OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 11 September 2025 commencing at 10.01 am and finishing at 3.10 pm.

Present:

Chair:	Councillor Jane Hanna OBE
Deputy Chair:	District Councillor Dorothy Walker
Councillors:	Ron Batstone Judith Edwards Gareth Epps Emma Garnett Paul-Austin Sargent
District Councillors:	Paul Barrow Katharine Keats-Rohan Elizabeth Poskitt Louise Upton
Co-Optees:	Barbara Shaw
Officers:	Ansaf Azhar, Director of Public Health at Oxfordshire County Council Karen Fuller, Director of Adult Social Services at Oxfordshire County Council Sharon Barrington, Associate Director Acute Provider Collaborative Veronica Barry, Executive Director of Healthwatch Oxfordshire Dr Michelle Brennan, GP and Chair of the Oxfordshire GP Leadership Group Peter Burke, Chair, Thames Valley Faculty Board, Royal College of General Practitioners Niki Cartwright, Director of Delivery, BOB ICB – Mental Health, Learning Disability, SEND and community Julie Dandridge, Strategic Lead for Primary Care across BOB ICB Rachel Jeacock, Primary Care Lead Hannah Mills, Director of Delivery UEC and Elective Dee Nic Sitric, Chief Executive of Autism Champions Matthew Tait, BOB ICB Chief Delivery Officer Omid Nouri, Health Scrutiny Officer

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

45/25 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Cllr Edosomwan. Apologies were also received from co-optee member Slyvia Buckingham.

46/25 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Barbara Shaw declared that she was the chair of Healthwatch and a patient safety partner.

Cllr Garnett declared that they were employed by the Department of Primary Healthcare at the University of Oxford.

Cllr Hanna declared an interest as an employee of SUDEP Action.

47/25 MINUTES

(Agenda No. 3)

The minutes of the meeting held on 05 June 2025, were **APPROVED** as a true and accurate record.

48/25 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Olly Glover MP expressed concern about the continued absence of a GP surgery at Great Western Park in Didcot, emphasising that this had increased pressure on existing surgeries and affected healthcare access for nearby villages. He acknowledged earlier engagement with the ICB but noted the lack of recent public updates since planning permission was granted, and he called for an update to ensure progress towards building the new facility so residents could access primary healthcare as needed.

Roseanne Edwards noted Banbury's growing population and criticised the reduction of services at Horton Hospital, warning the John Radcliffe Hospital could not meet future demand. She called for a review of the Horton's downgrade and urged improved planning and collaboration to address local healthcare needs.

Joan Stuart shared concerns that NHS eye departments are under-resourced, risking patient sight, and criticised the impact of private providers on the Oxford Eye Hospital. She urged a review of private sector involvement in NHS cataract surgery and backed the Royal College of Ophthalmologists' call for action.

Graham Shelton raised concerns about abolishing Healthwatch Oxfordshire and Councils of Governors, warning this would weaken local patient voice and accountability. He urged the committee to oppose these changes due to their impact on public oversight.

Stella Hornby warned that unchecked growth in private cataract surgery could destabilise NHS ophthalmology by diverting funds, impacting staff, and jeopardising training and emergency services. She called for an urgent review of private sector involvement to protect the Eye Hospital's future.

49/25 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 5)

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

1. Musculoskeletal Services in Oxfordshire
2. Audiology Services in Oxfordshire
3. Cancer Services in Oxfordshire
4. Oxfordshire as a Marmot Place
5. Oxfordshire System Pressures

Members noted ongoing concerns about musculoskeletal services, stressing that rheumatology faces the greatest need and longest waits. They requested future responses focus more on rheumatology, rather than orthopaedics.

50/25 GENERAL PRACTICE ACCESS AND ESTATES

(Agenda No. 7)

Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire - Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board) was invited to present a report on General Practice (GP) Access and Estates in Oxfordshire.

