OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 16 April 2026 commencing at 10.00 am and finishing at 3.28 pm.

Present:

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

Officers:

- Dr Lola Martos (Consultant old age psychiatrist and Clinical Director Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate, Oxford Health NHS Foundation Trust).
- Catherine Sage (Associate Director, Adult & Older Adult Mental Health and Partnerships Oxford Health NHS Foundation Trust).
- Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust).
- Jess Wilshire Jess Willsher (CEO, Oxfordshire Mind)
- Matthew Tait (Executive Delivery Officer, Thames Valley ICB).
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council)
- Bhavana Tank (Head of Joint Commissioning Live Well).
- Donna Husband (Head of Public Health Programmes – Start Well – public Health, Oxfordshire County Council)
- Mark Chambers (Head of Children's Community Services Community Health Services, Dentistry and Primary Care Directorate | Oxford Health NHS Foundation Trust)
- Emma Leaver (Chief Operating Officer for Community Health Services, Dentistry & Primary Care, Oxford Health NHS Foundation Trust)
- Taylor Nicola (Senior Clinical Lead for Public Health)
- Ansaf Azhar (Director of Public Health, Oxfordshire County Council).

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.

14/26 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies for absence were received from Councillor Judith Edwards.

15/26 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Councillor Garnett declared a personal interest as an employee of the University of Oxford, Primary Health Care Department.

Barbara Shaw declared a personal interest as Chair of Healthwatch Oxfordshire (HWO) and as a Patient Safety Partner at Oxford University Hospitals NHS Foundation Trust (OUH).

Sylvia Buckingham declared a personal interest as a Patient Safety Partner and a Trustee of Healthwatch Oxfordshire.

The Chair declared her standing interest as an employee of a national epilepsy and sudden unexpected death in epilepsy (SUDEP) charity.

No further declarations were made.

The Committee **NOTED** the declarations of interest.

16/26 MINUTES OF THE PREVIOUS MEETING
(Agenda No. 3)

The Committee considered the minutes of the meeting held on 29 January 2026.

The Committee **AGREED** that: the minutes of 29 January 2026 be amended, where necessary, following checking against the meeting recording to capture aspects of what a member of the public raised regarding eyecare services; and that the final amended version be treated as a true and accurate record once those checks had been completed.

17/26 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Three members of the public had registered to address the Committee.

Dr Andrew Johnson (retired Consultant Surgeon):

Dr Johnson spoke on maternity services at Horton General Hospital; due to technical issues he could not join live, so a written statement was read to the Committee.
He said removing consultant-led maternity in 2016 reduced local access and reassurance for families, and raised concerns about capacity and quality at the John Radcliffe, citing a CQC "requires improvement" rating. He argued workforce pressures could be mitigated by reinstating a consultant-led Horton unit using rotational staffing from the John Radcliffe, noting similar models elsewhere.

The Committee **NOTED** that maternity services remained an ongoing focus of the Committee's scrutiny work.

Joan Stewart (Keep Our NHS Public):

Ms Stewart said long waits and limited theatre capacity at Oxford Eye Hospital persisted, with reliance on leased theatres and constrained consultant availability. She warned delays were driving patients to the independent sector, undermining NHS training, workforce sustainability and financial viability. She also raised concerns about a lack of data on A&E presentations with complications after independent-sector surgery, arguing this reduced transparency and effective contract management.

The Committee was asked to continue scrutinising eye care services and to investigate further.

Jane Southworth (Member of Public):

Ms Southworth described being moved onto an unexplained "virtual clinic" pathway at Oxford Eye Hospital despite longstanding glaucoma and awaiting surgery, with no in-person ophthalmologist and scans reviewed remotely weeks later. She said criteria and safeguards were unclear, the model was difficult for older/frail patients, and she requested Eye Hospital senior managers attend a future Committee meeting to explain the changes and the impact on the hospital's teaching role.
In response, the Chair thanked Ms Southworth and confirmed that the Committee took these concerns seriously.

The Committee **NOTED** the public representations.

18/26 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 5)

The Committee considered written responses received to previous recommendations issued by the Committee, including responses relating to:

- Oxfordshire Neighbourhood Health Plan.
- Adult Autism and ADHD Services.

The Committee **NOTED** the responses to previous recommendations.

19/26 CHAIR'S UPDATE

(Agenda No. 6)

The Chair provided a comprehensive verbal update on activity since the Committee's previous meeting in January.

