Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 20 November 2025 at 10.00 am

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

If you wish to view proceedings, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Membership

Chair:	Councillor Jane Hanna OBE		
Deputy Chair:	District Councillor Dorothy Walker		
Councillors:	Ron Batstone	Gareth Epps	Susanna Pressel
	Imade Edosomwan	Emma Garnett	
	Judith Edwards	Paul-Austin Sargent	
District Councillors:	Katharine Keats-Rohan	Val Shaw	
	Elizabeth Poskitt	Louise Upton	
Co-Optees:	Sylvia Buckingham	Barbara Shaw	
Date of Next Meeting:	*29 January 2026*		

For more information about this Committee please contact:

Committee Officer: *Scrutiny Team*

Email: *scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

November 2025

What does this Committee review or scrutinise?

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

How can I have my say?

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

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

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AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 14)

To **APPROVE** the minutes of the meeting held on 11 September 2025 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, i.e. 06 November 2025

Requests to speak must be submitted no later than 9am three working days before the meeting, i.e. 17 November 2025

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 15 - 18)

The Committee received a response to its Recommendation on retaining the independent patient voice in Oxfordshire.

The Committee is asked to **NOTE** this response.

6. Establishment of Primary Care Access and Estates Working Group (Pages 19 - 24)

The purpose of this item is for the Committee to formally AGREE to the establishment, scope and timescales of a Primary Care Access and Estates Working Group. This Working Group will specifically focus on General Practice Services in Oxfordshire.

The Committee is **RECOMMENDED** to:

1. **CONFIRM** its support for the establishment of a Primary Care working group.

2. **AGREE** to the proposed membership of the working group (Cllr Jane Hanna, City Cllr Louise Upton, Cllr Gareth Epps, Cllr Paul-Austin Sargent, Cllr Ron Batstone, District Cllr Katharine Keats-Rohan).

3. **AGREE** to the scope and Methodology of the working group's planned activities.

4. **AGREE** to receive an update on the working group's activities and findings and recommendations in June 2026.

7. Chair's Update (Pages 25 - 60)

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

A report was submitted to the ICB on behalf of the Committee with recommendations on General Practice Services in Oxfordshire, this is attached in the agenda papers for this item.

A report was submitted to Oxfordshire system partners on behalf of the Committee with recommendations on retaining the Independent Patient Voice Function in Oxfordshire. This can also be found in the agenda papers for this item.

Another report was also submitted on behalf of the Committee with recommendations on Eyecare Services in Oxfordshire. This is also attached in the agenda papers for this item.

The Committee is asked to **NOTE** the attached letter sent the Secretary of State for Health and Social Care, on behalf of the Committee, on 29th September 2025, to request a national review of independent service providers in NHS ophthalmology.

The Committee is asked to **NOTE** the attached letter that was also sent to all of Oxfordshire's MPs, on behalf of the Committee, on the 7th October 2025, to brief the MPs and seek their support for retaining the Independent patient voice in Oxfordshire.

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

8. Children's Emotional Wellbeing and Mental health (Pages 61 - 206)

Caroline Kelly has been invited to present two reports on the topic of Children's Emotional Wellbeing and Mental Health.

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

1. A report providing an update on the Children's Emotional Wellbeing and Mental Health Strategy and CAMHS Services.

2. A report providing an update on School Health Nurses in Oxfordshire.

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

9. Healthwatch Oxfordshire Update (Pages 207 - 216)

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.

10. Neighbourhood Health Plan for Oxfordshire (Pages 217 - 224)

Dr Michelle Brennan and Dan Leveson have been invited to present a report providing an update on the ongoing work to develop a Neighbourhood Health Plan for Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make before this plan is presented to the Oxfordshire Health and Wellbeing Board for approval on 4 December 2025.

11. Forward Work Plan (Pages 225 - 226)

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

12. Actions and Recommendations Tracker (Pages 227 - 232)

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.

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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 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 .....

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: Retaining the functions of Healthwatch Oxfordshire

Lead Cabinet Member(s) or Responsible Person:

- Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Dan Leveson (Director of Places & Communities, BOB ICB)
- Stephen Chandler (Deputy Chief Executive and Executive Director for People, Oxfordshire County Council).
- Ansaf Azhar (Director of Public Health, Oxfordshire County Council).
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council).

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

Deadline for response: Tuesday 4th November 2025.

Response to report:

Enter text here.

We acknowledge and appreciate the recommendation from the Oxfordshire Joint Health Overview and Scrutiny Committee regarding the safeguarding and development of the Healthwatch function, and the importance of engaging and meaningfully consulting with all local stakeholders to ensure national reforms meet patient and community needs at neighbourhood level.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

It is important to clarify that Healthwatch Oxfordshire operates under a statutory framework, as set out in the Health and Social Care Act 2012. As such, the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and system partners do not have the authority to directly safeguard or alter its statutory functions. However, we fully recognise and value the unique role Healthwatch plays in amplifying the independent patient and public voice, and its contribution to shaping services through evidence-based insight.

While we cannot commit to safeguarding Healthwatch's statutory function, the ICB and system partners are committed to ensuring the patient and public voice remains central to our work. We will continue to work collaboratively with Healthwatch Oxfordshire and other community partners to ensure that community insight informs our planning, decision-making, development and delivery of services, particularly as we implement national reforms.

We also welcome the opportunity for Oxfordshire HOSC to scrutinise any local decisions relating to patient and public engagement before they are made, and will ensure transparency and openness in our approach.

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
'For system partners to safeguard and develop the Healthwatch function, and to 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. It is recommended that the Oxfordshire JHOSC has an opportunity to scrutinise any local decisions on this before they are made.'	Partially accepted	We cannot commit to safeguarding Healthwatch's statutory function, the ICB and system partners are committed to ensuring the patient and public voice remains central to our work. We will continue to work collaboratively with Healthwatch Oxfordshire and other community partners to ensure that community insight informs our planning, decision-making, development and delivery of services, particularly as we implement national reforms. We also welcome the opportunity for Oxfordshire HOSC to scrutinise any local decisions relating to patient and public engagement before they are made, and will ensure transparency and openness in our approach.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC)

20 NOVEMBER 2025

Report on the establishment of a Primary Care Working Group

Report by Director of Law and Governance and Monitoring Officer

RECOMMENDATIONS

The Committee is **RECOMMENDED** to

1. **CONFIRM** its support for the establishment of a Primary Care working group.

2. **AGREE** to the proposed membership of the working group (Cllr Jane Hanna, City Cllr Louise Upton, Cllr Gareth Epps, Cllr Paul-Austin Sargent, Cllr Ron Batstone, District Cllr Katharine Keats-Rohan).

3. **AGREE** to the scope and Methodology of the working group's planned activities.

4. **AGREE** to receive an update on the working group's activities and findings and recommendations in June 2026.

CONTEXT

1. Primary care is the foundation of the NHS and the first point of contact for most patients. In Oxfordshire, general practice is under increasing pressure due to rising demand, workforce shortages, estate limitations, and the need to modernise service delivery. These pressures are compounded by population growth, housing development, and changing patient expectations.

2. Recent reports to HOSC have highlighted some variation in access to appointments, challenges in recruiting and retaining GPs and nurses, and delays in progressing key estate projects such as the Didcot Great Western Park and Bicester Health Centre expansions. There is also concern about the administrative burden on clinicians, which may detract from time spent on direct patient care.

3. In response, during its public meeting on 11 September 2025, the Committee agreed to establish a working group to undertake a deep dive into these issues. The group will explore the systemic barriers to effective primary care delivery and identify practical, locally tailored solutions that can be implemented by the ICB and its partners.

4. The establishment of a primary care working group is designed to be a deep dive mechanism—bringing together elected members, NHS representatives, and the patient voice (via input from Healthwatch Oxfordshire)—to interrogate the systemic issues affecting primary care capacity, access, and estate provision.

5. Therefore, the overarching purpose of this review into primary care is to investigate the challenges facing primary care in Oxfordshire and develop evidence-based recommendations to improve capacity, access, estate development, and service integration, with a focus on sustainability and equity.

SCOPE OF WORKING GROUP FOCUS/ACTIVITY:

6. The scope of the working group's activity has been informed by a combination of avenues including; reviews conducted as part of its public meeting items (and reports submitted for these) on GP access and provision; conversations with NHS commissioners from the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB); reports it has heard from elected County and District Cllrs in Oxfordshire on challenges residents are experiencing with primary care access; reports heard directly from individual GPs on the challenging landscape they are operating under; and verbal and written reports from Healthwatch Oxfordshire as well as members of the wider public who have addressed the Committee in its public meetings.

7. Below are a list of themes that the working group intends to focus on as part of its review:

Workforce Capacity and Clinical Time Balance

- Assess GP and nurse staffing levels across Oxfordshire.
- Examine recruitment and retention challenges, including the impact of short-term funding schemes.
- Investigate the balance between administrative burden and protected clinical time for GPs and practice staff.

Access Equity and Patient Experience

- Map variation in appointment availability between practices.
- Map variation in numbers of General Practitioners per practice against trend in number of registered patients.
- Explore barriers to access including digital exclusion, rural isolation, and transport limitations.
- Review patient satisfaction and continuity of care.
- Align primary care provision with housing growth and local plans.
- Forecast future demand and estate needs using demographic and utilisation data.

Estate Constraints and Expansion Planning

- Identify practices operating in undersized or outdated premises.
- Review progress on major estate projects (e.g. Great Western Park, Bicester Health Centre).

- Examine the use of developer contributions (Section 106, Community Infrastructure Levy [CIL]) and planning obligations.

Alternative Funding Models and Design Solutions

- Investigate schemes deemed unviable under traditional capital models.
- Explore the role of district valuers and local authorities in unlocking new approaches.
- Consider modular builds, public-private partnerships, flexible leasing, and repurposing of existing estate.

· **Service Integration and Transformation**

- Evaluate the rollout and impact of the Modern General Practice model.
- Assess the development of neighbourhood health hubs and co-located services.

Use of Digital tools and technology:

- Review the use of digital tools, including the use of AI and virtual consultations.
- Digital exclusion but also resilience and data security and communications.

STAKEHOLDER ENGAGEMENT:

8. The working group will engage with a wide range of stakeholders to ensure a comprehensive and inclusive review. These will include:

- NHS Buckinghamshire, Oxfordshire and Berkshire West ICB (including estates, workforce, and commissioning leads). This would include Dan Leveson (BOB ICB Director of Places & Communities) and Julie Dandridge (Strategic lead for primary care across Oxfordshire).

- Healthwatch Oxfordshire. This would include Veronica Barry (Executive Director of Healthwatch Oxfordshire) and Barbara Shaw (Chair of Healthwatch Oxfordshire).

- District council planning officers (Names/details of Officers to be confirmed).

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

- GP practice representatives and Primary Care Networks (Names/details of these to be confirmed).

- NHS Property Services and district valuers.

- Local MPs and councillors (where appropriate).

9. Engagement will be conducted through online Microsoft Teams meetings, written submissions, and site visits. The working group will also consider feedback from any recent public consultations and surveys.

EXPECTED OUTPUTS AND OBJECTIVES:

10. The working group will submit a written report to the wider Committee in its public meeting in June 2026. This report will summarise the working group's activities as well as findings, any evidence gathered, and any recommendations it proposes to the wider Committee for agreement to be issued to the ICB and/or local authorities in Oxfordshire.

11. The working group will likely make recommendations to the ICB and local authorities around the following potential areas:
    a. Estate planning and funding strategies.
    b. Workforce support and administrative reform.
    c. Access improvement and digital inclusion.
    d. Evaluation and rollout of service transformation models.

12. The working group will also seek to identify of priority areas for investment and/or policy change for primary care, and will potentially write to the Secretary of State for Health and Social Care to express some of its findings that may be relevant to this.

13. In addition, the working group will discuss, and agree a proposed framework for the ongoing monitoring and scrutiny of primary care delivery. This will be crucial to enhance transparency around primary care at a time when residents experience challenges first hand in being able to access basic GP appointments. This ongoing scrutiny will also be crucial in the context of any advancements made by the ICB and its system partners around establishing a Neighbourhood Health framework for Oxfordshire.

TIMELINE:

Month	Activity
November 2025	Initial meeting and confirmation of scope
December 2025	Stakeholder mapping and initial evidence gathering
January 2026	Thematic working group online session with NHS commissioners and Individual GPs on: *Workforce and Access*
February 2026	Thematic working group online sessions with NHS commissioners, Individual GPs, and Healthwatch Oxfordshire: *Access equity and patient experience*

March 2026	Thematic working group online sessions with NHS commissioners, Individual GPs, and local authority planning officers: *Estates constraints and Estate Planning; Alternative funding models and design solutions.*
April 2026	Thematic working group online sessions with NHS commissioners, Individual GPs, and Healthwatch Oxfordshire: *Service integration and transformation; Use of digital tools and technology.*
April 2026	Site visits to GP practices. Collating all written evidence/data submitted to working group on GP access and Estates.
May 2026	Drafting of findings and recommendations
June 2026	Final report presented to wider Committee.

RISKS AND MITIGATION STRATEGIES:

Risk	Description	Mitigation
Limited stakeholder engagement	Key stakeholders may be unavailable or unwilling to participate	Early engagement and clear communication of purpose and benefits.
Data gaps or inconsistencies	Incomplete or outdated data may hinder analysis	Triangulate data from multiple sources; request updated datasets from ICB, NHS partners, and Healthwatch.
Scope creep	Risk of expanding beyond manageable boundaries	Maintain focus on agreed thematic areas outlined above.
Delays in evidence gathering	Scheduling conflicts or resource constraints may impact timeline	Build in contingency time; prioritise critical evidence early
Lack of implementation of recommendations	Risk that findings are not acted upon	Engage decision-makers throughout the process; align recommendations with strategic priorities and funding opportunities

LEGAL IMPLICATIONS

14. Pursuant to Part 6.1B of the Oxfordshire County Council constitution:

    'The Committee may appoint such Working Groups of their members as they may determine to undertake and report back to the Committee on specified investigations or reviews as set out in the work programme. 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.'

15. This report outlines the nature and purpose of the working group being set up, as well as the fixed timescales that the working group will operate under. The

membership of the working group has also been shaped by the rules around political balance.

16. There are no other legal implications associated with this working group's deep-dive review into GP access and estates, nor are there any other legal implications arising from this report (its intent being to provide the Committee with an overview of the working group's membership, scope, and anticipated activities and timescales).

    Comments Checked by: Jay Akbar (Head of Legal and Governance and Deputy Monitoring Officer).

FINANCE IMPLICATIONS

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

    Comments checked by Drew Hodgson (Strategic Finance Business Partner).

Contact Officer: Dr Omid Nouri
Health Scrutiny Officer
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November 2025

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

General Practice Access and Estates in Oxfordshire

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

Report to:
- Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire).
- Matthew Tait (BOB ICB Chief Delivery Officer).
- Dr Michelle Brennan (GP and Chair of the Oxfordshire GP Leadership Group).
- Rachel Jeacock (Primary Care Lead).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on General Practice (GP) access and estates in Oxfordshire during its public meeting on 11 September 2025. The report provided a summary of GP services activity and some steps being taken to improve access to primary care for residents.

2. The Committee would like to thank Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire); Matthew Tait (BOB ICB Chief Delivery Officer); Dr Michelle Brennan (GP and Chair of the Oxfordshire GP Leadership Group); and Rachel Jeacock (Primary Care Lead) for attending the meeting and answering questions from the Committee in relation to GP services. The Committee also wishes to thank Veronica Barry (Executive Director, Healthwatch Oxfordshire) and Peter Burke (Chair, Thames Valley Faculty Board, Royal College of General Practitioners) for their attendance and participation in the discussion.

3. The topic of GP services is of significant interest and concern by the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the NHS to Council to not only deliver primary care services promptly and efficiently, but to explore how to address rising demand for these services through exploring Estate expansion.

4. Upon commissioning the report from the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) for this item, some of the insights the Committee sought to receive were as follows:

   - Details on appointment availability and timeliness.

   - The mechanisms in place to ensure equitable access for patients who struggle with digital or telephone systems.

- How patient experience and feedback was being monitored, and what such feedback is indication as to the nature of GP services.

- The impacts of barriers to recruiting newly qualified GPs under the Additional Roles Reimbursement Scheme.

- Details on the timelines and expected impacts of the new surgery in Great Western Park and the Bicester Health Centre expansion?

- How the ICB is prioritising estate improvement projects given capital and space constraints?

SUMMARY

5. During the 05 June 2025 meeting, 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 also stressed that strengthening general practice was key to future neighbourhood health plans, with further improvements still needed.

6. 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.

7. It was discussed as to 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.

8. 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.

9. The discussion also revolved around the ICB's approach to prioritising estate improvement projects, including the role of the Community Infrastructure Levy (CIL). 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.

10. The Committee noted the Director of Public Health's emphasis 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.

KEY POINTS OF OBSERVATION:

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

Reporting on access equity: Equitable access to primary care is a foundational principle of the NHS, underpinning its mission to provide high-quality healthcare to all, regardless of background or circumstance. In recent years, the landscape of general practice has undergone significant transformation, driven by digital innovation, demographic change, and evolving patient expectations. Against this backdrop, the Committee is recommending that the ICB develop regular reporting on access equity, specifically addressing digital exclusion, rural access, and variation in appointment availability between practices. This recommendation is not only timely but essential for safeguarding the fairness and effectiveness of primary care provision.

Regular reporting on access equity serves several critical functions. First, it provides transparency and accountability, enabling both the public and policymakers in Oxfordshire to scrutinise how well the health system is meeting its obligations. Second, it can allow for the identification of disparities and the targeting of interventions where they are most needed throughout the County. Third, it supports continuous improvement, enabling the Oxfordshire system to adapt to changing needs and circumstances.

The Committee understands that, while Oxfordshire performs well compared to national averages in terms of appointment availability and patient satisfaction, these aggregate figures can mask significant variation at the local level. For example, the report received by the Committee for this item notes that 88% of patients in Oxfordshire are seen within two weeks of contacting their practice, compared to 86% nationally, and 55.5% have same-day appointments. However, these averages do not reveal whether certain groups—such as those living in rural areas, those with limited digital access, or those registered at specific practices—face greater barriers to care.

Furthermore, the digital transformation of primary care, accelerated by the COVID-19 pandemic, has brought many benefits, including greater convenience and efficiency. The Committee notes the rollout of online consultation tools and the NHS App, which allow patients to book appointments and manage prescriptions remotely. However, not all patients are able to benefit equally from these innovations. Digital exclusion—defined as the inability to access or use digital technologies—remains a significant barrier for older adults, people with disabilities, those in deprived areas, and some ethnic minority groups.

Academic research underscores the risks of digital exclusion. A 2022 study in the *British Journal of General Practice* found that patients who were older, less affluent, or had lower levels of education were less likely to use online consultation systems, potentially exacerbating health inequalities[1]. Similarly, the King's Fund (2021) has warned that the shift to digital-first primary care could leave behind those who lack internet access or digital literacy[2].

Other areas have recognised this challenge and taken steps to address it. In Greater Manchester, for example, the Health and Social Care Partnership has implemented a "Digital Inclusion Programme" that provides training and support to patients who struggle with technology, ensuring that digital transformation does not come at the expense of equity[3]. Regular reporting on digital exclusion in Oxfordshire would enable the ICB to monitor the extent of the problem, evaluate the effectiveness of interventions, and ensure that alternative access channels—such as telephone and face-to-face appointments—remain available.

Furthermore, Oxfordshire's geography encompasses both urban centres and rural communities, each with distinct healthcare needs and challenges. The report submitted to the Committee notes that practice mergers and branch closures, such as the closure of Hedena Health's Marston Pharmacy site, can affect local access, particularly for those in remote areas. Rural patients may face longer travel times, limited public transport, and fewer healthcare options, all of which can impede timely access to care.

Nationally, rural access to primary care has been a persistent concern. The National Centre for Rural Health and Care (2023) highlights that rural GP practices often struggle with recruitment and retention, leading to reduced appointment availability and increased pressure on remaining staff[4]. In Lincolnshire, for example, the local ICB has developed a "Rural Access Dashboard" that tracks appointment availability, travel distances,

[1] Green, M.A., et al. (2022). "Digital exclusion and access to general practice: a cross-sectional survey." British Journal of General Practice.
[2] King's Fund (2021). "Digital transformation in primary care: risks and opportunities."
[3] Improving health and care in Greater Manchester | Greater Manchester Integrated Care Partnership
[4] National Centre for Rural Health and Care (2023). "Rural Health Inequalities in England."

and patient satisfaction by postcode, enabling targeted investment in mobile clinics and telemedicine solutions.

Academic literature supports the need for granular, location-specific data. A systematic review by Farmer et al. (2016) in BMC Health Services Research found that rural residents in England were more likely to report difficulties accessing GP services, and that regular monitoring was essential for identifying and addressing these disparities. By developing regular reporting on rural access, the Oxfordshire ICB can ensure that resources are allocated fairly and that rural communities are not left behind.

While Oxfordshire's overall performance on appointment availability is commendable, the JHOSC report acknowledges that there is variation between practices. Factors such as staffing levels, premises, management practices, and patient demographics can all influence how quickly and easily patients can secure appointments. Without regular, practice-level reporting, these differences may go unnoticed, leading to pockets of unmet need and frustration.

Other regions have demonstrated the value of benchmarking and transparency. In London, NHS North-West London publishes quarterly "Access Equity Reports" that compare appointment availability, waiting times, and patient satisfaction across practices. This has enabled the identification of outliers and the sharing of best practices, driving improvements across the board.

Academic studies reinforce the importance of monitoring variation. Roland et al. (2019) in the Journal of Health Services Research & Policy argue that regular, comparative reporting is essential for quality improvement, enabling commissioners and providers to learn from high-performing practices and support those that are struggling.

Policy Alignment and Future Directions

The NHS's "Fit for the Future – 10 Year Health Plan for England" (2025) places equity at the heart of its vision for neighbourhood health teams and personalised care. Regular reporting on access equity aligns with national policy and supports the ICB's statutory duty to cooperate with local authorities on health matters. It also complements existing data sources, such as the GP Patient Survey and Friends and Family Test, by providing more granular, actionable insights.

To implement this recommendation effectively, the ICB should develop standardised metrics for digital access, rural provision, and appointment variation, report at regular intervals, and engage stakeholders in interpreting the data and co-designing solutions. This approach will not only enhance transparency and accountability but also support evidence-based decision-making and continuous improvement.

Conclusion

In summary, the recommendation for the ICB to develop regular reporting on access equity across Oxfordshire is justified by the need to ensure that all residents—regardless of digital literacy, geographic location, or practice affiliation—can access timely and appropriate primary care. Drawing on evidence from Oxfordshire, national examples, and academic research, it is clear that regular, transparent reporting is essential for identifying disparities, targeting interventions, and promoting fairness and quality in primary care provision. By embracing this recommendation, Oxfordshire can lead the way in delivering truly equitable healthcare, aligned with both local needs and national ambitions.

Recommendation 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.*

Rollout plan and evaluation of Modern General Practice model: The Modern General Practice Model (MGPM), as outlined in the HOSC paper, is a conceptual and operational shift in how primary care is delivered. Introduced in 2024, it aims to better align capacity with patient need, improve the experience of care, and enhance the working environment for general practice staff. Its core components include optimising contact channels (telephone, online, in-person), structured information gathering at first contact, care navigation to prioritise need, better allocation of capacity across multidisciplinary teams, and building capability in data use and digital tools.

While the model is ambitious and well-intentioned, its success depends on consistent implementation and rigorous evaluation. Without a clear rollout plan and metrics to assess progress, the risk is that Modern General Practice could become a fragmented initiative with potentially uneven impact across Oxfordshire's diverse communities. A rollout plan provides clarity on how, when, and where the Modern General Practice model will be implemented. It ensures that practices are supported with the necessary resources, training, and infrastructure to adopt the model effectively. The HOSC paper notes that the ICB is working with practices to support implementation, including funding and incentives, but lacks detail on timelines, milestones, or geographic prioritisation.

This lack of specificity is problematic given the variation in practice size, staffing, and patient demographics across Oxfordshire. For example, practices range from serving 3,300 to over 42,000 patients, and some operate in converted houses or outdated buildings with limited capacity for expansion. A rollout plan would allow the ICB to tailor support to local contexts, ensuring that smaller or rural practices are not left behind.

Nationally, NHS Greater Manchester's "Primary Care Blueprint" offers a useful precedent. It outlines phased implementation of digital triage, workforce expansion, and patient engagement strategies, with clear

timelines and responsibilities. Such structured planning has enabled more consistent adoption and better outcomes across the region.[5]

Equally critical is the development of an evaluation framework to assess the impact of Modern General Practice. The paper submitted to the Committee provides some data on appointment volumes and patient satisfaction, noting that 88% of patients are seen within two weeks and 55.5% receive same-day appointments. However, these metrics alone do not capture the full picture of patient experience, staff wellbeing, or service efficiency. An evaluation framework should ideally include:

- *Patient Experience Metrics:* Beyond appointment speed, measures should include ease of access across channels, continuity of care, and satisfaction with care navigation. The GP Patient Survey and Friends and Family Test offer useful starting points, but more granular, practice-level data is needed (and this should be made as accessible and transparent as possible).

- *Staff Wellbeing Indicators:* The success of Modern General Practice hinges on the morale and resilience of staff. Metrics such as workload distribution, burnout rates, and job satisfaction should be tracked. Research by West et al. (2020) in the *British Medical Journal* highlights the link between staff wellbeing and patient outcomes, underscoring the need for systematic monitoring[6].

- *Service Efficiency Measures:* These should include utilisation of multidisciplinary teams, reduction in unnecessary GP appointments, and improvements in triage accuracy. The *Health Foundation's 2022 report* on "Efficiency in Primary Care" recommends using data dashboards to monitor these metrics in real time[7].

In London, NHS North Central London ICB has implemented a "Primary Care Outcomes Framework" that tracks these dimensions across practices. This has enabled targeted support and shared learning, improving both patient and staff outcomes.

Furthermore, publishing a rollout and evaluation framework also supports equity. The paper submitted to the Committee acknowledges that while Oxfordshire performs well on average, there is variation between practices. Without transparent reporting, disparities in access and quality may persist. Moreover, the shift to digital-first care risks excluding patients who lack internet access or digital literacy—a concern echoed in Healthwatch Oxfordshire's June 2025 report, which found that some patients face significant barriers to navigating new systems. Academic literature reinforces this point. A study by Green et al. (2022) in the *British Journal of General Practice* found that digital

[5] Greater Manchester Primary Care Blueprint
[6] Time for a rebalance: psychological and emotional well-being in the healthcare workforce as the foundation for patient safety | BMJ Quality & Safety
[7] Access to and delivery of general practice services - Health Foundation.pdf

exclusion disproportionately affects older adults, those with disabilities, and people in deprived areas[8]. An evaluation framework must therefore include equity metrics, such as digital access rates and outcomes by demographic group.

Moreover, publishing a rollout and evaluation framework enhances transparency and public trust. Patients and stakeholders need to understand how changes are being made, what impact they are having, and how concerns are being addressed. This is particularly important in a context where changes to access systems can be confusing or disruptive. The *King's Fund* (2021) emphasises that transformation in primary care must be co-designed with patients and communities, and that regular reporting is key to maintaining engagement and accountability[9]. By committing to publish its plans and progress, the ICB can demonstrate its responsiveness to public concerns and its commitment to continuous improvement.

Recommendation 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.*

Progressing Great Western Park and Bicester Projects: Primary care is the bedrock of the NHS, and its infrastructure must evolve to meet the changing needs of communities. The report submitted to the Committee for this item acknowledges that many GP premises across Buckinghamshire, Oxfordshire, and Berkshire West (BOB) are outdated, often housed in converted residential buildings or older purpose-built surgeries that no longer meet modern healthcare standards. With 154 practices operating out of 223 sites, the report notes that "very few have room to expand," and many have "outgrown their existing space".

In this context, the Great Western Park (Didcot) and Bicester Health Centre projects are not merely capital investments—they are essential responses to demographic pressures and service delivery challenges. Great Western Park is a rapidly growing residential area, and Bicester is one of Oxfordshire's key urban centres. Without timely expansion of primary care facilities in these locations, patients could face longer waits, reduced access, and increased pressure on neighbouring practices.

The Committee's call for an urgent update on the timeline of delivery is rooted in the principle of public accountability. It is pivotal that there are specific milestones, completion dates, or progress indicators. In the absence of such detail, stakeholders—including patients, councillors, and healthcare professionals—are left uncertain about when and how

[8] Implications of the changes to patient online records access in English primary care | British Journal of General Practice
[9] Shaping the future of digital technology in health and social care - Digital Collections - National Library of Medicine

these improvements will materialise. Any lack of clarity could be particularly concerning given the broader challenges facing the NHS estate. The report highlights constraints such as "lack of capital, high rental costs, and lack of suitable options," which make investment difficult. Without a published timeline, there is a risk that these projects may be delayed or deprioritised, despite their strategic importance.

The Committee understands that in August 2024, the ICB issued a letter to all Heads of Planning outlining the types of planning applications it should be consulted on and the use of Community Infrastructure Levy (CIL) funding to support primary care estate projects. The report submitted to the Committee confirms that healthcare has been allocated 20% of the infrastructure proportion of CIL funding from South Oxfordshire and Vale of White Horse District Councils, with contributions approved for extensions in Abingdon and Great Western Park. Given these commitments, it is essential that the ICB demonstrate how planning obligations are being translated into tangible infrastructure improvements. A written timeline update would show how developer contributions are being used, when construction will begin, and when new facilities will be operational.

Other regions have faced similar challenges and responded with structured, transparent estate planning. In North East London, the ICB has developed a "Primary Care Infrastructure Delivery Plan" that maps estate needs against population growth projections and includes detailed timelines for each project. This approach has enabled the region to secure additional capital funding and coordinate with local authorities more effectively[10].

Academic research also supports the need for proactive estate planning. A study by Imison et al. (2018) for the Nuffield Trust found that "poor premises are a barrier to service transformation" and that "investment in estate must be aligned with service redesign and population needs." The authors argue that without clear delivery plans, estate projects risk being reactive and fragmented, undermining their potential impact[11].

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

Alternative funding models and design solutions for primary care estate expansion: Many practices across Oxfordshire have outgrown their existing premises, and traditional capital schemes are increasingly failing to deliver viable solutions. The Committee is aware that while developer contributions via Section 106 and the Community Infrastructure Levy (CIL) have been secured, bureaucratic delays and rigid funding mechanisms could also hinder timely deployment.

[10] Primary care transformation - NHS North East London
[11] Improving access and continuity in general practice | Nuffield Trust

This situation is not unique to Oxfordshire. Nationally, the NHS faces a historic backlog in estate maintenance and capital investment. According to the NHS Confederation, the NHS has had half the average rate of capital investment compared to other OECD (Organisation of Economic Cooperation and Development) countries since the 1970s, with over 27,000 clinical service incidents in the last five years linked to estate failures. The House of Lords Library also notes that reliance on general taxation and tight capital controls has limited the NHS's ability to invest strategically in infrastructure[12].

Across the UK, several alternative funding models and design approaches are being explored to overcome the limitations of traditional capital schemes:

- *Public-Private Partnerships (PPPs):* These have been used to deliver estate improvements through shared risk and investment. While controversial in some contexts, PPPs can offer flexibility and speed when structured transparently.

- *Modular and Rapid Build Solutions*: Organisations like Health Spaces have demonstrated that modular construction can reduce delivery times by up to 30%, offering cost-effective and scalable solutions for expanding capacity[13].

- *Flexible Leasing and Repurposing:* NHS Property Services and AHR Architects have promoted the repurposing of underutilised estate and flexible leasing arrangements to support community-based care and integrated service delivery[14].

- *Technology-Enabled Estate Optimisation:* The NHS Estate Optimisation Guide outlines how data-driven space utilisation can help identify and transform vacant or inefficient spaces, aligning estate use with clinical demand[15].

- *Neighbourhood Health Hubs*: The NHS Confederation's September 2025 briefing advocates for the development of neighbourhood health centres that co-locate services, reduce duplication, and improve access, particularly in underserved areas[16].

Furthermore, design innovation is equally critical. The NHS Estate Strategy and planning guidance stresses the importance of adaptable, sustainable, and patient-centred design that can evolve with changing service models. This includes:

[12] Reimagining estates funding | NHS Confederation / Long-term sustainability of the NHS: Options for systems and funding - House of Lords Library
[13] Healthcare Estates | NHS & Private Health | Health Spaces

[14] NHS Property Services | Using innovative technologies to optimise the NHS Estate
[15] NHS Property Services | Using innovative technologies to optimise the NHS Estate
[16] Transforming-NHS-estate-enable-neighourhood-health-service.pdf

- Multi-purpose spaces that accommodate different services.
- High-street drop-in centres for accessible care.
- Reconfigured offices for neighbourhood care delivery.
- Digital-ready infrastructure to support virtual consultations and AI-enabled diagnostics[17].

These approaches can not only improve patient experience and staff wellbeing but also enhance operational efficiency and long-term resilience.

Given these insights, the JHOSC's recommendation for the ICB to produce a plan for Oxfordshire is both pragmatic and strategic. Such a plan should:

- Map current estate pressures and future demand.
- Identify schemes deemed unviable under traditional models.
- Engage district valuers and local authorities in co-designing solutions.
- Explore alternative funding routes, including CIL, Section 106, PPPs, and modular builds.
- Align with national estate optimisation frameworks and the NHS 10-Year Plan.

This plan would not only unlock stalled projects but also position Oxfordshire as a leader in estate innovation, capable of delivering modern, equitable, and sustainable primary care infrastructure.

In essence, the recommendation for the ICB to collaborate with district valuers and local authorities to explore alternative funding models and design solutions is a necessary response to the systemic challenges facing NHS estate development. By producing a localised plan, Oxfordshire can overcome bureaucratic inertia, leverage innovative approaches, and ensure that its primary care estate is fit for the future. This is not just about buildings—it is about enabling better care, closer to home, for every resident.

Recommendation 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.*

[17] Estate Strategy and Masterplanning | Medical Architecture

Legal Implications

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

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

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

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

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

Annex 1 – Scrutiny Response Pro Forma

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October 2025

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

Retaining the functions of Healthwatch Oxfordshire

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

Report to:
- Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Dan Leveson (Director of Places & Communities, BOB ICB)
- Stephen Chandler (Deputy Chief Executive and Executive Director for People, Oxfordshire County Council).
- Ansaf Azhar (Director of Public Health, Oxfordshire County Council).
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered two reports from Healthwatch Oxfordshire during its public meeting on 11 September 2025. The first report provided a summary of what Healthwatch Oxfordshire heard from service users in relation to GP services, Muscular Skeletal Services, and the NHS app. The second report provided a brief summary of national developments and plans to abolish local Healthwatch organisations, and highlighted the importance of upholding the functions that Healthwatch provides and the role of the independent patient voice.

2. The Committee would like to thank Veronica Barry (Executive Director, Healthwatch Oxfordshire) for attending the meeting and providing a summary of the importance of the Healthwatch function. The Committee also thanks Matthew Tait (Chief Delivery Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB]) for his input and for reiterating the value that the Healthwatch function provides in gathering feedback from patients and service users.

3. The Committee notes that a motion was unanimously agreed by Oxfordshire County Council in its Full Council meeting on 09 September 2025, which called for the:

   'Leader 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.'

4. This motion was proposed by Cllr Jane Hanna (HOSC Chair), and the full wording of it can be found at the bottom of this report below.

5. This matter is of significant concern and interest by the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the Council and its partners to not only deliver services promptly and efficiently, but to also invest time and resource into supporting and listening to the voices of service users.

SUMMARY

6. During the 05 June 2025 meeting, 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 Committee also emphasised the value of Healthwatch's contributions to both its own scrutiny as well as to decision-making by system partners in Oxfordshire, noting the strong local support for its continued function following recent national announcements about its future.

7. Both the District and County Council members of the Committee highlighted their support for Healthwatch Oxfordshire, and praised the valuable insights the organisation provides through gathering patient feedback.

8. 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.

9. The Committee discussed the importance of system partners safeguarding and developing the Healthwatch function. It was also agreed that there should be meaningful consultation with local stakeholders, and that the Committee should have the opportunity to review any local decisions prior to their implementation. The Committee also agreed to write to local MPs about their concerns, and supported the core characteristics of the independent patient/public voice underpinned by Healthwatch.

KEY POINTS OF OBSERVATION:

10. The proposed abolition of local Healthwatch bodies, as outlined in the July 2025 *Dash Report*, presents a pivotal moment for the future of independent patient and public voice in health and social care. While these national reforms might aim to rationalise patient voice pathways and improve accountability, there is significant risk that the unique strengths of Healthwatch—its independence, local engagement, and ability to amplify seldom-heard voices—could be lost. This report draws on recent reports from Healthwatch Oxfordshire, national Healthwatch evidence, and academic studies to support the Committee's recommendation: that system partners safeguard and develop the Healthwatch function within Oxfordshire, engaging and consulting with all stakeholders, and ensuring local scrutiny of any changes.

The Value of Healthwatch Oxfordshire: Local Impact and Evidence
Healthwatch Oxfordshire has, over more than a decade, established itself as a trusted, independent partner in the local health and care system. Its statutory functions, as set out in the Local Government and Public Involvement in Health Act 2007 (amended by the Health and Social Care Act 2012), include promoting public involvement, monitoring standards, gathering and representing patient views, and making recommendations for improvement. These functions are not merely bureaucratic; they are the foundation for meaningful change.

In 2024–25 alone, Healthwatch Oxfordshire engaged 5,321 people who shared their experiences of health and social care, and 577 submitted reviews via the Feedback Centre[1]. The organisation published 38 reports on improvements people want to see, and pioneered community research to ensure seldom-heard voices—such as those from the Sunrise Multicultural Centre and Chinese community groups—are brought to the fore[2].

The impact of this work is tangible. The July 2025 *Women's Health Services Report* led directly to the development of a women's health strategy for Buckinghamshire, Oxfordshire and Berkshire West ICB, and prompted commitments from Oxford University Hospitals NHS Foundation Trust to reduce waiting times, improve patient information, and train staff in cultural competency. Similarly, the June 2025 *Urgent and Emergency Care Report* informed winter planning and resulted in the development of a new online service for urgent and emergency care. These are not isolated examples; they reflect a consistent pattern of Healthwatch Oxfordshire's evidence-based advocacy leading to real improvements in local services.

Healthwatch Oxfordshire's independence is central to its effectiveness. As an organisation not entirely beholden to service providers or commissioners, it has built trusted relationships with communities and acted as a critical friend to the system. Its reports and recommendations have influenced provider responses and system planning, with all reports available in accessible formats to ensure transparency and inclusivity.

***Healthwatch's National context and value*:** The value of Healthwatch is not confined to Oxfordshire. Across England, 152 local Healthwatch organisations operate as statutory bodies, funded by and accountable to their local authorities. Their core functions—promoting public involvement, monitoring standards, obtaining views, and making recommendations—are replicated nationwide[3].

Local Healthwatch bodies have conducted thousands of 'Enter and View' visits to health and care facilities, enabling direct monitoring and

[1] https://healthwatchoxfordshire.co.uk/report/healthwatch-oxfordshire-annual-impact-report-2024-25/
[2] https://healthwatchoxfordshire.co.uk/impact/impact-of-our-research/
[3] The future of Healthwatch and independent scrutiny.pdf,

improvement of services. Healthwatch England and local Healthwatch organisations have published numerous reports that have shaped national policy and local service delivery, such as influencing the NHS Long Term Plan and improvements in patient safety[4].

Collaboration is another hallmark of Healthwatch's value. Healthwatch groups work together at Integrated Care Board (ICB) level, providing insight to committees such as the Quality Committee, Population and Patient Experience Committee, and Prevention and Health Inequalities Committee[5]. Their evidence has been used to inform strategies and planning at both local and national levels, ensuring that reforms are shaped by real patient and community experiences.

Independent evaluations, such as that conducted by Healthwatch York, have highlighted Healthwatch's effectiveness in partnership working and influencing health and social care across Humber and North Yorkshire[6]. The risks of losing this independence are well documented: Healthwatch Richmond's analysis warns that losing the independent patient voice undermines the credibility and effectiveness of feedback, which is essential for system improvement[7].

The value of the Healthwatch function and the independent patient voice is further supported by a growing body of academic literature. A 2025 *British Medical Journal* article on the NHS 10-year health plan for England emphasises "patient choice, voice and feedback at the heart of how we define and measure quality." The study warns that the closure of local bodies championing public engagement risks weakening the impact of patient voices, noting that in almost every serious case of failure, patients and families had raised concerns long before problems reached public attention[8].

In a 2018 research project entitled *Public Engagement in Health,* Healthwatch England summarises academic evidence showing that public engagement improves health outcomes, service design, and accountability. The study concluded that independent patient voice mechanisms, such as Healthwatch, are crucial for effective engagement[9].

Additionally, research from *Kingston University* and *King's College London* has found that local Healthwatch organisations act as 'consumer champions' in health and social care, with their daily practices vital for representing citizen views and influencing systems[10]. These studies

[4] GOV.UK: Strengthening Peoples Voices in Health and Social Care
[5] Healthwatch Oxfordshire Report to HOSC Sept 2025.pdf
[6] Healthwatch York Evaluation
[7] Healthwatch Richmond
[8] BMJ, 2025; 390:r1949
[9] Healthwatch England Literature Review
[10] Kingston University Research; King's College London

highlight the importance of independence and local presence for effective advocacy and system change.

Furthermore, Healthwatch Surrey and Healthwatch Kingston have also published analyses warning that centralising patient voice functions risks creating significant gaps in understanding the public's perspective, as people's experiences are more than singular interactions with providers[11].

Risks of Losing Independence and Local Engagement: The *Dash Report* proposes dissolving Healthwatch England and local Healthwatch bodies, transferring statutory functions to local authorities and integrating engagement with ICBs. While the intention is to rationalise patient voice pathways and improve accountability, there is uncertainty about how these changes will be implemented and the risk of losing the independent, locally-rooted voice that Healthwatch provides. Therefore, losing this independence undermines the ability to provide honest feedback and drive system improvement. Centralising or entirely abolishing the local Healthwatch function risks losing the nuanced, locally-rooted understanding of patient needs and experiences.

Hence, any new model for patient and public engagement that local system partners agree on must retain key principles for an effective public voice, which should include:

- Independence from service providers and commissioners, building trust.
- Local presence and understanding, especially at neighbourhood level and among seldom-heard communities.
- Public need as the driver, not just system priorities.
- Integration across health and social care boundaries.
- An influential, confident voice acting as a critical friend.

These principles are essential for maintaining credibility, trust, and effectiveness in representing public views and driving service improvement.

Local Delivery of National Reforms: The case for Safeguarding the Healthwatch function should also be seen in the context of the local system's delivery of other national reforms at Place. If system partners are to embark on implementing reforms (including around the creation of a new Neighbourhood Health Model for Oxfordshire), then the value of an independent patient voice function is also pivotal in this regard. The Healthwatch function's approach—grounded in local engagement, evidence, and independence—can help to ensure that reforms are shaped by the real experiences and needs of residents. The organisation's ability to reach seldom-heard groups, support digital

[11] Healthwatch Surrey; Healthwatch Kingston

inclusion, and address inequalities is vital for effective local delivery of national reforms.

The Committee's recommendation for system partners to engage and consult with all stakeholders is supported by Healthwatch's track record of transparent reporting, collaborative working, and responsiveness to public feedback. Scrutiny by the Oxfordshire HOSC before any local decisions are made will help to complement the integrity and effectiveness of the independent patient voice function.

In essence, retaining and developing the Healthwatch function in Oxfordshire is essential to ensure that the public voice remains credible, effective, and influential in shaping health and social care services. The evidence from Healthwatch Oxfordshire's work, national Healthwatch activity, and academic studies demonstrates the value of independence, local engagement, and meaningful consultation. As national reforms progress, safeguarding these principles will be critical to meeting patient and community need at Place and neighbourhood level.

RECOMMENDATION:

11. Below is the recommendation issued by the Committee to Local system partners in Oxfordshire:

'For system partners to safeguard and develop the Healthwatch function, and to 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. It is recommended that the Oxfordshire JHOSC has an opportunity to scrutinise any local decisions on this before they are made.'

FULL WORDING OF COUNCIL MOTION:

"Council notes with concern that Oxfordshire Healthwatch and local Councils of Governors of Oxfordshire hospitals are to be abolished within a new Health and Social Care Act, and integrated into existing local departments, with queries diverted to the NHS App.

The Council endorses the work of Healthwatch Oxfordshire for listening and helping thousands of patients each year, recognising that many vulnerable residents do not use the NHS App. Their team shared patient and carer experiences in thirty eight reports influencing local improvements through the Health and Wellbeing Board, the Place Based Partnership and contributions to the Joint Health Overview and Scrutiny Committee.

As part of the ten year NHS plan, Health and Wellbeing Boards are required to develop neighbourhood plans with NHS partners to shift more resource to prevention and from hospitals to a neighbourhood health service model. The financial, workforce and integration challenges are significant. Patients and the public will need

- *A trusted and credible local body, to speak for patients, offering constructive challenge and supporting communities' engagement*
- *their elected members and lower tier councils with relevant local knowledge engaged*
- *Safe public spaces, including scrutiny, to speak up*

Council calls on the Leader 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."

Legal Implications

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

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

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

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

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

Annex 1 – Scrutiny Response Pro Forma

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October 2025

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

Oxfordshire Eyecare Services

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

Report to:
- Matthew Tait (Chief Delivery Officer, BOB ICB)
- Hannah Mills (Director of Delivery – UEC and Elective, BOB ICB)
- Sharon Barrington (Associate Director Acute Provider Collaborative, BOB ICB)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on eyecare services in Oxfordshire during its public meeting on 11 September 2025. The report provided a summary of the commissioning, delivery, and geographical spread of eyecare service activity.