Also in attendance to support the Committee and answer their questions were Matthew Tait (BOB ICB Chief Delivery Officer), Dr Michelle Brennan (GP and Chair of the Oxfordshire GP Leadership Group), Rachel Jeacock (Primary Care Lead), Veronica Barry (Executive Director of Healthwatch Oxfordshire), Peter Burke (Chair, Thames Valley Faculty Board, Royal College of General Practitioners), Ansaf Azhar (Director of Public Health at Oxfordshire County Council), and Karen Fuller (Director of Adult Social Services at Oxfordshire County Council).

The Strategic Lead for Primary Care highlighted progress through new approaches and increased GP recruitment. She acknowledged persistent challenges with primary care estates, such as inadequate premises and limited funding, though some expansion projects were in progress. The Strategic Lead for Primary Care also stressed that strengthening general practice was key to future neighbourhood health plans, with further improvements still needed.

The Chair of Thames Valley Faculty Board echoed concerns about estate resources, referencing the Ten-Year Health plan and Leng review. He stressed prevention, evidence-based screening, and the vital role of primary care amid rising demand and insufficient GP growth in Oxfordshire.

Members raised the following questions and concerns:

- How widely the Modern General Practice Model had been adopted across Oxfordshire's 64 practices. Officers indicated that the model had been implemented as a national programme, not by local GP choice, and that practices had adopted omni-channel access, though the communication to patients about these changes could have been improved.

- What strategies were in place to maintain or improve the current rate of 88% of patients being seen within two weeks. The response explained that maintaining or improving the 88% rate of patients being seen within two weeks depended on continuously adapting systems and being agile, but was fundamentally limited by the finite number of appointments GPs could offer each day due to staffing and estate constraints. The introduction of additional roles through the reimbursement scheme had helped improve access, yet the lack of physical space in practices restricted further expansion. It was described as a "chicken and egg scenario," with improvements in access reliant on both workforce and estate capacity, and while some progress had been made, significant further improvement would require addressing these underlying resource limitations.

- While the patient survey showed above average ease of contacting practices by phone, some practices had as low as 21% reporting easy access, indicating wide variation. The Strategic Lead for Primary Care explained that the ICB supported practices with lower scores by deploying a team to help improve access, sharing successful approaches from higher-performing practices, and introducing cloud-based telephony systems to better manage call queues and reduce complaints about long waits.

  It was also discussed and noted that national efforts, such as the red tape challenge and recommendations from the NHS Confederation, aimed to clarify which administrative tasks should remain with hospital clinicians rather than being shifted to GPs, with examples like fit notes after operations. It was also mentioned that new contractual changes from October would require online access to remain open during core hours, potentially increasing administrative burden and raising concerns about the risk of waiting lists in general practice.

- How estate organisation responded to planning applications, the use of section 106 agreements, and the ICB's approach to prioritising estate improvement projects, including the role of the Community Infrastructure Levy (CIL) in South Oxfordshire, the Vale, and other areas, as well as the ICB's capacity to release funding in the context of urgent population growth.

  It was explained that the ICB generally responded to all planning applications notified by councils and was successful in securing developer contributions, particularly in South and Vale, but faced challenges in spending these funds due to capital and revenue constraints. The use of CIL was highlighted as offering greater flexibility and the ability to accumulate and use funds upfront, with ongoing efforts to expand its use in West Oxfordshire and Cherwell. The urgency of population growth and the need for timely release of funding, especially for projects like Great Western Park, were acknowledged, with the

current delays attributed to NHS bureaucratic processes rather than lack of funds.

- What was the best way for local councils to assist the ICB in planning the use of CIL and section 106 funds, and what would be the quickest method to ensure the money was spent. The Strategic Lead for Primary Care indicated that councils should provide clear, written plans detailing their needs for health infrastructure, as this would enable the drafting of robust section 106 agreements and facilitate the allocation of CIL funds. It was noted that processes remained slow due to bureaucracy and grant agreements, regardless of the funding route, but ongoing dialogue between councils and the ICB was encouraged to improve efficiency.

