as the local MP.

17. As a result of this scrutiny in September 2025 and the concerns identified with GP services in Oxfordshire, the Committee therefore resolved to create a time-limited Working Group to undertake a more focused "deep dive" into matters relating to primary care access, workforce pressures and estate capacity across the county.

18. The establishment of the working group was formally confirmed by the Committee at its meeting on 20 November 2025, at which point the Committee also agreed the proposed membership of the working group and its scope and methodology. The working group was tasked with developing a clearer understanding of the underlying drivers of access challenges in general practice, identifying structural and system-level barriers, and exploring potential solutions that could be pursued by the Integrated Care Board and its partners.

19. The agreed membership of the Working Group comprised elected members drawn from the Joint Health Overview and Scrutiny Committee and district councils, reflecting the cross-system nature of the issues under consideration. Membership included Cllr Jane Hanna, City Cllr Louise Upton, Cllr Gareth Epps (until his appointment as a Cabinet Member at Oxfordshire County Council), Cllr Paul-Austin Sargent, Cllr Ron Batstone, and District Cllr Katharine Keats-Rohan. District Cllr David Rogers was appointed by the Committee on 11 June 2026 to join the Working Group after the departure of Cllr Gareth Epps. Officer support was provided by the Health Scrutiny Officer, with input and attendance at evidence sessions from representatives of the NHS Buckinghamshire, Oxfordshire and Berkshire West

Integrated Care Board, Healthwatch Oxfordshire and other relevant stakeholders as appropriate.

20. In agreeing the scope of the Working Group, the Committee made clear that its focus should extend beyond short-term performance metrics and consider the wider factors influencing access to GP services. The agreed remit therefore included examination of primary care capacity and access arrangements, workforce sustainability and workload, the adequacy and delivery of primary care estates, and the interaction between population growth, housing development and health infrastructure planning. Particular emphasis was placed on understanding how these issues interact at system level and the implications for patients, practices and local communities across Oxfordshire.

21. The working group was also asked to consider relevant national policy and guidance, alongside local data and patient experience evidence, in order to contextualise Oxfordshire's challenges within the broader NHS policy framework. The Committee requested that the Working Group report back on its activities (including any interim findings and proposed recommendations) by June 2026.

Stakeholder Engagement Undertaken:

22. The Working Group engaged with (and expresses thanks to) a range of stakeholders to produce a review that is inclusive and comprehensive. These include:

    - NHS Thames Valley ICB (including estates, workforce, and commissioning leads). This includes Dan Leveson (BOB ICB Director of Places & Communities) and Julie Dandridge (Strategic lead for primary care across Oxfordshire).

    - Healthwatch Oxfordshire; including Veronica Barry (Executive Director of Healthwatch Oxfordshire) and Barbara Shaw (Chair of Healthwatch Oxfordshire).

    - South and Vale District council planning and estates officers.

    - Individuals representing General practitioners (including Dr Michelle Brennan, Dr Richard Wood, Dr Peter Burker, and Dr James McNally).

    - Local County and District councillors.

23. Engagement was conducted through online Microsoft Teams meetings, written submissions, and site visits. The Working Group also received written submissions including:

    - GP Appointment data and registered patient list sizes per practice from January 2023-December 2025 (labelled Annex A).

    - GP Appointment trends data month by month from January 2025-December 2025 (labelled Annex B).

- GP Patient Survey data as of the most recent collection in January 2025 (labelled Annex C).

- GP workforce data (labelled Annex D).

- Report submission to the working group from the Buckinghamshire, Oxfordshire, and Berkshire West Local Medical Committee on *Demand, Capacity & Activity in General Practice.* (labelled Annex E).

- The Healthwatch Oxfordshire report on what Healthwatch has heard about GP services in Oxfordshire from April 2025-March 2026.

- A written submission from Cherwell District Cllr David Rodgers on his views and understanding of primary care services.

- NHSE publication on the *Red Tape Challenge; recommendations and next steps.*

- NHSE guidance on *Bridging the interface between primary and secondary care, mental health and community services.*

- The Royal College of General Practitioners Study on uncovering the drivers and costs of unnecessary GP workload.

- The GP services update report submitted to the JHOSC as part of the Committee's public meeting item on GP services in its September 2025.

24. Further academic and policy-based sources have been independently utilised as part of informing the findings and recommendations of the Working Group on the current state of GP services.

Summary of working group activity and sessions:

25. This section provides an overview of the sessions that the working group held, including a summary of who the sessions were with, and the themes that were discussed in each session.

26. Below is a table which provides a summary at a glance of the sessions, followed by a breakdown of what was discussed in each session.

Date	Who with	Main focus
13 Feb 2026	Thames Valley ICB	GP access and workforce pressures
23 Feb 2026	BOB Local Medical Committee	GP staffing, workload and access
10 Mar 2026	Thames Valley ICB	Workforce and demand data

18 Mar 2026	South & Vale District Council officers	Planning and GP estates (Didcot GWP)
21 Apr 2026	Healthwatch Oxfordshire	Patient experience and access
23 Apr 2026	Thames Valley ICB	Primary care estates and infrastructure
9 June 2026	Thames Valley ICB	Digital tools and models in GP services.

Breakdown of Working Group Meetings and Evidence Gathered:

1. **ICB Session – Access to GP Services, Workforce Sustainability and Quality survey from Patients**

13 February 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This initial session with the Integrated Care Board focused on the overall accessibility of GP services in Oxfordshire and the sustainability of the primary care workforce, establishing a system-level context for the Working Group's work. ICB officers outlined the scale of demand pressures, noting sustained growth in registered patient numbers driven by housing development, population change, and increasing clinical complexity within the community.

A significant part of the discussion centred on workforce supply, including difficulties recruiting and retaining GPs and other clinical staff, and the reliance on short-term schemes to stabilise services. Members explored how workforce shortages translated into practical access issues for patients, including reduced appointment availability and pressures on continuity of care. The Working Group also questioned how far national workforce initiatives were delivering tangible local benefit and whether current planning assumptions adequately reflected Oxfordshire's rate of population growth.

There was also discussion about the importance of the national formula for funding of practices and the national contract, and that reform to improve the funding position of practices was critical.

While estates were not the principal focus, the discussion explicitly linked workforce capacity to physical estate limitations, with ICB officers acknowledging that constrained or outdated premises often prevented practices from expanding staffing or service offer even where demand and funding existed. This meeting helped frame access and workforce as interdependent system issues, rather than isolated challenges. The session was also helpful in exploring publicly available data links and the limits of usability of these for the working group; and securing agreement from the ICB to produce Oxfordshire focused tables for use in the next session.

2. BOB Local Medical Committee session – Practice-Level Perspective on Access, Workforce and Capacity

23 February 2026 – Dr Richard Wood (Chief Executive, BOB Local Medical Committee)

The session with the Local Medical Committee provided a front-line general practice perspective, complementing ICB data with lived organisational experience. Discussion concentrated on the operational reality of delivering access under sustained pressure, including the cumulative effect of workforce shortages, administrative burden, and increasing patient expectations.

The LMC described wide variation between practices in their ability to respond to demand, influenced by workforce stability, estate size, and local population characteristics. Particular emphasis was placed on how administrative workload and contractual requirements were consuming clinical time, limiting the extent to which practices could increase face-to-face capacity even where workforce numbers appeared stable on paper.

The Working Group explored how estate constraints exacerbated workforce pressures, with small or poorly-configured premises restricting recruitment of additional staff, limiting multidisciplinary working, and constraining modern models of care. The discussion reinforced the link between estates, workforce sustainability and access, and highlighted the risk that practices operating at the margins could become increasingly fragile without structural intervention.

3. ICB Session – Data on Demand, Workforce and Access Trends

10 March 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This meeting focused on quantitative data underpinning the working group's enquiry, allowing members to scrutinise trends in demand and capacity in detail. ICB officers presented data on registered patient list growth, GP workforce numbers, appointment volumes and utilisation patterns, including seasonal fluctuation and local variation.

The working group examined how increases in registered populations compared with workforce growth, and discussed the implications for future access if current trends continued. Members explored the limitations of headline workforce figures and probed how factors such as part-time working, portfolio roles and sickness absence affected real-world capacity. The discussion also addressed variation between localities, highlighting areas experiencing particularly acute pressure.

Attention was given to how data was used by the ICB to inform commissioning and prioritisation decisions, and whether existing mechanisms were sufficiently responsive to rapid population growth linked to new housing developments. This session strengthened the evidence base for the working group's findings by grounding narrative concerns about access in objective trend data.

Attention was also given to the capacity of the ICB (given its reorganisation into a Thames Valley ICB), and on what the associated impact would be on support by the ICB to practices that were struggling, and the capacity of the ICB to work in a timely way with district councils on primary care estate. This has been a critical theme from the BOB JHOSC as well as the Oxfordshire JHOSC for many years, constituting a priority concern.

4. Oxfordshire District Councils Session – Planning Systems and Primary Care Estates

18 March 2026 – South Oxfordshire and Vale of White Horse District Council planning and estates Officers

This meeting examined the local planning context influencing delivery of primary care infrastructure, with a particular focus on the interface between local authorities and the NHS. District council officers explained how planning obligations, including Section 106 agreements and Community Infrastructure Levy funding, were negotiated and the constraints affecting their deployment for health infrastructure.

A detailed case study of Didcot Great Western Park illustrated longstanding challenges in aligning housing growth with GP estate capacity. Discussion explored issues such as funding viability, land ownership, timing mismatches between development and NHS capital approval, and the complexity arising from multiple organisations holding different parts of the delivery responsibility. There was also a negative impact on continuity when NHS personnel changed.

Very detailed attention was given to the particular barriers existing at every stage along the timeline; from before the approval of local housing estate provision and the building of the estate, and the consequences including funding implications as well as GP estate implications for a local population. The increased housing developments resulted in delays in registering patients at local practices, with this having negative impacts on existing practices and the public.

The Working Group scrutinised whether existing planning and funding mechanisms were sufficiently robust to support timely primary care expansion, particularly in high-growth areas. Members also considered how earlier and more structured engagement between district councils and the NHS might mitigate delays and improve outcomes. This session was central in evidencing that primary care access is shaped by planning and infrastructure decisions well beyond the NHS.

4. Healthwatch Oxfordshire Session – Patient Experience and Inequality of Access

21 April 2026 – Healthwatch Oxfordshire

This session focused on patient experience of accessing GP services, ensuring that resident perspectives informed the working group's analysis. Healthwatch shared themes arising from its engagement work, including persistent difficulties securing appointments, challenges navigating digital systems, and concerns about continuity of care.

The discussion explored how digital access requirements were affecting different population groups, particularly older residents without carers or advocates, those with limited digital confidence, and people with learning difficulties or other additional needs. Healthwatch also highlighted how variations in practice responsiveness contributed to perceived inequality between communities.

The Working Group considered how patient experience should be used alongside quantitative access metrics, recognising that measures of availability alone did not always reflect the quality or equity of access. This meeting reinforced the importance of embedding patient voice within recommendations on GP service design and access improvement.

The discussion included the existing local model which included an independent patient voice and what would be lost without that. (Future digital models will be explored in a future dedicated session that the working group will have with the ICB on digital models for primary care).

5. ICB Session – Primary Care Estates, Infrastructure and Strategic Planning

23 April 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This session focused in-depth on primary care estates capacity, drawing together themes from earlier meetings. Officers outlined the current condition and distribution of GP premises across Oxfordshire, the constraints affecting expansion, and the impact of organisational restructuring on estates capability within the ICB.

The discussion examined in depth three specific estate case studies, Great Western Park, Bicester Health Centre, and Wallingford Medical Centre, considering progress to date, remaining barriers, and lessons for future developments. Members explored how estate limitations restricted workforce growth, constrained service transformation, and limited the ability to deliver more integrated models of care. There was also discussion of the particular barrier of the NHS valuation of rent and why this has taken so long, being a major contributor to delay.

The Working Group also discussed longer-term approaches, including neighbourhood health hubs, and questioned how future estate planning could better align with population growth and service redesign. This session clearly demonstrated how estates underpin the working group's core themes of access, workforce sustainability and service resilience.

6. ICB session- Digital tools and models in primary care services

9 June 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This session examined the ICB's role in providing and managing GP digital infrastructure, including IT equipment, remote access solutions, data storage arrangements and support services. The Working Group heard that significant work

had been undertaken to modernise GP technology, with particular emphasis on improving system resilience, supporting remote working and moving towards nationally provided digital platforms such as SharePoint, OneDrive and NHS Mail. Concerns were also discussed regarding the forthcoming replacement of Commissioning Support Unit services and the need to maintain continuity and resilience during that transition.

The Working Group also examined the evolving clinical systems landscape in primary care. Officers described the continued use of EMIS Web and System One across most practices and discussed emerging products such as Medicus. Members explored the challenges of introducing new clinical systems, including data migration, interoperability with existing applications, training requirements and the ability of suppliers to provide adequate support at scale. The importance of robust due diligence and engagement with practices before significant system changes was emphasised throughout the discussion.

A substantial part of the session focused on digital access and digital inclusion. The Working Group explored the extent to which digital tools can improve patient access to services while also recognising that some groups may face barriers. Discussion highlighted concerns that people living with frailty, older patients, those with complex needs (including people with learning disabilities), and individuals with limited digital skills, could be disadvantaged if services became overly reliant on technology. Officers described measures being taken to support digital inclusion, including digital cafés, support through Patient Participation Groups and maintaining alternative access routes such as telephone and face-to-face contact.

The Working Group also considered cybersecurity, information governance and business continuity arrangements. Officers explained the regulatory standards that NHS digital systems must meet and described contingency arrangements in place should systems fail. Members sought assurance that risks were being actively managed and that appropriate governance arrangements existed to maintain public confidence in digital services.

Finally, the session explored the use of the NHS App and other digital patient-facing tools. Members raised concerns about inaccurate or out-of-date information appearing within the app and discussed the processes available for escalation and correction. Officers acknowledged these issues and confirmed that concerns could be escalated to national teams where required.

27. Therefore, in line with its original scope, these meetings collectively allowed the Working Group to:

- Examine access to GP services from system, practice and patient perspectives.
- Assess workforce sustainability using both data and front-line insight.
- Understand how estate capacity and planning systems constrain service expansion.
- Start exploring digital access and patient experience, including inequality impacts.

- Identify structural issues requiring coordinated action across the NHS and local authorities.

Key snapshot extrapolations from Primary Care Data provided to the group:

28. The Working Group was provided with a comprehensive set of quantitative and qualitative datasets by the Integrated Care Board, covering GP appointment activity, patient list growth, workforce capacity and patient experience (Annexes A–D). When considered together, these datasets provide a clear picture of how demand, capacity and access interact across Oxfordshire's primary care system.

29. An overarching extrapolation is that high activity does not equate to sufficient or equitable access. The GP appointment and registered patient list data (Annex A), alongside monthly appointment trend data for 2025 (Annex B), demonstrate that practices across Oxfordshire are delivering consistently high volumes of appointments against a background of sustained list growth. The data does not suggest a system experiencing short-term pressure or seasonal fluctuation; rather, it points to a structural demand–capacity imbalance, particularly in areas of population growth. This indicates that access challenges are not driven by under-delivery of appointments but by demand that continues to rise faster than underlying capacity.

30. A second key extrapolation is that workload intensity within general practice is increasing even where appointment numbers are stable or rising. Workforce data (Annex D), considered alongside appointment trends (Annex B), suggests that growth in activity has not been matched by a proportional increase in full-time equivalent GP capacity. This implies that the marginal increase in demand is being absorbed through intensified workload rather than expanded capacity. The working group noted that this aligns with national evidence showing that appointment data alone significantly under-represents the total volume and complexity of work undertaken in general practice.

31. Patient experience evidence provides an important contextual layer to this picture. The GP Patient Survey results (Annex C) show that while many patients report positive experiences once they secure care, difficulties in contacting practices, obtaining timely appointments and seeing a preferred clinician persist. When viewed alongside Annexes A, B and D, this suggests that access problems are not primarily about willingness or effort within practices, but about constrained capacity and system design. High appointment delivery is therefore compatible with ongoing patient frustration, particularly where continuity of care and flexibility are reduced.

32. A further extrapolation is that access pressures are unevenly distributed, even when aggregate data appears stable. Combining list growth data (Annex A) with patient experience findings (Annex C) indicates that practices serving fast-growing areas, rural communities or populations with additional access barriers are more likely to experience acute pressure. The working group noted that this reinforces the need to treat access inequality as a structural issue rather than a side-effect of individual practice performance.

33. Finally, when workforce, activity and patient experience data are read together, they point to a system operating close to capacity with limited resilience. High baseline activity leaves little headroom to absorb additional demand, service change or workforce attrition. This helps explain why relatively small disruptions—such as staff absence, delayed estate development or interface failures elsewhere in the system—can have disproportionate effects on patient access.

Summary Table: What Each Dataset Tells the Working Group

Dataset	What the Data Shows	Key Extrapolation for the Working Group
Annex A – GP appointments and registered patient list sizes (2023–2025)	Sustained list growth and high appointment delivery across practices	Demand is structurally rising; access issues are not explained by low activity
Annex B – Monthly appointment trends (2025)	Consistently high activity throughout the year	Pressure is continuous rather than seasonal; limited slack in the system
Annex C – GP Patient Survey (Jan 2025)	Mixed patient experience, with persistent access barriers	High throughput does not automatically result in good access or continuity
Annex D – GP workforce data	Limited growth in GP capacity relative to demand	Increasing workload intensity and reduced resilience within practices

National Context: General Practice, Access, Workforce Sustainability and Primary Care Estates:

34. The work of the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) Primary Care Access and Estates Working Group has taken place during a period of unprecedented transition within the NHS. Few sectors of the health service have experienced more sustained policy attention over the last decade than general practice. Nationally, general practice has been expected to respond simultaneously to increasing demand, growing workforce shortages, an ageing population, greater levels of multimorbidity, rising patient expectations, digital transformation, financial constraint, and a fundamental reorientation of ambition that healthcare move away from acute hospitals and into prevention in communities. These pressures have been further compounded by the legacy impacts of the COVID-19 pandemic and the wider challenges facing the NHS estate, and a social care system also under strain.

35. Consequently, national policy has increasingly moved away from viewing access to general practice as simply a question of appointment availability. Instead, there is growing recognition across government, NHS England, independent health policy organisations and professional bodies that access is the product of a

complex interaction between workforce, workload, infrastructure, technology, continuity of care, population growth, social need and system integration. NHS England's Fuller Stocktake argued that improving access requires fundamental reform of how primary care is organised and integrated with wider services rather than simply increasing appointments[1]. The 10 Year Health Plan for England subsequently identified primary care as central to the shift from hospital-based care to neighbourhood-based services and highlighted the need to align workforce, estates and digital transformation[2]. Analysis by The King's Fund has similarly emphasised that pressures in general practice are driven by a combination of workforce shortages, growing demand and increasing complexity of patient need[3]. The Health Foundation has highlighted the impact of demographic change and rising multimorbidity on primary care demand[4], while the Nuffield Trust has argued that workforce, workload and access challenges are interdependent and require system-wide responses[5]. Professional bodies have reached similar conclusions. The Royal College of General Practitioners has identified workload intensity and retention as key determinants of access through its study *Uncovering the Drivers and Costs of Unnecessary GP Workload*[6], whilst the British Medical Association has consistently highlighted the widening gap between patient demand and workforce capacity within general practice[7]. These findings collectively support the conclusion that access to general practice is influenced by a broad range of interconnected factors extending far beyond appointment availability alone.

36. Many of the issues examined by the Working Group mirror precisely those identified in national studies and policy reviews. Challenges relating to primary care estates, workforce sustainability, rising patient demand, continuity of care, administrative burden, neighbourhood working and housing growth are not unique to Oxfordshire. However, the scale of population growth across parts of rural Oxfordshire including in the Vale of White Horse area, coupled with longstanding estate challenges and variation in access, means that national developments have particular significance and impacts for local services in Oxfordshire.

The growing demand challenge:

37. One of the most significant issues affecting general practice, both nationally and within Oxfordshire, is the sustained growth in demand for primary care services. Whilst public debate often focuses on the availability of appointments, national evidence increasingly demonstrates that the challenge facing general practice is considerably more complex. Demand is being driven not simply by an increase in population, but by a combination of demographic change, increasing levels of chronic illness, rising multimorbidity, greater public expectations, increasing mental

[1] NHS England – *Next steps for integrating primary care: Fuller Stocktake Report*
[2] Department of Health and Social Care – *Fit for the Future: 10 Year Health Plan for England*
[3] https://www.kingsfund.org.uk/publications/understanding-gp-pressures
[4] https://www.health.org.uk/publications/reports/understanding-demand-for-general-practice
[5] https://www.nuffieldtrust.org.uk/topic/general-practice
[6] https://www.rcgp.org.uk/getmedia/26330bb5-eecc-4e25-84b3-bbc0f5614dd7/Uncovering-the-GP-workload-burden-A-study-of-the-drivers-and-costs-of-unnecessary-and-hidden-workload-%E2%80%93-December-2025.pdf
[7] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice

health need, and a continuing shift of activity from hospitals into community-based settings. As a result, general practice is now expected to manage larger numbers of patients, with greater levels of complexity, across a broader range of services than at any previous point in the history of the NHS.

38. Nationally, general practice remains the front door to the NHS and accounts for the overwhelming majority of patient contacts with the health service. NHS England, the Health Foundation and the Nuffield Trust have all highlighted that demand for general practice has increased substantially over the last decade, driven in part by England's ageing population and increasing prevalence of long-term conditions. Research published by the Health Foundation demonstrates that people are increasingly living longer with multiple long-term conditions, creating a pattern of demand that is significantly more complex than simple episodic illness and requiring more frequent and intensive clinical intervention[8]. Similarly, the Nuffield Trust has noted that the growth in multimorbidity is placing unprecedented pressure on primary care services because patients increasingly require coordinated management across multiple conditions rather than isolated interventions[9].

39. The King's Fund has argued that increasing demand should not be understood solely through the lens of appointment volumes. Its analysis suggests that the nature of consultations has changed markedly over time, with GPs spending increasing amounts of time managing complex physical and mental health needs, coordinating care across different services, addressing social determinants of health and supporting populations with increasingly sophisticated expectations regarding access and responsiveness[10]. This is reinforced by research published in the *British Journal of General Practice*, which found that consultation complexity has risen significantly over time and that the average consultation increasingly involves multiple conditions, medications and care needs being addressed simultaneously[11].

40. The challenge has been compounded by activity flowing into primary care from other parts of the health system. Successive governments have sought to deliver more care outside hospital settings, a direction that has accelerated following publication of the Government's 10 Year Health Plan for England in July 2025. The Plan explicitly sets out a strategic shift “from hospital to community” and places general practice at the centre of a future neighbourhood health service, envisaging far more care being delivered locally through multidisciplinary teams and primary care networks rather than acute hospitals[12]. This reflects conclusions previously reached by NHS England's Fuller Stocktake, which argued that the future sustainability of the NHS depends upon significantly enhancing the role of primary

[8] https://www.health.org.uk/publications/reports/understanding-demand-for-general-practice
[9] https://www.nuffieldtrust.org.uk/topic/general-practice
[10] https://www.kingsfund.org.uk/publications/understanding-gp-pressures
[11] https://bjgp.org/content/69/680/e720
[12] 10 Year Health Plan for England

care and integrated neighbourhood teams in managing both urgent and long-term care needs[13].

41. Whilst these reforms offer significant opportunities, they also imply a substantial increase in the volume and complexity of activity expected from general practice. The Health Foundation has observed that healthcare demand is increasingly shaped not only by demographic trends but by changing patterns of disease, including rising rates of obesity, diabetes, cardiovascular disease and mental ill-health[14]. Academic studies have similarly demonstrated that mental health presentations to primary care have increased significantly over recent years, with many GPs now reporting that mental health care forms a substantial proportion of daily workload. Research published in the *Lancet Psychiatry* identified general practice as playing an increasingly central role in meeting unmet mental health demand, particularly in areas where specialist services face capacity constraints[15].

42. Against this national backdrop, the evidence reviewed by the JHOSC's primary care working group suggests that Oxfordshire is experiencing many of these challenges in an acute form. Data supplied by the Integrated Care Board (Annex A) demonstrates significant growth in registered patient populations across most Oxfordshire practices between January 2023 and December 2025. Importantly, this growth is not evenly distributed, creating particular inequalities of access in areas worst affected. Practices serving areas of substantial housing development and population expansion have experienced considerably greater growth pressures than others. In Oxfordshire, this has mainly been focused in rural parts of the County, which is also where there is a growing aging population compared with the city which has not experienced this housing and population growth (this being the case particularly in the Vale of White Horse and South Oxfordshire areas). This finding is consistent with concerns raised repeatedly during the Working Group's discussions regarding communities such as Didcot, Bicester and other growth locations across the county. The Working Group heard evidence suggesting that population growth has frequently outpaced corresponding investment in primary care infrastructure, creating significant challenges for practices attempting to absorb new demand within existing capacity constraints.

43. GP appointment trend data supplied to the Committee by the ICB (Annex B) provides further evidence of the sustained nature of demand pressures. Rather than displaying temporary spikes or purely seasonal pressures, the data in Annex A indicates consistently high levels of appointment activity across successive months. This suggests that the challenge facing Oxfordshire is not one of occasional demand surges but of sustained system pressure operating throughout the year. National analyses by NHS England have similarly shown that general practice is now delivering record numbers of appointments, but that increased activity has frequently failed to translate into corresponding improvements in

[13] NHS England – Fuller Stocktake
[14] https://www.health.org.uk/publications/long-reads/health-in-2040
[15] https://www.thelancet.com/journals/lanpsy/home

patient-perceived access, indicating that growing demand often absorbs gains in capacity[16].

44. The Working Group also noted that increasing demand is being experienced alongside changing patient expectations. The expansion of digital services, same-day access models, online consultation systems and improved communication technologies has brought considerable benefits for many patients. However, research commissioned by Healthwatch England and analysed by the King's Fund demonstrates that public expectations regarding convenience, speed of access and responsiveness have risen significantly as a consequence, creating additional challenges for practices already operating under pressure[17]. National GP Patient Survey data consistently shows that patient satisfaction is closely linked not merely to whether appointments are available, but whether patients feel they can access the right professional, at the right time, through the right route.

45. A further dimension of demand recognised nationally is the interaction between deprivation, rurality and healthcare utilisation. Research published by the Health Foundation shows that populations living in more deprived areas often experience higher levels of need whilst receiving proportionately less healthcare resource—a phenomenon often referred to as the "inverse care law"[18]. Oxfordshire presents an interesting challenge in this regard, combining affluent areas with pockets of significant deprivation, alongside extensive rural communities who are also experiencing inequalities of access if they happen to be in the areas with high housing and population growth. The working group's review of patient experience evidence suggests that the impact of rising demand is therefore unlikely to be felt uniformly across the county, with some communities facing greater barriers to access than others.

46. Taken together, the national and local evidence presents a compelling picture. Growth in demand for primary care is being driven by multiple interconnected factors: housing and population growth, ageing demographics, increasing multimorbidity, rising mental health needs, greater public expectations, service shifts from hospitals into communities, and broader societal change. The significance of the challenge lies not simply in the number of additional appointments required, but in the increasing complexity of the work that those appointments represent. The working group therefore concluded that rising demand should be understood as a systemic issue affecting workforce planning, estates capacity, neighbourhood service design, continuity of care, digital access arrangements and long-term sustainability. Crucially, the evidence suggests that no single intervention will be sufficient to address these pressures; rather, a coordinated and integrated response will be required if general practice is to continue meeting the needs of Oxfordshire's growing and changing population.

[16] NHS England – GP Appointments Data
[17] https://www.healthwatch.co.uk/news/2026-03-11/our-position-gp-access; https://www.kingsfund.org.uk/publications/public-satisfaction-nhs
[18] https://www.health.org.uk/publications/long-reads/reducing-health-inequalities

The National GP Contract: Policy Framework, Recent Reforms and Implications for General Practice:

47. Any assessment of the current challenges facing general practice must recognise the central role played by the national General Medical Services (GMS) contract and wider GP contractual framework. Whilst public debate often focuses on appointment availability, workforce numbers or patient satisfaction, the reality is that many aspects of how general practice operates are shaped by national contractual arrangements negotiated between NHS England, the Department of Health and Social Care and the British Medical Association's General Practitioners Committee. The GP contract determines not only how practices are funded, but also influences workforce models, service priorities, access arrangements, digital requirements, quality improvement activity and the wider role expected of general practice within the NHS[19].

48. Over the past two decades, GP contracts have evolved from relatively straightforward arrangements focused on core medical services towards increasingly complex frameworks that seek to use contractual incentives and funding mechanisms to drive wider healthcare transformation. The modern GP contract now encompasses core practice funding, the Quality and Outcomes Framework (QOF), enhanced services, Primary Care Network (PCN) requirements, workforce reimbursement arrangements, digital obligations and access expectations. As a result, changes in the national contract can have significant implications for how practices organise services and how patients experience access to care[20].

49. Recent years have seen substantial changes to the contractual framework for general practice. NHS England's 2025/26 and 2026/27 contract reforms represented some of the most significant contractual changes since the introduction of Primary Care Networks. The 2025/26 contract included approximately £969 million of additional investment, comprising increased core contract funding and support for advice and guidance activity between primary and secondary care. Contract reforms also expanded the Additional Roles Reimbursement Scheme (ARRS), enabling Primary Care Networks to employ a broader range of professionals, including GPs and practice nurses alongside pharmacists, physiotherapists, social prescribers and care coordinators. These reforms were intended to improve workforce capacity, support modern multidisciplinary models of care and improve patient access[21].

50. The contracts also strengthened expectations around digital access, online consultation systems and modern access models. These developments reflect the continued national emphasis on the "Modern General Practice" approach, whereby practices are expected to improve responsiveness through a combination of care navigation, structured patient contact routes, digital systems and more effective use of multidisciplinary teams.

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19 [england.nhs.uk], [bma.org.uk]
20 [england.nhs.uk]
21 NHS England GP Contract Documentation 2025/26 / BMA Analysis of GP Contract Changes 2025/26

51. The significance of recent contractual reforms extends beyond access alone. They form part of a wider transformation agenda reflected in the Government's 10 Year Health Plan for England, which seeks to shift care from hospitals into communities and create a "Neighbourhood Health Service" delivered through integrated multidisciplinary teams. The GP contract is increasingly being used as a mechanism to support this transition by encouraging collaboration through Primary Care Networks, supporting integrated workforce models and incentivising closer working between primary care, community services and other local partners.

52. This direction of travel has its roots in NHS England's Fuller Stocktake, which argued that future primary care should be organised around neighbourhood populations and integrated multidisciplinary teams rather than stand-alone practices operating independently[22]. Increasingly, contractual arrangements are being designed to support these objectives through network-level delivery, collaborative workforce models and shared service provision[23].

53. The working group recognises that recent contractual reforms have delivered tangible benefits. Additional investment in Primary Care Networks has enabled many practices nationally to recruit members of the wider multidisciplinary team who would previously have been unaffordable. This has allowed pharmacists to undertake medication reviews, physiotherapists to manage musculoskeletal presentations, social prescribing teams to support wider wellbeing needs, and care coordinators to assist patients with complex conditions.

54. National evaluations conducted by NHS England suggest that these roles have contributed to expanding clinical capacity and reducing pressure on GPs by ensuring that patients are directed to the most appropriate professional. NHS England has consistently linked such workforce diversification to improved productivity and better utilisation of clinical skills[24]. Oxfordshire has benefited from many of these developments. Workforce data reviewed by the Working Group demonstrates growth in the wider primary care workforce, reflecting the broader national trend towards multidisciplinary delivery models. Annex D shows that many practices now rely on a much broader range of staff than would have been typical a decade ago, enabling practices to meet rising demand despite ongoing recruitment pressures affecting GPs themselves.

55. However, despite these positive developments, significant concerns have emerged regarding the impact of the contractual framework on the sustainability of general practice. One of the most persistent criticisms raised nationally by organisations such as the British Medical Association and the Royal College of General Practitioners is that contractual reforms have often increased activity expectations faster than core capacity. Whilst workforce diversification has expanded the number of staff working within primary care, the underlying demand facing practices has continued to grow. The BMA has repeatedly argued that although recent

[22] Fuller Stocktake Report
[23] [england.nhs.uk], [navigator....lth.org.uk]
[24] NHS England Network Contract DES

contracts have increased funding, they have not fully compensated for rising workload, inflationary pressures and increasing complexity of care[25].

56. Evidence considered by the Working Group suggests that these concerns are reflected locally. The GP appointment data and monthly trend data within Annexes A and B (of this report) demonstrate sustained growth in patient activity and registered list sizes, whilst workforce data suggests continuing pressures on GP availability and workload. The Working Group repeatedly heard during its sessions with the BOB Local Medical Committee and the Integrated Care Board that activity growth has often outpaced increases in capacity, leading to concerns about clinician wellbeing, sustainability and continuity of care.

57. Furthermore, whilst the contract has successfully facilitated recruitment into wider multidisciplinary teams, concerns remain that continuity of care and experienced clinical leadership can be diluted if workforce planning focuses primarily on overall workforce numbers. Research cited by the King's Fund and published within the *British Journal of General Practice* suggests that continuity of care is strongly associated with improved outcomes, reduced hospital admissions and higher patient satisfaction[26]. These findings are particularly relevant given concerns raised through Oxfordshire's GP Patient Survey data and patient experience evidence regarding continuity and access to preferred clinicians (found in Annex C of this report).

58. Another increasingly important issue is the relationship between contract design and workload. Whilst the GP contract seeks to improve access, national studies suggest that general practice continues to experience substantial administrative burden arising from reporting requirements, quality frameworks, interface issues and system-generated activity. The Royal College of General Practitioners' report *Uncovering the Drivers and Costs of Unnecessary GP Workload* concluded that a substantial proportion of GP activity originates from avoidable administrative tasks and workload transferred from elsewhere in the NHS. The report estimated that such activity consumes significant clinical time that could otherwise be available for patient care[27]. This challenge prompted the introduction of NHS England's Red Tape Challenge, which seeks to reduce bureaucracy and unnecessary workload within primary care[28]. The existence of these initiatives demonstrates a growing national recognition that improving access cannot simply be achieved through contractual requirements for more appointments or new access routes. It also requires active efforts to reduce avoidable demands on clinician time. The Working Group heard similar concerns throughout its evidence-gathering sessions.

59. For Oxfordshire, the significance of the GP contract extends well beyond funding arrangements. The contractual framework increasingly shapes how practices

[25] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice
[26] https://www.kingsfund.org.uk/publications and https://bjgp.org/content/72/715/84
[27] https://www.rcgp.org.uk/getmedia/26330bb5-eecc-4e25-84b3-bbc0f5614dd7/Uncovering-the-GP-workload-burden-A-study-of-the-drivers-and-costs-of-unnecessary-and-hidden-workload-%E2%80%93-December-2025.pdf.
[28] https://www.gov.uk/government/news/gp-reforms-to-cut-red-tape-and-bring-back-family-doctor

organise access, recruit staff, utilise digital technologies, work within Primary Care Networks and interact with wider neighbourhood-based services.

60. The Working Group's review suggests that many national contractual reforms are directionally positive and consistent with broader policy objectives around integration, prevention and multidisciplinary care. However, it also highlights that contractual reform alone cannot resolve underlying pressures relating to workforce sustainability, estates capacity, housing growth, continuity of care and workload intensity.

61. Consequently, whilst the national GP contract provides important opportunities and resources to support the transformation of primary care, its success in Oxfordshire will depend heavily on local implementation and the extent to which workforce planning, estates development, digital transformation and neighbourhood service reform are pursued in a coordinated and integrated manner. The evidence considered by the working group suggests that the future sustainability of general practice will depend not only on the contents of the national contract itself, but on how effectively local systems are able to translate those contractual reforms into meaningful improvements for both patients and clinicians.

Primary Care Estates, Housing Growth and Infrastructure Planning: A Critical Determinant of Access to General Practice:

62. Whilst discussions regarding access to general practice frequently focus on workforce numbers, appointment availability and digital access routes, there is increasing recognition nationally that the physical primary care estate is one of the most significant determinants of whether patients can access timely and sustainable GP services. Put simply, workforce expansion, neighbourhood models of care and increased appointment capacity cannot be delivered if practices lack sufficient space, infrastructure and facilities to accommodate them. Over recent years, healthcare policy has increasingly shifted towards recognising estates not as a peripheral issue but as a core strategic enabler of service delivery, workforce sustainability and healthcare transformation. This change in thinking is particularly relevant to Oxfordshire, where significant housing growth and population expansion have coincided with longstanding concerns regarding primary care infrastructure capacity.