2. The Committee would like to thank Matthew Tait (Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB Chief Delivery Officer); Hannah Mills (Director of Delivery – Urgent Emergency Care and Elective, BOB ICB); and Sharon Barrington (Associate Director Acute Provider Collaborative, BOB ICB) for attending the meeting and answering questions from the Committee in relation to eyecare services. The Committee also wishes to thank Veronica Barry (Executive Director, Healthwatch Oxfordshire) and Peter Burke (Chair, Thames Valley Faculty Board, Royal College of General Practitioners) for their attendance and participation in the discussion.

3. The topic of eyecare services is of significant interest and concern by the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the NHS to not only deliver eyecare services promptly and efficiently, but to explore how to address rising demand for these services and for eyecare procedures.

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

   - How eye care services are commissioned and managed.
   - The geographical distribution of eyecare facilities in Oxfordshire.
   - Whether there are sufficient numbers of eyecare professionals (ophthalmologists, optometrists, and support staff) to meet the demand?
   - Waiting times for routine and urgent eyecare appointments.

- Were there any barriers to accessing eye services, such as transportation issues, financial constraints, or lack of awareness?
- Were there standard protocols and guidelines in place for the diagnosis and management of eye conditions?
- How the quality of eyecare was measured and monitored?
- What was the level of patient satisfaction with the services provided?
- What referral pathways existed for patients requiring specialised eye care?
- Details on the sustainability of NHS eye care departments.

SUMMARY

5. During the 11 September 2025 meeting, the BOB ICB Chief Delivery Officer confirmed the ICB's support for sustainable secondary care. The Chief Delivery Officer also highlighted challenges between NHS and private providers, and stated that they were adhering to national policy on provider choice and tariffs.

6. It was also discussed as to 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.

7. There were also 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.

8. It was enquired as to 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.

9. The discussion also addressed 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.

KEY POINTS OF OBSERVATION:

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

Monitoring contract outcomes and patient satisfaction: Effective oversight of healthcare services requires not only robust data collection but also the ability to interpret and act on that data in a way that is responsive to local needs. In the context of eyecare services commissioned by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), adopting this in the form of a dashboard would serve as a vital tool for transparency, accountability, and continuous improvement. The report submitted to the Committee for this item outlines a complex landscape of eyecare provision; spanning primary optometry, intermediate care, and secondary hospital services. While contract management arrangements exist, including the use of the Quality in Optometry (QiO) toolkit and periodic reviews, there is little indication of a unified, real-time system that tracks performance across providers or captures patient satisfaction in a systematic way. This fragmentation risks obscuring service gaps, delays in referrals, and variations in patient experience.

There are key benefits to having a localised dashboard, as it could allow the ICB and stakeholders to:

- *Track contract outcomes*: Including service delivery against agreed metrics, referral efficiency, and adherence to clinical pathways.
- *Monitor patient satisfaction*: Using real-time feedback mechanisms to identify trends, concerns, and areas for improvement.
- *Support place-based decision-making*: By enabling granular analysis at the district or neighbourhood level, the dashboard would help tailor interventions to local needs.
- *Enhance transparency and public trust*: Making performance data accessible to patients and the public would reinforce accountability and support informed choices.

Other regions have successfully implemented dashboards that demonstrate the feasibility and impact of such tools: Mid and South Essex ICB developed a series of comprehensive outcomes and performance dashboards as part of a stewardship programme. These dashboards enabled easy monitoring of delivery against the NHS Triple Aim—improving population health, service quality, and resource efficiency—while addressing health inequalities[1]

Furthermore, academic literature supports the use of comprehensive and adaptable dashboards in healthcare settings. A study by Dowding et al. (2015) in *BMC Medical Informatics and Decision Making* found that dashboards improve clinical decision-making by presenting data in a user-friendly format. Similarly, research by Cresswell et al. (2020) in *BMJ Health & Care Informatics* emphasised that dashboards enhance organisational learning and responsiveness when integrated into routine workflows.

Moreover, to be effective, such a dashboard should:

- Integrate data from multiple sources, including contractors, Independent Service Providers, and NHS Trusts.
- Include both quantitative metrics (e.g., appointment wait times, referral rates) and qualitative feedback (e.g., patient satisfaction surveys).
- Be co-designed with stakeholders, including clinicians, commissioners, and patient representatives.
- Be updated regularly and made accessible to both professionals and the public.

Therefore, the recommendation to establish a localised dashboard for eyecare services in Oxfordshire is not merely a technical suggestion—it is a strategic imperative. It aligns with national best practices, responds to local service challenges, and supports the broader goals of the NHS to deliver high-quality, equitable, and patient-centred care. By investing in such a tool, the ICB would demonstrate its commitment to transparency, responsiveness, and continuous improvement, ultimately enhancing outcomes for patients across Oxfordshire.

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

Raising awareness of services: The report submitted to the Committee for this item highlighted that NHS-funded sight tests and optical vouchers are available under General Ophthalmic Services (GOS) contracts, with eligibility determined nationally. However, the report also notes that these

[1] [ardengemcsu.nhs.uk]

services are delivered by private optical businesses, which rely on commercial promotion and patient self-referral. This model inherently disadvantages individuals who are less engaged with high street optometry, including older adults, people with disabilities, and those living in rural or economically deprived areas.

Healthwatch Oxfordshire's 2024 findings, referenced in the report, reveal that while patients generally had positive experiences with eye care appointments, they also faced challenges related to transport, costs, and accessing services locally. Some patients expressed frustration at not being able to receive outpatient eye care at their local health facility, and others struggled with early appointment times and busy waiting areas. These barriers are compounded by a lack of awareness about entitlements to NHS-funded sight tests and optical vouchers, particularly among those who may benefit most.

Public information campaigns are a proven tool in addressing health inequalities and improving service uptake. According to a study published in the *Health Promotion International Journal*, health literacy is a key determinant of health outcomes, and effective public health communication must go beyond information provision to empower individuals to act[2]. A targeted campaign can help bridge the gap between entitlement and access by clarifying eligibility criteria, demystifying the process of obtaining sight tests and vouchers, and signposting individuals to local providers.

National Eye Health Week, coordinated by Eye Health UK, offers a successful model of how targeted campaigns can raise awareness. In 2023, the campaign highlighted that 4.7 million NHS sight tests were lost due to pandemic-related disruptions, and cost concerns led 1 in 5 people to cancel or postpone appointments[3]. The campaign used localised data to identify hotspots of avoidable sight loss and tailored messaging to encourage uptake. Similarly, the Eyecare Trust's campaigns have used a mix of national advertising, local events, and media engagement to promote eye health among specific demographics[4].

To be effective, the campaign must be tailored to the needs of vulnerable and underserved populations. This includes:

- *Older adults and people with disabilities*: who may face mobility challenges and digital exclusion.

- *Residents of rural areas:* where transport options are limited and local services may be sparse.

[2] Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century | Health Promotion International | Oxford Academic
[3] Vision Matters - National Eye Health Week
[4] NEHW 2023: raising awareness of eye health

- *Economically deprived communities:* where cost concerns and competing priorities may deter individuals from seeking care.

The campaign should use multiple channels, including print, radio, community outreach, and digital platforms. It should be co-designed with community representatives to ensure cultural relevance and accessibility also. Trusted intermediaries such as GP practices, schools, libraries, and voluntary organisations can play a key role in disseminating information and assisting individuals in navigating eligibility criteria.

The recommendation to involve local authorities and voluntary sector partners is both pragmatic and strategic. These organisations have deep roots in their communities and are well-positioned to deliver culturally sensitive and locally relevant messaging. For example, Age UK, Citizens Advice, and local disability networks can help disseminate information and assist with navigating eligibility criteria. The ICB's existing commissioning infrastructure can be leveraged to coordinate messaging across providers and ensure consistency. Local authorities can support the campaign through their public health teams, while voluntary sector partners can provide outreach and engagement in hard-to-reach communities. Collaboration with local Healthwatch organisations can also prove useful in this regard. In Surrey, the County Council and Surrey Heartlands and Frimley ICBs collectively worked with Healthwatch Surrey to boost awareness of NHS-funded sight tests; which allowed for more effective outreach[5].

Furthermore, academic literature supports the role of targeted health communication in improving service uptake. A 2015 study in the *British Journal of General Practice* found that lower health literacy was associated with reduced use of preventive services, including eye care[6]. In rural settings, outreach must also address geographic isolation. A 2020 study by Smith et al. in *Health & Place* found that community-based interventions, including mobile clinics and local champions, significantly improved access to care in rural England[7].

In addition, policy frameworks such as the NHS Long Term Plan and the Health Inequalities Strategy emphasise the importance of targeted interventions to reduce disparities in access and outcomes. The proposed campaign aligns with these priorities and supports the broader goals of the NHS to deliver equitable, patient-centred care.

Therefore, launching a targeted public information campaign to raise awareness of NHS-funded sight tests and optical vouchers is a necessary and evidence-based intervention. It addresses a clear gap in service utilisation, aligns with national best practices, and supports the broader goals of health equity and prevention. By working with local

[5] Sight (eye) tests for children and young people | Healthwatch Surrey
[6] A mismatch between population health literacy and the complexity of health information: an observational study - PMC
[7] Spatial Lifecourse Epidemiology Reporting Standards (ISLE-ReSt) statement - ScienceDirect

authorities and voluntary sector partners, the ICB can ensure that the campaign reaches those who need it most—residents in rural and deprived areas who are currently underserved. This recommendation is not only justified but urgent, and its implementation will be a meaningful step toward reducing avoidable sight loss and improving population health in Oxfordshire.

Recommendation 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.*

Shared digital records: Shared digital records between providers is a forward-looking and necessary step toward improving the quality, efficiency, and equity of care across the county. In a health system increasingly characterised by complexity, fragmentation, and rising demand, the ability to share patient information seamlessly across organisational boundaries is no longer a luxury—it is a foundational requirement for safe, effective, and person-centred care.

The Committee understands that as with many other systems around the country, Oxfordshire's health system experiences challenges including duplication of services, gaps in continuity of care, and inefficiencies in referral pathways. These problems are particularly acute in areas such as ophthalmology, where patients often move between primary optometry, intermediate care, and secondary hospital services. Without shared digital records, each provider may rely on incomplete or outdated information, leading to repeated tests, missed diagnoses, and delays in treatment. NHS England encourages the use of shared digital records for eyecare services, and is promoting a blueprint that could help to set the foundations for this[8].

The NHS Long Term Plan and the "What Good Looks Like" framework from NHS England both emphasise the importance of shared care records in achieving integrated, data-driven care. The Connecting Care Records programme, which succeeds the Shared Care Records initiative, also aims to ensure that authorised professionals have secure access to person-centred information across settings[9]. The Health Foundation's April 2025 analysis stresses that while most NHS trusts now have electronic patient records (EPRs), many are not using them to their full potential. The report calls for a national strategy to unlock the benefits of EPRs, including improved care quality, productivity, and safety[10].

[8] NHS England » Blueprinting
[9] NHS England » Connecting Care Records programme
[10] Electronic patient records: why the NHS urgently needs a strategy to reap the benefits - The Health Foundation

Moreover, academic literature supports the role of shared digital records in improving continuity of care. A study by Cresswell et al. (2020) in *BMJ Health & Care Informatics Journal* found that integrated digital systems reduce duplication, enhance communication, and support better clinical outcomes[11]. Similarly, Greenhalgh et al. (2017) in *The Lancet* argued that shared records are essential for managing complex, multi-morbidity cases in community settings. Additionally, the Health and Social Care Committee's 2023 report on digital transformation in the NHS emphasises that digitising services and enabling data sharing are critical to personalising care, reducing disparities, and improving system performance[12].

To be successful, the development of shared digital records in Oxfordshire must:

- *Ensure interoperability:* across NHS Trusts, GP practices, optometry providers, and voluntary sector organisations.
- *Address digital exclusion*: by providing alternative access routes and support for those without digital literacy or connectivity.
- *Protect data privacy and security:* with robust governance frameworks and consent protocols.
- *Be co-designed with stakeholders*: including patients, clinicians, and community representatives.
- *Include evaluation metrics:* such as reductions in duplicated tests, improved referral times, and patient satisfaction scores.

The Oxfordshire Health & Wellbeing Board Neighbourhood Health Workshop held on 24th October 2025 also discussed the importance of vertical and horizontal integration, data-driven decision-making, and reducing duplication in resource allocation—all of which align with the goals of shared digital records.

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

Workforce recruitment and retention: The report submitted to the Committee for this item highlights that while General Ophthalmic Services (GOS) contractors have not reported shortages of optometrists for routine sight tests, there are systemic pressures affecting sustainability. Independent Service Providers (ISPs) delivering low-complexity cataract surgery have inadvertently destabilised NHS ophthalmology training pathways, reducing opportunities for trainees and

[11] Investigating the use of data-driven artificial intelligence in computerised decision support systems for health and social care: A systematic review - Kathrin Cresswell, Margaret Callaghan, Sheraz Khan, Zakariya Sheikh, Hajar Mozaffar, Aziz Sheikh, 2020

[12] Digital transformation in the NHS - Health and Social Care Committee

increasing reliance on experienced staff for complex cases. This has created knock-on effects for eye casualty and other specialist services, stretching workforce capacity and impacting service resilience.
Moreover, the report notes that acute ophthalmology departments remain challenged by high demand and long waiting lists, despite collaborative efforts across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) system. These pressures underscore the need for a proactive workforce strategy that addresses recruitment, retention, and training across community and hospital settings.

A dedicated workforce strategy would enable the ICB and Primary Eyecare Services to:

- *Identify and address geographic disparities:* Rural and deprived areas often struggle to attract and retain optometrists, leading to inequitable access to care.

- *Support continuity of care:* Stable staffing in community settings reduces reliance on hospital services for minor conditions and improves patient experience.

- *Future-proof the system*: By investing in training and career development, the strategy can mitigate the impact of national workforce shortages and policy changes.

The strategy should include measures such as flexible working arrangements, professional development opportunities, and financial incentives for newly qualified optometrists to work in underserved areas.

Furthermore, other regions have implemented successful workforce strategies that Oxfordshire can potentially learn from. For instance, on a national scale, NHS England's Workforce Plan emphasises the need for integrated workforce planning across primary and secondary care, including targeted recruitment campaigns and retention incentives for shortage specialties[13]. On a more regional scale, the Greater Manchester Health and Social Care Partnership introduced a "Grow Your Own" programme for optometry, offering bursaries and mentorship to encourage local recruitment[14]. Additionally, the North East and North Cumbria ICB piloted golden handshake schemes for newly qualified optometrists willing to work in rural practices, which had the effect of improving coverage in hard-to-reach areas[15]. These examples demonstrate that targeted incentives and collaborative planning can significantly improve workforce stability and service accessibility.

Research consistently shows that workforce shortages are a major determinant of health inequalities. A study by Buchan et al. (2022) in *Human Resources for Health* found that targeted recruitment and

[13] NHS England » NHS Long Term Workforce Plan
[14] Shifting left for getting it right: Lessons from primary care optometry developments in Scotland
[15] Shifting left for getting it right: Lessons from primary care optometry developments in Scotland

retention strategies, including financial incentives and career progression pathways, are effective in addressing shortages in community health services[16]. Similarly, Imison et al. (2016) in *The King's Fund report on workforce planning* emphasised that integrated approaches—linking education, commissioning, and service delivery—are essential for sustainable healthcare systems[17]. In ophthalmology specifically, a 2021 study in *Eye journal* highlighted that workforce constraints are a key barrier to reducing waiting times for cataract surgery and glaucoma management. The authors recommended expanding community-based optometry roles to alleviate pressure on hospital services—a goal directly aligned with this HOSC recommendation[18].

To succeed, an eyecare workforce strategy should consider the following points as part of its implementation:

- *Map current workforce distribution*: to identify priority areas for intervention.
- *Engage educational institutions:* to create pipelines for newly qualified professionals.
- *Offer incentives*: such as relocation packages, loan repayment schemes, and funded CPD opportunities.
- *Foster collaboration*: between NHS Trusts, ISPs, and community providers to ensure training opportunities are maintained despite shifts in service delivery models.

The strategy must also address retention by creating supportive working environments, promoting career progression, and recognising the contribution of eyecare support staff alongside optometrists.

Recommendation 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.*

Legal Implications

11. 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

[16] Leadership in HRH: remembering the future? | Human Resources for Health
[17] Reshaping the workforce to deliver the care patients need | Nuffield Trust
[18] The community optometry workforce in Scotland: supporting sustainable eye care delivery | Eye

 Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

12. 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'.

13. 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.

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

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

Annex 1 – Scrutiny Response Pro Forma

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

October 2025

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OXFORDSHIRE COUNTY COUNCIL

Cllr J Hanna OBE

Chair, Oxfordshire Health Overview and Scrutiny Committee

11 November 2025

Dear Secretary of State for Health & Social Care,

Subject: Request for a National Review of Independent Service Providers in NHS Ophthalmology

I am writing to you on behalf of the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC), in support of the Royal College of Ophthalmologists' recent response to the NHS Payment Scheme consultation for 2025/26. Their submission raises significant concerns regarding the impact of current and proposed payment structures on the sustainability and quality of NHS ophthalmology services.

The College's response highlights the unintended consequences of profit-driven care, particularly the risk of Independent Service Providers (ISPs) prioritising profitable procedures such as cataract surgery, retinal injections, and low-risk glaucoma, at the expense of comprehensive care for complex and sight-threatening conditions. This shift threatens the ability of NHS Trusts to deliver equitable and high-quality ophthalmic care, and may exacerbate inequalities in patient access and outcomes.

In light of these concerns, the JHOSC supports the Royal College of Ophthalmologists' call for a national review into the use and oversight of ISPs in NHS-funded cataract surgery and related services. Specifically, we recommend scrutiny of non-contracted activity, coding practices, and referral pathway payments, to ensure patient safety and system integrity.

We strongly support this request and urge the Department of Health & Social Care to commission a formal, independent review of ISPs within NHS ophthalmology. Such a review should assess the impact of ISPs on service delivery, workforce stability, financial sustainability, and patient outcomes, and make recommendations for future policy and oversight.

We also endorse the College's proposal for a six-month formal review following any implementation of new payment schemes, to ensure that intended outcomes are achieved and corrective action can be taken if necessary.

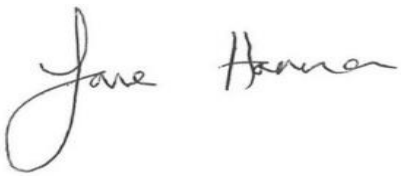
The Committee was concerned during local scrutiny of Opthalmology services to learn about the negative local impacts of ISPs and that the plans are to accelerate this programme. Whilst the national Choice framework enables existing providers to extend their offer and for new providers to enter the market if they meet specific criteria to deliver Consultant led services, there is no cap to this activity and spend. Whilst this gives patients of non-complex procedures greater choice and shorter waiting times, this is

having a destabilising impact on wider NHS Trust Ophthalmology services and was distorting clinical priorities.

Whilst simpler high volume cataract procedures can be subject to a longer wait without impacting clinical outcome, this is not the same for more complex patients who are at significant exposure to harm and then to needing other NHS services such as emergency care. There were other concerns about the ability of the local NHS to monitor the quality and safety of the standard contracts of the ISPs and that without direct contracts local oversight was inherently more limited.

Thank you for considering this request. We would welcome the opportunity to contribute further to this important discussion and to support efforts to safeguard the future of NHS ophthalmology services.

Yours sincerely,



Cllr Jane Hanna OBE

Chair, Oxfordshire Joint Health Overview Scrutiny Committee

OXFORDSHIRE COUNTY COUNCIL

Cllr J Hanna OBE

Chair, Oxfordshire Health Overview and Scrutiny Committee

11 November 2025

Dear Oxfordshire MPs,

Preserving and supporting the independent Patient Voice in Oxfordshire:

I am writing on behalf of the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) to brief you on a matter of significant importance to our local health and care system: the future of the independent patient voice in Oxfordshire.

Recent national proposals, as outlined in the July 2025 Dash Report, are likely to result in the abolition of local Healthwatch bodies and also the Council of Governors of acute Trusts who have staff and patient representation and currently oversee appointments

The extent of our concern is reflected in a recent Oxfordshire County Council motion agreed cross party which was also supported by the Oxfordshire HOSC, which includes all District as well as County Council representation and independent members.

While we recognise that these legislative changes are imminent and that the structure of Healthwatch Oxfordshire as an entity may not be preserved, we believe there remains a compelling case for ensuring that the core functions Healthwatch has provided—namely, a truly independent, locally-rooted patient voice—are not lost in the process of reform.

Over the past decade, Oxfordshire has benefited greatly from having a dedicated function that gathers, represents, and amplifies the views of patients and the public. This function has operated independently of service providers and commissioners, enabling it to build trust with communities and act as a critical friend to the system. Through its work, thousands of residents have been engaged, seldom-heard voices have been brought to the fore, and evidence-based recommendations have led to tangible improvements in local services—from the development of women's health strategies to enhancements in urgent and emergency care.

The independence and local presence of this patient voice function have been central to its effectiveness. It has ensured that feedback is honest, credible, and reflective of the real experiences and needs of Oxfordshire's communities. Academic studies and national evidence consistently highlight that such independent mechanisms are crucial for improving health outcomes, service design, and accountability. The risk, as reforms progress, is that centralising or integrating these functions within larger bodies could dilute their independence and weaken their ability to represent local perspectives.

As system partners in Oxfordshire consider how best to implement national reforms, we urge that the principles underpinning the independent patient voice are safeguarded. This means retaining a function that is:

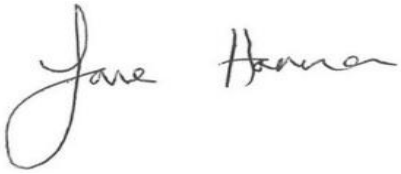
- Independent from service providers and commissioners,
- Locally present and engaged, especially at neighbourhood level,
- Driven by public need rather than solely system priorities,
- Able to reach seldom-heard groups and address inequalities,
- Confident and influential in shaping service improvement.

We are not seeking to resist the direction of national policy, but rather to ensure that, whatever new model emerges, Oxfordshire continues to benefit from a robust, independent patient voice function. We believe this is essential for maintaining the credibility and effectiveness of public engagement in health and social care, and for ensuring that reforms are shaped by the real experiences of our residents.

We would greatly value your support in advocating for the preservation of these principles as national reforms are delivered locally. Your engagement will be vital in helping system partners design and implement a model that retains the strengths of the independent patient voice function that has served Oxfordshire so well.

Should you wish to discuss this matter further or require additional information, please do not hesitate to contact me.

Yours sincerely,



Cllr Jane Hanna OBE

Chair, Oxfordshire Joint Health Overview Scrutiny Committee

Divisions Affected – N/A

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

20 November 2025

Children and Young People Scrutiny Paper to include:

CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH

CHILDREN AND ADOLESCANT MENTAL HEALTH SERVICE

Report by
Corporate Director of Children's Services
Corporate Director of Public Health & Community Safety
ICB Place Director for Oxfordshire
&
Service Director – Oxford Health Foundation Trust, Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate

1. RECOMMENDATION

The Committee is RECOMMENDED to acknowledge the

Progress on the actions within the Emotional Mental Health and Wellbeing Strategy action plan, note progress made with new CAMHS initiatives to address specific needs of children and their families.

2. Executive Summary

This document is a comprehensive report presented to the Oxfordshire Joint Health Overview and Scrutiny Committee on 20 November 2025, focusing on the emotional wellbeing and mental health of children and young people in Oxfordshire. It outlines progress on the Emotional Mental Health and Wellbeing (EMH&WB) Strategy, developments in the Child and Adolescent Mental Health Service (CAMHS), and addresses key system challenges, collaboration, and future plans.

3. Part 1 – Emotional mental health and wellbeing Strategy

The strategy which was launched in 2022 focused on the following elements:

- Provide early help and create supportive environments
- Develop a confident workforce
- Ensure positive transitions
- Improve Access to specialist services

The strategy is also embedded within the I-Thrive model of delivery of child and adolescent mental health services developed by Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families.

Following the launch of the strategy an action plan to address the gaps in the system was implemented and the key deliverable areas are as follows:

- Digital offer and directory of services
- Family Learning and support programmes
- Whole school wellbeing resilience programme
- Development of system performance dashboard to track progress of the implementation of the action plan
- 16-25 transition service
- Training Programme for the children and young people's workforce
- Wider determinants of health

4. Progress Update

We have taken a partnership approach to the development and implementation of the action plan to deliver on the aims and objectives within the strategy. This is to ensure that we make best use of public resources and working within set budgets across the system.

An overview of the progress made for each action in the action plan is as follows:

4.1 Digital offer and directory of services

The Tellmi Mental Health Service was commissioned in July 2024 to provide digital peer support and counsellor intervention (high risk flags only) to anyone aged 11 - 18 across Oxfordshire. The impact seen in the first year of a three-year contract is detailed below.

The first year has been dedicated to building the foundations of the Tellmi service in Oxfordshire. This has included connecting with key networks, engaging staff through training and beginning to work directly with young people. This has been a crucial step, ensuring the service is understood, trusted and ready to grow in its impact over the contract duration.

In year 1, Tellmi has provided a safe supportive space for 433 young people with good levels of engagement across gender and age. 75 young people have received support for high risk issues. This is 17% of Oxfordshire users.

Outputs

- Active users 433
- Female 65%
- Male 25%
- Non-binary 2%
- Age 11-13 46%
- Age 14-18 54%

Combined 2024 and 2025 impact surveys with 44 responses from users in Oxfordshire. The results resemble the results for other areas.

- Autism diagnosed 11%
- Autism undiagnosed (including on a waiting list for diagnosis) 27%
- ADHD diagnosed 9%
- ADHD undiagnosed (including on a waiting list for diagnosis) 32%
- Diagnosed Learning Difficulties (dyslexia, dyscalculia, dyspraxia, dysgraphia) 9%
- Undiagnosed Learning Difficulties (dyslexia, dyscalculia, dyspraxia, dysgraphia) 23%

Outcomes

- 77% of users feel less alone since using Tellmi
- For 32%, Tellmi is their only form of mental health support
- 85 have been using Tellmi for more than a month

Stakeholder engagement
Stakeholders across Oxfordshire have shown a genuine enthusiasm for implementing Tellmi within their communities.

- 71% of users came from school related activities
- 20% from the clinical pathway
- 83% of schools are engaged on some level in year 1
  - Of those, approximately 40% of schools have launched Tellmi
  - 23% have had further engagement such as staff training and awareness raising through assemblies and student workshops

The Tellmi Directory contains 700+ nationally available resources such as national support services, websites, books, apps, user stories and wellbeing quizzes. In Oxfordshire users also benefit from 23 local listings including Oxme, SeeSaw, Byhp, Here4Youth and Oxfordshire Mind. The Tellmi Directory has proven to be a valuable resource with. The positive uptake seen in Oxfordshire confirms the benefit of providing locally relevant resources.

There were:

- 3,8883 directory visits in year 1
- 160 (37%) users accessed 260 different resources in the directory
- The most popular directory resources were for anxiety and depression
- 25 local listings have been viewed 172 times
- The Oxfordshire CAMHS is the most popular local resource and was used 40 times

Transition to adulthood
Tellmi is only commissioned to provide our premium service to young people aged 11 - 18. Once they reach 19 years old they are no longer able to access the localised Directory or counsellor support for high risk users. However, these young adults can access the free version of Tellmi. Between August 2024 and July 2025 Tellmi supported 105 adults in Oxfordshire who were over the age of 18.

4.2 Family learning and support programmes

A piece of work to understand the current family learning and support programmes[1] was completed throughout 2024-25 which undertook a mapping exercise and a survey was completed with parents and carers and providers of parenting support programme. This information then supported the development of a gap analysis to support any new commissioning proposals of new family support programmes . The implementation of any new programmes will be part of the Family Hub programme whereby we aim to provide resources to families within their communities as well as digitally. We also plan to provide a multi-disciplinary team function of clinical and non clinical staff as part of the NDC re-design project to support families in caring for neurodivergent children, this will aim to address the gap for sensory knowledge and support which was identified during this commissioning exercise.

4.3 Whole school wellbeing resilience programme

The aim of this project was to work with schools to map out resources available to embed good Mental Health and wellbeing practices to pupils and for schools to be aware of resources they can signpost children too if and when required. CAMHS hosted a all day IThrive workshop in November 2023 to map out the resources across Oxfordshire although the engagement from schools across Oxfordshire was relatively low the feedback received was positive. It was felt that It was felt that schools would benefit more from direct work on skilling up the workforce within schools to adopt a Whole School Approach (WSA). This has been lead by the CAMHS MHST's which have delivered the following during 2024/25:

- 203 WSA activities delivered
- 6462 children reached directly

[1] Appendix 1 – overview of parenting support programmes

- Set up 5 WSA champions across Oxfordshire
- parental feedback re: workshops was unanimously positive ("extremely helpful")

Overview of the WSA programme delivered by MHST's in CAMHS can be found in Appendix 2[2]

4.3.1 CAMHS Mental Health support in schools project:
Within the CAMHS transformation programme there is a workstream on Mental Health support to schools the objectives for this workstream are as follows:

- For schools to be able to better support CYP Mental Health needs in schools and build resiliance to address concerns without the need for specialist service input
- Roll out 100% of MHST's county wide by 2029
- Clinical input into MHST's
- Oxfordshire Well Schools – Public Health
- Support the Emotional school based avoidance cohort and increase up take in school attendance
- Emotional Mental Health and Wellbeing resources to Oxfordshire Primary Schools – Public Health

The project team meets monthly to track progress across all the objectives and reports progress to the CAMHS project board which feeds into the SEND Transformation Programme.

4.3.2 The OxWell Survey [1] is a large-scale bi-annual survey designed to measure wellbeing (health and happiness) of children and young people aged 9–18-year-olds. Oxfordshire participates in this survey and data is made available to participating schools and the public health team in Oxfordshire County Council. The questions and participation rate is different for each survey, therfore it is difficult to make direct comparisons.

In the 2023 survey 7,133 students took part in Oxfordshire from 12 out of 245 primary schools, 15 out of 43 secondary schools, and all 3 Further Education colleges. Key findings included bullying in primary school, loneliness and body image. Sleep quality and sleep problems were widely reprorted due to worries about the climate/environment, their family not having enough money, and worry about what is going to happen.

The data for the primary schools that took part in 2025 has not yet been fully cleaned and added to the dashboard. The participation rate was much higher this year due to targeted comms. The data from the secondary school that took part in the 2025 survey shows that:

- **Mental health:** The percentage of students with a high severity of depression and anxiety symptoms (above clinical threshold range) according to

[2] Appendix 2 – MHST Whole School approach presentation

the Revised Child Anxiety and Depressions Scale (RCADS25) slowly increases year on year (from 8% in year 7 to 12% in year 11).

- **Neurodiversity:** 19% of secondary students identified as either having ADHD, being autistic, or neurodivergent in another way. Of these, 57% identified as having ADHD (or ADD), and 33% as having autism. Only 18% of those who identified as having ADHD/ADD were diagnosed by a healthcare professional, and this figure was just 16% for those with autism.
- **Gender Diversity:** Those who identified as gender diverse (1% of pupils in secondary school) were less likely to feel safe at home, and substantially more likely to worry about going to school. They are more likely to have been bullied in the past couple of months, and face more bullying incidents through a greater number of methods than the Oxfordshire baseline.
- **Bullying:** Less than 1/3 of secondary students feel that their school deals well with bullying (31%).
- **Feelings of belonging:** 52% of secondary students agree that they feel that they are a part of their school, however current and previous CWCF, those who identify as neurodivergent, and those with SEN/EHCP were more likely to disagree.
- **Ethnic groups:** Secondary students from minority ethnic groups were more likely to feel unsatisfied with what it is like to be a student at their school, disagree that their school deals well with bullying, and disagree that their school deals well with racism compared to Oxfordshire baselines.
- **School Support:** The most common forms of semi-formal support used by secondary students were form tutors (12%), other school staff (6%) and other teachers (10%). Support from school staff was reported by students to be helpful, with year 7 most likely to rate form tutors as helpful (17%).

This is data from the OxWell dashboard which currently includes over 16,000 responses (out of over 20,000) from secondary school pupils whose data was able to be cleaned and added to the dashboard. The data from the survey is still undergoing validation and therefore the exact figures may be subject to change.

[1] Publications : OxWell

4.3.3 Well Schools Programme

Well Schools is a national movement of over 2,000 schools and trusts taking positive action to improve education outcomes by supporting the health and happiness of their staff and pupils across the UK. In Oxfordshire, a partnership has been formed to respond to local need, collaborate to share best practice, and overcome challenges together — ensuring that wellbeing remains a central driver for school improvement.

At its heart, Well Schools is a school improvement tool – designed to help schools place wellbeing at the centre of everything they do, recognising that when pupils and staff are physically and emotionally well, great things happen. The framework focuses on four interconnected pillars:

- **Well Culture:** *putting wellbeing at the heart of school life so that everyone can thrive and achieve their potential*.

- **Lead Well:** *empowering staff and pupils to shape and lead their school through strong voice, workload support, professional development and wellbeing governance*.
- **Move Well:** *ensuring every pupil is prepared physically and mentally for learning and for life through high-quality PE, extracurricular opportunities, active travel and daily physical activity.*
- **Live Well:** *equipping pupils with the essential skills to thrive in a digital world, through leadership, volunteering, educational visits and a strong health and wellbeing curriculum.*

4.3.4 Public Health Emotional Mental Health and Wellbeing Offer to primary schools

The development of a new public health approach to mental health for primary schools in Oxfordshire began in July 2025 in response to the increasing need for a preventative approach for CYP and school. Working in partnership, an intervention will be available to all primary schools in Oxfordshire from 2026 to support good mental health in children and provide schools with the training, tools and resources to wellbeing as they support children to transition to secondary school and beyond.

The project will include analysis of the bi-annual OxWell data and the production of detailed comms and reports to schools to inform appropriate tailoring of the intervention. It will enable public health to fully engage and support schools to review the information and support school staff to embed initiatives aligned to individual school needs. It will also work closely with a research partner to fully evaluate the project.

A full-time project coordinator be employed for the duration of the project to work with schools and existing services in Oxfordshire, including mental health support teams, CAMHS, school health nurses, school sports partnership and community development staff to ensure partnership working and maximise the potential of the project.

The proposed intervention in schools will include a professional development programme to empower staff (teachers, pastoral care workers, support workers and senior leaders) to deliver a universal evidence-based psychological intervention for children, focusing on movement and mental health promotion activities for CYP, with training for school staff to deliver the intervention, and additional training for parents, teachers and support staff.

In addition, an early targeted intervention for children who need more help such as those with poor attendance or a risk of exclusion and to tackle health inequalities will be included. A suite of training for parents/carers, and trusted adults will provide the support and training to help them support their children’s physical and mental wellbeing.

The next steps are to commission a provider organisation early 2026 to deliver a 3+1-year programme for all schools in Oxfordshire, gradually building the

delivery over a three-year period. A proposed offer to secondary schools is currently being reviewed for further development in 2026.

4.4 Development of system performance dashboard to track progress of the implementation of the action plan

This work has been consumed by the creation of a SEND data dashboard whereby CAMHS services are being tracked via the SEND improvement work. The BOB ICB also track performance on all CAMHS services across the region which feeds into NHSE data sets so we can compare neighbours and see where Oxfordshire are ranked nationally.

Progress on all workstream within the EMH&WB strategy action plan are reviewed a the EMH&WB board bi-monthly and RAG rated to support any delays.

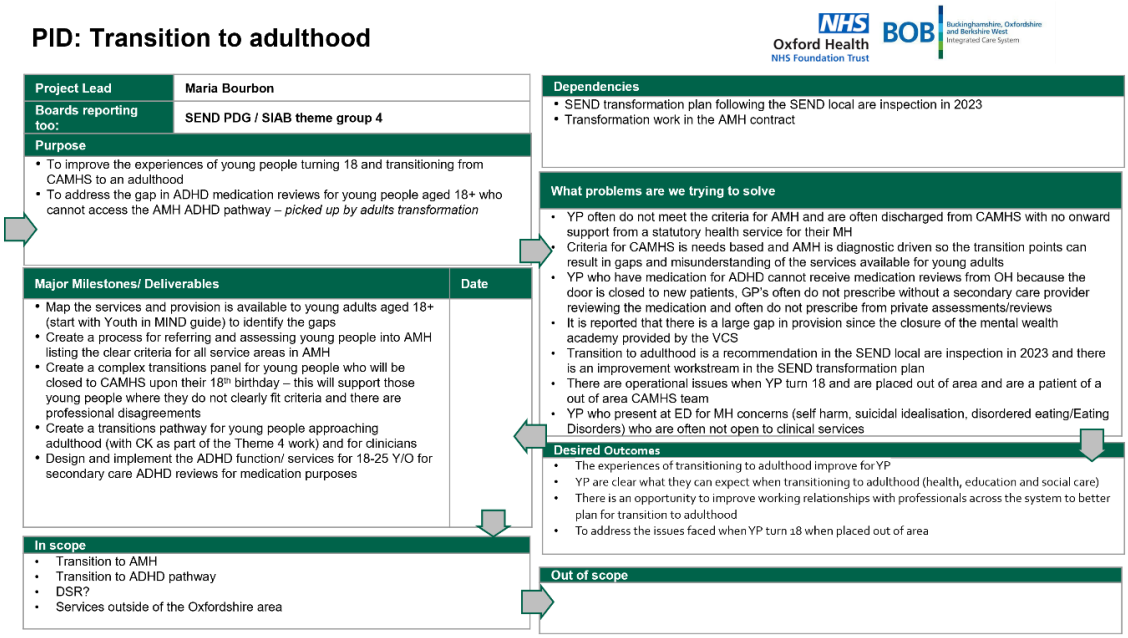
The JSNA provides a good dashboard that is automated by power BI Children and Young People dashboard in the JSNA. The dashboard is used to identify and clarify need, and we used it to develop interventions, projects and any business cases. It is used to continually review service provision across our CYP contracts and adjust according. In addition to quantitative data there are bi-annual OXWELL survey's published to children and young people to gain their views on health, including their Mental Health and emotional wellbeing.

SEND CYP group – plan to talk to children in primary and secondary schools and want to put a survey or poll on tellmi to gather qualitative views.

4.5 16-25 transition service

To support a better transition to adulthood for young people open to CAMHS we have created a transformation workstream that is part of the new CAMHS contract that went live in 2025 to address the transition process for young adults when they turn 18.

The Project Initiation Document:



PID: Transition to adulthood

Oxford Health NHS Foundation Trust | BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Project Lead	Maria Bourbon
Boards reporting too:	SEND PDG / SIAB theme group 4

Purpose

- To improve the experiences of young people turning 18 and transitioning from CAMHS to an adulthood
- To address the gap in ADHD medication reviews for young people aged 18+ who cannot access the AMH ADHD pathway – *picked up by adults transformation*

Major Milestones/ Deliverables | **Date**

- Map the services and provision is available to young adults aged 18+ (start with Youth in MIND guide) to identify the gaps
- Create a process for referring and assessing young people into AMH listing the clear criteria for all service areas in AMH
- Create a complex transitions panel for young people who will be closed to CAMHS upon their 18th birthday – this will support those young people where they do not clearly fit criteria and there are professional disagreements
- Create a transitions pathway for young people approaching adulthood (with CK as part of the Theme 4 work) and for clinicians
- Design and implement the ADHD function/ services for 18-25 Y/O for secondary care ADHD reviews for medication purposes

In scope

- Transition to AMH
- Transition to ADHD pathway
- DSR?
- Services outside of the Oxfordshire area

Dependencies

- SEND transformation plan following the SEND local are inspection in 2023
- Transformation work in the AMH contract

What problems are we trying to solve

- YP often do not meet the criteria for AMH and are often discharged from CAMHS with no onward support from a statutory health service for their MH
- Criteria for CAMHS is needs based and AMH is diagnostic driven so the transition points can result in gaps and misunderstanding of the services available for young adults
- YP who have medication for ADHD cannot receive medication reviews from OH because the door is closed to new patients, GP's often do not prescribe without a secondary care provider reviewing the medication and often do not prescribe from private assessments/reviews
- It is reported that there is a large gap in provision since the closure of the mental wealth academy provided by the VCS
- Transition to adulthood is a recommendation in the SEND local are inspection in 2023 and there is an improvement workstream in the SEND transformation plan
- There are operational issues when YP turn 18 and are placed out of area and are a patient of a out of area CAMHS team
- YP who present at ED for MH concerns (self harm, suicidal idealisation, disordered eating/Eating Disorders) who are often not open to clinical services

Desired Outcomes

- The experiences of transitioning to adulthood improve for YP
- YP are clear what they can expect when transitioning to adulthood (health, education and social care)
- There is an opportunity to improve working relationships with professionals across the system to better plan for transition to adulthood
- To address the issues faced when YP turn 18 when placed out of area

Out of scope

To support this work the transition process was mapped out with Adult Mental Health (AMH) colleagues and based on learning from real case examples and feedback from young people and their families improvements were made to this process which includes a new Transitions Panel to discuss with AMH colleagues Young People turning 18. Of which in the last year there were 1500 young people had turned 18. The new panel has been running for the last 3 months, with good feedback from clinicians and managers in both CAMHS and AMH services.

Wider 18-25 y/o work to start in December - scope and outputs will include recommissioning of non-clinical services through VCS, that better meet the needs of this client group.

The BOB ICB and OHFT also are working on a ADHD medication review service for 18-25 as this is currently a gap and area of need to diagnosed young people with ADHD who require medication.

4.6 Training Programme for the CYP workforce

In November 2023, Public Health commissioned Oxfordshire Mind to deliver mental health and suicide prevention training to professionals and volunteers across the County. The training provision is targeted to the CVS, and other small organisations. In the first year of delivery of the contract, Oxfordshire Mind trained a total of 609 individuals across their core offer of training courses which included general mental health awareness, suicide awareness and 2 mental health and suicide prevention courses aimed specifically at staff working with children and young people. These were:

CYP courses run

Youth Mental Health First Aid – 9 courses to date
Youth Champion – 3 courses to date

SPEAK training – 4 courses to date

2024-2025
Youth Mental Health First Aid – 89 attendees
Youth Champion – 13 attendees
SPEAK - 46 attendees

2025-2026
Youth Mental Health First Aid – 5 attendees
Youth Champion – 16 attendees
SPEAK – 15 attendees

The contract includes funding for a co-ordinator role who identifies individuals/organisations/communities in need of training and matches them up with appropriate evidence-based training. The co-ordinator role also ensures that the training available is meeting the needs of the local staff and volunteers and also is targeted to those supporting Oxfordshire residents most at risk of poor mental health and wellbeing.

Feedback on the courses has been consistently positive and and the provider continually strives to improve the service based on feedback and local need. For example, a recent review of the suicide prevention course aimed at staff working with children and young people concluded that the course content could be more specific to young people. In response to this, Oxfordshire Mind have partnered with Nai's House to make improvements to the course and ensure it's fit for purpose. This partnership will ensure the course is co-designed with young people and utilising suicide prevention expertise from Nai's House.

Making Every Contact Count (MECC) Training has been delivered to primary schools and early years settings. It is an approach that uses evidence-based behaviour change techniques to help everyday conversations with people to improve their health and wellbeing. Key issues being raised in these training sessions by attendees include food banks, housing, cost of living, sleep routines for children.

Other training Initiatives

The Department for Education[3] is offering a grant of £1,200 for eligible state-funded schools and colleges in England to train a senior mental health lead to develop and implement a whole school or college approach to mental health and wellbeing. This training is not compulsory, but it is part of the government's commitment to offer this training to all eligible schools and colleges by 2025. The latest figures show take-up across Oxfordshire is 55%, compared to 62% across South-East, and approximately 60% nationally. We are keen to encourage further take up of the grant across the county, as having a trained senior mental health lead in a setting plays an important role in the whole school/college approach and therefore the mental health and wellbeing support available to children and young people. This is a great opportunity for schools and colleges

[3] https://www.gov.uk/guidance/senior-mental-health-lead-training

to access funded training which offers full flexibility to meet the needs of the individual setting. We will continue to promote this opportunity locally.

The Department for Health and Social Care have also produced resources[4] for education settings for staff to teach mental wellbeing topics to both primary and secondary students, with flexible, ready-to-use content co-created with teachers and young people.

Mind-Ed[5] is a free, multi-professional online training resource on the mental health of children, young people, adults and older peopled, developed by Health Education England in partnership with the NHS and professional bodies including Royal College Psychiatry and Royal College of Paediatrics and Child Health. It includes sessions on a number of topics relevant to early years mental health as well as a specific public mental health training module.

4.7 Wider determinants of health

The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. The quality of the built and natural environment such as air quality, the quality of green spaces and housing quality also affect health. Good level of development and educational attainment is linked to health behaviours and outcomes throughout a person's life and varies considerably by socioeconomic position.

4.7.1 CIPS/CHDO/Grants

Publication of Community Insight profile reports for all 14 areas was concluded in June 2025 and can be accessed here alongside an interactive dashboard Oxfordshire Data Hub – Health and Social Care – Community Insight Profiles. To support taking forward actions arising from the Community Insight report recommendations, Community Health Development Officer posts have been funded for each of the areas where a profile has been developed. Along with a small grants scheme to support community projects that help deliver the recommendations from the community profiles.