- The Chair advised that a report containing the Committee's recommendations on maternity services had been submitted to Oxford University Hospitals NHS (OUH) Foundation Trust on behalf of the Committee. The report was included within the agenda papers for transparency.

- A letter had been sent on behalf of the Committee to the Chief Executive and Chair of OUH seeking clarification in relation to errors identified in data presented to the Committee at its January public meeting item on maternity. The letter had also requested further information regarding engagement with families affected by maternity service concerns. A response had since been received from the Trust's Chief Executive, which was published as an addendum to the agenda.

- Correspondence from the Committee had continued with families affecting by OUH maternity services since January, and the Committee had taken the unusual step of offering to facilitate an initial process-planning discussion between families and the Trust to help establish an engagement approach that might be acceptable to all parties. The offer remained open and families had also been reminded of the standard routes through which they could continue to address the Committee directly in public meetings.

- The Chair updated Members on developments relating to joint health scrutiny arrangements. She reported that the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (BOB JHOSC) had met on 17 March 2026, and that, following the establishment of the new Thames Valley Integrated Care Board on 1st April 2026 with an expanded geography, proposals would be brought forward to formally dissolve the BOB JHOSC and to establish a new Thames Valley JHOSC. Recommendations

made by the BOB JHOSC remained available to Members and the public via the published minutes of its last meeting.

- There was currently one vacant cooptee position on the Committee. A recruitment exercise would be initiated with the aim of appointing an additional co-opted member ahead of the Committee's June meeting.

- The Chair reported on the work of the Primary Care Working Group, which had met four times since January, including sessions with officers of the Integrated Care Board, the Chair of the Local Medical Committee, and district council officers. She highlighted that scrutiny had focused in particular on primary care estates, including progress on the Didcot Great Western Park health facility, where a developer had now been appointed. She confirmed that further scrutiny, including visits to GP practices and additional working group sessions on estates in Didcot, Bicester and Wallingford, was planned, with findings to be reported back to the Committee in due course.

- Regarding the Substantial Change Working Group focusing on the redevelopment of Wantage Community Hospital; the Chair explained that, although negative media coverage had referenced delays, the working group's scrutiny had identified that the primary cause related to asbestos and iron issues identified during surveys. She advised that these issues had now been addressed and that completion was anticipated in late summer or early autumn 2026.

- On eye care services, the Chair reminded Members that the Committee had previously written to the Department of Health and Social Care to express concern about the impact of independent sector provision on NHS ophthalmology services. In addition to ongoing local scrutiny, Freddie van Mierlo MP had offered to pursue a response at national level on the Committee's behalf. Eyecare remained a live issue for the Committee's future work programme.

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

20/26 MENTAL HEALTH MOTION FROM COUNCIL

(Agenda No. 7)

The Committee considered a report by the Health Scrutiny Officer relating to a motion passed by Oxfordshire County Council at its meeting on 9 December 2025. The motion requested that the Health and Wellbeing Board invite the Joint Health Overview and Scrutiny Committee to investigate and report on how mental health services provided by Oxford Health NHS Foundation Trust and wider system partners

were addressing the rising prevalence and impact of poor mental health among adults and children in Oxfordshire.

The Chair outlined the context to the motion, explaining that it had been debated late in the Full Council agenda and had received cross-party support, reflecting the shared recognition of the scale of mental health need locally and nationally. She advised that, due to time constraints at Full Council, it had not been possible for the Committee to explain that substantial scrutiny of children's emotional wellbeing and mental health services had already been completed in November 2025, resulting in a detailed report with multiple recommendations, the formal response to which was still awaited.

The Chair explained that the Committee's agreed work programme already included scrutiny of adult and older adult mental health services, scheduled for the current meeting, including consideration of transition issues between children's and adult services. She therefore proposed that the Committee formally note the request arising from the Full Council motion, reaffirm its existing and ongoing scrutiny of mental health services across the age spectrum, and incorporate its findings into its next Annual Report to Council.

The Chair confirmed that mental health was already a recurring theme across the Committee's work programme, and that future scrutiny items, including sessions with the ambulance service and other providers, would provide further opportunities to explore system-wide impacts. She further proposed that, as part of its formal response to the motion, the Committee could write to the Secretary of State for Health and Social Care, summarising key findings from its scrutiny of children's and adult mental health services and highlighting relevant national context.