  The Director of Public Health noted that rising primary care demand was a national issue, with population growth outstripping GP capacity, especially in Didcot. They highlighted the need for neighbourhood health centres, expanded roles for other clinicians, and clear communication with the public to help manage demand and create additional GP capacity.

  The Chair of Thames Valley Faculty Board added that there was now an underused resource of GPs, with some unemployed and even emigrating due to lack of job opportunities, despite calls for more GPs. He suggested that the system should better utilise available GP resources to address demand.

- What safeguards were in place for patient safety regarding physician associates, and whether the ICB had observed any changes in patient outcomes or satisfaction related to their use. It was explained that physician associates generally did not see undifferentiated patients, were supervised by GPs, and had regular debriefs; the ICB had not observed any changes in patient outcomes or satisfaction linked to physician associates.

Cllr Sargent left the meeting at this stage

- How was Oxfordshire preparing to align with the neighbourhood health service model and whether there would be an opportunity to scrutinise the governance arrangements. It was explained that Oxfordshire was at the start of its neighbourhoods journey, already delivered many community services, and was developing layered approaches and governance structures involving the Health and Wellbeing Board, the Place-Based Partnership, and a Primary and Community Care Board, with a commitment to bring back details for scrutiny as arrangements developed.

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

1. For the ICB to develop regular reporting on access equity across Oxfordshire, including digital exclusion, rural access, and variation in appointment availability between practices.

2. To publish a rollout plan and evaluation framework for the Modern General Practice model, including metrics for patient experience, staff wellbeing, and service efficiency.

3. To urgently progress and provide a written update on the timeline of delivery of the Great Western Park and Bicester Projects.

4. For the ICB to work with district valuers and local authorities to explore alternative funding models and design solutions for estate expansion where traditional schemes are deemed unviable. It is recommended that the ICB produces a plan for Oxfordshire.

5. For the Committee to AGREE to establish a Primary Care and Community Working Group to conduct a deep dive into some of the challenges in primary care capacity, access, estates, and provision.

51/25 OXFORDSHIRE EYECARE SERVICES

(Agenda No. 8)

Matthew Tait (BOB ICB Chief Delivery Officer) was invited to present a report on Eyecare Services in Oxfordshire.

Also, in attendance to support the Committee and answer their questions were Hannah Mills (Director of Delivery UEC and Elective), Sharon Barrington (Associate Director Acute Provider Collaborative), Ansaf Azhar (Director of Public Health at Oxfordshire County Council), and Karen Fuller (Director of Adult Social Services at Oxfordshire County Council).

Stella Hornby (Consultant Ophthalmologist at the Oxford Eye Hospital who initially spoke as a public speaker) also joined the Committee upon the Chair's invitation.

The BOB ICB Chief Delivery Officer confirmed support for sustainable secondary care, highlighted challenges between NHS and private providers, and stated adherence to national policy on provider choice and tariffs. The Director of Delivery emphasised equal application of the national tariff and ongoing work in ophthalmology. The Associate Director explained that the single access model improved patient choice, cited responses to Healthwatch Oxfordshire recommendations on eyecare services, and listed enhancements in information, accessibility, and engagement.

Members raised the following questions and concerns:

- How did the ICB ensure consistency, quality, and good value across primary, intermediate, and secondary eyecare services, and what was the approach to procuring new services and reviewing contracts. Officers explained that the ICB held regular meetings with providers, monitored patient feedback and activity, and relied on national accreditation standards for clinical consistency and safety. It was noted that value for money checks were conducted when procuring new services or reviewing contracts, with more influence over local intermediate services, while national tariffs applied to acute and private providers.

- What mechanisms were in place to ensure that private eyecare providers adhered to the same rigorous standards as the NHS; as well as what contractual authority were exercised over private suppliers, and the processes for addressing instances of provider failure and patient complications.