The CHDO (and ICB funded Well Together programmes) in the first 10 areas where a Community Insight Profile was produced are being jointly evaluated by the University of Oxford as part of the Oxfordshire Health Humanities Project. The first phase of the evaluation took place between January to December 2024 and focussed on an evaluation of the roles within each programme and the processes involved with setting up the grant schemes. A second phase is now under way and due to be completed in March 2026 which will go into greater depth around the value of longer-term investment in this type of approach and the impact of the programmes that have been grant funded and facilitated by the roles. The phase 1 report can be accessed here: Oxfordshire Health Humanities Project | TORCH | The Oxford Research Centre in the Humanities

4.7.2 Food Poverty - *Good Food Oxfordshire*
4,400 views of the **community food map** it continues to be updated and shared (cooking, growing spaces, markets, community food service, markets).

Review and refresh of pledges for the Food Poverty Action Plan. Since 2021, over 40 organisations have pledged nearly 70 actions addressing food poverty through emergency provision, building resilience, and prevention , more information **here**.

Trained 40 frontline workers from 27 organisations through MECC-based workshops to better support those experiencing food poverty.

Training videos on Food Poverty and Healthy Start achieved over 500 views and 64 team pledges.

4.7.3 Healthier food environment

Bite Back report "Everywhere We Go We're Surrounded; young people (aged 16-18) explore how to make the food system healthier in Oxfordshire" share their stories and evidence on junk food advertising and food available in Local Authority owned spaces across Oxfordshire for example leisure centres. Video is available to watch **here** (3 minutes) and full report **here**. Recommendation for local authorities to bring in a healthier advertising policy to promote healthier food options over junk food.

4.7.4 Healthier vending machine project underway working with Serco the provider of Oxford City leisure centres in 5 locations. It involves funded healthier stock drops e.g fruit and nut snack, messaging highlighting new options, free tasters, and training for leisure centre staff on understanding health and food.

4.7.5 Air Quality – Sustainable School Streets Strategy has been adopted and a pilot looking at green infrastructure to help reduce air pollution in school playgrounds and raise awareness of the school run via cars plays a part. The results of the School Streets report has been completed and the next phase of School Streets are being planned. A tool and associated modelling is now available to inform policy options which may increase or decrease air pollution, by quantifying the impact on health in terms of health conditions and cost to the NHS and social care.

4.7.6 Green Spaces and access to nature – CAG Oxfordshire has been supporting at least two community gardens in areas of deprivation. The Berinsfield community garden has involve working with young families and school children, providing access to nature and wellbeing support.

Training in Green Social Prescribing has been commissioned for health and care practitioners to support social prescribers and others working with adults and families increase their confidence in making referrals to nature based interventions.

4.7.7 Housing

A Housing Health Needs Assessment has been completed, which has identified the impacts of housing in Oxfordshire on children and families health, with recommendations made. The Better Housing Better Health service continues to support families staying warm in the winter and cool in the summer.

A project with Oxfordshire Community Rail Partnership to support confident travel to green spaces for wellbeing or jobs for employment for young people, in the first instance, Care Leavers.

5. Emotional Mental health and Wellbeing HOSC questions

5.1 How the contributions of system partners align with the strategy's vision to place children at the centre of decision-making.

Following the launch of the Children and Young People Emotional Mental Health and Wellbeing Strategy there have been new forums for system partners across health (including public health), education and social care to come together to track progress on the action plan and assess the impact this has made to children. Substantial progress has been made with the action plan as outlined in this report and the impact has been measured via feedback from children, their families and services they access. However this has been particularly challenging in a cost recovery climate both within Oxfordshire County Council and the BOB ICB where new opportunities to gain additional funding to support new initiatives has been difficult. Despite this resources from Public Health has provided much needed support to children and young people which was reflected in the 2024-25 Director of Public Health's annual report.

In 2024 a new SEND Youth Forum made up of children and young people with SEND who work with leaders to co-produce new services, system changes to improve the lives of children with SEND. A new initiative is being discussed to recognise services that actively support children with SEND whereby services will be offered a seal of approval from the SEND Youth Forum which can be promoted digitally and in the centres the services operate. The Oxfordshire Parent / Carer Forum OXPCF are members of the boards to track progress on all the actions and are involved in the individual workstreams to ensure they are co-produced and that children are at the centre of both the design and decision making of service improvements.

5.2 How do you measure the state of collaboration with the NHS and with schools with families ?

The Oxfordshire CAMHS service, delivered by Oxford Health Foundation Trust completed a wide independent engagement piece of work with children, their families and system partners including schools and social care services during July- August 2025. This involved using several targeted surveys and conducting 16 focus groups. Schools feedback areas to improve such as the referral form, inconsistent communications about services and misinterpretation of CAMHS messaging, the need for clearer pathways and team roles and barriers to

digitally excluded families. Oxford Health have taken this feedback on board and have a plan to address the areas of concern and ideas on how to improve the perception of the service:

Next steps following the engagement piece of work:

- **Oct** 25 – Feedback sessions and analysis
- **Oct** 25 – Convert to comms actions, operational actions, strategy agreement
- **Nov** 25 – strategy creation
- **Dec** 25 – strategy delivery and implementation

In relation to the emotional mental health and wellbeing of young people with SEND, there is a comprehensive structure for collaboration across the local area partnership. The ICB, health providers, local authority, education and parent carer forum work together through a robust governance structure to deliver against the SEND Local Area Inspection Priority Action Plan. Positive feedback has been received from both the Department for Education and OFSTED on the opportunities that have been created through new governance arrangements to improve system working. There is tracking of KPIs, audits and reflective sessions to measure the impact of this partnership working.

5.3 What have you learnt are the levers to collaboration and the barriers for each partner.

To address the gaps and needs for Children and Young People emotional mental health and wellbeing we need to include a wide range of stakeholders across the health, education and social care system which is often referred to as the Special Educational Needs and Disabilities (SEND) system. Levers to collaboration relies heavily on effective collaboration between schools and early year settings, health professionals, local authorities, parents, and the young people themselves. This collaboration is essential for delivering the best possible outcomes for children and young people. However, achieving successful partnership working can be complex, with various factors acting as levers (enablers) or barriers (obstacles).

5.3.1 Levers (Enablers) of Successful Collaboration:

- **Clear Communication**: Open, honest, and consistent communication between all parties ensures that everyone is well-informed, expectations are managed, and misunderstandings are minimised, this has been supported by the SEND communication strategy and newly revised Memorandum of Understanding (MOU) with the Oxfordshire Parent/ Carer Forum, SEND Together Annual conference and termly SEND conversations with parents and carers.
- **Shared Vision and Goals**: When all stakeholders have a common understanding of the desired outcomes for children and young people with SEND, collaboration becomes more purposeful and focused. This has been achieved by working together to address the Priorities in the Priority Action Plan, development of the new SEND strategy and creation of the revised MOU.
- **Strong Leadership**: Leaders who champion collaborative approaches and foster a culture of partnership can drive positive change and encourage

buy-in across services. This has been achieved with having all system partner leaders attend SIAB meetings, chaired by the Independent Chair – Steve Crocker.

- **Joint Training and Professional Development:** Opportunities for multi-agency training help build mutual understanding, respect, and shared expertise, breaking down professional silos. This has been achieved through various workshops to share expertise and learning from each other across the system. Another example is the free training for Speech, Language and Communication offered to Early Year settings and Primary Schools delivered by the SALT service and SEND Advisory Teacher service.
- **Co-production with Families**: Involving parents, carers, children and young people in decision-making ensures that services are tailored to individual needs and that families feel valued and empowered. This is demonstrated via EHCP annual reviews on an individual child level and also by including parent / carer representatives on commissioning bords to be part of the commissioning process.
- **Effective Use of Resources**: Pooling resources and sharing information can lead to more efficient and coordinated support for children and young people. This is an area we are aiming to address via the County Council's S75 with the BOB ICB.
- **Supportive Policy and Legislation**: National and local policies that prioritise collaboration and provide clear guidance can set the tone for effective partnership working. This is demonstrated through the SEND OFSTED/CQC inspection framework and we look forward to reviewing the new SEND white paper to further support collaboration.

5.3.2 Barriers to Successful Collaboration

- **Poor Communication**: Inconsistent or unclear communication can breed mistrust, confusion, and disengagement among stakeholders. This was the case prior to the 2023 SEND local area inspection however now we have a robust project management resource and commitment from system leaders to share regular updates this is no longer a barrier.
- **Resource Constraints**: Limited funding, staff shortages, and time pressures have restricted opportunities for joint working and have affected the ability to address certain weaknesses in the system such as addressing long waits for health services. There are inconsistencies to joint funding of health services across the BOB region which has led to a post code lottery and cross boarder disputes between NHS trusts.
- **Cultural and Organisational Differences**: Differing priorities, values, and working practices between agencies (e.g., education vs health) have at times hindered collaboration. However the SEND Priority Action Pan has addressed this and all partners have understood the priorities that need to be jointly addressed.
- **Inflexible Systems and Processes**: Bureaucratic procedures or rigid eligibility criteria can prevent timely and responsive support this can be seen in health services for instance. There have also been barriers to successful collaboration with obtaining data and creating dashboards across the system. However the commitment to partnership working has meant that sharing data is still supported however this is a manual process.

5.4 How actions undertaken by system partners support the Health and Wellbeing Board's "Start Well" domain.

The Director of Children's Services wrote the Health and Wellbeing Strategy Start Well paper in June 2025 to the Health and Wellbeing Board outlining the programme of work.

The Family Hub and Neighbourhood Health Teams will play an important role in addressing the two Start Well priorities in the Health and Wellbeing Strategy. The following initiatives are also supporting these priorities:

5.4.1 Strengthening the whole school approach:

Tellmi, School Health Nurses and the MHST's have continued to strengthen whole-school mental health cultures across Oxfordshire by working collaboratively with schools, staff and parent communities.
A key example of this is the growing relationship with the Oxford Parent Carers Forum (OxPCF), which demonstrates how Tellmi actively supports parents to confidently nurture their child's mental health and actively complements the work taking place in schools.

5.4.2 Collaborative parent engagement and education:

Tellmi has established a positive relationship with OxPCF, enabling direct engagement with parent carers across Oxfordshire. In partnership with the forum we have distributed educational resources for parents to support their children in digital and physical formats that are easy to use. We delivered an online webinar designed to help parents understand safe online behaviours and how peer support services like Tellmi can support their child's wellbeing. Following very positive feedback, Tellmi has been invited to deliver a second webinar, demonstrating strong parental engagement and the value of this approach.

5.4.3 Strengthening the school-home-digital support triangle:

The development of Family Hubs will include a digital Family Hub covering emotional health and wellbeing services.
The OxPCF webinar model supports the development of a nurturing culture by aligning messages between school staff, parents and the digital support children access outside of school via Tellmi. Parents reported feeling more informed and reassured about how Tellmi operates safely, which helps build trust and encourages conversations at home about mental health. Schools benefit from this increased parental understanding, as it reinforces a joined up approach to student support, resilience and early intervention.

5.4.4 Empowering staff to support students with confidence:
83% of schools in Oxfordshire have engaged with the service on some level, and 40% have fully launched the service. Schools participating in the Tellmi service receive guidance through resources and training on how to communicate with students, staff and parents about the benefits of peer support and safe spaces like Tellmi. This contributes to a more nurturing culture where staff feel supported in responding to student needs and know that similar messages are being reinforced at home.

5.4.5 Inclusive, needs-led support for the SEND Community:
Working with OxPCF ensures the needs and voices of parents of children with SEND (often the parents themselves are SEND) are heard and embedded in our approach. This inclusive engagement model helps schools strengthen their nurturing culture by ensuring mental health support is accessible and appropriate for all families. The repeat invitation to host a webinar to parent carers at OxPCF demonstrates trust and recognition that Tellmi offers safe, relevant and valued support for young people, including those with additional needs.

5.4.6 Wellcomm roll out
Wellcomm: a speech, language and communication screening and intervention tool has been rolled out across 419 Early Years settings including 381 childminders to offer targeted early help to children 0-5 years old. In March 2025 a pilot across 45 primary schools was launched which has been incredibly successful whereby 1045 children have been screened and progress is been made with 145 children upon their second screening. This cost effective tool has been received well and supports priority 1: children receive the best start in life.

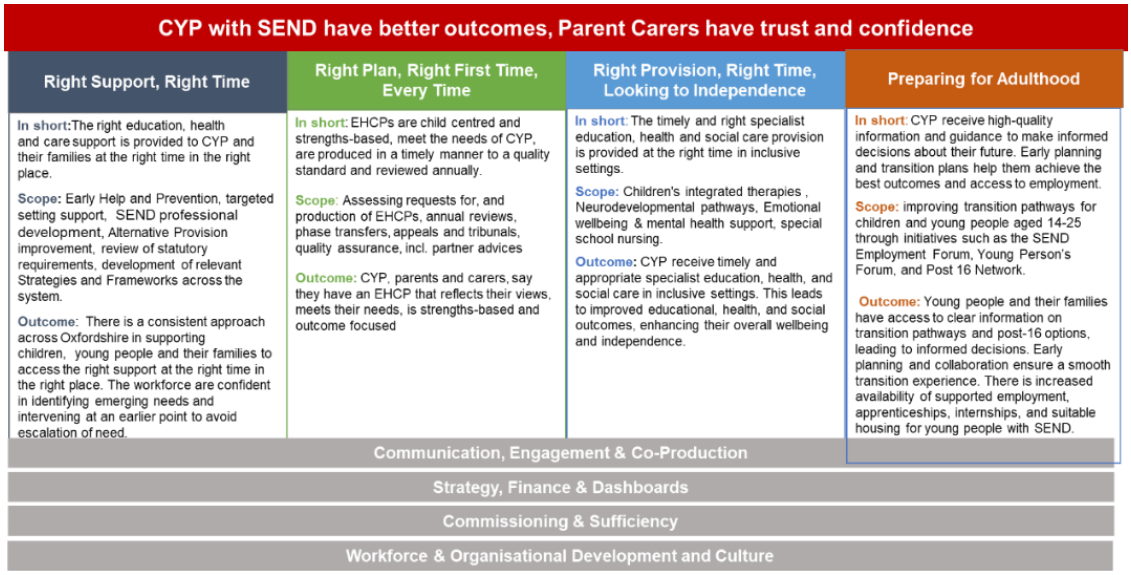
5.5 Outline how progress is being tracked against the strategy's priorities. Include any metrics or dashboards.

The Children's Emotional Mental Health and Wellbeing board meets bi-monthly and tracks progress on the strategy action plan. Specific reports and presentations are shared to board members which outline progress and impact to Children and Young People. Progress and any delays are tracked at the SIAB meeting whereby CYP emotional mental health and wellbeing is a workstream within Theme 3 – Right Provision, right time, looking to independence' via highlight reports which are RAG rated for SIAB board members to reflect on.
There is also a CAMHS project board which meet monthly to track progress on the 4 CAMHS transformation projects (NDC re-design, Transition to Adulthood, mental health support in schools and the complex children framework) also feeds into SIAB via the Theme 3 group.

There is also a SEND dashboard that report KPI's to SIAB, examples include therapy and CAMHS waiting times[6] and access rates.

5.6 How recent inspections and systemic challenges in SEND provision might be shaping emotional wellbeing and mental health services for children, and if there are any strategy revisions accordingly.

The SEND local area inspection in July 2023 resulted in a priority action plan to address 5 key priorities. Since 2023 we have worked hard as a local area partnership to make progress in these areas. Ongoing feedback and deep dive and review has been undertaken by the Department for Education which has confirmed incremental progress and improvements. We await the findings of our recent monitoring visit (September - October 2025). We are also in the process of updating our partnership SEND strategy, which will inform emotional wellbeing and mental health services for children with SEND.
The way that the SEND improvement programme is structured is via theme groups which aim to address a number of APA's across a spectrum of need, this is demonstrated as follows:



The majority of the work to support CYP mental health and emotional wellbeing is within theme 3 however there are cross overs in other theme groups such as theme group 1 is aimed at delivering early help. Interventions such as Tellmi, Mental Health training at universal settings and parenting support programmes now sit within theme group 1. CAMHS and acute services report to theme group 3 to support the more specialist level of need along with theme group 4 – Transition to Adulthood whereby there are CAMHS transition improvements.

Below is a table that demonstrates the Emotional Mental Health and Wellbeing action plan projects and where they sit within the SEND improvement programme. There were additional projects that have formed since the launch of the EMH&WB strategy that support the PAP which include:

[6] Appendix 3 – CAMHS dashboard

- Complex children framework
- Neuro developmental conditions redesign project to move to a needs led model
- Roll out of WellComm in Primary Schools (speech, language and communication needs – SLCN)

The table below support the gaps identified in the EMH&WB strategy and SEND Local Area Inspection outcome report 2023.

EMH&WB strategy action plan workstreams	**Theme group 1 – Right Support Right Time**	**Theme group 2 - Right Plan, Right First Time, Every Time**	**Theme group 3 – Right Provision looking to independence**	**Theme group 4 – Preparation to Adulthood**
Digital offer and directory of services	Tell Mi app		SHARON platform– CAMHS	
Family Learning and support programmes	Family Hub development			
Whole school wellbeing resilience programme			MH in Schools CAMHS transformation project	
16-25 transition service				Transition to Adulthood CAMHS transformation work
Training Programme for the children and young people's workforce	PH MH training in universal services Features in the Early Help Strategy			
Does not feature in the EMH&WB strategy but			Complex children framework	

addresses the PAP			NDC redesign project to move to a needs led model Roll out of WellComm in Primary Schools (SLCN)	

5.7 How data is being used, including through the JSNA or elsewhere, to shape the strategy as well as actions being taken to address children's mental health.

JSNA dashboard Children and Young People dashboard in the JSNA is used to identify and review need, and for service development. Data from hospitals including ED attendances for self harm- prompts deep dives into certain issues/trends.

The OxWell Survey 2025[1] is a large-scale annual survey designed to measure wellbeing (health and happiness) of children and young people aged 9–18-year-olds. Oxfordshire participates in this survey and data is made available to participating school and the public health team in Oxfordshire County Council.

5.8 How the strategy is aligning with or supporting Marmot principles (best start in life, fair employment, healthy living).

As part of the work to improve health equity in the County Oxfordshire are partnering with the Institute of Health Equity and are a Mamot Place. As part of embedding Marmot principles in the system, IHE have undertaken a review of "**Best start in life**" focusing on early years to the age of 25, with the aim of identifying what is driving inequalities, and where the challenges or blockers are.

In phase one of this project they aimed to gain an understanding of context by hearing from stakeholders working within the system and providing an independent review of data. They have completed an initial draft, with recommendations. Phase two will commence in late 2025, when they will engage with key system leaders to build on the momentum of current work, with a focus on identified inequalities. There will be a focus on gaining commitment from system leaders to take forward recommendations in the report. The partnership group will review the strategy and action against the Marnot Principles and consider the recommendations from the "**Best start in life**" review.

5.9 Is there a whole Oxfordshire approach - what is this for children and what does success look like?

Our whole Oxfordshire approach to supporting the emotional mental health and wellbeing of children and young people is set out in the emotional mental health and wellbeing strategy to identify and meet need as early as possible. This is also supported by the Early Help Strategy and the work of the Early Help teams along with system partners.

This is complemented by our Oxfordshire Children and Young People's Plan which sets out our vision for a child first county where every child and young person can thrive. We want every child to get the best possible start in life and to have opportunities to be the most they can be. This strategy is delivered through our Oxfordshire Children's Trust Board and a wide range of other partnership boards, such as our SEND local area partnership and our Early Help and Prevention Partnership Board.

A new area of development in Oxfordshire is planning for a county-wide Family Hub network, which will bring together partnership early help services to provide support at the earliest stage, in local communities, for children and families. We are beginning to design the model for this in collaboration with partners and aligned to national government guidance.

5.10 How are vulnerable children identified and supported?

There are a range of comprehensive, partnership mechanisms in place to identify and support children with their emotional mental health and wellbeing across the health, education and social care system. These include:

- The 0-19 service – school health nurses
- CAMHS service – single point of access (SPA) and MHST's
- GP's
- The Multi agency safeguarding hub (MASH) who will direct the child/family to the appropriate level of intervention within Children's Services
- Schools
- Community paediatric service
- Tell mi app
- Wellcomm tool

We work together to make sure that the child's needs are met by the most appropriate service. The future ambition is for these services to be co-located through the Family hub and Neighbourhood Health Team initiatives.

5.11 In a school setting are there good practice examples of schools developing a nurturing culture which supports staff in schools and parents to nurture good mental health. How are staff working with vulnerable children supported in their own mental health.

School Health Nurses (SHNs) have an essential role in supporting schools with CYP MH particularly during times of sudden or unexpected deaths, such as the loss of a student. They provide emotional support to those affected, help

identify young people who may be at greater risk of emotional distress, and work with school staff to respond to the needs of the family and the wider school community. SHNs also liaise with other agencies to offer advice and arrange referrals for additional support when needed.

When a sudden or unexpected death occurs within a school, the impact can be felt across the entire community. Young people may require help to process what has happened, understand their emotions, and feel able to return to learning. In Oxfordshire, the Postvention protocol, developed from research and best practice, guides schools and colleges in identifying and supporting students who may be at risk of suicide. This protocol helps schools prepare for the possibility of a suspected suicide, outlines how to respond effectively when such an event occurs, and ensures suicide prevention is integrated into the curriculum.

When a young person dies by suspected suicide or sudden unexpected death, SHNs provide vital support for both students and staff by being available in a safe location within the school where individuals can express their thoughts and feelings about the loss. School staff, who are often deeply affected as well, benefit from having someone to talk to and a supportive space. Typically, SHNs are based in the school library, which may also house a remembrance book for students to write, draw, or otherwise share their emotions regarding the person who has died.

School Health Nurses (SHNs) are actively involved in the planning and response following a sudden death in a school community, guided by established Standard Operating Procedures designed to support staff during these rare but challenging events. They work closely with Child and Adolescent Mental Health Services (CAMHS) to quickly identify any students already known to the service, and will share the names of those most affected so that early support can be provided if needed. Children can also access a NHS grant funded service called Seesaw which provide bereavement counselling for children affected by death in their families. SHNs also reach out to parents and carers, offering advice on how to support their children through this difficult period and providing information about where to find further help if necessary.

SHNs work in pairs and are supported by senior colleagues. They remain present in the school as long as required, with the named SHN for each school continuing to provide ongoing support to both students and staff as needed. Prioritising the wellbeing of School Health Nurses (SHNs) in schools affected by sudden or unexpected events is essential. Staff benefit from strong support provided by senior SHNs, including Clinical Education Leads, who offer supervision and guidance on emerging issues. These leads can step in when needed, ensuring SHNs have time and space to process difficult situations. Regular daily debriefs are held both within the school and across the service, giving staff the opportunity to discuss and reflect on their experiences and emotions.

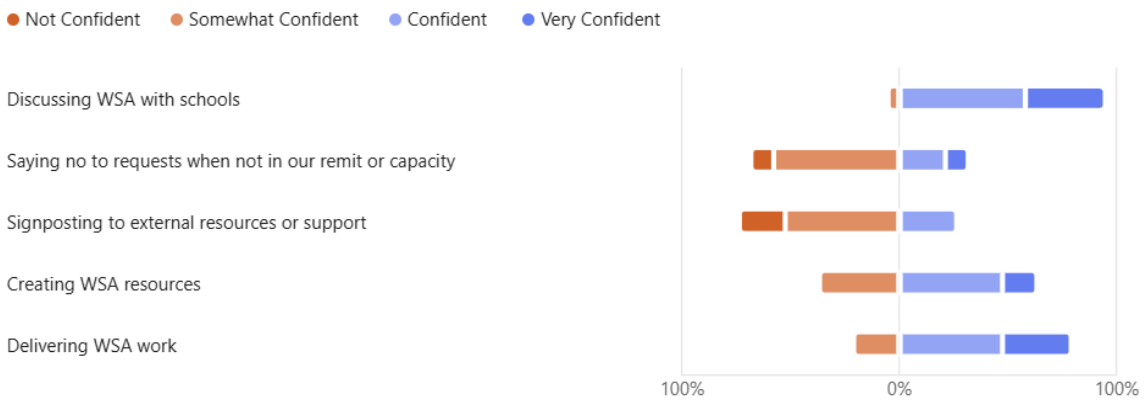
An example of the SHN providing support to a child who was experiencing anxiety and was missing school can be found in appendix 4[7]

MHST's also provide whole school approach training with school staff such as anxiety training to enable schools staff to enable a positive mental health environment and support children's wellbeing. There are 5 Whole School Approach champions who are passionate about WSA and finding the most effective, impactful, research backed ways of working with our schools. The feedback received was extremely positive, these comments were received following the anxiety training:

Following the training, what two things will you take away and put into practice?

Small steps	Muscle relaxation - try this with my class Research grounding	Reducing reassurance Steps to reduce avoidance	Reducing reassurance Externalising for younger chn
- It was interesting to learn about coping and safety behaviours. - I would like to look at the book recommended: Helping your child with fears and worries	Think about how I respond to children with anxiety making sure I respond appropriately. Understand that children's worries should not be shrugged off by telling them that everything will be okay.	Review responses to worries	

CAMHS constantly measure the WSA champions confidence in delivering WSA as shown in the survey results below. CAMHS can then focus on the weaker areas and provide targeted support to champions to increase their confidence:



[7] Appendix 4 – SHN case study

6. Health Overview & Scrutiny Recommendation Response Pro Forma

Please see a update on the recommendations from HOSC

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.	Progress Update May 2024	Progress November 2025
1. To work on developing explicit and comprehensive navigation tools for improving communication and referral for services at the neighbourhood level and within communities. It is recommended that piloting such navigation tools in specific communities may be a point of consideration.	Partially accept	We work closely with partners across Oxfordshire who offer advice, support and interventions for children, young people and their families and are currently tendering for a peer support app for CYP to support their mental health and well-being with a directory of local services to meet their needs. We recognise the importance of ensuring that local communities and neighbourhoods are connected to service provision in their areas. This is also important to the workforce so that	The Healthy Child and Young Person Public Health Service 0-19 years is now working at a more local level to respond to need and information is being made available in these 11 localities for CYP, families and settings. The CYP digital app has been tendered and we are currently in the standstill period following the outcome of the	Tellmi the CYP digital app went live in July 2024 and was aimed at all schools in Oxfordshire aged 11-18. The app has been extremely successful with 433 young people engaging with the app. See appendix 5[8] below for the year 1 report: The new Early Help strategy has been launched and implemented across the Oxfordshire Safeguarding Partnership Work will be progressing in 2026 on the Family Hubs and Neighbourhood Health teams to support the NHS

[8] Appendix 5 – Tellmi annual report

		they know who their local link is for support and services. This recommendation applies to all system partners to ensure that information is made available. HOSC can also support this approach with members of the scrutiny committee sharing information through their networks. The new SEND Local offer also provides details how to apply for help and includes a directory of local provision that both CYP and their families as well as professionals can access. This has been co-produced with Oxfordshire Parent Carer Forum and is key action in the priority action plan the link for the new website: Oxfordshire SEND local offer | Oxfordshire County Council	tender, we hope to be able to implement the app by start of the 24/25 academic year. The Local Offer is live and improvements are continuously being made as new content becomes available. The refresh of the Early Help strategy is now being lead by Delia Mann and is part of the SEND Transformation programme.	10 year plan to ensure people access support within their communiites. The Oxfordshire response to Neighbourhood Health teams will be submitted to NHSE by December 2025.

		As part of the early help strategy refresh this year OCC Children's Services will be ensuring the offer of early help is accessible to all families to find information to support them along with resources available within the local offer and linked with FIS.		
2. To ensure adequate co-production with children and their families as part of continuing efforts to deliver the strategy, including considerations of how children and families can be placed at the heart of commissioning. It is also recommended for an early review with the users of the digital offer once this becomes available; to include testing with neurodivergent children and other children known to be at higher risk of mental ill health.	Accepted	Co-production is a critical part of the strategy development and the commissioning cycle. This approach was adopted for the development of the emotional health and wellbeing strategy and in the commissioning of the digital offer. The Council recognises that improvements can be made and in future tenders we would like CYP to be able to be part of the evaluation process. We are working with	The CYP digital app has been tendered and we are currently in the standstill period following the outcome of the tender, we hope to be able to implement the app by start of the 24/25 academic year. CYP will be invited to review the app 6 months after this	CAMHS launched a Comms survey and engagement piece of work in Summer 2025 and have established a plan to respond to feedback received parents, carers and CYP along with professional stakeholders. Supportive steps and the SHARON platform has been implemented in CAMHS to support parents of children with mental health or neurodivergent needs.

		procurement and legal colleagues to enable this to happen without being at risk of breaching contract procurement regulations and legal challenge. We have built reviews and service improvement into the digital offer and will be able to provide updates in due course.	has been implemented. Guidance for involving children and young people in tender evaluations is being drafted with legal and procurement colleagues.	Tellmi feedback on the app, any % of children identifying as neurodivergent on the app Children are routinely part of tender processes.
3. To continue to explore and secure specific and sustainable sources of funding for the Strategy to be effectively delivered in the long-run.	Accepted	Funding for supporting emotional health and wellbeing comes from a number of government departments and organisations. This includes Department for Education and NHS England as well as funding provided to the voluntary and community sector and for research and evaluation to grow the evidence base on what works. As a system we will strive to identify sustainable sources of funding for Oxfordshire.	Grants and funding from NHSE are being used to support development of services to address gaps in service provision for CYP to support them with their mental health. The BOB ICB is currently in financial turnaround therefore new investment	Public Health have prioritised resources for services to support non-clinical interventions to children with Mental Health needs which include TellMi and MH training and aim to invest significant funding into development EMH&WB resources to primary schools which will be evaluated by a university in 2026. The funding position with Children's social care and the ICB remains un-changed.

		Local funding streams will be determined by the financial envelope provided to us nationally for this work. Any proposals to increase resources to better meet the needs of CYP in Oxfordshire are being managed by the SEND Priority Action Plan to address priorities identified during the Local Area SEND inspection by OFSTED and CQC.	opportunities may be limited to support the action plan of the strategy. However opportunities to apply for time limited funding such as the Better Care Fund are being explored to support CYP.	
4. To ensure that children and young people and their families continue to receive support that is specifically tailored toward their needs. It is recommended that a Needs-Based Approach is explicitly adopted, as opposed to a purely Diagnosis-Based Approach. This could allow for early intervention to be initiated as soon as possible.	Accepted	System partners recognise the recommendation to be needs led and provide support to children, young people and families at the earliest opportunity utilising the Think Family Approach and as endorsed within the Early Help Strategy to offer the right support at the right time. Oxford Health are already taking this needs-	The new contract for The Healthy Child and Young Person Public Health Service 0-19 years has commenced and this has a Think Family approach, health visiting workforce will now be supporting children and families up to the age of 8 years.	Work has started to move to a needs leaf approach for children who are autistic. CAMHS have been piloting a AI tool to support with triaging NDC diagnosis requests and aim to utilise this to create a profiling tool. A kick off event has been scheduled on the 25th November to learn from Portsmouth and Kent practitioners who have developed a needs lead approach. NHSE are also bench marking ICB areas in

		led approach through Universal Public Health Services for CYP. Oxford Health CAMHS service also commission Autism Oxfordshire to give CYP and their families pre-diagnoses support for those waiting for a Neuro-development Conditions assessment. We are exploring different ways of commissioning and delivering Neuro-development Conditions assessment services across the BOB ICB as long waits are a national issue. Addressing waits for Neuro-development Conditions assessments is also an action in the SEND Priority Action Plan.	Work is also underway to develop the Early Years and Prevention Strategy. The Early Years Strategy and Board are also in development following meetings with system partners. As part of the SEND Transformation programme the use of profiling and intervention tools are being explored to identify and address children's needs early to prevent needs escalating, some local authorities have reduced demand into the NDC pathway by 80% from using	the South East to provide support in adopting a needs lead approach. The roll out of the WellComm tool in Primary schools and Early Year settings has supported children who are neuro divergent to be able to communicate more effectively.

			profiling tools and feedback from families has been good and they have felt that their child has benefited and outcome measurements have been extremely positive.	
5. That consideration is given to the use of a simple and evidence-based standardised evaluation measure, that is suitable across all services that are working on Children's mental health in community settings.	Partially accepted	Evaluations tell us what works and what does not. An evaluation should be a rigorous and structured assessment of a completed or ongoing activity, intervention, programme or policy that will determine the extent to which it is achieving its objectives and contributing to decision-making. Collecting feedback, data and local intelligence from children and young people, communities and services is essential to inform a needs-led approach. We will explore what guidance and	As part of the SEND Transformation programme the use of profiling and intervention tools are being explored to identify and address children's needs early to prevent needs escalating, some local authorities have reduced demand into the NDC pathway by 80% from using profiling tools and feedback from families has been good and they have felt that their	Oxford Health are using a platform called True Colours in order to capture and be able to review routine outcome measures. The digital platform is linked to patient records and remote web-based access is used to support completion by the young person and/or parent/carer. The True Colours system uses established and Nationally recommended outcome measures for a range of general and specific mental health difficulties and links into National CYP reporting for the NHS. CAMHS are using some basic measures on referral,

		evidence-based practice is available to address this recommendation. We would also like to recommend that this is broader than 'children's mental health in community settings' to recognise the impact of wider determinants on emotional health and wellbeing for children, young people and their families. Children's Services already utilise SDQ's to measure and evaluate children's Mental Health for Children We Care For and we could look to expand this practice to a wider cohort of children to further explore their needs.	child has benefited and outcome measurements have been extremely positive. The are a range of profiling tools to assess children with special educational needs, Neurodivergent needs and speech and language	assessment and discharge. These are the CGAS, RCADS or SDQ and Goal Based Outcomes. The True Colours system tracks repeated measures to show progress and final outcome, but it is acknowledged that not all cases will show change on general measures. In addition , some teams may use more symptom specific measures at these points to pick up more on specific issues. Patient, parent/carer feedback can also be gathered through the IWGC system but the use of this is currently being reviewed by the Trust as it doesn't quite capture required information. NDC Needs Lead approach is being developed as explained in this paper and we aim to launch this offer in 2026.

				WellComm: a speech, language and communication tool has been implemented in Early Years settings and is being trailed in 45 schools. the reports RAG rate a child from their assessment and tailored interventions are offered to meet their needs. When a child is re-screened three months later we are seeing reductions in red and amber and increases in green.

7. Part 2– Child and Adolescent Mental Health Service (CAMHS)

7.1 Overview of service updates

Since the CAMHS service last reported to HOSC in November 2023 there have been new service developments to respond to the needs of children in Oxfordshire and to respond to new national and regional developments. The following are an overview of o the new services within CAMHS.

7.2 Development of Supportive Steps

CAMHS have developed and implemented a new programme: 'Supportive Steps' which aims to support parents to be able to support their children who may have mental health difficulties. The new service has been developed over the past 8 months, we know that building and supporting parent / child relationships and helping build parental or carer capacity is key in helping children and young people address mental health issues.
The team provides workshops covering the fundamentals of mental wellbeing, preparing for change, engaging with therapy and overall understanding the CAMHS pathway. The offer draws on the power of parent peer support, social prescribing and evidence based clinical care to ensure families are offered a robust service right from the very start of their journey with us.

Supportive Steps update:
- Developing self help videos for parents and carers
- Workshops – 2 cohorts will be running alongside each other – families will wait no longer than 5 weeks before the next run starts.
- Pilot – solution focused approach offer with dedicated supportive steps workers.

'We are with you' update:
- Blenheim Palace have given a FREE regular space for our in person groups / walks
- Running two groups per month – one in person / one online
- Data collection process in place to capture feedback / activity
- Dedicated communications regarding what is on offer and how to sign up will be implemented
- Holding a joint fathers group with Ox United

Groups update:
- Psychologist informed group activity
- 14 + emotional literacy group starting November 2025
- Under 14's group starting January 2026
- Getting Help staff will be supporting the groups

7.3 Shared Enterprise Project

CAMHS Family Assessment and Safeguarding Service (FASS) in partnership with Childrens Social care have carried out a shared enterprise project to pilot a joint

agency collaboration between health and social care for high-risk complex families open to both agencies:

- Through identifying, screening, consultation and assessing parents together
- Delivering a therapeutic parenting group
- Forms part of the treatment offer within FASS, CAMHS, The Lighthouse Parenting Programme.

Achievements and updates to date :

- 147 families on repeated CP Planning were considered for the project. 63 were of these families were on Getting More Help wait lists and reviewed.
- Five families who were identified have been re-referred to FASS. A reflection of the chronic nature of difficulties. Repeat cycle, balancing need for support change/ capacity to engage.
- Ongoing process of gathering feedback from parents who were screened but did not engage in the treatment/mapping the child's journey.
- Ongoing longer-term needs being identified from this cohort, which we are in a position to assist with.
- Families need to be identified early – earlier intervention and before experiencing repeated CP planning. An early offer but also highlights the need for longer term /complex needs

7.4 Anxiety and Depression Clinic (AnDY)

For the past year Oxford Health Foundation Trust have worked in partnership with Oxford University to set up a research clinic within CAMHS called AnDY. The clinic offers high-quality treatments to young people with anxiety, depression, and/or obsessive compulsive behaviour. Through the clinic research is supported that improves our understanding of the development and maintenance of anxiety, related disorders and depression in young people, and that supports the development of targeted, effective and accessible treatment. The clinic has received 302 referrals since May 2024, 69.4%* have diagnosed or suspected autism. 97% are working towards their goals, 88% have improved functioning, 77% have reported improved symptoms.

7.5 CAMHS Transitions and Interface

For the past 2 years, we have had 2 clinicians working closely with colleagues in Oxford University Hospitals and Childrens Social Care to support transitions when a young person presents to a acute hospital with mental health difficulties or having self-harmed as well as coordination when a young person is admitted to the place of safety under Section 136. Appendix 6[9] gives further detail of the work that the team does and its developments over the last few years.

Oxford Health and Commissioning Colleagues within OCC have been working on creating transition process on a page for all health, education and social care pathways to share processes with young people and their families and improve processes based on feedback from young people and their families.

[9] Appendix 6 – CAMHS Transition presentation

7.6 Development of AI to support Neurodevelopmental Assessment

CAMHS Neurodevelopmental conditions (NDC) service are conducting a range of transformation activity to maximise clinical resource by:

1. gathering clinical information using a online form rather than clinical time
2. triaging cases using this form and matching complexity to clinical time (different clinic models)
3. use AI to complete triaging of referrals into different complexity levels
4. use AI to suggest tailored early help for families waiting for a diagnosis
5. us AI to complete strength and need reports
6. the long term aim is to utilise the AI tool to move to a needs lead approach and only offer a full diagnosis where clinically required e.g. for medication purposes

Progress to date:

1. created, tested and trailed the form in True Colours
2. set up clinics completing assessments in 9, 6 or 4 hours depending on complexity
3. information from the form and triage is now starting to train the AI (safe information governance systems set up)

7.7 Thames Valley Link Programme

In February 2022 Oxford Health as lead provider was successful in the bid for the Framework for Integrated Care known as the Thames Valley Link Programme locally. We had to rebid in December 2024 and was successful for a further 4 years of funding until March 2029. The vision, principles, and intended outcomes of the Framework for Integrated Care and the services it will underpin, have been developed as a response to the NHS England & NHS Improvement Long Term Plan (LTP) commitment to provide additional support for the most vulnerable children and young people with complex needs across multiple domains between the ages of 0-18.

We support children and young people with complex needs (CYP) in the Thames Valley (TV) to thrive in the community. We are committed to collectively improving our approaches to identifying and supporting these CYP early, to engaging them and their families (incl. carers) in creative ways to access the care they need, to support and work with professionals across settings and to provide care that is integrated, trauma-informed and systemic. We will achieve this by building upon the existing TV infrastructure, making it easier to navigate and access support. We have a partnership with a third sector organisation ‘RAW’ who provide Youth Workers within the county based teams.

Teams have been implemented within Oxfordshire, Berkshire and Buckinghamshire and have worked with 755 cases up to June 2025 (346 of those Oxfordshire cases), and are offering advice, consultation, assessment and direct interventions.

8. CAMHS HOSC questions:

8.1 Details on CAMHS referral data and waiting times, ideally broken down by age group, condition type, and local geography by Districts, PCN and/or Schools.

Please Appendix 7[10] for a breakdown of data as requested, please note we are unable to break this data down by PCN area.

8.2 How the cost-of-living crisis or broader inequalities may be exacerbating mental health challenges among children and young people.

We know that adults living with financial stress are at increased risk of mental health problems and poor mental wellbeing. This in turn influences parental mental health, family relationships and parenting, impacting on the mental health of children and adolescents. Sleep quality and sleep problems were widely reported in the 2023 Oxwell survey, reason cited included worries about their family not having enough money and worry about what is going to happen.

A sense of belonging and activities outside of school are a protective factor for mental wellbeing; the ONS Mental Health of Children and Young People survey 2023 found that more than 1 in 4 children aged 8 to 16 years (26.8%) with a probable mental disorder had a parent who could not afford for their child to take part in activities outside school or college, compared with 1 in 10 (10.3%) of those unlikely to have a mental disorder. JSNA_2024_mental_health_final.pdf.

Poverty makes everything more difficult and mental illness has a number of causes which can be attributed to both nature and nurture. Please see examples of two children both with generic risks of developing ADHD and how broader inequalities affect both these children:

Child A:
- Brain with genetic risk of ADHD
- mother well nourished, in stable relationship with partner
- no financial problems
- good multigenerational support
- child breast fed and then fed on home cooked balanced diet
- good primary school with small number of children in class all with English as first language
- lots of exercise and access to outdoor space

Outcome: Child manages fine. Does not need medication for ADHD, achieves academic potential, no mental health problems, passes exams and apprenticeship, manages stable relationships.

Child B:
- Same brain and genetic risk
- mother smokes and drinks in pregnancy

[10] Appendix 7 – CAMHS dataset

- father has addiction problems and there is domestic violence
- financial difficulties and often in poverty
- bottle fed and consumes processed foods
- not outside space
- school with lots of children from deprived families, 32 in class lots of SEN
- Child struggles to learn, behavioural problems referred to CAMHS

Outcome: Needs stimulant medication, lots of behavioural issues, not meeting academic potential, exclusions, antisocial behaviour, involvement of social care, needs EHCP, high risk of criminality and prison, unlikely to manage to work, high risk of teenage pregnancy in partners, high risk of illicit drug use, increased risk of becoming a looked after child.

8.3 Relationship with schools- CAHMS checklists are used in some schools for referral to CAMHS. Is there a standard check - is it evidence based and does it rely on child self-report or related also to known risks and with parental report?

CAMHS have several ways to make a request for service into CAMHS –

- Self-referral via the Single Point of Access (SPA) via a phone consultation
- Online professional referral form
- GP colleagues have their own referral proforma
- Clinicians use evidence-based screening questionnaires to support the triage process, this helps SPA formulate the needs and make a timely decision around next steps for the YP and family. The questions used in our online referral form also prompt referrers to think about their answers and provide us with the most relevant information.

8.4 Details on any staffing pressures as well as staff wellbeing, recruitment and retention challenges, and how these may affect service delivery?

- Current sickness rate is below Trust target of 4.5% and Oxfordshire CAMHS is currently 2.67%. Main sickness reason is Cough, Colds and Flu
- Current vacancy rate has increased from 6.30% to 7.66%
- Wellbeing champions hold various team events on a regular occurrence. These can be anything from a coffee morning, lunchtime walks, sunflower challenge etc.
- On a wider scale, all of Oxfordshire CAMHS wellbeing champions come together to help seek donations for a Christmas raffle for all the staff.
- We also sub contract NDC assessments to the Owl centre and Helios for anxiety and depression to support capacity in teams.

8.5 Whether there are any innovative workforce models or partnerships being trialled to mitigate any recruitment or retention issues.

Oxford Health have supported a pilot of remote workers to work digitally only. Once evaluated this may be something that is implemented more if results prove to be positive

Oxford Health have a recruitment incentive programme and operate HR fairs all over the country which were successful. OH also offer staff rotational posts which are popular.

Oxford health also offer a varied apprenticeship scheme especially for non clinically trained MHST practitioners.

8.6 How CAMHS services continue to expand any digital offers available for children and young people or patients. What measures do you have of effectiveness of digital offers?

CAMHS have purchased SHaRON which is a parent/carer peer support digital platform. There are 2 SHaRON platforms one for NDC (that covers the BOB region) and one for the main CAMHS service parent/carers. They are safe spaces for parent/carers to ask questions, connect with others and it is monitored by camhs clinicians who are able to pick up any issues and give advice/signposting if needed. Oxfordshire have the highest number of SHARON users- 1993 across the BOB region.

Breakdown of BOB region SHaRON users.

	Total Members
Berkshire	653
Oxfordshire	1933
Buckinghamshire	723
Total	3309

We offer appointments online where appropriate and feedback is that a lot of parents generally prefer as it saves them driving to appointments. There is a mixture of feedback from young people some prefer being seen face to face which is always a choice.

8.7 Data Outcomes for children in Oxfordshire; including suicides, A&E, hospital admission, as well as number of days admitted for.

Oxfordshire Tier 4 admission numbers

2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
66	52	53	49	29	45	21

Please note 25/26 is only a partial year.