63. The evidence considered by the Working Group demonstrates that many of the challenges facing Oxfordshire mirror wider national concerns. Across England, healthcare leaders are increasingly questioning whether existing primary care infrastructure is capable of supporting the future NHS envisioned through the Government's 10 Year Health Plan, the Neighbourhood Health Service model, and the continued transfer of care from hospitals into community settings. These questions are particularly pressing in areas experiencing substantial housing growth where population increases frequently outpace healthcare infrastructure delivery.

64. The NHS estate is increasingly recognised as one of the most significant barriers to healthcare transformation. Historically, policy discussions have focused primarily on workforce recruitment and funding, but a growing body of national evidence

demonstrates that infrastructure constraints can significantly limit the effectiveness of investment in services and staff. The Institute for Government's report *Delivering a General Practice Estate Fit for Purpose* argues that many GP premises across England are ageing, undersized and increasingly unable to support modern service delivery. The report highlights that significant proportions of the primary care estate were designed for a model of care that relied on small teams of GPs and nurses rather than the multidisciplinary teams now promoted by national policy. The report concludes that estate limitations increasingly constrain workforce growth, integrated working and service expansion[29].

65. Similarly, NHS Property Services has noted that more than twenty major national reviews published since 2017 have raised concerns regarding the suitability of NHS premises. Its report *Making Neighbourhood Health Centres a Reality* argues that many existing facilities are unable to accommodate emerging neighbourhood-based models of care and highlights the significant backlog of maintenance and infrastructure investment required nationally[30].

66. These concerns have become sufficiently significant that the House of Commons Health and Social Care Committee launched a dedicated inquiry in 2026 examining the role of estate infrastructure in delivering the Government's proposed Neighbourhood Health Service. The inquiry specifically identified ageing infrastructure, estate capacity, capital investment and the relationship between healthcare infrastructure and population growth as key challenges facing the NHS[31].

67. One of the most important developments in recent national policy is the growing recognition that estate capacity and workforce capacity are fundamentally interconnected. National GP contracts and workforce programmes have increasingly invested in multidisciplinary working through Primary Care Networks, supporting the recruitment of pharmacists, physiotherapists, social prescribing link workers, mental health practitioners, care coordinators and other healthcare professionals. However, multiple organisations have highlighted that workforce expansion is often constrained by a lack of physical space within practices.

68. The Fuller Stocktake specifically identified premises as one of the major barriers to implementing integrated neighbourhood teams and argued that workforce expansion would be difficult to achieve without parallel investment in infrastructure. The report emphasised that multidisciplinary teams require consulting rooms, meeting space, diagnostic facilities and integrated working environments that many existing GP premises struggle to provide[32]. This issue has been repeatedly raised within Oxfordshire. Evidence received by the Working Group suggests that in most locations practices are already operating at or near capacity, limiting opportunities to recruit additional staff even where workforce funding is available. Members heard that estate constraints may frequently be the factor preventing practices from

[29] https://www.instituteforgovernment.org.uk/sites/default/files/2024-06/Delivering-general-practice-estate-fit-for-purpose.pdf.
[30] NHS Property Services – Making Neighbourhood Health Centres a Reality.
[31] Health and Social Care Committee Inquiry on Neighbourhood Health Service Estates.
[32] NHS England – Fuller Stocktake

expanding services, rather than a lack of willingness or workforce funding opportunities.

Emergence of Neighbourhood Health and the Need for Modern Infrastructure:

69. The publication of the Government's 10 Year Health Plan for England in July 2025 marks a significant shift in expectations regarding the role of primary care infrastructure. The Plan proposes a fundamental shift "from hospital to community" and places primary care at the heart of a new Neighbourhood Health Service[33]. To support this ambition, NHS England has subsequently published both a *Neighbourhood Health Framework* and detailed *Neighbourhood Health Centre Guidance*. These documents recognise that delivering integrated neighbourhood-based healthcare requires a very different type of estate compared to traditional GP premises. Future facilities are expected to accommodate wider multidisciplinary teams, community services, mental health provision, social prescribing, prevention services and partnership working with local authorities and voluntary organisations[34].

70. The guidance explicitly describes primary care infrastructure as an essential enabler of neighbourhood working and highlights the need for estate planning to be integrated with population growth forecasts, workforce strategies and local development plans. This is highly relevant to Oxfordshire, where future implementation of neighbourhood models will inevitably depend upon the availability of suitable infrastructure across both urban and rural communities.

71. Alongside estate condition and capacity, housing growth has emerged as one of the most important challenges affecting primary care nationally. Across England, significant concerns have been raised regarding the ability of healthcare infrastructure to keep pace with large-scale residential development. Whilst planning policy mechanisms such as Section 106 Agreements and Community Infrastructure Levy (CIL) contributions are intended to support infrastructure provision, numerous national reviews have identified challenges regarding funding, viability, timing and coordination between local authorities, NHS organisations and developers.

72. The Town and Country Planning Association, the Local Government Association and the NHS Confederation have all argued that health infrastructure needs to be integrated much earlier within strategic planning processes if communities are to receive adequate healthcare provision from the outset[35]. The challenge is particularly significant in Oxfordshire. The county is expected to accommodate more housing growth over coming decades, with major development sites continuing to emerge across several districts. Evidence reviewed by the Working Group identified concerns that in some locations healthcare infrastructure has historically lagged behind population growth, creating situations where additional demand is absorbed by existing practices for extended periods before expansion projects can be delivered.

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[33] 10 Year Health Plan for England

[34] Neighbourhood Health Framework and Neighbourhood Health Centres Guidance

[35] https://www.nhsconfed.org/publications and https://www.local.gov.uk/topics/planning-housing-and-infrastructure/planning

73. The Working Group's examination of major Oxfordshire schemes, including Great Western Park and Bicester Health Centre, reflects concerns seen in many parts of the country. Nationally, numerous examples demonstrate how delays in healthcare infrastructure delivery can have long-term consequences for access. Studies conducted by NHS Property Services and the King's Fund have shown that where health facilities are planned retrospectively—after population growth has already occurred—access pressures become more difficult and expensive to remedy[36]. Conversely, areas that have successfully integrated healthcare planning into strategic housing and place-making processes have generally been better placed to accommodate growth. Several Integrated Care Systems are increasingly using population health modelling and integrated infrastructure planning to identify healthcare requirements far earlier within the planning cycle. The Government's Neighbourhood Health agenda explicitly encourages this approach, recognising that effective healthcare infrastructure planning must be aligned with broader place-based development strategies[37].

74. The evidence reviewed by the Working Group suggests that primary care estates should no longer be viewed simply as a property issue. Rather, they should be understood as a fundamental determinant of access, workforce sustainability, service integration and neighbourhood healthcare delivery. National policy is increasingly clear that the future NHS will depend upon the ability to deliver more care closer to home, through integrated neighbourhood teams operating from modern, flexible and appropriately sized facilities. Oxfordshire's significant housing growth, combined with the ambition to improve access and expand neighbourhood-based models of care, means that proactive infrastructure planning will be essential.

75. The Working Group therefore concluded that effective primary care estate planning must be regarded as a core strategic function rather than a reactive response to emerging demand. Early engagement between the Integrated Care Board, district planning authorities, developers and local communities will be essential if healthcare infrastructure is to keep pace with future growth. Failure to do so risks undermining many of the wider ambitions contained within national policy and could constrain the ability of general practice in Oxfordshire to meet the needs of its growing population in the years ahead.

Case study 1- Great Western Park, Didcot: Relationship Between Housing Growth, Primary Care Capacity and Estate Delivery

The Scale of Growth and Why Great Western Park Matters:

76. The Working Group selected Great Western Park as a dedicated case study for this deep-dive because it encapsulates many of the challenges that have emerged repeatedly throughout the inquiry. It demonstrates the practical consequences of sustained population growth, highlights the importance of primary care estate as a determinant of access, and illustrates the difficulties that can arise when healthcare

[36] https://www.kingsfund.org.uk/publications/nhs-capital and NHS Property Services
[37] House of Commons Library – 10 Year Health Plan Analysis

infrastructure is not delivered within the same timeframe as major residential development.

77. Great Western Park represents one of the largest housing developments in Oxfordshire. The development is expected to comprise approximately 3,300 homes and has formed a major component of Didcot's expansion over the last fifteen years. The development was originally conceived as a major urban extension that would include a range of supporting infrastructure, including education, transport, community facilities and healthcare provision. Evidence reviewed by the working group indicates that the principle of delivering primary healthcare infrastructure alongside housing growth has been accepted by planners, developers, the NHS and elected representatives for many years. Land for a GP facility was secured through planning obligations associated with the development and the need for healthcare infrastructure has never been disputed[38].

78. However, despite widespread agreement regarding need, the delivery of the health facility has significantly lagged behind occupation of the development itself. Residents have moved into thousands of new homes whilst the new health facility remains undelivered. As a result, existing GP services have been required to absorb increasing demand generated by the expanding population (see Annex A of this report which shows increases in patient list sizes). The Working Group concluded that Great Western Park therefore provides a valuable opportunity to examine the implications of allowing substantial population growth to proceed ahead of healthcare infrastructure delivery.

79. Importantly, Great Western Park does not exist in isolation. Members noted that Didcot continues to experience broader strategic growth pressures through developments such as Valley Park and other allocated sites. Consequently, the challenge faced by local primary care services is not simply accommodating one housing development but responding to cumulative population growth across the wider Didcot area.

Growing Demand and Pressure on Existing Services:

80. A recurring message throughout the Working Group's inquiry was that access pressures in primary care are often described as workforce issues when in reality they arise from a combination of population growth, infrastructure constraints and increasing demand. The evidence considered by the working group indicates that this dynamic is clearly visible within Didcot. Data provided by the Integrated Care Board demonstrates sustained levels of appointment activity across local practices and significant patient list sizes within the locality. The Didcot Health Centre Practice alone had a registered population approaching 20,000 patients by 2025 and was delivering thousands of appointments each month (see Annex A data pack on GP appointment data).

81. The Working Group was keen to emphasise that population growth does not simply translate into additional appointments. Growth generates demand across the entire

[38] [bucksoxonb...icb.nhs.uk], [whitehorsedc.gov.uk], [thisisoxfo...hire.co.uk]

primary care system. New residents require registration, preventative care, childhood immunisations, maternity services, long-term condition management, mental health support and wider health interventions. Over time, these demands become cumulative. Evidence previously presented to JHOSC by the Integrated Care Board acknowledged that existing primary care estate within Didcot had already absorbed significant growth through previous expansions and internal reconfiguration projects. This included the extension of Woodlands Medical Centre and conversion of existing space into additional consulting accommodation. However, the ICB also advised that these measures alone were insufficient to address longer-term population growth, hence the strategic importance attached to the Great Western Park project.

82. The Working Group considered this particularly significant because it challenges a common assumption that access problems can be resolved purely through improving appointment systems or increasing workforce numbers. The evidence suggests that there comes a point where physical estate capacity itself becomes the limiting factor. Once consultation rooms, treatment spaces and associated infrastructure are fully utilised, opportunities for further expansion become increasingly constrained.

Understanding the Delays: Why a Recognised Need Has Proven Difficult to Deliver:

83. One of the most important aspects of the Great Western Park case study concerned understanding why delivery has proven so difficult despite broad agreement that the facility is required. The working group heard evidence that the project has been affected by a combination of legal, financial, planning and organisational complexities rather than a single identifiable cause. The project requires coordination between multiple bodies including the Integrated Care Board, NHS England, Vale of White Horse District Council, healthcare property developers, GP providers, district valuers and legal advisers. This inherently creates a more complex delivery environment than many other forms of infrastructure[39]. Significant progress was made in 2023 when the ICB approved a business case for the project, citing the strategic need arising from population growth within Didcot. The project was subsequently advanced towards planning and delivery stages, and planning permission was secured during 2025. However, by late 2025 the ICB announced that the proposed funding model submitted by the original developer was no longer considered affordable under NHS reimbursement arrangements and did not comply with the requirements of the Premises Costs Directions. As a result, the ICB concluded it could not proceed with the proposal and began seeking alternative development partners[40].

84. The Working Group attached considerable importance to this issue because it highlights a structural challenge affecting primary care estate delivery nationally. Members noted that healthcare facilities are frequently dependent upon complex reimbursement arrangements and private development models. Consequently, even where land is available, planning consent is secured and strategic need is established, projects may still face significant barriers if the financial model underpinning delivery becomes unviable. This was reinforced by evidence

[39] [bucksoxonb...icb.nhs.uk]
[40] [bucksoxonb...icb.nhs.uk], [thisisoxfo...hire.co.uk], [whitehorsedc.gov.uk]

considered elsewhere in the inquiry indicating that many primary care estate projects struggle to satisfy traditional value-for-money assessments despite there being a clear service need.

What Great Western Park Reveals About the Wider Primary Care Estate System:

85. The Working Group concluded that Great Western Park is illustrative of broader issues affecting primary care estates nationally. A key lesson concerns the relationship between housing growth and infrastructure delivery. Whilst healthcare provision is increasingly recognised as essential infrastructure, current funding and delivery arrangements can often mean that primary care facilities are delivered later than schools, roads or residential units. In practical terms, this means that population growth frequently occurs before corresponding healthcare capacity is available. The consequences are significant. Existing practices absorb demand over extended periods, access pressures increase, appointment availability becomes constrained and workforce pressures intensify. By the time new facilities are delivered, services may already have been operating under strain for many years.

86. The Great Western Park experience raises important questions regarding whether current systems are sufficiently proactive. A consistent theme emerging from evidence sessions with the ICB and district planning officers was that many interventions remain reactive. Infrastructure is often expanded once growth has occurred rather than being delivered in anticipation of it. The Working Group believes that this case study therefore supports a broader argument that primary care infrastructure should be treated more explicitly as a prerequisite for sustainable growth rather than a consequence of growth.

Key Conclusions Drawn by the Working Group:

87. The Working Group's analysis of Great Western Park ultimately informed several of its wider findings and recommendations. Firstly, the project demonstrates that primary care estates are not simply property matters; they are a fundamental determinant of access. Estate constraints directly influence workforce capacity, appointment availability and service resilience. Secondly, the project illustrates that housing growth and healthcare infrastructure remain insufficiently aligned under current arrangements. Whilst planning obligations can secure land and contributions, delivery remains vulnerable to wider financial and system challenges. Thirdly, the Working Group concluded that population growth should be regarded as one of the most significant future drivers of demand within Oxfordshire primary care services. Finally, the case study reinforces the need for earlier and more structured engagement between healthcare commissioners, planning authorities, developers and central government. Many of the challenges encountered at Great Western Park could have been mitigated through stronger strategic alignment between housing delivery, infrastructure planning and healthcare funding arrangements.

88. For these reasons, Great Western Park has become one of the central examples underpinning some of the working group's recommendations found below in this report. It illustrates not only the challenges currently facing Oxfordshire but also the

policy changes that may be required if future growth is to be supported by healthcare infrastructure delivered at the right scale and at the right time.

Case Study 2- Bicester Health Centre: Primary Care Capacity, Population Growth and Estate Modernisation

89. The experience of Bicester Health Centre provides a particularly important case study for understanding the challenges facing primary care infrastructure across Oxfordshire and nationally. Whilst debates about GP access often focus on workforce shortages, appointment availability, or digital transformation, the Bicester example demonstrates that the physical estate within which healthcare is delivered remains a critical determinant of access, capacity, workforce sustainability and service quality.

90. The case illustrates a wider national issue identified repeatedly by NHS England, Integrated Care Boards and parliamentary committees: many GP practices are operating from buildings that were designed for smaller populations and older models of care. Modern primary care requires space for multidisciplinary teams, digital infrastructure, community services, preventative programmes and integrated neighbourhood working. However, across Buckinghamshire, Oxfordshire and Berkshire West, the NHS has acknowledged that many practices have outgrown their premises and have limited ability to expand. The proposed expansion of Bicester Health Centre therefore represents more than a local estates project; it is an example of how health systems are attempting to respond to rapidly increasing population demand whilst simultaneously delivering the ambitions of modern neighbourhood healthcare.

91. For the Working Group, the Bicester case provides a useful lens through which to explore several interconnected themes:

- Population growth and healthcare demand.
- The relationship between housing development and health infrastructure.
- The importance of primary care estate capacity.
- Barriers to delivering estate expansion.
- The role of planning and infrastructure funding.
- Future opportunities for neighbourhood health and integrated care.

92. The case also demonstrates why scrutiny of primary care estates is increasingly important if local authorities are to fulfil their responsibilities for promoting health and wellbeing and ensuring that healthcare infrastructure keeps pace with community growth.

<u>Population Growth, Demand Growth and the Strategic Importance of Bicester:</u>

93. Bicester represents one of the clearest examples in Oxfordshire of the challenge facing NHS primary care infrastructure in areas of sustained housing growth. Over the past decade, the town has experienced substantial expansion through a series of major housing developments, including Kingsmere, Graven Hill and other strategic allocations identified within local planning frameworks. Whilst these developments have contributed significantly to housing supply and economic

growth, they have also generated corresponding increases in demand for healthcare services. Evidence reviewed by the Working Group demonstrated that Bicester Health Centre's registered patient list increased from approximately 16,216 patients to 20,173 patients between January 2023 and December 2025. This represents growth of approximately 24.4% over a relatively short period, making it one of the most rapidly expanding practices considered during the working group's inquiry. At the same time, the practice was delivering in excess of 8,000 appointments per month, demonstrating the scale of demand being managed by primary care teams.

94. The significance of these figures extends beyond simple population growth. An increase of nearly a quarter in the registered patient population has implications for every aspect of practice operations. Additional patients require more GP appointments, more nursing capacity, more prescription processing, expanded chronic disease management programmes, greater administration support and increased demand for preventative services. Such growth also creates pressures on continuity of care, with larger patient populations placing additional pressures upon clinicians seeking to maintain long-term relationships with patients and families.

95. The Working Group considered that Bicester therefore provides a practical demonstration of a challenge that is occurring nationally: healthcare demand can increase significantly within a relatively short timeframe, whilst the infrastructure needed to accommodate that growth often develops at a much slower pace. The result is that primary care providers can become victims of their communities' success, serving rapidly expanding populations from premises originally designed for much smaller catchment areas.

The Bicester Health Centre Expansion Project:

96. A key reason why the working group selected Bicester as a case study was because it demonstrates both the challenges and opportunities associated with estate expansion. Unlike Great Western Park, which involves the development of new primary care infrastructure, the Bicester project centres upon the expansion and repurposing of existing NHS estate. Evidence provided to the working group identified plans to expand Bicester Health Centre into accommodation vacated by Oxford Health NHS Foundation Trust, thereby increasing the number of consulting and clinical rooms available within the facility. At first glance, utilising vacated NHS accommodation may appear to be a relatively straightforward solution. However, the Working Group concluded that the project illustrates the complexity of delivering what might otherwise seem to be modest estate improvements.

97. The fundamental objective of the project is not simply to increase floor space. Rather, it is to create additional clinical capacity within one of Oxfordshire's fastest-growing communities. Additional consulting rooms create the opportunity to accommodate more clinicians, expand appointment availability and support wider multidisciplinary teams. They also help create the infrastructure necessary for future service transformation and neighbourhood-based delivery models.

98. The modern primary care increasingly relies upon multidisciplinary approaches involving GPs, practice nurses, pharmacists, social prescribers, mental health practitioners, care coordinators and other professionals. Expanding workforce capacity therefore requires physical accommodation for those staff. Without additional rooms, practices may find themselves unable to maximise the benefits of national workforce initiatives because there is nowhere for additional professionals to work. The Bicester project therefore demonstrates that estate capacity is often a precondition for workforce expansion rather than a consequence of it.

What the Bicester Case Reveals About the Relationship Between Estates and Access:

99. Throughout the inquiry, the working group repeatedly heard that physical estate constraints can directly affect patient access to services. The public debate surrounding GP access often focuses upon appointment availability, waiting times and workforce shortages. However, evidence gathered throughout the inquiry suggested that estate limitations frequently sit behind many of these access challenges. If a practice lacks consulting space, it becomes more difficult to recruit additional clinicians. If additional clinicians cannot be accommodated, the ability to increase appointment numbers is restricted. If appointment supply cannot increase at the same rate as demand, patients experience greater difficulty securing appointments. The Working Group considered that Bicester illustrates this relationship particularly clearly. With a patient population growth of over 24% during the period examined, maintaining existing service levels would itself require significant increases in capacity. Improving access, continuity of care and workforce resilience requires additional capacity beyond merely keeping pace with demand growth.

100. The case therefore highlights that estate investment should not be viewed as a separate infrastructure issue. It is fundamentally an access issue. The quality, size and functionality of primary care premises directly influence how many patients can be seen, how quickly they can be seen and which services can be provided locally.

Planning, Infrastructure Funding and System Coordination:

101. A further lesson emerging from the Bicester case concerns the relationship between healthcare planning and housing growth. During evidence sessions, the working group explored concerns regarding the extent to which healthcare infrastructure planning is sufficiently integrated with local planning and development processes. Discussions highlighted wider system concerns regarding the alignment of housing growth, infrastructure provision and primary care capacity planning. Evidence submitted to the Working Group suggested that stronger engagement between health organisations and planning authorities is required if healthcare infrastructure is to keep pace with population growth.

102. The Bicester experience demonstrates that healthcare infrastructure cannot be considered after development has occurred. By the time thousands of new residents have moved into newly completed homes, the demand has already materialised. Estate projects, however, may require years of planning, business

case development, funding approvals and implementation. The Working Group concluded that this creates a structural risk whereby primary care services are continually attempting to catch up with growth rather than planning proactively for it. Therefore, Bicester demonstrates the importance of:

- Earlier engagement between Integrated Care Boards and planning authorities.
- Stronger alignment between Local Plans and healthcare infrastructure planning.
- Greater use of infrastructure planning mechanisms to identify future healthcare requirements.
- More strategic forecasting of future primary care demand arising from large housing developments.

103. The lessons are applicable not only to Bicester but to emerging growth locations across Oxfordshire and the wider Thames Valley region.

Implications for Neighbourhood Health and Future Service Models:

104. The Bicester project also has significance beyond traditional GP services. National policy increasingly focuses on neighbourhood health models that bring together primary care, community services, mental health support, preventative services and wider partners around local populations. The Working Group considered how estate projects such as Bicester Health Centre could contribute to these ambitions. Modern healthcare delivery requires facilities capable of accommodating a range of professionals and services working collaboratively. Older buildings designed solely around a traditional GP-partner model may struggle to support emerging models of care.

105. The proposed expansion at Bicester therefore offers an opportunity not merely to deliver additional appointments, but to create infrastructure capable of supporting future integrated neighbourhood working. The case highlights the importance of ensuring that estate projects are designed with future service transformation in mind rather than simply addressing immediate capacity pressures.

Working Group Conclusions and Lessons Learned:

106. The Bicester Health Centre case study generated two important conclusions for the Working Group's broader inquiry into primary care access and estates. Firstly, it demonstrated that rapid population growth can significantly increase healthcare demand within a relatively short period, creating pressures that are difficult to manage without corresponding expansion of estate capacity. The observed 24.4% increase in registered patients provides a clear example of this phenomenon. Secondly, the case reinforced the Working Group's conclusion that estate and workforce issues cannot be considered independently. Additional workforce capacity can only be fully utilised where sufficient clinical accommodation exists.

Case Study 3 - Wallingford Medical Practice: Future-Proofing Primary Care Infrastructure

107. The Wallingford Medical Practice case study provides one of the most significant examples examined by the working group. Unlike the case of Bicester Health Centre, where the focus has largely been on expanding existing NHS accommodation, Wallingford represents a much more fundamental challenge concerning the long-term suitability of primary care infrastructure and the need for entirely new premises. The Working Group conducted a site visit to Wallingford Medical Practice on 16 July 2026, and witnessed first hand some of the challenges with the existing estate. The insights outlined below in this section were partly informed by the briefing and tour of the building that the group received during the site visit.

108. The working group considered Wallingford because it illustrates a number of strategic issues facing primary care nationally and locally, including ageing infrastructure, population growth, rising healthcare demand, workforce expansion, planning processes, capital investment challenges and the development of neighbourhood-based models of care. Importantly, the Wallingford project demonstrates that some estate challenges cannot be solved through incremental modifications to existing premises and instead require comprehensive redevelopment solutions. The case therefore provides valuable lessons for the wider Oxfordshire health and care system about how primary care infrastructure must evolve to meet future demand.

From Incremental Expansion to Complete Redevelopment: The Evolution of the Wallingford Project:

109. One of the most significant findings emerging from the Wallingford case study is that the current estate challenge did not emerge suddenly. Rather, it has developed gradually over many years as population growth, service expectations and models of healthcare delivery have evolved. The existing Wallingford Medical Practice building dates from the 1980s and has already undergone three separate extensions over approximately thirty years. The fact that the building has been extended repeatedly demonstrates that attempts have been made over a prolonged period to respond to rising demand through incremental expansion. However, despite those efforts, the existing premises are no longer suitable for providing modern primary care services and further piecemeal adaptations are unlikely to provide a sustainable solution.

110. This is a particularly important lesson for the Working Group. Throughout the inquiry, members encountered examples of primary care premises where temporary or incremental solutions had been adopted over many years. Whilst such approaches can provide short-term benefits, the Wallingford experience demonstrates that there eventually comes a point at which an estate can no longer be adapted efficiently and a more fundamental solution becomes necessary. The proposed redevelopment at Winterbrook Meadows therefore represents more than a relocation exercise. It represents a strategic decision that the future healthcare needs of Wallingford cannot be accommodated within the limitations of the existing

estate and that entirely new infrastructure is required if services are to grow in line with anticipated demand.

Quantifying the Scale of the Estate Deficit:

111. The Working Group considered that one of the most compelling aspects of the Wallingford evidence is the availability of robust estate planning data which quantifies the scale of the current problem. The current surgery provides approximately 797 square metres of accommodation. NHS capacity modelling undertaken for the project suggests that the building is already approximately 46 per cent undersized for current requirements and could become approximately 59 per cent undersized by 2033 if anticipated population growth and service requirements materialise.

112. These figures are striking because they illustrate that the estate challenge facing Wallingford is not simply a question of needing one or two additional consulting rooms. Instead, the evidence suggests a significant mismatch between the size of the premises and the needs of the population being served. The proposed new facility is planned to provide approximately 1,898–1,922 square metres of accommodation, representing an increase of more than 1,100 square metres compared with the existing building and more than doubling the available clinical space.

113. The scale of the proposed increase reflects the fact that modern primary care requires significantly more space than was envisaged when many practices were originally developed. Contemporary healthcare delivery involves multidisciplinary teams, teaching facilities, digital infrastructure, collaborative working environments and integrated services that would not have been anticipated when the current Wallingford building was first designed.

114. For the Working Group, this raises an important question for the wider health system: how many other practices across Oxfordshire may currently be operating from buildings that were designed for healthcare models of the 1980s and 1990s rather than the needs of the 2030s?

Population Growth, Demographic Change and Rising Complexity of Demand:

115. Whilst the Wallingford estate challenge is substantial, the Working Group recognised that the issue cannot be understood solely through the prism of buildings. The underlying driver remains growing and increasingly complex healthcare demand.

116. Data reviewed by the working group indicated that Wallingford Medical Practice's patient list increased from approximately 18,116 patients to 19,108 patients between January 2023 and December 2025. During this period the practice was providing around 8,700 appointments per month, demonstrating both the scale of service delivery and the intensity of activity already taking place within the existing premises. However, the strategic significance of Wallingford lies less in historic growth and more in expected future growth. The wider Wallingford and Surrounds Primary Care Network serves approximately 34,128 residents and

forecasts population growth of approximately 14.9 per cent over the following five years. The area has a higher proportion of older residents than Oxfordshire overall, including significant numbers of people aged over eighty-five.

117. The implications of this are profound. Healthcare demand does not increase in a linear fashion. An additional thousand residents may generate very different levels of healthcare activity depending upon age profile, health inequalities, housing type and prevalence of long-term conditions. Older populations typically require:

- More frequent GP consultations.
- Greater medicines optimisation activity.
- Increased management of long-term conditions.
- More community nursing input.
- Stronger integration with social care.
- Greater coordination between primary and secondary care services.

Consequently, the challenge facing Wallingford is not merely accommodating population growth. It is accommodating increasingly complex healthcare demand that may grow faster than raw population figures alone would suggest.

<u>Winterbrook Meadows: Integrating Healthcare Infrastructure into Growth Planning:</u>

118. Perhaps one of the most important strategic lessons arising from the Wallingford case study concerns the relationship between healthcare planning and wider development planning. The proposed new medical centre forms part of the wider Winterbrook Meadows development and has been brought forward jointly by Wallingford Medical Practice and Berkeley Homes. The proposal includes a purpose-built healthcare facility of approximately 1,898 square metres with associated parking, landscaping and supporting infrastructure. The new facility would be located within the wider growth area and would replace the existing surgery on Reading Road.

119. The Working Group considered this particularly significant because it demonstrates the benefits of integrating healthcare infrastructure into the planning of major developments at an early stage. A recurring theme throughout the inquiry was concern that healthcare infrastructure frequently lags behind housing development. New homes may be occupied years before new healthcare capacity becomes available, leaving existing services struggling to absorb growing demand.

120. The Wallingford project potentially offers a different model. By embedding primary care infrastructure within a wider strategic development, there is greater opportunity to ensure that health facilities develop alongside population growth rather than attempting to catch up after growth has already occurred. This approach is consistent with planning policies referenced within the scheme that identify health infrastructure as a key requirement for future development within Wallingford. The Working Group considered that this provides a valuable lesson for planning authorities, developers and NHS organisations across Oxfordshire.

Enabling Workforce Expansion and Neighbourhood Health:

121. A key theme emerging throughout the working group's inquiry has been that workforce challenges and estate challenges are inseparable. The NHS has invested heavily in multidisciplinary teams through initiatives such as the Additional Roles Reimbursement Scheme. General practice now increasingly relies upon pharmacists, physician associates, care coordinators, social prescribers, mental health practitioners and advanced nurse practitioners. However, evidence gathered throughout the inquiry consistently suggested that workforce funding alone cannot increase patient access if there is insufficient physical space to accommodate additional professionals. The Wallingford project provides a particularly clear example of this issue.

122. The new facility will support wider Primary Care Network functions, workforce training and future service development in addition to core GP services. The working group concluded that the project should therefore be viewed not simply as a building project but as an access improvement project, a workforce sustainability project and an enabler of neighbourhood health. Without the new premises, future workforce growth may be constrained by the physical limitations of the existing building. With the new premises, opportunities exist to expand services, increase appointment capacity, improve resilience and support wider integrated care delivery.

Lessons for Primary Care Access and Estates Across Oxfordshire:

123. The Wallingford case study generated several broader lessons which the Working Group considered applicable across Oxfordshire and the wider Thames Valley system. Firstly, estate challenges frequently develop gradually over many years before becoming critical. Organisations should therefore monitor estate adequacy proactively rather than waiting until buildings reach capacity limits. Secondly, population growth forecasts must be integrated into long-term estate planning. Once healthcare demand has materialised, estate projects often require many years to progress through planning, approval and delivery processes. Thirdly, estate investment should not be viewed as an isolated infrastructure issue. The evidence from Wallingford demonstrates that workforce expansion, patient access, service transformation and neighbourhood health ambitions are all dependent upon having sufficient physical capacity. Fourthly, the case demonstrates the value of integrated planning between NHS organisations, local planning authorities and developers. The Winterbrook Meadows proposal provides an example of how healthcare infrastructure can be incorporated within wider strategic growth planning rather than addressed retrospectively.

124. Finally, the Working Group concluded that Wallingford demonstrates the growing importance of future-proofing primary care infrastructure. The purpose of the new facility is not merely to solve today's estate problems but to create capacity capable of supporting healthcare delivery, workforce growth and population needs over the coming decades. In that sense, Wallingford represents one of the clearest examples examined during the inquiry of how long-term investment in primary care estates can underpin improved access, workforce sustainability, integrated care and system resilience.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

125. This section highlights five key observations and points that the Working Group has in relation to GP services in Oxfordshire. These five key points of observation have been informed by the evidence received by the group from its sessions, its site visits, as well as from written submissions/data supplied. These points of observation have been used to determine the recommendations being made by the Working Group which are outlined below:

Importance of an integrated approach to improving access to general practice (ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole): The evidence considered by the Working Group demonstrates that access to general practice in Oxfordshire is shaped by the combined effects of population growth, workforce capacity, estate constraints and the design of access routes, rather than by any single factor in isolation. The Working Group therefore concluded that meaningful and sustainable improvements in access can only be delivered through a single, integrated approach, in which workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole.

Analysis of GP appointment activity and registered patient list sizes between January 2023 and December 2025 (Annex A) shows that most practices across Oxfordshire are serving a growing registered population, with significant variation in list size growth between areas. While the data demonstrates that practices are collectively delivering very high volumes of appointments, it also highlights substantial differences in demand pressure at practice level. In particular, practices serving areas of rapid housing growth have experienced disproportionate increases in registered patients without corresponding increases in clinical capacity or physical space. The working group noted that, under such conditions, additional appointments alone cannot resolve access issues where workforce availability and estate capacity are already fully stretched.

This is reinforced by the month-by-month GP appointment trend data for January to December 2025 (Annex B). The data indicates that appointment volumes fluctuate seasonally but remain consistently high throughout the year, reflecting sustained demand rather than short-term pressure. However, the working group observed that delivery of high appointment numbers has not translated into a uniform improvement in patient experience. This supports national evidence that appointment counts do not capture the full range of work undertaken in general practice, nor the intensity and complexity of consultations now required. The working group therefore concluded that reliance on appointment data as a proxy for access risks obscuring underlying capacity constraints.

Patient experience evidence, as captured in the most recent GP Patient Survey (January 2025, Annex C), provides further context. While many patients reported positive experiences once they were able to secure an appointment, results relating to ease of contact, waiting times and choice of appointment type showed considerable variation. The working group noted that these findings align with feedback gathered by Healthwatch Oxfordshire, which highlights that improvements implemented through digital and triage-based access models have not been experienced equally across all population groups. This reinforces the conclusion that changes to access routes, when implemented separately from workforce and estates planning, can unintentionally widen inequalities rather than reduce them.

Workforce data (Annex D) was central to the Working Group's analysis. Although Oxfordshire has benefited from the introduction of additional roles through multidisciplinary teams, the data shows that growth in full-time equivalent GP capacity has not kept pace with increasing demand and list sizes. Moreover, the distribution of workload within practices has changed significantly, with GPs increasingly managing higher-complexity cases alongside supervision, triage and administrative responsibilities. National research demonstrates that GPs dedicate immense time to work that sits outside direct face-to-face consultations, including tasks generated at the interface between primary and secondary care[41]. The Working Group therefore concluded that workforce planning, if considered independently of system design and workload drivers, cannot deliver sustainable access improvements.

The interaction between workforce limitations and estate constraints is particularly significant. Evidence reviewed by the working group shows that practices operating from constrained or outdated premises face limits on the number and type of clinical staff they can accommodate, restricting both appointment capacity and the development of neighbourhood-based, multidisciplinary working. National analyses show that many primary care estates were not designed to support modern service models, with limited flexibility to expand or reconfigure space[42]. In Oxfordshire, this challenge is intensified in areas of population growth where estate delivery has lagged behind housing development, resulting in persistent access pressure despite high clinical effort.

The Working Group also considered how digital access and neighbourhood models interact with these pressures. Evidence from the GP Patient Survey (Annex C) demonstrates that while digital routes may improve convenience for some patients, they are not a substitute for sufficient clinical capacity or appropriate physical infrastructure. National Healthwatch evidence consistently highlights that digital-first approaches, when introduced without adequate support and alternative routes, risk disadvantaging digitally excluded populations[43]. The working

[41] RCGP, Uncovering the GP workload burden
[42] Institute for Government
[43] Healthwatch England

group concluded that digital access must therefore be planned alongside workforce availability and estate suitability, rather than deployed as a stand-alone solution.

Experience from other parts of the country reinforces this conclusion. Integrated care systems that have aligned workforce strategy, estates investment and service redesign—such as North Central London and Hertfordshire and West Essex—demonstrate that access improvements are more sustainable when these elements are considered together[44]. Conversely, where initiatives have progressed in isolation, systems have struggled to convert activity growth into improved patient experience.

The Committee's examination of GP services in its September 2025 public meeting focused appropriately on understanding activity, performance and programmes underway. The working group's subsequent analysis, drawing on detailed appointment, population, workforce and patient experience data (Annexes A–D), shows that the primary challenge now facing Oxfordshire is not the absence of initiatives, but the absence of a coherent framework linking them. Without such integration, gains in one area—such as increased appointment delivery or expanded digital access—are repeatedly constrained by workforce, estates or system-generated workload pressures elsewhere.

For these reasons, the working group concluded that the Integrated Care Board should adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. This approach provides the clearest route to sustainable improvements in access, more equitable patient experience, and a transparent basis for future scrutiny by the Oxfordshire Joint Health Overview and Scrutiny Committee.