Following discussion, the Committee indicated that it was content with this approach.

The Committee **AGREED** to:

- **NOTE** the request arising from the Full Council motion.
- **CONFIRM** that it had already undertaken scrutiny of children's mental health services and was undertaking scrutiny of adult and older adult mental health services at the current meeting.
- Incorporate its findings and observations into its next Annual Report to Council.
- Write to the Secretary of State for Health and Social Care to highlight key findings and concerns identified through its mental health scrutiny work.

21/26 ADULT AND OLDER ADULT MENTAL HEALTH SERVICES IN OXFORDSHIRE

(Agenda No. 8)

Dr Lola Martos (Consultant old age psychiatrist and Clinical Director Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate, Oxford Health NHS Foundation Trust); Catherine Sage (Associate Director, Adult & Older Adult Mental Health and Partnerships Oxford Health NHS Foundation Trust); Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust); Jess Wilshire (Chief Executive, Oxfordshire Mind); Matthew Tait (Executive Delivery Officer, Thames Valley ICB); Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); and Bhavna Taank (Head of Joint Commissioning Live Well); were invited to attend in order to present a report with an update on Adult and Older Adult Mental Health services in Oxfordshire.

The Chair welcomed the officers and set out the context for the item, noting that it formed part of the Committee's agreed work programme and responded directly to the motion passed by Full Council in December 2025, requesting further scrutiny of mental health services.

The Oxford Health NHS Foundation Trust (OH) Chief Operating Officer for Mental Health and Learning Disability outlined the national and local context, explaining that adult mental health services continued to experience sustained increases in demand, rising clinical complexity, and significant workforce pressures. Referrals to adult mental health services had increased year-on-year, with a growing proportion of people presenting with complex trauma, co-existing substance misuse, neurodivergence and social needs such as housing instability. These pressures had affected flow through services and contributed to challenges in meeting waiting-time expectations in some pathways.

The Associate Director for Adult and Older Adult Mental Health and Partnerships provided further detail on community services and access. The Community Mental Health Transformation Programme had been central to current service redesign and aimed to strengthen multidisciplinary working, improve access, and embed voluntary and community sector support within neighbourhood-based models. While investment had supported the development of new roles such as peer support workers, officers noted that recruitment and retention of experienced mental health professionals, including nurses and consultant psychiatrists, remained challenging and continued to place pressure on teams.

Members queried waiting times for assessment and treatment, particularly for adults with serious mental illness and for older adults accessing memory services and dementia pathways. The OH Consultant Old Age Psychiatrist and Clinical Director acknowledged that demand for older adult mental health services, including memory assessment, had increased substantially, reflecting demographic change and greater awareness. She advised that this had led to longer waits in some areas, but

emphasised that work was under way to streamline diagnostic pathways, strengthen links with primary care, and ensure that people received meaningful support while awaiting formal diagnosis.

The Committee explored the operation of crisis services, including crisis resolution and home treatment teams. Officers explained that crisis services were under sustained pressure, with high demand and increasing acuity, but that the Trust remained committed to supporting people safely in the community wherever possible. The Executive Delivery Officer for the Integrated Care Board highlighted the importance of system-wide coordination, noting that pressures in mental health services had impacts across the wider urgent and emergency care system. Partners were working together to manage demand, improve flow, and reduce the need for admission where safe alternatives existed.

Members raised concerns about inpatient capacity and delayed discharges, particularly for older adults with mental health needs and dementia. Officers confirmed that delayed discharge was often linked to wider system factors, including availability of social care, appropriate housing, and community support. The Head of Joint Commissioning – Live Well explained that joint commissioning arrangements sought to address these challenges by strengthening community provision and improving alignment between health and social care, but acknowledged that progress was constrained by workforce availability and funding pressures.

The Committee asked how the experiences of older adults and carers were being reflected in service design. The Chief Executive Officer of Oxfordshire Mind described the voluntary sector's role in supporting people and carers to navigate the mental health system and highlighted feedback consistently received from carers about fragmentation and the difficulty of understanding who to contact at different points in a person's care. She emphasised the importance of integrated, person-centred pathways and of recognising carers as partners in care.

Workforce wellbeing and sustainability were then discussed. Officers described ongoing efforts to support staff through supervision, training and flexible working, while recognising that sustained pressure had an impact on morale and retention. Members emphasised the importance of ensuring that staff wellbeing was treated as integral to service quality and safety, rather than as a secondary consideration.