Average length of stay (days) for all discharged Oxfordshire Patients

2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
98	112	123	141	114	87	76

Age standardised rate for suicide aged 10-24 years for BOB ICB region 2018-2022 count was 72, rate 4.7 Fingertips | Department of Health and Social Care

Suicide data for the BOB ICB region:

County	Berks	
Number recorded	27	
Male	20	
Female	7	
Berks:	M	F

County	Bucks	
Number recorded	23	
Male	18	
Female	5	
Bucks:	M	F

County	Oxon	
Number recorded	57	
Male	46	
Female	11	
Oxon:	M	F

Source: Thames Valley Police Real Time Surveillance System

8.8 Details around the funding arrangements in place for CAMHS services, and the sustainability of these.

The CAMHS service which is £22m per year will solely be funded by the NHS (NHSE and ICB) from January 2026. Funding from agencies will be focused on services that those agencies are statutory responsible for. OCC also provide the Family Solutions Plus Mental Health service for parents and the clinical psychology services and Attach team for Children We Care For and Care Leavers living in supported housing. OCC also makes effective use of pupil premium plus for Children We Care For to meet Mental Health
needs where CAMHS services cannot respond outside of the County

8.9 The status of any data reporting recoveries following any recent cyber incidents.

Oxford Health has not been the subject of any recent cyber incidents. There was a national incident in 2022 that the Trust was impacted by. This resulted in a reporting recovery programme which concluded in FY 24/25. The Trust continues to develop new reporting insights to support operational care delivery.

9. Recommendations from HOSC for CAMHS service

9.1 For patients to receive effective and good quality aftercare upon being discharged from hospital; and for there to be close coordination with families as well as with other partners/services within the system for ensuring discharged patients receive adequate and sustainable support upon leaving hospital. It is also recommended that discharged patients and their families receive clear signposting to appropriate help.

The SEND system has developed a complex children's case framework to ensure that there is effective multi agency planning in discharges of care from acute and T4 units with clear escalation processes. This will ensure that children are discharged from hospital with the right support and placement (if needed) at the thanright time to prevent re-admission. This is further supported through the Oxford Health LD and Autism Liaison team who track children on the Dynamic Support Register (DSR) and provide a lead key worker role to children with autism and or learning disability. The key worker is a crucial person that will work with the child/young person and their families or advocate and provide referrals and sign posting to local resources if required. This team will also direct a LAEP or CETR meetings to prevent admission into hospital and work with commissioning and operational colleagues to ensure that all members of a child's care team are involved in planning and crises mitigation. The 50/50 funding agreement between

the ICB and OCC for S117 eligible children has been key to ensuring a placement or services are in place to ensure no delays to the child's discharge from hospital.

9.2 To ensure that children and their families who are on waiting lists for treatment receive appropriate communication as well as support so as to avert the prospects of their mental health declining further.

CAMHS have improvement to reduce waiting times in Getting Help and Getting More Help via a task force to focus on the longest waits utilising funding that has been re-distributed to CAMHS from within Oxford Health. Activity includes purchasing online assessments via Helios and the Owl Centre and purchasing additional temporary staffing for a period of time to carry out assessments. CAMHS are conducting follow up phone calls with CYP and their families for those on the waiting list to review their needs while they wait. Supportive steps is also being developed to offer to families to offer a tailored living well with neurodiversity which will become part of the move towards working in a needs lead approach.

9.3 To work on improving communications campaigns to create a better understanding of the CAMHS service and how it also relates to any other early intervention services.

Oxford Health conducted a engagement piece of work in 2025, see appendix 8[11] outlining the approach and recommendations.

10. Financial Implications

There are no financial implications to content of the report at this stage.

11. Legal Implications

There are no legal implications to the content of the report at this stage. Legal colleagues have been engaged to ensure compliance with the Contract Procurement Regulations in respect of the commissioning of the mental health digital app.

12. Staff Implications

There are no new or additional staff implications to the content of the report.

13. Equality & Inclusion Implications

One of the primary aims of the emotional wellbeing and mental health strategy is to reduce health inequalities in a range of priority groups. The views and input from the main beneficiaries of the content of the report – children, young people and families continue to be sought as the development of the work.

14. Sustainability Implications

There are no sustainability implications to the content of the report.

[11] Appendix 8 – CAMHS comms survey overview

15. Risk Management

There is a risk that gaps will not be met causing further detriment to children and young people, however this is being addressed through the Emotional Mental Health and Wellbeing Board and SEND Programme following the OFSTED inspection.

Directors:

Lisa Lyon - Corporate Director of Children's Services
Ansaf Azhar - Corporate Director of Public Health & Community Safety
Dan Leveson - ICB Place Director for Oxfordshire
Grant MacDonald – Chief Executive for OHFT

Officers:
Caroline Kelly
Head of Commissioning – Start Well, Oxfordshire Health, Education and Social Care (HESC) Joint Commissioning across Oxfordshire County Council and the BOB ICB

Adam Briggs
Deputy Director of Public Health, Oxfordshire County Council

Vicky Norman
Head of CAMHS - OHFT

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Appendix 1 - Parenting Support programmes overview

Background:

The Parenting Support Programme project aims to support parents and carers of children and young people aged 0–18 years, and up to 25 years for those with an Education, Health and Care Plan (EHCP) who are in full-time education or employment.

The initiative is designed to ensure that families across Oxfordshire have equitable access to effective parenting support. This collaborative, data-informed project involves multiple stakeholders and emphasises accessibility, inclusivity, and meeting the diverse needs of children, young people, and their families across the county.

Project Objectives:

- Identify and map existing parenting support programme provision across Oxfordshire.
- Capture lived experiences and outcomes for parents and carers.
- Establish categories of need across localities.
- Assess gaps in current provision and evaluate demand for various programme types and delivery methods.
- Evaluate programme objectives, goals, and outcomes, including completion rates and accessibility (addressing needs such as mental health, SEND, learning disabilities, domestic violence, etc.).
- Analyse geographical distribution to ensure equitable access across all localities.
- Consider financial accessibility, including whether programmes are free or require payment.
- Develop strategic recommendations for future commissioning, including costed options to address identified needs.
- Develop a centralised and accessible digital platform and web page that consolidates resources, offers clear signposting, and provides effective pathways for families.

Data Mapping:

- A targeted survey was distributed to providers of parenting programmes across Oxfordshire to aggregate programme types, delivery methods, participant engagement, geographic coverage, and perceived demand.

- Simultaneously, a separate survey was issued to parents and carers who had participated in these programmes to capture their experiences and the outcomes achieved, unfortunately despite widespread advertisement and encouragement from the Oxfordshire parent carer forum three responses were received.

- An internal data analysis was undertaken to determine the categories of need among children and young people across all Oxfordshire localities, to support a direct comparison between identified needs and the availability of parenting support and programmes

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OVERVIEW OF PARENTING PROGRAMME MARKET

The market for parenting programmes in Oxfordshire is diverse. Primary schools, voluntary sector organisations, alternative provision settings, and charities are the main providers, with additional support from community centres, nurseries, youth services, and health professionals.

A wide range of parenting support programmes is available. Frequently attended programmes include Family Links, Health Support/Advice, Peep Learning Together, and SWIFT. Specialised interventions address areas such as Parent Wellbeing, Adolescent Mental Health, baby and toddler support, and SEN assistance, anxiety and exam stress and depression parenting workshops are also being delivered by MHST's.

The primary objectives are to increase parental knowledge, strengthen family support systems, promote children's mental health, and enhance parental confidence and attachment.

Available programmes address key needs, including mental health and emotional wellbeing for both parents and children, development of self-care and independence, special educational needs and disabilities (SEND), learning disabilities, sensory and physical needs, and autism. The market particularly focuses on supporting families with complex and varied challenges.

Most programmes are delivered in person, facilitating meaningful engagement. However, online and alternative methods are also used to provide greater flexibility and accessibility, especially for families facing barriers to traditional participation.

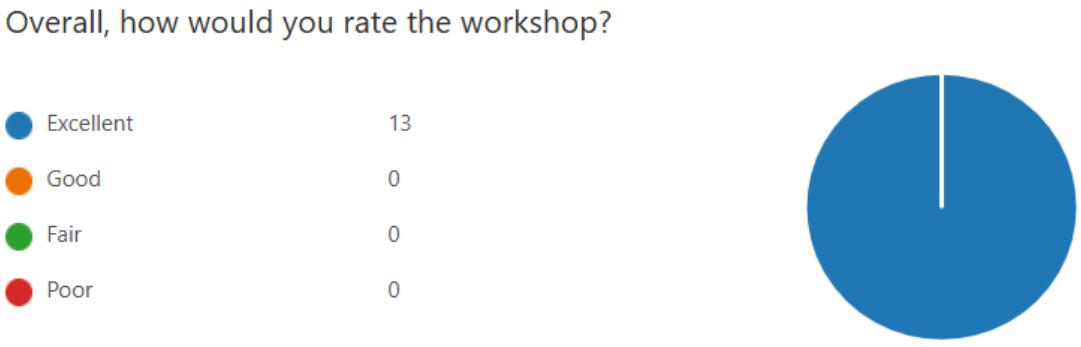
Parenting programmes are available throughout Oxfordshire, covering localities such as Abingdon, City North and South, Didcot, North, South East, West, and countywide services. While access is broad, certain areas report higher concentrations of need.

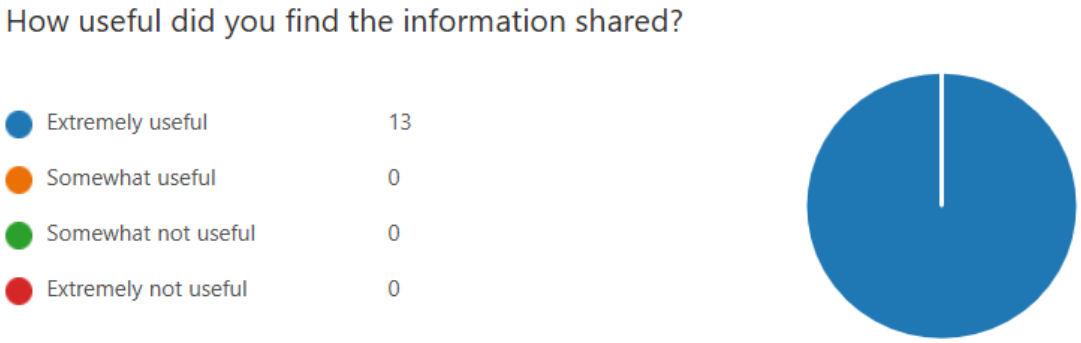
Most programmes are offered free of charge, minimising financial barriers and promoting equitable access. Where fees are required, these are generally minimal (approximately £5 per session), with some programmes adjusting pricing based on family circumstances.

There is significant demand for parenting programmes, evidenced by waiting lists and continued requests for additional support. Completion rates are relatively high, at around 75%, though there remains potential to further increase engagement and address factors that may impact completion.

High-demand programmes include SWIFT, Early Days, Family Links, Peep Learning Together, Triple P, and others. There is also notable demand for universal programmes on behaviour management and anxiety, in-person support for teen parents, fathers, and kinship carers, early years support for deaf children, and expanded SEND (including support for neurodivergent children and sensory issues) language and communication and educational support.

Mental health and counselling services are particularly sought, especially for young people aged 13–25 and their parents, with existing waiting lists. Service providers recommend developing new programmes and expanding current offerings to address these emerging needs. This is evidenced by the roll out of Parent Behaviour workshops delivered by MHST's.
Feedback from MHST's:





Across all five localities in Oxfordshire, the most prevalent challenges include mental health concerns (for both parents/carers and children), learning disabilities, domestic violence, emotional abuse, neglect, and challenging behaviour. Additional issues reported include physical disabilities, substance misuse, self-harm, sensory needs and the needs of young carers.

KEY PARENT AND CARER FEEDBACK

Parenting programmes are generally effective, achieving high satisfaction rates and measurable improvements in parenting skills, parental wellbeing, and child behaviour.

Parents consistently value these programmes, describing them as helpful, supportive, and empowering. Notable outcomes include enhanced relationships, increased parental confidence, and a better understanding of children's needs. Additional benefits reported are improved prosocial behaviour in children, better parental mental health, and practical strategies for family life.

However, some groups remain less engaged or unconvinced, and there are gaps in content, such as cultural inclusion and explanations of early parenting challenges that should be addressed.

Successes:

- Across nearly all programmes, parents consistently described their experiences as helpful, supportive, and empowering. Programmes such as OXPIP (Parent–Infant Psychotherapy), Botley Bridges Family Support, and Willowcroft School (Nurturing Programme) were especially noted for creating safe, inclusive, and friendly environments.

- Many parents reported measurable improvements in their parenting confidence and skills. For example, Brookside Longfields and Launton Schools (Family Links) and Grow Families (Parenting Puzzle) saw 100% and 75% of parents, respectively, reporting increased confidence and understanding of their children's needs.

- Programmes like OXPIP and The Berin Centre were credited with improving parent-child relationships and reducing parental anxiety and depression. Parents also observed increased prosocial behaviour and reduced emotional difficulties in their children.

- Parents valued gaining practical strategies for managing difficult behaviours and nurturing themselves and their children, particularly in Grow Families (Parenting Puzzle) and AFI UK (BOMA Cross-Cultural Parenting).

- Programmes such as BYHP (Tackling Youth Homelessness) were described as empowering, with all participants reporting positive change after completion.

- Parents valued the Parent Behaviour Workshops delivered by the MHST's: "Different strategies for calming and holding boundaries"

- "Knowing that the school approach is the same and that rewarding the small things can have a big impact. Also nice to know you're not alone!"

- "Practical strategies and science behind behaviour"

Areas for Improvement:

- Inclusivity and Engagement: Several programmes noted gaps in engaging specific groups. For example, OXPIP had low participation from Black and Asian minority groups, while AFI UK (BOMA) was limited to African parents and had low male involvement.
- Programme Impact: Some parents in Grow Families (Parenting Puzzle) and Botley Bridges Family Support did not feel the programme made a significant difference to their parenting or remained unsure about the benefits.
- Content Gaps: Oxford Health 0–19 Years Service lacked detailed explanations on hormonal and brain changes in early parenthood, which some parents found important for understanding emotional challenges in the first weeks.
- Accessibility and Duration: BYHP had limited presence in secondary schools, and AFI UK (BOMA) faced challenges with restricted locations and short training periods.
- Effectiveness of Strategies: In Willowcroft School (Nurturing Programme), some parents felt not all strategies improved their skills.
- Support and training on sensory needs was required, when the Occupational Therapy Service piloted a Sensory OT scheme in 2023-24 the uptake on parenting programmes focused on sensory support was extremely high which was delivered to 9 parent groups (supporting 113 children).

KEY PROVIDER FEEDBACK

Successes:

- Strong Engagement and Completion Rates: Most programmes report high completion rates (around 75% or higher), indicating strong engagement and perceived value among participating families.
- Positive Outcomes: Programmes are successful in educating parents about their children's needs, supporting attachment, and boosting parental confidence.
- Personalised Support: The range of programme types allows providers to meet varied needs, from behaviour management to SEND and mental health.
- Collaboration: Providers benefit from collaborative working with other services, such as Early Help, Family Centres, and commissioning teams.
- High Demand: Providers consistently report high demand for their programmes, particularly those focused on mental health, SEND, and early years support.

Challenges:

- Capacity and Resources: High demand for programmes often exceeds current capacity, leading to waiting lists and potential unmet need, especially for mental health and SEND support.
- Completion Barriers: While completion rates are generally good, there is room for improvement. Some parents face barriers to finishing programmes, such as time constraints or accessibility issues, which need further investigation.
- Limited Data and Engagement: Survey fatigue and limited parent/carer engagement with feedback exercises constrain the ability to gather comprehensive data and fully understand needs.

GAPS

Despite a robust and diverse parenting support offer, Oxfordshire faces ongoing challenges in reaching all families equitably. Addressing these gaps, by expanding targeted programmes, increasing capacity, enhancing engagement, and creating a centralised information hub will be critical to ensuring that no family is left behind.

Recent mapping and feedback highlight several persistent gaps in the provision of parenting support across Oxfordshire:

Under served Groups:
There are notable gaps in support for specific groups, including fathers (however the role of the new app Dad Pad aims to address this need), kinship carers, and parents of children with unique needs such as early years deaf children and teen parents. These groups often face barriers to accessing personalised programmes, resulting in unmet needs within the current offer.

Geographical Inequality:
Provision is uneven across the county, with rural localities particularly affected. Families in these areas may have less access to certain programme types, underscoring the need for more targeted outreach and flexible delivery models to ensure equitable access. The intention is to deliver the parenting support programmes from Family Hubs in the future to ensure families can access support within their community.

Programme and Capacity Gaps:
There is a shortfall in programmes addressing behaviour management, anxiety regulation, and SEND and sensory support, especially for preschool children. Additionally, high demand for mental health and counselling services has led to waiting lists, delaying timely support for families.

Engagement and Accessibility:
While many programmes are free and offer flexible delivery (in-person, online, hybrid), there is a need to further enhance engagement particularly through richer, in-person feedback mechanisms. Improved accessibility also depends on maintaining free provision and expanding flexible options.

Information Fragmentation:
Families often struggle to find comprehensive information about available support as information on parenting support programmes is displayed in several places on the OCC website. The absence of a centralised digital hub makes it harder for parents and carers to navigate the system and access the help they need.

NEXT STEPS

Collaboration Across Services:
There is a strong focus on fostering collaboration between key services. This will

include Family Hubs, LCSS, and Families First, to ensure a coordinated and holistic approach to parenting support, while minimising duplication of effort.

Data Mapping and Needs Assessment:
Ongoing internal data collation and analysis are being conducted to map categories of need by locality, assess demand, and identify gaps in current provision. These activities will support expanded outreach, enable the personalisation of programme content to diverse needs, and facilitate the collection of more comprehensive feedback, ultimately strengthening the impact and inclusivity of parenting support programmes.

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WHOLE SCHOOL APPROACH CHAMPIONS

24/25 Review

WSA CHAMPIONS

Michelle (West)

Alix (North)

Nadya (City)

Imogen (City)

Habibah (South)

Along with your managers we help coordinate and support the planning and delivery of WSA work in the team.

We are passionate about WSA and finding the most effective, impactful, research backed ways of working with our schools!

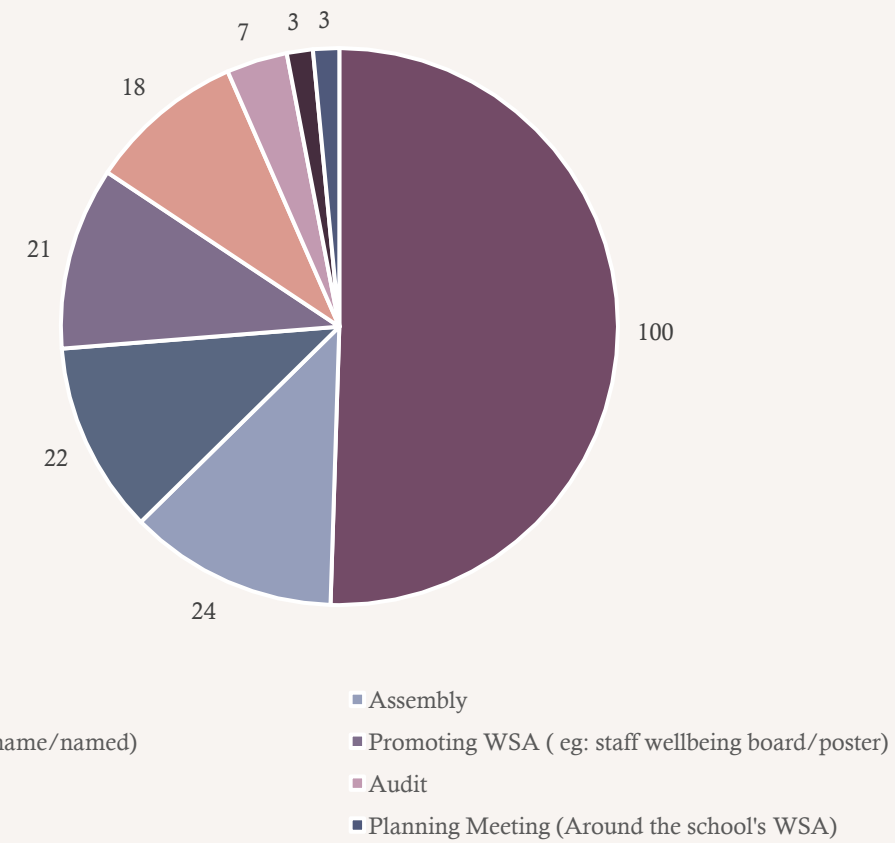
AGENDA

- Highlights from 24/25 WSA data
- Sharing feedback from CYP, parents and schools
- Results from staff survey and a chance to feed back
- Discussing our plans as WSA Champions for 25/26
- Questions/thoughts
- WSA SIP

2024/2025 WSA ACTIVITY

203

Logged Activities



HOW MANY CYP DID WE REACH DIRECTLY?

Any guesses??

HOW MANY CYP DID WE REACH DIRECTLY?

6462

FEEDBACK HIGHLIGHTS
Transition Workshops

I LIKED:

"They made me feel less nervous about going to secondary school"

"The people were really nice"

"When we drew our worry buddy"

"Everything it really helped a lot about worries"

I LEARNED:

"All emotions are valid, not to be so worried but it's okay to be worried"

"To tell a trusted adult"

"About fight flight freeze"

"How to calm my breathing down and calm myself down"

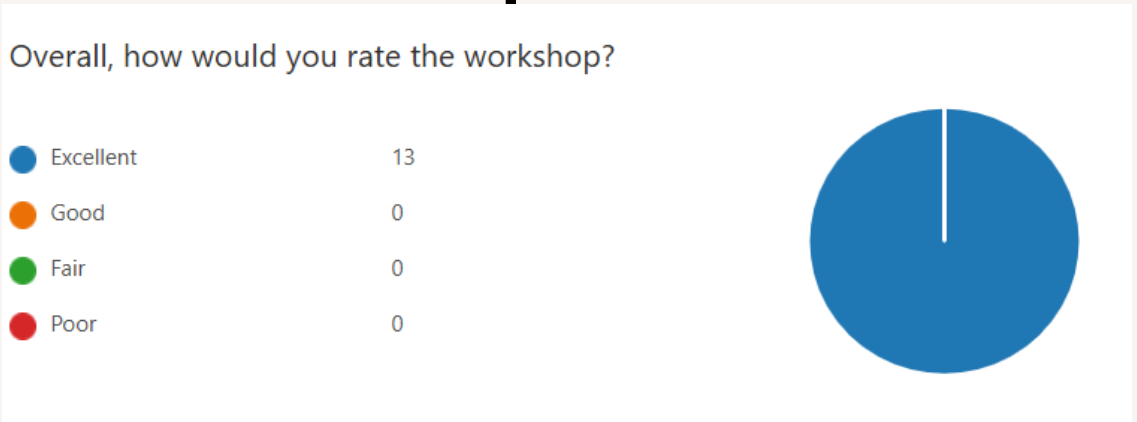
FEEDBACK HIGHLIGHTS Parent Behaviour Workshops

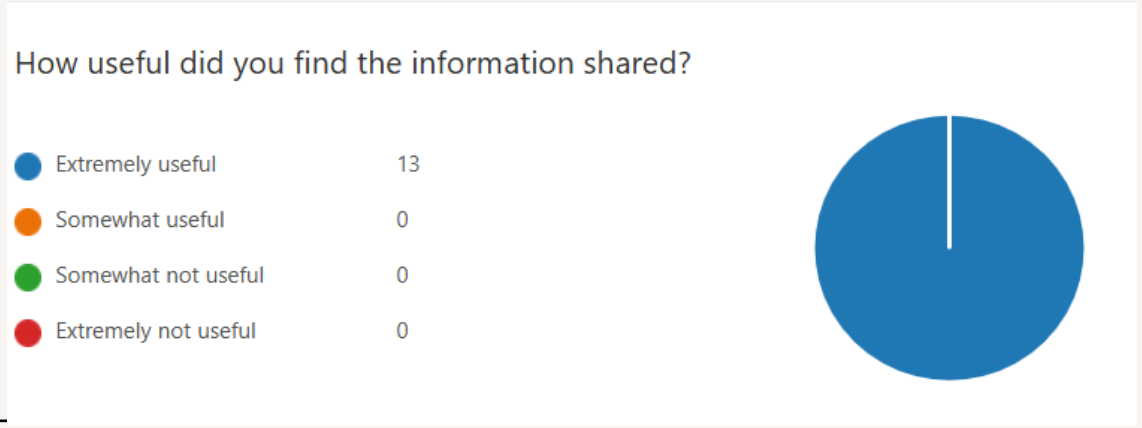
WHAT I FOUND HELPFUL:

"Different strategies for calming and holding boundaries"

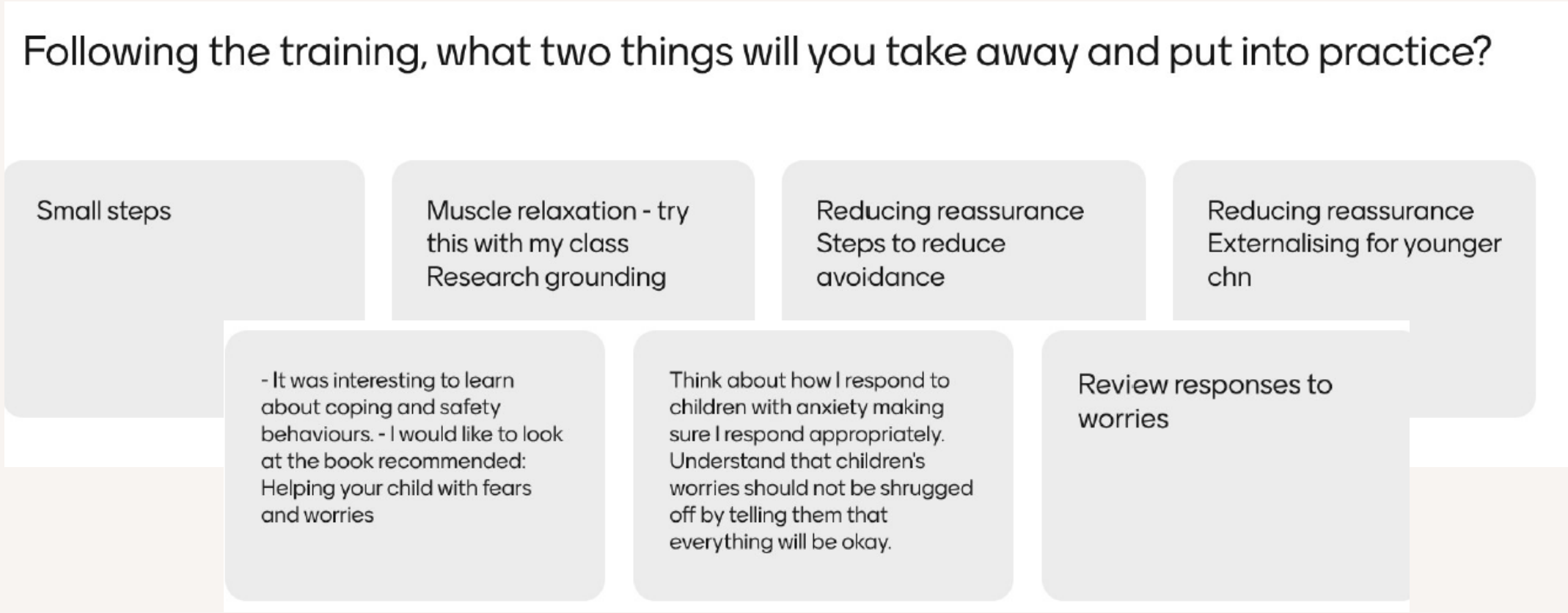
"Knowing that the school approach is the same and that rewarding the small things can have a big impact. Also nice to know you're not alone!"

"Practical strategies and science behind behaviour"





FEEDBACK HIGHLIGHTS Staff Anxiety Training



FEEDBACK HIGHLIGHT

Feedback form

Thank you for attending our MHST workshops. We appreciate your feedback below:

How would you score how confident you felt managing your child's behaviour before todays workshop:

Least confident 1 2 3 4 5 (6) 7 8 9 10 Most confident

How would you score how confident you feel managing your child's behaviour now:

Least confident 1 2 3 4 5 6 7 8 (9) 10 Most confident

What did you find most helpful about the workshop?

Logical strategies - with the ability to individualise + adapt ♡

What did you find least helpful about the workshops?

Is there anything we can do to improve the workshops?

Keep doing what you are doing It is making a difference, + you are appreciated

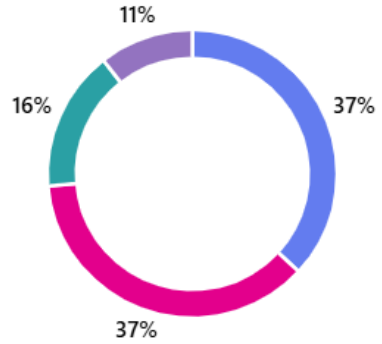
Any further comments?

Thank you

HOW MUCH TIME DO YOU SPEND ON WSA EACH WEEK?

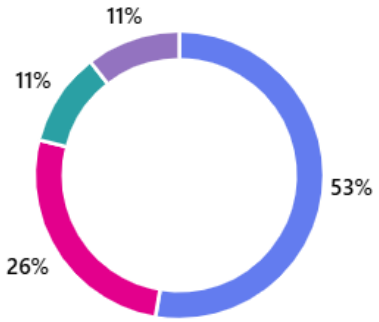
1. On average, how many hours of WSA work are you delivering each week?

0-1	7
1-2	7
2-3	3
3-4	2
4 plus	0



2. On average, how many hours of prep time for WSA activities are you doing each week?

0-1	10
1-2	5
2-3	2
3-4	2
4 Plus	0



WHAT HAVE YOU ENJOYED DELIVERING?

WHAT WORK DO YOU FEEL IS MOST IMPACTFUL?

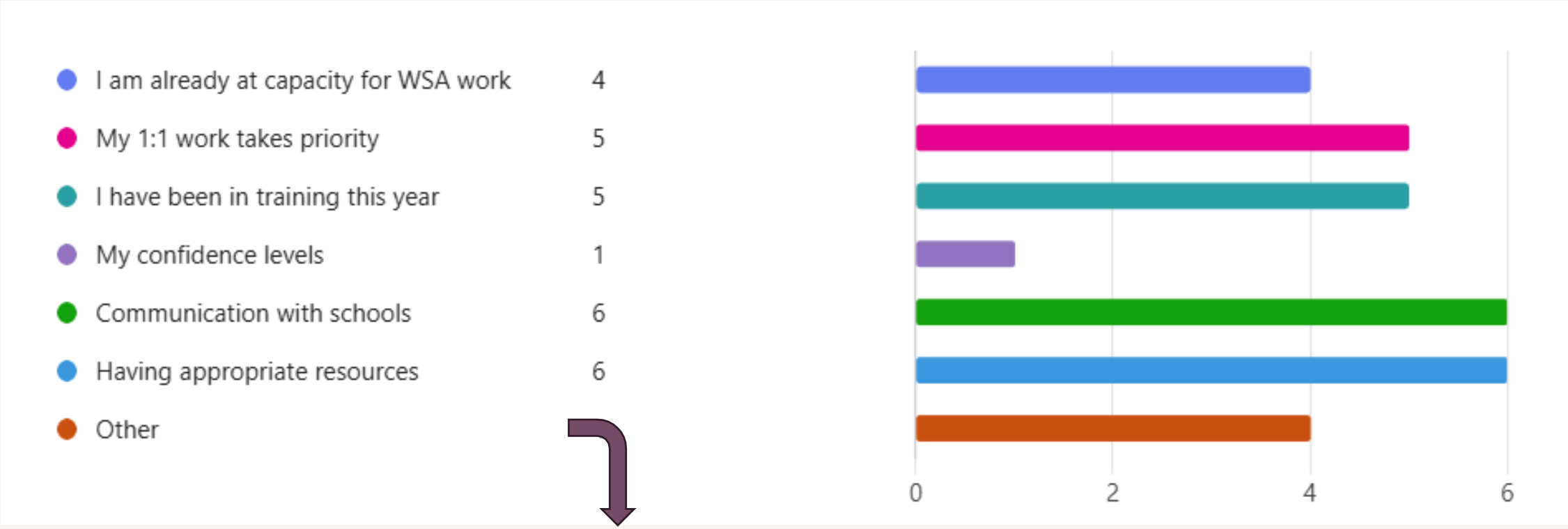
- Parent workshops – behaviour, anxiety, emotional regulation
- Transition workshops with CYP
- Exam stress workshops
- Workshops with CYP and parents together

….it's a triad of support which works most impactfully ie. staff training, parent workshop & pupil workshop focusing on 1 subject in particular = high impact

WHAT CHALLENGES HAVE YOU FACED?

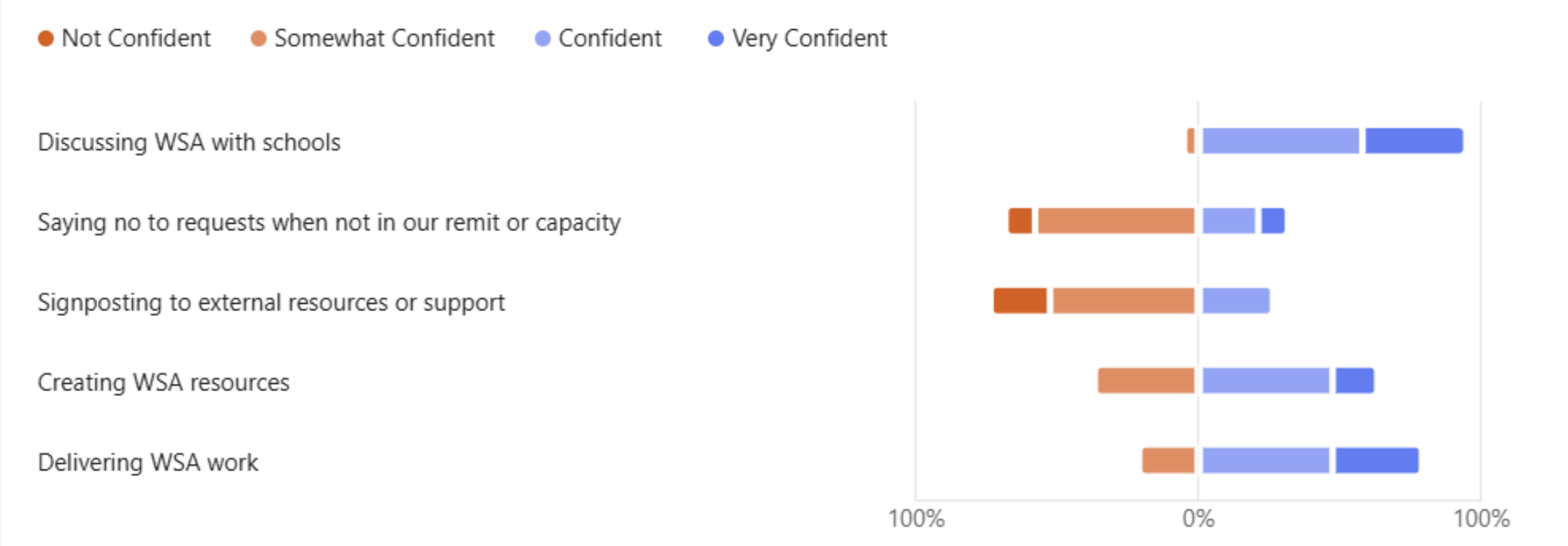
- Parental engagement and turnout
- Staff training, often dealing with burnout and stress
- Communication around planning WSA with schools
- Assemblies, are they impactful?

BARRIERS TO DOING MORE WSA WORK

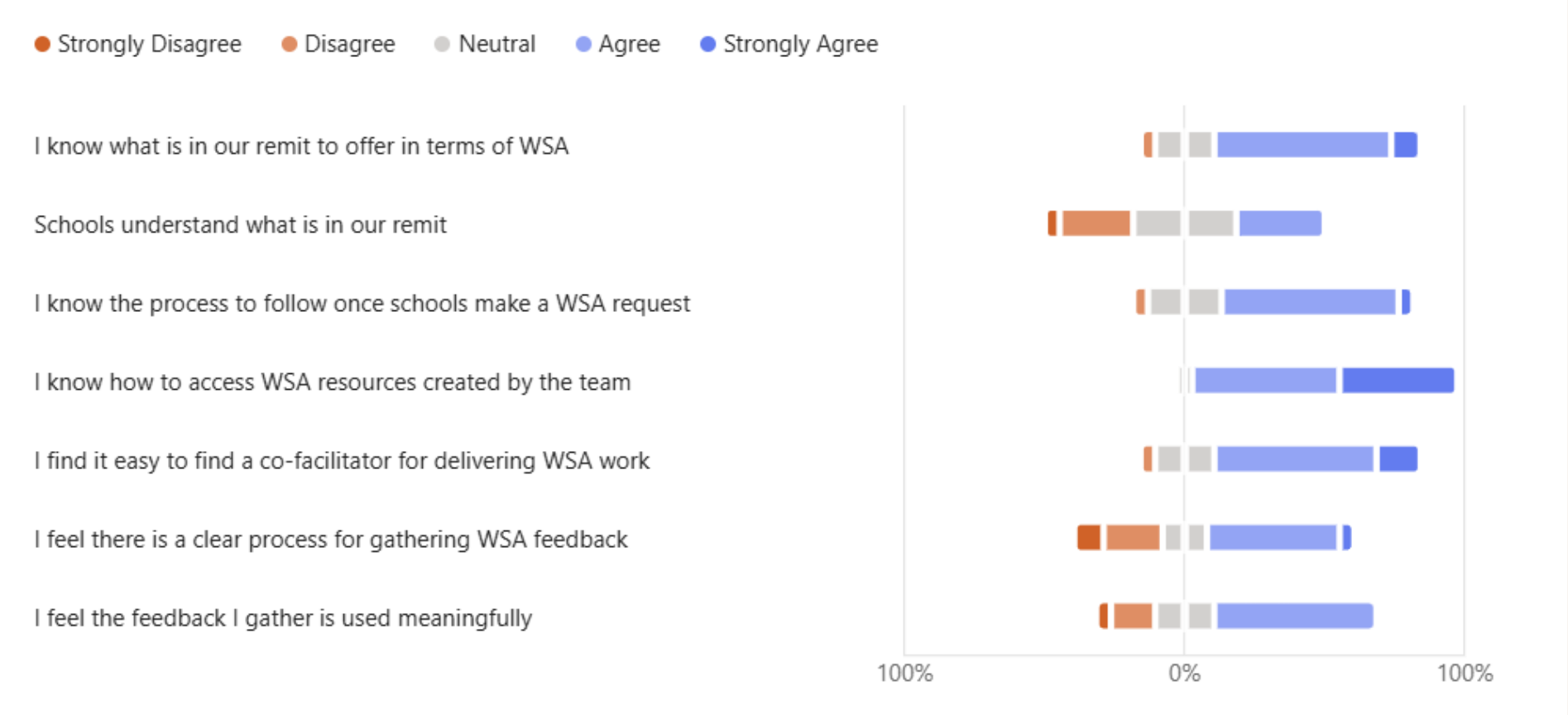


Having clearer expectations around job planning and WSA and more equality across practitioners and teams

TEAM CONFIDENCE LEVELS AROUND WSA

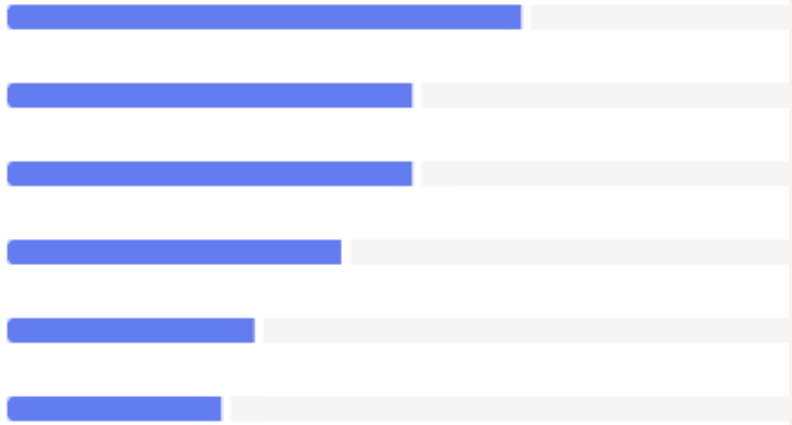


WSA PROCESSES



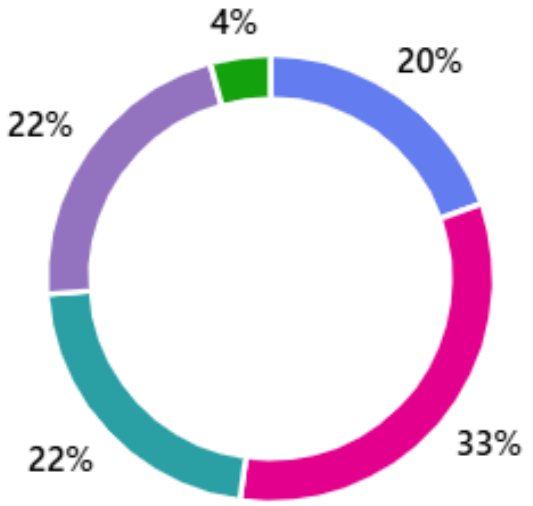
PRIORITIES FOR WSA CHAMPIONS

1. Working on our resource bank (e.g. tidying sharepoint, creating master slides, filling gaps, etc)
2. Establishing clear processes (e.g. flowchart of process, creating a list of offer, booking WSA in, etc)
3. Accessing student voice and participation within WSA
4. Standardised feedback procedures
5. Sourcing and sharing useful WSA links, updates and research
6. Creating links with other MHSTs



FORUMS FOR WSA DISCUSSION

WSA themed away day	9
Regular slot in business meeting	15
Teams channel to share links/updates	10
Regular slot in the clinical team meeting	10
Other	2




Thank you
2+2=4
A+B=C

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FOR EXTERNAL DISTRIBUTION

Team: Oxfordshire CYP (ADHD & Autism) ONLY	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of referrals received (Diagnostic and Treatment Teams Combined)	140	181	153	254	165	184	200	210	195	287	259	275
No. of patients waiting for assessment							3,013	3,049	3,060	3,092	2,996	3,478
Average (mean) waiting time for an assessment (weeks)								92	94	94	93	85
Average (median) waiting time for an assessment (weeks)								79	79	78	76	61
Total Number of Assessments Completed												
Total Number of First Appointments Completed	23	44	41	41	60	76	73	88	66	63	81	59
Total Number of Follow Up Appointments Completed	371	611	646	554	516	706	659	714	561	594	685	601

Team: Oxfordshire CYP (ADHD & Autism) ONLY	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of referrals received (Diagnostic and Treatment Teams Combined)	203	258	240	172	131	142	192	209	187	275	181	171
No. of patients waiting for assessment	3,539	3,743	3,492	3,526	3,634	3,633	3,649	3,569	3,631	3792	4242	4358
Average (mean) waiting time for an assessment (weeks)	80	80	82	81	81	84	91	88	94	90	96	90
Average (median) waiting time for an assessment (weeks)	56	54	54	54	55	59	63	67	71	73	77	72
Total Number of Assessments Completed	27	106	73	104	120	99	52	30	36	58	23	34
Total Number of First Appointments Completed	44	52	37	54	44	44	45	24	31	25	28	22
Total Number of Follow Up Appointments Completed	568	708	634	622	475	598	588	585	599	516	618	599

Team: Oxfordshire CYP (ADHD & Autism) ONLY	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Number of referrals received (Diagnostic and Treatment Teams Combined)	142	189	114	91	72
No. of patients waiting for assessment	4356	4539	4630	4470	4599
Average (mean) waiting time for an assessment (weeks)	95	99	100	97	99
Average (median) waiting time for an assessment (weeks)	76	79	81	78	78
Total Number of Assessments Completed	31	25	32	33	20
Total Number of First Appointments Completed	29	31	39	49	45
Total Number of Follow Up Appointments Completed	507	568	745	759	490

Measures	**Notes**
Number of referrals received	* Referrals to all CAMHS O NDC Teams, not just the Assessment pathway only
No. of patients waiting for assessment	* No. of patients waiting for an assessment with CAMHS O NDC
Average (mean) waiting time for an assessment (weeks)	* This data is for those CYP waiting, not CYP seen. It includes the CYP who have been waiting the longest as well as those who have only just been added to the waiting list
Average (median) waiting time for an assessment (weeks)	* This data is for those CYP waiting, not CYP seen. It includes the CYP who have been waiting the longest as well as those who have only just been added to the waiting list
Total Number of Assessments Completed	* Data includes 3rd party assessments
Total Number of First Appointments Completed	* First appointments completed for all NDC Teams combined, this includes assessment and treatment teams
Total Number of Follow Up Appointments Completed	* Follow ups completed for all NDC teams combined, this includes assessment and treatment teams

Correspondence: BusinessServices@oxfordhealth.nhs.uk

L Case Study Template

Please complete the following table with brief details of the good practice/changes/intervention you wish to share. You do not need to answer all of the questions – they are just prompts for each section.