Recommendation 1: *For the Integrated Care Board to adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. It is also recommended that variation between localities and communities is supported in this process. The ICB needs to enhance its own capacity to work with local authorities and communities to expand capacity of primary care services in light of increases in demand.*

Taking active steps to reduce avoidable GP Workload: The working group concluded that active steps to reduce avoidable, system-generated workload on general practice are essential to protecting clinical capacity and improving patient access in Oxfordshire. This conclusion arises from a consistent theme across the evidence considered by the working group: that pressures on access are not primarily explained by a lack of effort or productivity within general

[44] North Central London Infrastructure Strategy

practice, but by the cumulative burden of work generated by the wider health system that falls to GPs by default.

Local appointment activity and registered patient list data (Annex A) show that general practices across Oxfordshire are delivering very high volumes of appointments against a backdrop of sustained population growth. Registered list sizes of GP practices across Oxfordshire as a whole increased by an average of 8.4% between January 2023 and December 2025. This is placing additional demand on practices without a commensurate increase in clinical or administrative capacity. Month-by-month appointment trends for 2025 (Annex B) demonstrate that activity remains consistently high throughout the year rather than being driven by short-term seasonal spikes. Despite this, patient experience data (Annex C) indicates that many patients continue to report difficulties in accessing care, particularly in contacting practices and securing timely appointments. The working group concluded that this apparent contradiction—high activity alongside persistent access problems—cannot be adequately explained by appointment supply alone.

A central explanation lies in how GP time is consumed. Workforce data (Annex D) confirms that while Oxfordshire has benefited from growth in wider primary care roles, growth in full-time equivalent GP capacity has not kept pace with demand and complexity. This mirrors national trends, where GPs are increasingly required to manage complex, multi-morbid patients, provide supervision within multidisciplinary teams, and absorb additional tasks generated elsewhere in the system. National analysis by the *British Medical Association* highlights that workload growth in general practice has significantly outstripped workforce growth over the past decade, undermining sustainability and access despite record appointment delivery[45].

Evidence submitted by the BOB Local Medical Committee (Annex E) was particularly influential in shaping this recommendation. The LMC highlighted that a substantial proportion of GP workload arises not from patient-initiated demand, but from tasks transferred—formally or informally—from secondary care, community services and wider public systems. This includes follow-up investigations, onward referrals, medication queries, care coordination and administrative work that does not require GP-level expertise but nonetheless consumes clinical time. This finding aligns closely with national research by the Royal College of General Practitioners, which estimates that “unnecessary” and hidden workload costs practices over £400 per GP per day and contributes directly to burnout, reduced retention and loss of clinical capacity[46].

The working group’s evidence sessions reinforced these findings. In sessions with NHS representatives, members repeatedly heard that poorly designed interfaces between primary and secondary care

[45] BMA – Pressures in General Practice
[46] RCGP, Uncovering the GP workload burden).

continue to generate avoidable workload for general practice. Tasks such as incomplete discharge information, inappropriate test result follow-up and unclear referral pathways were identified as routine sources of additional work. National guidance published through the NHS England Red Tape Challenge explicitly recognises these interface failures as a major driver of GP workload and calls for integrated care boards to take active steps to reduce bureaucracy rather than allowing work to default to general practice[47]. Complementary guidance from the Getting It Right First Time programme sets out clear standards for improving processes between primary, secondary, mental health and community services, with the explicit aim of relieving pressure on GPs and improving patient flow[48].

Patient experience evidence further supports the working group's conclusion. The GP Patient Survey (Annex C) and Healthwatch Oxfordshire's engagement between April 2025 and March 2026 consistently show that patients' frustration with access often reflects delays created by system processes rather than unwillingness or inefficiency within practices. Healthwatch evidence points to confusion about care pathways, repeated contacts generated by unresolved administrative issues, and increased demand for GP intervention when other services are difficult to access. National Healthwatch reporting echoes these themes, warning that failure to address access barriers across the system risks entrenching inequality and driving patients back to general practice as the "service of last resort"[49].

The Working Group also drew on learning from other parts of the country. Integrated care systems that have actively addressed system-generated workload—by standardising referral processes, clarifying responsibilities at discharge and investing in interface roles—have demonstrated improvements in GP capacity and patient flow. For example, Cheshire and Merseyside's work on implementing standardised interface principles has been cited nationally as good practice in reducing avoidable GP workload and improving system efficiency[50].

Academic literature published in the *British Journal of General Practice* also highlights that measuring access purely through appointment numbers obscures the "hidden labour" of general practice, much of which is driven by system design rather than patient need[51].

The GP services update item considered by the Committee in its September 2025 meeting rightly focused on understanding activity levels and programmes underway. However, the Working Group's subsequent scrutiny, informed by detailed data (Annexes A–D), professional evidence (Annex E) and national research, demonstrates that further improvements in access cannot be achieved simply by increasing

[47] NHS England – GP Red Tape Challenge
[48] GIRFT – Bridging the interface
[49] Healthwatch England
[50] RCGP – Red Tape Challenge response
[51] BJGP editorial

appointment counts or introducing new access routes. Without addressing avoidable, system-generated workload, any additional clinical capacity released will continue to be absorbed by inefficiencies elsewhere in the system.

Therefore, the Working Group concluded that active steps must be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system. This is not a request for further information, but a call for systemic action by the Integrated Care Board to protect scarce clinical capacity, improve sustainability within general practice and deliver meaningful improvements in patient access across Oxfordshire.

Recommendation 2: *For active steps to be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system, in order to protect clinical capacity and improve patient access. It is recommended that there is collaboration with local General Practice leaders (as well as patient representative bodies) to explore ways to reduce excessive administrative non-clinical work for qualified GPs; and that there is national escalation when this excessive work is owed to national constraints.*

Ensuring Sustainable Workforce Models in General Practice: The Working Group concluded that improving access to general practice in Oxfordshire cannot be achieved through a narrow focus on workforce headcount alone. Instead, the evidence considered by the working group demonstrates that long-term sustainability depends on how workload is distributed, how continuity of care is supported, and whether experienced GPs are able and willing to remain in practice. For this reason, the working group recommends that the Integrated Care Board ensures workforce models explicitly address workload intensity and retention, rather than relying primarily on increases in staffing numbers.

Local data on registered patient lists and appointment activity between January 2023 and December 2025 (Annex A) shows sustained and, in many areas, accelerating growth in demand for general practice. Registered list sizes have increased unevenly across Oxfordshire, reflecting housing growth and demographic change, with some practices absorbing significantly higher patient-to-GP ratios than others. While overall appointment volumes have risen, the working group noted that list growth increases not only the number of consultations but also the complexity of work, as larger lists inevitably contain greater numbers of older patients and people with multiple long-term conditions.

Month-by-month appointment trends for 2025 (Annex B) reinforce this picture. Appointment delivery remains consistently high throughout the year, suggesting that general practice is already operating near the limits of its available capacity. However, the working group observed that sustained appointment volume does not equate to sustainable workload. National research demonstrates that appointment counts capture only a portion of the work undertaken in general practice and do not reflect the

cognitive, administrative and coordination burden that increasingly characterises GP roles[52]. As a result, workforce models based primarily on appointment throughput risk masking intensifying pressures on individual clinicians.

Workforce data (Annex D) was central to the working group's analysis. While Oxfordshire has seen growth in wider primary care roles, including those funded through multidisciplinary team arrangements, growth in fully qualified, experienced GPs—particularly on a full-time equivalent basis—has been limited. Evidence consistently shows that GP workload intensity has risen faster than the GP workforce, contributing to reduced job satisfaction, increased part-time working, and early retirement[53]. The working group therefore concluded that workforce sustainability cannot be assured through recruitment alone, without parallel action to manage workload and support retention.

The submission from the BOB Local Medical Committee (Annex E) strongly reinforced this conclusion. The LMC highlighted that workload intensity—rather than absolute staffing numbers—is a key determinant of GP retention. Experienced GPs are increasingly choosing to reduce sessions or leave practice altogether due to cumulative workload pressures, including administrative burden and system-generated tasks that detract from direct patient care.

Evidence from the Working Group's sessions with NHS partners further demonstrated that workload intensity is closely linked to system design. Poorly defined interfaces between primary and secondary care routinely shift work to GPs, increasing complexity and time pressure without corresponding resource transfer. The NHS Red Tape Challenge similarly identifies excessive administrative burden as a driver of poor workforce sustainability and reduced continuity of care[54].

Continuity of care emerged as a critical theme linking workforce sustainability and patient experience. GP Patient Survey results from January 2025 (Annex C) show that patients place high value on seeing a preferred or familiar clinician, particularly those managing long-term or complex conditions. Healthwatch Oxfordshire's engagement work between April 2025 and March 2026 on GP services in Oxfordshire reinforces this, highlighting patient frustration when continuity is disrupted by high staff turnover, reliance on locums, or fragmented workforce models (the outcome report will be published on the Healthwatch Oxfordshire website by June 2026). Academic research, including from the King's Fund, also consistently demonstrates that continuity of care is associated with improved patient outcomes, reduced hospital admissions, and higher professional satisfaction among GPs, all of which contribute to workforce retention[55].

[52] British Journal of General Practice
[53] BMA – Pressures in General Practice).
[54] NHS England – Red Tape Challenge
[55] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice

The Working Group noted that models which prioritise workforce flexibility without protecting continuity risk undermining both patient experience and staff retention. Evidence from other parts of the country indicates that systems investing in smaller, stable clinical teams and protecting experienced GPs' roles within them see better retention outcomes than those relying heavily on short-term staffing solutions. For example, integrated care systems that have explicitly linked retention strategies to workload reduction and continuity—such as parts of Greater Manchester and Cheshire and Merseyside—have been cited by national bodies as demonstrating more sustainable general practice models[56].

The GP services update item discussed by the Committee in September 2025 appropriately focused on understanding activity levels and workforce initiatives underway. However, the Working Group's subsequent, deeper scrutiny demonstrates that a focus on staffing numbers alone risks obscuring the factors that determine whether clinicians remain in practice. Without addressing workload intensity, continuity of care and the working conditions experienced by senior GPs, increases in workforce supply may result only in churn rather than sustainable capacity.

Hence, the Working Group concluded that the Integrated Care Board must ensure workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs. This approach recognises that experienced clinicians are a finite and valuable resource, and that protecting their capacity and wellbeing is essential to improving access, maintaining quality, and ensuring the long-term resilience of general practice across Oxfordshire.

Recommendation 3: *That the Integrated Care Board ensures that workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs, rather than focusing solely on staffing numbers.*

Prioritising the reduction of inequalities in access to GP Services: The Working Group concluded that improving access to GP services in Oxfordshire must be accompanied by a deliberate and sustained focus on reducing inequalities in access. Evidence considered by the Working Group demonstrates that improvements in headline access metrics do not translate evenly across population groups or geographies, and that without targeted action, existing disparities risk being entrenched or widened. For this reason, the working group recommends that the Integrated Care Board prioritises action to ensure that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth.

[56] RCGP – Continuity and Retention

Analysis of GP appointment data and registered patient list sizes between January 2023 and December 2025 (Annex A) shows significant variation across Oxfordshire in both list size growth and demand pressure. Practices serving areas of rapid housing development have seen disproportionate increases in registered patients over a short period, often without a corresponding expansion in workforce or estate capacity. The working group noted that such areas face particular challenges in maintaining timely access, as increased list size translates directly into higher baseline demand. Month-by-month appointment trends during 2025 (Annex B) show that while practices collectively deliver high volumes of appointments throughout the year, this activity does not resolve uneven access where underlying capacity constraints and population change are not evenly distributed.

Patient experience data highlights how these pressures translate into inequality. Results from the January 2025 GP Patient Survey (Annex C) show marked variation in patients' ability to contact their practice, secure appointments and see a preferred clinician. While many respondents report good experiences once an appointment is obtained, the working group noted that ease of access remains a persistent challenge for particular groups. Healthwatch Oxfordshire's engagement work on GP services between April 2025 and March 2026 reinforces this finding, with access to GP services remaining one of the most common issues raised by residents (the outcome of this study will be published on the Healthwatch Oxfordshire website by June 2026). Healthwatch evidence points to consistent barriers faced by rural residents, people with limited digital skills, and those living in areas undergoing rapid population growth, particularly where existing services have not expanded at the same pace.

Rural inequality emerged strongly in both the data and the Working Group's sessions. Rural practices often serve geographically dispersed populations, with fewer alternative providers nearby and greater reliance on a small number of clinicians. Workforce data (Annex D) shows that such practices can be more vulnerable to staffing gaps and fluctuations, with limited ability to absorb sudden increases in demand. National research confirms that rurality is associated with lower GP-to-patient ratios and longer travel times, compounding access issues even where appointment availability appears comparable on paper[57]. The Working Group concluded that policies aimed at improving access must explicitly recognise rural context, rather than assuming uniform delivery models are appropriate across the county.

Digital exclusion was another recurring theme. While digital access routes can improve efficiency and convenience for some patients, evidence reviewed by the working group shows that these benefits are not universal. GP Patient Survey data (Annex C) indicates that a proportion of patients struggle with online access or prefer telephone or

[57] RCGP – Health inequalities).

face-to-face contact. Healthwatch Oxfordshire also reported that older residents, people with disabilities, those on low incomes and individuals with limited English proficiency are disproportionately disadvantaged by digital-first models when alternative routes are constrained. This mirrors national findings from Healthwatch England, which has repeatedly warned that digital transformation in general practice risks widening inequalities unless supported by inclusive design and sufficient analogue access[58].

Moreover, workload pressures amplify these inequalities. Evidence from the BOB Local Medical Committee (Annex E) highlights that system-generated workload reduces the capacity of practices to offer flexible, responsive access, particularly in high-pressure areas. Nationally, the Royal College of General Practitioners has demonstrated that unnecessary and hidden workload consumes significant clinical time that could otherwise be directed towards patient access, with a disproportionate impact on practices serving more complex or deprived populations[59]. The Working Group concluded that unless workload pressures are addressed, practices in high-need areas will be least able to improve access, thereby exacerbating inequality.

Evidence from the Working Group's sessions with NHS organisations reinforced the importance of system coordination. Members heard that interfaces between primary, secondary and community services often generate additional demand for GP intervention, particularly where access to other services is limited. National NHS England guidance on bridging the interface between services recognises the role of poor system design in diverting patients back to general practice, disproportionately affecting areas with fewer alternative access routes[60]. Similarly, the NHS Red Tape Challenge acknowledges that bureaucratic burdens and unclear responsibilities reduce system efficiency and have uneven impacts across communities[61].

In addition, the written submission to the Working Group from Cherwell District Councillor David Rodgers illustrated how these issues intersect in areas of rapid growth. The submission highlighted the gap between housing delivery and primary care capacity, with new residents placing additional demand on already-stretched practices before new infrastructure is delivered.

National policy literature, including from the *Institute for Government's* work on GP estates, consistently identifies this mismatch as a driver of access inequality, particularly where local planning systems and healthcare commissioning are insufficiently aligned[62]. The Working Group concluded that populations affected by rapid growth are at

[58] Healthwatch England – GP access
[59] RCGP – Unnecessary workload study
[60] GIRFT – Bridging the Interface
[61] NHS England – Red Tape Challenge
[62] Institute for Government – GP estates

particular risk of deteriorating access if inequality is not explicitly addressed.

Learning from other parts of the country reinforces the need for a targeted approach. Integrated care systems that explicitly prioritise equity—such as Greater Manchester and parts of London—have used population health data to tailor access initiatives to specific communities, combining workforce support, outreach and flexible access routes. Evaluations from these systems demonstrate that access improvements are more likely to be sustained, and inequalities reduced, when services are designed around local need rather than uniform targets[63].

Therefore, the Working Group's analysis demonstrates that aggregate improvement does not guarantee equitable improvement. Drawing on detailed data (Annexes A–D), professional evidence (Annex E) and patient experience, the Working Group concluded that reducing inequalities in access requires explicit prioritisation and sustained action by the Integrated Care Board.

For the above reasons, the Working Group recommends that the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. This approach recognises that equitable access is not a by-product of general improvement but a core objective that must be actively pursued if the benefits of investment and reform are to be shared fairly across the county.

Recommendation 4: *That the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. It is recommended that local patient voices and the scrutiny function have meaningful input into the design and commissioning of GP services.*

Treating primary care estates capacity as a critical determinant of access: The Working Group concluded that capacity within primary care estate is a fundamental determinant of access to GP services in Oxfordshire. Evidence reviewed by the working group demonstrates that workforce growth, appointment delivery and service transformation are all constrained by the availability, suitability and timing of primary care infrastructure. Where estate provision fails to keep pace with population growth and changing models of care, access pressures emerge that cannot be resolved through short-term operational measures. For these reasons, the working group recommends that the Integrated Care Board treats primary care estates capacity as a critical system issue and

[63] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/tackling-health-inequalities

ensures that planning, delivery and expansion of infrastructure are proactively aligned with housing development and population change.

Local GP appointment and registered patient list data between January 2023 and December 2025 (Annex A) illustrates the scale of demand growth across Oxfordshire and its uneven geographical distribution. Practices serving areas of significant housing development, including in the Vale of White Horse area, have experienced rapid increases in registered list sizes over a relatively short period, often without corresponding increases in consulting space, clinical rooms or supporting facilities. While practices have continued to deliver high volumes of appointments, the Working Group noted that physical estate limitations place a limit on the number of clinicians who can be accommodated and the range of services that can be delivered. Appointment trends for 2025 (Annex B) show sustained activity across the year, reinforcing the conclusion that access challenges in growth areas are structural rather than seasonal.

The relationship between estates and workforce capacity was explored in depth through workforce data (Annex D) and evidence sessions held by the Working Group. The data shows that even where funding is available to recruit additional staff, practices operating from constrained premises are often unable to expand their workforce. National analysis confirms that inadequacies in GP premises are a significant barrier to recruitment and retention, particularly where buildings are outdated, inflexible or too small to support multidisciplinary teams[64]. The Working Group therefore concluded that estate capacity directly limits the effectiveness of workforce initiatives intended to improve access.

Evidence submitted by the BOB Local Medical Committee (Annex E) reinforced this assessment. The LMC highlighted that estate constraints contribute to workload intensity by restricting opportunities to redesign services, share workload across roles, or co-locate community services. Nationally, the Royal College of General Practitioners has also emphasised that unsuitable premises increase administrative inefficiency and contribute to unnecessary workload, reducing the time available for direct patient care[65]. The Working Group concluded that estate limitations therefore exacerbate both access problems and workforce sustainability challenges.

Patient experience evidence further underlines the importance of estates provision. GP Patient Survey results from January 2025 (Annex C) show variation in access and satisfaction that correlates with capacity pressures at practice level. Healthwatch Oxfordshire's engagement between April 2025 and March 2026 consistently highlights difficulty in securing timely appointments in fast-growing communities, alongside frustration where practices are perceived to be "over capacity". Healthwatch evidence mirrors national findings that access problems are

[64] Institute for Government – Delivering a general practice estate fit for purpose
[65] RCGP – Uncovering the drivers and costs of unnecessary GP workload

particularly acute where population growth outstrips infrastructure delivery[66]. The Working Group concluded that patients' experience of access is shaped not only by appointment systems, but by whether physical infrastructure has expanded in line with need.

The issue of delayed or misaligned estate delivery was a recurring theme in the working group's sessions with NHS partners and local authority representatives. Members heard evidence of cases where GP premises were delivered years after housing completion, leaving practices to absorb new residents without additional space or facilities. The written submission from Cherwell District Councillor David Rodgers provided a local illustration of this challenge, highlighting how gaps between housing delivery and health infrastructure place sustained pressure on existing practices and undermine public confidence in access to services. National policy analysis from the Institute for Government and elsewhere identifies this misalignment as a systemic issue arising from fragmented responsibilities between planning authorities, developers and healthcare commissioners[67].

National NHS policy increasingly recognises the need for proactive and integrated estate planning. NHS England guidance on neighbourhood health centres emphasises that primary care infrastructure must be planned as a long-term enabler of service delivery, integrated with workforce and service models, and aligned with local growth strategies[68]. Similarly, guidance produced through the Getting It Right First Time programme highlights the inefficiencies that arise where primary care infrastructure is delivered retrospectively, forcing general practice to compensate for wider system shortcomings[69].

Learning from other parts of the country reinforces the Working Group's conclusions. Integrated care systems such as North Central London and parts of Greater Manchester have demonstrated that early, structured engagement with planning authorities and developers enables primary care estates to be delivered alongside housing growth, rather than lagging behind it. These systems have shown that proactive estate planning supports workforce recruitment, service integration and more equitable access[70]. By contrast, areas where estate planning is reactive continue to report persistent access challenges despite high clinical effort.

The GP services update item considered by the Committee in September 2025 focused appropriately on service activity and improvement initiatives. However, the working group's subsequent scrutiny demonstrates that without treating estate capacity as a core determinant of access, such initiatives are constrained in their impact. Evidence from

[66] Healthwatch England – GP access
[67] Institute for Government
[68] NHS England – Neighbourhood health centre guidance
[69] GIRFT – Bridging the interface
[70] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice

Annexes A–E, combined with patient experience and national research, indicates that once access pressures have emerged due to inadequate infrastructure, they are difficult and costly to reverse.

Therefore, the Primary Care Access and Estates Working Group recommends that the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, ensures early and structured engagement with local planning authorities and developers, and secures the timely delivery of adequate, fit-for-purpose primary care facilities as communities expand. This proactive approach is essential to protecting access, supporting workforce sustainability and ensuring that the benefits of growth and development in Oxfordshire are matched by timely and equitable provision of primary care services.

Recommendation 5: *That the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, and ensures that the planning, delivery and expansion of primary care infrastructure in Oxfordshire is proactively aligned with population growth and housing development. It is recommended that there is early/structured engagement with local planning authorities and developers; and a timely delivery of adequate, fit-for-purpose primary care facilities as communities expand, rather than responding retrospectively once access pressures have already emerged.*

Legal Implications

126. 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.

127. 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’.

128. 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.

LIST OF ANNEXES:

- Annex A – GP Appointment data and registered patient list sizes per practice from January 2023-December 2025.

- Annex B - GP Appointment trends data month by month from January 2025-December 2025 (labelled Annex B).

- Annex C- GP Patient Survey data as of the most recent collection in January 2025.

- Annex D- GP workforce data.

- Annex E- Report submission to the working group from the Buckinghamshire, Oxfordshire, and Berkshire West Local Medical Committee on *Demand, Capacity & Activity in General Practice*.

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September 2026

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Month	GP Name	PCN Name	List Size - Jan 2023	List Size - Jan 2025	List Size- Growth	Appointments	Appointments Per 1,000 Patients
Dec-2025	THE HART SURGERY	HENLEY SONNET PCN	10,669	10,457	-1.99%	7,741	740.3
Dec-2025	DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,296	19,634	1.75%	8,563	436.1
Dec-2025	ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	6,482	7,032	8.49%	3,312	471.0
Dec-2025	DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,870	13,312	3.43%	6,800	510.8
Dec-2025	EYNSHAM MEDICAL GROUP	EYNSHAM & WITNEY PCN	15,468	16,314	5.47%	10,160	622.8
Dec-2025	TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,318	8,447	1.55%	4,563	540.2
Dec-2025	CHALGROVE & WATLINGTON SURGERIES	THAME PCN	7,404	8,052	8.75%	4,186	519.9
Dec-2025	HEDENA HEALTH	CITY - OX3+ PCN	29,273	26,904	-8.09%	8,367	311.0
Dec-2025	BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,087	9,076	-0.12%	4,094	451.1
Dec-2025	SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	18,782	19,305	2.78%	7,895	409.0

Dec-2025	ST BARTHOLOMEWS & HOLLOW WAY MED CENTRE	SPIRES PCN	21,473	29,231	36.13%	9,022	308.6
Dec-2025	MORLAND HOUSE SURGERY	THAME PCN	11,317	11,320	0.03%	4,323	381.9
Dec-2025	NETTLEBED SURGERY	HENLEY SONNET PCN	4,301	3,961	-7.91%	1,680	424.1
Dec-2025	BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	17,267	23,484	36.01%	9,502	404.6
Dec-2025	WINDRUSH MEDICAL PRACTICE	EYNSHAM & WITNEY PCN	20,057	21,385	6.62%	7,729	361.4
Dec-2025	NEWBURY STREET PRACTICE	WANTAGE PCN	15,741	15,967	1.44%	7,565	473.8
Dec-2025	SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,844	9,841	-0.03%	4,335	440.5
Dec-2025	BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	10,462	9,979	-4.62%	2,471	247.6
Dec-2025	BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	5,612	6,300	12.26%	4,469	709.4
Dec-2025	WINDRUSH SURGERY	BANBURY ALLIANCE PCN	8,816	9,072	2.90%	4,506	496.7

Dec-2025	OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,453	12,502	0.39%	4,099	327.9
Dec-2025	MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	17,296	15,104	-12.67%	7,608	503.7
Dec-2025	BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	41,600	42,002	0.97%	13,500	321.4
Dec-2025	CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,661	15,326	-2.14%	8,940	583.3
Dec-2025	THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	11,451	12,420	8.46%	7,033	566.3
Dec-2025	BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,597	9,926	3.43%	3,829	385.8
Dec-2025	CHURCH STREET PRACTICE	WANTAGE PCN	17,585	20,349	15.72%	10,459	514.0
Dec-2025	CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,429	3,388	-1.20%	1,656	488.8
Dec-2025	THE BELL SURGERY	HENLEY SONNET PCN	10,281	10,979	6.79%	5,198	473.4
Dec-2025	MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,484	5,961	8.70%	2,435	408.5
Dec-2025	WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	18,116	19,108	5.48%	8,714	456.0

Dec-2025	MONTGOMERY HOUSE SURGERY	BICESTER PCN	17,093	16,398	-4.07%	6,741	411.1
Dec-2025	MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	12,956	14,631	12.93%	6,724	459.6
Dec-2025	WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,346	9,661	3.37%	4,062	420.5
Dec-2025	WOODLANDS MEDICAL CENTRE	DIDCOT PCN	16,329	18,841	15.38%	10,460	555.2
Dec-2025	MANOR SURGERY	CITY - OX3+ PCN	19,459	26,616	36.78%	14,146	531.5
Dec-2025	GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,354	7,371	0.23%	3,873	525.4
Dec-2025	WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,181	6,239	0.94%	2,718	435.6
Dec-2025	BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,131	7,939	11.33%	4,936	621.7
Dec-2025	THE RYCOTE PRACTICE	THAME PCN	12,921	13,778	6.63%	6,924	502.5
Dec-2025	WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	17,499	19,373	10.71%	8,795	454.0
Dec-2025	BICESTER HEALTH CENTRE	BICESTER PCN	16,216	20,173	24.40%	8,070	400.0

Dec-2025	THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	17,589	19,963	13.50%	8,162	408.9
Dec-2025	DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	12,003	12,194	1.59%	4,116	337.5
Dec-2025	CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	4,702	5,218	10.97%	3,022	579.1
Dec-2025	BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	8,154	8,050	-1.28%	3,746	465.3
Dec-2025	HIGHTOWN SURGERY	BANBURY ALLIANCE PCN	12,062	12,396	2.77%	6,954	561.0
Dec-2025	ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	5,710	6,159	7.86%	2,990	485.5
Dec-2025	WOODLANDS SURGERY	BANBURY ALLIANCE PCN	8,320	9,963	19.75%	4,066	408.1
Dec-2025	COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	11,007	12,013	9.14%	3,309	275.5
Dec-2025	SIBFORD SURGERY	UNALLOCATED	3,041	3,255	7.04%	998	306.6
Dec-2025	LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	443	515	16.25%	892	1,732.0
Dec-2025	GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,528	10,481	-0.45%	6,142	586.0

Dec-2025	NUFFIELD HEALTH CENTRE	EYNSHAM & WITNEY PCN	12,133	11,721	-3.40%	6,618	564.6
Dec-2025	BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	11,771	12,331	4.76%	5,343	433.3
Dec-2025	JERICHO HEALTH CENTRE	OXFORD CENTRAL PCN	10,177	12,343	21.28%	2,303	186.6
Dec-2025	LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,628	9,282	-3.59%	4,618	497.5
Dec-2025	NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	6,018	13,563	125.37%	4,921	362.8
Dec-2025	THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	13,176	12,739	-3.32%	5,805	455.7
Dec-2025	KES@NORTHGATE	OXFORD CENTRAL PCN	6,381	6,714	5.22%	1,653	246.2
Dec-2025	THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,484	5,335	-2.72%	3,561	667.5
Dec-2025	ALCHESTER MEDICAL GROUP	BICESTER PCN	21,297	21,482	0.87%	5,890	274.2
Dec-2025	COGGES SURGERY	EYNSHAM & WITNEY PCN	7,914	8,561	8.18%	3,557	415.5
Dec-2025	OAK TREE HEALTH CENTRE	DIDCOT PCN	11,045	10,985	-0.54%	4,404	400.9

GP Name	PCN Name	List Size - Jan 2023	List Size - Jan 2025	List Size- Growth	31/01/25	28/02/25	31/03/25	30/04/25	31/05/25	30/06/25	31/07/25	31/08/25	30/09/25	31/10/25	30/11/25	31/12/25	Average Appointments Per 1,000 Patients
THE HART SURGERY	HENLEY SONNET PCN	10,669	10,457	-1.99%	8599	7356	8132	7473	7456	7725	7904	6774	8169	9548	7939	7,741	755.60
DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,296	19,634	1.75%	8099	7396	8292	7641	7511	7549	8161	6979	8195	11374	8886	8,563	418.69
ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	6,482	7,032	8.49%	3671	3583	3633	3597	3477	3664	3598	3204	4024	4544	3325	3,312	517.06
DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,870	13,312	3.43%	6945	5791	6068	5835	5575	5929	6619	5286	6421	8114	5830	6,800	470.83
EYNSHAM MEDICAL GROUP	EYNSHAM & WITNEY PCN	15,468	16,314	5.47%	12628	10723	11143	10665	9945	9964	10706	9337	10484	12889	9934	10,160	656.79

TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,318	8,447	1.55 %	4917	4969	5020	4535	4633	4725	5318	4394	5246	6074	4545	4,563	581.46
CHALGROVE & WATLINGTON SURGERIES	THAME PCN	7,404	8,052	8.75 %	3607	3213	3585	3046	3339	3694	3738	3019	3810	4912	3971	4,186	456.62
HEDENA HEALTH	CITY - OX3+ PCN	29,273	26,904	-8.09 %	11621	10869	12108	10594	10426	10785	8492	7516	8875	10073	8834	8,367	367.23
BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,087	9,076	-0.12 %	5047	4709	5011	4338	4471	4369	4710	3926	4669	5454	4361	4,094	506.45
SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	18,782	19,305	2.78 %	8821	8067	8465	8193	8143	8228	8779	6862	7913	10125	8395	7,895	431.17
ST BARTHOLOMEWS & HOLLOW	SPIRES PCN	21,473	29,231	36.13 %	9653	8948	9341	8968	8793	9014	9382	8340	10500	12509	9584	9,022	325.15

WAY MED CENTRE																	
MORLAND HOUSE SURGERY	THAME PCN	11,317	11,320	0.03%	5196	4390	4486	4750	4568	4814	4987	3931	4787	7057	4505	4,323	425.46
NETTLEBED SURGERY	HENLEY SONNET PCN	4,301	3,961	-7.91%	1785	1583	1697	1545	1537	1651	1840	1609	1746	1948	1716	1,680	427.86
BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	17,267	23,484	36.01%	12077	10762	11672	11030	11312	11446	11436	9218	10096	9966	9904	9,502	455.70
WINDRUSH MEDICAL PRACTICE	EYNSHAM & WITNEY PCN	20,057	21,385	6.62%	9224	7816	8506	7943	8226	8558	9024	7968	8712	8711	7979	7,729	391.22
NEWBURY STREET PRACTICE	WANTAGE PCN	15,741	15,967	1.44%	8314	7073	7773	7240	7179	7664	8057	6671	7260	8026	7173	7,565	469.69
SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,844	9,841	-0.03%	5067	4446	4504	4271	4312	4569	4919	3633	4254	5794	4043	4,335	458.52
BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY	10,462	9,979	-4.62%	3077	2790	2882	2762	2672	2733	2754	2321	2699	3306	2609	2,471	276.21

	NETWORK PCN																
BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	5,612	6,300	12.26%	4892	4312	4915	4335	4356	4737	4652	3988	4650	5023	4191	4,469	721.16
WINDRUSH SURGERY	BANBURY ALLIANCE PCN	8,816	9,072	2.90%	5537	4831	5339	5053	4971	4914	5510	4590	5461	6451	5432	4,506	574.98
OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,453	12,502	0.39%	4762	4328	4523	4306	4444	4264	4559	3774	4408	6158	4279	4,099	359.30
MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	17,296	15,104	-12.67%	8452	7621	8510	7387	6918	7943	8677	6453	7966	9810	8219	7,608	527.26
BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	41,600	42,002	0.97%	17853	14235	15129	14073	12354	14869	15458	12023	15295	15889	15931	13,500	350.40
CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,661	15,326	-2.14%	8360	7626	8494	7708	7602	7557	8341	6996	7150	11005	8800	8,940	536.01

THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	11,451	12,420	8.46%	8111	7259	7465	6808	6717	7203	7551	6278	7280	9056	7506	7,033	592.24
BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,597	9,926	3.43%	3601	3248	3258	2968	3110	3471	3727	3099	3751	4082	3922	3,829	353.16
CHURCH STREET PRACTICE	WANTAGE PCN	17,585	20,349	15.72%	11094	9632	10079	9523	9948	10103	11772	9232	10806	12427	10375	10,459	513.74
CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,429	3,388	-1.20%	1911	1540	1878	1712	1822	1910	1874	1561	1753	2253	1611	1,656	528.36
THE BELL SURGERY	HENLEY SONNET PCN	10,281	10,979	6.79%	5878	4776	5562	4904	4960	5027	5604	4625	5349	5746	5546	5,198	479.51
MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,484	5,961	8.70%	2789	2596	2900	3040	2528	2713	2919	2251	2854	4172	2814	2,435	475.47
WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	18,116	19,108	5.48%	9898	8931	9505	8176	8318	8936	9651	7952	9460	12919	9409	8,714	487.88

MONTGOMERY HOUSE SURGERY	BICESTER PCN	17,093	16,398	-4.07%	8893	8085	8266	7738	8236	8667	8911	7794	8824	9316	8019	6,741	505.60
MARCHAMRD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	12,956	14,631	12.93%	8119	7116	7161	6859	6750	7188	7252	6342	6803	7573	6583	6,724	481.11
WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,346	9,661	3.37%	4556	4080	4015	4734	4228	4489	4502	3362	4945	5620	4579	4,062	458.65
WOODLANDS MEDICAL CENTRE	DIDCOT PCN	16,329	18,841	15.38%	10886	9040	10262	8956	9375	9032	10712	8536	10478	13308	10714	10,460	538.54
MANOR SURGERY	CITY - OX3+ PCN	19,459	26,616	36.78%	15708	13770	15165	14782	13684	14553	15789	13412	15022	16614	14045	14,146	553.21
GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,354	7,371	0.23%	4236	3936	4070	3992	3653	3937	4073	3315	3901	6020	4193	3,873	556.22

WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,181	6,239	0.94%	3135	2871	3038	3237	2792	2845	2922	2603	2808	4199	2901	2,718	481.77
BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,131	7,939	11.33%	5577	4739	5115	4634	4582	5103	4881	4251	4960	6274	4916	4,936	629.47
THE RYCOTE PRACTICE	THAME PCN	12,921	13,778	6.63%	7405	6404	6828	6610	6607	6872	7207	6470	7326	9727	6980	6,924	516.28
WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	17,499	19,373	10.71%	10357	8942	9763	8414	7965	9158	9686	7741	9642	13395	10141	8,795	490.37
BICESTER HEALTH CENTRE	BICESTER PCN	16,216	20,173	24.40%	7658	7939	8470	8560	7694	8194	8579	6969	8046	10164	8892	8,070	409.93
THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	17,589	19,963	13.50%	8845	7536	8502	8459	7458	8364	8305	6942	8503	11786	8102	8,162	421.46
DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE	12,003	12,194	1.59%	4732	4257	4684	4511	4126	4482	4506	4100	4379	6740	3991	4,116	373.30