Members also questioned how inequalities in access and outcomes were being addressed, particularly for people living in rural areas or from disadvantaged communities. Officers confirmed that identifying and tackling inequalities was a core focus of service development and commissioning, with data used to highlight variation in access and outcomes and voluntary sector partners playing a key role in reaching underserved groups.

The Chair specifically raised the issue of the Warneford Hospital redevelopment project, noting its importance to the future configuration of adult and older adult mental health services in Oxfordshire. The Committee asked for clarity on the current

status of the project, its relationship to wider mental health strategy and service transformation, and whether there continued to be risks or uncertainty that might impact patients, staff or service planning.

In response, the Chief Operating Officer for Mental Health and Learning Disability explained that the Warneford redevelopment remained a live project within the Trust's estates and capital planning framework. He advised that the redevelopment was intended to support modern, therapeutic models of inpatient care and to bring ageing facilities up to required standards, but acknowledged that progress had been affected by national capital constraints, wider construction pressures and the complexity inherent in redeveloping a live clinical site.

The Executive Delivery Officer for the Integrated Care Board added that the Integrated Care Board remained engaged with the Trust on the Warneford project at a system level. The redevelopment formed part of broader system planning for mental health infrastructure and that assurance processes continued through established governance routes. While recognising Members' concerns about timescales, he emphasised that capital decisions were subject to national processes and affordability considerations and that these factors were outside local control.

The Associate Director for Adult and Older Adult Mental Health and Partnerships confirmed that, in the meantime, services at the Warneford continued to operate safely and that interim mitigations and maintenance arrangements were in place. Clinical risk and patient safety were kept under regular review and that service planning did not assume early delivery of the redevelopment until formal approvals were secured.

Members welcomed the clarification but stressed the importance of transparency and ongoing communication with the Committee, given the Warneford's strategic role in Oxfordshire's mental health system and its significance to staff morale, recruitment and service user confidence.

Discussion returned to crisis and inpatient services more broadly. Officers described sustained pressure on crisis pathways and inpatient beds, noting that high acuity and complexity were increasing length of stay and affecting flow. The Head of Joint Commissioning – Live Well explained that joint commissioning efforts focused on strengthening community alternatives and improving discharge pathways, but acknowledged that system-wide capacity constraints continued to present challenges.

Concluding the item, the Chair reflected that the session had illustrated both the scale of the challenges facing adult and older adult mental health services and the importance of sustained, system-wide action. Members agreed that continued scrutiny would be essential, particularly in relation to waiting times, workforce capacity, crisis provision and the experience of older adults and carers.

The Committee **AGREED** to issue the following recommendations subject to any necessary minor amendments by the Chair and the Health Scrutiny Officer offline:

1. That system partners treat equity of access as a core performance objective, with explicit action taken where neighbourhood-level variation is identified, including: addressing gaps in crisis alternatives and Safe Haven coverage, and ensuring that any neighbourhood-based models benefit rural and more deprived communities as effectively as urban areas.

2. That system partners treat co-production as a core performance objective for development and delivery neighbourhood mental health centres. It is recommended that there is an inclusion of local councils, local members and local voluntary sector working with lived experience families at any neighbourhood level included in the work programme.

3. That access standards for adult community mental health services are applied in a clinically meaningful way. It is recommended that there are clear safeguards to ensure that: early contact does not displace therapeutic continuity, that data definitions are consistent across teams, and that performance management reinforces quality and outcomes, not just speed of access.

4. For collaboration amongst system partners to identify what is needed locally for the implementation of the new government guidance on key workers/named worker for personalised care and on implementation of the Patient and Carer Race Equality Framework.

5. For collaboration amongst system partners on reducing/preventing out of area placements to include independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient. It is also recommended that there is a review that includes patients, families, and the voluntary sector to determine whether community placements are working well as a safe and conducive home setting protective against worst outcomes.

6. For any performance targets for access to physical health checks for mentally ill patients to be met. It is recommended that there are timely and regular physical health checks for those with comorbidities, and to also include a check-up of their long-term conditions.

7. For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a community mental health centre in every community; for mental health investment to be placed on a statutory footing; and for there to be support for expansion of section 75 agreements for pooled budgets or other clear mechanisms and levers for the local integration and shared ownership needed. It is recommended that local system partners call

for national support to move to multi-year funding for commissioning of the voluntary sector, and that there be clear timely arrangements for the delivery of the Modern Service Framework for mental health.