Title of case study Short descriptive title including linked HIA	HIA 1 5-19- supporting Emotional Health and Resilience. Student experiencing anxiety affecting school attendance
Author of case study Name, job title, locality	School Nurse
Abstract/Synopsis –(not essential but helpful) Short summary of the case study *Max 100 words*	Year 8 student sought support of school nurse as high levels of anxiety meant she struggled to enter her lessons. She had missed 2 days of school during the first week of term as felt physically unwell with stomach/headaches and nausea. A short and intense episode of support, including liaison with school staff and mother, use of Clear Fear app and calming strategies, enabled her to be able to attend school and go into lessons.
The starting point • What was the issue/health need? • What impact was this having? • Who was affected? *Max 200 words*	Student B self-referred to school nurse as was aware from an assembly that she could access her via Drop In. Explained that she had a panic attack at the bus stop on second day of term and did not go into school. She missed 2 days during the second week due to feeling unwell and was very tearful. Identified her own anxiety and shared that she had some friendship issues and felt other girls were staring and laughing at her. She had asked her mother if she could be 'home schooled' as couldn't face school anymore. This was affecting her whole family as they did not know how to support her.
The solution/practice development • How was the solution identified? • Who was involved in this discussion? *Max 250 words*	Following initial meeting with B, I contacted her head of year with her consent, who had not appreciated how she was feeling. She was able to sit in the learning support centre and speak with a support worker to discuss the issues she was having with her peers and to outline some restorative work with them. I arranged to see her the next day to look at triggers and strategies. During the next appointment we completed a health review focussing on diet, sleep, routines, social activities as well as worries at home and school. This gave a clear picture of areas that could be improved for her to focus on. We also discussed triggers for her anxiety and strategies she could use to be in control of her feelings. We looked at the Stem 4 Clear Fear app which she downloaded for information and ideas. We practised some breathing techniques to calm her when she felt anxious. She agreed to use a notebook to write down any difficulties she was having and how she managed them. The restorative work with her friend was in progress and she felt happier that things were improving in such a short space of time.

	I arranged to see her in 2 weeks to see how she was progressing. Following this appointment it was agreed that B would access the school nurse in drop in when she needed to, enabling her to be empowered in managing her feelings and confident to access support if necessary.
The action • What process was followed/put in place? • Who was involved in implementing the action/care? • What resources were required? *Max 250 words*	Plan was discussed with school support worker and head of year. B had spoken to her mother and sister, and they were both supporting her using the strategies identified
The outcome • What had you hoped to achieve? • What did you achieve? • How was this measured? *Max 200 words*	I hoped that a short intervention would resolve the immediate issues created by returning to school in a new year group. She was aware of the support I could give and by liaising with relevant school staff many of her fears were addressed. Her appointment with me in week 3 of term was positive and she had been in school every day. She felt she did not need another appointment but knew how to access me. Initially her Goal Based Outcome score was a 2. This had increased to an 8 at her 3rd appointment with the school nurse.
The impact • Who was impacted by the changes? Staff? Service? Patients? Families? Other? • What was the short-term impact? • What was the long-term impact? • Did you get feedback from the family if appropriate – what was this? *Max 200 words*	The short-term impact was positive as she no longer feared walking into school or class. She was able to integrate with peers following restorative work from school staff. She has not had any further time off school. She felt supported knowing she could access the school nurse if she felt she needed further support. The strategies she used could be used in the future as needed. As this was identified early and addressed within 3 weeks the long-term impact cannot yet be measured.
Evaluation • What were the benefits? And for whom	I am fortunate to be in my school 4 days a week so am well known to staff and students, who feel comfortable in coming to see me. I have the same office and am valued by the school.

• What were the challenges? • What did you learn? • Is there learning for the service? • What are your future plans/next steps? *Max 250 words*	Challenges in other areas mean regular accessibility can be an issue. I feel that Bs issues may not have been addressed as early if I hadn't been there, when she came in a distressed state. This early intervention had a very positive outcome for her and her family.
Any contact details for further info	

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Tellmi Annual Impact Report
Oxfordshire 2024 - 2025
Page 139
Reflecting on a year of
#Impact
tellmi

#Summary

Outcome measures, app usage, and user feedback show that Tellmi is providing valued mental health support throughout Oxfordshire in the first year of the contract.

In July 2024 the Tellmi Mental Health Service was commissioned to provide digital peer support and counsellor intervention to anyone aged 11 - 18 across Oxfordshire. This report describes the impact seen in the first year of a three-year contract.

Our first year has been dedicated to building the foundations of the Tellmi service in Oxfordshire. This has included connecting with key networks, engaging staff through training and beginning to work directly with young people. Establishing these foundations has been a crucial step, ensuring the service is understood, trusted and ready to grow in its impact over the contract duration.

In year 1, Tellmi has provided a safe supportive space for 433 young people with good levels of engagement across gender and age. This reflects a strong uptake across the 11-18 age range showing that the service is reaching young people who need it most during key stages of their development.

75 young people have received support for high risk issues. This is 17% of Oxfordshire users.

Stakeholders across Oxfordshire have shown a genuine enthusiasm for implementing Tellmi within their communities; **71% of users came from school related activities, 20% from the clinical pathway.**

In year one, 83% of schools are engaged on some level. Of those, approximately 40% of schools have launched Tellmi and 23% have had further engagement such as staff training and awareness raising through assemblies and student workshops, all positively rating the service and activities.

The Tellmi Directory has proven to be a valuable resource with 160 (37%) users accessing 260 different resources in the Directory.

Our comprehensive understanding of the key priorities and focus areas across Oxfordshire is a cornerstone of our strategy. This insight enables us to develop a well-informed strategic plan that aligns with the needs of the community, ensuring that the impact of Tellmi continues to grow. By remaining attuned to local challenges and opportunities, we aim to enhance the effectiveness of our services and maximise our positive influence on the mental health landscape in the region.

#Active Users

Total Users: 433

Female: 65%

Male: 25%

Non-binary: 2%

Age 11-13: 46%

Age 14-18: 54%

#Outcomes

77% of users feel less alone since using Tellmi.*

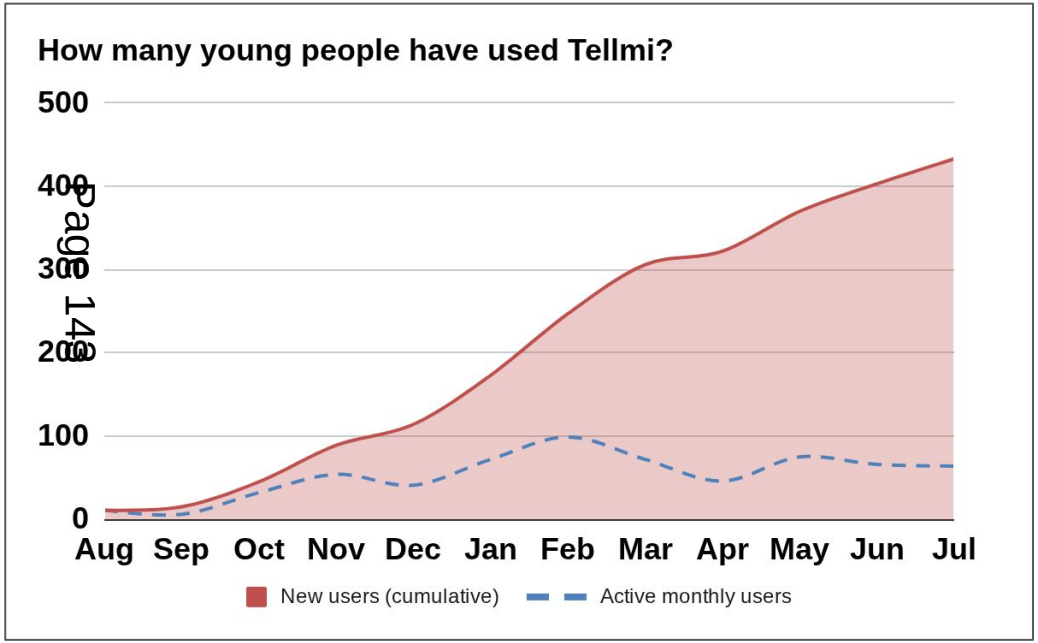
For 32%, Tellmi is their only form of mental health support.*

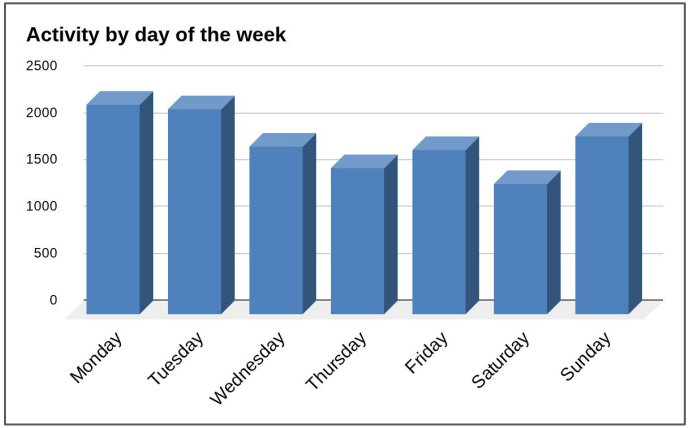
85 have been using Tellmi for more than a month.

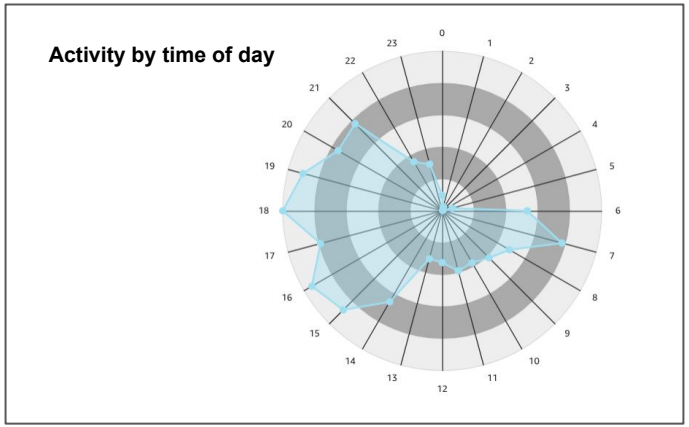
75 young people have received support for high risk issues.

*Results taken from the Tellmi Impact Survey 2024 & 2025, Oxfordshire respondents (n=44)

#Growth A solid foundation







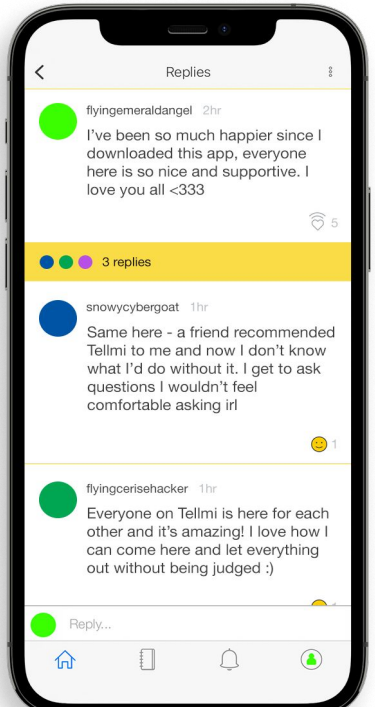
#Metrics 12,798 interactions from 433 users.

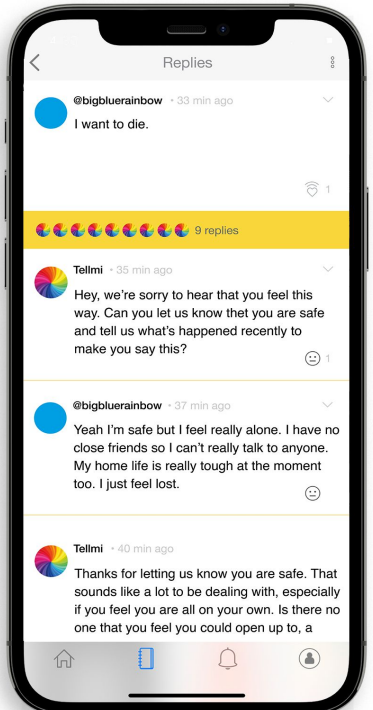
1,379
Posts

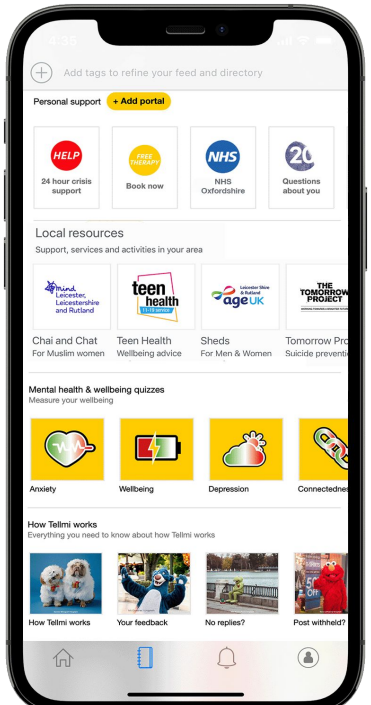
4,700
Replies

282
High Risk Posts

296
Directory Resources







#Retention Long-term flexible support

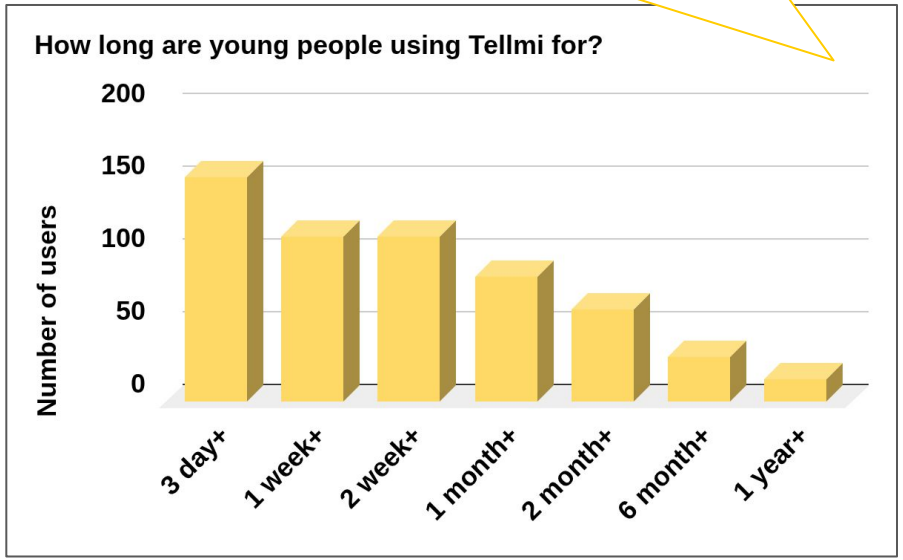
Tellmi is designed to help people manage their mental health. It is a tool that can be used as and when it is needed. Many young people use Tellmi to seek support for a specific problem but we also see a substantial number of young people using Tellmi for an extended period.

Therapeutic interventions, such as those delivered by CAMHS, typically last between six and twelve weeks, however 46% of young people referred for therapy only ever attend for a single session (Edbrooke-Childs, 2001).

In the UK the average 30 day retention rate for Health and Fitness Apps is 3% (Business of Apps, 2025). **Tellmi's 30 day retention rate in Oxfordshire is 20%.**

The benefit of commissioning Tellmi over multiple years is that it allows us to reinforce our offer through activities in schools and with VCSFEs. It also enables continuity of care, allowing young people who need extended support to be able to access it.

I'm not on the app often but the community is always amazing and supportive - thank you for cultivating such a safe and welcoming place to vent frustrations, worries, etc.
💛💛💛

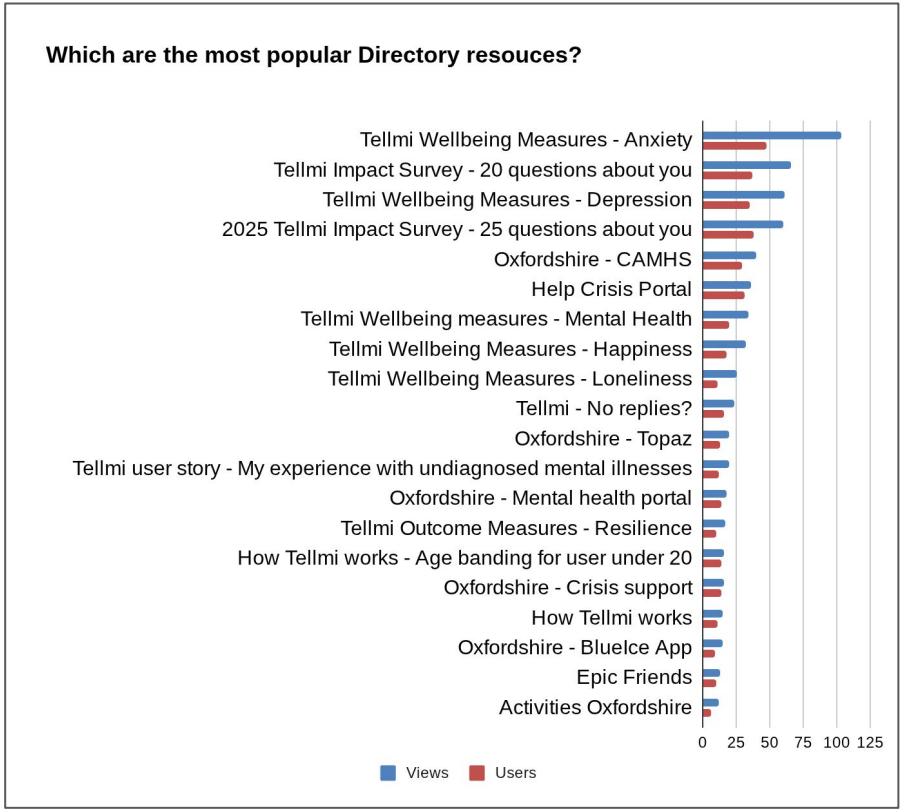


#Resources 3,883 directory visits

The Tellmi Directory contains 700+ nationally available resources such as national support services, websites, books, apps, user stories and wellbeing quizzes. In Oxfordshire users also benefit from 23 local listings including Oxme, SeeSaw, Byhp, Here4Youth and Oxfordshire Mind. During the summer an additional set of 11 summer activities were also added to the Directory.

In total 160 (37%) users have viewed 260 different resources. 25 local listings have been viewed 172 times. The Oxfordshire CAMHS is the most popular local resource and was used 40 times. Typically, in non-commissioned areas only 15% - 20% of users access the free version of the Directory. The positive uptake seen in Oxfordshire confirms the benefit of providing locally relevant resources.

“I do enjoy it. Whenever i have the time, i like to come on here and help people out. It serves as a good distraction and makes me feel good about myself when people are thankful for it, as sometimes i feel i’m not as appreciated as i want to be”

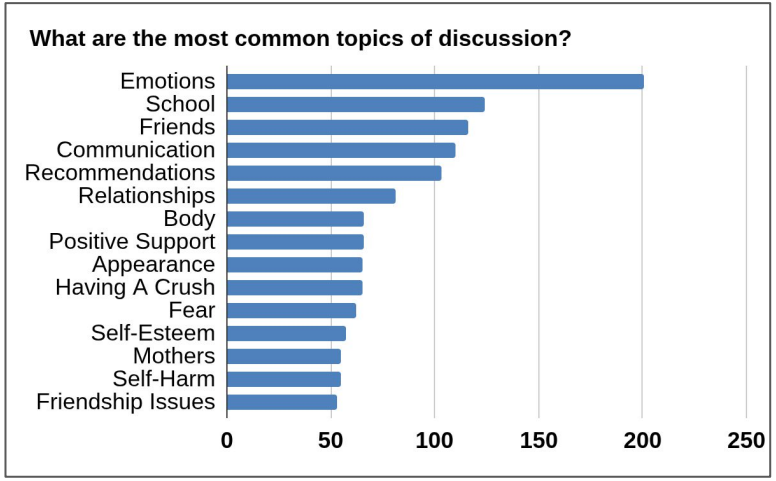


#Insights 171 different topic discussions

When a post is moderated it is topic tagged. This gives us valuable insight into the different issues that users face. 171 different topics have been discussed by Oxfordshire users.

‘Communication’ is a common topic nationally, not just in Oxfordshire. Young people regularly use Tellmi to improve their communication with friends, partners, family and teachers. Through peer support young people increase their confidence and resilience to dealing with difficult conversations.

‘Loneliness’ and ‘Anxiety’ are being discussed less in Oxfordshire than other areas. Self-esteem, appearance and school are all discussed more frequently. This may reflect the needs of a small group of users, however, we will share these insights with local schools and provide suggestions for useful resources to be given to students.



“I just want to look in the mirror and not start crying”

“Please don’t be unkind to yourself. Look in the mirror and draw hearts in lipstick to express love for yourself. Tell yourself you will love and look after your body because it’s the only one you have ❤️”

#Delivery 40% of schools have launched Tellmi

The aim of our outreach programme is to raise awareness and build trust in the Tellmi service, as well as to teach people the importance of seeking help early.

Schools

In year one, we concentrated on the foundational work needed to embed the service in Oxfordshire, from sharing resources to delivering staff training and assemblies.

83% of schools are engaged on some level. Of those, approximately 40% of schools have launched Tellmi and 23% have had further engagement activities.

As we move into year 2, our focus will shift towards delivering more in-person workshops to provide even greater direct support for young people. We would also like to work more closely with key stakeholders within school settings such as MHSTs and school nursing teams to increase engagement with the service.

VCSEs and Community partners

In year one, **we delivered 41 introductory sessions including staff training with VCSEs and wider partners** to support them to embed the service.

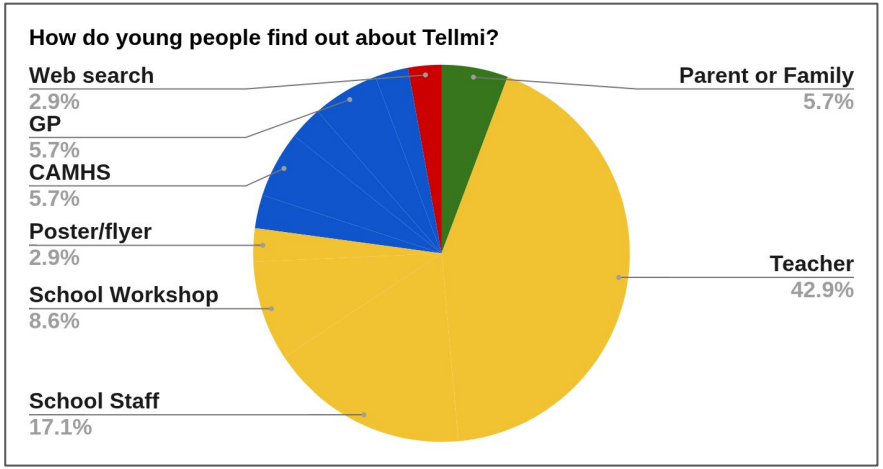
To extend our reach, we ran marketplace stalls and connected with organisations and schools at a number of conferences and events, including the CAMHS Showcase, OxPCF SEND conference, Carers Oxfordshire, TYSS and LCSS partner events.

#Delivery

Clinical Pathway

Whilst Tellmi has seen a good level of uptake amongst schools, in year 2, we would like to build on our relationship with CAMHS and counselling providers to increase referrals to Tellmi. Waitlists for these services in the regions remains high, which highlights a need for further collaboration and integration of Tellmi within clinical settings. A more coordinated and formalised referral system is needed to ensure consistent care, as signposting alone is not enough.

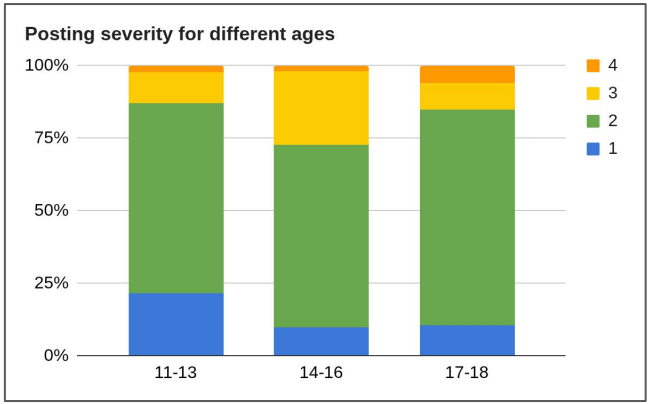
"Thank you so much I think Tellmi is a wonderful service and just what young people need in this generation." Nicole Wareing -Oxfordshire CAMHS Patient and Family / Carer Engagement Coordinator

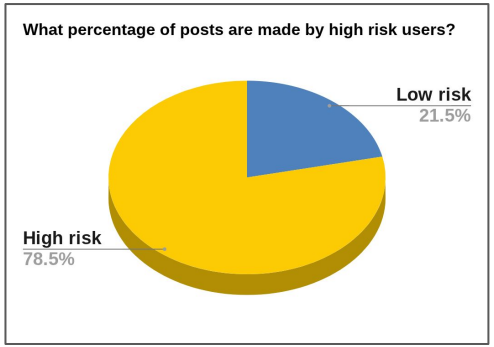


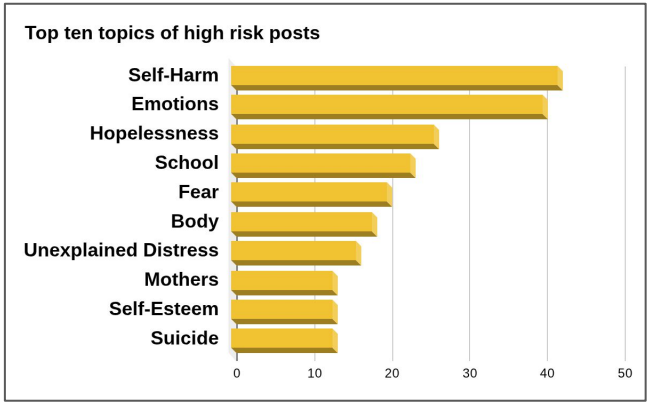
The percentage of young people who find Tellmi through the clinical pathway **20%**

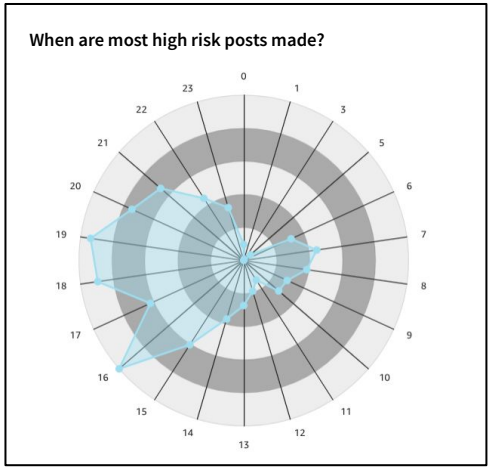
71% The percentage of young people who find Tellmi through school related activities or staff.

#Impact 75 people received high risk support









Between 1st August 2024 and 31st July 2025, Tellmi supported **75 young people with more severe issues**. This is 17% of all Oxfordshire users.

Tellmi's unique preemptive counsellor intervention sets it apart from other service providers. During moderation all posts and replies are risk assessed from level 1 - no risk to 5 - urgent risk. Posts or replies that are identified as level 4 (high risk) or level 5 (urgent) are immediately transferred to a qualified counsellor who checks that the user is safe and helps them to unpack the issue or to access local services or specialist support.

Because Tellmi counsellors can see longitudinal data, it is easy for them to assess changes in risk levels. This saves crucial time and it also spares users from having to reiterate painful problems over and over again.

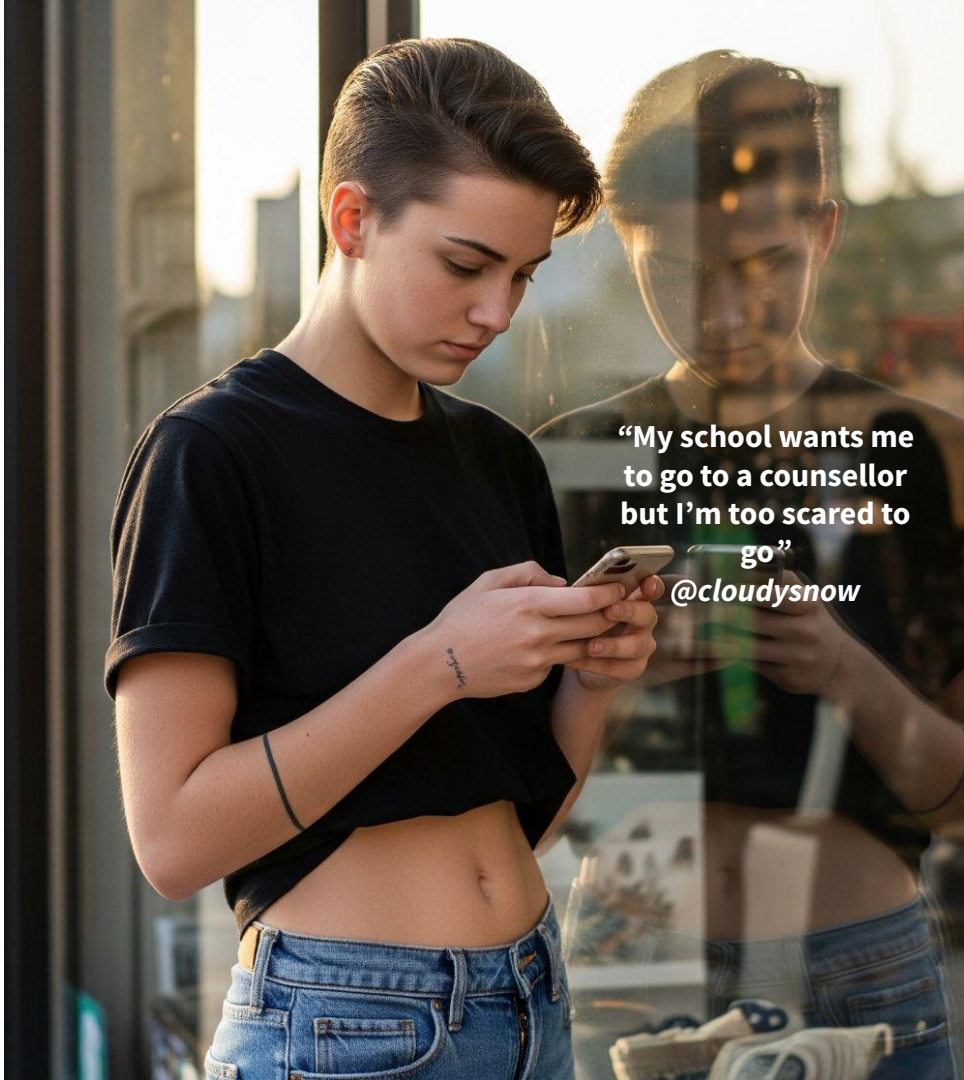
#Case Studies

@cloudysnow is at sixth form and has been a Tellmi user since the end of 2024. Their first two posts described feelings of wanting to die and not having any support. They had only talked to one person before reaching out to Tellmi and that person was no longer available for support.

Over the following months @cloudysnow shared more about how they were feeling and eventually gained the courage to talk to a teacher who suggested that they try to get some counselling. @cloudysnow explained to Tellmi users that they were frightened by the idea of counselling. The community responded by sharing examples of positive counselling experiences.

@cloudysnow has made over 50 replies to help other users. This is an important part of peer support. Research shows that the person giving support often derives more benefit than the person receiving the support.

@cloudysnow is a good example of a long-term user who dips in and out of Tellmi to get support when they need it. Our model for early help means that we are able to provide the right level of support to match the young person's needs.



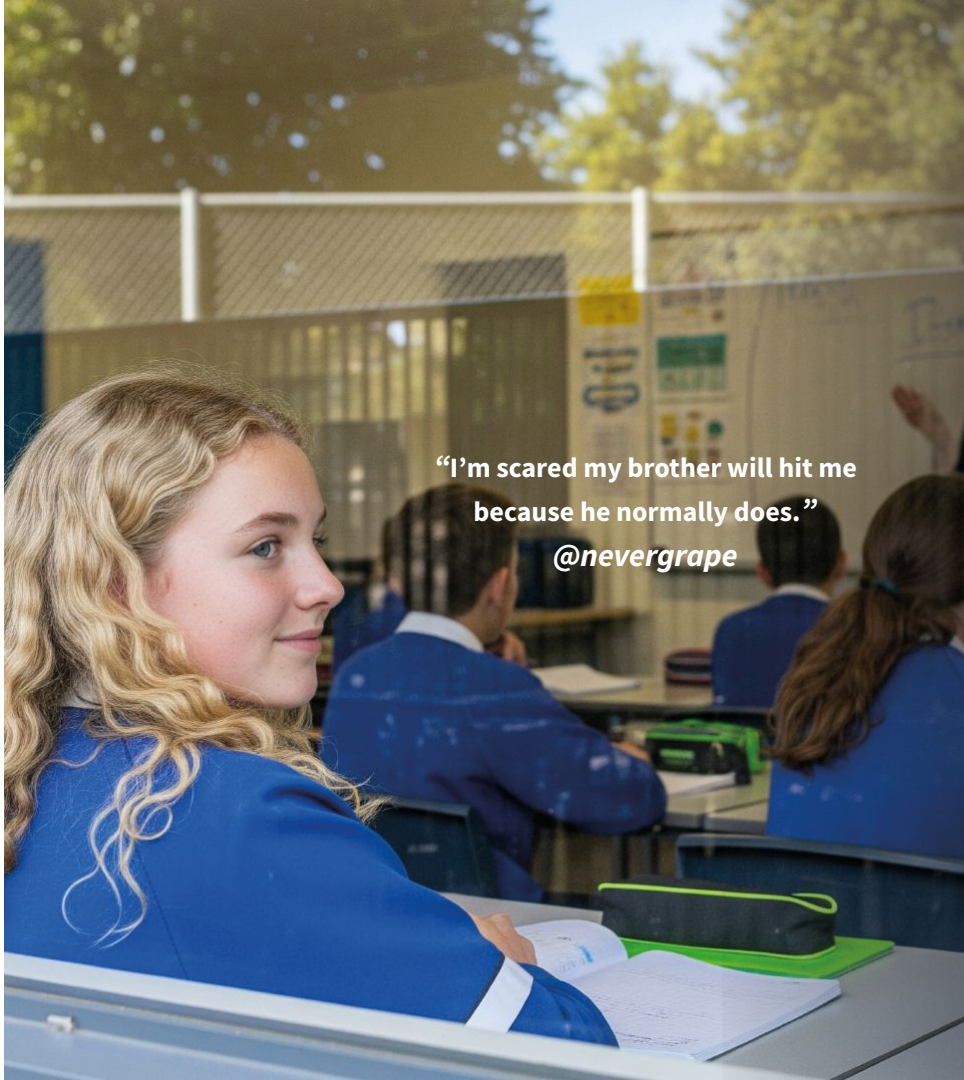
#Case Studies

@bluewasp is in Key Stage 3 at one of our engaged schools. They joined Tellmi in the autumn of 2024 and have used it consistently for the last ten months. They typically make two or three posts a month on a wide range of topics including questions about their sexuality, bullying, how to deal with a violent brother, trouble sleeping and coming to terms with a bereavement.

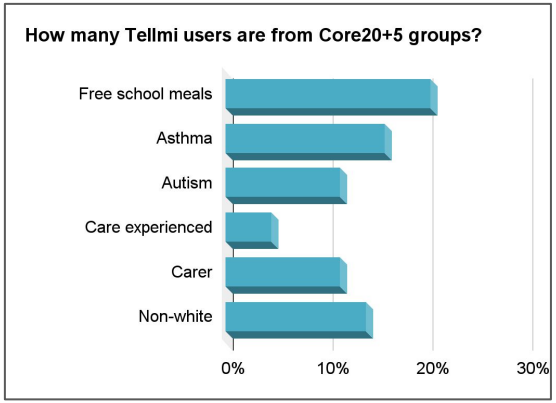
Generally, their posts are mild to moderate needing only support from their peers. However, they have made one post about suicidal ideation which received suppport from the counselling team.

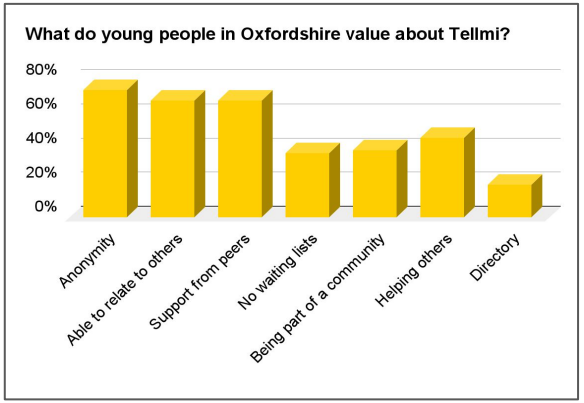
Their activity on Tellmi has slowed down over the summer, which is not uncommon. Without revealing their identity, we will be suggesting to their school that they remind students about Tellmi as young people sometimes forget.

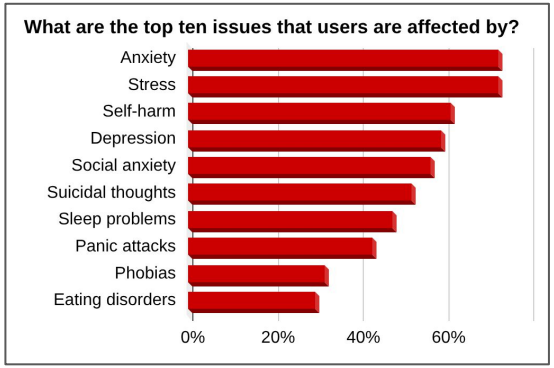
@bluewasp is a good example of a young person who needs occasional help but wouldn't meet the threshold for a formal intervention. Tellmi provides them with a safe place to get help in the moment that they need it.

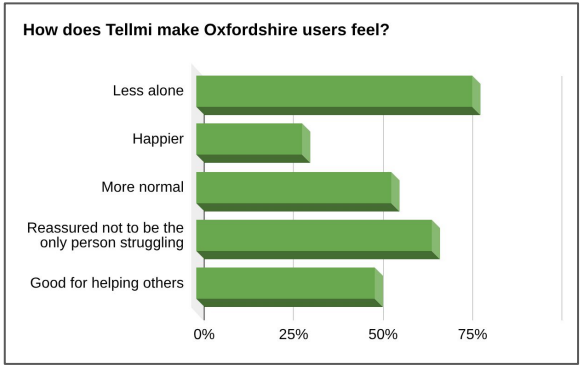


#Outcomes Preliminary results









Indicative early data from the 2024 and 2025 Tellmi Impact Survey (n=44)

Every year Tellmi invites users to complete an impact survey that helps us to understand why young people are using Tellmi and what benefits they get from the service. Usually, around 10% of users complete the survey. The number of respondents from Oxfordshire is currently small because the service is only in its first year. However, these preliminary results which are in-line with the our national results indicate that young people in Oxfordshire are seeing positive outcomes from using Tellmi.

"I get therapy but tellmi helps way more, it's like a support group but a lot easier as it's anonymous, I don't have to worry about going somewhere or seeing other people"

#Value

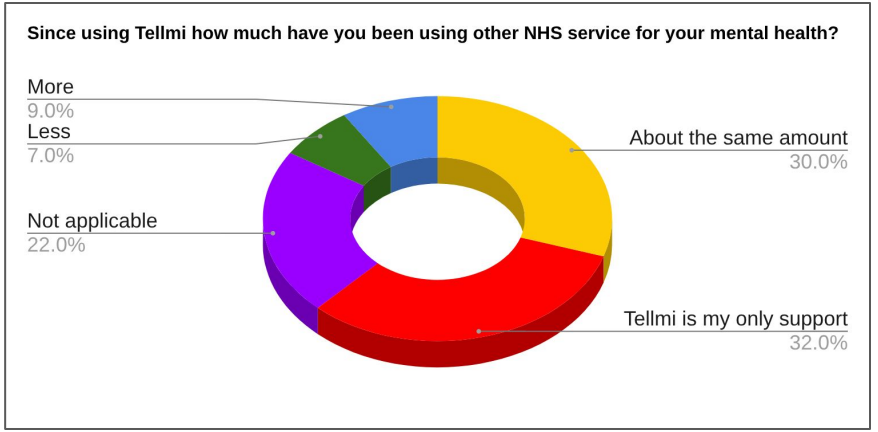
Data from our 2024 & 2025 Impact and Outcomes Survey shows that Tellmi is the only source of support for 32% of users and 7% are using other NHS services less as a result of using Tellmi.

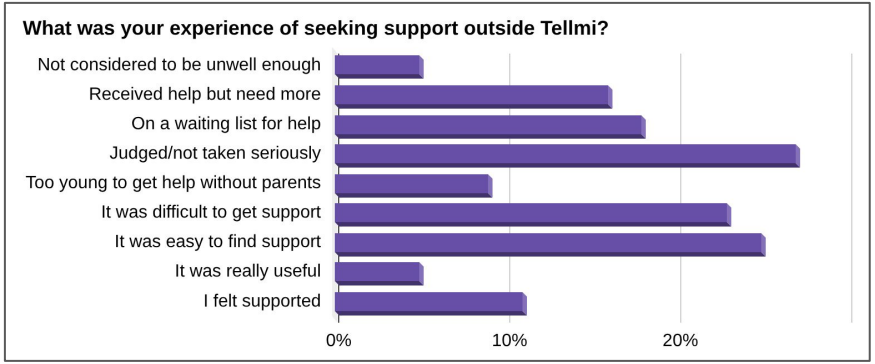
Our data demonstrates the benefits of providing early help to young people who would not otherwise access services. Before finding Tellmi 20% of respondents to our impact survey had wanted help but didn't know who to turn to. Early intervention protects the mental health and wellbeing of users and generates substantive positive returns on investment, not just for health, but for the education, criminal justice and social welfare sectors too. Making Tellmi available in Oxfordshire reduces the risk of issues escalating into much more costly mental health conditions.

Transition to adulthood

Tellmi is only commissioned to provide our premium service to young people aged 11 - 18. Once they reach 19 years old they are no longer able to access the localised Directory or counsellor support for high risk users. However, these young adults can access the free version of Tellmi.

Between August 2024 and July 2025 Tellmi supported 105 adults in Oxfordshire who were over the age of 18.





#Social Value

Tellmi has delivered **social value worth £35,204** against a target of £35,911 for the first year putting us on track to meet the target set for the whole 3-year period.

In April 2024 Tellmi was awarded £200,000 by SBRI-H, an NHS funded scheme, to develop and pilot a new programme to support job seekers who are facing mental health issues. Oxfordshire is the primary beneficiary of this project. We have completed five months of co-creation development activities with job seekers and work coaches from Oxford, Banbury and Witney. The programme is due to go live in October with a target of supporting 100 job seekers from Oxfordshire with mental health support and work experience over a 6-month period.

We have also delivered social value by:

- employing a moderator from Oxfordshire,
- including clinicians from Oxfordshire in our autism research project,
- delivering a webinar on the mental health challenges facing young people with undiagnosed autism,
- supporting young people aged 19+ via the free version of Tellmi, and;
- running mental health training for staff.

#Priorities Meeting Council Objectives

Tellmi has helped Oxfordshire County Council meet local priorities and objectives set out in the Oxfordshire Joint Health and Wellbeing Strategy 2024-2030 and the Director of Public Health Annual Report: Children and Young People's Mental Health.

Council Priority 1: Improved emotional wellbeing and mental health of children and young people, with positive transitions to adulthood

How Tellmi helped Oxfordshire County Council achieve it: 433 young people in Oxfordshire benefited from Tellmi's evidence-based mental health support (some stats from impact survey). By improving wellbeing among young people, Tellmi supports successful transitions into adulthood.

Council Priority 2: A prevention first approach with meaningful measures to tackle drivers of poor mental wellbeing in childhood

How Tellmi helped Oxfordshire County Council achieve it: Tellmi increases access to mental health support to ensure a prevention first approach is taken to address drivers of poor mental health. With no waiting list or assessment, those who may otherwise face barriers to accessing support are able to do so. 32% Tellmi users in Oxfordshire had no other support.

Council Priority 3: Increased and diversified capability to support CYP with their emotional and mental health needs at the earliest opportunity

How Tellmi helped Oxfordshire County Council achieve it: The Tellmi Directory increases access to wider local services and resources, diversifying local capacity to support young people at the earliest opportunity. 160 users accessed 260 different resources in the Tellmi Directory, including 23 local resources.

Council Priority 4: Closer partner collaboration to align and improve our system approach to accessing help

How Tellmi helped Oxfordshire County Council achieve it: Tellmi held 41 introductory sessions including staff training with VCSEs, clinical pathway providers including CAMHS and wider partners to support them to embed the service. 20% of young people found Tellmi through the clinical pathway, and we intend to build on our relationship with CAMHS and counselling services to increase this during the second year of the contract

#Priorities Meeting Council Objectives

Council Priority 5: Strive to reduce mental health problems by addressing wider factors

How Tellmi helped Oxfordshire County Council achieve it: Tellmi addressed wider factors contributing to mental health problems by increasing access to inequality groups. Anonymity and pre-moderation reduces stigma and increases accessibility, particularly for users who face health inequalities and barriers accessing support. They can seek help without fear of retribution in a safe and supportive online community, 14% of Tellmi users are not White British, 11% have a diagnosis of autism, and 20% are on free school meals.

Council Priority 6: Prioritise opportunity, activity, independence, and community

How Tellmi helped Oxfordshire County Council achieve it: Tellmi has engaged with the wider community through activity with schools. 83% of schools in Oxfordshire are engaged on some level and 40% have launched Tellmi. Alongside this, we began direct engagement with young people in Oxfordshire, running three half-term sessions with TYSS, delivering four assemblies to over 400 students from years 7 to 11 and running transition workshops with 180 students to support their move into secondary school. By utilising the Tellmi app to develop mental health self-management skills, we have increased independence among local young people.