  The Director of Delivery stated that private providers were subject to the NHS standard contract and accreditation checks, with quality monitored through contractual mechanisms and feedback. However, it was acknowledged that when the ICB did not hold a direct contract, oversight was weaker, and there was no systematic way for NHS hospitals to report or track complications arising from private providers. Where incidents were reported, the ICB's quality teams investigated and, if necessary, conducted multi-agency reviews for recurring issues.

- There were concerns raised about the destabilising impact of independent service providers (ISPs) on NHS ophthalmology pathways and training. It was explained that the growth of ISPs providing low complexity cataract care had reduced the number of suitable cases for NHS trainees, leading to the loss of trainees and affecting the quality of training.

  Efforts were being made to arrange joint training opportunities with ISPs, but challenges remained, such as limited frequency of training lists and ISPs preferring more experienced trainees. It was noted that Oxford had been particularly hard hit, with training quality and appeal reduced, and that national work was ongoing to address these issues.

  Members pushed further about how NHS trainees in eyecare were being trained, and what support the ICB provided for retaining ophthalmologists and optometrists, and the challenges faced around staff retention.

  Officers indicated that recruitment and retention were key to service sustainability, with positive developments seen through closer collaboration among NHS trusts in the region, such as offering opportunities to work across different sites and services. However, it was acknowledged that further details on ophthalmologist recruitment would need input from the Trust, and that retention remained a significant challenge, especially in specialties like ophthalmology.

- Members expressed concern about the perception that the healthcare market, particularly in ophthalmology, had expanded beyond manageable limits. They were troubled by the suggestion that the ICB had limited ability to address the resulting challenges, such as the absence of a cap on service provision and the associated financial risks. In response, it was explained that national policy restricts the ICB's capacity to control market size or impose spending limits.

  However, measures like the implementation of a single point of access have been introduced to help manage referrals and enhance patient choice. While acknowledging the constraints of national policy, the ICB emphasised its ongoing collaboration with NHS Trusts to support departmental sustainability, despite lacking the flexibility to limit the number of providers or financial exposure.

- Whether there were any geographical differences in the provision of eyecare services and how such differences were measured. Officers explained that general optometry services were available across the area, including domiciliary options for housebound patients, and that onward referrals included arrangements for patient transport if needed. It was noted that the single point of access system allowed patients to choose from a range of providers, including those outside the immediate area, and that contracts existed with providers beyond the local footprint to ensure coverage for rural and cross-border patients.

  Additionally, eligible patients could access patient transport services, and for those not meeting the national eligibility criteria, the service would signpost them to alternative options, including voluntary organisations and local offers, acknowledging that transport remained a significant issue, especially in rural areas.

- There were concerns about the use of Artificial Intelligence (AI) tools in the single point of access process, specifically whether patients interacted with real people or AI, and how this affected those who struggled with IT, learning difficulties, or hearing impairments. The Director of Delivery clarified that while an AI tool was used for some referrals, patients with identified difficulties could be referred directly to speak with a person, usually by their optometrist. Additionally, measures such as flexible call times and support from others were in place to help those unable to use the AI system, though availability in different languages was still being developed.

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

1. For the ICB establish a localised dashboard to monitor contract outcomes and patient satisfaction across Oxfordshire.

2. To launch a targeted public information campaign to raise awareness of NHS-funded sight tests and eligibility for optical vouchers, especially among vulnerable and underserved populations. It is recommended that the ICB works with local authorities and voluntary sector partners to improve outreach in rural and deprived areas.

3. To explore the development of shared digital records between providers to reduce duplication and improve continuity of care.

4. For the ICB and Primary Eyecare Services to collaborate on a workforce strategy to recruit and retain optometrists and support staff, particularly in areas with known shortages. It is recommended that incentives are explored for newly qualified professionals to work in Oxfordshire's community settings.