8. For collaboration among system partners to ensure that transitions from children's to adult's mental health services are as smooth and supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions.

22/26 UPDATE ON THE DEVELOPMENT OF THE ALL-AGE AUTISM STRATEGY
(Agenda No. 9)

Karen Fuller (Corporate Director - Adult Social Care); Bhavna Taank (Head of Joint Commissioning – Live Well – Housing, Education and Social Care); Dee Nic Sitric (Chief Executive- Autism Champions and Expert by Experience); and Matthew Tait (Executive Delivery Officer, Thames Valley Integrated Care Board); attended to present and discuss the draft All-Age Autism Strategy for Oxfordshire and the strategy's ongoing development.

The Chair introduced the item by noting that the strategy remained in draft and that the Committee welcomed the opportunity to provide scrutiny at this stage of its development prior to its sign off at the Health and Wellbeing Board.

The Corporate Director – Adult Social Care described the strategy as having been "on quite a journey" and stressed that, while it remained draft, it represented a significant shift in approach and language. The strategy had been co-produced across multiple organisations and that the drafting process had required repeated pauses, reflection and revision, particularly where language and framing risked reinforcing a deficit narrative.

The Chief Executive of Autism Champions and Expert by Experience provided a detailed account of lived experience and, critically, the lived experience of participating in co-production itself. She described co-production as a term that was frequently used but often misunderstood, and explained that meaningful co-production required autistic people and the autistic community to be involved from the beginning and throughout delivery, rather than being consulted at the end. The experience of attending and waiting through an extended agenda had been anxiety-provoking even though she had supportive "anchors" in the room and prior experience of attending. Small acts of reassurance (such as being approached and acknowledged in a supportive manner by the Health Scrutiny Officer), constituted practical "reasonable adjustments" and were often more impactful than large, formal interventions.

The Chief Executive of Autism Champions and Expert by Experience then addressed the broader content and direction of the strategy. She described autism as frequently "invisible" in ways that made system engagement harder, noting that autism could not be reliably inferred by appearance and that autistic presentation varied widely across

individuals. She described the challenge of engaging key stakeholders and seldom-heard voices, particularly non-speaking autistic people, emphasising that engaging non-speakers required time, relational practice and specialist expertise that were often difficult to secure within tight drafting timetables and constraints.

A significant part of the discussion focused on the difficulty of system engagement during the strategy's development. The Chief Executive of Autism Champions and Expert by Experience explained that securing the right stakeholders "in a room" had been extremely difficult and described this as a recurring barrier, despite some successful engagement activity. A major engagement session at the King's Centre had attracted high attendance from autistic people and which had been led effectively by autistic members of the working group, but she stressed that engagement remained one of the hardest aspects of delivery because the system often struggled to understand or prioritise autism as a cross-cutting issue.

The Committee explored the strategy's language, particularly around the framing of "treatment". The Chief Executive of Autism Champions and Expert by Experience challenged the implication that autism itself required treatment, noting that autism was an identity and a way of being human, not an illness. The system should instead focus on reducing stigma and removing barriers created by services and environments, so that autistic people were not pressured to fit into narrow expectations that served others' comfort rather than their own wellbeing.

Members and contributors also linked autism to wider system issues discussed earlier in the meeting, including mental health and transitions. The Chief Executive of Autism Champions and Expert by Experience stated that autism "pervaded" mental health pathways and that distress caused by unmet reasonable adjustments could present as mental health symptoms. She also stressed that autistic children became autistic adults and that the system must not allow people to "fall off a cliff" at transition points.

The Committee also heard reflections on education. The Chief Executive of Autism Champions and Expert by Experience described education as feeling separate from health, social care and mental health even though Education, Health and Care Plans were inherently multi-system. The complexity created by differing statutory responsibilities, including that education provision was the only statutory "surface" within Education, Health and Care Plans, despite the fact that many determinants of outcomes lay in health, social care and system integration. She noted difficulties engaging some education settings and highlighted the political and structural complexity of securing system-wide alignment.

Lisa Lyons (Director of Children's Services, Oxfordshire County Council) joined the meeting at this point.

