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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