Lunch was taken at 12:21. The Committee returned at 13:14

52/25 ADULTS AUTISM AND ATTENTION DEFICIT HYPERACTIVITY DISORDER SERVICES

(Agenda No. 10)

Matthew Tait (BOB Integrated Care Board Chief Delivery Officer) was invited to present a report on Adults Autism and Attention Deficit Hyperactivity Disorder services in Oxfordshire. Niki Cartwright (Director of Delivery, BOB ICB – Mental Health, Learning Disability, SEND and community), and Dee Nic Sitric (Chief Executive of Autism Champions) also attended to support the Committee and answer their questions.

The BOB ICB Chief Delivery Officer introduced the Adults Autism and ADHD services item by highlighting the significant pressures on access and waiting times, the complexity of the market, and the financial challenges, noting that these issues were not unique to Oxfordshire.

The Director of Delivery explained that Autism and ADHD services were paused due to high demand and noted plans for transformation programmes with input from those with lived experience. The Chief Executive of Autism Champions supported the involvement of lived experience in service design, praised the collaborative ADHD programme, but raised concerns over limited progress and engagement in the autism strategy.

Members discussed the following questions and concerns with officers:

- What immediate steps could be taken to reduce the waiting lists for adults autism and ADHD services. The BOB ICB Chief Delivery Officer responded that there were no specific short-term measures available to rapidly reduce the waiting lists, explaining that while the right to choose market had improved access, the exponential increase in demand meant waiting times would likely not decrease quickly. He emphasised that the solution lay in a long-term transformation programme, improved contractual frameworks, and national support, rather than any quick fixes.

- Why Autism assessments had been capped at 110 per year and whether any modelling had informed this figure. The BOB ICB Chief Delivery Officer explained that the cap reflected the level of activity that could be provided within the existing contract funding, rather than being based on modelling, and the Director of Delivery confirmed it was determined by what the provider could deliver within the financial envelope, noting that this approach might need to be reconsidered as demand increased.

- What support and communication available to people with Autism and ADHD was provided while services were being developed. The Director of Delivery explained that people were signposted to a range of local voluntary sector services and that a future community offer was being developed to provide accredited support options.

  She added that communication with those on waiting lists had been limited until there was clear information to share, but ongoing engagement workstreams would

address this. The Executive Director of Autism Champions also highlighted the importance of moving away from a purely diagnostic approach and focusing on meeting needs, suggesting that the ADHD transformation pathway considered how to support people without requiring a formal diagnosis.

- Concerns were raised about the Shared Care Fund for ADHD, how well it was working, and the rate of GP engagement. The Director of Delivery explained that the new Shared Care protocol had only recently been signed off, with increased annual funding and plans for advice, guidance, and training to help GPs feel confident in prescribing. She noted that GP participation in shared care was voluntary, and not all were currently engaged, but the changes were expected to improve uptake.

  The Executive Director of Autism Champions emphasised that the agreement was a significant achievement resulting from collaborative work, and the BOB ICB Chief Delivery Officer added that it was a foundational step for future progress in the system.

- Whether having a formal diagnosis of ADHD or autism was truly valuable, or if resources should instead be focused on developing strategies to help people regardless of diagnosis. The Executive Director of Autism Champions responded that while a diagnosis could be important for those needing medication or personal understanding, the system should move towards meeting needs without requiring a formal diagnosis.

  She explained that the ADHD transformation programme was considering access criteria to prioritise those who most needed a diagnosis, but ultimately aimed for a model where support was available based on need rather than diagnosis alone. The Director of Delivery added that the future community offer would provide resources and support options for all, not just those with a formal diagnosis.

  The discussion included a point about reasonable adjustments in the workplace, where the Executive Director of Autism Champions clarified that, legally under the Equality Act, reasonable adjustments should be needs-led and not dependent on a formal diagnosis. She emphasised that employers are required to provide adjustments based on an individual's needs, and that the definition of "reasonable" may vary between individuals and employers. The conversation highlighted the importance of understanding and supporting each person's requirements, regardless of whether they have an official diagnosis.