	(NORA) PCN																
CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	4,702	5,218	10.97 %	3048	2913	3165	2928	2839	3192	3409	2670	3061	4594	2967	3,022	603.81
BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	8,154	8,050	-1.28 %	3701	3275	3661	3403	3574	3590	3970	3558	3713	5412	3750	3,746	469.49
HIGHDOWN SURGERY	BANBURY ALLIANCE PCN	12,062	12,396	2.77 %	6895	6153	7079	6332	6481	6565	7147	5789	6934	8265	7090	6,954	549.13
ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	5,710	6,159	7.86 %	3371	3292	3244	3161	2926	3053	3359	2605	3149	3794	3097	2,990	514.71
WOODLANDS SURGERY	BANBURY ALLIANCE PCN	8,320	9,963	19.75 %	4558	4405	4535	4430	4117	4133	4733	3874	4495	5768	4239	4,066	446.26
COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	11,007	12,013	9.14 %	3602	3373	3736	3255	3213	3185	3402	2583	3310	4324	3438	3,309	282.54

SIBFORD SURGERY	UNALLOCATED	3,041	3,255	7.04%	1165	1035	1162	1033	975	1070	1075	912	997	1756	985	998	336.99
LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	443	515	16.25%	1173	1107	1077	922	904	1003	1120	898	1142	1238	1141	892	2,041.59
GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,528	10,481	-0.45%	6727	6003	6836	6426	5869	6094	6738	5550	6050	7541	7164	6,142	613.33
NUFFIELD HEALTH CENTRE	EYNSHAM & WITNEY PCN	12,133	11,721	-3.40%	7612	6670	6693	5962	5571	5722	6500	5449	6280	7619	6576	6,618	549.38
BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	11,771	12,331	4.76%	6776	6000	6231	5724	5410	5309	5471	4091	4952	7022	5753	5,343	460.10
JERICHO HEALTH CENTRE	OXFORD CENTRAL PCN	10,177	12,343	21.28%	2358	2254	2450	2077	2017	2396	2110	1768	2122	2941	2396	2,303	183.59
LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,628	9,282	-3.59%	5564	4348	4819	4374	4522	4825	4965	4032	5154	6172	4953	4,618	523.83
NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	6,018	13,563	125.37%	6467	5759	6043	5162	5590	5968	5751	4472	5143	7078	5678	4,921	418.00

THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	13,176	12,739	-3.32%	7150	6157	6574	6117	6154	6339	6726	5065	6176	8112	6114	5,805	500.36
KES@NORTHGATE	OXFORD CENTRAL PCN	6,381	6,714	5.22%	1967	1990	2045	1791	2019	2006	1844	1439	1847	2500	2239	1,653	289.69
THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,484	5,335	-2.72%	3647	3075	3557	3595	3172	3078	3636	2945	3207	4895	3262	3,561	650.27
ALCHESTER MEDICAL GROUP	BICESTER PCN	21,297	21,482	0.87%	6453	5864	6109	5352	5003	5421	5592	4714	5823	8475	6184	5,890	274.96
COGGES SURGERY	EYNSHAM & WITNEY PCN	7,914	8,561	8.18%	3682	3344	3747	3222	3478	3459	3646	3109	3703	4426	3867	3,557	420.90
OAK TREE HEALTH CENTRE	DIDCOT PCN	11,045	10,985	-0.54%	4937	4754	5205	4857	4438	4393	4613	4012	5068	6307	4526	4,404	436.31

GP Name	PCN Name	List Size - Jan 2025	GP Patient Survey - Overall Experience	% I phoned the practice	% Online, using the practice website	% Online, using the NHS App	% Online, using a different website or app	% Another way
THE HART SURGERY	HENLEY SONNET PCN	10,457	91%	29%	61%	5%	1%	*
DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,634	58%	66%	10%	4%	*	3%
ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,032	92%	84%	5%	1%	1%	3%
DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	13,312	73%	77%	3%	3%	*	5%
EYNSHAM MEDICAL GROUP	EYNSHAM & WITNEY PCN	16,314	82%	36%	35%	7%	1%	1%
TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,447	78%	66%	10%	7%	0%	3%
CHALGROVE & WATLINGTON SURGERIES	THAME PCN	8,052	92%	80%	1%	4%	1%	4%
HEDENA HEALTH	CITY - OX3+ PCN	26,904	77%	35%	37%	14%	1%	2%

BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,076	62%	74%	4%	0%	2%	0%
SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	19,305	74%	65%	12%	14%	2%	2%
ST BARTHOLOMEWS & HOLLOW WAY MED CENTRE	SPIRES PCN	29,231	68%	64%	14%	6%	5%	0%
MORLAND HOUSE SURGERY	THAME PCN	11,320	94%	73%	4%	10%	2%	0%
NETTLEBED SURGERY	HENLEY SONNET PCN	3,961	88%	68%	8%	5%	0%	0%
BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	23,484	80%	59%	16%	6%	2%	7%
WINDRUSH MEDICAL PRACTICE	EYNSHAM & WITNEY PCN	21,385	79%	37%	33%	15%	3%	3%
NEWBURY STREET PRACTICE	WANTAGE PCN	15,967	68%	38%	29%	24%	*	1%
SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,841	86%	67%	2%	14%	5%	4%
BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	9,979	84%	72%	6%	9%	2%	7%
BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	6,300	96%	71%	7%	11%	0%	3%

WINDRUSH SURGERY	BANBURY ALLIANCE PCN	9,072	57%	76%	11%	2%	4%	*
OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,502	77%	60%	10%	16%	0%	0%
MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	15,104	64%	54%	16%	9%	7%	1%
BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	42,002	62%	63%	16%	14%	1%	2%
CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,326	78%	70%	4%	4%	2%	1%
THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,420	66%	54%	20%	8%	0%	0%
BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,926	82%	75%	5%	7%	0%	5%
CHURCH STREET PRACTICE	WANTAGE PCN	20,349	77%	42%	35%	12%	2%	2%
CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,388	80%	71%	8%	9%	1%	1%
THE BELL SURGERY	HENLEY SONNET PCN	10,979	93%	82%	8%	2%	2%	2%
MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,961	94%	82%	3%	5%	0%	2%

WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	19,108	91%	77%	4%	11%	0%	3%
MONTGOMERY HOUSE SURGERY	BICESTER PCN	16,398	57%	47%	35%	2%	2%	2%
MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	14,631	78%	72%	17%	2%	2%	2%
WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,661	74%	63%	15%	6%	3%	0%
WOODLANDS MEDICAL CENTRE	DIDCOT PCN	18,841	62%	52%	28%	5%	1%	6%
MANOR SURGERY	CITY - OX3+ PCN	26,616	92%	51%	28%	9%	0%	*
GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,371	83%	47%	24%	8%	1%	2%
WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,239	97%	88%	1%	0%	1%	0%
BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,939	87%	85%	3%	2%	0%	1%
THE RYCOTE PRACTICE	THAME PCN	13,778	88%	67%	12%	7%	3%	1%
WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	19,373	70%	34%	37%	20%	3%	*

BICESTER HEALTH CENTRE	BICESTER PCN	20,173	88%	65%	13%	7%	8%	2%
THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	19,963	79%	64%	4%	10%	2%	2%
DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	12,194	77%	36%	37%	19%	0%	0%
CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	5,218	93%	83%	3%	5%	1%	0%
BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	8,050	86%	92%	0%	1%	1%	0%
HIGHTOWN SURGERY	BANBURY ALLIANCE PCN	12,396	80%	72%	11%	5%	1%	2%
ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	6,159	90%	67%	11%	4%	5%	5%
WOODLANDS SURGERY	BANBURY ALLIANCE PCN	9,963	81%	87%	3%	3%	0%	0%
COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	12,013	84%	74%	3%	*	0%	3%
SIBFORD SURGERY	UNALLOCATED	3,255	92%	86%	3%	1%	0%	3%
LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	515	95%	79%	0%	0%	0%	0%

GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,481	79%	29%	48%	6%	1%	1%
NUFFIELD HEALTH CENTRE	EYNSHAM & WITNEY PCN	11,721	79%	73%	4%	3%	0%	0%
BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	12,331	68%	81%	2%	0%	*	1%
JERICHO HEALTH CENTRE	OXFORD CENTRAL PCN	12,343	85%	82%	2%	3%	2%	4%
LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,282	78%	33%	53%	7%	3%	1%
NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	13,563	81%	76%	5%	8%	2%	2%
THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	12,739	74%	61%	6%	4%	3%	0%
KES@NORTHGATE	OXFORD CENTRAL PCN	6,714	89%	72%	5%	5%	3%	3%
THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,335	67%	77%	6%	3%	0%	0%
ALCHESTER MEDICAL GROUP	BICESTER PCN	21,482	71%	69%	16%	3%	1%	4%
COGGES SURGERY	EYNSHAM & WITNEY PCN	8,561	84%	78%	3%	8%	0%	1%
OAK TREE HEALTH CENTRE	DIDCOT PCN	10,985	66%	47%	43%	5%	2%	*

Month	GP Name	PCN Name	List Size - Jan 2025	Admin/Non-Clinical staff	Direct Patient Care staff	GP staff	Nurses	Admin/Non-Clinical staff per 1000 patients	Direct Patient Care staff per 1000 patients	GP per 1000 patients	Nurses per 1000 patients
Jul-2025	THE HART SURGERY	HENLEY SONNET PCN	10,457	12.85	6.21	6.88	2.17	1.23	0.59	0.66	0.21
Jul-2025	DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,634	18.41	4.53	10.62	3.37	0.94	0.23	0.54	0.17
Jul-2025	ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,032	10.14	5.32	6.41	1.71	1.44	0.76	0.91	0.24
Jul-2025	DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	13,312	13.84	1.53	7.13	4.07	1.04	0.12	0.54	0.31
Jul-2025	EYNSHAM MEDICAL GROUP	EYNSHAM & WITNEY PCN	16,314	22.13	19.17	14.39	2.95	1.36	1.18	0.88	0.18
Jul-2025	TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,447	10.13	2.00	3.40	2.85	1.20	0.24	0.40	0.34

Jul-2025	CHALGROVE & WATLINGTON SURGERIES	THAME PCN	8,052	8.64	4.15	5.12	2.00	1.07	0.51	0.64	0.25
Jul-2025	HEDENA HEALTH	CITY - OX3+ PCN	26,904	29.68	8.53	11.07	4.57	1.10	0.32	0.41	0.17
Jul-2025	BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,076	7.03	3.39	2.74	1.91	0.77	0.37	0.30	0.21
Jul-2025	SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	19,305	20.31	4.07	9.28	4.65	1.05	0.21	0.48	0.24
Jul-2025	ST BARTHOLOMEWS & HOLLOW WAY MED CENTRE	SPIRES PCN	29,231	31.44	10.05	13.74	2.57	1.08	0.34	0.47	0.09
Jul-2025	MORLAND HOUSE SURGERY	THAME PCN	11,320	7.74	1.49	7.07	0.57	0.68	0.13	0.62	0.05
Jul-2025	NETTLEBED SURGERY	HENLEY SONNET PCN	3,961	6.69	1.31	2.43	2.37	1.69	0.33	0.61	0.60
Jul-2025	BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	23,484	29.87	15.70	16.37	4.15	1.27	0.67	0.70	0.18
Jul-2025	WINDRUSH MEDICAL PRACTICE	EYNSHAM & WITNEY PCN	21,385	38.63	12.04	15.44	6.21	1.81	0.56	0.72	0.29
Jul-2025	NEWBURY STREET PRACTICE	WANTAGE PCN	15,967	17.16	4.33	7.12	3.56	1.07	0.27	0.45	0.22
Jul-2025	SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,841	13.58	0.35	12.77	2.19	1.38	0.04	1.30	0.22

Jul-2025	BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	9,979	8.48	1.25	2.61	1.00	0.85	0.13	0.26	0.10
Jul-2025	BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	6,300	4.79	0.80	8.40	1.17	0.76	0.13	1.33	0.19
Jul-2025	WINDRUSH SURGERY	BANBURY ALLIANCE PCN	9,072	8.19	1.33	6.43	2.44	0.90	0.15	0.71	0.27
Jul-2025	OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,502	13.01	3.89	7.41	1.87	1.04	0.31	0.59	0.15
Jul-2025	MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	15,104	19.44	8.05	6.87	4.29	1.29	0.53	0.45	0.28
Jul-2025	BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	42,002	59.54	22.05	19.85	18.82	1.42	0.52	0.47	0.45
Jul-2025	CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,326	24.41	7.61	7.71	4.01	1.59	0.50	0.50	0.26
Jul-2025	THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,420	13.69	1.36	6.08	2.39	1.10	0.11	0.49	0.19
Jul-2025	BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,926	12.51	2.72	8.02	1.00	1.26	0.27	0.81	0.10
Jul-2025	CHURCH STREET PRACTICE	WANTAGE PCN	20,349	18.81	7.84	11.40	6.93	0.92	0.39	0.56	0.34

Jul-2025	CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,388	6.99	0.69	2.21	0.77	2.06	0.20	0.65	0.23
Jul-2025	THE BELL SURGERY	HENLEY SONNET PCN	10,979	8.47	1.45	8.03	2.69	0.77	0.13	0.73	0.24
Jul-2025	MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,961	6.87	1.32	4.21	0.53	1.15	0.22	0.71	0.09
Jul-2025	WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	19,108	10.96	5.88	12.99	4.01	0.57	0.31	0.68	0.21
Jul-2025	MONTGOMERY HOUSE SURGERY	BICESTER PCN	16,398	21.73	6.57	8.91	4.53	1.32	0.40	0.54	0.28
Jul-2025	MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	14,631	0.00	0.00	13.12	2.79	0.00	0.00	0.90	0.19
Jul-2025	WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,661	12.99	2.95	4.41	1.91	1.34	0.31	0.46	0.20
Jul-2025	WOODLANDS MEDICAL CENTRE	DIDCOT PCN	18,841	18.11	4.78	11.00	2.95	0.96	0.25	0.58	0.16
Jul-2025	MANOR SURGERY	CITY - OX3+ PCN	26,616	34.96	13.13	21.31	7.01	1.31	0.49	0.80	0.26
Jul-2025	GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,371	10.81	1.43	4.64	1.43	1.47	0.19	0.63	0.19

Jul-2025	WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,239	6.16	9.35	6.93	1.35	0.99	1.50	1.11	0.22
Jul-2025	BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,939	8.07	3.67	3.27	2.41	1.02	0.46	0.41	0.30
Jul-2025	THE RYCOTE PRACTICE	THAME PCN	13,778	13.64	6.52	10.21	5.31	0.99	0.47	0.74	0.39
Jul-2025	WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	19,373	18.34	13.45	10.81	3.79	0.95	0.69	0.56	0.20
Jul-2025	BICESTER HEALTH CENTRE	BICESTER PCN	20,173	22.29	9.25	13.12	6.53	1.10	0.46	0.65	0.32
Jul-2025	THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	19,963	17.28	2.19	11.53	3.45	0.87	0.11	0.58	0.17
Jul-2025	DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	12,194	18.17	6.68	7.43	1.80	1.49	0.55	0.61	0.15
Jul-2025	CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	5,218	6.11	4.16	4.82	3.07	1.17	0.80	0.92	0.59
Jul-2025	BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL	8,050	13.59	1.71	5.01	2.78	1.69	0.21	0.62	0.35

		ALLIANCE (NORA) PCN									
Jul-2025	HIGHTOWN SURGERY	BANBURY ALLIANCE PCN	12,396	20.25	5.12	6.91	4.07	1.63	0.41	0.56	0.33
Jul-2025	ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	6,159	6.97	5.43	4.37	0.79	1.13	0.88	0.71	0.13
Jul-2025	WOODLANDS SURGERY	BANBURY ALLIANCE PCN	9,963	11.44	1.20	4.48	0.93	1.15	0.12	0.45	0.09
Jul-2025	COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	12,013	11.73	0.64	6.16	1.88	0.98	0.05	0.51	0.16
Jul-2025	SIBFORD SURGERY	UNALLOCATED	3,255	4.00	0.29	0.99	0.40	1.23	0.09	0.30	0.12
Jul-2025	LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	515	3.80	0.00	2.89	3.41	7.38	0.00	5.61	6.63
Jul-2025	GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,481	14.69	0.27	7.64	2.20	1.40	0.03	0.73	0.21
Jul-2025	NUFFIELD HEALTH CENTRE	EYNSHAM & WITNEY PCN	11,721	20.40	2.43	10.32	3.00	1.74	0.21	0.88	0.26
Jul-2025	BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	12,331	11.69	3.36	6.02	5.57	0.95	0.27	0.49	0.45
Jul-2025	JERICHO HEALTH CENTRE	OXFORD CENTRAL PCN	12,343	3.85	0.40	4.87	1.20	0.31	0.03	0.39	0.10
Jul-2025	LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,282	8.40	1.13	4.17	2.37	0.90	0.12	0.45	0.26

Jul-2025	NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	13,563	15.20	5.48	6.44	2.35	1.12	0.40	0.47	0.17
Jul-2025	THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	12,739	15.05	4.68	7.71	2.05	1.18	0.37	0.60	0.16
Jul-2025	KES@NORTHGATE	OXFORD CENTRAL PCN	6,714	4.79	1.27	2.69	1.10	0.71	0.19	0.40	0.16
Jul-2025	THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,335	7.36	4.63	3.35	1.24	1.38	0.87	0.63	0.23
Jul-2025	ALCHESTER MEDICAL GROUP	BICESTER PCN	21,482	20.07	9.48	9.65	3.77	0.93	0.44	0.45	0.18
Jul-2025	COGGES SURGERY	EYNSHAM & WITNEY PCN	8,561	8.95	3.24	5.89	1.33	1.05	0.38	0.69	0.16
Jul-2025	OAK TREE HEALTH CENTRE	DIDCOT PCN	10,985	10.97	2.00	3.84	4.07	1.00	0.18	0.35	0.37

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Berkshire, Buckinghamshire & Oxfordshire LMCs

Chief Executives Dr Matt Mayer & Dr Richard Wood
Chair of Board Dr Simon Ruffle

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16 Feb 2026

Report for HOSC: Demand, Capacity & Activity in General Practice in BBO. The BBOLMC SitRep

Methodology

The BBOLMC collects data from participating practices across several different measures, including:

- The **number of medical record entries** made by the practice each week within EMIS (the medical records system) and which type of staff member made those entries.
- The **number of in-coming telephone calls** each week. Practices are asked to also include into this total count the number of e-consults (online form submissions) and other contact points (such as walk-ins).
- The **number of GPs** they have in the practice each week.
- How much protected (ring-fenced) **admin time** a GP is given per week, outside of direct patient care.

This local data is used for two purposes:

1. To provide a Situation Report ("SitRep") on measures of demand, capacity, and activity in General Practice
2. To generate an *Operational Pressures Escalation Level* ("OPEL") score for each practice. OPEL scores are mathematically derived, based on the data submitted by the organisation. They have been used by hospital trusts for many years as a method of declaring operating pressures. The BBOLMC OPEL system was the first of its kind for General Practice. Below, we provide an OPEL score in two domains: demand-vs-capacity, and admin workload.

A methodology paper is available on request which gives greater detail about data collection, derived conclusions, and the many assumptions that potentially confound the data below.

Participation

Participating is voluntary for practices. It is a manual process which takes approximately 5-10 minutes of practice time each week. Uptake is limited. Out of approximately 200 practices in Berkshire, Buckinghamshire and Oxfordshire (BBO), Approximately 20-30 submit data on a weekly basis, which covers a (non-contiguous) population footprint of c.325,000 patients. Approximately 15 of the submitting practices are from Oxfordshire, which covers a footprint of c.195,000 patients.

We do not audit practice submissions for data quality. Practice contributions are not necessarily consistently done on a weekly basis. There was also a significant increase in the number of participating practices from April 2023 (prior to that, it was only c.13 practices across BBO). Thus, interpretation of the data should be done with caution.

BBOLMC is the data controller. Practices participate under a confidentiality agreement which specifies that BBOLMC will never release granular practice-level data without the practice's express prior consent.

Results

Demand

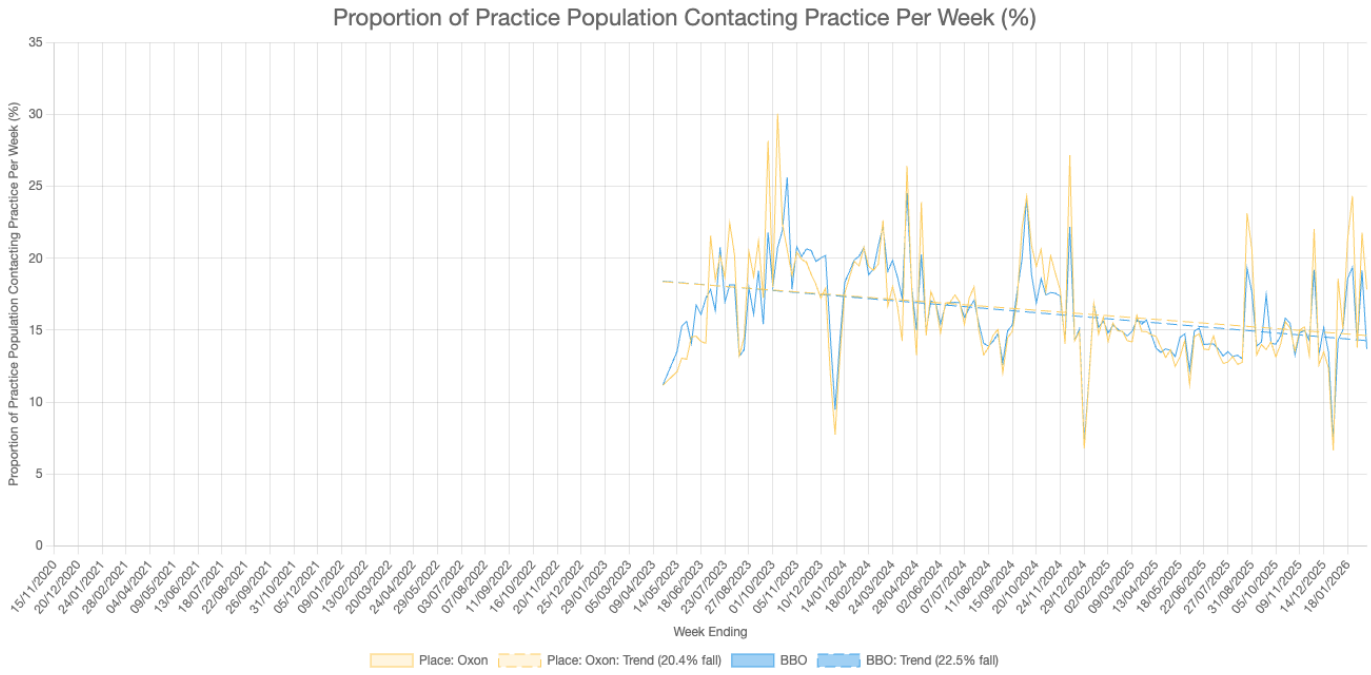


Chart 1: The proportion of Practice Population Contacting Practice Per Week (%). The blue line is all BBO; and the yellow line is for Oxfordshire practices specifically.

Data collection for incoming demand started in April 2023.

Chart 1 shows the proportion of Practice Population Contacting Practice Per Week (%). This summates gross income telephone call numbers + e-consults + walk-ins + any other contact points the practice is able to capture and report to us, per week. This total figure is divided into the practice population size to give us an estimate of the total % of the population calling weekly. As telephone lines are open 5 days per week, dividing the weekly figure by 5 will give an average daily demand figure.

The weekly average is c.15%. This means the equivalent of **1 in 7 of every person in the population contacts their practice each week**. The estimated daily average is 3% of the population. Of course, some patients will contact their practice many times, and some not at all (the figures are an average across the population).

Of note, the number of contacts into the practice has fallen steadily from April 2023 until now – a 20% decline for Oxfordshire. Reasons for this decline are not clear but may include:

- Patient health may theoretically be improving (we have no data to support this)
- Patients are giving up (chimes with anecdotal experience)
- It may be artefactual: From October 2024, GP contract changes triggered a shift away from telephone calls into the practice and towards online submissions to practices, and this *may* not be captured by the data submitted by practices which had priorly put a lot of emphasis on counting telephone contacts.

Capacity

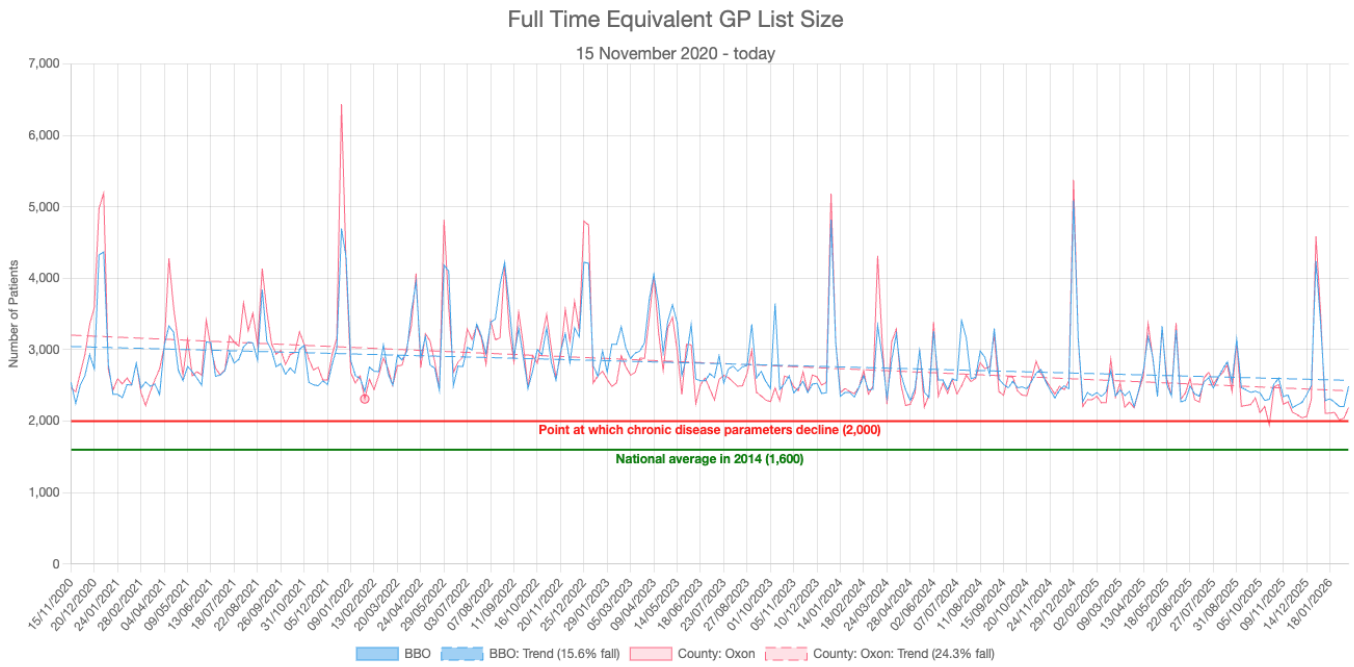


Chart 2: Full time equivalent GP list size over time in BBO (blue) and Oxon (pink).

Chart 2 shows Full time equivalent patient list size with two benchmarks:

1. comparison with national averages from 2014 [using national data sources] – the green horizontal line; and
2. the point at which international published research from developed healthcare systems shows that chronic disease parameters are known to decline (a full-time-equivalents GP list size of 2000[i]) – the red horizontal line.

The local FTE list size is calculated by taking the number of GP sessions available in the practice per week, and dividing that into the practice population (to give GP list size per session) and then multiplying that by 9 to arrive at a FTE (a full time GP is 9 sessions). "GP sessions" includes principals, salarieds, locums, and trainees (but not medical students). It also includes admin and business sessions - viz., all GP sessions contracted by the practice per week. It is a dynamic measure of GP “bums on seats” on a weekly basis. This data is not publicly available elsewhere at local and national level.

Across all data going back to November 2020, the FTE GP list size for BBO is c. **2,877**. For Oxfordshire specifically it is **2,724**. These figures are significantly above ‘safe’ levels associated with optimal management of chronic disease (the red line). (NB: this internationally specified ‘safe level’ of a list size of 2000 pts per full time GP was published prior to the diversification of the General Practice workforce as part of the PCN DES additional roles scheme).

The FTE GP list size has decreased steadily, indicating more GPs for the population. The reason for this may be:

- Changes in the GP contract in April 2024 which allowed specific ring-fenced PCN workforce funds to be allowed to employ newly qualified GPs.
- Artefactual: there was a significant increase in the number of participating practices from April 2023.

Activity

[i] Cited in Van Den Homberg & Campbell (2013). *Is ‘practice size’ the key to quality of care?* British Journal of General Practice, September 2013; 459-460

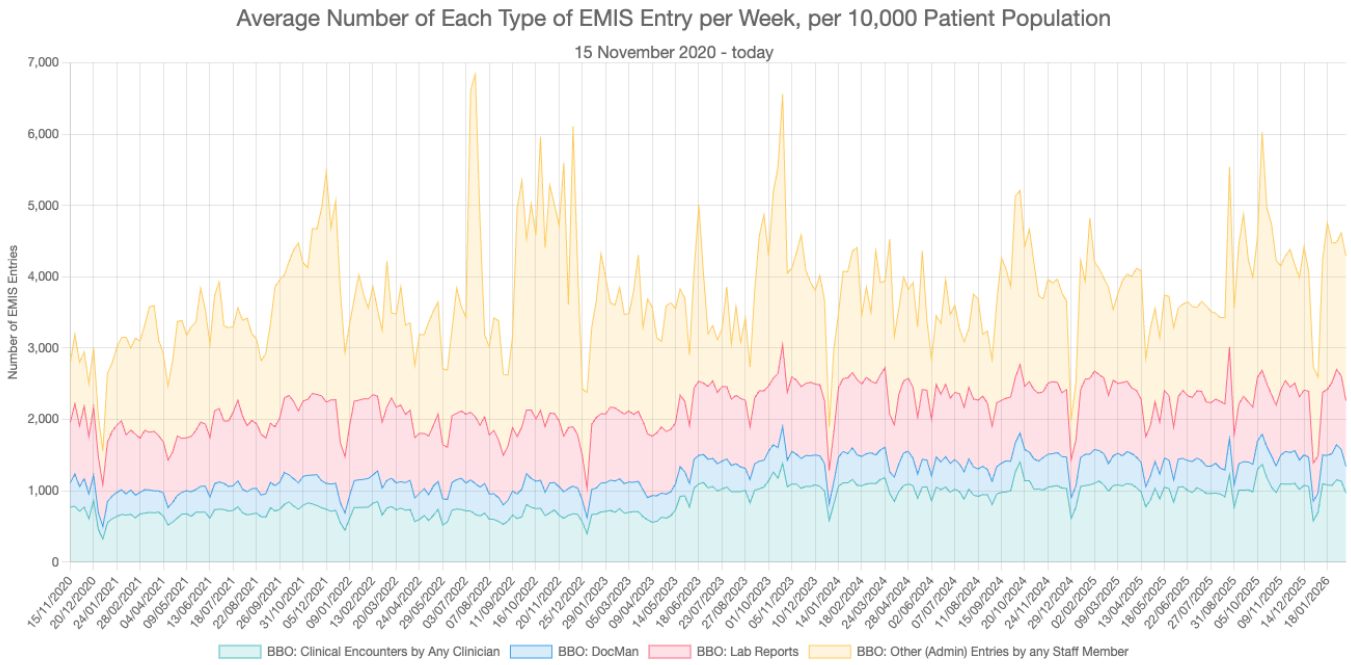


Chart 3: the average number of medical record entries made by a typical practice each week. Green is clinical entries (contacts with a patient). The remainder are admin-related.

Chart 3 shows the average number of medical record entries made by a typical practice each week. The types of medical records entries are subdivided into:

- **clinical encounters** (green: records of a consultation with a patient)
- **docman** (letters read by a practice member of staff and filled into the notes, such as hospital clinic letters)
- **lab reports** (red; results of tests received from the lab, read by the clinician, and filed into the notes)
- **All other** EMIS entries being created weekly within the practice

Data is shown using a denominator of a practice population of 10,000.

The medical record entry counts do NOT include medical record entries that are "externally generated" (such as OOH entries into EMIS, or Covid vaccination programme entries), or SMS/email messages between practice and patient. So, it only counts medical record entries generated manually, internally within the practice.

The data shows that only 25% or less of medical record entries are from consultations with patients. The remaining **75% of all medical record entries are admin-related**.

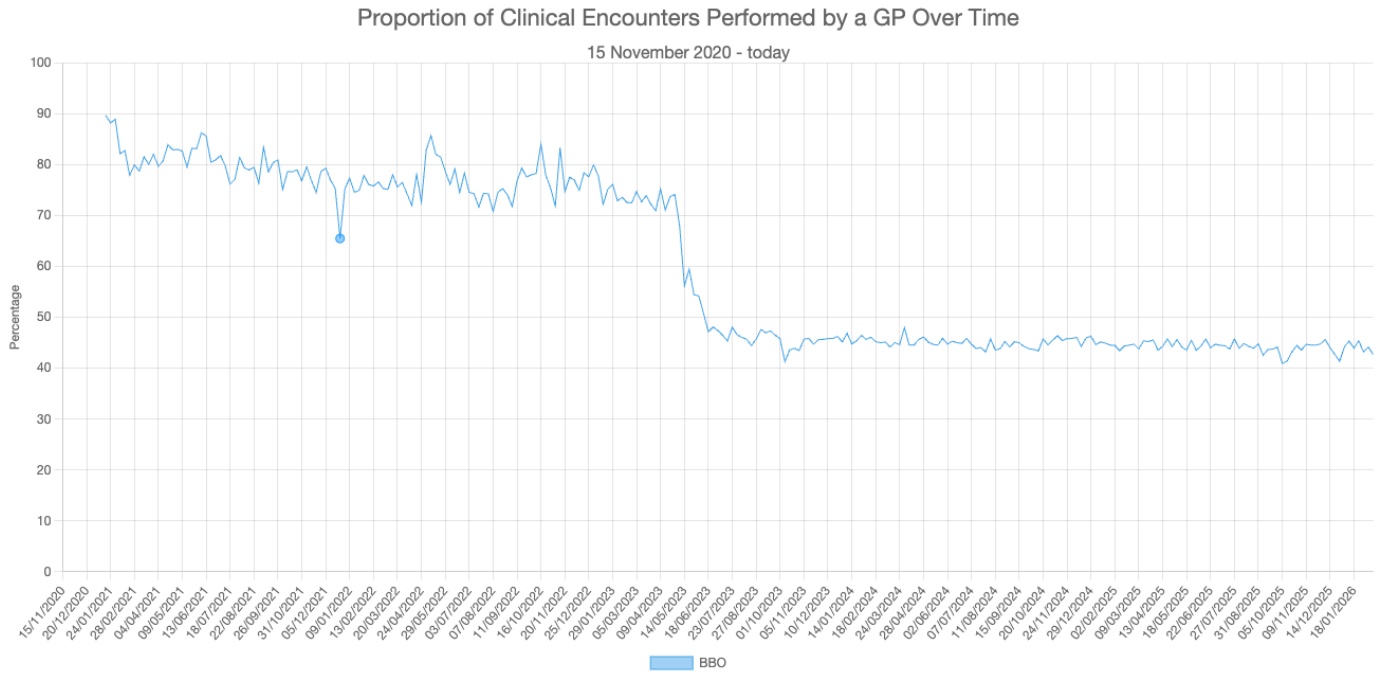


Chart 4: The proportion of clinical encounters that are conducted by a GP, as opposed to another patient-facing allied health professional.

Chart 4 shows the proportion of clinical encounters that are conducted by a GP, as opposed to another patient-facing allied health professional. Which AHPs are included depends on the practice's 'clinical user group' settings specified in EMIS but, as a general rule, it includes Nurses (any type), advanced nurse practitioners, paramedics, pharmacists, health visitors, physiotherapists, phlebotomists, physician assistants, and Midwives, but not healthcare assistants.

55% of all clinical consultations in the practice are now delivered by a non-GP.

The steep drop in April 2023 corresponds to the point at which the pilot phase ceased, and data collection was rolled out across all BBO so may be artefactual. However, the imposed GMS contract for the year 2023-24 showed continued significant real-time cuts to general practice and this drop may therefore have reflected practices cutting back their finances by employing AHPs (funded by the PCD DES additional roles reimbursement scheme) rather than GPs (funded from practice income).

Demand-Capacity Matching

In 2021 Oxfordshire Healthwatch performed a survey[ii] of patients contacting their practice in the previous month and asked them the reason for their contacting their practice. From this data we extrapolated that approximately 56% of all patient contacts to a practice ideally required a consultation with a GP *specifically* (rather than an allied health professional, or administrative staff).

If we apply this % figure to the total amount of contacts per week for a given practice, we can estimate how many GP appointments each participating practice needs per week. For example, if a practice receives 1000 contacts from a practice per week, 560 will ideally need a GP appointment.