Tellmi Annual Impact Report
Oxfordshire
2024 - 2025

CAMHS transformation presentation:

Transitions information HOSC.ppt

November 2025

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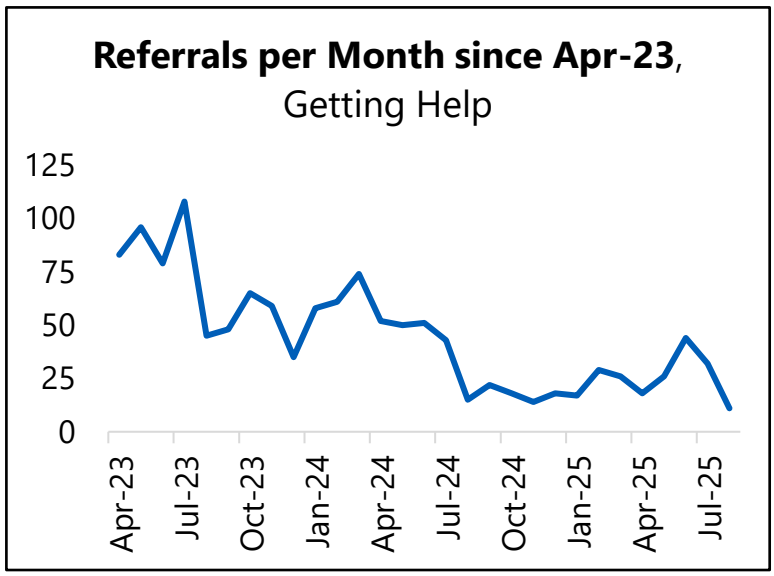
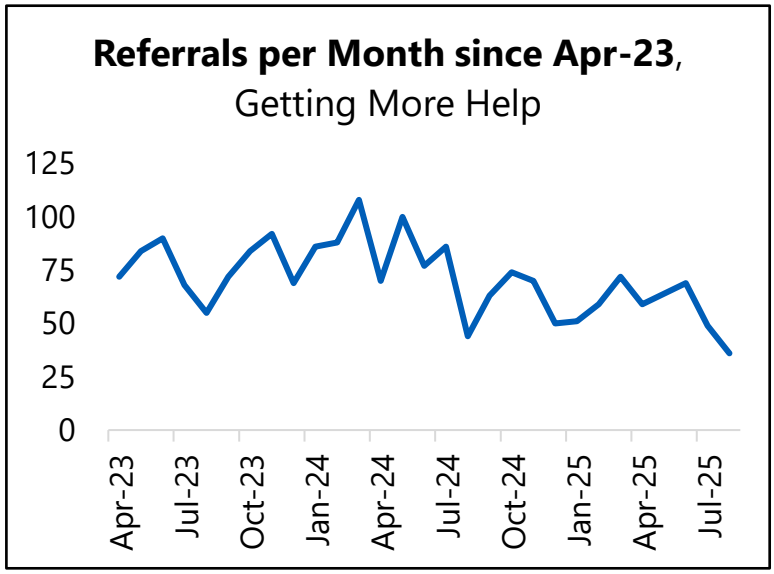
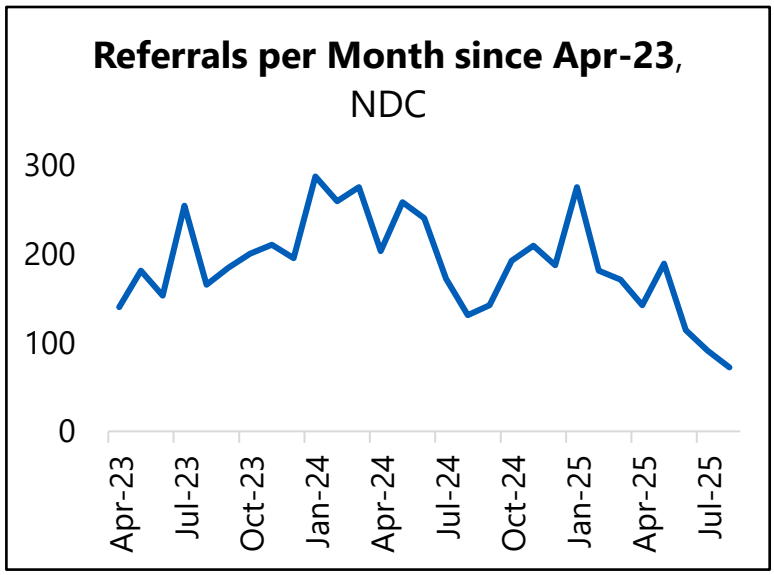
Referrals Per Month

	GH	GMH	NDC
Apr-23	83	72	140
May-23	96	84	181
Jun-23	79	90	153
Jul-23	108	68	254
Aug-23	45	55	165
Sep-23	48	72	184
Oct-23	65	84	200
Nov-23	59	92	210
Dec-23	35	69	195
Jan-24	58	86	287
Feb-24	61	88	259
Mar-24	74	108	275
Apr-24	52	70	203
May-24	50	100	258
Jun-24	51	77	240
Jul-24	43	86	172
Aug-24	15	44	131
Sep-24	22	63	142
Oct-24	18	74	192
Nov-24	14	70	209
Dec-24	18	50	187
Jan-25	17	51	275
Feb-25	29	59	181
Mar-25	26	72	171
Apr-25	18	59	142
May-25	26	64	189
Jun-25	44	69	114
Jul-25	32	49	91
Aug-25	11	36	72







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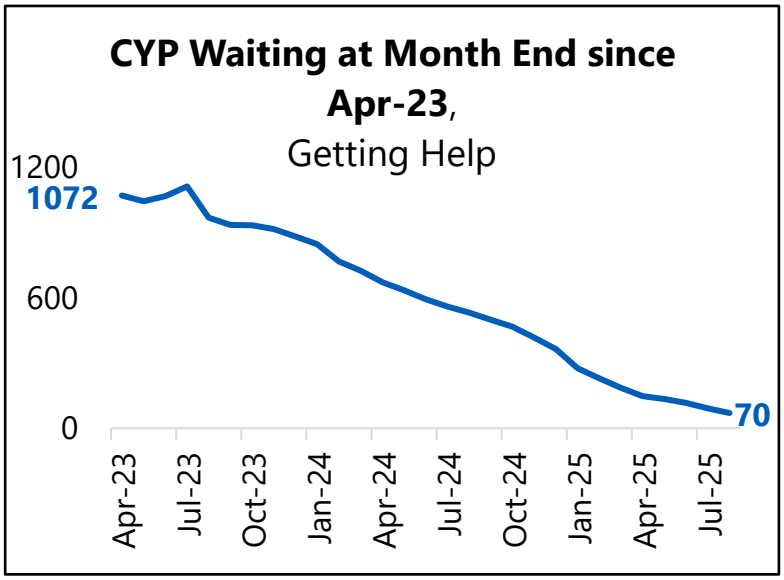
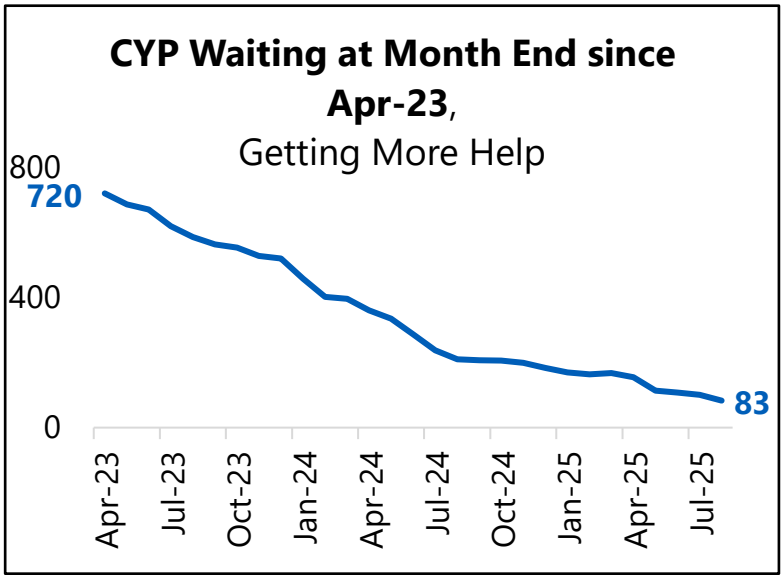
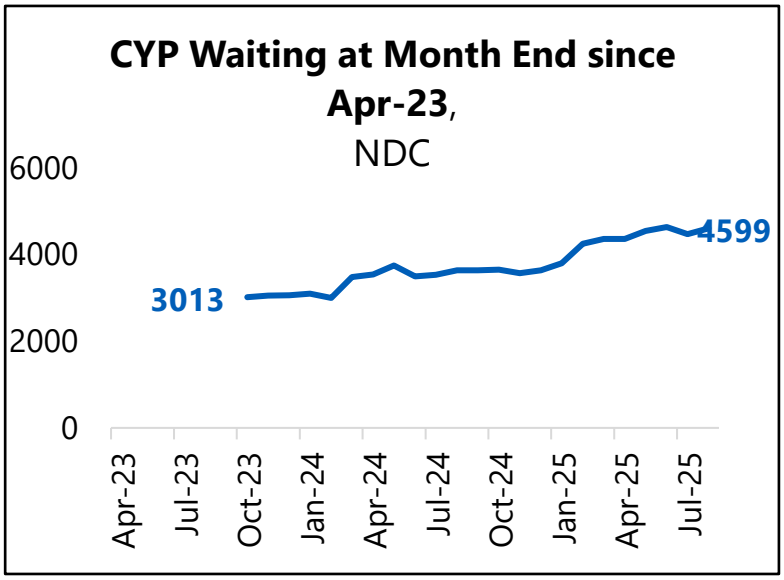
CYP on Waiting List at Month End

	GH	GMH	NDC
Apr-23	1072	720	
May-23	1046	686	
Jun-23	1069	670	
Jul-23	1114	619	
Aug-23	970	586	
Sep-23	937	563	
Oct-23	935	553	3013
Nov-23	918	528	3049
Dec-23	883	520	3060
Jan-24	848	458	3092
Feb-24	768	402	2996
Mar-24	726	396	3478
Apr-24	673	361	3539
May-24	635	335	3743
Jun-24	594	287	3492
Jul-24	561	238	3526
Aug-24	532	210	3634
Sep-24	500	207	3633
Oct-24	468	206	3649
Nov-24	417	199	3569
Dec-24	364	183	3631
Jan-25	276	170	3792
Feb-25	230	164	4242
Mar-25	186	168	4358
Apr-25	147	155	4356
May-25	134	114	4539
Jun-25	116	108	4630
Jul-25	91	101	4470
Aug-25	70	83	4599







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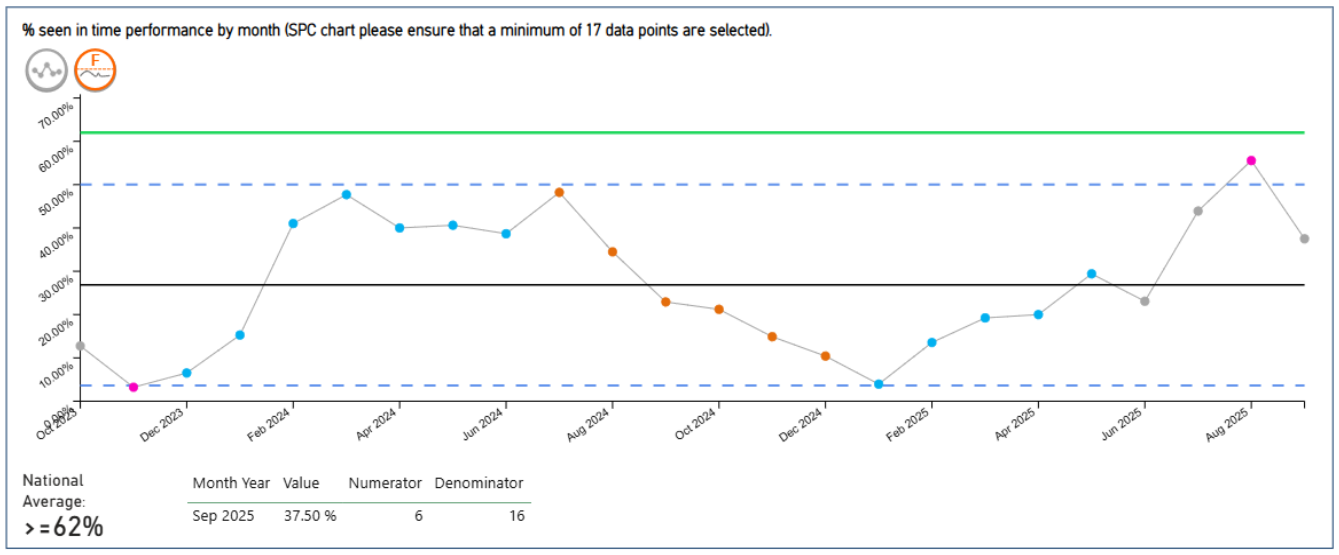
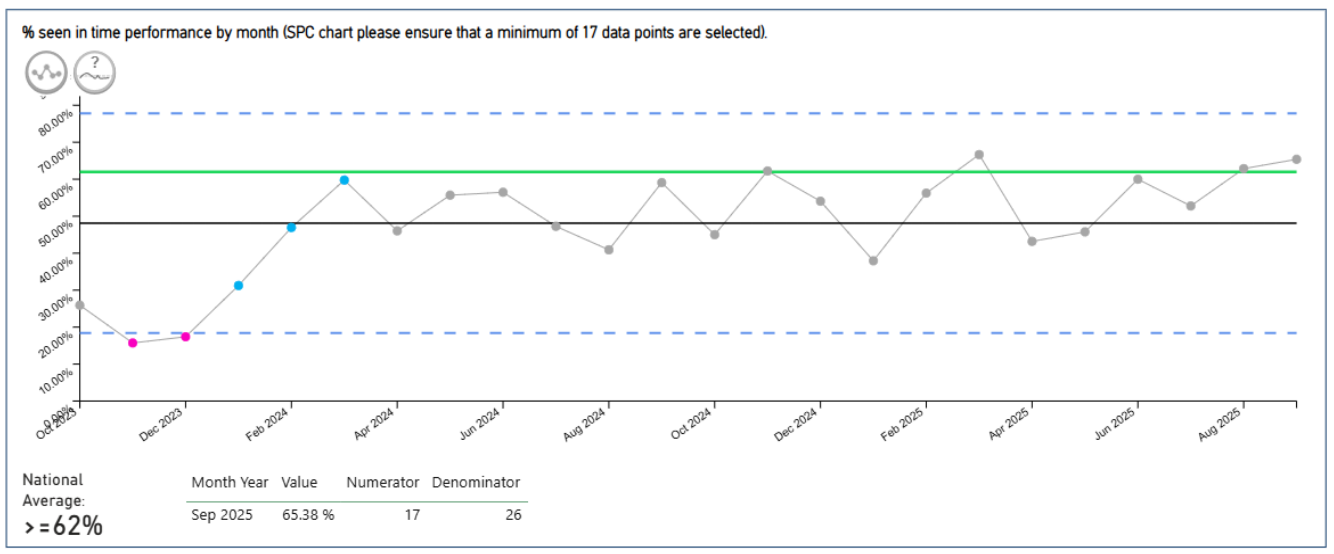
Getting Help 4WW Performance



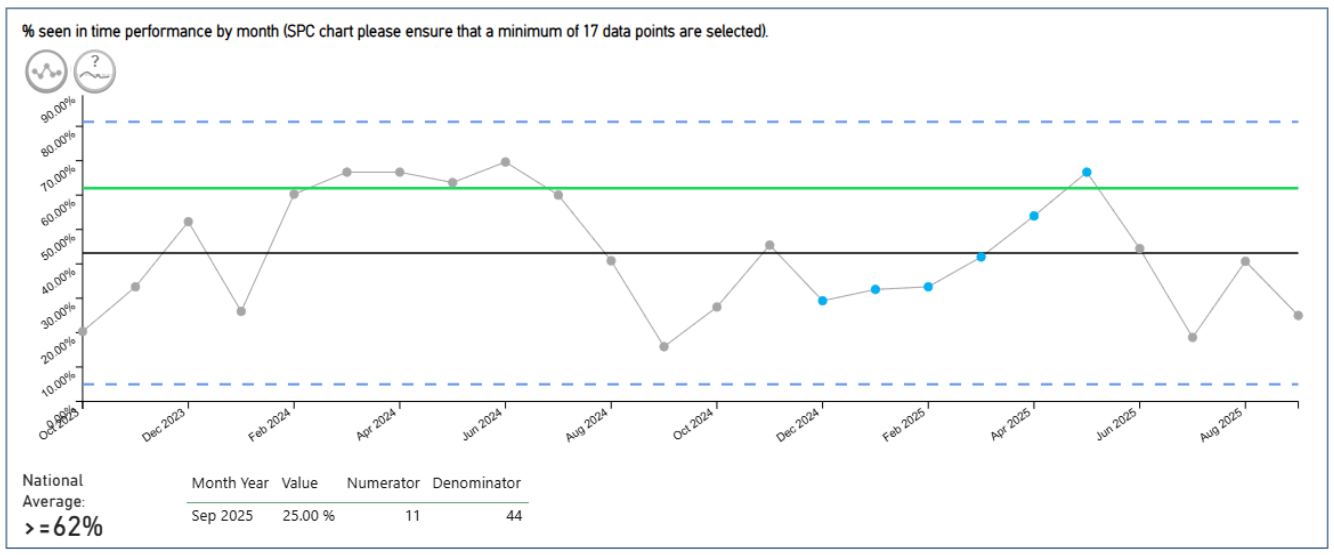
** The full national metric 4 week wait rules are not being used / represented here, as they are still being developed on our internal dashboards*

Getting More Help 4WW Performance



** The full national metric 4 week wait rules are not being used / represented here, as they are still being developed on our internal dashboards*

NDC (All Teams) 4WW Performance



** The full national metric 4 week wait rules are not being used / represented here, as they are still being developed on our internal dashboards*

Optional: NDC Diagnostic Team - Average Waiting time for an Assessment (since Nov-24)

NDC Diagnostic: Average waiting time for CYP who have been assessed (from Nov-24)

	Weeks	Years
Mean	197	3.8
Median	213	4.1

** N.B. The average waiting time in weeks is calculated based on the waiting time of the CYP who have been assessed since November 2024. The waiting time starts from when the CYP are referred to the NDC Diagnostic Team and stops on the date of their assessment*

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Referrals by Age at Referral since Apr-23

Age Group (Years)	Referrals
< 5	19
5	237
6	523
7	640
8	678
9	601
10	673
11	580
12	850
13	918
14	946
15	959
16	703
17	520
> 18	16
Total	**8863**

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Referrals by School since Apr-23

School	Referrals
Unknown	1295
King Alfred's	153
Didcot Girls' School	151
The Warriner School	142
Home Schooling	134
Wood Green School	130
The Cherwell School	120
The Marlborough Church of England School	114
John Mason School	114
North Oxfordshire Academy	111
Larkmead School	111
Cheney School	109
Wallingford School	108
The Cooper School	97
Bartholomew School	97
Matthew Arnold School	96
The Oxford Academy	93
Wheatley Park School	93
Faringdon Community College	90
Chipping Norton School	87
Oxford Spires Academy	84
Gosford Hill School	81
OXF-The Bicester School	80
Lord Williams's School	80
The Henry Box School	79
Wykham Park Academy	78
Carterton Community College	73
St Birinus School	71
Burford School	68
Abingdon and Witney College	66
Aureus School	65
Heyford Park Free School	62
Chenderit School	56
Gillotts School	56
Fitzharrys School	51
The Blake Church of England Primary School	48
Europa School Uk	47
Blessed George Napier Catholic School and Sports College	46
OXF-Whitelands Academy	45
Charlton Primary School	43
Banbury and Bicester College (Banbury Campus)	42

Referrals by School since Apr-23

School	Referrals
The Swan School	41
Eynsham Community Primary School	41
Not in Education, Employment or Training (NEET)	40
Bure Park Primary School	40
Hill View Primary School	40
Stephen Freeman Community Primary School	39
Langford Village Community School	36
Larkrise Primary School	34
Pegasus School	34
Bloxham Church of England Primary School	34
St John the Evangelist CofE VA Primary School	33
Icknield Community College	33
Hanborough Manor CofE School	32
Hanwell Fields Community School	32
Edith Moorhouse Primary School	32
Longfields Primary and Nursery School	30
Barley Hill Primary School	30
St Nicolas Church of England Primary School, Abingdon	30
Northern House School	29
OXF-Langtree School	29
Bayards Hill School	28
Chilton County Primary School	28
Caldecott Primary School	28
Dunmore Primary School	28
Cutteslowe Primary School	27
Wheatley Church of England Primary school	27
OXF-UTC Oxfordshire	27
North Kidlington Primary School	27
Greyfriars Catholic School	26
John Blandy Primary School	26
Millbrook School	26
Tyndale Community School	25
Northbourne Church of England Primary School	25
Harriers Banbury Academy	25
Glory Farm Primary School	25
St Nicholas CofE Primary School	24
Southwold County Primary School	24
Wantage Church of England Primary School	24
Windmill Primary School	24
St John's Primary School	23
Edward Feild Primary School	23

Referrals by School since Apr-23

School	Referrals
Benson Church of England Primary School	23
Wood Farm Primary School	23
Hardwick Primary School	23
Manor School	23
Oxford High School GDST	23
Gateway Primary School	22
Gagle Brook Primary School	22
Witney Community Primary School	22
Orchard Meadow Primary School	21
St Edburg's Church of England (VA) School	21
Rush Common School	21
Five Acres Primary School	20
Christopher Rawlins Church of England Voluntary Aided Primary School	20
Tackley Church of England Primary School	20
Burford School and Community College	20
West Witney Primary School	20
St Nicholas' Church of England Infants' School and Nursery Class, Wallingford	20
Willowcroft Community School	20
King's Meadow Primary School	20
Fir Tree Junior School	20
Queen Emma's Primary School	20
Rose Hill Primary School	20
OXF-The Iffley Academy	20
Windale Community Primary School	19
Headington School	19
Garsington Church of England Primary School	19
Cholsey Primary School	19
All Saints Church of England (Aided) Primary School	19
St Kenelm's Church of England (VC) School	19
Church Cowley St James Church of England Primary School	18
Bampton CofE Primary School	18
Marcham Church of England (Voluntary Controlled) Primary School	18
Carterton Primary School	18
St Mary's Church of England (Aided) Primary School, Chipping Norton	18
Chesterton Church of England Voluntary Aided Primary School	18
Queensway School	18
Watlington Primary School	17
Sutton Courtenay CofE Primary School	17
St Mary and John Church of England Primary School	17
OXF-Middleton Cheney Primary Academy	17
Magdalen College School	17

Referrals by School since Apr-23

School	Referrals
Hagbourne Church of England Primary School	16
Woodeaton Manor School	16
St Swithun's CofE Primary School	16
Drayton Community Primary School	16
John Henry Newman Academy	16
Orchard Fields Community School	16
St Philip and James' Church of England Aided Primary School Oxford	16
OXF-Sonning Common Primary School	16
Sibford School	16
Cranford House School Trust Limited	16
St Gregory the Great Catholic Secondary School	16
West Kidlington Primary School	16
Ducklington Primary School	16
Meadowbrook College	16
Ladygrove Park Primary School	16
St Leonard's Church of England Primary School	16
Brookside Primary School	16
The Elms Primary School	15
Abbey Woods Academy	15
William Morris Primary School	15
St Helen and St Katharine	15
Dashwood Banbury Academy	15
Wychwood Church of England Primary School	15
Grove Church of England School	14
Tower Hill Community Primary School	14
Aureus Primary School	14
Bicester Community College	14
Folly View Primary	14
Hook Norton Church of England Primary School	14
St Joseph's Catholic Primary School, Banbury	14
Aston and Cote Church of England Primary School	14
The Grange Community Primary School	14
Oxford St Nicholas' Primary School	14
The Batt Church of England Voluntary Aided Primary School	14
Cokethorpe School	13
New Marston Primary School	13
John Hampden Primary School	13
Oxford Tutorial College	13
St Edmund's Catholic Primary School	13
Langtree School	13
GEMS Primary Academy	13

Referrals by School since Apr-23

School	Referrals
Abingdon School	13
St Blaise CofE Primary School	13
Enstone Primary School	13
The Downs School	13
Botley School	13
Chalgrove Community Primary School	12
St Joseph's Catholic Primary School, Carterton	12
Harwell Primary School	12
Bishop Loveday Church of England Primary School	12
Standlake Church of England Primary School	12
Thameside Primary School	12
William Fletcher Primary School	12
Launton Church of England Primary School	12
Stockham Primary School	12
St Christopher's Church of England School, Cowley	12
Charlbury Primary School	12
d'Overbroeck's College	12
East Oxford Primary School	11
Woodstock Church of England Primary School	11
Wolvercote Primary School	11
Holy Trinity Catholic School, Chipping Norton	11
Badgemore Primary School	11
Futures Institute Banbury	11
Headington St Andrew's Church of England Primary School	11
St Ebbe's Church of England Aided Primary School	11
Crowmarsh Gifford Church of England School	11
OXF - St Frideswide Church of England Primary School	11
Wootton St Peter's Church of England Primary School	11
Stanton Harcourt CofE Primary School	11
Wychwood School	11
Faringdon Junior School	10
Rye St Antony School	10
Great Rollright Church of England (Aided) Primary School	10
Trinity Church of England Primary School	10
Brize Norton Primary School	10
Madley Brook Community Primary School	10
The Hendreds Church of England School	10
Stonesfield School	10
St Barnabas' Church of England Aided Primary School	10
OXF-Oxford Spires Academy	10
St Joseph's Catholic Primary School, Thame	10

Referrals by School since Apr-23

School	Referrals
Orion Academy	10
Clanfield CofE Primary School	10
Dr South's Church of England Primary School	10
Burford Primary School	9
Our Lady of Lourdes Catholic Primary School, Witney	9
North Leigh Church of England (Controlled) School	9
St John Fisher Catholic Primary School, Littlemore	9
Great Milton Church of England Primary School	9
Bladon Church of England Primary School	9
New Hinksey Church of England Primary School	9
Horspath Church of England Primary School	9
Appleton Church of England (A) Primary School	9
Cumnor Church of England School (Voluntary Controlled)	9
Our Lady's Abingdon	9
The Unicorn School	9
OXF-Kings Sutton Primary School	9
Barton Park Primary School	9
Longworth Primary School	9
OXF-Woodcote Primary School	9
Hailey Church of England Primary School	9
Dragon School	9
St Francis Church of England Primary School	9
Leafield Church of England (Controlled) Primary School	9
Long Furlong Primary School	9
West Oxford Community Primary School	9
The King's School	8
OXF-Shrivenham Church of England Controlled School	8
St Edward's School	8
Radley Church of England Primary School	8
OXF-Goring Church of England Aided Primary School	8
St Michael's Church of England Primary School, Steventon	8
Blewbury Endowed Church of England Primary School	8
Freeland Church of England Primary School	8
Kingham Hill School	8
Nettlebed Community School	8
Shipston High School	8
St James Church of England School, Hanney	8
Buckland Church of England Primary School	8
Meadowbrook College (Banbury Campus)	8
Clifton Hampden Church of England Primary School	7
Thomas Reade Primary School	7

Referrals by School since Apr-23

School	Referrals
Deddington Church of England Primary School	7
Brightwell-Cum-Sotwell Church of England (C) Primary School	7
Oxford Montessori Schools	7
Sandhills Community Primary School	7
Carswell Community Primary School	7
Chinnor St Andrew's Church of England Primary School	7
Bletchingdon Parochial Church of England Primary School	7
Mabel Prichard School	7
OXF-Chacombe CEVA Primary Academy	7
St Joseph's Catholic Primary School, Oxford	7
Bloxham School	7
Marston St Michael's CofE Primary School	7
Stanford in the Vale Church of England Primary School	7
Wroxton Church of England Primary School	6
Stadhampton Primary School	6
Kirtlington Church of England Primary School	6
Chilworth House School	6
Sibford Gower Endowed Primary School	6
St Aloysius' Catholic Primary School	6
The Manor Preparatory School	6
Long Wittenham (Church of England) Primary School	6
Uffington Church of England Primary School	6
Fritwell Church of England Primary School	6
Combe Church of England Primary School	6
RAF Benson Community Primary School	6
Swalcliffe Park School Trust	6
St Mary's Catholic Primary School, Bicester	6
Kineton High School	6
Marsh Baldon Church of England Controlled School	6
Shiplake Church of England School	6
Gateway School	6
Tudor Hall School	6
Kingham Primary School	6
St Thomas More Catholic Primary School, Kidlington	6
Sir William Borlase's Grammar School	6
OXF-Chipping Warden Primary Academy	5
OXF-Longcot and Fernham Church of England Primary School	5
St Hugh's School	5
LVS Oxford	5
Oakley Church of England Combined School	5
Bicester Technology Studio	5

Referrals by School since Apr-23

School	Referrals
Cropredy Church of England Primary School	5
Dorchester St Birinus Church of England School	5
Wantage Academy Primary School	5
The Ridgeway Church of England (C) Primary School	5
Hillcrest Park School	5
Checkendon Church of England (A) Primary School	5
St Johns CofE Academy	5
Mulberry Bush School	5
Beckley Church of England Primary School	5
New College School	5
Didcot Sixth Form	4
St Amand's Catholic Primary School	4
Chadlington Church of England Primary School	4
Shellingford Church of England (Voluntary Aided) School	4
Whitelands Park Primary School	4
Our Lady's Catholic Primary School	4
Reading College	4
St John's Catholic Primary School, Banbury	4
Fitzwaryn School	4
Longford Park Primary School	4
Chandlings	4
Cherry Fields primary school	4
Cowley Our Lady's Catholic Primary School	4
Maiden Erlegh Chiltern Edge	4
Charlton-on-Otmoor Church of England Primary School	4
Bishopswood School	4
Sunningwell Church of England Primary School	4
Kidmore End Church of England (Aided) Primary School	4
South Moreton School	4
Fringford Church of England Primary School	3
The Oratory Preparatory School	3
Hornton Primary School	3
City of Oxford College	3
Radley College	3
St Peter's Church of England Primary School, Cassington	3
John Watson School	3
St Peter's Church of England School, Alvescot	3
Huckleberry Therapeutic School	3
Tower Hill Primary School	3
Woodcote Primary School	3
Aylesbury Grammar School	3

Referrals by School since Apr-23

School	Referrals
The Henley College	3
Abingdon Preparatory School	3
Aston Rowant Church of England Primary School	3
Henley Sacred Heart Catholic Primary School	3
Dry Sandford Primary School	3
Aylesbury High School	3
St Mary's Church of England Primary School, Banbury	3
Valley Road School	3
Witney Windrush C of E Primary School	3
Danesfield School	3
OXF-South Stoke Primary School	3
Long Crendon School	3
Marsh Gibbon CofE Infant School	3
Springfield School	3
Bruern Abbey School	3
OXF-Marsh Gibbon CofE Primary School	3
Tetsworth Primary School	3
Bishop Carpenter Church of England Aided Primary School	3
St Laurence Church of England (A) School	2
Meadowbrook College (Abingdon)	2
Peppard Church of England Primary School	2
Beech Lodge School	2
WIL-Lydiard Park Academy	2
BRK-Maiden Erlegh School in Reading	2
OXF-St Christopher's Church of England School, Lechlade	2
St Mary's School	2
Stratford Girls Grammar School	2
St Michael's Church of England Combined School	2
WIL-Longleaze Primary School	2
Little Milton Church of England Primary School	2
Manor Primary School	2
Great Tew County Primary School	2
Bardwell School	2
North Hinksey Church of England Primary School	2
Icknield School	2
The Beaconsfield School	2
Endeavour Academy, Oxford	2
Waddesdon Church of England School	2
WIL-Highworth Warneford School	2
OXF-Kingfisher School	2
Rupert House School	2

Referrals by School since Apr-23

School	Referrals
Grendon Underwood Combined School	2
Apprenticeship	2
Brill Church of England School	2
Chipping Campden School	2
Basildon C.E. Primary School	2
Windrush Valley School	2
Wendover Chiltern Academy Secondary	2
City of Oxford College, Activate Learning	2
Frank Wise School	2
The Oratory School	2
The Cotswold School Academy	2
Moulsford Preparatory School	2
St Joseph's Catholic Primary School	2
Shenington Church of England Primary School	2
OXF-Newbottle and Charlton Church of England Primary School	2
The Treehouse School	2
Sir Thomas Fremantle School	2
Brailes C.E. Primary School	2
Whitchurch Combined School	2
Dr Radcliffe's Church of England School	2
Ewelme CofE Primary School	2
Mill Lane Community Primary School	2
Slade Nursery School	1
St Swithun's School	1
Avon Park School	1
St Clare's, Oxford	1
WIL-Nyland School	1
Farmor's School	1
Wootton-by-Woodstock Church of England (Aided) Primary School	1
Finmere Church of England Primary School	1
Brightwalton C.E. Aided Primary School	1
King's High School	1
Sir Henry Floyd Grammar School	1
Haddenham Junior School	1
Sir William Ramsay School	1
Kings Oxford	1
South Stoke Primary School	1
The Grange School	1
Faringdon Infant School	1
Naphill and Walters Ash School	1
Cuddington and Dinton CofE School	1

Referrals by School since Apr-23

School	Referrals
Finstock Church of England Primary School	1
Alfriston School	1
Bledlow Ridge School	1
Activate Learning	1
The Hill Primary School	1
Steeple Claydon School	1
The Ilsleys Primary School	1
WIL-The Farringdon Centre	1
Fir Tree Primary School and Nursery	1
Stokenchurch Primary School	1
The Mandeville School	1
Streatley C.E. Voluntary Controlled School	1
OXF-Watchfield Primary School	1
Grandpont Nursery School	1
St John the Evangelist C.E. Nursery and Infant Sch	1
BaNES - Westfield Primary school	1
OXF-Whitchurch Primary School	1
BRK-Red Balloon Learner Centre Reading	1
New Horizons Learning Centre - Courtney	1
West Herts College	1
Chesham Bois Church of England School	1
Longwick Church of England Combined School	1
Pangbourne College	1
Emmer Green Primary School	1
Bracken Leas Primary School	1
Shiplake College	1
Caversham Park Primary School	1
Christ Church Cathedral School	1
Princes Risborough	1
European School	1
Queen Anne's School	1
Goring Church of England Aided Primary School	1
Folly Hill Infant School	1
WIL-Minety Church of England Primary School	1
Queensmead House School	1
WIL-Royal Wootton Bassett Academy	1
Cothill House	1
Maiden Erlegh School	1
Lewknor Church of England Primary School	1
Stoke Row Church of England School	1
BUC-Beachborough School	1

Referrals by School since Apr-23

School	Referrals
Witney St Mary's Church of England Infant School	1
Radnage CofE Primary School	1
Iver Heath Infant School and Nursery	1
Chilworth House Upper School	1
Summer Fields School	1
Oak Tree Nursery and Primary School	1
Banbury and Bicester College (Bicester Campus)	1
St Mary's Church of England School	1
Great Marlow School	1
BUC-Dair House School	1
Denham Village School	1
St Mary's School Ascot	1
The Abbey School Reading	1
Roundwood Primary School	1
Great Western Academy	1
Watchfield Primary School	1
Croughton All Saints CofE Primary School	1

Oxford Health
NHS Foundation Trust

Oxfordshire CAMHS Communication survey work (updated October 2025)

Summary of approach and findings together with next steps

Introduction

A quantitative survey (with limited qualitative elements) took place during February and March 2025.

The survey was informed by professionals working in CAMHS and as well as communication aimed to provide information to help other projects (ie ADHD/autism assessment waits.

CAHMS worked with trust communications, Oxfordshire County Council, Oxfordshire PCF, Oxfordshire Healthwatch to share on website, flyers, Instagram, newsletters, talks and other mediums.

It was primarily a communications survey but other questions included. This meant the feedback received is useful for many other projects – and commissioners.

Artificial intelligence was used to analyse some of the quantitative comment.

Surveys took place before any tactical interventions were made to communications so as to provide a baseline.

People involved

The following groups were invited to take part in the survey:

1) Parent/guardian of child/ren or young person not currently using Oxfordshire CAMHS services click
2) Child/ren or young person not currently using Oxfordshire CAMHS services click
3) Parent/guardian of child/ren or young person waiting for assessment or treatment by Oxfordshire CAMHS
4) Child/ren or young person waiting for assessment or treatment by Oxfordshire CAMHS click
5) Parents/guardians whose children/young people are in treatment
6) Children/young people in treatment
7) GPs

8) Professionals working in education

Responses

In total, more than 600 young people, parents, professionals and others responded.

The vast majority of respondents were parents (about 450).

Summary conclusions

- Patients (and their parents) regard GPs, healthcare professionals and other professionals as the access point for CAMHS. But these groups report not being informed enough about waiting times and other aspects of some services. These groups need to be better informed with reliable and regular information.
- More than two thirds of GPs find it difficult sometimes or always to make a referral to CAMHS. We need to understand more about this but the forms process has been blamed.
- 7 out of 10 GPs report that they would probably use a consultation option if it were available. I understand that one is available and so this may be an issue of communication.
- Parents are the decision-makers about their children's mental health and favour looking for information on the internet about the subject – but they believe others to be looking on social media for this. Other groups believe this too but generally favour the internet also.
- Parents (and children) report about 4 in 10 children using any services while waiting and when parents are asked why, most they say they are not well enough informed to choose. They are also concerned about the waiting lists for such services.
- Children waiting for treatment say they don't know why they are waiting.
- CAMHS is generally contacting parents and children how they wish to be contacted (by emailed letter) but the clarity, content and regularity need to be improved. More information on waiting times is also requested.
- Parents of those waiting for treatment (and patients themselves) believe that the website is worse in terms of its clarity, readability, content and regularity than those who have children in treatment. This may reflect a level of disgruntlement with the service generally.
- Almost 50 per cent of professionals in schools who responded say they have named mental health support.
- More than half of school buy in mental health support from the private or charitable sector

- Professionals in schools generally find it easy to refer, certainly much easier than GPs do – and they are relatively better informed about services and waiting lists
- Half of children in treatment know what CAMHS stands for and a large percentage have searched for CAMHS online. They generally like the website information.
- Children not currently using services are quite inquisitive about CAMHS and look for information about it on the internet and in social media. They think the website is poor.
- Their parents are also inquisitive about CAMHS (50 per cent have looked for it online) and found the website easy to find, although they didn't like the content, its look, and did not find it easy to use or particularly readable.
- Generally, the more parents/patients use CAMHS the better they understand what it stands for
- All respondents feel the biggest barrier to referral is perception of the waiting list - but a considerable number are also worried that appointments "are difficult to get to".

Recommendations

1. **Review existing channels for GPs, healthcare professionals, and schools**. Newsletters might include information about services on offer, waiting times, alternatives and support while waiting.
2. **Consider holding online masterclasses for practices and/or roadshows to take along to GP practice training days to spread the word about CAMHS.**
3. **Conduct follow up focus group work with GPs to understand concerns over the referral form/process.** Once we understand this properly, we can address through training (GPs), change of process of communication.
4. **Identify GP consultation process (if it exists) and communicate this to GPs using the new channel.** If the process does not exist consider its introduction.
5. **Review whether possible to identify "your number in list" for waiting children** and how to communicate this (telephone message/update letter).
6. **Review and improve website.** This is your shopfront. Work with children and parents to get it right. Consider special section for parents on website to help them with additional and relevant information.
7. **Introduce social media presence <u>for signposting</u>**. Work with communications team and children on appropriate channels and relevant

posts which increase understanding of CAMHS services and signpost to the website/schools/GPs.

8. **Review newsletter channel for parents/children waiting for treatment. Work with parents of children currently waiting to understand what would help them.** Consider (carefully) adding information including waiting list information, new initiatives to address waits, services while waiting etc…). Increase frequency.
9. **Review all regular communication (letters and leaflets) for parents/patients** to ensure they are patient-focussed with good readability. Standardise (template) where possible to create consistent messaging.
10. **Look for opportunities to celebrate CAMHS successes** and share these in new channels and with your communications department.

Next steps

Focus groups with GPs, parents, teaching staff, council and social services staff took place during August and September.

Work with young people took place between June and September to understand their social media and web use. A number of children all also working with us to create social media content

All data and information from the research was brought together and presented to CAMHS staff and clinicians in September. There were also presentations to the Young People's Mental Health Board in the same month.

Work is now taking place with senior managers within CAMHS on strategic and tactical responses to the research.

This includes putting in place new channels and creating information and material for use by CAMHs teams

Vicky Norman

Head of Oxfordshire CAMHS

October 2025

OXFORDSHIRE SCHOOL NURSING SERVICE – COMPREHENSIVE UPDATE FOR HOSC (OCTOBER 2025)

Prepared by: Mark Chambers – Head of Children's Services
Date: 31st October 2025

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1. SERVICE REMIT AND SCOPE

The Oxfordshire School Health Nursing Service is part of the newly formed 0–19 Children and Young People's Public Health Service. The School Health Nursing Service formally joined the 0-19 service in September of 2024 as part of the phased implementation of the new integrated service contract. The new service provides Family Nurse Partnership, Health Visiting, School Health Nursing and the screening programmes of Vision Screening and the National Child Measurement Programme (NCMP) as part of 11 new fully integrated locality teams. The school health nursing elements are fully integrated into the new 0-19 but are described in this paper as the school nursing service for ease.

The service is led by Specialist Community Public Health Nurses (SCPHNs) – qualified nurses with master's level training in public health nursing related to children of school age. The team also includes community public health nurses (CPHNs) and school health care assistants working at universal, targeted, and specialist levels to address the full range of health needs of school-aged children (5–19 years). The service operates under the Healthy Child Programme (HCP) framework, delivering both preventative public health functions and support for more complex needs.

Key areas of the remit include:

2. SAFEGUARDING AND CHILD PROTECTION

Safeguarding is a central priority embedded in all activities of the 0-19 teams. School Health Nurses (SHNs) actively identify children and families who may need early help or protection, and they participate in multi-agency child protection processes. SHNs attend strategy meetings and child protection conferences, contribute to child protection plans, and complete health assessments for vulnerable children as needed. They are often the first to notice safeguarding concerns in school settings – for example, SHNs maintain an open-door policy in secondary schools for pupils to drop in with concerns, and they promptly refer serious issues to the Multi-Agency Safeguarding Hub (MASH) whenever required. Senior SHNs also take part in the county's *"Safety in Education"* forum, helping develop practical tools and guidance for safeguarding in schools. This multi-tiered involvement ensures that school nurses play a key role in protecting children and linking with social care, while still focusing on early intervention to prevent issues from escalating.

3. EMOTIONAL WELLBEING AND MENTAL HEALTH

Emotional wellbeing and mental health support are integral to the service's interactions with children and families. Young people can be referred for mental health support by school staff, health or social care professionals, or they may self-refer; access to an SHN is available on-site in every secondary school and college, and parents/carers can also refer via a Single Point of Access (SPA). Young people can also access the School Health Nursing Service confidentially through ChatHealth, a secure text messaging platform that enables them to seek advice and support directly from a nurse. This service is available during school hours and provides a discreet way for pupils to ask questions or discuss concerns without needing a face-to-face appointment, helping to remove barriers to accessing help and making support more approachable for those who may feel anxious or uncomfortable speaking in person.

SHNs work closely with school pastoral teams and counsellors and collaborate with Child and Adolescent Mental Health Services (**CAMHS**) and the new Mental Health Support Teams in schools to ensure students get appropriate help. They attend multi-agency self-harm steering group meetings to share information on emerging risks and resources for youth mental health. In practice, this means that any student struggling with issues such as anxiety, low mood, or self-harm has a clear pathway to get confidential support from the school nurse, who can provide brief interventions or facilitate referrals to specialist services as needed. Emotional health support is woven into every contact – even when a young person presents with a physical issue, SHNs assess and promote mental wellbeing as part of holistic care.

4. SEXUAL HEALTH EDUCATION AND SERVICES

Promoting safe sexual and reproductive health is a significant component of the 0–19 service. School nurses deliver age-appropriate education on topics like healthy relationships, consent, contraception, and STI prevention in various forums – from one-to-one consultations to classroom sessions and assemblies, often integrated into Personal, Social, Health and

Economic (PSHE) education in partnership with schools. Over 90% of Oxfordshire's SHNs are trained (or in training) to provide contraceptive counselling, and many have extended qualifications enabling them to directly deliver sexual health services to young people. For example, most secondary school nurses can supply condoms, perform pregnancy tests, and prescribe emergency contraception or the progestogen-only contraceptive pill under Patient Group Directions. Additionally, a subset of clinically specialised staff (with diplomas from the Faculty of Sexual and Reproductive Healthcare) can offer a broader range of contraception, including combined oral contraceptives, contraceptive injections or patches, and even fit contraceptive implants at college sites. These enhanced services mean that many students can conveniently access contraception and sexual health advice *at school*, from a trusted nurse, rather than needing to attend an off-site clinic. The sexual health lead nurse for the county is actively involved in Oxfordshire's Sexual Health Action Partnership, working with commissioners and providers of sexual health services to align school-based efforts with wider public health initiatives and to share learning about local needs.

5. IMMUNISATION COORDINATION

While immunisations themselves are delivered by the dedicated **School-Aged Immunisation Service** within Oxford Health, the school nursing team plays a supportive coordinating role. School nurses help ensure that particularly vulnerable or hard-to-reach children and young people are up to date with vaccinations. At key transition points (such as entry to primary school, transition to secondary at Year 6/7, and school leaving age), SHNs review vaccination records; if a child has missing immunisations, they will liaise with the Immunisation Team to follow up with the family. In their daily work, SHNs also encourage uptake of vaccines by addressing parental questions or concerns and referring families to the immunisation clinics as needed. This collaborative approach helps raise immunisation coverage and ensures no children "fall through the cracks" – for example, a child with complex needs or lacking GP registration who might otherwise miss routine jabs can be identified by the school nurse and linked into the immunisation programme. Looking ahead, SHNs are set to support each of their named schools in improving vaccine consent uptake by working collaboratively with school staff, parents, and pupils to address barriers and promote the importance of immunisation.