The Director of Children's Services reinforced the need to keep the strategy both accessible and deliverable. Strategies should not raise expectations with commitments that could not realistically be delivered, because failure to deliver would

erode trust further. Work would continue to produce a children and young people's version in a concise, accessible format, with young people supported to shape an appropriate version of the strategy and to place it within the local offer. The role of the Parent Carer Forum was formally recognised as instrumental in organising workshops and supporting the work to reach its current draft form.

The Committee then moved into detailed scrutiny of governance and accountability. It was queried as to how much authority and "teeth" the Autism Improvement Board would have to hold partners to account if delivery stalled. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care responded that the Autism Improvement Board was co-chaired jointly with lived experience leadership and included representation from partner organisations and lived experience groups. Six implementation groups would sit beneath the Board, corresponding to six key areas within the strategy, and that each group would report up with outcome measures and Key Performance Indicators (KPIs). Where delivery was not occurring, the Board chairs would have the ability to contact relevant organisations, pursue resolution, and escalate. Escalation routes existed through wider system governance, including relevant ICB boards, joint commissioning executive arrangements and place-based partnership structures where system partners were present.

In response, the Corporate Director – Adult Social Care distinguished between youth justice and the broader criminal justice landscape, clarifying accountability and offering assurance that children in youth justice settings were entitled to enhanced service provision, including screening and specialist support. When children were remanded they became entitled to enhanced support as children in care, and that this included screening for autism and ADHD alongside other needs, making this area potentially a "good news story" to incorporate into the strategy more explicitly.

Returning to implementation arrangements, the Head of Joint Commissioning – Live Well – Housing, Education and Social Care explained that an engagement event had been held on 4 December 2025 and that invitations to participate had been issued openly. Names were being compiled across statutory partners, lived experience communities and voluntary sector organisations, acknowledging that membership would not be perfect at the outset and would need to evolve as gaps were identified.

The Committee then discussed future-proofing in the context of local government reorganisation and potential disaggregation. Members asked how the strategy would be protected from being lost or reset if council structures changed. The Corporate Director – Adult Social Care responded that the local authority would continue to have a legal duty to maintain an autism strategy, regardless of structural changes, and that caveats would be included as appropriate. Disaggregation could create challenges for voluntary sector organisations' ability to operate across multiple authorities, and that hosting arrangements and mechanisms to preserve the learning and legacy of work would need to be considered actively.

The Committee examined financial modelling and asked when financial modelling would be completed, what budgets and partner organisations would be in scope, and how affordability would be assured before final approval. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care explained that much of the intended improvement should be cost-neutral, rooted in changes to practice, communication, training and pathway working rather than new-funded provision. However, implementation planning could surface areas of genuine cost, and that financial modelling would then consider existing budgets within pooled arrangements, local authority and ICB resources and other sector contributions, with the potential to divert existing funding and seek grant funding where appropriate. Officers emphasised that the system had no additional overall money and that affordability would therefore depend on realistic scoping and prioritisation of what could be delivered.

Finally, the discussion returned to outcomes and evaluation. The Committee asked how the system would know whether the strategy was actually achieving change beyond diagnostic waiting times, particularly in relation to reasonable adjustments, accessibility and "enabling" outcomes. The discussion linked this to the intent that an implementation plan would be reviewed annually, with actions being converted into business as usual where achieved and new KPIs set for subsequent cycles, supported by listening activity and ongoing feedback from autistic people and families.

The Committee expressed that the draft strategy represented a significant step forward, but that delivery would depend on clear governance, true co-production in implementation (including reaching beyond representative organisations), realistic financial scoping, and a robust outcomes framework capturing both quantitative and qualitative experience.

The Committee **AGREED** to issue the following recommendations subject to any necessary amendments offline by the Chair and Health Scrutiny Officer:

1. That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including: how partner organisations are held to account for delivery of agreed actions; how under performance or delay will be escalated; and how assurance will be reported to the Health and Wellbeing Board and shared with scrutiny.

2. That co production principles are explicitly embedded in delivery, not only strategy development, including: a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities, sequencing actions and reviewing progress within the implementation plan; and clarity on how lived experience feedback will directly influence commissioning, service redesign and system decisions.

3. That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope; the balance between new investment and reconfiguration of existing resources; and the affordability and sustainability of priority commitments.