Participating practices tell us how many GP 'bums on seats' they have per week (reported as how many 'GP sessions – or clinics - available per week. A clinic is assumed to be half a day). We can use this figure to answer the following question: *with the number of GPs a practice has available per week, how many patients would each GP need to see per clinic to meet the incoming demand*? For example, using the above worked example,

[ii] https://healthwatchoxfordshire.co.uk/wp-content/uploads/2022/05/20220504_GP-report_final.pdf

if there were 560 patient requests for a GP in a week, and 10 GP sessions/clinics available that week in the practice, each GP would need to see 56 patients per clinic to meet that demand.

We can then apply "BMA safe-working limits" to this activity. The BMA, in collaboration with the European GP Committee of the EU, has published safe working limits for the number of patient contacts a GP can safely manage in one day[iii]. The further a GP goes above this limit, the more unsafe their working. The limits are as follows:

- **Safe**: 12 patient contacts per session (25 per day). For the purpose of assigning an OPEL level to the practice, we classify this as working at **OPEL 1**.
- **Pressured Working**: 13-17 patient contacts per session (26-34 per day). We classify this as working at **OPEL 2**.
- **Unsafe working**: 18 – 21 patient contacts per session (36 – 42 contacts per day). We classify this as working at **OPEL 3**.
- **Off the scale**: >21 contacts per session (>42 contact per day). We classify this as working at **OPEL 4**.

Chart 5, below, displays the data in graph form for Oxfordshire specifically. The Y-axis is the number of contacts per GP session. The **blue line** is the number of contacts per session each GP in the practice is *actually* delivering per session. The **red line** is the number of contacts each GP would *need* to deliver per session if the practice were to meet all the demand for a GP coming in that week. The coloured background bands are the BMA safe working bands (OPEL 1 – OPEL 4):

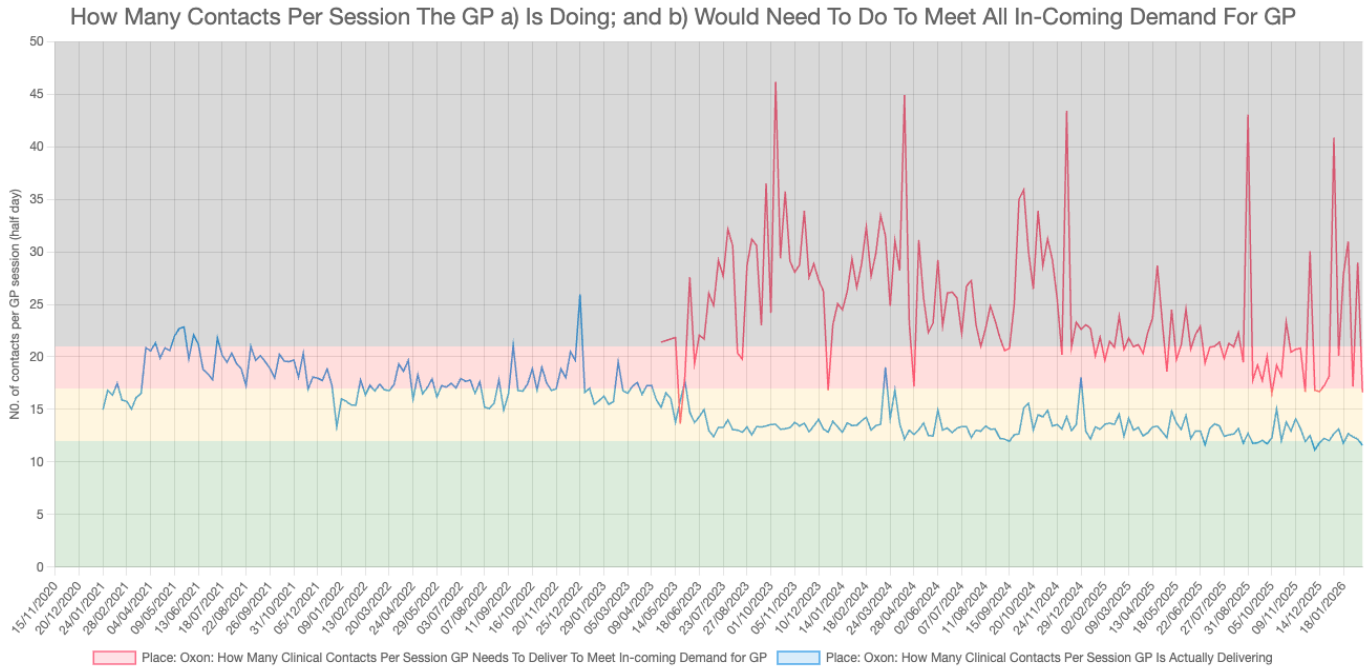


Chart 5: How many contacts a GP delivers per session (blue line), and how many contacts they would need to deliver to meet all the estimated demand for a GP (red line).

The **blue line** on this chart shows that in 2020-2021, GPs in Oxon were seeing approximately 18-20 patients per clinic (that is, 36-40 patients per day). This put them at 'unsafe levels' of working. Over the time, the number of contacts has reduced towards safer levels. This reduction likely reflects a combination of:

- Successful BMA-coordinated 'collective action' which empowered GPs to limit their contacts to what is safe.

[iii] https://www.bma.org.uk/media/1145/workload-control-general-practice-mar2018-1.pdf and https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-working-in-general-practice

- An increasing number of "simple" presentations being consulted by allied health professionals (chart 4) means that only the more complex presentations are left for GPs to see. This necessarily takes more time, necessitating a drop in the total number a GP can see per session.

The **red line** in the chart is the number of contacts per session each GP would need to see if it were to meet all the demand for a GP coming into the practice. This would put GP working predominantly into OPEL 4 – unacceptable working conditions for GPs and their patients.

The difference between the blue line and the red line is the mismatch between demand for GPs and GP capacity. In reality, this mismatch is managed by directing patients to allied health professionals, or other services in an attempt to meet their needs as best as can be done.

It is of note that the drive to have more patients seen by allied health professionals rather than their GP is a central tenet of both the *PCN DES* and the *NHS 10 Year Plan*. It is an attempt to increase the availability of a diversified – and often cheaper – workforce. It does, however, pose an existential challenge to the *raison d'etre* of a GP. Many GPs in practices went into the profession wishing to 'follow the patient and not the disease' – viz., to provide continuity of care for the patient, which means seeing the 'simple' things as well as the complex. The current direction of travel in our workforce, however, is to restrict what the GP sees to only the most complex. This reduces continuity of care and is likely to have adverse outcomes for patients in the long run. It also has the potential to reduce GP morale and work satisfaction.

Admin Burden

How little admin time is too little? The BMA safe working publications previously estimated that one GP clinical session of three hours was associated with one hour of required admin time. If we assume a BMA session to be 12 patient contacts, then then this equates to 5 minutes of admin time required per patient seen.

Because we know from our data collection the number of patient contacts a GP has per session on average, we can work out how much admin time they need: *5 mins x number of patients seen*. Practices tell us how much protected admin time each GP has per week on average. We can therefore compare how much GPs get on average with how much they need. The greater the disparity between the two, the greater the admin burden. To quantify this, we revert to the same BMA thresholds as above (chart 5) and create *admin OPEL levels* for each practice:

OPEL 1: Receiving BMA "safe" amount of time (5 mins per clinical encounter)

OPEL 2: Receiving up to 60% of BMA "safe" amount of time (3 mins per clinical encounter)

OPEL 3: Receiving up to 20% BMA "safe" amount of time (1 min per clinical encounter)

OPEL 4: Receiving less than 20% of BMA "safe" amount of time (<1 min per clinical encounter)

Chart 6 below reports the proportion of practices at each admin OPEL level in Oxfordshire.

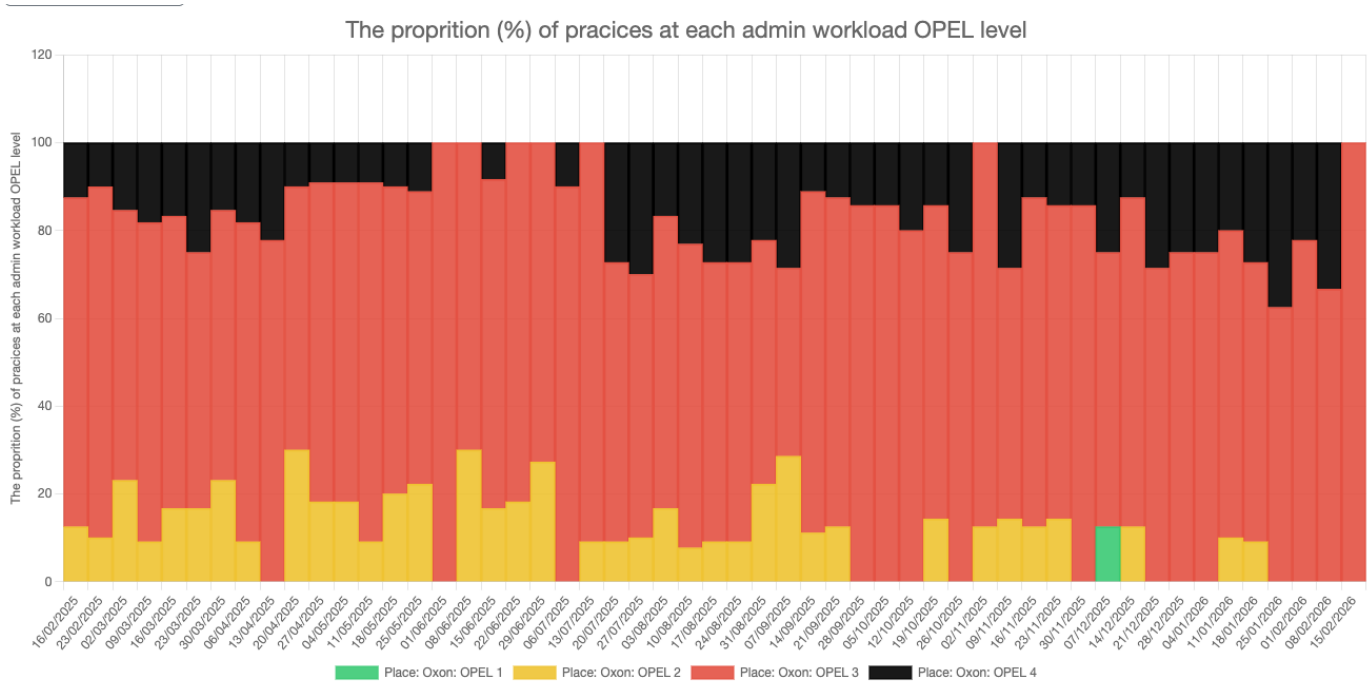


Chart 6: Admin burden: The proportion of practices at each admin OPEL.

Chart 6 shows that the majority of practices (>80%) can only ring-fence 20% or less of the admin time required for GPs (**OPEL 3**). Safe levels of adequate admin time (**OPEL 1**) are a rare event.

Conclusions

- The equivalent of 1 in 7 of every person in the population contacts their practice each week.
- the FTE GP list size for BBO is c.2,877. For Oxfordshire specifically it is 2,724. These figures are significantly above 'safe' levels associated with optimal management of chronic disease
- 75% of all medical record entries are admin-related.
- 55% of all clinical consultations in the practice are now delivered by a non-GP.
- Most practices are now delivering safe levels of patient contacts per session (12 contacts per clinic). Where they to meet all the demand for a GP coming into the practice, they would need to operate at dangerous levels of activity.
- Most practices (c.85%) receive only 20% or less of the admin time they need.

-END-

Thames Valley

Urgent and Emergency Care update for HOSC

Oxfordshire

August 2026

1. Oxfordshire Context

This document describes the work carried out over the previous year, including answers to the questions from HOSC committee members.

Urgent and emergency care (UEC) services are fundamental to ensuring people receive timely, safe and clinically appropriate care when they need it. National priorities, including the NHS 10 Year Health Plan, Medium-Term Planning and Financial Framework and national UEC planning requirements, reinforce the shift towards prevention, neighbourhood and community-based care, while protecting emergency services for those with the greatest clinical need.

The most significant area of focus and transformation will be the continued shift towards integrated community-based care. This brings primary care, acute providers, community services, mental health services, voluntary sector partners and councils together with shared outcomes and responsibility for improving health.

An aspect of this relates to how we meet the urgent care needs of adults with complex needs, children and young people. We continue to work together to increase the number of people who can be appropriately assessed and treated in their own home, reduce avoidable ambulance conveyances and avoidable hospital attendances, strengthening alternatives to admission and accelerating discharge.

As an Oxfordshire system we have a good history of working collaboratively and have developed working relationships that have resulted in positive changes across the Oxfordshire health and social care system. We will continue to develop UEC services to meet the increasing demand for health and care. Without this collaborative way of working, the growth in demand will continue to outpace available resources, leading to increased pressure for all providers.

2. Current State and progress against improvement programme

Our ambitions over the last few years are as follows.

- Prevent avoidable deterioration, ambulance conveyance, emergency department attendance and hospital admission;
- Provides timely assessment and treatment closer to home wherever clinically appropriate;
- Make urgent care easier to access and navigate;
- Protects emergency services for those who need them;
- Supports safe and timely discharge from hospital; and

- Reduce unwarranted variation and health inequalities while improving productivity and value.

Current pressures are across all providers; primary care, community services, hospitals and ambulance services and have increased each year. There is no one pathway that is experiencing a greater operational challenge in relation to demand and workforce.

In the community, services are challenged with people who are more complex, adults with frailty/long term conditions and children and young people with complex needs. The fact we are working hard to keep people in their own homes and to discharge patients home quicker adds to the demand and means we require a highly trained workforce to manage the complexity we are now treating outside of acute hospitals. Workforce within District nursing remains under significant pressure due to a variety of reasons, workforce capacity and existing funding does not meet all on the day demand. Oxford Health NHS Foundation Trust (OHFT) has recruited above establishment to meet same day demand. The trust continues to work with Thames Valley Integrated Care Board (TVICB) to see how this can be resolved.

Within the hospital setting, the Emergency Department (ED) at the John Radcliffe Hospital and Horton General Hospital has seen greater attendances in June and July this year, for both adults and children.

All services balance safety and quality with the increase in demand. This varies from the daily management of resources to continuously reviewing and developing pathways to meet the needs of Oxfordshire residents. We measure outcomes through our monthly situation report slide deck which covers all the pathways within UEC. An extract of this slide deck is in appendix 2 of this paper. In addition, we present a heatmap and productivity slide deck every quarter. All of these are reviewed at the Oxfordshire UEC Board.

2.1 John Radcliffe Hospital Emergency Department

- April to July, activity is up by **2.0%** compared to the same period last year, but this masks very different levels of activity in April and May vs June and July compared to the previous year.
    - Attendances in April and May 2026 were lower than the same periods in 2025/26 (-3.3% in April and -1.2% in May), and since then growth has been much higher month-on-month in **June** and **July** (+7.4% and +5.5% vs than the same months last year).
    - Growth for adults was +1.7% and for children it was +3.2%.
    - Growth is higher from non-ambulance arrival methods (walk ins + other categories): +5.9% (adults) and + 3.7% (children), with the increases observed also much higher in June and July vs April and May.

- Attendances via ambulance for April to July 2026 are lower compared to 2025.

2.2 Horton General Hospital Emergency Department

- April to July, activity is up by **6.2%** compared to the same period last year. Growth has been much higher each month but particularly in **April** and **May** (+8.0% and +8.3%, respectively). Growth in June and July vs the same period last year remained high but at a lower level (+4.8% in June and +3.8% in July).
    - Growth by adults (+4.2%) and children (+15.1%) in the period April – July 2026. Paediatric growth has been very high in April, May and July compared to 2025/26.
    - Growth is higher from non-ambulance arrival methods (walk ins + other categories): +6.6% (adults) and +16.7% (children).
    - Attendances via ambulance for April to July are lower compared to 2025.

Acuity increased during the months of June and July, this is mainly thought to be directly related to the heatwave. This has been challenging for all services, who have also had to deal with high sickness levels.

Length of stay for those 12hrs and over in both emergency departments increased up to December and reduced from January to April 2026 with a slight reduction from May to July 2026. However, conversion rate to admission continues to reduce gradually from 19% to 17%.

We had aimed to reduce the number of medical patients in speciality beds (i.e., non-medical beds) to improve the flow of people through the elective pathways. Although we were aiming for a greater reduction, from July 2025 to July 2026 there has been an 11% reduction. There was a 23% reduction in the length of stay for medical patients in speciality beds which is a significant improvement.

2.3 Community Services

2.3.1 Single Point of Access (SPA _Partial BCF funding)

Between April and July 2026, SPA managed rising telephone demand while maintaining improved responsiveness. Calls offered increased from 2,031 in April to 2,829 in July, and calls answered rose from 1,648 to 2,572 over the same period.

- Calls offered increased by approximately 39% over the four-month period.
- Call answering improved despite higher demand, with July recording the highest number of calls answered.
- Abandoned calls reduced from 383 in April and 385 in May to 183 in June, before rising to 257 in July; this remained below April and May levels despite increased call volumes.
- Average call-answer times remained close to the 30-second target: 30 seconds in April, 34 seconds in May, 38 seconds in June and 31 seconds in July.

Overall, the data indicates increased use of SPA alongside improved operational resilience and access for patients, carers and healthcare professionals.

2.3.2 Minor Injury Units (MIU)

Minor Injury Units activity increased by 3% between May and July 2026 compared with the same period last year. A high proportion of patients attending Henley MIU are from outside Oxfordshire, predominantly from Reading and the surrounding areas. This is partly because local MIUs in those areas operate by appointment only, whereas Oxfordshire MIUs offer a walk-in service, with some patients redirected via NHS 111. The service managed to maintain performance against the 4-hour wait target at 95% or over since April 2026.

2.3.3 General Practice Out of Hours Service (OOHs)

General Practice (GP) Out of Hours activity increased significantly in July 2026, with around 1,500 more cases than in the same month last year, exceeding forecast levels. Activity in April and May was broadly in line with the previous year, but June saw 833 additional cases, representing a 10% increase. This increased demand led to more ‘comfort calls’ to advise patients when the service was nearing closure and to redirect them to in-hours GP practices where appropriate. In many cases, patients no longer required GP contact because their symptoms had resolved; however, others still needed to speak with a GP or clinician to receive advice or be signposted to the most appropriate service.

Recruitment of Emergency Practitioners and Advanced Clinical Practitioners is having a positive impact by strengthening the non-medical workforce supporting the GP Out of Hours service. However, recruitment of both substantive GPs and in-house bank GPs remains challenging. Operationally, the service has continued to rely on agency GPs, and this has been further affected by changes to pay arrangements and the use of staff working through limited companies.

2.3.4 Urgent Community Response (UCR)

Urgent Community Response (UCR) activity increased overall between April and July 2026. Two-hour response referrals rose from 1,377 in April to 1,451 in May and 1,608 in June, before reducing to 1,473 in July. UCR continued to account for more than half of all same-day care referrals throughout the period: 56% in April, 54% in May, 56% in June and 54% in July.

Self-referrals and referrals from carers remained the most common referral route, with 495 referrals in April and 470 in May. From June, this was reported as a combined category, with 548 referrals in June and 498 in July. SCAS crew-with-patient referrals were the next most common source, with 201 in April, 188 in May, 188 in June and 172 in July.

Across all same-day care referrals, District Nursing remained the most common preferred pathway, with 725 referrals in April, 706 in May, 794 in June and 744 in July. The UCR two-hour visiting response pathway also increased overall, from 589 referrals in April to 674 in May and 763 in June, before reducing to 690 in July.

UCR performance against the two-hour visiting response standard remained consistently above 95%, with performance of 98.48% in April, 97.29% in May, 98.46% in June and 99.16% in July 2026.

2.3.5 Support to South Central Ambulance Service (SCAS) - taking referrals from 999 service (from the stack) – BCF funded.

Urgent Community Response (UCR) currently supports South Central Ambulance Service seven days a week, 8am–12pm, by identifying suitable people (Category 3 and 4 cases) who have called 999 and are on the 'stack' awaiting assessment in the community. This service will be extended from 4 hours to 12 hours per day, Monday to Friday, from 1st October 2026.

Between April and July 2026, the stack service managed 1,099 patients. Activity peaked in May and June, at 308 and 301 patients, before reducing to 266 in July; this remained above April activity of 224 patients.

- Average daily activity remained broadly consistent, ranging from 7.46 patients in April to 10.03 in June and 8.58 in July.
- In July, 151 patients were taken off the stack, compared with 156 in June and 164 in May.
- People more appropriate for an ambulance crew are handed back to SCAS reduced to 115 in July, compared with 145 in June and 144 in May, although this remained above April's 94.
- Signposting or onward referral reduced to 17 patients in July, compared with 18 in June and 25 in May, but remained above April's 6.

UCR visits for people who have called 999 remained consistent in July, with 75 visits compared with 73 in June, 92 in May and 74 in April, showing sustained need for rapid community assessment despite lower overall stack volume.

Overall, July shows a moderated but active stack position, with sustained clinical intervention, continued patient flow and fewer hand backs than in May and June 2026.

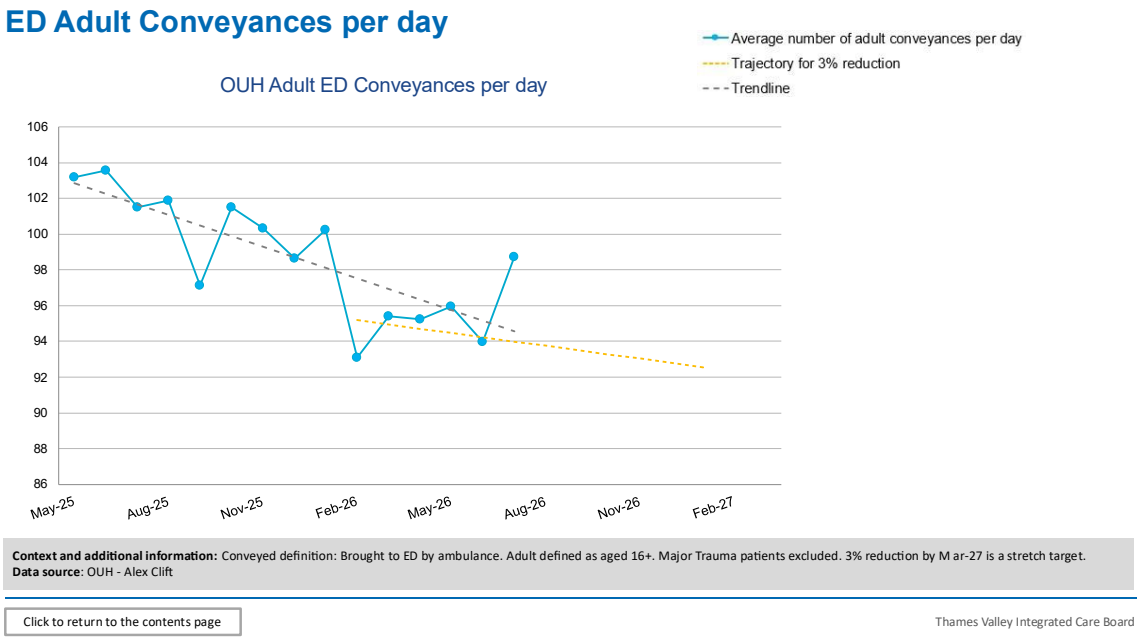
3.0 Shift from Hospital to the Community

3.1 Ambulance Conveyances

We set out to maintain or reduce ambulance conveyances to the Emergency Departments. As described above, this gradually reduced over the year, and we continue to see a reduction in ambulance conveyances from April - July 2026. Figure 1.0 on the following page illustrates the decrease in ambulance conveyances. However, we have observed an increase in the number of people who self-present to both Emergency Departments. We are working with South Central Ambulance Service (SCAS) to review all contacts with the 999 service for one week to see if they turned up to the Emergency Department (ED) after triage and assessment by SCAS.

Conveyances from Oxfordshire care homes has reduced by 18%, with a 26% reduction in emergency admissions from care homes. Oxford Health (OHFT) are supporting Care Homes with the Care Home Support Service and providing direct assess to the Single Point of Access for further advice and triage should it be required.

Figure 1.0 Ambulance conveyances for adults to Oxfordshire EDs



3.2 Ambulance Handovers

The average time to ambulance handover in the Emergency Departments reduced from 17 minutes to 15 minutes and 50 seconds. We have seen improvements in the excess handover times, and we continually work together to improve processes to minimise any ambulance handover delays.

3.3 Zero Growth in Emergency Admissions

We aimed to achieve zero growth in emergency admissions to general medical and gerontology wards. We achieved this in addition to a 4% reduction in emergency admissions. We monitor emergency readmissions, outcomes from assessing people in their own home and working across pathways to continuously improve to maximise outcomes for people.

3.4 Fall Prevention Programme

Falls remain a significant driver of urgent and emergency care demand in Oxfordshire, particularly for older people living with frailty or reduced mobility. However, the current performance picture suggests progress in some higher-risk pathways.

The Emergency Departments have also seen a reduction in the number of people conveyed by ambulance following a fall. However, at the same time, there has also been some increase in people walking into ED following a fall, suggesting that these may be different cohorts.

The work on prevention, community response and public messaging will continue alongside work with care homes and ambulance pathways. Overall, Oxfordshire's performance indicates progress in reducing more serious falls-related escalation from care homes and ambulance conveyance, but further work is needed to understand

and respond to falls-related walk-in attendances and to demonstrate the impact of current falls prevention services.

This work is being addressed through a monthly system-wide falls group attended by health, adult social care, district councils and voluntary sector partners, with the aim of reducing falls and falls-related admissions to hospital.

The programme has two core workstreams:

- Communications and engagement
- Measuring the impact of falls services

The communications workstream is focussed on practical prevention measures for residents, carers and community partners, including how to reduce falls risk, what support is available, and when urgent and emergency care is the correct response. This is particularly important considering the increase in falls-related walk-in attendances to ED.

The impact workstream is focused on strengthening how partners measure whether falls prevention activity is reducing avoidable harm and urgent care demand. To date, it has been difficult to demonstrate the impact of the full range of falls prevention services across the county. Partners are therefore developing a clearer methodology, drawing on learning from Integrated Neighbourhood Team evaluation, to link commissioned falls services with indicators such as ambulance conveyance, ED attendance, emergency admission, care home activity and community-based support. This will help the system understand where current activity is working and where further targeted action is needed.

Alongside work to reduce ambulance conveyance and care home admissions, residents and carers need clear information on how to reduce falls risk, what community support is available, and when urgent or emergency care is the right response.

One of our strategic providers has completed an independent review of people who have fallen whilst on the Home First pathway. This has resulted in several additional actions being put in place to support reducing the falls risks whilst people are in a recovery phase in their own home.

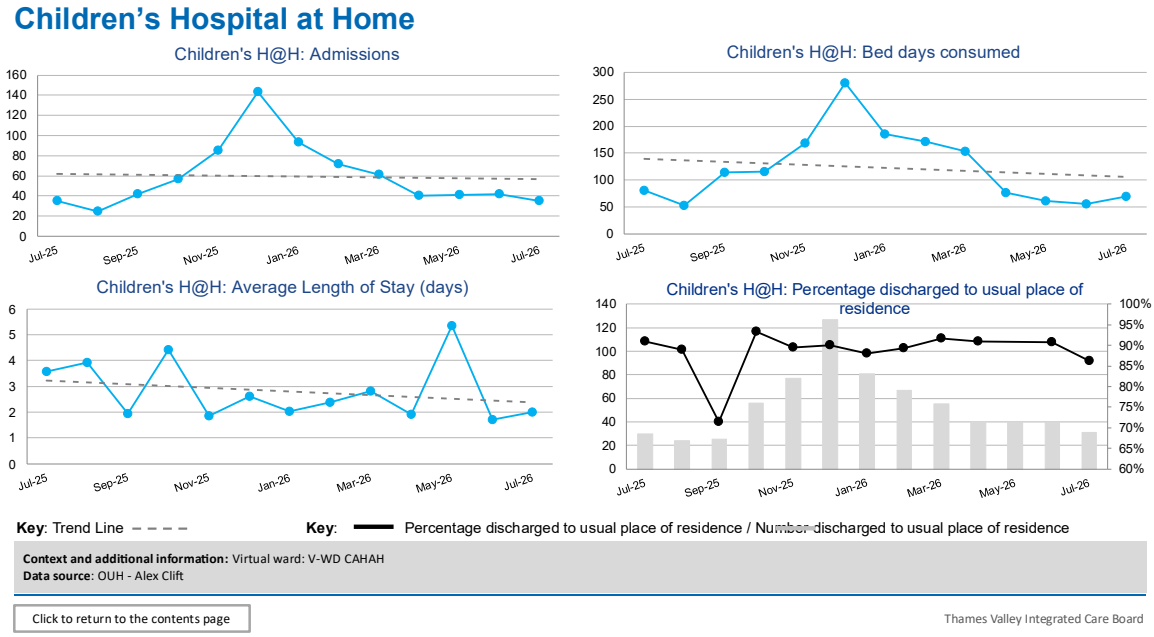
3.4 Hospital @ Home (Virtual ward) – BCF funded

Our aim was to deliver appropriate urgent care to more adults and children in their own homes (including care homes) and to avoid inappropriate or unnecessary conveyances to the hospital setting.

3.4.1 Children's Hospital at Home

The service is a partnership between the acute paediatric team in OUHFT and OHFT's Children's community nursing team. They worked together to increase the number of children they cared for over the winter months (Figure 2.0 following page). This helped to reduce emergency admissions for children and, for those who were admitted, reduced their length of stay in hospital.

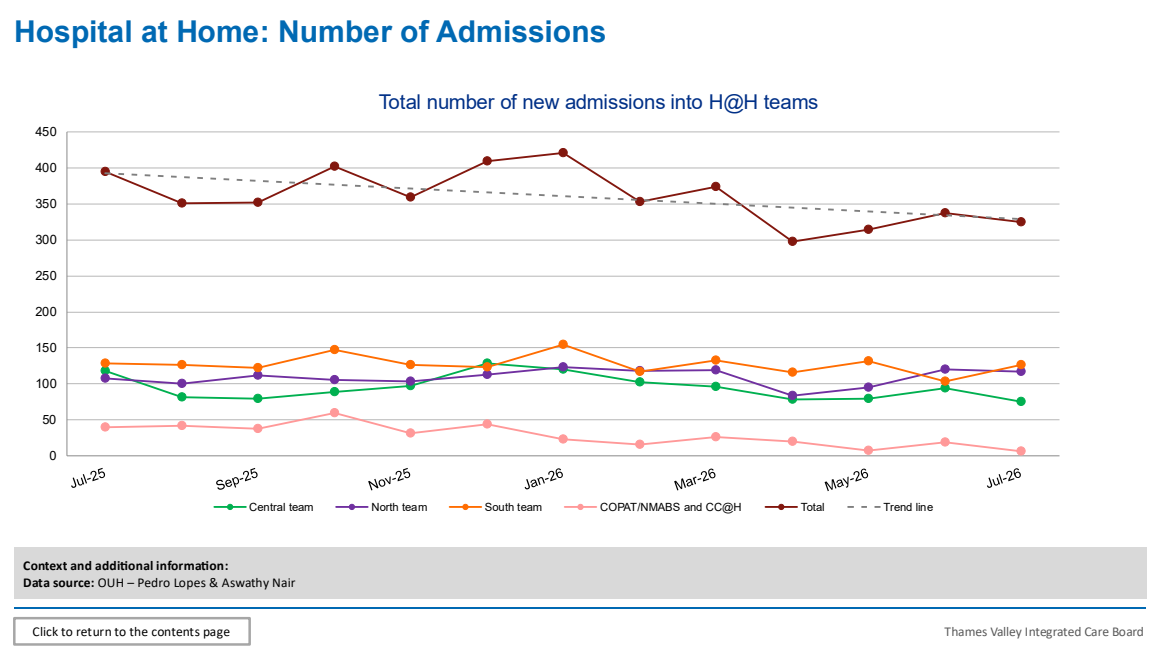
Figure 2.0 Children's hospital @ Home service



3.4.2 Adult Hospital at Home

Over the last 6 months, this service has seen a reduction in the number of people they are caring for but an increase in acuity (how ill they are). Most people assessed and treated in this service are complex and frail. In this service, we have seen progress and improvements in how people are treated for heart failure and respiratory disease. The service continues to develop and safely provide hospital level care in the person's own home.

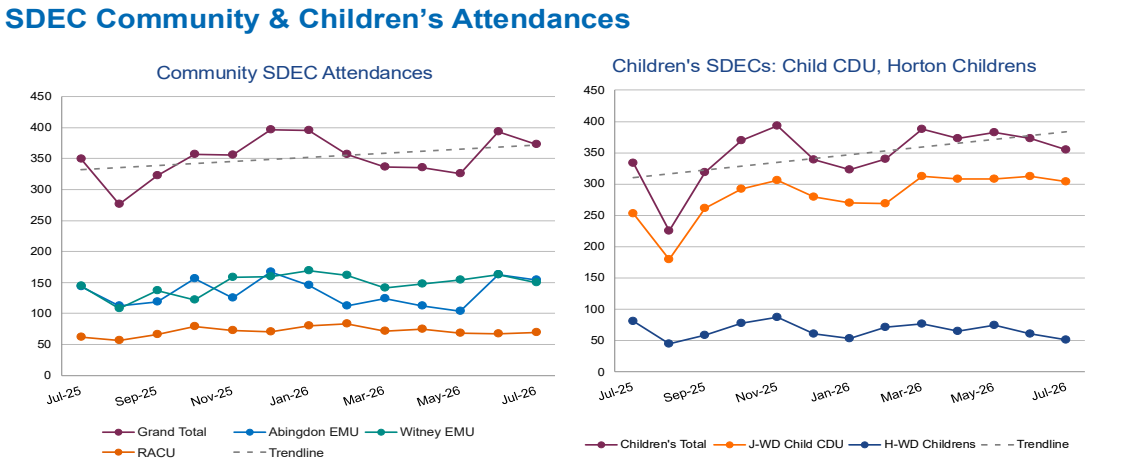
Figure 3.0 Number of admissions to Adult Hospital @ Home service



3.5 Same Day Emergency Care (SDECs)

Since April to July 2026, we have seen an increase in the number of people assessed in the following units: Frailty: Abingdon Emergency Multidisciplinary Unit (EMU), and Henley Rapid Access Care Unit (RACU). Children's Clinical Decision Units (CDU) at the John Radcliffe and Horton General Hospitals. This is illustrated in Figure 4.0 below.

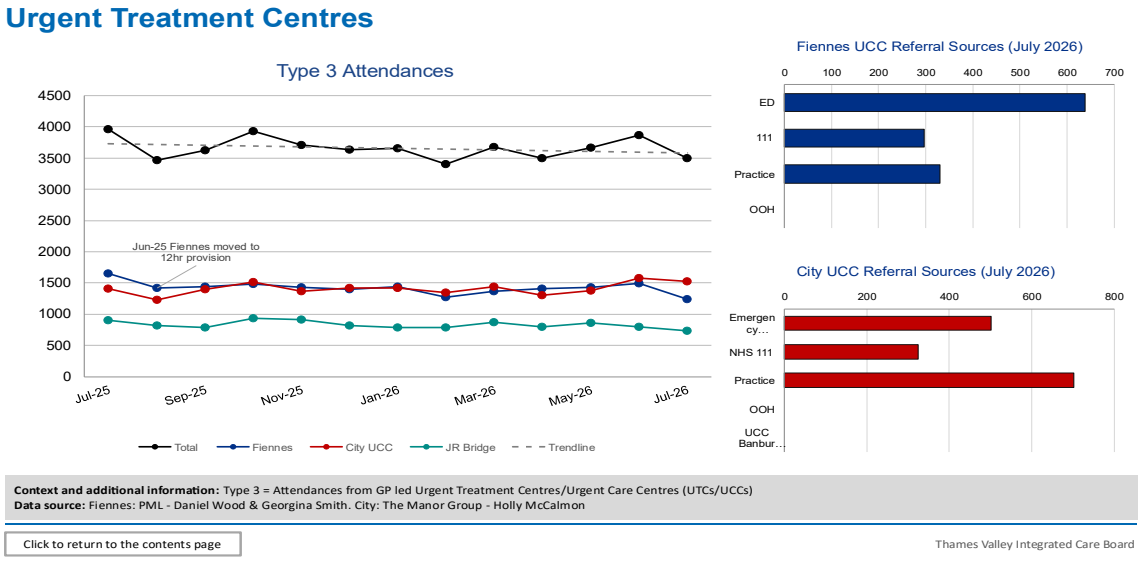
Figure 4.0 Community SDECs and Children's Clinical Decision Units



3.6 Urgent Treatment Centres

The Urgent Treatment Centres (UTCs) on the Horton General Hospital site and on the John Radcliffe site both have a consistent model of care and are working to ensure a consistent delivery of NHS 111 pathways. Both units are designated Urgent Treatment Centres and focus on those who are redirected from the Emergency Departments, referrals from NHS 111 but also support Primary Care where capacity allows.