6. SUPPORT FOR LONG-TERM CONDITIONS AND SPECIAL NEEDS

School nurses provide important support for children with long-term health conditions and disabilities in the school setting. They develop individualised health care plans for students who need them (for conditions like diabetes, epilepsy, severe asthma, severe allergies, etc.), working closely with specialist hospital or community nurses and paediatricians to ensure continuity of care between home, clinic, and school. For any child on their caseload with complex medical needs, the SHN can coordinate referrals to additional services (for example, to physiotherapy, continence services, or specialist charities) so that all needs are met holistically. Importantly, Oxfordshire has a dedicated specialist school nurse for Special Educational Needs and Disabilities (SEND) who leads on improving support pathways for children with SEND. Under this leadership, the service is developing more inclusive care pathways and "episodes of care" tailored to SEND pupils, to ensure they receive equitable support. In practice, this might include, for example, proactive transition support for a child with autism moving from primary to secondary, or close monitoring of a child with a chronic illness to adjust their care plan as they grow. The school nurses' goal is to help children with long-term conditions manage their health effectively so they can participate fully in school life.

(The service's remit also extends to broader public health promotion. School nurses contribute to PSHE curricula beyond the topics above – e.g. delivering sessions on hand hygiene, oral health, healthy eating, and substance misuse – and they partner with public health programs like The Training Effect to address issues such as youth vaping or internet safety. These activities are detailed under "Interventions Delivered" and "Outcomes" later in this report.)

7. COVERAGE AND ACCESS

7.1 Coverage: The Oxfordshire school nursing service covers *every* maintained school in the county, as well as academies and colleges, through locality-based teams. In total, the service is responsible for **5 further education colleges, 43 secondary schools, and 254 primary schools** in Oxfordshire. (Special schools are supported mainly by special school nurses who are part of the Children's Community Nursing Team in Oxford Health, but the school nursing teams provide

advice and resources to those schools' staff for PSHE and public health initiatives.) This comprehensive coverage ensures that virtually all school-aged children (including those who are home-educated, detailed below) have access to a school nurse.

7.2 Caseloads: As of a recent snapshot on 9 October 2025, the service was actively supporting **4,986 children and young people** across Oxfordshire through targeted or specialist interventions. *Targeted* support refers to short-term or early-intervention help for identified needs, while *specialist* support indicates ongoing or more intensive involvement for higher-need cases. Table 1 below provides a breakdown of the number of pupils receiving targeted and specialist support:

Education Setting	Receiving Targeted Support	Receiving Specialist Support
Primary school	637 pupils	802 pupils
Secondary school	1,007 pupils	1,138 pupils
Further Education (College)	35 students	254 students
Electively Home Educated	29 young people	13 young people
Total	**1,708 (targeted)**	**2,207 (specialist)**

Table 1: Children and young people receiving targeted or specialist school nurse support (Oct 2025).

In addition to the nearly 3,915 pupils in the above table, the service is supporting approximately **1071 children who require emergency medications** while at school. These are students with conditions like severe allergies or epilepsy – the school nurses ensure they have up-to-date emergency care plans and that school staff are trained to administer medications such as epinephrine auto-injectors or rescue anticonvulsants.

7.3 Referral Pathways and Accessibility: Students and families can access the school nursing service through multiple referral routes designed for ease of access. These include:

- **Self-referral:** Secondary school and college students can approach the school nurse directly during the nurse's weekly school clinic/drop-in. Self-referral is encouraged to empower young people to seek help independently.
- **School staff referral:** Teachers, pastoral staff, or SENCOs can refer a student to the SHN (typically by filling a simple referral form or contacting the locality team or by speaking directly the SHN when onsite).
- **Parent/carer referral:** Parents of children of any age can refer to the service, either via the Single Point of Access (**SPA**) phone/email system or through the dedicated texting service called ChatHealth.
- **Single Point of Access (SPA):** A centralised SPA triages all referrals for 5–19 services. For primary school-aged children (5–11), referrals (often from parents, school staff, GPs, etc.) are funnelled through the SPA, which then allocates to the appropriate locality team.
- **ChatHealth text service:** This is a confidential SMS service – there is a separate line for young people (11–19 years) and for parents of younger children. Young people can text issues or questions (ranging from emotional health to sexual health queries), and a school nurse responds within one working day. Parents use ChatHealth mostly to seek advice on topics like bedwetting (enuresis), behaviour challenges, sleep, or diet.
- **Scheduled drop-in clinics:** Each secondary school and college has at least a **weekly nurse presence** (the day(s) are publicised on school websites and student noticeboards). Students know when their SHN is on-site and can drop in without appointment. This consistent presence helps normalise accessing the nurse for any health concern.

- **Outreach to home-educated children:** Recognising that children **Electively Home Educated (EHE)** also need access, the service sends out a health newsletter three times a year to all known EHE families, with information on how to contact the school nursing team and key public health messages. When a child is withdrawn from school for home education, schools inform the locality SHN, and the family is proactively offered a health review at least annually (with encouragement to use ChatHealth for any interim advice).

These multiple pathways (referral form, text, phone, face-to-face) make the service highly accessible. Importantly, self-referral by youths is embraced – for instance, secondary students often self-refer for sensitive issues like sexual health or mental health, knowing they can see the nurse privately at school. To ensure awareness, school nurses promote their availability via assemblies and tutor group sessions, especially at the start of the year and for Year 7 inductions. Many schools also include the school nurse drop-in schedule in newsletters or on social media. Overall, the aim is that *no door is the wrong door*: whether a family speaks to their GP, teacher, or directly messages the nurse, the referral will reach the School Health Nursing team.

8. EQUITY OF ACCESS (URBAN/RURAL)

The service strives for **equitable coverage** across Oxfordshire's mix of urban and rural communities:

8.1 Every mainstream secondary school and college, whether in Oxford city or a small market town, has at least a weekly visit from a named school nurse (larger schools may have more frequent visits). If the allocated nurse is absent, the team endeavours to provide cover so that students are not left without access.

8.2 The allocation of nurse time per school is needs-based: the service profiles each locality annually, considering factors like the number of students, indices of deprivation, and rurality, to adjust staffing. A larger or higher-need school may get multiple nurse clinic days per week, whereas a very small rural secondary might get a half-day – but all get regular presence. This annual review helps address the "postcode lottery" by reallocating resources if certain areas show greater health needs or growth in student population.

8.3 **Rural areas:** One specific equity measure involves sexual health access. Some rural parts of Oxfordshire lack local sexual health clinics (for example, Faringdon has no nearby clinic). To mitigate this, school nurses serving those areas have been prioritised for enhanced sexual health training, such as the diploma in sexual health, so they can offer on-site services (like contraception) that students would otherwise have to travel far to obtain. This targeted upskilling means rural teens can receive nearly the same level of service in school as their urban counterparts.

8.4 The **ChatHealth** service equally benefits those in remote areas – a teenager in a village can get advice via text without needing to travel. If needed, the nurse can then arrange to see them at school or a convenient location. ChatHealth operates county-wide with a guarantee of response within 24 hours on weekdays, ensuring timely support regardless of location.

8.5 When unusual access issues arise (e.g. a student living in a very isolated area or attending an out-of-county school), the team makes individual arrangements, often liaising with the family's GP to ensure the child isn't missed.

In summary, **coverage is county-wide and inclusive**. The new locality model introduced in 2024 (described later in this report) has particularly improved equity by extending more support to primary schools and rural communities that historically had less school nurse time. All students, whether in city schools or rural settings, can access a school nurse by various means, and the service continually reviews its deployment to correct imbalances.

9. SERVICE ACTIVITY AND KEY METRICS

School nurses in Oxfordshire carry out a broad array of health interventions. These range from one-off health screenings or advice sessions to ongoing support for complex cases. The service uses a reporting template aligned with six High Impact Areas (national public health priorities for 5–19 services) to track its activities. **Table 2** below highlights selected key metrics from the 2024/25 academic year, illustrating the volume and types of interventions delivered:

Intervention / Contact Type (2024–25)	Volume
Safeguarding	
– Child protection conferences attended	539
– Multi-agency strategy meetings attended (re: at-risk children)	811
– *Non-statutory* safeguarding cases managed (below social care threshold)	1,369
– Health needs assessments for children in protection plans	378
Emotional / Mental Health	
– Emotional support contacts (youth presenting with worries or distress)	2,867
– Formal emotional health assessments conducted	831
– Self-harm risk reduction interventions	280
– Suicidality risk interventions (safety planning, urgent referral)	97
Sexual Health	
– Sexual health/relationship advice contacts (1:1 sessions)	2,331
– Condoms provided to young people (C-Card scheme)	666
– Emergency contraception provided (morning-after pill)	139
– Pregnancy tests administered – *of which, positive results*	322 (12 positive)
Physical Health & Lifestyle	
– Healthy lifestyle advice sessions (diet, exercise, smoking, etc.)	2,863
– Enuresis (bedwetting) follow-up appointments	580
– Emergency medication care plan reviews (e.g. EpiPen, seizure med)	285
School Needs & Additional Support	
– School attendance support interventions (health-related absences)	665
– SEND-specific support contacts (advice or input for SEND pupils)	364

Table 2: Selected service delivery metrics for Oxfordshire School Nursing (academic year 2024/2025). (Note: These figures count individual interventions/contacts, not unique individuals; one student may receive multiple interventions.)

The data above, drawn from the service's 5–19 Outcomes Framework, underscores the *breadth* and *volume* of work undertaken by school nurses:

9.1 **Safeguarding:** School nurses were heavily involved in child protection work, attending 539 child protection conferences and 811 strategy meetings called to address serious child welfare concerns. They also supported 1,369 lower-level safeguarding cases that did not meet social care thresholds (e.g. ongoing monitoring or early help for children causing concern). This shows that while nurses spend significant time on complex cases, they are also working on early intervention ("firefighting" and preventive safeguarding) for hundreds of children.

9.2 **Emotional Health:** The service handled a large number of emotional wellbeing cases – nearly 2,900 contacts for emotional support were provided to students struggling with issues like anxiety, stress, or low mood. In addition, nurses conducted 831 in-depth mental health assessments using structured tools for students with more significant concerns. They intervened in 280 instances of self-harm (helping a student reduce self-injury or safety plan) and 97 instances of suicidal ideation that required urgent support or referral. Importantly, school nurses liaised with CAMHS on at least 372 occasions during the year – ensuring that youths who needed specialist mental health care were referred or co-managed appropriately.

9.3 **Sexual Health:** School nurses provided 2,331 one-to-one sessions of sexual health or relationship advice to young people. Many of these likely occurred during drop-in clinics where teens sought information about contraception, STIs, or relationship issues. The nurses dispensed 666 condoms as part of the C-Card scheme to promote safe sex. They also directly supplied emergency contraception 139 times to students in need – highlighting the value of having that service available in schools to prevent unwanted pregnancies. A total of 322 pregnancy tests were done by school nurses, of which 12 were positive (in such cases, the nurse would provide support and referral for antenatal or termination care as appropriate). School nurses also emphasise the importance of encouraging young people who receive a positive pregnancy test to seek support from their parents or carers, particularly if their families are not already aware of the situation, ensuring they are not facing these challenges alone. These figures demonstrate an active role in sexual health prevention and early intervention.

9.4 **Physical Health & Lifestyle:** The nurses logged 2,863 contacts providing healthy lifestyle advice – this includes counselling on topics like nutrition, physical activity, sleep, as well as substance misuse (indeed, the data shows they addressed vaping 110 times, smoking 23 times, and drug/alcohol use ~111 times in those sessions combined). They conducted 580 follow-ups for enuresis (bedwetting) cases, helping families manage and overcome this common issue, and performed initial enuresis assessments for 233 new referrals. In managing emergency medications in schools, nurses oversaw at least 285 reviews of adrenaline auto-injector (EpiPen) care plans and dozens of reviews for epileptic seizure medication and other emergency drugs – ensuring schools are prepared to handle kids with severe allergies or epilepsy. They also followed up 133 cases of children flagged as overweight and 126 as underweight as part of the National Child Measurement Programme results, connecting those families with appropriate support.

9.5 **School participation:** School nurses supported education by tackling health factors affecting attendance and learning. They conducted 665 interventions related to school attendance – for example, working with students and parents where health issues were causing frequent absences, and developing strategies to improve attendance. They also provided input on 364 occasions for students with SEND or those requiring an Education Health and Care Plan (EHCP), ensuring their health needs were accounted for in education planning. Additionally, 499 transition health reviews were done for students moving schools (such as entry to secondary), smoothing those critical transitions.

9.6 Overall, the 5–19 service delivered **35,499 documented health contacts/interventions** over the year. This total indicates a very high level of activity, roughly averaging out to hundreds of nurse-pupil interactions per week across the county. It's important to note that these contacts span the spectrum from preventive health promotion (e.g. classroom sessions counted separately in educational delivery logs) to intensive one-on-one support. The *Multiple Contacts per Child* principle ("every contact counts") is evident – for example, a single nurse consultation might address multiple issues (like a session on anxiety that also covers sleep hygiene and some safeguarding screening) and get recorded under several categories.

10. HEALTH EDUCATION

In addition to the quantitative metrics, the service contributes significantly to health education in schools. In the 2024/25 school year, school nurses increased their input into PSHE lessons:

- In **primary schools**, they conducted sessions on topics such as hand hygiene and oral health (32 sessions in Autumn term 2024; 26 in Spring 2025; 22 in Summer 2025, with more oral health workshops planned for Autumn 2025).

- In **secondary schools**, they delivered a large number of sessions focusing on puberty, healthy relationships, sexual health, bullying, and transition (92 sessions in Autumn 2024; 94 in Spring 2025; 125 in Summer 2025). They also held 54 assemblies in Autumn (especially targeting new Year 7 cohorts to introduce the service).

These educational efforts, though not explicitly enumerated in the interventions table, form a core part of preventative work – reaching whole year groups with health messages. The high number of sexual health sessions in secondary (over 300 across three terms) is particularly noteworthy and ties in with the individual-level sexual health contacts recorded.

11. OUTCOMES ACHIEVED BY THE SERVICE

Measuring the outcomes or impact of school nursing interventions is complex, but Oxfordshire's service is taking steps to evaluate its effectiveness:

11.1 Goal-Based Outcomes (GBO): From September 2025, the service has begun implementing goal-based outcomes tools for individual interventions. This means that when a school nurse works with a young person (for example, on anxiety management or weight reduction), they establish the young person's own goals at the start and then assess progress on those goals at the end. This client-centred outcome measuring just started, so no data is available yet, but it will in future allow the service to demonstrate improvements from the perspective of the young people (e.g. % of goals achieved or average self-rated progress).

11.2 Public Health Outcomes: On a broader scale, the service contributes to longer-term public health outcomes such as improved vaccination uptake, healthy weight maintenance, reduced teenage pregnancy, and better mental health resilience. For instance, by working intensively with families of overweight children identified in Year 6, school nurses in some cases successfully engage them in lifestyle changes – evidenced by follow-up contacts and referrals to weight management programs. Likewise, the extensive sexual health education and on-site contraception provision likely contribute to Oxfordshire's relatively low rates of teen conceptions (though exact attribution is hard to quantify).

11.3 Case Study Examples: While not enumerated in this report, the service has numerous *qualitative success stories*. For example, school nurses have prevented possible life-threatening situations by early identification – such as noticing signs of an emerging eating disorder and getting the student into treatment, or catching an asthma pupil who had no inhaler at school and averting a potential emergency by coordinating care. The report preparation notes mention including a case study from a school (Marlborough School) and a dental health initiative, which illustrate positive outcomes; due to time constraints, these detailed stories are not included here, but they reinforce how school nursing interventions translate into real-life improvements (like improved oral hygiene in a whole school after a nurse-led campaign).

11.4 Service User Feedback: As described in the next section, feedback from young people and parents is very positive about the help they receive. High satisfaction (often 5-star ratings) and comments like *"the nurse really helped me feel better about myself"* or *"we got the support we needed when nowhere else would listen"* indicate the service is making a difference from the users' perspective. Moreover, the nurses' involvement in education (hundreds of PSHE sessions) can be seen as an outcome in itself – schools value this input and it ensures health messages reach all students, not only those who actively seek help.

11.5 Enhancing School Staff Competence: Another important way in which the service impacts the school community is through upskilling school staff. School nurses regularly deliver training sessions to teaching and pastoral staff on topics such as managing medical conditions (e.g., asthma, epilepsy). These training sessions not only equip staff with practical knowledge to respond effectively to pupil health needs, but also build confidence in dealing with sensitive issues. In addition, by facilitating group sessions with pupils on topics like emotional wellbeing and healthy relationships, nurses help create a more informed and supportive school environment, enabling staff to reinforce these key health messages in their daily interactions. Indirectly, the ongoing support nurses provide for individual young people often involves collaborative problem-solving with staff, further contributing to staff development and enhancing the overall culture of care within schools.

In summary, **the outcomes being achieved include**: improved access to health care for young people, earlier identification of problems (which can prevent more serious issues later), increased health knowledge and self-care skills among pupils, and maintained or improved health indicators in specific areas (for example, more children with a health condition having an up-to-date care plan, or more adolescents using contraception reliably). The service is continuing to improve its outcome measurement approach – combining quantitative data (like those in Table 2) with qualitative feedback and goal attainment measures – to better demonstrate its impact.

12. SUPPORT FOR PUPILS WITH SEND AND DISADVANTAGED BACKGROUNDS

Supporting vulnerable children, including those with Special Educational Needs and Disabilities (SEND) and those from disadvantaged or hard-to-reach backgrounds, is a priority for the school nursing service. Several strategies ensure these students are not left behind:

- **12.1 Proactive Identification and Planning:** School nurses maintain regular contact with each school's Special Educational Needs Coordinator (SENCO) and pastoral teams. They attend pastoral/SEN meetings in secondary schools and colleges, where staff discuss students causing concern. This enables SHNs to identify pupils with additional needs early and offer targeted support. For example, if a student with ADHD is struggling to manage their medication or a child from a disadvantaged family is frequently absent due to unmet health needs, the nurse will become involved through these channels.
- **12.2 Contribution to EHCPs:** Nurses contribute to the statutory Education, Health and Care Plans (EHCPs) for students who require them. They provide professional health reports for EHCP assessments, ensuring that a child's medical or mental health needs are clearly described and that appropriate health outcomes and provisions are included in the plan. During annual EHCP reviews, nurses often update on the child's health progress and advise on adjustments needed. This ensures an integrated approach where health, education, and social care professionals collaborate on the child's support plan.
- **12.3 Inclusive Service Delivery:** The service uses an inclusive approach so that all pupils and families know how to access the school nurse, regardless of background. This includes those who might not actively seek help. At transitional points (starting primary or secondary), every family receives information about the school health service. By normalizing the service as something for "everyone," it reduces stigma and encourages disadvantaged families or students with SEND to use it. The school nurses also conduct universal health education sessions (assemblies, newsletters, etc.) to reach those who might not come forward on their own, thereby indirectly benefiting shy or marginalized students.
- **12.4 Specialist Lead for SEND:** Oxfordshire employs a Specialist School Nurse for SEND who has created a SEND Champion Group within the nursing team. This network shares expertise and updates on supporting children with conditions like autism, learning disabilities, or physical impairments. It helps disseminate best practices and resources across all localities. For example, if new guidance on managing diabetes in schools comes out, or a particular training on supporting neurodiverse students is available, the SEND lead ensures all nurses are informed and trained. This means every nurse is better equipped to meet special needs.
- **12.5 Ongoing Training: SEND awareness training is mandatory** for all school nursing staff now. In addition, focused training on writing EHCP health reports, understanding specific disabilities, or managing co-morbid mental health issues in SEND children is provided as needed. This upskilling improves the quality of care for SEND pupils. School nurses also keep abreast of issues like the long waits for autism or ADHD assessments – they provide interim support and advice to families during the waiting period, working closely with CAMHS where necessary.
- **12.6 Targeting Disadvantage:** The service is cognizant of health inequalities. Nurses pay special attention to children from economically disadvantaged families, those known to social services, young carers, or children in care. They often liaise with the Locality Community Support Service (LCSS, the early help teams) to discuss any families who might benefit from a multi-agency early help plan. The new locality model has allowed nurses to spend more time in primary schools in less affluent areas, which previously had minimal nurse input – thus providing things like extra health screening or drop-ins at schools with higher free-school-meal percentages. Also, when sending out year-group communications (like the Year 6 transition letters or newsletters), the team makes sure the language is accessible and inclusive to all reading levels, and that these communications reach families who might not have digital access (paper copies via schools if needed).

Despite these efforts, challenges remain. Long waiting times for specialist services (for example, neurodevelopmental assessments for autism/ADHD) have been frustrating for families. School nurses have been helping by sharing management tips and resources provided by CAMHS while families wait including directing families to the *'living well with neurodiversity'* offer from CAMHS, but the unmet demand in the system at large is a pressure. The service has noted that

parental expectations can be high, understandably, and nurses sometimes act as intermediaries to reassure and support parents whose children are awaiting external help.

In essence, the school nursing service acts as a safety net and advocate for SEND and disadvantaged children. By embedding themselves in school processes, they catch issues early; by coordinating with other professionals, they make sure these children's holistic needs are addressed; and by being approachable and consistent, they gain the trust of families who might otherwise be wary of engaging with services. All this helps reduce health-related barriers to learning for Oxfordshire's most vulnerable young people.

13. STAFFING, RECRUITMENT & STAFF WELLBEING

The School Health Nursing service is delivered by a dedicated team of professionals, and maintaining a stable, well-supported workforce is critical to its success. Below is an overview of the staffing levels and measures taken to recruit, retain, and care for the staff:

14. STAFFING ESTABLISHMENT

As of October 2025, the core qualified nursing establishment for the school nursing service is approximately 34.2 whole-time equivalents (WTE). This includes 22.65 WTE Specialist Community Public Health Nurses (SCHPN) (Band 6) – these are the qualified school nurses leading the service in each locality – plus 2.39 WTE college nurses (also Band 6) dedicated to further education colleges, and 9.17 WTE community public health nurses (CPHN) (Band 5) who support the service. In addition, there are 11.4 WTE school health care assistants (Band 3) in the team that deliver the vision screening and NCMP programmes. While school nurse staffing nationally has been under pressure, Oxfordshire has managed to fill most of its posts; the staff in post are committed and many have long tenure in the county.

15. RECRUITMENT AND RETENTION

The service has a proactive approach to recruitment. It routinely offers student nurse placements and supports qualified nurses to undertake the SCPHN (School Nursing) speciality training, effectively "growing its own" school nurses – as noted later, two staff just qualified as SCPHNs and two more are in training. This helps with succession planning as older nurses retire. Retention has been good; turnover is relatively low at around 10%, thanks in part to the supportive work environment and opportunities for development. However, recruitment of experienced SCPHNs can be challenging (a national issue), so the service emphasises internal development and also occasionally recruits Band 5 nurses and supports them to upskill to Band 6 SCPHN roles.

16. CLINICAL SUPERVISION AND SUPPORT

To prevent burnout and ensure quality, regular supervision is in place. Every school nurse (and staff nurse) receives one-to-one clinical and management supervision every 6–8 weeks. In these sessions, they can discuss complex cases, workload, and personal development with a senior practitioner or manager. In addition, safeguarding supervision is provided frequently: there are scheduled group sessions led by the Trust's safeguarding team, plus ad-hoc one-to-one supervision for any staff dealing with a particularly challenging child protection case. The CAMHS team also offers one-to-one case discussions on request, which is extremely valuable when nurses are supporting a young person with serious mental health issues and need specialist input. This robust supervision framework ensures staff never feel "alone" in managing tough situations – they have a safety valve and expert guidance to maintain their own well-being and case quality.

17. TEAM MEETINGS AND PEER SUPPORT

Starting in September 2025, the service introduced monthly locality-based team meetings specifically for the School Health Nursing staff. These meetings (separate from general 0–19 team meetings) were a direct response to staff feedback wanting more peer connection. They are facilitated by the Clinical Education Leads and allow school nurses and their immediate colleagues to share experiences, discuss common issues, and support each other. The first such meetings

were very well received, as they allowed frank discussion and collective problem-solving (for example, a group might share how they handle a particular challenge like low engagement in a certain school, or brainstorm solutions to manage workload peaks like immunisation season). Issues raised are fed up to senior management so that the "voice from the field" is heard. This initiative has bolstered team morale and cohesion.

18. WELLBEING INITIATIVES

Oxford Health NHS Trust (the provider) has comprehensive staff wellbeing programs, which school nursing staff benefit from.

- **Employee Assistance Programme (EAP):** All staff have access to a 24/7 confidential helpline offering counselling, legal/financial advice, and emotional support on any personal or work issue.
- **Wellbeing Day:** Staff are entitled to an extra day of paid leave each year specifically for their wellbeing (a chance to decompress or attend to personal matters) – this has been in place for four years and is appreciated by the team.
- **Inclusive Support Groups:** The Trust runs supportive networks for staff who identify with certain groups – for example, there are specialist groups for LGBTQ+ staff, for staff with dyslexia, and for those going through menopause. School nurses can join these groups, which provide a sense of community and understanding around those aspects of personal life.
- **Workplace retreats:** A novel initiative allows staff to take part in periodic "resilience retreats" or reflection sessions during work hours. These might be guided mindfulness workshops or group reflective practice meetings that help staff process stress and maintain their emotional health. The combination of these efforts shows a strong organisational commitment to preventing stress and compassion fatigue among school nurses.
- **Flexible Working:** Though not explicitly detailed in the data, it's worth noting that the service tries to accommodate flexible working requests when possible (e.g., some school nurses work term-time only or part-time if they have young families). By doing so, they retain skilled staff who might otherwise leave. Managers also monitor workloads and adjust if someone is overloaded – for example, if one locality has an unexpected spike in safeguarding cases, the team can redistribute tasks or get back-up from neighbouring teams to ease the pressure.

Through these measures, Oxfordshire's school nursing service fosters a positive working environment. This not only helps keep staff turnover low, but it directly benefits the public: well-supported, experienced nurses are able to provide better care to children and are more likely to "go the extra mile." Nationally, over 80% of school nurses report that there are not enough staff to meet demand (and on average one nurse covers ~4,000 students), so ensuring the existing staff's wellbeing and efficiency is crucial. Oxfordshire's approach – strong supervision, professional development (next section), and wellbeing perks – has been highlighted by staff as enabling them to cope with what can be a very challenging role.

19. PROFESSIONAL DEVELOPMENT AND TRAINING

Continuous professional development (CPD) is a cornerstone of the school nursing service in Oxfordshire, ensuring that staff skills stay up-to-date and nurses are prepared for emerging health issues affecting youth. Key elements of the training and development programme are described below.

20. ANNUAL 5–19 SERVICE TRAINING DAY

At the start of each academic year, the service organises a comprehensive in-person study day for all school nursing staff. In September 2024, for example, this day focussed on enhancing expertise in working with the 5–19 age group, covering latest best practices and any new protocols. Staff valued this opportunity to learn together and share experiences across localities. It serves as a "launch" for the year with refreshed knowledge on topics like trauma-informed care or updated safeguarding guidance.

21. SPECIALIST COMMUNITY PUBLIC HEALTH NURSE (SCPHN) SPONSORSHIP

The service actively supports nurses to gain advanced qualifications. Recently, two nurses completed the SCPHN (School Nursing) postgraduate course and qualified as specialist community public health nurses. Two more staff are being recruited to start the course in the upcoming year. This not only boosts the number of qualified school nurses in the team but also motivates staff by offering clear career progression (Band 5 to Band 6) through education. The course is typically a 1-year full-time programme (or 1.5 years part-time) at master's level, and covering the cost/time is a significant investment by the service into its workforce.

22. LEARNING BEYOND REGISTRATION (LBR) MODULES

The service utilises LBR funding (continuing education funds) to send nurses on Level 7 modular courses to deepen specific skills. Recently, staff have taken modules in *Psychosocial care of children and adolescents* and in *Safeguarding*, both of which have had "positive impact on practise" according to feedback. This means, for instance, a nurse who did the psychosocial module may be better equipped to handle complex mental health issues or family dynamics, and one who did the advanced safeguarding module might take on a champion role for peer advising on tough cases.

23. SEXUAL HEALTH TRAINING PATHWAY

Given the emphasis on providing contraceptive services, there is a structured training pathway for sexual health:

- Each year, 2–3 nurses undertake a six-month Diploma in Sexual and Reproductive Health (funded by LBR). This is a significant qualification (often the Faculty of Sexual and Reproductive Healthcare (FSRH) diploma) enabling them to offer a wide range of interventions (like prescribing contraception or implant fitting).

- Additionally, all School Health Nurses (Band 6) and community public health nurses (Band 5) attend a 2-day sexual health course at least once (about a dozen staff per year rotate through it). This covers the basics of sexual health promotion, STIs, contraception options, etc., ensuring baseline competency across the team.

- For those directly involved in contraceptive clinics in schools, there is an annual update day to refresh knowledge and cover any new methods or guidelines. This keeps the trained nurses current (for example, learning about new STI treatment protocols or updates in national policy like HPV vaccination changes).

This tiered approach has resulted in an extremely well-trained team: as mentioned, 90%+ of nurses are trained or training in contraception counselling, and several hold advanced qualifications to provide clinical interventions. This training translates directly into expanded service delivery for students.

24. ADDITIONAL CLINICAL SKILLS TRAINING

The service also covers a breadth of other topics in its monthly in-house training sessions (delivered by the **2 full-time Clinical Education Leads**). Recent focuses have included:

- Enuresis (bedwetting) management – ensuring nurses can effectively run clinics for this common issue.

- Oral health promotion – teaching children good dental hygiene, a priority especially in areas with higher decay rates.

- Breastfeeding in the context of PSHE – even though school nurses deal with older children, some secondary students become teen parents, so staff are trained to support and advise on infant feeding or signpost appropriately.

- Vaping and substance misuse – with youth vaping on the rise, nurses were updated on how to educate about risks and support those trying to quit.

- The influence of social media personalities (like the TikTok influencer "Bonnie Blue" mentioned) – making sense of trends that affect youth health behaviours, so nurses can contextually address issues that kids bring up.

These sessions are often based on *identified needs* – if nurses report seeing a lot of a particular issue, the educators will arrange a training. The Clinical Education Leads coordinate these monthly sessions and invite external experts at times (for example, a diabetes nurse specialist might run a session on insulin pumps in schools). This responsiveness keeps training relevant and timely.

25. INDUCTION AND MENTORSHIP

New staff (including newly qualified SCPHNs or new Band 5s) are mentored by experienced colleagues. They go through an induction that covers school nursing policies, shadowing opportunities, and staged introduction to taking on complex cases. Given the autonomy required in this role, mentorship is crucial for at least the first 6-12 months.

The strong CPD culture means that school nursing staff continuously enhance their competencies, which benefits children and families through higher quality care. It also aids retention – staff feel invested in and can broaden their scope of practise (for example, a nurse might start being able to prescribe some medications under PGDs after relevant training, which is empowering). In sum, Oxfordshire's approach to training ensures that the school nursing workforce remains skilled, knowledgeable, and adaptable to new challenges (like emerging health trends or changes in national policy). This is particularly important as the health needs of children evolve (e.g. post-pandemic mental health needs surged, and nurses had to be ready with new skills to respond).

26. USE OF DIGITAL TOOLS IN SERVICE DELIVERY

The school nursing service leverages a range of digital tools and platforms to improve communication with service users, streamline record-keeping, and extend its reach. Key digital initiatives include:

26.1 ChatHealth Messaging Service: *ChatHealth* is a confidential text messaging service that has become a cornerstone of the 5–19 service, as described previously. There are two ChatHealth lines: one for young people (typically secondary school students) and one for parents of school-aged children. Usage of ChatHealth in Oxfordshire has been steadily increasing on both lines. Common inquiries on the parent line include managing bedwetting (enuresis), behaviour problems, sleep difficulties, and picky eating. On the young people's line, the majority of questions revolve around sexual health, relationships, or emotional wellbeing. For example, a teenager might text about anxiety issues or asking how to access contraception. The service guarantees a reply within one working day (often much sooner). ChatHealth greatly lowers barriers to access – teens who might be uncomfortable speaking face-to-face can reach out anonymously, and parents who are busy or unsure whom to call can send a quick text. The ease and privacy of this tool have made it very popular. School nurses rotate responsibility to monitor and respond on ChatHealth, using templated advice where appropriate but also encouraging follow-up appointments if needed. The system is integrated into their workflow and is praised for catching issues early. (Notably, ChatHealth has in some cases identified serious issues like suicidal thoughts or abuse, which nurses could then act on promptly.)

26.2 AccuRx (SMS via EHR): The service has *access* to AccuRx (a system for texting families directly from the electronic health record). AccuRx is a digital communication platform frequently used within NHS services to facilitate secure messaging and video consultations between healthcare professionals and service users. In the context of school nursing, AccuRx can be utilised for remote consultations, enabling nurses to offer advice, follow-up care, or initial assessments without requiring in-person appointments. The platform supports the efficient and confidential exchange of information, making it easier to maintain continuity of care, particularly for families or young people who may face barriers to attending appointments. Its integration with the electronic record system also ensures that all interactions are properly documented and accessible for future reference.

26.3 Electronic Records & Information Sharing: The team uses an electronic record system (EMIS) to document all contacts which is also used by primary care in Oxfordshire. This allows school nurses to see the full health record of the child as part of their interaction. The GP is also then able to view any interventions delivered by the schools nurses. **School Screener** is used notably for vision screening results and the National Child Measurement Programme (height/weight measurements in Reception and Year 6). The tool allows efficient input of screening outcomes and generates automated parent result letters. By using School Screener, results are recorded digitally

at the point of screening, reducing errors and speeding up communication to parents (e.g., a letter advising an eye test if vision screening was failed). It's an example of digital tech making old paper-based processes easier and more accurate. School Screener also includes a parent portal where results can be viewed digitally without the need for physical letters to be sent.

26.4 **Digital Newsletters:** The service produces **termly health newsletters** that are emailed out widely. These newsletters target different groups:

26.5 Parents of primary school children,

- Parents of secondary school students,
- Students in further education colleges,
- Families who are electively home-educating.

The content includes seasonal health tips, information on how to contact the school nurse, and promotion of services (for instance, reminding about ChatHealth, or publicising a mental health webinar). By sending these regularly, the service stays on families' radar. The school nurses have gathered email distribution lists (often through schools or via the SPA contacts). The newsletters help extend their health promotion reach beyond the school walls – e.g., a piece on managing exam stress or a reminder about the importance of sleep will go directly to households, reinforcing what might also be taught in school.

Transition Communications: In addition to newsletters, specific transition letters are sent:

26.6 Year 6 parents (as their child prepares to move to secondary) get letters informing them what the school nursing service will offer in secondary school and how to reach out.

26.7 Year 11 and Year 13 students (as they prepare to leave school or college) get letters with advice on transitioning to adult health services, information on things like registering with a GP if they haven't, and resources for mental health or sexual health as they move to work or university.

The service, in partnership with a youth co-production project (**Unloc YP**), is redesigning the Year 11 and 13 leavers' letters to make them more engaging and useful. This likely involves input from young people on what info they wish they'd had leaving school – making sure these letters genuinely support young people in navigating health issues post-school.

26.8 **Tellmi App:** Oxfordshire has adopted **Tellmi**, which is a moderated anonymous peer support app for young people (formerly called MeeToo). The service actively promotes Tellmi to students as a safe digital space to talk about issues like stress, body image, or bullying with peers and trained moderators. Every young person in the county has access to it at no cost. School nurses hand out postcards or digital links for Tellmi, integrating it into their toolkit for signposting. This recognition that online peer support can complement professional help is forward-thinking – it offers another layer of support for those who might not be ready to speak directly to an adult.

26.9 **Social Media and Web:** While not extensively detailed in the provided data, it is worth noting that the school nursing service likely collaborates with the Trust's communications to maintain an online presence. Many 0–19 services use Facebook or Twitter to relay information (e.g., clinic times or health advice). Given the emphasis on digital outreach, it's plausible Oxfordshire's team posts updates or health campaigns online. However, their primary focus has been direct communications like ChatHealth and newsletters rather than public social media.

In summary, digital tools have significantly extended the service's reach and efficiency. Young people today are digital natives, and the school nursing service has adapted by meeting them on those platforms – texting, apps, and email – rather than relying solely on traditional clinic appointments. This multi-channel approach means more touchpoints: a student might read a health tip in the newsletter, then encounter the nurse in a school assembly, feel comfortable to send a text via ChatHealth, and eventually come in for a face-to-face chat. All these digital touches support the overarching goal of accessible, timely health advice and intervention.

One challenge noted is keeping contact information current and ensuring equitable digital access. The service mitigates this by working closely with schools (who update contact lists) and by still providing non-digital options (phone or in-person) so that families who aren't tech-savvy aren't excluded. Nonetheless, the digital innovations like ChatHealth have been a great success, evidenced by rising usage and positive feedback from service users who value the convenience.

27. INTEGRATION WITH OTHER SERVICES AND INITIATIVES

The school nursing service doesn't operate in isolation – it is a key player in Oxfordshire's broader child health system and works in close partnership with other services to provide holistic support. The service also aligns itself with strategic initiatives like the development of community health hubs and the Marmot principles (addressing health inequalities).

28. COLLABORATION WITH CAMHS AND EARLY HELP SERVICES

There is a strong linkage between school nurses and mental health services:

28.1 School nurses regularly collaborate with **Child and Adolescent Mental Health Services (CAMHS)**. One formal touchpoint is attendance at the Self-Harm Steering Group (a multi-agency forum addressing youth self-harm). By participating in these meetings, school nurses share on-the-ground insights (e.g., trends in self-harm methods or triggers they're seeing in schools) and in return learn about best practices or resources to manage self-harm that they can apply in their interactions with students. It ensures consistency – a young person hears complementary guidance from their school nurse and CAMHS, rather than conflicting advice.

28.2 Beyond formal groups, there are day-to-day consults: as noted, CAMHS professionals are accessible for case discussions, and school nurses often facilitate or expedite referrals to CAMHS for students needing more intensive support. This two-way communication is crucial when children fall just below CAMHS thresholds; the school nurse might carry the interim support and needs to know the guidance from CAMHS on what to do or watch for.

28.3 In addition to ongoing collaboration, the 0–19 service is working closely with both CAMHS and Mental Health Support Teams (MHST) to co-produce a comprehensive Oxfordshire Emotional Health and Wellbeing Pathway. This joint effort aims to clearly map out the roles, referral routes, and support offers across the different services, ensuring that children and young people experience seamless transitions and timely access to the right level of care. By regularly meeting to review case studies and pathway effectiveness, the teams are identifying gaps, aligning thresholds, and developing shared resources, all of which contribute to a more integrated and responsive emotional health system for Oxfordshire's young people.

28.4 With **Early Help** services, school nurses engage via the **Locality Community Support Service (LCSS)**. LCSS organises locality-based network meetings where various professionals (early help workers, social workers, school reps, health visitors, school nurses, etc.) come together. School nurses attend these to discuss families who might not yet need social care involvement but do need multi-agency support (for example, a family struggling with housing and mild neglect issues). Through these networks, school nurses ensure that the health perspective is included in early help plans and that they are aware of non-health interventions provided to the family. It also builds personal relationships – the nurse knows the local family support worker by name, making it easy to pick up the phone and coordinate about a child.

28.5 In practical terms, if a student is part of an Early Help plan or a Team Around the Family, the school nurse will often be part of that plan – addressing any health actions. For example, if poor school attendance is being tackled, the nurse might handle the health assessment to see if undiagnosed health issues are contributing. The close integration means families get a unified plan rather than separate, disjointed efforts.

29. COMMUNITY HEALTH HUBS AND THE "MARMOT PLACE" APPROACH

Oxfordshire is in the process of establishing **Family Hubs** – multi-agency centres where children, young people, and families can access various health and wellbeing services in one place. The 0-19 service have been actively involved in the

planning and pathway development for these hubs and are represented on the programme board. They bring to the table their experience of what adolescents and children need and how they prefer to access services.

Regarding **Marmot Place**: Oxfordshire aspires to become a "Marmot County/Place," meaning it is committed to the policies outlined by Professor Sir Michael Marmot to reduce health inequalities and improve health for all. School nursing is inherently aligned with Marmot principles (which emphasise giving every child the best start in life, education, ill-health prevention, etc.). The service has been ensuring that its work feeds into this wider agenda:

- 0-19 service leaders participate in strategic discussions at the county level about public health priorities. They advocate for issues like the importance of addressing mental health in schools or the need for investment in school nursing as a preventive service.
- By aligning with Marmot principles, school nurses emphasise equity – e.g., trying to allocate more resources to deprived areas, as described earlier, and addressing the wider determinants (like connecting a family with a housing advisor if poor living conditions are impacting a child's health).
- A practical example of Marmot-informed work is the focus on reducing health inequalities: the data in the outcomes framework tracked only 199 contacts specifically under "reducing health inequalities" category, likely representing targeted outreach to marginalised groups. The service intends to grow that area, ensuring that minority groups or areas of deprivation are more proactively supported, which is a Marmot goal.

In essence, school nurses act as bridge builders between health, education, and social care. Their presence in multi-agency settings (from individual case meetings up to strategic planning committees) ensures the *voice of child health* is heard. The upcoming family hubs and the Marmot initiative are opportunities to further integrate services – school nurses are poised to play a key role in both, given their broad skillset and daily contact with children. This integration means families should experience a more joined-up system; for example, if a parent goes to a public consultation about a new health hub and mentions bullying issues, a school nurse in the planning group can flag that schools and school nursing need to be part of the solution.

30. ENGAGEMENT WITH STAKEHOLDERS, FAMILIES, AND THE PUBLIC

The school nursing service places great importance on engaging with stakeholders – from school staff to families and the wider community – to ensure the service is visible, accessible, and responsive to the needs of the population. Key aspects of this engagement include:

30.1 Strong Relationships with Schools: School Health Nurses are deeply embedded in school communities. They work hard to maintain robust, supportive relationships with headteachers, teachers, pastoral leads, and school governors. For instance, an SHN will meet regularly with a secondary school's pastoral lead to discuss general trends or any logistical issues (like where the drop-in clinic is best held). Many schools consider their nurse as part of the extended school team. This close relationship yields benefits: schools actively help promote the service (e.g., allowing nurses to speak at assemblies or including items in school newsletters), and in turn nurses align their health activities with school priorities. An example of stakeholder engagement is nurses supporting schools on sports days, health weeks, or parent evenings, which raises their profile and trust among staff and students.

30.2 Multi-Agency Communication: School nurses maintain regular communication with social care and other health professionals to coordinate support for children. They share information (with consent and following safeguarding protocols) so that everyone working with a child has a fuller picture. For example, if a family support worker is helping a family with routines and the school nurse is addressing sleep issues with the same family, they'll touch base to ensure consistency. This professional network engagement ensures the service is well-connected and viewed as a crucial partner by others in the child welfare system.

30.3 Voice of Children and Families: The service is committed to listening to service users' voices. They actively seek feedback from young people and parents about their experiences with the school nursing team. One of the main tools for this is the "I Want Great Care" (IWGC) platform – an online (or paper) feedback survey where users can

rate the service and leave comments. The survey is youth-friendly, using a 5-star rating and inviting free-text comments on what was good and what could be improved. It also collects some demographic data to ensure feedback is coming from a range of users. The school nursing service regularly reviews this feedback to identify lessons learned and areas for improvement. For example, in feedback from secondary school students in September 2024, some students suggested that the nurse's room wasn't private enough (others could see in) and that they weren't sure when the nurse was on site. In response, the nurses took action: some schools allowed blinds to be installed or changed the room to one in a more discrete location, and nurses increased their promotion of clinic times (via posters and tutor-time announcements). Another common theme was students wanting more awareness of the nurse's role – so the team stepped up campaigns to advertise what they do (the 54 assemblies for Year 7 mentioned earlier is one such response). By acting on what young people say, the service demonstrates it is co-producing improvements with those who use it.

30.4 Public and Community Outreach: School nurses endeavour to be visible not just in schools but in the broader community of children and families. They often attend school events like sports days, parents' evenings, and informal coffee mornings at primary schools. When present in these settings, they might set up a stall with health information or simply mingle and chat, offering advice or answering questions. This informal face time builds trust – a parent might be more likely later to call the nurse about a concern if they had a friendly chat at the school fair. It also helps reach families who might not come to the clinic; for example, a parent who is wary of formal services may open up in a casual chat at a coffee morning. The nurses also sometimes join community forums or youth clubs to promote health messages (e.g., attending a youth centre session on teenage health).

30.5 Engagement with Lived Experience Groups: There are instances where families with particular experiences (like having a child with SEND, or having been through child protection processes) form groups or forums. The school nursing service is keen to hear from these. For example, the SEND champion nurse might attend a local parent-carer forum to get input on how the service could better support SEND kids. Or the service might collaborate with organisations like Healthwatch or local charities to run focus groups. By engaging these voices, the service can tailor its approach.

30.6 Transparency and Public Accountability: At public meetings like HOSC, the service provides detailed reports (such as this one) demonstrating what they do. They are open about challenges and proud of successes, which helps build trust with the public and elected officials. Stakeholder engagement at this oversight level ensures the service remains aligned with community expectations and local authority public health objectives.