- Whether the Right to Choose Scheme in Oxfordshire only allowed access to private routes for those who could pay, or if it was available through the NHS. It was clarified that Right to Choose was indeed available to all via the NHS, not just privately, and that NHS-funded private Right to Choose expenditure in Oxfordshire had risen significantly, making the current model financially unsustainable.

- Concerns were raised about the underdiagnosis of Autism and ADHD in women and minorities, as well as the complexities faced by those with additional conditions like epilepsy, and how coproduction addressed these issues. The

Director of Delivery and the Executive Director of Autism Champions explained that there was significant research on the negative impact of delayed diagnosis, especially for women and underserved groups, and that the service aimed to improve inclusion and coproduction with diverse communities.

The need to join up learning from deaths, such as through the People with a Learning Disability and Autistic People (LeDeR) programme, and to ensure that complexity and intersectionality were considered in service design and commissioning intentions, was also highlighted.

- The extent of the planned introduction of AI tools, including how they would be used, monitored, and whether they would involve self-referral or triage. It was explained that the use of AI was still in the exploratory stage, with no trials underway yet, and that the main focus remained on stabilising services and implementing shared care protocols. The ambition was for AI to eventually support self-referral and provide tools for those waiting for diagnosis or needing support, but any implementation would be at least two years away and would prioritise supporting daily life rather than direct diagnosis.

- How the new access criteria for ADHD would help prioritise complex cases and manage demand. Officers explained that the access criteria aimed to ensure those most in need, particularly individuals requiring medication, would be prioritised for diagnosis and support, while others might be directed to community or digital support. The criteria were nearly finalised and intended to balance limited resources with the needs of the population, with implementation expected in the short term as part of the commissioning framework and service redesign.

- Concerns were raised about addressing inequalities, the All-Age Autism Strategy, and the challenge of engaging schools, especially given their independence. The BOB ICB Chief Delivery Officer answered that efforts were underway to introduce a needs-led approach, with ongoing discussions between education and health colleagues to support early intervention in schools. While a programme was already in place in another part of the region, Oxfordshire was beginning to adopt similar strategies, aiming to skill-up school staff and intervene early to prevent escalation. It was acknowledged that this required a cultural shift in how behaviour was viewed in schools and that further work was needed to ensure all relevant communities were included in co-production efforts.

- How monitoring and evaluating would be approached for the ADHD Transformation Programme and the Autism strategy. The Executive Director of Autism Champions answered that this was a work in progress, but monitoring and evaluation would be built into the ADHD programme during implementation, and the All-Age Autism strategy would include annual reviews of progress and barriers, rather than waiting until the end of a five-year plan. This could ensure continuous assessment and improvement.

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

1. For the ICB to urgently review and increase the annual assessment capacity for both Autism and ADHD services to better reflect current demand and reduce potentially unsafe waiting times.

2. For the development of a detailed timeline (and potentially a resource plan) for clearing the existing waiting lists, including the 2,229 adults awaiting ADHD assessments.

3. To undertake a formal review of Right to Choose (RtC) expenditure and its long-term viability, with options for integrating RtC providers into core commissioning.

4. For coproduction to remain at the heart of the development of the All-Age Autism Strategy. It is recommended that there are clearly identified stakeholders to ensure that all complexities are represented.

53/25 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 9)

Veronica Barry (Executive Director of Healthwatch Oxfordshire) was invited to present the Healthwatch Oxfordshire Update report. The BOB ICB Chief Delivery Officer also attended to support the Committee and answer any questions.