4. For a clear outcomes and performance framework to be developed. It is recommended that any outcomes and performance frameworks include diagnostic waiting times and access to support while waiting; consistency and effectiveness of reasonable adjustments across services; experiences of transitions; and lived experience and qualitative outcomes, not solely access metrics.

5. For system partners to work toward the development a children's version of the Autism Strategy.

23/26 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 10)

Veronica Barry (Executive Director, Healthwatch Oxfordshire) was invited to present the Healthwatch Oxfordshire Update Report.

Healthwatch's ongoing statutory role in gathering and representing patient and public experience across Oxfordshire's health and social care system was explained to the Committee. Healthwatch's continued engagement with a range of partnership boards and system forums was also highlighted.

Members noted the publication of a number of recent Healthwatch reports and pieces of community research. These included a report on experiences of musculoskeletal services**,** which identified persistent concerns around communication, appointment availability, cancellations, referral pathways and waiting times, alongside some positive feedback once care was accessed. The Committee noted that recommendations had been issued and that responses had been received from commissioners and the provider.

The update also highlighted community research activity, including work with the Sunrise Multicultural Centre in Banbury on cancer awareness and barriers to access, and engagement with rural communities as part of wider work on health inequalities. Members noted that these findings were intended to complement formal system performance data.

The Committee received an update on Enter and View activity, including visits to Katharine House Hospice and Ashurst Ward at Littlemore Hospital, and the publication of an Enter and View report relating to St Leonard's Ward at Wallingford Community Hospital. Members noted that all reports, including provider responses, were publicly available.

Healthwatch Oxfordshire also reported on recent and forthcoming public engagement activity**,** including a March 2026 webinar on Oxfordshire's work as a Marmot Place and a planned webinar providing an opportunity for public input into the Oxford Health NHS Foundation Trust strategy.

Members noted recurring themes from Healthwatch intelligence, including difficulties accessing GP and dental services, administrative barriers, and challenges navigating complaints processes. It was also noted that some forthcoming Healthwatch reports would be published after the local elections in line with Purdah guidance.

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

24/26 HEALTH VISITOR SERVICES IN OXFORDSHIRE

(Agenda No. 11)

Donna Husband (Head of Public Health Programmes – Start Well – Public Health, Oxfordshire County Council); Mark Chambers (Head of Children's Community Services Community Health Services, Dentistry and Primary Care Directorate | Oxford Health NHS Foundation Trust); Emma Leaver (Chief Operating Officer for Community Health Services, Dentistry & Primary Care, Oxford Health NHS Foundation Trust); and Taylor Nicola (Senior Clinical Lead for Public Health) were invited to present a report on Health Visitor Services in Oxfordshire.

Officers outlined the extent of organisational change following the establishment of the integrated 0–19 Children's Community Public Health Service, which had brought together health visiting, school nursing, and related services within locality-based teams operating under a single point of access. This model had been informed by learning from the COVID-19 period, evidence on widening inequalities across Oxfordshire, and the County's commitment to the Marmot principles.

Members questioned reported performance against mandated contacts, particularly delayed new birth and early years reviews, and sought clarity on how such delays arose and how risks were mitigated. The statutory window for new birth visits was extremely narrow and that apparent "misses" often reflected legitimate clinical and social circumstances, including prolonged hospital stays, overlapping midwifery involvement, parental choice to stay with family out of county, or non-attendance at clinic appointments.

Officers stressed that recorded performance metrics did not fully reflect the extent of follow-up activity undertaken by teams. Examples were provided of families who had initially failed to attend scheduled appointments but were subsequently followed up through home visits, enabling practitioners to assess both the child and the home environment. The Committee was reassured that delayed contacts did not equate to withdrawal of support and that persistence, professional curiosity, and escalation were embedded in practice.

Members expressed concern that families who did not engage might be those most at risk, particularly in more deprived or vulnerable circumstances. Officers described

clear escalation policies, including structured records review, checks against GP and safeguarding databases, and liaison with other universal and specialist services. Health visitors did not work in isolation but as part of multidisciplinary arrangements designed to ensure that no child became “invisible” to services.

The Committee explored arrangements for transition from maternity to health visiting care. Officers described close operational integration with midwifery services, including daily birth notifications, shared vulnerability scoring, and regular local and strategic meetings. The introduction of improved digital systems was noted to have strengthened information flow, although challenges remained around county borders, private births, and families moving shortly after delivery.