Figure 5.0 Urgent Treatment Centre activity

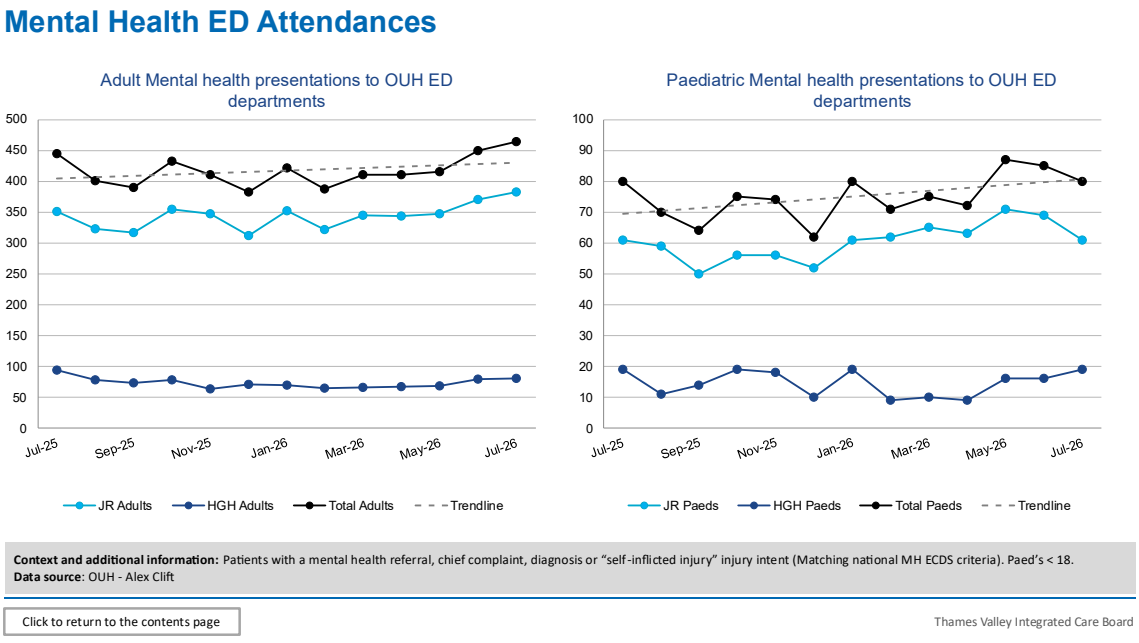


4.0 Mental Health

4.1 Mental Health in ED

The number of adults with a mental health issue has fluctuated throughout the year but there has been an 11% increase in children and young people who have attended ED with a mental health issue (Figure 6.0 below). However, OHFT have observed improved flow through mental health crisis and acute pathways and access to children and young people's services.

Figure 6.0 Mental Health ED Attendances



4.2 Reducing length of stay in inpatient mental health beds and reduction of out-of-area Placements

OHFT has an inpatient transformation programme that focusses on reducing length of stay.

The Better Care Fund has supported the utilisation and optimisation of the following services.

- Personality Disorder In-reach Team (PDIT)
- Use of one-off Flexible Use Fund to unblock practical barriers to discharge
- Care Home discharge / liaison team
- Connections integrated support workers and Housing Officer embedded within the Inpatient social work team (adult MH) and access to step-down / step-up beds

4.3 Evaluation of Integrated Neighbourhood teams

We are working with the department pf public Health at Oxford University to evaluate the impact of Integrated Neighbourhood teams (INTs) in areas of significant

deprivation within Oxfordshire. To date the evaluation has been completed for the two INTs in Banbury but the Oxford city has yet to have this completed.

In Banbury we carried out a retrospective observational study, looking at data from 12 months before and 12 months after the INT interventions. The data was collected from the INTs, OUHFT, Primary Care and Hospital @ Home services. This is continued to be worked on.

Both INTs in Banbury saw a reduction in ED attendances, Hospital admissions and Primary Care contacts post INT interventions. INTs were associated with positive service-specific changes in healthcare utilisation across GP, A&E, inpatient care, and Hospital at Home. We are working on the INT data for OX3 and the data for Children and Young People will not be analyzed until next year. We are hoping to have this review completed by October 2026.

5. Demand, Capacity and Patient Flow and Waiting lists

The daily focus is ensuring we have systems in place to effectively triage referrals and managing the existing capacity to meet the needs of those who require an assessment either in their own home or in the nearest appropriate clinical environment. These assessments can be on the day or the next day depending on the individual's needs.

To maintain safety, we have escalation process in place for when there is not the capacity to meet the on the day demand. Visiting services such as Hospital @ Home proactively review who they are visiting to see who can wait until the next day to accommodate a person who needs to be seen that day.

Within Oxfordshire, as issues (bottlenecks) arise, we discuss them on our daily morning system call. Should the need arise during the day, further escalation calls are organised. If we do not have a resolution and the issue is too large to resolve, we will set up a weekly taskforce group with representatives from all aspects of the pathway. We review the issues and develop interventions, which we pilot and evaluate. If interventions do not work, we review again until we have a solution.

5.1 Analysis of demand across pathways

Similar UEC pressures are observed across England. Over the summer months, we saw an increase in acuity and demand across all services. The impact of the heatwaves continued over July and August. Each year we estimate the demand expected over the forth coming winter. The Oxfordshire system will have to also carrying this out for the summer period to predict demand during potential heatwaves.

As mentioned previously, the Emergency Department continue to see an increase in attendances. There are times when the Emergency Department has an increase in attendances over a short time leading to overcrowding. As a result, some people may be temporarily cared for in a corridor within the ED. In May 2026, OUHFT have set up a 'corridor care elimination' taskforce to reduce and eradicate episodes of corridor care. OUHFT compares favourably for this metric when compared to similar multi-site trusts. Since 25th June 2026, OUHFT had no episodes of reportable ward corridor

care. Staff and patient experience are core improvement drivers and in addition to the national mandated metrics.

5.2 NHS 111

The data below in table 1.0 lists the number of NHS 111 referrals by pathway. Most NHS 111 pathways continue to be directed to the Oxfordshire Emergency Departments (EDs).

Table 1.0 Number of NHS 111 referrals by pathway

Month	ED	Urgent Care combined	SDEC	District Nurse SPA	UCR	Primary Care CAS	All referrals	Outside ED share
Jul 2025	2,418	1,197	24	44	30	54	3,767	35.8%
Aug 2025	2,354	1,117	16	44	35	30	3,596	34.5%
Sep 2025	2,428	1,011	23	46	67	27	3,602	32.6%
Oct 2025	2,642	1,134	25	28	83	38	3,950	33.1%
Nov 2025	2,495	1,059	19	22	80	25	3,700	32.6%
Dec 2025	2,473	1,136	29	36	115	42	3,831	35.4%
Jan 2026	2,497	1,151	19	38	90	31	3,826	34.7%
Feb 2026	2,061	1,020	14	26	77	22	3,220	36.0%
Mar 2026	2,261	1,254	14	28	105	20	3,682	38.6%
Apr 2026	2,307	1,351	7	43	72	34	3,814	39.5%
May 2026	2,453	1,458	16	28	103	29	4,087	40.0%
Jun 2026	2,582	1,375	17	45	96	30	4,145	37.7%
Jul 2026	2,605	1,395	17	51	102	38	4,208	38.1%
Available total	**31,576**	**15,658**	**240**	**479**	**1,055**	**420**	**49,428**	**36.1%**

This is also displayed in Figure 7.0 which illustrates the number of referrals to the EDs is greater than other Urgent treatment pathways**.** We are working with the two Urgent Treatment Centres to ensure that we have maximised the pathways from NHS 111, to take some of the pressure off the Emergency Departments.

Figure 8.0 (next page) shows the monthly number of referrals by type of service. We have reached out to SCAS NHS 111 control centre to see if how we can support their triage and clinical advisory service, to improve referrals to non-ED locations.

Figure 7.0 NHS 111 referrals to ED and other Urgent treatment pathways

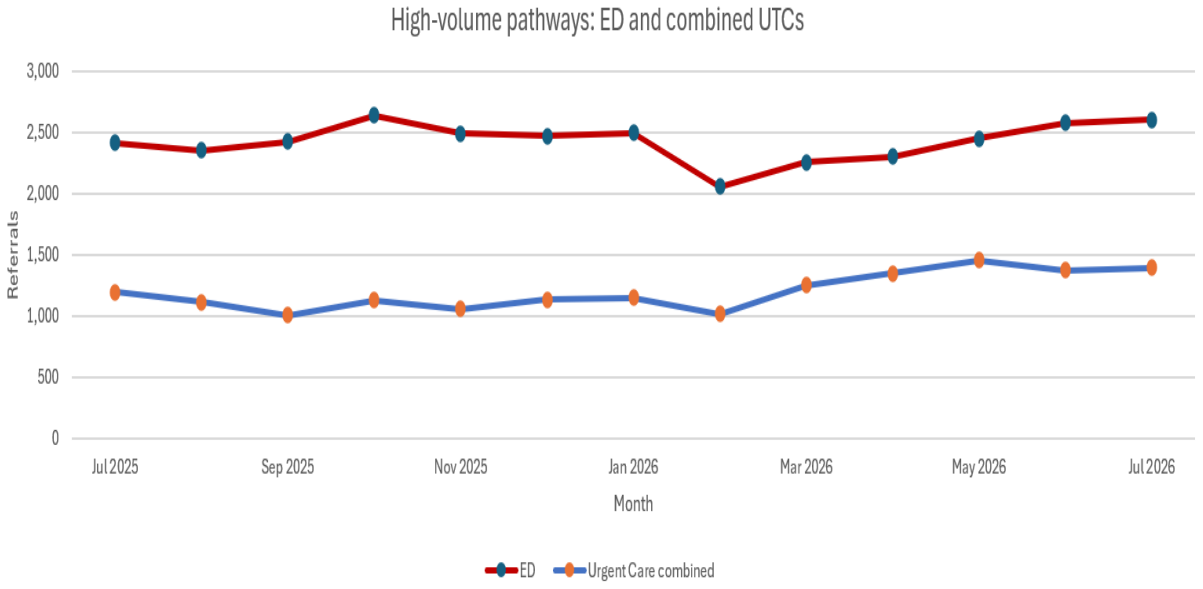
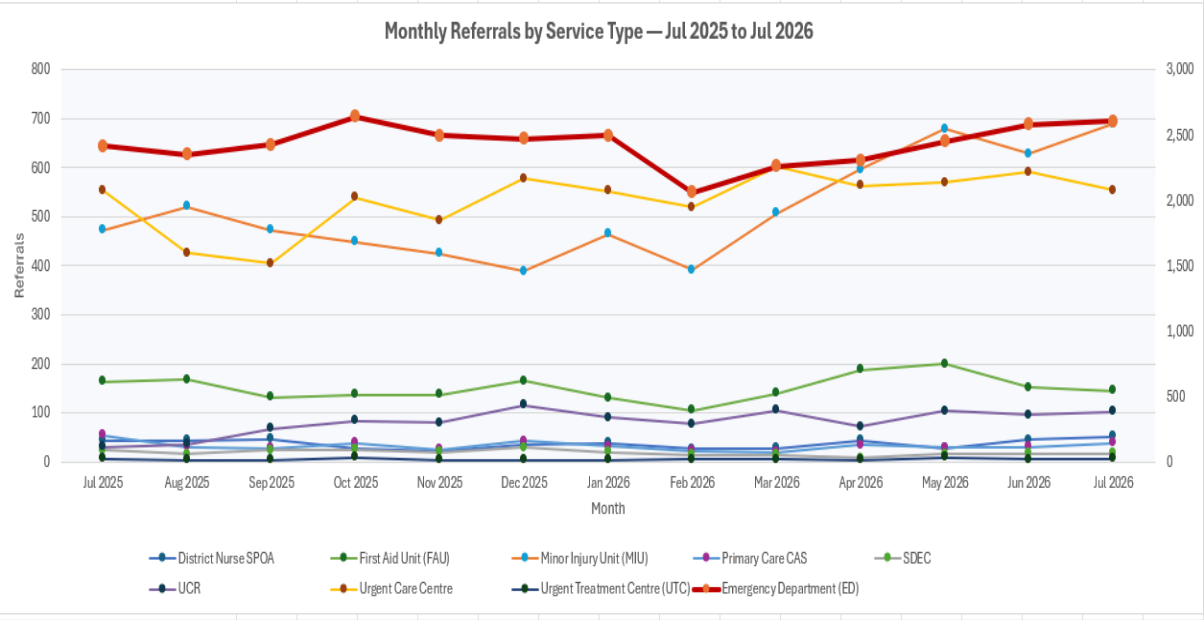


Figure 8.0 monthly referrals by service type



5.3 Population Health

Oxfordshire is working with Thames Valley ICB to continue the use and development of connected care to deliver our population health analytics. In data for Oxfordshire shows the following.

- Population for 80yrs plus will have increased by 21% in 5 years.
- Those with long-term conditions and frailty are growing fastest.
- Most complex 5%, use approximately 30% of resources (ED attendances, bed days, GP/community contacts).
- Inequality in our most deprived communities.

Population Health Management (PHM) underpins neighbourhood planning and delivery by using shared data and analytics, overlaid with local intelligence and community insight, we can identify people at risk of deterioration, prioritise proactive interventions and reduce unwarranted variation in outcomes. Primary Care, Public Health, social Care and health providers are working together to Identifying risk earlier and coordinating support around priority cohorts. We continue to develop integrated community services that prevent avoidable hospital use and support recovery at home. In areas of significant deprivation, we continue to reduce the health inequality gap by working with local communities to understand the access issues they face when accessing healthcare and providing education on how to manage their long-term conditions.

6.0 Hospital Discharge and Delayed Discharges

6.1 Reduce length of stay in hospital and ensure that people are cared for in the most appropriate setting

Throughout the year we have carried out various reviews of why people are delayed in in hospital. We have assessed where there are process gaps and opportunities to improve. One area reviewed, related to people not returning home on the day they were due to be discharged. One of the actions following the review, led to changes in how we communicate across the various services and the individual person and their family. In addition to escalation of potential delays with equipment house cleans etc.

We have also reviewed why we are seeing an increase in the number of people transferring to long term placements. The outcome of the review was that they were all appropriate.

There has been an increase in the number of people returning home with reablement. People who do not require a large reablement package of care, rarely wait more than one day but those with more complex needs and where additional training is required they wait an average of 5 days.

People who require rehabilitation in a community hospital continue to transfer to these units within 3 days. However, if a person requires a more specialised rehabilitation, then the wait is longer, 8-18 days delayed.

We have seen a reduction in the number of days for people waiting for long term placement, from 15 to 13 days.

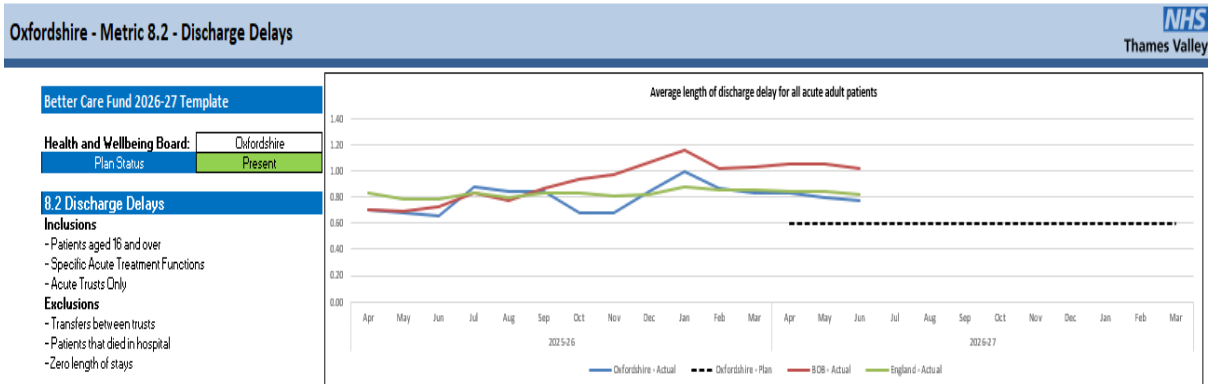
No more than 0.6% of people Medically Optimised for Discharge (MOFD) for 21 days or more. Reduce length of stay for those in bed-based rehabilitation, generic and specialist neuro rehabilitation

6.2 Hospital Discharge and Delayed Discharges

Improving hospital flow and reducing delayed discharge remains a key priority for Oxfordshire. The system continues to support high levels of discharge activity and maintain a Home First approach with the aim of enabling people to return home as soon as this is safe and appropriate. Overall length of stay for General Medicine and Geriatric Medicine emergency admissions has remained broadly stable at around eight days, but delays for people who no longer need acute hospital care remain a significant pressure.

Discharge performance has not improved at the same pace as admission avoidance. During 2025/26, bed days lost to discharge delays increased across pathways, and the average length of delay increased from 5.6 days in 2024/25 to 5.8 days in 2025/26, against a target of 5 days. Current in-year reporting also shows continuing pressure, with May 2026 performance showing an average delay per discharge of 0.8 days against a 0.6-day target; 86.6% of people discharged on their discharge-ready date against an 88% target; and an average delay of 6 days for those not discharged on their discharge-ready date against a 5-day target. The number of delayed discharges in OUHFT are like the rest of England but at a lower level than surrounding counties (Figure 9.0 below).

Figure 9.0 Discharge delays Oxfordshire compared to England



The causes of delay vary by pathway. For people returning home with support, delays are often linked to the complexity of care packages, including double-handed care, acute therapy, equipment, reablement capacity and coordination between hospital discharge teams and community services. For people requiring bed-based rehabilitation, delays relate to availability and flow through intermediate care beds. For people moving into long-term care, delays are more likely to be associated with complexity of need, family choice, availability of suitable placements and decision-making processes.

The current position suggests that delays are not attributable to one single part of the system. Acute therapy capacity, social care capacity, community provision, housing, workforce, equipment, medicines, transport and family choice can all contribute, but local analysis indicates that aspects relating to complex cases are also a significant factor, particularly for people returning directly home and those transferring to long term placements.

To address both capacity and process, the system response enhances Home First and Discharge to Assess pathways while strengthening reablement and intermediate care. By leveraging the use of OPTICA (NHSE's real-time discharge planning tool) for improved task tracking and escalation, teams gain clearer visibility into discharge tasks, unblock delays, and accelerate decision-making for complex cases. This ensures teams can pinpoint bottlenecks, establish clear action ownership, and maintain momentum against discharge-ready dates.

For people with more complex needs, timely and clear information provision is also important in supporting safe discharge and reducing avoidable delay. This includes ensuring that people, families and carers understand the discharge pathway, the role of Home First and reablement, what support will be provided, any chargeable and non-chargeable elements of care, and what will happen if needs change after discharge.

6.3 End of Life Care

Over June and July 2026, we have reviewed the people who were discharged from hospital with Discharge to Assess (D2A) and known to palliative care teams but not end of life (imminently dying). We focused on the experience of the individual, their carers/family and the care providers.

It was clear that we needed to change this pathway, to one where greater support was available should the person deteriorate. Over the summer we have piloted this group of people being discharged with OUHFT's CARe (Crisis Assessment Response) team and referred to community palliative care teams once they are at home. To date this is working well, but a thorough review will be conducted considering the person and their cares/family's views.

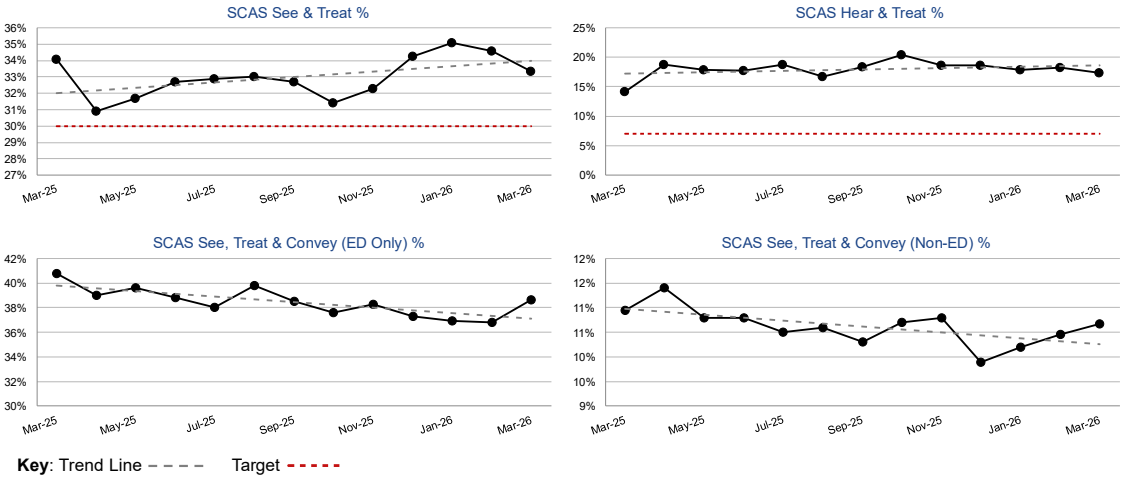
The pathway for those who are palliative or end of life and the difference between specialist and community palliative care will be described and communicated to all health care professionals within Oxfordshire

7.0 Summary

In summary Oxfordshire has observed a reduction in ambulance conveyances but a steady increase in the number of people who present at the ED's. Alternatives to ED are continuously being reviewed and developed with both NHS 111 and 999 service. We continue to focus on assessing and treating people where appropriate in their own home. The number of people delayed in hospital has not reduced as expected over the summer months but has remained at a similar level to late spring. We continue to work on reducing length of stay across the various pathways. The INTs in Banbury have shown post INT interventions, there is a reduction in Primary Care contacts, ED attendances and hospital admissions.

Appendix 1 Additional Oxfordshire data for UEC pathways

SCAS: See & Treat, Hear & Treat

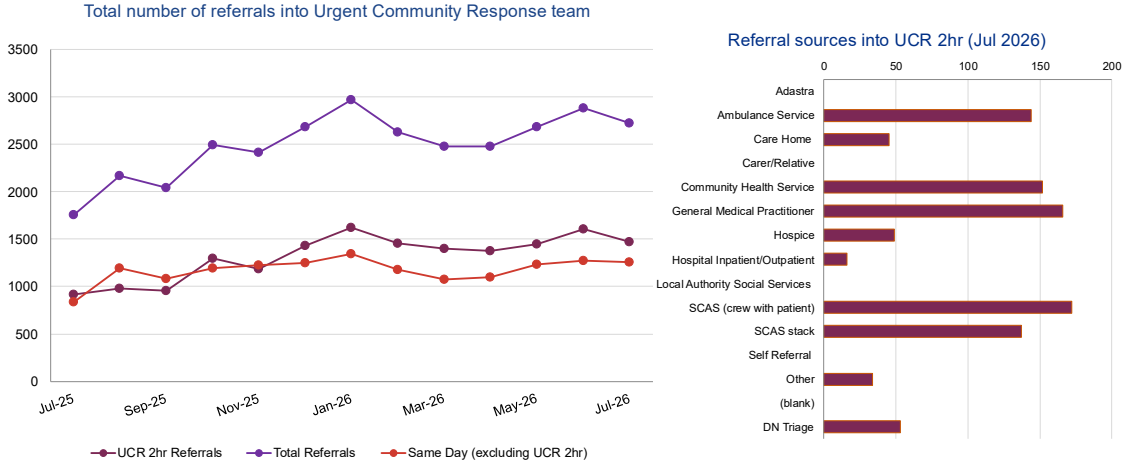


Key: Trend Line – – – – Target - - - - -

Context and additional information: SCAS dispatch area = North. Targets provided by Andrew Battye.
Data source: SCAS - Andrew Battye

Click to return to the contents page

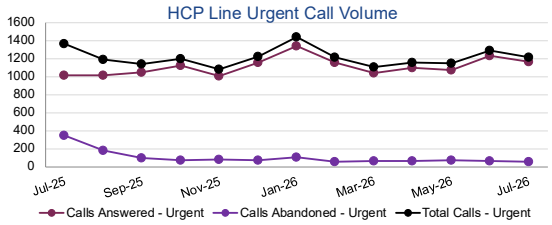
Single Point of Access (SPA) - Same day urgent care demand

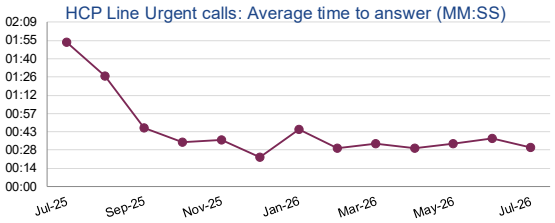


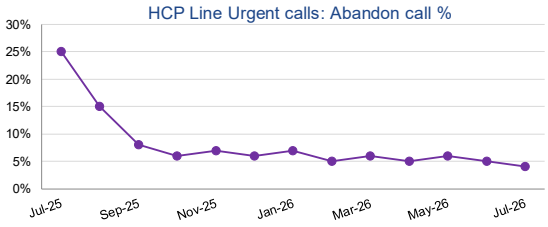
Context and additional information:
Data source: OH – Gareth Cox & Dee Pelakauskaite

Click to return to the contents page

Single Point of Access (SPA) – HCP Line Urgent calls



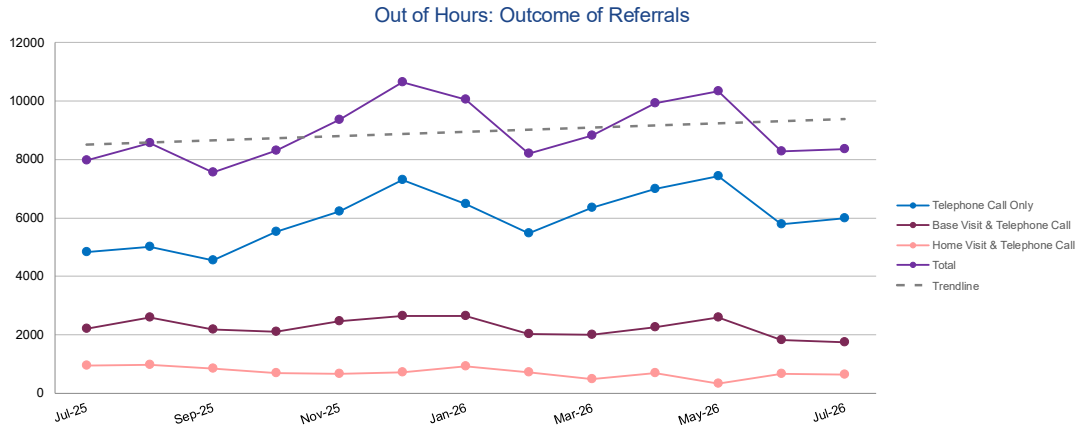




Context and additional information: Healthcare Professional (HCP) line.
Data source: OH – Gareth Cox & Dee Pelakauskaite

Click to return to the contents page

Out of Hours Referrals

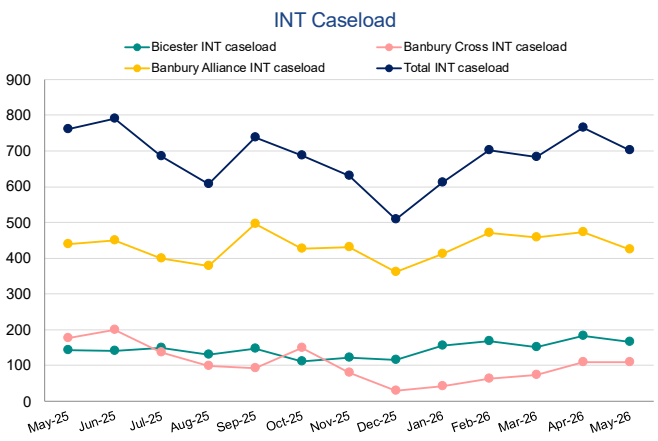


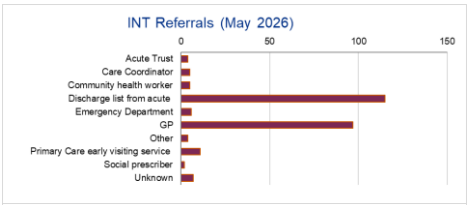
Context and additional information:
Data source: OH – Gareth Cox & Dee Pelakauskaite

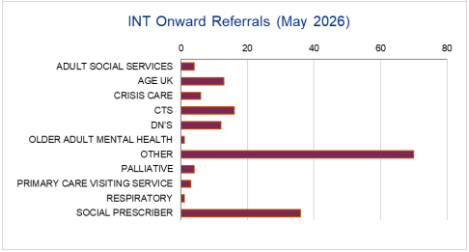
Click to return to the contents page

Integrated Neighbourhood Teams (INTs)

INTs included: Bicester, Banbury Alliance & Banbury Cross





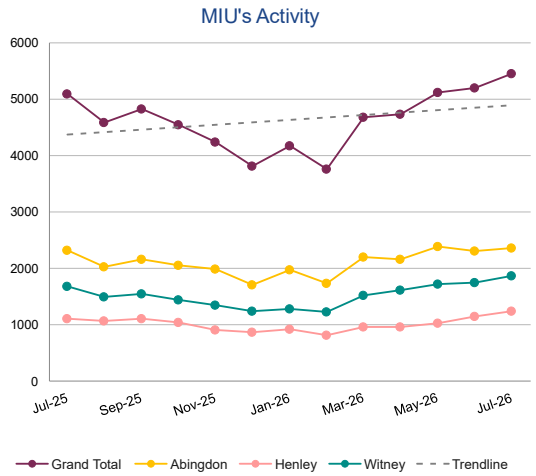


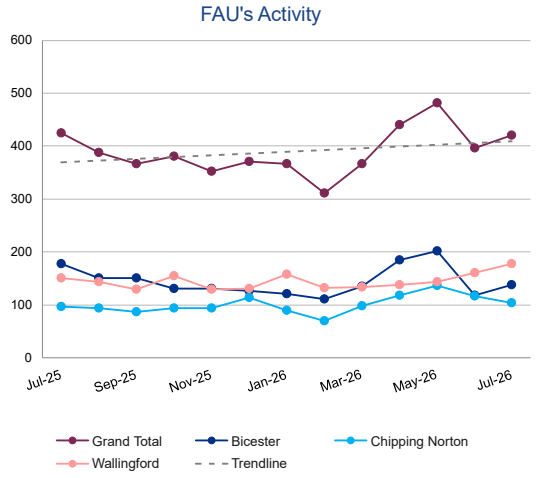
Caseload definition: Patients with an INT stay at any point during the month

Context and additional information: OX3+ data to be incorporated soon. INT referrals uses admission dates; INT onward referrals uses discharge dates. Banbury Cro ss data incomplete.
Data source: Bicester INT (Jodie Loverock-Pates), Banbury Alliance INT (Hayley Wilkinson), Banbury Cross INT (Amanda Walters)

Click to return to the contents page

MIU's and FAU's

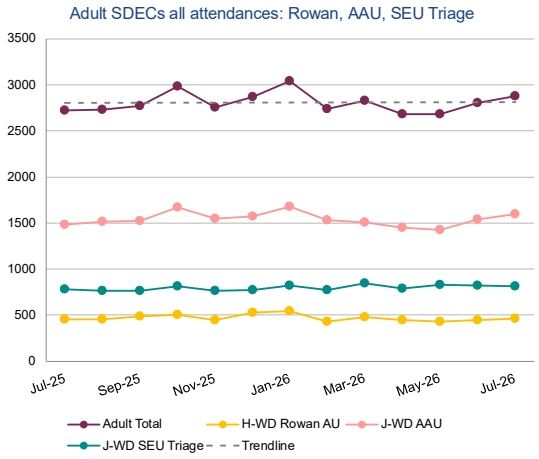


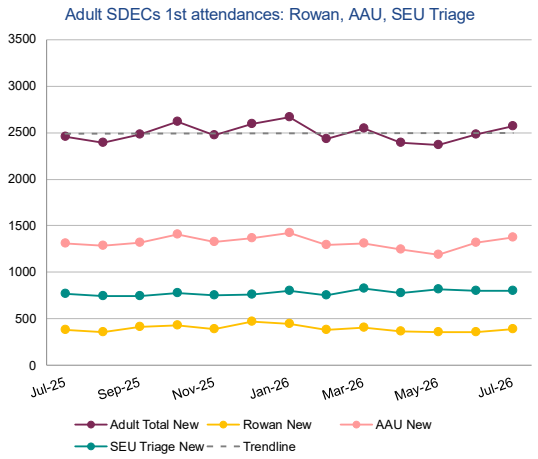


Context and additional information: Chipping Norton FAU only includes CNIPCS activity i.e. those with a referral source of 111.
Data source: OH – Gareth Cox & Dee Pelakauskaite, Chipping Norton - Lindsay Rudeforth (SCAS), Wallingford - Simon Nash (BOB ICB)

Click to return to the contents page

SDEC Acute Attendances

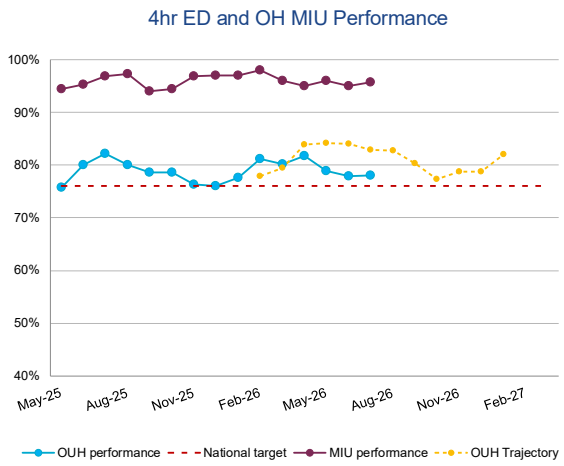


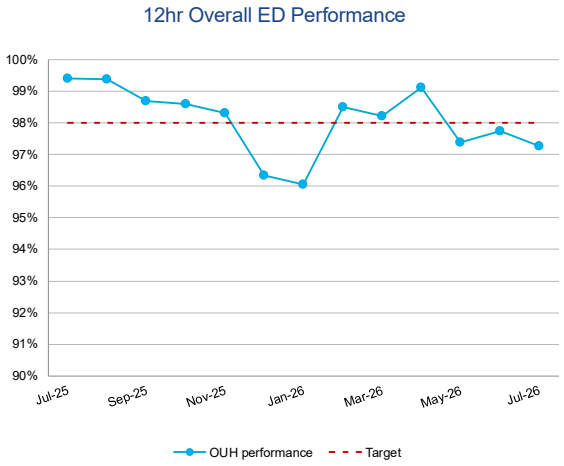


Context and additional information: Home leave ward stays excluded.
Data source: OUH – Alex Clift

Click to return to the contents page

ED and MIU 4hr Performance



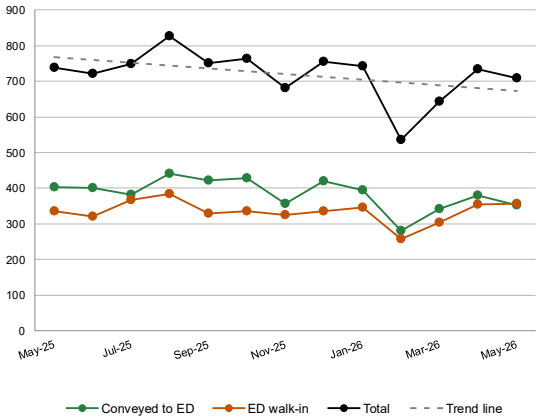


Context and additional information: The percentage of patients admitted, transferred or discharged within 4hrs of ED arrival. 4hr acute national ED target of 76%
Data source: OUH - Alex Clift, OH – Gareth Cox & Dee Pelakauskaite

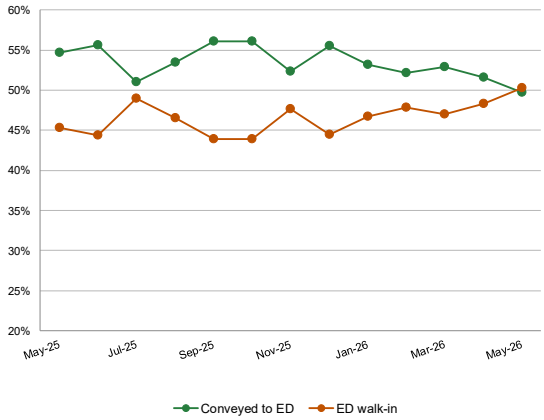
Click to return to the contents page

ED Attendances for fallers aged 65+: By arrival mode

ED Attendances for 65+ fallers: Number by arrival mode



ED Attendances for 65+ fallers: % by arrival mode

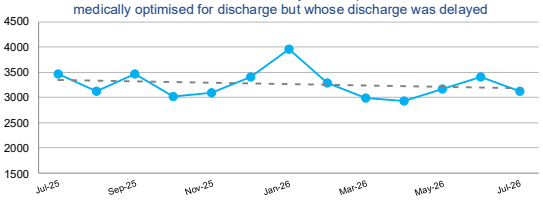


Context and additional information: Conveyed definition: Brought to ED by ambulance. Criteria: ED Injury Mechanism of 'Fall - Tripping', 'Fall - Slipping' or 'Fall from height of less than one metre'
Data source: OUH - Alex Clift