30.7 Students as Health Champions: Another form of engagement is empowering students themselves. Some secondary schools have *health champions* or peer mentors trained by the school nurses to spread health messages. While not explicitly documented in the provided content, it's a known approach. These student partners help amplify the nurse's work and keep the service real to their peers. It's an example of indirectly engaging the wider student body in co-delivering health promotion.

In all these ways, the school nursing service emphasises a community-oriented, user-centred approach. They are not just a clinical service that waits for referrals; they actively go out to where children and families are, listen to them, and adapt. This approach fosters goodwill and a positive reputation. In practise, headteachers are likely to advocate for the school nursing service because they see the nurses' commitment to the school's welfare; parents speak well of the nurses because they feel heard; and young people themselves come to see the school nurse as *their* resource, not an authority figure to be avoided.

31. FEEDBACK AND LESSONS LEARNED

A crucial component of service development is analysing feedback from service users and using it to drive improvements – essentially a "You said, we did" approach. The Oxfordshire school nursing service systematically collects feedback and has implemented changes based on what they've learned:

31.1 Feedback Mechanism (IWGC):

The service uses I Want Great Care (IWGC), a patient feedback platform adapted for children's services, to gather input from young people and their families. The survey asks respondents to rate the care on a 5-star scale and

provides two free-text boxes: one for what they liked and one for suggestions on what could be improved. By September 2024, numerous secondary school students had provided feedback through this tool. The anonymity and accessibility of IWGC (which can be filled online via a link or QR code that nurses give out) encourages honest opinions.

31.2 Positive Feedback:

The majority of feedback from young people is very positive, praising the caring nature and helpfulness of the nurses. For example, (students said things like *"The nurse listened to me and didn't judge"* or *"I felt much better after talking – thank you!"*. Parents often express gratitude for support with issues like toileting or mental health and highlight the relief at having someone to turn to. While individual quotes aren't in our text, the high star ratings indicate a strong appreciation for the service's impact.

31.3 Areas for Improvement:

Some feedback did highlight areas to improve. Privacy was one such area as mentioned above. **Accessibility of information** was another – some students said they weren't sure how to contact the nurse or when the nurse was available. Others had minor suggestions like "the room could be more welcoming" or "wish we had more sessions on stress management."

31.4 Responsive Changes:

The school nursing team has taken these suggestions on board and made concrete changes:

31.5 They ensured private spaces for consultations: in response to feedback about rooms, they worked with schools to make simple modifications (installing blinds or curtains on glass doors where needed, reassigning a different room if one was too public, etc.). This directly addressed the privacy concern so that students feel more secure confiding in the nurse.

31.6 They adjusted clinic times: In at least one case, if feedback indicated the nurse's drop-in hours weren't convenient (for example, clashing with lunch or not advertised well), the nurse either shifted the timing or added an extra slot. They also re-advertised their availability – some nurses created bright posters or had reminder announcements so that every student knows when and where to find them.

31.7 They improved service promotion: Feedback suggested not all students were aware of the breadth of issues they could bring to the nurse. In response, the team ramped up promotion: more assemblies (especially at term starts), stalls at school events, and including the school nurse intro in school handbooks for new students. Essentially, *"if students don't know what we do, we need to tell them more clearly"* – and they did.

31.8 Another outcome of feedback was focusing on the waiting experience. Some notes from younger children's parents suggested that waiting for an appointment could be stressful – thus, nurses arranged their schedules to minimize waiting times and often offered drop-in clinics instead of strict appointments, which families found easier.

31.9 Shared Learning:

The team doesn't treat feedback in isolation; themes from one school's feedback are shared across all localities. For example, once they saw how effective it was to put blinds up in one school, they proactively checked other schools for similar issues. When students in one area highlighted stress about transition to college, the nurses in other areas pre-emptively added more info on that topic in their Year 11 sessions. This way, lessons learned in one locality benefit the whole county service.

31.10 Service Culture:

Embracing feedback has become part of the service's culture. Staff are proud when they get positive comments, and they openly discuss critical feedback without defensiveness – focusing on solutions. Every quarter, the team reviews IWGC results and comments. If a particular nurse receives a critique, the team supports that nurse to improve (for example, if a comment said a nurse was hard to reach by phone, colleagues might help by implementing a better phone coverage system).

31.11 Impact of Changes:

These feedback-driven changes have had tangible impact. Since addressing the privacy and advertising issues, an uptick in self-referrals was observed in some schools – indicating more students were comfortable and knew about the service. Schools have also commented that after these improvements, students appear more willing to visit the nurse. Additionally, the act of responding to feedback builds trust: when students see that their suggestions led to real changes, they feel heard and respected, which encourages further engagement and honesty in the future.

In conclusion, the school nursing service actively learns from feedback and adapts. The willingness to make even small adjustments (like scheduling or environmental tweaks) has enhanced the quality of care and user satisfaction. This continuous improvement loop means the service stays user-focused and keeps evolving to meet the needs of children, young people, and families in the best possible way.

32 LOCAL CONTEXT AMID NATIONAL CHALLENGES

National reports in recent years have raised concerns that school nurses are increasingly overwhelmed with complex safeguarding cases, leaving less time for their preventative public health role. Oxfordshire's experience reflects some of these challenges, but proactive changes have been made to mitigate the impact and preserve the service's wider remit.

33 NATIONAL PERSPECTIVE

A joint policy statement (2014) by public health organisations highlighted that *"the majority of school nurses reported being unable to fulfil their public health role,"* with 38% of school nurses spending over half their time on child protection or child-in-need cases. In other words, across the UK many school nurses are so occupied with the most at-risk children that they struggle to do health promotion or early intervention for the broader population. This situation, described as "firefighting rather than prevention," is seen as unsustainable because it compromises the Healthy Child Programme's preventive aims. The **SAPHNA survey** also mirrors this: school nurses feel stretched to breaking point, often covering thousands of pupils each, which forces them to prioritise crises over routine health education. [saphna.co] [nursinginp...actice.com],

34 LOCAL WORKLOAD AND MODEL CHANGES

In Oxfordshire, the demand and complexity of cases have indeed increased, especially following the COVID-19 pandemic. More children and young people are presenting with mental health crises, safeguarding disclosures, or complex psychosocial issues, adding pressure on the school nursing team. However, rather than allowing the preventive work to be completely eroded, the service underwent a restructuring in September 2024 with the commissioning of the new 0–19 service:

34.11 From School-Based to Locality-Based: Previously, each secondary school and college had its own dedicated full-time school nurse on site (which was a strength in accessibility but inadvertently left primary schools with much less input). With the new 0–19 locality model, nurses now cover *all* ages 0–19 in a given area, and specifically for school nursing, each nurse visits their assigned secondary schools weekly (not full-time there). This shift allowed the freed capacity to be reallocated to primary schools, which historically had limited nurse involvement. As a result, primary-aged children now receive far more equitable support (for example, nurses can run clinics or do classroom sessions in primary schools regularly, which was not possible when all nurses were tied to secondaries). Thus, while secondary schools lost an on-site everyday nurse, they still get at least weekly service, and primary schools gained significant service. This addresses a previous *inequity* and is a win from a prevention standpoint – many issues can be caught earlier in primary years.

34.12 Maintaining Relationships: Importantly, because Oxfordshire had a period where nurses were school-based, they built strong relationships in those schools. Even after moving to locality teams, those relationships persisted. Schools still consider the nurse "theirs," even if she's not there every day, and will reach out. Nurses have worked hard to reassure schools that although the model changed, they will still respond to urgent issues promptly and will be

flexible if a school has greater needs suddenly. Essentially, the trust established means the new model hasn't led to schools disengaging; instead, they appreciate that now their feeder primaries are also getting support.

34.13 Safeguarding as a Team Effort: The service has emphasised that safeguarding is everyone's business, not solely the school nurse's responsibility. Within the multi-disciplinary 0–19 teams, cases are discussed and, where appropriate, shared or escalated. For instance, the most complex family might have both a health visitor (for a baby sibling) and a school nurse involved; they can jointly visit, or one can cover relevant meetings. The school nurses are also supported by the trust's safeguarding leads, the service leadership and by social care for tasks that truly belong to social workers (school nurses should not become de facto social workers). The service echoes the national guidance that while they contribute vitally to safeguarding, it *"should not interfere with performance of their own public health functions"*. By conscientiously referring up cases that need social worker lead and by declining inappropriate asks (for instance, if asked to take on something outside their scope in a social care-led plan), they protect some time for their preventive work. [saphna.co]

34.14 Ongoing Preventative Roles: Despite higher complexity, Oxfordshire school nurses have sustained their prevention activities. They remain heavily involved in delivering PSHE content (as demonstrated by the large number of sessions on health topics in schools) and continue to provide sexual health services and general health advice in schools. The team has not withdrawn to a reactive-only service; they still run drop-ins for any health topic, do assemblies, do ChatHealth advice – all preventive measures. Nurses are adept at balancing: they triage their workloads so that urgent safeguarding is addressed *immediately*, but once those are in hand (or handed over appropriately), they return attention to things like health promotion campaigns.

34.6Early Intervention and Referral:

The local philosophy is to intervene early and refer appropriately. For example, if a student has moderate mental health issues, the nurse might do a short intervention but then refer to a school counsellor or CAMHS before it becomes a crisis – thus preventing escalation and freeing the nurse to move to the next student. By not holding onto cases longer than necessary and connecting youth to specialised services in time, they manage their capacity. The downside is that many specialist services (CAMHS, etc.) have long waits, which is beyond the nurses' control and can leave them supporting kids longer than ideal because no one else is available. That said, they do their best to bridge those gaps with interim support as described.

34.7Impact of the 0–19 Model:

The new locality model **enabled more equitable service distribution** and arguably a broader preventive reach (especially in primaries). It was a proactive move that anticipated exactly the national concern – by sharing nurses across schools, you gain flexibility. If one school's safeguarding load explodes, the nurse can spend more time there that week, and maybe a bit less at a school that's quiet; previously, if a nurse was tied to one school, they couldn't shift their time as easily to where needed. Now the **team-based approach** allows resources to be targeted dynamically.

35 LOCAL DATA VS NATIONAL REPORTS

Locally, while no formal time-and-motion data is given here, anecdotal evidence suggests Oxfordshire's school nurses are still managing to perform their public health role. For instance, they delivered hundreds of preventative sessions and interventions as shown in the metrics – those wouldn't happen if all their time was swallowed by safeguarding. At the same time, they did participate in thousands of safeguarding-related activities (Table 2), confirming they too are dealing with high complexity.

The national reports act as a caution: without sufficient staffing, a school nurse becomes a "damage controller" rather than a health promoter. Oxfordshire's response has been to advocate for and implement measures to bolster capacity – e.g., hiring more staff (two new SCPHNs qualifying and two more in training will help expand capacity slightly), and making internal adjustments for efficiency (like better admin support, digital tools to save time on paperwork, etc.). Senior members of the team also sit on multi-agency panels (such as family safeguarding model meetings) to ensure cases are appropriately allocated.

One specific local adaptation is that each secondary school still has an identified lead nurse, even if that nurse is only there part of the week. This maintains clarity for safeguarding channels – school staff know *who* to call when something arises (avoiding diffusion of responsibility). If a nurse is spread too thin, they risk missing things; Oxfordshire tries to mitigate that by clear assignment and by ensuring nurses aren't pulled in too many directions at once.

Finally, feedback loops have helped: by asking schools and students for feedback, the service can tell if their preventive presence is slipping. So far, the feedback (as noted) has been that students continue to value the service's availability on a range of issues. If one day feedback indicated "we only see the nurse when something bad happens; otherwise we never hear from them," that would be a red flag aligning with the national warning. Thankfully, local feedback shows nurses are still known for helping with everything from stress to sex ed, not just appearing for crises.

In summary, Oxfordshire's experience "aligns and diverges" from the national picture:

- Aligns, in that school nurses here are indeed dealing with more complex cases and feeling the strain of rising demand, reflecting the national trend.
- Diverges, in that through service model innovation and teamwork, they have avoided an excessive reduction in preventative work. They actively continue early intervention and health promotion roles, and share safeguarding duties within a multidisciplinary context so that it doesn't completely dominate their workload.

The service remains vigilant. The report acknowledges that the increased complexity and post-Covid demand have put pressure on all services, including school nursing, and contributed to longer waits elsewhere. In this climate, the school nurses' commitment to *"remain responsive to the evolving needs of our community"* is clear – they regularly seek feedback and adapt accordingly. The HOSC can take assurance that Oxfordshire's school nursing service is aware of the national concerns and has proactively adapted its practise to ensure it can continue delivering both safeguarding and prevention effectively, rather than sacrificing one for the other.

healthwatch Oxfordshire

Your voice on health and care services

Report to the Oxfordshire Joint Health Overview and Scrutiny Committee

November 20th 2025.

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1. Healthwatch Oxfordshire reports to external bodies

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

We attend Health and Wellbeing Board, Health Improvement Board, Children's Trust Board, Health Improvement Board, Oxfordshire Place Based Partnership and Oxfordshire Neighbourhood Health and Marmot Oxfordshire meetings. We bring insight into committees at Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level.

A summary of our **Quarter 2** (Jul-Sep) activity can be found here: https://healthwatchoxfordshire.co.uk/impact/activities-and-achievements/

We made formal comment on emerging local and national strategy here: https://healthwatchoxfordshire.co.uk/news-and-events/correspondence/

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

Healthwatch Oxfordshire reports published:

The following reports were published since the last meeting and can be seen here: https://healthwatchoxfordshire.co.uk/reports All reports are available in **easy read**, and word format.

- **Trans and non-binary people's experiences of GP services in Oxfordshire- (October 2025)**
- **Digital healthcare and the NHS App -Voices from Oxfordshire (Nov 2025)**

See below for our two summaries of these reports

To read more about the **impact** of all our reports, and commissioner and provider responses and agreed actions, see here: https://healthwatchoxfordshire.co.uk/impact/

healthwatch Oxfordshire

Trans and non-binary people's experiences of GP services in Oxfordshire

Trans, non-binary and gender diverse (trans+) people are more likely to experience poor physical and mental health, and to face barriers in getting the health and care they need.

As part of a national study, Healthwatch England commissioned Healthwatch Oxfordshire to listen to local trans+ people in the county about their experiences of using GP services. We heard from 45 trans+ people via an online survey, in-person outreach and in-depth phone conversations.

What did we hear?

We heard that there are examples of good practice across Oxfordshire, where trans+ people are treated with respect and dignity, and able to access the care they need – but that this is inconsistent.

Some of the trans+ people we spoke to do not feel confident using their GP practice. People told us about barriers and challenges including:

- Long waits for NHS Gender Dysphoria Clinics (GDCs) and a lack of support while waiting
- A 'postcode lottery' of access to gender-affirming hormone therapy
- GPs not having the understanding of, or confidence in, trans healthcare to provide the support people need
- A lack of clarity and transparency in terms of what trans+ people can expect from GP practices and how to access care and support
- Not being respected, or being misgendered, by practice staff
- Problems with changing personal details (such as name, title and gender marker), including people losing their previous NHS records, being misgendered at the practice or in communications, and losing access to preventative screening.

"My GP seems okay with my identity but was not comfortable with continuing my testosterone prescription without specialist involvement even though I have been discharged by the NHS GDC back into the care of the GP."

"GP did not feel qualified to do anything and relied on me to get informed."

"My GP changed my gender marker without my consent or asking me if that was what I wanted at the time. I hadn't started transitioning medically and I would have preferred to wait as I was going through health issues and this just made things more difficult to explain to NHS specialists outside of transition related care."

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We heard about the positive difference it makes when:

- GP practice staff are compassionate, respectful and willing to learn
- GPs support people to access and navigate gender-affirming care, for example through referrals, bridging prescriptions, shared care or blood tests
- Administrative changes are made quickly and effectively.

"My GP is empathetic and has been proactive in learning about things that are less familiar and chasing up possible avenues for me to receive some specific procedures."

"We appreciate all the hard work to be inclusive, accepting, patient and understanding. Every doctor has checked my name and pronouns."

What happens next?

We have sent our report to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, which commissions GP services in Oxfordshire. They have committed to commissioning training for GP practice staff on understanding and competency in trans healthcare, providing guidance for GPs on prescribing gender-affirming hormone therapy, and setting up an LGBT+ page on their engagement platform, Your Voices.

Talk to us!

You can share feedback about your GP practice and other health and care services at:

- **healthwatchoxfordshire.co.uk/services**
- **hello@healthwatchoxfordshire.co.uk**
- **01865 520520**

Local support

Here are details of some local support organisations:

- Local events and organisations for trans+ people in Oxford **oxfordtransrights.org/trans-in-oxford**
- Abingdon Queer Action **@abingdonqueeraction** on Instagram and **@abingdonqueer** on Facebook
- Topaz – social group for LGBT+ young people **www.topazoxford.org.uk**
- Silver Pride – Age UK events for older LGBTQ+ people in Didcot and Banbury. Contact **community@ageukoxfordshire.org.uk** or **01235 849434**
- My Life My Choice LGBT self-advocacy group – for LGBT people with a learning disability **mylifemychoice.org.uk/lgbt-group**

Thanks to everyone who shared their views with us!

You can read our full report by scanning the QR or at healthwatchoxfordshire.co.uk/report/trans-experiences

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Digital health care and the NHS App – voices from Oxfordshire

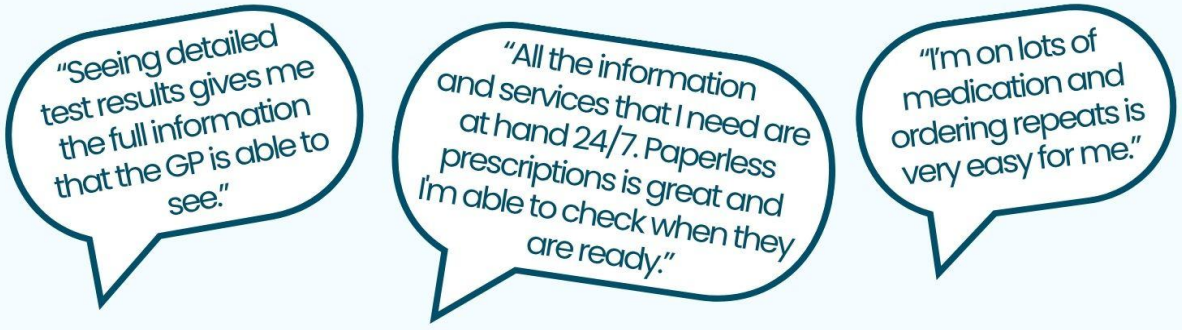
What did we do?

NHS England is undergoing major reform, including the expansion of digital health tools and services such as the NHS App. Although there is evidence of the benefits of using digital technology for health care, many people still face barriers using it.

We ran two surveys (one online and one face-to-face) to capture the views and experiences of people from a variety of backgrounds across Oxfordshire. In total we heard from 823 people.

What did we hear?

- Almost everyone said that they had heard of the NHS App, and most people had used it at least once.
- The commonest reasons for using the App were to:
  - Order repeat prescriptions (76%)
  - View personal health records and GP notes (70%)
  - Book and manage health appointments (43%)
- 58% of people agreed that the NHS App helps them manage their health and care.
- People value the ease of use, convenience, efficiency and access to information on the App.



Those who told us they had poor access to technology (signal, cost or equipment) or low confidence or skills in using digital methods, and those wanting to maintain choice around use of digital health care, found it difficult to use the NHS App or chose not to use it.

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- A quarter of the people we reached face-to-face across the county told us they had not used the NHS App.
- There is geographical variation - not all GP practices offer access to the full range of digital services on the App.
- Many people said they felt that digital technology is too impersonal and overlooks the essential 'human contact' aspect of health care.
- Some people feel 'forced' into using the App and are worried that digitalisation might affect their access and choice in health care.

What do we think should be improved?

Based on what you told us, we have made a series of recommendations for improvements, around:

- Increasing tailored support and accessibility for patients to use the NHS App
- Clarity about choice and data safety
- Involving patients in testing future NHS app development
- Addressing barriers in Oxfordshire, including rural digital access and cost

You can read our recommendations in full in our report - see the link below.

What happens next?

We have sent our report and recommendations to the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and other health leaders in Oxfordshire.

We will continue to share what you told us about using the NHS App with health and care decision-makers in Oxfordshire.

Thanks to everyone who shared their views with us!

You can read our report in full by scanning the QR code or at www.healthwatchoxfordshire.co.uk/nhs-app

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- **Enter and View Visits**

We have statutory powers under the Health and Social Care Act 2012 to make **Enter and View** visits to publicly funded local health and social care services. The aim of these visits is to identify what works well and what could be improved to make people's experiences better. Since the last meeting we made Enter and View visits to the following services:

- Breast Imaging Unit -Churchill Hospital
- Children's Ward – Horton Hospital
- Wintle Ward, Warneford.

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

- Well Pharmacy, Marston (October 2025)

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

Healthwatch Oxfordshire Webinars: Since the last meeting we held two public webinars:

- September on the '**NHS Ten Year Plan**' with speakers from BOB ICBattended by 60 people.
- October on **Cancer Care** and support with speakers from Maggie's and Thames Valley Cancer Alliance.

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

Our **next webinar** will be on:

- '**Neighbourhood Health' Tuesday January 20th 2026. 1-2pm.** Zoom link via above.

Our ongoing work includes:

- A focus on hearing from people about views on **end of life care**, https://healthwatchoxfordshire.co.uk/have-your-say/complete-a-survey/ with online survey supplemented by focused outreach. Working alongside Oxfordshire Palliative Care network and others.
- In Quarter 2 we engaged directly with approximately 506 people across the county through attending events, hospital stands, community gatherings and play days and Patient Participation group meetings.
- Additional funding with OCC (Oxfordshire Community Research Network) to undertake community led development of a toolkit for community researchers in Oxfordshire. This takes place from Sept-Dec via 4 workshops to co-produce the materials. Over 20 people attending from grassroots groups in Oxfordshire's priority areas.
- Community research including, focus on hearing from families living in temporary accommodation, members of the Chinese community.
- Working with Sunrise Multicultural Centre with a focus on cancer awareness, and bringing in Breast Nurse to speak with the women's group.

3. What we are hearing from the public:

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

The top three services we hear about are: GP services, outpatient services, and Muscular Skeletal services (Cora Health). Examples of comments include:

Arriving by ambulance at A&E after a serious fall out walking, my wife was admitted efficiently and without undue delay. I felt she was treated efficiently and with great consideration and understanding for her situation. She was in great pain following what was later diagnosed to be an upper limb fracture. The staff were incredibly kind and attentive to her needs as the diagnosis and treatment progressed. I felt it was an example of the NHS proving itself at its best. The experience demonstrated

to us both that the people of the NHS were exceptional people. (Online review: John Radcliffe)

I visited Henley MIU to have stitches for a laceration on my face. Nurse [name] and nurse associate [name] were both amazing. (outreach at Henley)

Henley MIU Nurse was efficient, friendly and gave me the time I needed. They explained how my wound was being treated and how I needed to care for it. I left reassured, clutching an NHS sheet on wound care, thinking how lucky I was. (outreach at Henley)

I have been waiting for an appointment for my knee since march of this year, every time it gets close to my appointment I get a message to say the that appointment has been cancelled, it's extremely hard to get through via the phone system… I am left in constant pain, my mental wellbeing is badly affected by this, I am struggling with my job and potentially my job is at risk due to lack of action from Cora Health, they simply are not fit for purpose! (online review Cora Health)

Months after leaving hospital, still waiting for a telephone assessment let alone treatment. Effectively no NHS physio after discharge. (online review Cora Health)

For one of the referrals they forgot to send a piece of paper so by the time I had the appointment it was out of date and I had to go back to the doctor. Then numerous appointments were cancelled. It's been confusing - I was given a phone appointment but then was given another one and told 'you can't have more than one appointment on the system'. I had an appointment yesterday which I'd been led to believe would involve an injection but in fact it was just an assessment and the next appointment isn't until after Christmas. (online review Cora Health)

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Oxfordshire Place-based Partnership

Oxfordshire Neighbourhood Health and Care

November 2025

Introduction

1. The national and local priority in health and care over the next 5-10 years is to bring support closer to where people live, work, and connect. It will create a proactive, community-led system that focuses on what matters most to local people, staying well, staying independent, and staying connected. This will be enabled by **three key shifts**: from hospital to community, from sickness to prevention, and from analogue to digital. Neighbourhood Health and Care embodies these shifts.
2. This approach will strengthen relationships between communities, the statutory sector and the voluntary, community, faith and social enterprise (VCFSE) sector. By **working together** and recognising the expertise that already exist within neighbourhoods, we can provide the right combination of health and care services, practical support, and social connection. This approach is aligned to the delivery of the *Oxfordshire Way.*
3. At this stage the guidance is only partly released but the overall direction is understood. Neighbourhood Health and Care Plans will need to be approved by the Oxfordshire Health & Wellbeing Board in [date] subject to the final guidance. This report updates HOSC on the development and engagement work to date, and sets out next steps.
4. HOSC is asked to note the report and highlight any key issues to be considered in the planning process.

Planning and oversight requirements

5. NHS England and the Department of Health and Social Care (DHSC) have developed a variety of **guidance and framework documents** relevant to Neighbourhood Health and Care which set out national expectations and the opportunity. These include:
    - 10 Year Health Plan for England: fit for the future, July 2025.
    - Medium Term Planning Framework, October 2025.
    - Strategic Commissioning Framework, November 2025.
    - Draft Model Neighbourhood Framework, awaiting publication.
    - National Framework for Neighbourhood Health Plans, awaiting publication.
    - Model System Archetypes, awaiting publication (commissioning and provision, including types of contracts).
    - Model Neighbourhood Health Centres Archetypes, awaiting publication (for existing estate and potential new).
    - Revised Better Care Fund [BCF] guidance 2026/27, awaiting publication. NHS England has been clear that the BCF should be aligned to Neighbourhood Health and Care delivery, and it may be that this will set out how investment should support both programmes.
6. The **Oxfordshire Neighbourhood Health and Care Plan** will be overseen and approved by the Oxfordshire Health and Wellbeing Board (HWB) ahead

of April 2026, this will also be followed by an operational plan by quarter 2. 2026/27 is recognised as being a transition year for Neighbourhood Health and Care, with the requirement to produce a more comprehensive plan for the next five years, commencing from April 2027 alongside anticipated legislative changes enabling HWBs to become formally accountable for Neighbourhood Health and Care plans. This would be aligned to the timeline for Local Government Reorganisation.

7. Oxfordshire has established governance and oversight arrangements to support with the design, development and delivery of Neighbourhood Health and Care. Although the HWB will approve and monitor delivery of plans, the Oxfordshire Place Based Partnership (PBP) will be responsible for leading the delivery of Neighbourhood Health and Care via the **Primary and Community Care Board** which has been established to deliver this**.**
8. **Figure 1** sets out how the Oxfordshire Neighbourhood Health and Care programme has been designed. It seeks to align statutory and organisational governance with a range of existing programme Boards to support the design and delivery of Neighbourhood Health and Care. These alignments of boards and workstreams are intended to be broad and inclusive and will be reviewed on a regular basis to ensure key stakeholders are involved as the programme develops.

Emerging Governance - 2026

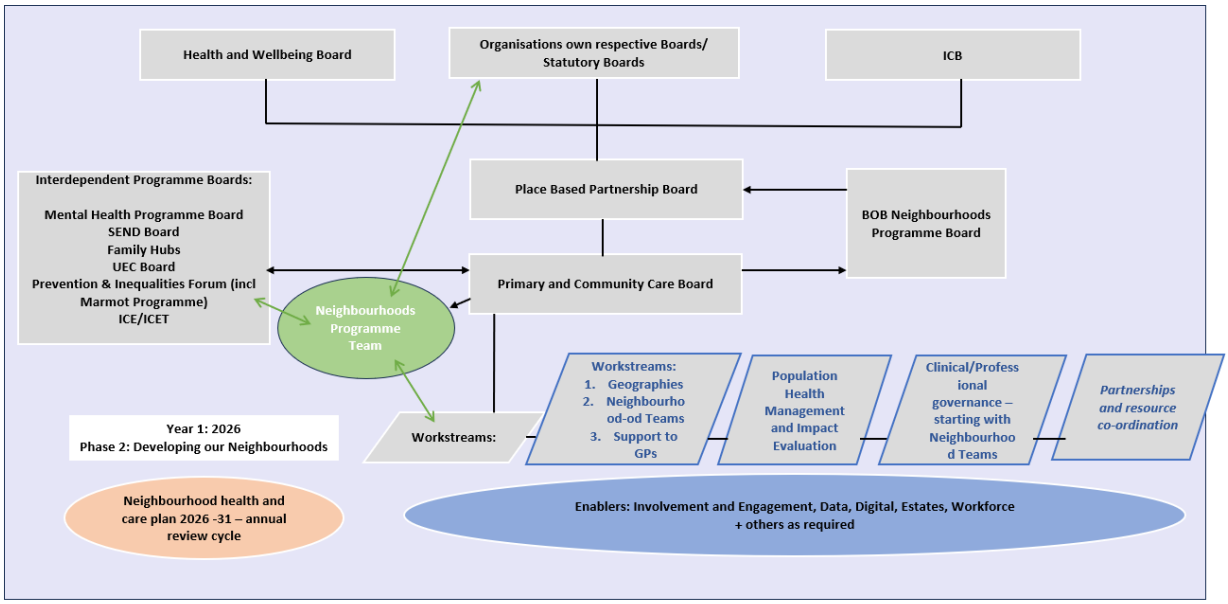

Figure 1. Emerging Governance for Oxfordshire Neighbourhood Health and Care.

9. Given the importance and scale of Neighbourhood Health and Care, there is a need to involve and **engage a wide variety of stakeholders** outside of these governance arrangements. Several events have already taken place but there is a commitment to ensure that this continues.

Examples of neighbourhood working in Oxfordshire - learnings

10. Although Neighbourhood Health and Care is a relatively new term, Oxfordshire has a track record of delivering multiple components of this. Plans are being developed to extend this throughout Oxfordshire, to enable more equitable outcomes for some of the most vulnerable and complex residents.
11. Oxfordshire has four mature **Integrated Neighbourhood Teams** (INTs) that support some of the most frail residents within their footprints. These teams came about through population health management (PHM) approaches to firstly identify key population cohorts, and then to organise resources that better coordinate and deliver care. Initial findings are positive and suggest that those under the care of INTs have avoided and/or reduced inpatient care. There are also two specialty INTs that focus on children and young people (CYP) and high intensity users (HIU).
12. Two Primary Care Networks are currently running weekly **multi-disciplinary team** (MDT) meetings with gerontology support focusing on frailty, this means residents can receive care and support closer to their home, often in a more timely manner.
13. There are several organisations that deliver **at scale primary care** services in Oxfordshire, these include home visiting services, out of hours support and urgent care centres (UCC). This puts Oxfordshire in a good position to consider how multi neighbourhood providers could bring further benefit to Oxfordshire residents.
14. Outside of formal health-led services there are a number of locality-based initiatives that might be aligned to future Neighbourhood Health and Care, such as Community Health Development approaches in the most deprived areas, Local Area Coordination and “patch-based” locality working in social care or the VCSFE.
15. The redevelopment of Wantage Community Hospital, co-produced with the local community and health and care partners, to co-locate a wider range of services aligned to local population needs highlights an example of adapting an existing asset through a range of funding sources to improve community-based care.

Progress to date

16. Throughout the summer, a series of workshops took place to socialise the concept of Neighbourhood Health and Care. Attendees represented multiple sectors, organisations and perspectives, these included health and social care, local government, academia, the care sector, patient participation groups (PPG), Healthwatch Oxfordshire and the wider VCFSE sector.
17. The workshops culminated in an **agreed vision** (**Figure 2**) for Oxfordshire, a list of consolidated challenges and critical thinking in terms of an improvement methodology applied to real world scenarios.

- Oxfordshire Neighbourhood Health and Care is committed to delivering a model of care that is
  - **simple** to navigate
  - **accessible** to all
  - rooted in **prevention**
- Long-term **sustainability** is driven by **integrated and collaborative** working across providers, ensuring coordinated and efficient use of resources. This approach is underpinned by a continued focus on **high-quality care**, defined by **patient safety**, **experience**, and **outcomes**, and supported by a **compassionate** culturally **attuned** workforce.
- Strong and evolving **partnerships** with **communities** remain central to developing neighborhoods. Fostering **trust**, **relevance**, and shared **accountability** for health and wellbeing.

Figure 2. Oxfordshire Neighbourhood Health and Care Vision

18. Much subsequent correspondence from NHS England and DHSC regarding Neighbourhood Health and Care has focussed on how it will galvanise health and social care services. Whilst this is undoubtedly of great importance, stakeholders throughout Oxfordshire have been keen to highlight the relevance and significance of the **wider determinants of health** and building on the existing strong partnership work across social care and health and wellbeing. This fits well with the Oxfordshire **Marmot County** work that is underway, as well as the Oxfordshire Health and Wellbeing Strategy, and the delivery of the Oxfordshire Way.
19. The Oxfordshire Neighbourhood health and Care plan will be designed and delivered across the broad range of factors that impact the health and wellbeing of residents, summarised in **Figure 3**.

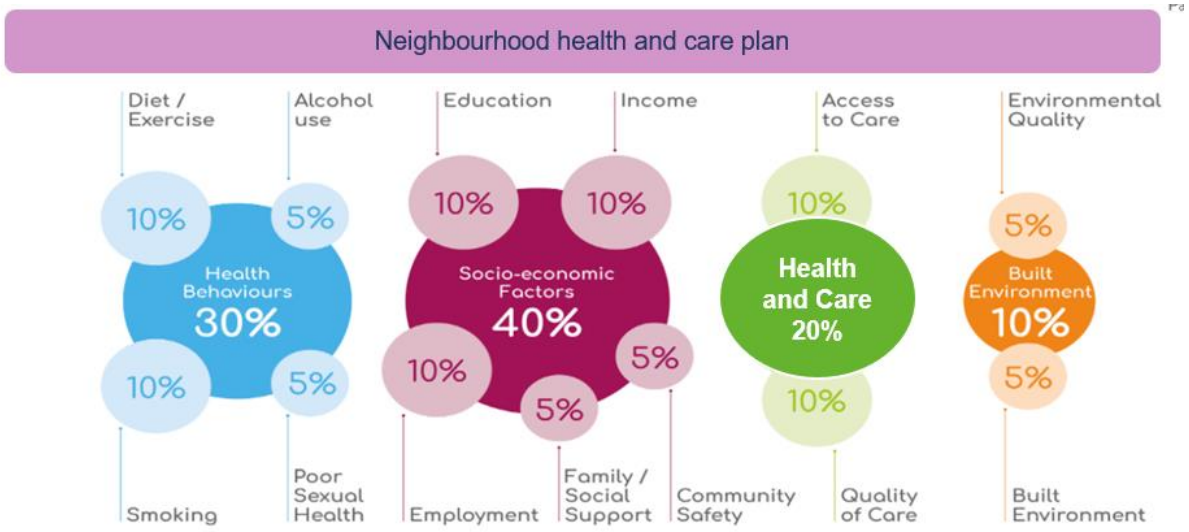

Figure 3. Wider determinants of health and wellbeing

20. HWB members recently participated in a workshop to consider how Neighbourhood Health and Care may impact delivery of the **Health and Wellbeing Strategy**, across the life course (Start Well, Live Well, Age Well).

Alongside wider stakeholder engagement, a set of **design principles** for Neighbourhood Health and Care have been developed (Figure 4) and socialised with wider stakeholders. These complement the principles which underpin the Health and Wellbeing Strategy; preventing ill health, tackling health inequalities, closer collaboration

Figure 4. Neighbourhood Health and Care design principles

21. To simplify messaging around Neighbourhood Health and Care, the following ambitions set out **what is expected to be different** for residents:
    - More people and families supported to live independently in their homes and local communities.
    - Narrowing health inequalities for the most underserved communities and disadvantaged population groups.
    - Strong alliances between the VCFSE sector, local government and health and care services enabled through engagement and involvement between people, families and staff.
    - Data alongside local insights and experiences from people, families and staff directly informs decision making.
    - Resources are aligned to achieve equity of outcomes amongst neighbourhoods and residents.
    - Oxfordshire recognised as a model for how a rural-oriented and historical city county with world-class research, development and innovation delivers neighbourhood-based health and care.
22. The graphic in Figure 5 helps depict what a Neighbourhood structure could look like for residents. Input has been sought from a wide variety of stakeholders and it is anticipated that this will be updated as collective thinking progresses throughout Oxfordshire. Please note, terminology is variable and everchanging, the production of a glossary of terms and definitions is underway.

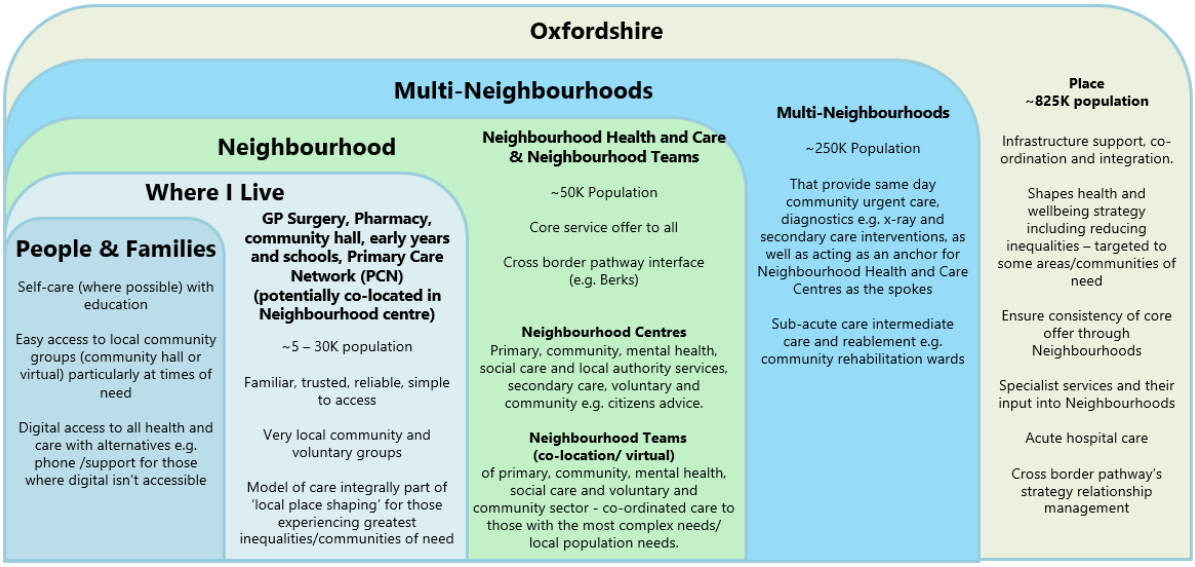

Figure 5. Draft Neighbourhood structure

Population Health Management (PHM) Approach

23. Oxfordshire is making efforts to improve the approach its population health management (PHM) and evaluation capability. This is aligned to multiple agendas and strategies and particularly relevant to Neighbourhood health and care.
24. Public Health (amongst other organisations and functions) in Oxfordshire has both capability and capacity with regards to PHM. It has been identified by leaders as being the most logical place to drive forward PHM, through a health and social care lens. Alongside ongoing developments associated with PHM, Oxfordshire is also developing a Health Impact Evaluation Unit, this will help identify which initiatives and interventions are having the greatest impact, in real time.
25. The Health Economics Unit has been commissioned in partnership by Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB and Oxfordshire County Council (OCC) to complete a short-term piece of work to support improvements in this area. The aim of this engagement is to increase and optimise PHM and evaluation capability, capacity and culture throughout Oxfordshire, it will involve:
    - Mapping of PHM capacity and capability (including human and digital resources).
    - Delivery of training modules, tailored to relevant staff groups.
    - Development of PHM data packs through place, locality and PCN populations.
    - Applied learning to real world scenario to identify key population / cohorts and potential interventions.

Next Steps

26. To further progress planning and delivery requirements for Neighbourhood Health and Care, Oxfordshire has been divided into four planning units (North, West, City and South) to complete some time limited work. This will allow more in depth and meaningful stakeholder engagement with professionals and residents alike.
27. Each planning unit has been allocated a coordinator who has been tasked with the following between now (November) and April 2026.
    - Identify named liaisons from local sectors to map local connections and relationships.
    - Bring together and build upon existing community asset and capability mapping for cluster geography.
    - Identify local strengths, gaps and challenges to help inform development of Neighbourhood Health and Care plan.
    - Develop plan to agree neighbourhood geographies that are yet to be determined, alongside any further issues to overcome.
    - Identify local priorities or approaches or relevance to neighbourhoods e.g. care pathways, population cohorts.
28. The above tasks are subject to changes as per the forthcoming "National Framework for Neighbourhood Health Plans". It is anticipated that these steps will support Oxfordshire to develop its' Neighbourhood Health and Care Plan ahead of April 2026. This will also enable organisations and stakeholders to develop and strengthen relationships with local partners.
29. Further stakeholder engagement will take place throughout coming months, and indeed throughout the life of this programme. As a starting point, a reference group has now been established, alongside a dedicated forum for VCFSE engagement in Oxfordshire. This will be utilised alongside existing community networks and trusted relationships that have further developed in recent years, such as those obtained through the Well Together Programme, Community Health Development Officers and Local Area Coordinators.
30. The plan will be drafted in conjunction with other NHS and Local Authority plans and associated processes, for example the Better Care Fund Plan. Oxfordshire's long standing joint commissioning arrangements and track record of system working, mean that there are established approaches, principles and forums to not only develop a plan for Neighbourhood Health and Care, but also to deliver it.

Report drafted by Chris Wright, Associate Director of Place – Oxfordshire, BOB ICB, on behalf of **Oxfordshire Neighbourhood Health and Care Programme Team**:

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Work Programme 2025/26
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna | Dr Omid Nouri, Health Scrutiny Officer, omid.nouri@oxfordshire.gov.uk

COMMITTEE BUSINESS

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
20 November 2025				
Children's Emotional Wellbeing and Mental Health (Strategy, CAMHS, and School Nurses)	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from system partners with an update on the delivery of the Children's Emotional Wellbeing and Mental Health Strategy, CAMHS services, and School Nurse services.	Overview and Scrutiny	Caroline Kelly
Neighbourhood Health Plan for Oxfordshire	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update on the development of the governance framework as well as the initial steps taken by system partners as part of establishing a neighbourhood health plan for Oxfordshire.	Overview and Scrutiny	Michelle Brennan
29 January 2026				
Director of Public Health Annual Report	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive the draft Director of Public Health Annual Report prior to its launch at Oxfordshire's Full Council.	Overview and Scrutiny	Ansaf Azhar
Health Visitors Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on Health Visitor Services in Oxfordshire	Overview and Scrutiny	Dan Leveson

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
Maternity Services in Oxfordshire	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report with an update on ongoing developments and challenges around maternity services. This will also be a progress update on recommendations previously issued by the Committee	Overview and Scrutiny	Olivia Clymer
16 April 2026				
South Central Ambulance Service Performance Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from SCAS on its CQC improvement journey and on its performance in Oxfordshire more broadly.	Overview and Scrutiny	David Eltringham
Oxfordshire Learning Disability Plan	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from system partners on the development and launch of the Oxfordshire Learning Disability plan/strategy.	Overview and Scrutiny	Karen Fuller
Dentistry Services in Oxfordshire	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from the NHS Integrated Care Board on developments around improving NHS dentistry access and contracts.	Overview and Scrutiny	Hugh O Keefe

Recommendation Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Omid Nouri, Health Scrutiny Officer, omid.nouri@Oxfordshire.gov.uk

The action and recommendation tracker enables the Committee to monitor progress against agreed actions and recommendations. The tracker is updated with the actions and recommendations agreed at each meeting. Once an action or recommendation has been completed or fully implemented, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker.

KEY	Report due	With Cabinet / NHS	Complete

Recommendations:

Meeting date	Item	Recommendation	Lead	Update/response
11-Sept-25	Retaining the functions of Healthwatch Oxfordshire	1. For system partners to safeguard and develop the Healthwatch function, and to 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. It is recommended that the Oxfordshire JHOSC has an opportunity to scrutinise any local decisions on this before they are made.	Matthew Tait, Dan Leveson	With NHS Partners
11-Sept-25	GP Access & Estates in Oxfordshire	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.	Julie Dandridge, Matthew Tait, Dr Michelle Brennan, Rachel Jeacock	Sent to NHS on 11-Nov-25

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
		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.		

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
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	CM Children and Young People	Update provided in Agenda item 8
06-Jul-24	GP Provision	Julie Dandridge; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	Hugh O'Keefe; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	Rachel Corser; Dan Leveson	Progress update to be provided
26-Nov-24	Medicine Shortages	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date	Item	Lead	Update
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	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
05-Jun-25	Oxfordshire Healthy Weight	Derys Pragnell	Progress update to be provided
05-Jun-25	BOB ICB Operating Model Update	Matthew Tait; Dan Leveson	Progress update to be provided
05-Jun-25	Health and Wellbeing Strategy Outcomes Framework	Cllr Leffman; Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
05-Jun-25	Oxford Health NHS Foundation Trust People Plan	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	Progress update to be provided
11-Sept-25	Musculoskeletal Services in Oxfordshire	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	Progress update to be provided
11-Sept-25	Cancer Services in Oxfordshire	Matthew Tait; Felicity Taylor; Andy Peniket	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date	Item	Lead	Update
11-Sept-25	Audiology Services in Oxfordshire	Matthew Tait; Neil Flint; Phil Gomersall	Progress update to be provided
11-Sept-25	Oxfordshire System Pressures	Dan Leveson; Lily O'Connor; Karen Fuller	Progress update to be provided