Members were advised that vulnerability assessments were dynamic rather than static and were reviewed throughout the antenatal and early postnatal period, enabling proactive targeting of additional support where risk increased. Officers clarified that reported data focused on face-to-face contacts, even where telephone contact or hospital-based engagement had occurred, creating a risk that activity was under-represented in headline figures.

Members referred to sections of the report describing increasing acuity, safeguarding activity, and complexity within caseloads, and questioned how this was reflected in staffing models. Officers explained that locality team sizes were intentionally uneven, weighted for deprivation, vulnerability, geography, and travel time, rather than population size alone. The service delivered a very high volume of mandated contacts each month across the county and that workforce modelling had been explicitly designed to protect universal provision while enabling targeted intervention.

Officers advised that a comprehensive demand-and-capacity review was underway, including a time-and-motion study to reassess whether assumptions made at the start of the contract remained valid. The Committee welcomed the dynamic nature of this approach but emphasised the need for continued assurance that safeguarding demands were not crowding out preventative activity.

Members returned repeatedly to the balance between statutory safeguarding responsibilities and universal preventative work. Officers described the use of a skill-mixed workforce, with clinic-based provision supporting efficient universal delivery and enabling health visitors to focus on more complex cases. The integrated 0–19 model was cited as enabling a more coherent lead professional role for families with children of different ages, reducing duplication and hand-offs between services.

Members explored the principle of continuity in detail, including references in the report to visits being delayed to preserve continuity with the same practitioner. Officers explained that continuity was valued by families, supported trust, and enhanced safeguarding judgement by allowing practitioners to recognise changes over time. This approach could affect reported performance against strict timeframes, but officers argued that clinical value outweighed the marginal impact on metrics.

The Committee welcomed the extension of health visiting involvement beyond age five for families with ongoing needs, describing this as a significant development that helped bridge the gap between early years and school-age services. Members noted the introduction of additional pre-school reviews and their relevance to school readiness.

Members raised concerns about food insecurity, temporary accommodation, and material deprivation affecting families with babies and young children. Officers described how such issues were escalated through appropriate channels and addressed in partnership with housing, voluntary sector, and other statutory services. Health visitors acted as system-navigators and advocates rather than sole problem-solvers.

The Committee explored links to the Best Start in Life programme, Family Hubs development, and Marmot priorities, and was assured that Health Visitor Services were a core component of whole-system planning for early years outcomes.

The discussion also covered immunisation uptake, infant feeding, breastfeeding, obesity prevention, screen time, and speech and language development. Officers described an extensive health promotion offer, including local groups, digital support through ChatHealth, infant feeding hubs, and enhanced feeding support. The Committee welcomed evidence of improved breastfeeding continuation rates and the proactive sharing of safeguarding intelligence arising from hospital data to inform age-appropriate prevention messaging.

Members questioned the robustness of digital systems and data integration, particularly following previous cyber incidents affecting NHS organisations. Officers outlined strengthened cyber security standards, business continuity planning, and the benefits of alignment with GP clinical systems. While acknowledging that data consistency across the system remained a work in progress, the Committee welcomed progress toward more integrated intelligence to support early identification of need.

The Committee noted the scale of transformation undertaken by the service, the complexity of current demand, and the central role of health visiting in prevention, safeguarding, and early years outcomes.

The Committee **AGREED** to issue the following recommendations subject to any necessary amendments required by the Chair and Health Scrutiny Officer offline:

1. That health visitors are integrated into whole system planning in the community. It is recommended for integration of HV services within Best Start in Life, with improvements to information to babies, children and families.

2. For Health visitor services to continue to focus away from crisis management to core health functions including addressing the impacts of health inequalities on families.

3. For Health visitor services to continue to work on promoting specific issues such as health immunisation uptake and breastfeeding.

4. For there to be an assessment/review of workforce capacity; to ensure safe management of caseloads and to provide essential early intervention for families.

5. To continue to prioritise continuity of the Health Visitors visiting families as well as the Four Year Visits.

25/26 FORWARD WORK PLAN
(Agenda No. 12)

The Committee considered its Forward Work Programme.

The Committee **AGREED** the proposed Forward Work Programme for the June 2026 meeting, and to delegate authority to the Chair and Health Scrutiny Officer to make necessary adjustments to the programme should circumstances require changes between meetings.

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

The Committee **NOTED** the Actions and Recommendations Tracker.

..... in the Chair

Date of signing .....

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