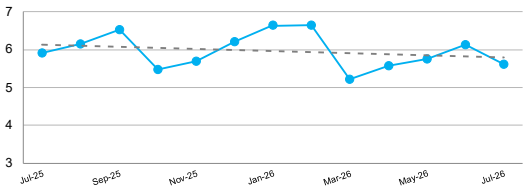
Click to return to the contents page

Total number of bed days lost for delayed discharges (OUHFT)

The total number of Acute bed days lost to patients who were medically optimised for discharge but whose discharge was delayed

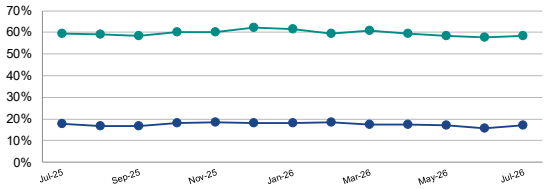


Average days away from home for MOFD patients in acute inpatient wards



Key: MOFD Days lost — Trend Line

Proportion of patients who were discharged before midday & 17:00

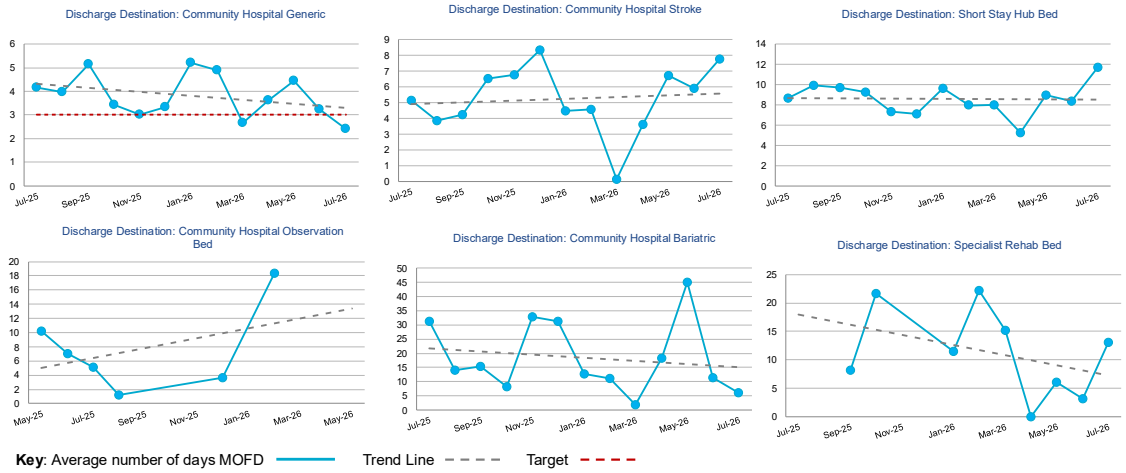


Key: % discharged before 17:00 — % discharged before midday

Context and additional information:
Data source: OUH - Alex Clift

Click to return to the contents page

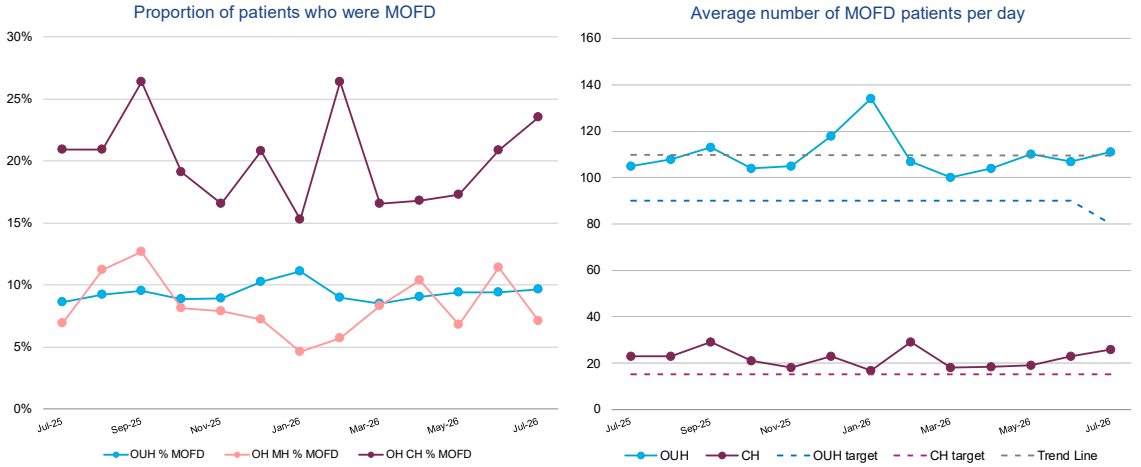
Days away from home for OUHFT MOFD patients: Pathway 2 breakdown



Context and additional information: Y-axis: Average number of days MOFD. Typical number of MOFD discharges a month: Generic: 65, Stroke: 10 , SSHB: 40, Observation: 2, Bariatric: 1, Rehab: 1.
Data source: OUH - Alex Clift

Click to return to the contents page

Proportion of patients who were MOFD and average number of MOFD per day

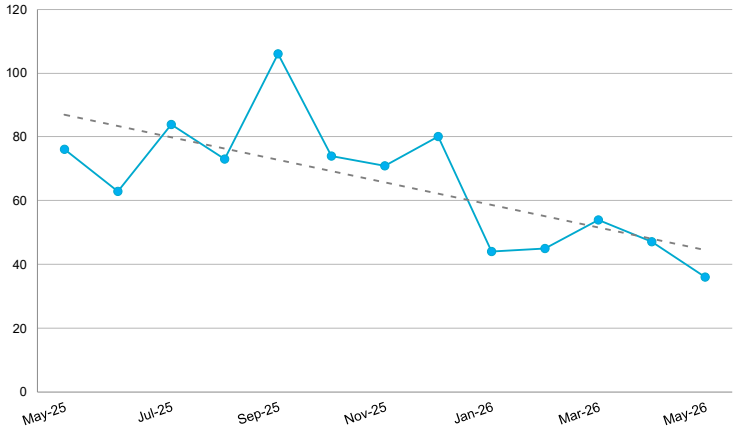


Context and additional information: Left chart: OH community hospitals % based on a fixed denominator of 110 beds. MH = Mental Health. CH = Community Hospitals.
Right chart: OUH target of 80 patients per day by Jul-26 and to maintain this over winter. CH target of 15 patients per day.
Data source: OUH - Alex Clift, CH – Gareth Cox, OH MH - Dee Pelakauskaite

Click to return to the contents page

Same day cancelled discharges OUHFT

Same day cancelled discharges



Cancellation reasons
(Latest month)

Reasons	HGH	JR	NOC	Total
NMFD	2	11		13
Medical intervention	1	8		9
Equipment delay	1	1	1	3
Property readiness	1	2		3
Family Concerned	1	1		2
Back to Toc		1		1
Declined provider		1		1
Family not ready		1		1
Operational process/Admi/Ward (OUH)	1			1
Provider capacity		1		1
Provider refused to pick Up		1		1
Total	**7**	**28**	**1**	**36**

Context and additional information: This data is unvalidated
Data source: OCC – Alice Brough

Click to return to the contents page

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NHS
Thames Valley

Oxfordshire Urgent and Emergency Care Winter Plan

August 2026

1.0 Introduction

Urgent and emergency care (UEC) services are fundamental to ensuring people receive timely, safe and clinically appropriate care when they need it. National priorities, including the NHS 10 Year Health Plan, Medium-Term Planning and Financial Framework, and national UEC planning requirements, reinforce the shift towards prevention, neighbourhood and community-based care, while protecting emergency services for those with the greatest clinical need.

The Oxfordshire health and social care system focusses on integrated working across, ambulance providers, voluntary sector, Oxford Health Foundation NHS Trust (OHFT), Oxford University Hospitals NHS Trust (OUHFT), General Practices, home care providers, care homes, Principle Medical Limited (PML), and adult social care at Oxfordshire County Council and district councils.

2.0 Our Ambition Winter 2026/2027

We continue to develop pathways that enable people to receive the right care, in the right place, first time.

We are continuing to work on the development of neighbourhoods to strengthen prevention and care closer to home, streamline people's access to alternatives to hospital, and supporting hospitals to focus on those who require emergency or specialist care.

3.0 Areas of Focus for the Oxfordshire 2026/27 Winter Plan

- Neighbourhood development: Focus on early intervention and prevention-based approaches e.g. frailty support to prevent falls to gradually reduce risks in the community that can lead to unplanned admission and improve integrated urgent care access across community, social care and primary care services when same day care needs arise.
- Reducing ED attendances and emergency admissions
- Community services: Maximising on the day triage/assessment in the person's own home accessing Single Point of Access, Urgent Community Response and Hospital at Home teams
- Reducing emergency admissions by 10% by 2029
- Mental Health: SCAS MH Crisis pathway/guidelines and avoiding people with no physical health needs but have a mental health need attending an Emergency Department

- Ambulance Services: Reducing Cat 2 response times, maximising hear and treat, reducing conveyances to ED, and achieving ambulance handovers under 45 minutes
- Intermediate Care: Reducing length of stay for those who require support to return home and bed occupancy within frailty cohort bed bases

4.0 Standards to be Delivered

- **Oxfordshire residents:** I want to tell my story once within one connected NHS. I have one team looking after me. They speak to each other and work together for my best interests.
- **Single point of Contact:** People are triaged through Single Point of Access/Clinical Assessment Service, with the following outcomes:
    - provided with advice
    - directed to community pharmacy
    - directed to a local Urgent Treatment Centre (UTC) or Same Day Emergency Care unit (SDEC) (sometimes via patient transport if required)
    - navigated directly to assessment at home
- **Hospital at Home services & Urgent Community Response**: If someone falls or deteriorates, an Urgent Community Response (UCR) team arrives within 2 hours. Instead of being rushed to an acute bed, the person would be admitted to a Virtual Ward / Hospital at Home service.
- Follow on from Hospital at Home or Urgent Community Response teams will be via community teams and primary care working together to put anticipatory care plans in place.
- If attendance at hospital is necessary, the person will be transferred to the appropriate clinical assessment area.
- If a hospital admission was needed, when they are ready to return home, the person is discharged rapidly under a single Home First model (Discharge to Assess).
- Wider Primary Care Services: people are directed to urgent dental care, optometry's Minor Eye Condition Service, or the expanding role of community pharmacists as independent prescribers.

5.0 Metrics and outcomes

The Oxfordshire system has metrics that are used to monitor the impact of the Winter Plan and our year-round integrated improvement programme.

The Oxfordshire UEC System metrics are a combination of the following:

- NHS Oversight Framework 26/27 metrics

- BCF Core Metrics 26/27
- Locally determined metrics

All metrics will have a baseline established with agreed targets and trajectories (where possible and relevant). These metrics will be reported in the monthly boards and local governance routes within provider services.

Table 1.0: Winter Plan Interventions and Outcomes

Issue	Intervention	Outcomes
5% of residents account for ~342,000 hospital bed days per year.	Developing the foundations for neighbourhood approaches with a focus on complex needs and frailty in areas where integrated neighbourhood teams (INTs) are not yet present. Improve the integration of visiting services responses within a neighbourhood	Reduction in emergency admissions by 10% by 2029.
Reducing inappropriate ambulance conveyances	OHFT SPA extending taking call from the 999 stack from 4 hrs a day to 12hrs a day Monday to Friday Continue to develop guidelines with ambulance service to improve outcomes for residents	Point prevalence audits of conveyances to ED. Completion of people with MH crisis and chest pain guidelines
Achieving ambulance handovers under 45mins	Review ambulance handover delays and process that led to the delay	Zero ambulance handover delays over 45 mins
Overcrowded ED Prolonged length of stay up to and over 12 hrs	November 2026: Increasing capacity to take referrals directly from	**< 5%** of Type 1 ED attendances waiting over

	the 999 stack and increasing visiting capacity	12 hours for admission for those with frailty
Minimise conveyances from Care Homes	Care homes with direct access to SPA	Maintain low conveyance rate from care homes
Eliminating corridor care in the Emergency Department	OUHFTs programme of work that focusses on this	Zero corridor care
Reduce the number of people who are delayed in hospital.	Reducing LOS for those who require support to return home from hospital	20% reduction in the number of people in hospital waiting to return home
Identification of those who may be End of life within bed-based care	Identification of those with complex needs and have been admitted to hospital 2-3 times in the previous months.	People are supported to die in a place of their choice
Moving to zero out of area placements for MH patients	Focus on reducing the length of stay within MH inpatients beds	Zero out of area placements for MH patients

6.1 Neighbourhood Development

We are using population health intelligence to identify and proactively support people at greatest risk of deterioration with a particular focus on adults with frailty, people with complex needs, and children and young people.

Over the longer term, we will strengthen integrated neighbourhood and community-based health and care to improve proactive, preventative support, to reduce risk and prevent avoidable admissions. Alongside we will enable p people to be assessed, treated and supported at home, or closer to home, wherever appropriate at times when an urgent care need arises –this will include Urgent Community Response, Hospital at Home/virtual wards, intermediate care, Home First and Discharge to Assess, supported by effective clinical and social care decision-making and coordination.

We will work across the full breadth of primary care, NHS 111, community, ambulance, mental health and acute services to strengthen clinical navigation and create more integrated pathways. We will seek greater consistency in access, referral and assessment arrangements, including appropriate use of NHS 111 direct booking and Single Points of Access.

Community Services

Integrated Single Point of Access (SPOA) and clinical assessment services will support integrated working and timely assessments within the community setting. We will continue to develop how we work together to reduce duplications in assessments and home visiting and maximise direction to clinics/unit-based services for those who are ambulatory.

- Maximising capacity with the Same Day Emergency Care (SDEC) units
- Integrating Urgent Community Response (UCR) across visiting services for on-the-day or next-day assessments
- Maximising Hospital at Home capacity by carrying out regular review of those in the service to create capacity for more people to be assessed and treated in their own home
- Continue to increase the number of people being assessed for their care needs in their own home to improve people's quality of life.
- Continue to develop Single Point of Access seven days a week and working with the Out of Hours service to provide the Health Care Professional advice line 24/7

6.3 Integration

- **Integrate visiting services:** to optimise home visiting services where adults and children need to be assessed and treated in their own home, directing those who are ambulatory to clinic/unit-based settings. Using Connected Care to improve communication within neighbourhood teams/primary care to help identify high-risk people within the community setting by creating alerts for those who have accessed emergency or urgent care services.
- **Through neighbourhood working** to gradually reduce risk in the community and improve access to integrated urgent care to reduce demand on primary care, avoidable secondary care admissions, emergency department attendances and within social care, the number of hours required for long term care.
- **Adult social care**: to work with strategic providers to increase the percentage of acute and rehabilitation adult discharges followed up within 72 hours and remaining in the community 12 weeks after reablement.
- **Ambulance services**: to focus on those with the greatest emergency need by maximising the number they virtually assess, working with community clinical advisory services to support the most appropriate service to assess the person in their own home, reducing inappropriate conveyances to ED and for those who are conveyed, achieving ambulance handovers under 45mins

6.4 Mental Health

OHFT are working with South Central Ambulance Service (SCAS) to maximise the use of the 24/7 CRISIS mental Health phone line to support SCAS crews with triage and the most appropriate pathway for those in a mental health crisis.

OHFT are continuing to develop the provision of 24/7 crisis team through expansion existing services. This is expected to be countywide by November 2026. It includes a professional advice line 24/7 for the police and health professionals, both of which work to ensure people in a mental health crisis are assessed and treated in the most appropriate setting.

Mental Health teams working collaboratively with neighbourhood teams and primary care to improve access to both services for those with a significant mental health condition.

SCAS MH Crisis pathway/guidelines have been developed to avoid people with a mental health need, but no physical health needs, attending an emergency department.

OHFT are working on reducing the length of stay for adult inpatients and minimising out-of-area placements for mental health patients.

OHFT also provide additional support for an all ages via a 24/7 in-house resourced mental health text service called ChatHealth.

OHFT MH services are continuing to work on refining opportunities to for people to be assessed in places such as safe havens. This also involves increasing the staffing capacity across community services and the mental health hotline in response to increased demand. There is continued focus on safety / crisis planning for high intensity users or urgent / emergency care services.

6.5 Acute Hospital Flow

We work with South Central Ambulance Service to support them achieving response times to those who have urgent life treating conditions (Category 2 response times), maximising hear and treat, reducing conveyances to ED, and achieving ambulance handovers under 45mins.

We need to achieve the following:

- 10% reduction in emergency admission by 2029 for frailty cohorts
- 10% reduction in ED attendances, acute admissions and Primary Care contacts for High Intensity users.
- Reducing ambulances conveyances to ED
- achieving ambulance handovers under 45mins
- Achieving the 4 and 12 hr standard for EDs
- Eliminating corridor care within the Emergency Departments

6.6 Discharge Standards

- Continued focus on people returning to their own home to identify any gaps or delays in processes. Working with people, their families and carers to identify the most appropriate discharge destination to meet their needs.
- Reducing length of stay for those who require support to return home and bed occupancy within frailty cohort bed bases.
- In relation to mobility, working with people in the community to improve their level of independence and quality of life.
- For winter, the focus will be on reducing the number of people who are delayed in hospital, reducing average delay across discharge pathways and ensuring that discharge remains safe, person-centred and supported by appropriate community services. This aligns with the Better Care Fund delivery plan, which supports the community, reablement, equipment, technology enabled care and intermediate care capacity needed to deliver sustained improvements in hospital flow.

7.0 Oxfordshire System Governance

All the providers within Oxfordshire, including SCAS and the patient transport service, meet virtually Monday to Friday at 08:30 to share information on UEC pressures and escalations. Actions are taken to resolve issues as they arise for any aspect of the pathway.

The need for further calls during the day is agreed or people can use this group to communicate with throughout the day if a decision to hold an escalation call is required after the morning meeting.

The winter plan is monitored monthly through the Oxfordshire Urgent and Emergency board. At time of escalation the key stakeholders of this group will meet on a more frequent basis.

8.0 Risks and Challenges

The Oxfordshire Urgent and Emergency Care system recognises the following potential risk that may impact on the winter period 2026/27:

There is concern that after seeing an increase in demand over the summer months, the system will not have the capacity or time to recover before we experience the expected increase in demand over the winter months. We will continuously monitor and adjust our plans as the needs change.

Appendix 1: Oxfordshire Place Assurance

The tables below highlight the local assurance as per the NHSE Winter Assurance Checklist published on 17th July 2026:

Section B: 26/27 Winter Plan checklist			Confirm (Y/N)
Prevention and vulnerable cohorts			
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes
Flow, occupancy and discharge			
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	Yes
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	Yes
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes
Demand, capacity, and surge management			
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	Yes
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes

Community Health Capacity			
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days	Yes

Whole System Response			
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes

Appendix 2: Thames Valley Integrated Care Board Assurance

Sections 4,7 and 8 requires assurance from Thames Valley ICB:

Primary Care, NHS 111 and admission avoidance		
4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.

Leadership, operational grip and resilience		
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.
	7.5	The Board is assured thatplans are in place to support staff welfare through periods of high demand.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

10 SEPTEMBER 2026

INDEPENDENT RESIDENT AND PATIENT VOICE UPDATE

Report by Susannah Wintersgill

RECOMMENDATION

1. **The COMMITTEE is RECOMMENDED to:**

a) **NOTE** the work undertaken to date by the Independent Patient Voice Working Group to explore future independent resident and patient voice arrangements in Oxfordshire.

b) **CONSIDER** the principles identified by the Working Group and the ongoing mapping/insight-gathering exercise that will inform the development of future options.

c) **RECEIVE** the emerging findings from the community engagement exercise presented by Remind Research, noting that the final report will follow.

Summary

2. This report updates the Committee on the work of the Oxfordshire Health and Wellbeing Board Independent Patient Voice Working Group, which was established to explore future independent resident and patient voice arrangements for health and social care in Oxfordshire.

3. The report sets out the national and local context for this work, including the Government's proposal, through the Health Bill 2026-27, to abolish Healthwatch England and local Healthwatch organisations. It explains the establishment and activity of the working group to date and outlines the principles identified to guide any future independent resident and patient voice function.

4. The report also describes progress with the system-wide insight-gathering exercise commissioned to inform the working group's consideration of future arrangements. At the meeting, the Committee will receive a presentation from Remind Research on the approach taken and the emerging findings from public engagement with stakeholders and residents, including young people. These findings are emerging and the final report will follow.

Introduction

5. This report provides an update on the activities of the Oxfordshire Health and Wellbeing Board Independent Patient Voice Working Group, which was established to explore future independent voice arrangements for Oxfordshire. It includes a chronological timeline setting out how and why the group was established.

6. This is a timely update in the context of the Health Bill 2026-27 progressing through Parliament, with national policy moving from proposal towards implementation. It also follows recent correspondence between the Secretary of State for Health and Social Care and the Oxfordshire Joint Health Overview and Scrutiny Committee, in which the Committee expressed concern about the proposed abolition of Healthwatch England and local Healthwatch organisations, including Healthwatch Oxfordshire.

7. Specifically, the Committee asked that, should the Government's proposals proceed, local systems retain sufficient flexibility to develop arrangements that preserve genuinely independent, locally rooted patient and resident voice. This request is central to the work of the Health and Wellbeing Board working group.

National context

8. In July 2025, national proposals set out in the Dash Review signalled the Government's intention to abolish Healthwatch nationally and locally, alongside the abolition of Councils of Governors of Acute Trusts, which currently provide formal routes for staff and patient representation across NHS Foundation Trusts. These proposals formed part of a wider programme of reforms intended to simplify the health and care landscape and strengthen accountability for patient experience and service improvement.

9. Subsequent correspondence shared with local system partners and the Oxfordshire Joint Health Overview and Scrutiny Committee confirmed this position. The Department of Health and Social Care, via Oxfordshire MPs, reiterated that Healthwatch would not continue as a statutory entity and that any local response or decision would need to align with national legislation.

10. In May 2026, the Government introduced the Health Bill 2026-27 to Parliament. The Bill includes provisions to abolish Healthwatch England and Local Healthwatch organisations and transfer relevant functions to integrated care boards and local authorities. Following its Second Reading in June 2026, the Bill completed Commons Public Bill Committee scrutiny in July 2026.

11. The next stage of Parliamentary consideration is the Commons Report Stage, scheduled for 7 September 2026, after which the Bill must complete its remaining Commons stages and proceed to the House of Lords for further scrutiny before it can receive Royal Assent.

12. The final legislative arrangements and implementation timetable have therefore not yet been determined. On 2 September 2026, the Department of Health and

Social Care will provide an online update for local authority commissioners on Healthwatch arrangements. An officer representative from Oxfordshire County Council will attend this meeting.

Local context

13. On 9 September 2025, Oxfordshire County Council unanimously passed a cross-party motion calling on the Leader of the Council and Cabinet to: "Urgently consider how the Council working with NHS partners can safeguard and develop the Healthwatch function and engage and meaningfully consult with all local stakeholders to ensure the local delivery of national reforms at neighbourhood level best meet patient and community need."

14. This motion was subsequently discussed by Cabinet on 18 November 2025where Cabinet:

    - Acknowledged and noted the motion and the impending abolition of Healthwatch.
    - Endorsed the importance of the Healthwatch function, including the contribution of 38 patient-experience reports under the leadership of Dr Veronica Barry, executive director of Healthwatch Oxfordshire.
    - Supported system-wide work to safeguard the independent patient voice, while noting that any redesign must remain within emerging national legislation.

15. At its 18 November meeting, Cabinet did not take an executive decision. Instead, it referred the matter to system partners, including the Oxfordshire Health and Wellbeing Board, to progress work to protect independence in any future model.

16. On 4 December 2025, the Oxfordshire Health and Wellbeing Board agreed to establish a working group to explore future arrangements for an independent patient voice and to report back to the wider Board.

17. At its next meeting on 12 March 2026, the Board agreed the group's membership, its engagement remit, delegated authority to oversee a programme of public engagement, and requested that the working group report back with recommendations.

18. In establishing the working group, the Board recognised that final local arrangements for a patient voice function cannot be determined until any legislation is passed. However, it considered that there was value in developing an evidence base and exploring potential options to understand the implications of different approaches and support future decision-making, should changes be required.

19. On 3 July 2026, the Chair of this Joint Health and Overview Scrutiny Committee wrote to the Secretary of State for Health and Social Care regarding the proposed abolition of Healthwatch England and local Healthwatch organisations. The letter highlighted the importance of maintaining an

independent patient and resident voice and requested that, should the Government proceed with its proposals, local systems be given sufficient flexibility to develop arrangements that reflect local circumstances and community needs.

20. On 31 July 2026, the Department of Health and Social Care responded, confirming the Government's intention to proceed with the abolition of Healthwatch, subject to the passage of the Health Bill through Parliament. The response stated that responsibility for patient and public voice would in future sit with Integrated Care Boards and local authorities, supported nationally through a new Patient Experience Directorate within the Department.

21. On 23 May 2026, an update report was provided to the Health and Wellbeing Board on the establishment and early work of the Independent Patient Voice Working Group. The group currently comprises the members listed below and is supported by Dr Omid Nouri, Scrutiny Officer at Oxfordshire County Council.

- Chair of the Health and Wellbeing Board (To be determined).
- Vice-Chair of the Health and Wellbeing Board and Chair of Oxford University Hospitals NHS Foundation Trust (To be determined).
- Ansaf Azhar (in his capacity as Director of Public Health).
- Karen Fuller (in her capacity as Director for Adult Social Care).
- Grant Macdonald (in his capacity as Chief Executive of Oxford Health NHS Foundation Trust).
- Michelle Brennan (in her capacity as a representative of Oxfordshire's GP Leadership Group)
- Dan Leveson (as a representative of the Thames Valley Integrated Care Board).

22. The working group will provide a second update report to the Board at its next meeting on 24 September 2026, and is expected to report its findings to the Oxfordshire Health and Wellbeing Board on 10 December 2026 when it is hoped that there will be greater clarity on the Government's legislative arrangements and implementation timetable.

Activity of the Independent Patient Voice Working Group to date

23. The working group first met on 23 January 2026. The purpose of the meeting was to consider the current role of Healthwatch in enabling independent resident and patient voice across Oxfordshire, including the scale and breadth of its activity; and to scope the range of other evidence required to inform the group's deliberations.

24. Veronica Barry, Executive Director of Healthwatch Oxfordshire, and Barbara Shaw, Chair of Healthwatch Oxfordshire, contributed to the first item. Dr Omid Nouri, Scrutiny Officer, was nominated to coordinate activity for the group and to undertake a desk research exercise to map existing patient and resident voice activity across Oxfordshire health and social care system partners. In addition, Oxfordshire County Council's Communications, Marketing and

Engagement team was asked to scope and commission a community engagement package.

25. At this meeting, the working group also agreed the following principles for a future independent resident and patient voice function:

- Brand – trusted and recognised. If not the existing Healthwatch brand, will this then be a different brand?
- Trust- especially with communities and patients.
- Ability to act and set areas of focus independently.
- Consolidation of functions and avoiding duplication between system partners, CVS, engagement teams and patient involvement mechanisms.
- Capacity building in communities.

26. The working group also identified supplementary principles to inform the future function. These were:

- Preserving the "bridge" function between the public and system, with local focus and voice.
- Triangulation of patient experience.
- Use of staff insight and quality data.

Independent primary research

27. As requested by the working group, Oxfordshire County Council has commissioned Remind Research, an independent research agency, to undertake a community engagement programme on future independent resident and patient voice arrangements in Oxfordshire.

28. After consideration, it was agreed that this work was best suited to a qualitative approach with segmented target audience groups. This approach enables participants to explore their experiences, needs and expectations in greater depth than would be possible through a survey or at event/on street discussions, helping to identify nuanced views, concerns and opportunities for future arrangements. It also allows the perspectives of groups with differing experiences of health and care services to be understood and compared.

29. At its second meeting on 7 May 2026, the Health and Wellbeing Board working group helped shape the design, methodology and discussion topics for the community engagement programme, ensuring it was focused on the issues most relevant to Oxfordshire residents and stakeholders.

29. Overall, the community engagement programme focuses on three core audiences: a cross-section of Oxfordshire stakeholders with an interest in patient, resident and service user voice; adult residents who are frequent and infrequent users of health and social care services; and young people aged 13 to 17 who are frequent and infrequent users of services. It seeks to reflect a range of backgrounds and experiences, including people with experience of

social care, primary healthcare and existing patient involvement arrangements such as Healthwatch.

30. The methodology comprises a series of qualitative interviews and focus groups. Up to 20 stakeholder perspectives are being gathered through in-depth interviews with representatives from statutory organisations, the voluntary and community sector, and other organisations with an interest in patient and resident voice. Adult residents have participated in focus groups and, where appropriate, individual interviews to support inclusion and accessibility. Separate face-to-face interviews are being held with young people to ensure that their views and experiences are reflected within the findings.

31. At its core, the engagement is designed to test and refine the emerging principles identified by the working group, understand attitudes towards current and future patient voice arrangements, identify any gaps or unmet needs, and explore the characteristics that stakeholders and residents believe should underpin future arrangements.

32. Tailored discussion guides have been developed for different audience groups to explore current experiences of patient and public involvement in health and social care, awareness and perceptions of Healthwatch Oxfordshire, views on the Government's proposed reforms, and expectations for future patient voice arrangements. Participants have been invited to consider the strengths and limitations of current arrangements, identify the functions and characteristics that should be preserved in any successor model, and discuss the balance between independence, influence, accountability and public trust.

33. Through the discussion guides, participants are also sharing their views on the draft core and supplementary principles for a future independent resident and patient voice function developed by the Board. This includes identifying gaps, priorities and potential tensions within the proposed principles to help inform the working group's consideration of future arrangements.

34. At the point of providing this report, this work is still ongoing but emerging findings from all stages of the research undertaken thus far are being brought together through thematic analysis to identify common themes, areas of consensus and differences in perspective between audiences.

35. Rachel McGrail, Director at Remind Research, will present the emerging findings to Committee. The final report will be circulated to committee members and published on the county council's Let's talk Oxfordshire consultation portal.

System-wide mapping of existing patient and resident voice functions

36. In parallel with the independent community engagement programme commissioned from Remind Research, the working group has initiated a system-wide mapping exercise to understand the patient and resident voice functions that already exist across Oxfordshire's health and care system. This exercise is being undertaken because any future local model for independent patient and resident voice must be designed with a clear understanding of the existing landscape. It would not be sufficient simply to consider what may be lost if Healthwatch is abolished as a statutory body; the working group also needs to understand what routes for listening, engagement, feedback, challenge and accountability are already operated by system partners, how those routes are used, where they add value, and where there may be gaps, duplication or fragmentation.

37. The purpose of the mapping exercise is therefore both descriptive and strategic. Descriptively, it seeks to build a shared evidence base about the current patient and resident voice arrangements across the County Council, NHS providers, the Integrated Care Board, district and city councils, and other relevant parts of the local system. Strategically, it is intended to help the working group consider how any future model could complement, strengthen and connect existing functions, rather than duplicate them or create an additional layer of activity without a clearly defined purpose. This is particularly important because the emerging national direction suggests that some responsibilities currently associated with Healthwatch may transfer to local authorities and Integrated Care Boards. In that context, Oxfordshire needs to be able to distinguish between functions that could appropriately sit within statutory organisations and those that require visible independence, local credibility and the ability to challenge commissioners and providers on behalf of residents.

38. The exercise is also intended to support a more informed discussion about what independence should mean in practice. The working group has already identified independence, trust, recognised routes for engagement, community reach, triangulation of evidence and the avoidance of unnecessary duplication as important principles. The mapping work provides a practical means of testing those principles against the services, processes and engagement mechanisms that already exist. For example, it enables the group to consider whether current arrangements are primarily designed to gather feedback for service improvement, support formal complaints and concerns, co-produce services, involve residents in strategic planning, reach seldom-heard communities, or provide independent challenge. These distinctions matter because not all patient voice activity performs the same function, and not all engagement routes are equally able to provide residents with confidence that their views can be raised independently of the organisations responsible for commissioning or delivering services.

39. Methodologically, the mapping exercise is being taken forward as a structured desk-based and partner-led insight exercise, coordinated by the Scrutiny Officer supporting the working group. System partners have been asked to identify the

patient and resident voice functions that exist within their organisations and to provide a short description of how each function operates and what purpose it serves. This includes, for example, formal patient experience mechanisms, engagement and consultation functions, routes for gathering service user feedback, arrangements for involving residents in service design or improvement, patient participation or involvement structures, complaints and concerns routes where these generate wider learning, and mechanisms used to bring community insight into strategic decision-making. The intention is not only to compile a list of activities, but to understand the role each activity plays within the wider system and the extent to which it contributes to listening, learning, accountability, influence and independent challenge.

40. Responses are being sought from the key organisations represented in the working group and from wider local partners where relevant. This includes Oxfordshire County Council, Oxford University Hospitals NHS Foundation Trust, Oxford Health NHS Foundation Trust, the Integrated Care Board, Healthwatch Oxfordshire, district and city council engagement leads, and other local partners whose work contributes to resident and patient voice. The exercise deliberately sits alongside, rather than instead of, the independent community engagement work. The Remind Research work is gathering qualitative insight from residents, young people and stakeholders about expectations for future independent voice arrangements. The mapping exercise, by contrast, is examining the system architecture that already exists. Taken together, these two strands should allow the working group to compare what residents and stakeholders say is needed with what the system currently provides.

41. Once the information from partners has been collated, it will be analysed thematically to identify the principal categories of patient and resident voice activity across Oxfordshire. This analysis will consider where functions are concentrated, where similar forms of engagement are taking place across several organisations, where there are opportunities for better alignment or shared learning, and where there may be gaps in relation to independence, accessibility, geographic reach, seldom-heard communities, feedback loops and escalation routes. Particular attention will be given to whether existing mechanisms enable residents to see how their feedback has influenced decisions, whether insight is routinely shared across organisational boundaries, and whether there is a clear route through which recurring themes in patient experience can be elevated from individual organisational learning into system-wide improvement and scrutiny.

42. The outputs from the mapping exercise will be shared first with the Independent Patient Voice Working Group so that members can consider the findings alongside the emerging evidence from the independent engagement programme. They will then inform the update to the Health and Wellbeing Board at its meeting on 24 September 2026, where the Board will be able to consider the interim evidence base before more developed options and recommendations are brought forward. The findings will also be shared with the Joint Health Overview and Scrutiny Committee, recognising the Committee's established role in considering patient experience, system accountability and the implications of national reforms for Oxfordshire residents. This approach is

intended to ensure that the evidence gathered is not held only within the working group, but is visible to the wider local governance arrangements that will need to understand and scrutinise future proposals.

43. The working group has been clear that the mapping exercise should not pre-empt decisions about any future model. The final shape of local arrangements will depend on the passage of national legislation, any accompanying guidance, future funding arrangements, and the conclusions drawn from the engagement and mapping evidence. However, undertaking this work now places Oxfordshire in a stronger position to respond constructively and quickly once the national position becomes clearer. It ensures that any future proposal can be grounded in evidence about both current system capacity and resident expectations, rather than being developed in isolation or in response to legislative change alone. In doing so, the mapping exercise forms a central part of the working group's broader objective: to protect the strengths of independent patient and resident voice in Oxfordshire while ensuring that any successor arrangements are coherent, locally rooted, influential and capable of adding value across the health and care system.

Next Steps

36. Members of the working group, supported by Dr Omid Nouri, will continue to meet periodically to advance this work. An update report, including the full findings from the primary research conducted by Remind Research and the desk-based mapping exercise, is scheduled to be presented at the Board's next meeting on 24 September 2026. The working group is expected to present its final report to the Health and Wellbeing Board on 10 December 2026, when it is hoped that there will be greater clarity on the Government's legislative arrangements and implementation timetable.

37. Following this, further updates will be brought to the Board and Committee where are key milestones or substantial developments or decisions required.

Financial Implications

38. There are no direct financial implications arising from this update report. The engagement exercise commissioned to help inform a future independent patient voice function has been funded from existing consultation and engagement service budgets.

Comments checked by:

Bick Nguyen-McBride, Finance Business Partner

Legal Implications

38. There are no direct legal implications arising from this report.

39. As set out above, the Health Bill is currently progressing through Parliament and is next due to be considered on 7th September. This report sets out local activity in response to the proposed abolition of Healthwatch England and Local Healthwatch, to understand the local picture in anticipation of new arrangements yet to be determined at a national level and for which the timetable is, as yet, unclear.