The Executive Director of Healthwatch Oxfordshire introduced the Healthwatch item by highlighting recent issues, such as problems with school transport for children with autism, and explained the broad and unique role Healthwatch played in bridging the gap between the public and the health and care system, including signposting, engagement, and scrutiny. The Chair responded by emphasising the value of Healthwatch's contributions to scrutiny and decision-making in Oxfordshire, noting the strong support for its continued function following recent national announcements about its future.

District and County Council members of the Committee highlighted their support for Healthwatch Oxfordshire, and praised the valuable insight they provide.

The BOB ICB Chief Delivery Officer stated that his organisation valued Healthwatch highly, especially its role in the place-based partnership, and shared concerns about the direction of travel regarding its future. He confirmed that they were keen to work with Healthwatch Oxfordshire across the region to design a future model that retained its expertise and independence, acknowledging that independence was a real issue in any redesign.

The Committee discussed recommending that system partners safeguard and develop the Healthwatch function, ensure meaningful consultation with local stakeholders, and allow the Committee to review any local decisions before implementation. They also considered writing to local MPs about concerns, supported the core characteristics of public voice outlined by Healthwatch, and emphasised the need for independence and local relevance in any future arrangements.

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

1. For system partners to safeguard and develop the Healthwatch function within Oxfordshire, and to engage and meaningfully consult with all local stakeholders, to ensure the local delivery of national reforms at Place or neighbourhood level best meet patient and community need. It is recommended that the Oxfordshire JHOSC has an opportunity to scrutinise any local decisions on this before they are made.

Cllr Garnett left the meeting at this stage.

54/25 CHAIR'S UPDATE

(Agenda No. 6)

The Chair updated the Committee that, following the unexpected government announcement about the future of Healthwatch, she and the Health Scrutiny Officer had met regularly with the Executive Director of Healthwatch Oxfordshire to stay informed and provide support. The Chair also brought a motion to the County Council, which received unanimous backing, emphasising the importance of maintaining the Healthwatch function to support the independent patient voice in Oxfordshire.

The Chair highlighted the value of Healthwatch's contributions to scrutiny and decision-making, noting that its involvement strengthened the committee's work and benefited system partners. She reiterated the commitment to ensuring the continuation of Healthwatch's functions and the independent patient voice, regardless of any national changes.

The following points were also highlighted by the Chair:

- There were two reports in the agenda papers for this item, containing recommendations from the Committee on: Oxfordshire System Pressures, and on Oxfordshire as a Marmot Place.

- Members of the Buckinghamshire, Oxfordshire, and Berkshire West Joint Health Overview Scrutiny Committee (BOB HOSC) had received a briefing from the BOB Integrated Care Board's (ICB) Chief Executive on 25 July 2025 to discuss the recent NHS reforms and the cuts to ICB running costs. A public BOB HOSC meeting was scheduled for 16 October to discuss this further and to ensure ongoing public scrutiny of these crucial developments.

- The Health Scrutiny Officer and Chair met with Richard Wood (Chief Executive, BOB Local Medical Committee) and Peter Burke (Chair, Thames Valley Faculty Board, Royal College of General Practitioners) on 4 September 2025 to discuss some of the current challenges in relation to GP services in Oxfordshire.

- The Health Scrutiny Officer and Chair met with the Chair of Oxford University Hospitals NHS Foundation Trust, and agreed to hold quarterly meetings with

the Chair to be updated on key developments.

- A letter was sent on behalf of the Committee to the Chief Executive of the BOB Integrated Care Board, requesting further information on a recent Oxfordshire Neighbourhood Health Bid.

The Committee **NOTED** the update.

55/25 FORWARD WORK PLAN
(Agenda No. 11)

The Committee **AGREED** to set up an online meeting to review the work programme, including integrating the GP working group and planning for a focus on children at the next public meeting in November.

56/25 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 12)

The Committee **NOTED** the progress made against the action and recommendation tracker.

The Health Scrutiny Officer clarified that some outstanding items on the tracker remained on the tracker as further updates were expected.

..... in the Chair

Date of signing .....