Comments checked by:

Janice White, Principal Solicitor – ASC, SEND and Education.

Susannah Wintersgill
Director Public Affairs, Policy and Partnerships

Background papers: Nil

Contact Officer: Dr Omid Nouri (Health Scrutiny Officer)
Carole Stowe (Engagement & Consultation Manager)

September 2026

Your voice on health and care services

Report to the Oxfordshire Joint Health Overview and Scrutiny Committee

September 2026

Table of Contents

1. Our 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 attended and reported to Health and Wellbeing Board (July 2026) and Health Improvement Board (June 2026). We attend Primary and Community Board, Oxfordshire Place Based Partnership, and Oxfordshire Health Inequalities Forum and Oxfordshire Marmot Place meetings.

We published Healthwatch Oxfordshire **Annual Impact Report** outlining our work in **2025-6**. During this year:

To read the full report and see the recording of our team presentation: https://healthwatchoxfordshire.co.uk/reports-hub/1726

2. Our research reports

We make sure we hear from people via a mix of methods, including survey online and in paper form, and through ongoing face to face outreach, on the streets, at events and community settings. 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

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

➢ Views and experiences of palliative and end of life care in Oxfordshire

We used a survey and phone interviews to hear from **110 local residents** about their views and experiences of palliative and end-of-life care for adults in Oxfordshire. We asked what is important to people towards the end of their lives, and what might support people to have conversations about their wishes with family, friends, or health and care professionals. We also asked people about any experiences they had had of end-of-life or palliative care services.

What we heard: We heard that many people had clear and consistent priorities about what mattered to them most at the end of life: **being close to loved ones**, **feeling safe and comfortable**, and receiving **good quality care**. Most people said they would **prefer to die at home or in a hospice** rather than in a care home or hospital. Although many people had thought about or discussed their wishes, not everyone had made formal plans and some people said they were unsure about how and when to have end-of-life conversations.

People told us about positive aspects of palliative and end-of-life care, including having **control over decisions**, **management of symptoms and pain**, being treated with **dignity and compassion**, and receiving support that recognised both **the patient as a whole person** and those close to them. However, some people had experienced challenges including **difficulties accessing support** and services, **gaps in communication**, **lack of coordination** between different health and care providers, **poor communication**, and **inadequate quality and continuity of care**.

People suggested improvements to palliative and end-of-life care including around information and access to support and services; communication and encouraging earlier conversations about end-of-life wishes; strengthening coordination between services; strengthening staff capacity and skills and increasing support for families. Throughout, we heard about the importance of care and support that builds on people's existing networks, assets and communities, that is culturally appropriate, and that takes into account the wishes of people who are dying and their loved ones, supporting them to live and die well.

Based on what we heard, we made a series of recommendations for improvements. We shared our report and recommendations with the Thames Valley Integrated Care Board, Oxford University Hospitals NHS Foundation Trust, Oxford Health NHS Foundation Trust, Oxfordshire County Council and other health and care-decision makers in Oxfordshire. Provider responses can be seen on our reports page.

➢ What we heard about hospitals (August 2025 - July 2026)

We published a summary report outlining the themes of feedback and public comments about hospital care, across Oxford University Hospitals NHS Foundation Trust Hospitals (OUHT), including Horton and John Radcliffe, Nuffield and Churchill Hospitals in the past year 2025-6. This was gathered over the year, via our research projects, rural engagement, regular hospital stands, Enter and View and face to face conversations during outreach at events and community activities across the county. Read the report here: https://healthwatchoxfordshire.co.uk/reports-hub/1771

We heard a range of themes including positive feedback about good communication, compassionate care and professionalism from NHS staff. We also heard about things that can be improved, including interface, communication between primary and secondary care, administration, information and communication, interpreting whilst waiting for hospital appointments, waiting times and cancellations. Parking remains an ongoing frustration. In our research in rural areas, we also heard about the challenges, time and cost of reaching hospitals, in particular for those who don't drive or have to use taxi, or lack local community or poor public transport links:

> *I've had a fair number of neuro ophthalmology appointments at the JR in Oxford during the last 6 months which entails catching 3 buses or trying to get a lift at least part of the way as it's such a difficult place to access if you aren't allowed to drive*
>
> *Desperately need community transport to attend John Radcliffe Hospital. I attend regular appointments and a taxi is approx. £140 return. There is no easy way to get there.*

Forthcoming reports include:

- Rural insights from 14 **rural areas** for Oxfordshire County Council as part of the wider Marmot focus on health inequalities. The report will be presented by Public Health to Health and Wellbeing Board in September.

3. Our webinars

Our **next webinar** will take place on **Tuesday 15th September from 1pm - 2pm** and will focus **on end-of-life and palliative care.**

We will be joined by guest speakers Gabbie Parham, Senior Matron for Community Nursing, and Antoinette Broad, Clinical Lead and Matron for Community Nursing, from Oxford Health, and Victoria Bradley, Clinical Lead and Consultant in Palliative Care Medicine, from Oxford University Hospitals.

Our speakers will talk about what their services offer, and the importance of early conversations about end-of-life wishes and advanced care planning. All are very welcome to attend. Join us on the day using **this zoom link:** Zoom link

4. Community Research guide and training

We **delivered face to face training for 15 community researchers**, building on the stages of community research in the '*How to Guide – co-produced with community researchers in Oxfordshire*' launched in May. Two full day training workshops were delivered by Katharine Howell (HWO), Nigel Carter (Oxford Community Action) and Makena Lohr (freelance). These were funded by Oxford Brookes University in support of the Oxfordshire Community Research Network.

We will be running further community researcher training sessions in October, along with ongoing online peer support sessions for community researchers over the next six months.

See here for online version of the guide
https://healthwatchoxfordshire.co.uk/community-research-how-to-guide which can be used by anyone in Oxfordshire and is free for others to promote and use.

To read more about the impact of all our work and all our 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 also snapshot summaries of our month-by-month work.

https://healthwatchoxfordshire.co.uk/latest-news/2026/08/a-snapshot-of-our-work-in-july

5. 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.

We were also delighted to hear that feedback we'd shared with Oxford Health following our previous Enter and View visit had fed into plans for a refurbishment project at Abingdon Community Hospital's Emergency Multidisciplinary Unit (EMU). You can read more about the improvement work on Oxford Health's website Major overhaul of Abingdon's emergency multidisciplinary unit | Oxford Health NHS Foundation Trust, and congratulations to Oxford Health for driving this project through for the benefit of patients, carers and staff.

- We visited Abingdon Hospital Minor Injuries Unit (MIU) in July (report forthcoming)

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

Listening out and about across Oxfordshire

Since July we have attended a number of events and groups across Oxfordshire to hear their views on health and social care, including experiences of maternity care and postnatal support. For example, we attended Banbury, Bicester and Berinsfield Play Days, Grove and Wantage family group at Wantage Library, Rachel House in Banbury among other events and groups.

6. 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 community

events. This enables us to raise what we are hearing, including emerging themes, with health and care providers and commissioners.

Ongoing themes include hearing about:

- SEND and autism support,
- Primary and secondary care interface and communication across, between and within services, discharge support.
- We continue to hear from people making complaints to services, including time taken to receive responses
- Travel to hospital from rural areas – distance, time and cost of taxi, and parking challenges including for disabled visitors

  *Parking absolute nightmare, have to allow over an hour to park with a blue badge and often just can't park at all. All the car park spaces are full from 8am in the morning and stay full all day. I can't take a bus, taxis are £50 return which as disabled on a low income is a lot of money, so try to arrange appointments times only when I hope I can park in the morning, driving there very early and waiting for my appointment time. So I don't miss my appointment, it's very demoralising as I want to maintain as much as my independence, but parking issues make it very stressful (*Feedback online re John Radcliffe*)*

The report published this week on 'What you told us about hospitals' gives insight into public feedback on hospital care. Speaking specifically to HOSC agenda, the following give insight into some of the public feedback we have received directly about the services at the **Horton Hospital**:

> *Services are good at the Horton hospital and easy to get there and park. Can drop in for X-ray if requested by GP*
>
> *I'm disabled in a wheelchair, the movement in the corridors is difficult as it's too narrow.*
>
> *A nurse called [name] rang me and asked questions relevant to my upcoming admission for a procedure I am about to have and feeling anxious about. Talking with her, she was lovely talking about at first my date of birth as her birthday is similar - made me feel less worried and towards end made me laugh which put me at more ease. Such a lovely kind person*

I was very well treated with respect and kindness. I felt that there was a total feeling off calmness and professionalism.

*Made to feel welcome and help you every step of the way, nothing is to much for them always happy to help. (*online feedback*)*

*From the moment I arrived my nurse was incredibly kind and gentle. I was feeling very anxious about the procedure, but she instantly made me feel calm, safe and cared for. The young lady from the anaesthetic team came to speak with me before the procedure — she was so lovely, explaining everything clearly and reassuringly. One of the surgeons also came to introduce herself and talk me through what would happen. She was warm, caring and professional, which helped me feel completely at ease. When I woke up in recovery, the team there were just as kind and attentive. Back on the ward, I was once again looked after beautifully by [name] and [name]. They couldn't have done more for me — so compassionate, patient and genuinely caring. If it hadn't been for these wonderful people, I would have felt very frightened, but their kindness and professionalism made all the difference. They are an absolute credit to the hospital, and we are truly lucky to have such dedicated staff caring for patients. (*feedback centre*)*

Excellent surgery and excellent local Horton Hospital. Can take us up to two hours to get to Oxford hospitals! Had MRI scan at Horton on Sunday excellent new facility. Banbury and its growing population and its many rural communities deserve more facilities like these at the Horton. As you are getting older you need hospital care near at hand. It often takes us 2 hours to get to Oxford Hospitals in the traffic. This is hard when in mid-eighties. More services at the Horton Hospital is urgently needed with the rapidly building programme in the area

I am profoundly deaf. Over the years, the service has diminished. It used to have a walk-in clinic to have any hearing aid issues looked at - 2 times a week at Horton Hospital and once at Cope Road. Now, it has literally no drop in facility at all. Add to this that JR too now has no walk in facility to assist anyone, leaves us with no emergency provision whatsoever in the whole of Oxfordshire serving our area. If your aid needs to be looked at, you have to email (obviously deaf patients cannot ring up!) and request an appointment. You then sit and wait for an email response which is rarely quick, even if addressed as URGENT. Even if you request an urgent appointment, you wait

well over 10 days to be seen. Deafness causes isolation, vulnerability and also prevents you from working if the aids you have stop working and you have to wait often over a week to be seen.

7. Future of Healthwatch

Healthwatch Oxfordshire continues as an independent charity to be here to listen to people using health and care services and ensuring their voices are heard by decision makers. The proposed Health Bill https://bills.parliament.uk/bills/4124 includes removal of statutory function of local Healthwatch as an independent voice, and shifts responsibility for engaging, listening and acting on patient feedback to local authorities and to Integrated Care Boards. It is a time of great complexity and change, across all levels of the health and social care landscape, and with additional impact of local government reorganisation for Oxfordshire.

The bill is going through parliament, with its third reading in the commons on 6th September and with potential to be enacted by April 2027 if on timeline. We are working closely with health and social care system to explore future iterations for independent voice, and a commissioned report on this will be presented to Oxfordshire Health and Wellbeing Board on 24th September.

Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Oxfordshire Joint Health Overview and Scrutiny Committee
Thursday 10 September 2026

Horton Hospital Update Report
Oxford University Hospitals NHS Foundation Trust

Content

Oxford University Hospitals NHS Foundation Trust Horton Hospital Update Report

1. Purpose

1.1. To support the Health Overview and Scrutiny Committee (HOSC) in its duties by providing a response to a series of questions focussed around the Horton General Hospital (HGH).

2. Background

2.1. The HOSC has requested a detailed response to a series of questions relating to the HGH.

2.2. OUH is structured to manage its healthcare provision by services across all its sites, rather than by individual site. Therefore, much of the information requested requires bespoke preparation and analysis.

2.3. Given the above and noting the operational challenges and pressures that the NHS is currently experiencing, with agreement from the Health Scrutiny Officer, OUH will provide its response in two phases, with submissions planned for September and November 2026. Annex 1 summarises how OUH's response is split between the two phases.

2.4. This paper brings together the HOSC questions and the Trust's detailed responses for the September submission.

2.5. HOSC's questions are shown in italics throughout the response ahead of OUH's response.

3. Response to HOSC Queries

Strategic Role of the Hospital

- ***Provide an overview of the Horton General Hospital's current role within the OUH system and the wider Thames Valley health system.***
- ***Explain how the Horton fits within OUH's clinical strategy and service model and estates.***

- ***Describe the hospital's function as a local hospital serving Banbury, north Oxfordshire and neighbouring areas of Northamptonshire and Warwickshire.***
- ***Outline any significant changes in the hospital's role, service offer or strategic direction over the past five years.***

3.1 Overview: HGH remains a critical part of Oxford University Hospitals NHS Foundation Trust (OUH), providing a broad range of local hospital services for the population of Banbury, north Oxfordshire and neighbouring communities in Northamptonshire and Warwickshire. Consistent with previous discussions with the Joint Oxfordshire Health Overview and Scrutiny Committee (JHOSC), OUH's approach has been to have the HGH as a strong and viable local hospital, delivering care as close to home as possible while ensuring patients have access to specialist and highly complex services delivered across the wider OUH network when required.

3.1.1 Within the OUH system, the HGH performs an important role as the local provider of emergency, urgent, outpatient, diagnostic, day case, rehabilitation and community-facing hospital services. The hospital is home to a busy Emergency Department, acute medical services, diagnostics, maternity services, outpatient clinics, elective procedures and integrated care services. It acts as both a local access point for healthcare and as part of a wider networked model of care across OUH's four hospital sites. This enables patients to receive care locally while supporting access to specialist expertise available when needed.

3.2 Clinical strategy and service model: The HGH's role aligns with OUH's clinical strategy, which emphasises delivering excellent patient care, improving outcomes, reducing inequalities and providing care in the most appropriate setting. HGH supports this approach as an essential component of a networked OUH model, combining local accessibility with the benefits of being part of a large teaching hospital organisation. This approach supports clinical sustainability, workforce resilience and high-quality care.

3.3 Estates: From an estate's perspective, the HGH remains a strategically important healthcare asset for the northern part of Oxfordshire. OUH's response has been incremental reinvestment:

3.3.1 A £115,000 maternity unit redevelopment funded new clinic rooms, scanning facilities and an improved midwifery station, enabling three new high-risk obstetric clinics a week delivered by the John Radcliffe specialist teams from late 2025.

3.3.2 An expanded musculoskeletal interventional service for bone and soft-tissue tumours went live at the end of 2025.

3.3.3 The Horton General Hospital continues to benefit from targeted estates investment, with a number of schemes already completed or underway, including upgrades to the Mayflower Suite, electrical infrastructure, operating theatres, staff facilities and diagnostic imaging.

3.3.4 In addition, a pipeline of proposed developments over the coming years includes further investment in emergency care, ambulatory services, women's diagnostics and renal services, reflecting OUH's continued commitment to maintaining and enhancing high-quality facilities for patients and staff in Banbury.

3.4 Hospital's functions and changes: Over the past five years, the HGH has continued to evolve in response to changing population needs, workforce challenges, service transformation and lessons from the COVID-19 pandemic. While some services have been redesigned through networked and clinically led models, the overall strategic direction has remained consistent: to retain the HGH as a sustainable local hospital delivering a comprehensive range of services for its catchment population.

3.4.1 Looking ahead, the ambitions set out in the NHS 10-Year Health Plan reinforce the importance of hospitals such as the HGH. National policy emphasises shifting care closer to home, an increased focus on prevention, and making better use of technology and diagnostics. The HGH is well placed to contribute to these objectives by acting as a local hub within a networked model of care, supporting earlier intervention, more joined-up pathways and improved access for the communities it serves while remaining fully integrated within the wider OUH and Thames Valley healthcare system.

3.5 Current Services Delivered at the HGH: A comprehensive description of services currently provided on the Horton site, including:

- ***Urgent and Emergency Care.***
- ***Acute and general medicine.***
- ***Diagnostics and imaging.***
- ***Elective and day-case surgery.***
- ***Outpatient services.***
- ***The Brodey centre and any Cancer services delivered at the site.***
- ***Maternity and obstetric services (high-level overview only).***
- ***Community and integrated services delivered from the site.***
- ***Specialist outreach clinics and visiting consultant-led services.***
- ***Any services delivered jointly with Oxford-based sites.***

3.5.1 Urgent and emergency care. Timely access to urgent and emergency care is critical to the health of the population. OUH was ranked as having one of the best performances nationally for the 4hr wait standard and HGH is a key part of this success. In 2025/26 OUH achieved 78.5% four-hour performance for all emergency care types. OUH achieved 70.7% four-hour performance for Type 1 Emergency Departments, which comprises the Emergency Departments at both the John Radcliffe and Horton General Hospitals. Emergency attendances increased at both sites, with 5.5% growth at Horton General Hospital. In response to the 5.5% growth in emergency attendances at Horton General Hospital, the Trust is strengthening operational resilience across the urgent and emergency care pathway.

3.5.1.1 The HGH operates an emergency department with an emergency admission unit, functioning as the front door for acute presentations from Banbury and the surrounding catchment. This sits alongside a dedicated Emergency Assessment Unit (EAU) for further assessment of admitted patients.

3.5.2 Acute and general medicine. Acute general medicine is delivered on-site, supported by inpatient wards such as F Ward and the Oak High Care Unit, which provides higher-dependency monitoring near the Emergency Department and main reception.

3.5.3 Diagnostics and imaging. A radiology department provides imaging support across the site's emergency, medical, surgical and outpatient pathways, underpinning same-site diagnosis without automatic transfer to Oxford for routine scans.

3.5.4 Elective and day-case surgery. The four operating theatres support elective day case surgery delivered through the HGH Day Case Unit, which covers a range of planned procedures for patients who do not require overnight admission.

3.5.5 Outpatient services. The outpatient department runs consultant clinics covering a broad spread of specialties and allowing patients to be seen locally rather than travelling to the John Radcliffe for routine review.

3.5.6 Cancer services (Brodey Cancer Centre). The Brodey Cancer Centre treats cancer patients on-site, with a palliative care team which includes; a full-time nurse and a visiting consultant from Katharine House Hospice, based in the department. Three oncologists hold regular weekly outpatient clinics, plus a haematologist is based at the HGH. There are no inpatient oncology or haematology beds at the HGH, so some patients still require treatment in Oxford.

3.5.6 Maternity and obstetric services (high level overview requested). The HGH's maternity provision operates as a midwifery-led unit rather than a full consultant-led obstetric unit; women requiring specialist obstetric care are transferred to the Women's Centre at the John Radcliffe or to other neighbouring units. There is a Midwifery Led Birthing Unit and Specialist clinics along with scanning. Recent investment has added visiting high-risk obstetric clinics.

3.5.7 Community and integrated services. A satellite outpatient unit of the Oxford Kidney Unit provides dialysis and renal care from the HGH Renal Unit, operating

extended hours to serve local patients without requiring travel to Oxford for routine treatment.

3.5.8 Specialist outreach and visiting consultant-led services. Beyond outpatients generally, this includes the weekly oncology and high-risk obstetric clinics already noted, and the recently expanded musculoskeletal interventional service for soft-tissue and bone tumours, delivering specialist image-guided procedures under general anaesthesia, particularly valuable for children and patients with complex needs.

3.5.9 Services delivered jointly with Oxford-based sites. Several HGH services are explicitly run in partnership with teams based in Oxford; the satellite renal dialysis unit under the Oxford Kidney Unit, the high-risk obstetric clinics staffed by John Radcliffe specialists, oncology and haematology pathways that route more complex inpatient cases to Oxford, and outpatient clinics generally, which rely on consultants visiting from Oxford-based specialties rather than a locally resident consultant workforce.

3.6 Access to Care and Patient Flows

- ***Explain patient pathways into and through the Horton.***
- ***Describe where patients are routinely treated locally and where onward transfer to other sites is required.***
- ***Provide information on patient flows between the Horton, the John Radcliffe, Churchill and other regional hospitals.***
- ***Outline any known challenges relating to travel, transport or access for local residents.***

The tables below show the changes in activity using the Compound Annual Growth Rate (CAGR) method, and the growth form 2024/25 to 2025/26.

3.6.1 Admissions (elective and emergency)

Site	*CAGR (2019/20-2025/26)*	*Growth 2024/25 to 2025/26*
Horton General Hospital	*2.4%*	*1.1%*
Churchill Hospital	*-1.4%*	*1.6%*
John Radcliffe Hospital	*3.7%*	*6.0%*
Nuffield Orthopaedic Centre	*-0.4%*	*3.0%*

3.6.2 Outpatient attendances

Site	CAGR (2019/20-2025/26)	Growth 2024/25 to 2025/26
Horton General Hospital	2.6%	3.1%
Churchill Hospital	3.7%	4.3%
John Radcliffe Hospital	4.5%	3.1%
Nuffield Orthopaedic Centre	3.2%	4.8%

3.6.3 For inpatient services at HGH, using the CAGR method since 2019/20 to 2025/26, the specialties accounting for the highest share of activity saw increases in admissions within General Internal Medicine (+4.1%), Gastroenterology (+2.9%), Paediatric services (+2.0%), General Surgery (+1.3%) and Emergency Medicine (+10.7%).

3.6.4 For outpatient services, using the CAGR method since 2019/20 to 2025/26, there was growth in Physiotherapy (+2.1%), Medical Oncology (+9.4%), Renal Medicine (+0.6%), Cardiology (+6.0%), Gynaecology (+12.6%), Paediatric services (+5.7%), Ophthalmology (+0.5%) and Gastroenterology (+7.9%). Higher volume services that recorded a decrease included Obstetrics and Midwifery (-5.1%) and Orthopaedic services (-2.4%).

3.6.5 In 2025/26, 1550 / 4.98% of admitted pathways started at the HGH were transferred to another site, including the John Radcliffe (58% of transfers from the HGH), the Churchill Hospital (8% of transfers from the HGH), regional hospitals (28% of transfers from the HGH) and other OUH sites, chiefly Katherine House Hospice (6%)

3.7 Travel and transport: HGH on site car parks are at capacity most days of the working week (Monday to Friday). There are regular bus services, including between Oxford and Banbury, and to the railway station and onto Chipping Norton.

3.7.1 OUH offer schemes to staff to help them travel more sustainably, these include a Liftshare Scheme, a Cycle to Work Scheme, (with the opportunity to purchase a bike and pay through salary sacrifice), renting a bike through providers. Lockable cycle units have also been installed at the HGH to support cyclists

3.7.2 OUH's Travel and Transport Team proactively works with Oxford County Council to understand what schemes could become available for staff, patients and visitors.

3.8. Quality, Safety and regulatory assurance

- ***Summarise the most recent regulatory assessments for services at the Horton.***
- ***Outline key findings from recent Care Quality Commission inspections.***
- ***Explain actions taken in response to recommendations, areas requiring improvement or regulatory feedback.***
- ***Provide evidence of progress made and measurable outcomes where available.***

3.8.1Most recent regulatory assessment: The most recent Care Quality Commission (CQC) assessment of services at the HGH was an unannounced inspection of the Horton Midwifery Led Unit and took place on 7 and 8 October 2025. The Trust received the final report on the 4 June 2026. The report confirmed that the maternity service had improved from 'Requires Improvement' at the previous October 2023 inspection to 'Good' overall, with 'Good' ratings across Safe, Effective, Caring, Responsive and Well-led. The wider Horton General Hospital location rating also changed to 'Good' following as a result of this report. Importantly, the CQC confirmed that the previous breaches relating to safe care and treatment and good governance had been addressed, and that the Horton maternity service was not in breach of any regulation.

There have been no other regulatory assessments at the HGH.

3.8.2 Key CQC findings: The CQC found that the service demonstrated a strong commitment to safety, person-centred care and collaborative working with women, families, staff and healthcare partners. Inspectors highlighted compassionate and respectful care, effective multidisciplinary working, appropriate risk assessment, safe medicines management, strengthened infection prevention and control arrangements, and good support for staff wellbeing.

The service was also recognised for supporting women to access maternity care closer to home, including through outpatient clinics, additional high-risk obstetric clinics, a new ultrasound machine and outreach services for vulnerable or migrant women.

The assessment also identified areas requiring further improvement. These cover local governance and escalation of risk, audit of telephone advice contacts, documentation and MEOWS escalation, the on call and second midwife model, unit level equality, diversity and inclusion (EDI) action plans, and visible local quality improvement. The CQC also noted that the waiting area did not allow staff a clear line of sight to women attending the midwife assessment clinic.

3.8.3 Actions taken in response: As there was no breach in regulations, the Trust was not required to submit a formal action plan to CQC. Actions have been incorporated into the Trust's Perinatal Improvement Programme rather than managed as a separate regulatory plan.

For the HGH, the improvement programme includes actions on local governance and risk escalation, audit of telephone advice contacts, documentation and MEOWS escalation, the on-call and second-midwife model, unit-level equality, diversity and inclusion plans, and visible local quality improvement activity.

3.8.4 Evidence of progress and measurable outcomes: The specific line-of-sight concern has been addressed through completion of the maternity outpatient area refurbishment, including a new midwifery station in the waiting area to improve visibility, communication and support for women attending clinics.

3.8.4.1 The improvement actions are being monitored through the Perinatal Assurance Group, Integrated Assurance Committee and quarterly Trust Board reporting.

4. The Trust notes that there is still an 'Requires Improvement' rating in relation to HGH Emergency Department but this was last inspected in June 2019. The Trust has continued to work on actions in relation to the national waiting time standards that RI rating in the 'Responsive' category. Conclusions

4.1. This report brings together the HOSC questions and the Trust's detailed responses for the September submission. It is asked to note the Trust's response to the September 2026 HOSC Horton General Hospital queries, recognising the hospital's continued strategic role within OUH and the wider health system.

4.2. The Committee is asked to note that further responses will be submitted to HOSC in November 2026, following completion of additional workstreams and final review and sign-off by the Chief Executive.

Annex 1: Summary of OUH's response split between the two phases.

September Submission:

1. Strategic Role of the Hospital

- Provide an overview of the Horton General Hospital's current role within the OUH system and the wider Thames Valley health system.
- Explain how the Horton fits within OUH's clinical strategy and service model and estates.
- Describe the hospital's function as a local hospital serving Banbury, north Oxfordshire and neighbouring areas of Northamptonshire and Warwickshire.
- Outline any significant changes in the hospital's role, service offer or strategic direction over the past five years.

2. Current Services Delivered at the Horton

A comprehensive description of services currently provided on the Horton site, including:

- Urgent and Emergency Care.
- Acute and general medicine.
- Diagnostics and imaging.
- Elective and day-case surgery.
- Outpatient services.
- The Botley centre and any Cancer services delivered at the site.
- Maternity and obstetric services (high-level overview only).
- Community and integrated services delivered from the site.
- Specialist outreach clinics and visiting consultant-led services.
- Any services delivered jointly with Oxford-based sites.

4. Access to Care and Patient Flows

- Explain patient pathways into and through the Horton.
- Describe where patients are routinely treated locally and where onward transfer to other sites is required.
- Provide information on patient flows between the Horton, the John Radcliffe, Churchill and other regional hospitals.
- Outline any known challenges relating to travel, transport or access for local residents.

7. Quality, Safety and Regulatory Assurance

- Summarise the most recent regulatory assessments for services at the Horton.
- Outline key findings from recent Care Quality Commission inspections.
- Explain actions taken in response to recommendations, areas requiring improvement or regulatory feedback.
- Provide evidence of progress made and measurable outcomes where available.

November 2026 Submission:

3. Demand, Activity and Population Need

- For population purposes please clarify the catchment postcodes: OX16 9AL, CV33 , CV35 , CV36 , CV37 , CV47 , GL56 , MK18 , NN11 , NN12 , NN13 , OX15 , OX16 , OX17 , OX20 , OX25 , OX26 , OX27 , OX5 , OX7 ?
- Present activity data and demand trends for the principal services delivered at the Horton over recent years.
- Describe how demand has changed since the COVID-19 pandemic.
- Outline any projected future demand arising from: population growth; demographic change; ageing population trends; and any planned housing growth across north Oxfordshire and Banbury.
- Identify the services experiencing the greatest levels of demand or operational pressure.
- Explain how demand at the Horton compares with activity at other OUH sites.

5. Workforce Sustainability

- Provide an overview of workforce establishment levels across major clinical services.
- Describe current recruitment and retention challenges.
- Highlight any areas reliant on locums, agency staffing or rotational workforce models.
- Explain how workforce challenges affect service resilience and future planning.

6. Estate and Infrastructure

- Provide an update on the condition, capacity and utilisation of the Horton estate.

- Outline split for Horton of the £10m for Horton trust to tackle long-term estate problems - Banbury FM including any major capital investment undertaken in recent years.
- Describe current estate constraints affecting service delivery.
- Provide an update on future estate plans and investment priorities for the site.
- Explain the independent review in 2018 and the unsuccessful Health Infrastructure Programme bid to government and how OUH has adapted its longer-term plans since then.
- Assessment of the Brodey Cancer Centre and plans for investment

8. Improvement Programmes and Service Development

- Describe major improvement programmes currently underway at the Horton.
- Highlight service developments introduced during the last three years.
- Explain improvements made to: patient experience; waiting times; diagnostics; elective recovery; urgent care; workforce resilience.
- Outline any planned service enhancements over the next three to five years.
- Outline the current model of maternity care provided at the Horton site; with a brief update on recent inspection findings and subsequent improvement work for maternity services specifically delivered at the Horton site
- Assessment of whether maternity services across Oxfordshire would benefit from an upgrade of the Horton General Hospital maternity unit.

9. Future Opportunities and Risks

- the principal opportunities for the Horton over the next few years;
- key risks to maintaining and expanding local services;
- dependencies on workforce, capital funding, national policy and system partnerships;
- how OUH intends to ensure the Horton remains a sustainable and resilient hospital serving local communities

Work Programme 2026/27
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
10 September 2026				
Independent Patient Voice Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a detailed update on the steps being taken by the Health and Wellbeing Board and system partners to explore what a future local independent patient voice could look like subsequent to government's planned abolition of Healthwatch.	Overview and Scrutiny	Ansaf Azhar (Director of Public Health) Carole Stowe (Healthwatch contract manager)
Horton General Hospital Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update from Oxford University Hospitals NHSFT on the current services delivered at the Horton Hospital, as well as what the local demand patterns are for such services.	Overview and Scrutiny	Olivia Clymer (Director of strategy and partnerships, OUH)
System Pressures Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update from Oxfordshire system partners on the steps being taken to address Urgent and Emergency Care pressures.	Overview and Scrutiny	Lily OConnor (Urgent Emergency Care Director for Oxfordshire, Thames Valley ICB+ OCC joint post)

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
26 November 2026				
Neighbourhood Health Plan Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a detailed update on the steps being taken by system partners and the Health and Wellbeing Board around developing the neighbourhood health plan for Oxfordshire.	Overview and Scrutiny	Michelle Brennan
Horton General Hospital	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an ***additional*** update from Oxford University Hospitals NHSFT on the current services delivered at the Horton Hospital, as well as what the local demand patterns are for such services.	Overview and Scrutiny	Olivia Clymer
Epilepsy Services Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update from Oxford University Hospitals NHSFT and the Thames Valley ICB on the current state of epilepsy services in Oxfordshire, Progress against previous HOSC recommendations for this item will also be reviewed.	Overview and Scrutiny	Olivia Clymer Dan Leveson
11 February 2027				
NHS Complaints processes	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on the current NHS complaints processes within Oxfordshire, and the efficacy of these.	Overview and Scrutiny	Dan Leveson Olivia Clymer Sam Shepard

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
Eyecare Services	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report with an update from Oxford University Hospitals NHSFT on the current state of Eyecare services within Oxfordshire, and to receive an update on previously made HOSC recommendations on these services.	Overview and Scrutiny	Olivia Clymer Dan Leveson
Medicines Management Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update from the Thames Valley ICB and Oxford University Hospitals NHSFT on Medicines Management. Progress against previous HOSC recommendations for this item will also be reviewed.	Overview and Scrutiny	Olivia Clymer Dan Leveson

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Recommendation Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Dr 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
16 April 2026	Adult/Older Adult Mental Health	1. That system partners treat equity of access as a core performance objective, with explicit action taken where neighbourhood-level variation is identified, including: addressing gaps in crisis alternatives and Safe Haven coverage, and ensuring that any neighbourhood-based models benefit rural and more deprived communities as effectively as urban areas.	Dr Rob Bale	**Accepted** See agenda item 5
		2. That system partners treat co-production as a core performance objective for design, development and delivery neighbourhood mental health centres. It is recommended that there is an inclusion of local councils, local members and local voluntary sector working with lived experience families at any neighbourhood level included in the work programme.		**Partially Accepted** See agenda item 5

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
		3. That access standards for adult community mental health services are applied in a clinically meaningful way. It is recommended that there are clear safeguards to ensure that: early contact does not displace therapeutic continuity, that data definitions are consistent across teams, and that performance management reinforces quality and outcomes, not just speed of access.		**Accepted** See agenda item 5
		4. For collaboration amongst system partners to identify what is needed locally for the implementation of the new government guidance on key workers/named worker for personalised care and on implementation of the Patient and Carer Race Equality Framework. (PCREF).		**Partially Accepted** See agenda item 5
		5. For collaboration amongst system partners on reducing/preventing out of area placements to include independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient. It is also recommended that there is a review that includes patients, families, and the voluntary sector to determine whether community placements are working well as a safe and conducive home setting protective against worst outcomes.		**Partially Accepted** See agenda item 5

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
		6. For any performance targets for access to physical health checks for mentally ill patients to be met. It is recommended that there are timely and regular physical health checks for those with comorbidities, and to also include a check-up of their long-term conditions.		**Accepted** See agenda item 5
		7. For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a co-produced community mental health centre in every community; for mental health investment to be placed on a statutory footing; and for there to be support for expansion of s75 agreements for pooled budgets or other clear mechanisms and levers for the local integration and shared ownership needed. It is recommended that local system partners call for national support to move to multi-year funding for commissioning of the voluntary sector, and that there be clear timely arrangements for the delivery of the Modern Service Framework for mental health.		**Partially Accepted** See agenda item 5
		8. For collaboration among system partners to ensure that transitions from children's to adults mental health services are as smooth and supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions		**Accepted** See agenda item 5

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
16 April 2026	All-Age Autism Strategy	1. That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including: how partner organisations are held to account for delivery of agreed actions; how under performance or delay will be escalated; and how assurance will be reported to the Health and Wellbeing Board and shared with scrutiny.	Karen Fuller, Ian Bottomley, Bhavna Taank	**Accepted** See agenda item 5
		2. That co production principles are explicitly embedded in delivery, not only strategy development, including: a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities, sequencing actions and reviewing progress within the implementation plan; and clarity on how lived experience feedback will directly influence commissioning, service redesign and system decisions.		**Accepted** See agenda item 5
		3. That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope; the balance between new investment and reconfiguration of existing resources; and the affordability and sustainability of priority commitments.		**Partially Accepted** See agenda item 5
		4. For a clear outcomes and performance framework to be developed. It is recommended that any outcomes and performance frameworks include diagnostic waiting times and access to support while waiting; consistency and effectiveness of reasonable adjustments across services; experiences of transitions; and lived experience and qualitative outcomes, not solely access metrics.		**Accepted** See agenda item 5

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
		5. For system partners to work toward the development a children's version of the Autism Strategy.		**Accepted** See agenda item 5
29th January 2026	Director of Public Health Annual Report	1. To embed CIPs into routine commissioning and service design, ensuring decisions explicitly reference CIP findings and community led priorities.	Ansaf Azhar	**Accepted** See agenda item 5
		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.		**Accepted** See agenda item 5
		3. For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes, including Well Together and physical activity pathways.		**Partially Accepted** See agenda item 5
		4. To move Community Health Development Officer, Well Together roles and community led programmes onto multi-year 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.		**Partially Accepted** See agenda item 5

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
		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.		**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

The action and recommendation tracker enables the Committee to monitor progress against agreed actions and recommendations. The tracker is updated with the actions and recommendations agreed at each meeting. Once an action or recommendation has been completed or fully implemented, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker.

KEY	Delayed	In Progress	Complete

Actions:

Meeting date	Item	Action	Lead	Update/response
No outstanding action items				

Recommendation Update Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair 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 updates 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
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
06-Mar-25	OUHFT Maternity Services in Oxfordshire	Olivia Clymer, Yvonne Christley; Andrew Brent	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date	Item	Lead	Update
05-Jun-25	Oxfordshire Healthy Weight	Derys Pragnell	Progress update to be provided
05-Jun-25	Health and Wellbeing Strategy Outcomes Framework	Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	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

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