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

## Adult & Older Adult Mental Health in Oxfordshire

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

**Report to:**

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

## INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on adult and older adult mental health services in Oxfordshire in its public meeting on 16 April 2026.

2. The Committee would like to thank 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); Dan Leveson (Director for Places and Communities- Thames Valley ICB); Matthew Tait (Executive Delivery Officer, Thames Valley ICB); Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); and Bhavana Tank (Head of Joint Commissioning Live Well); for attending the meeting and answering questions from the Committee.

3. Mental health services for adults is of significant interest and concern to the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by Oxfordshire's system partners to tackle declining mental health and to improve the support available for adults living with ill mental health. In line with the recent Oxfordshire County Council motion on mental health, the Committee was also keen to investigate the degree of prevention work amongst system partners to ensure that support is not only provided at the point of actual mental health crisis.

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

- An assessment of demand and capacity for mental health services.
- An overview of current service models.
- Information on existing care pathways.
- System-Wide KPIs for Serious Mental Illness.
- Waiting times and access.
- The experiences of mental health service users.
- Funding, workforce and resource sustainability for mental health services.
- The degree of efficacy of multi-Agency working and system integration.
- How residents/patients with co-occurring or complex needs are supported.
- Details on crisis care, emergency response and inpatient provision.
- Details on inpatient bed capacity and out of county placements.
- An update on mental health estates, including on the Warneford hospital redevelopment and any other critical estate challenges.
- The degree to which prevention work is being adopted and evaluated.
- Details around transitions from children's to adult services; including how young people with complex or long-term conditions are identified early for transition planning, and the degree of local adherence to national transition guidance.

## SUMMARY

5. During the 16 April 2026 meeting, the Chair 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 Committee had already undertaken scrutiny of Children's emotional wellbeing and mental health (including CAMHS services) and issued several recommendations as part of this deep-dive into children's mental health services.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. The Committee 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. Members 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. 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. The redevelopment was intended to support modern, therapeutic models of inpatient care and to bring ageing facilities up to required standards.

14. Crisis and inpatient services more broadly were also discussed. 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.

## KEY POINTS OF OBSERVATION:

15. This section highlights eight key observations and points that the Committee has in relation to adult and older adult mental health services in Oxfordshire. These eight key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

***Treating equity of access as a core performance objective:*** The JHOSC's recommendation that system partners treat equity of access as a core performance objective in adult and older adult mental health services reflects a fundamental principle of modern health policy: that equal provision does not necessarily produce equal outcomes. Instead, systems must actively identify and address variation in access, experience, and outcomes across different communities. This is particularly critical in mental health, where disparities are both entrenched and multifactorial. The Health and Social Care Committee report into Community Mental Health Services 2026 found that timely access to mental health care is a matter of safety, dignity, and equity; with delays in care leading to preventable crisis, greater distress, poorer outcomes, and higher costs to the system. The severity gap, where people fall between high and low intensity services is a national system failing.

A substantial body of evidence also demonstrates that mental health need is not distributed evenly across populations, and neither is access to care. Research consistently shows that people living in the most deprived communities experience significantly higher levels of mental ill-health, yet are less likely to access or benefit from timely and effective support. For example, analysis by the Mental Health Foundation highlights that individuals in the most deprived areas of England are 64%

more likely to experience common mental disorders, while systemic barriers continue to shape access to services[1].

Similarly, the King's Fund identifies persistent inequalities in access to care, with certain groups—particularly ethnic minorities, older adults, and those in deprived areas—under-represented relative to their level of need[2]. These patterns are not incidental; they reflect wider structural determinants such as housing, employment, social isolation, and service configuration. As such, expecting equity to emerge organically from uniform service provision is unrealistic. It must be actively pursued[3].

Within the Oxfordshire context of local delivery, the report submitted to the Committee emphasises that neighbourhood-based delivery and increasing demand illustrates both an opportunity and a risk. While localisation of services has the potential to improve accessibility and responsiveness, it can also create what is often described in the literature as a "postcode lottery" if variation between neighbourhoods is not actively monitored and addressed. Academic commentary on neighbourhood health services explicitly warns that localisation must be accompanied by deliberate mechanisms to ensure equitable access across settings, particularly between urban and rural populations[4].

Furthermore, the Committee's focus on ensuring that neighbourhood models benefit rural and more deprived communities as effectively as urban areas is especially well-founded. Rural mental health inequalities are both under-recognised and deeply embedded. The Centre for Mental Health highlights that rural populations face distinctive barriers including physical isolation, limited service visibility, reduced transport options, and digital exclusion, all of which restrict timely access to support[5].

Parliamentary evidence has similarly identified concerns about the adequacy and accessibility of mental health provision in rural areas, particularly following wider reductions in local services and social infrastructure[6]. These disparities are further compounded by socioeconomic deprivation, which intersects with geography to create cumulative disadvantage[7].

From a systems perspective, this means that a model designed primarily around urban density and infrastructure—such as centrally located crisis hubs or services clustered around acute hospitals—may be inherently less accessible to dispersed or marginalised populations unless deliberate adaptations are made. The Committee's recommendation

[1] source / [mentalhealth.org.uk]
[2] Mental Health 360 | Inequalities | The King's Fund
[3] [kingsfund.org.uk]
[4] [bjgp.org]
[5] [centreform...lth.org.uk]
[6] Rural Mental Health - Environment, Food and Rural Affairs Committee
[7] [publicatio...liament.uk]

therefore reflects a recognition that equity requires differentiated delivery, not uniform distribution.

Moreover, the recommendation being made by the JHOSC also highlights specific concern regarding the coverage and accessibility of crisis alternatives, including Safe Havens. This is an important area for scrutiny, as crisis services often represent the most immediate interface between individuals in acute distress and the health system.

Evidence on crisis cafés and Safe Haven models demonstrates their potential to provide accessible, non-clinical alternatives to emergency departments, offering early intervention and emotional support in less stigmatising environments. Qualitative research has identified their key functions as including diversion from A&E, improved access to crisis care, and provision of safe spaces for individuals in distress[8]. A broader scoping review similarly found that such services can reduce emergency department use and alleviate social isolation, although challenges remain around consistency and equitable access[9].

Crucially, however, the effectiveness of crisis alternatives is highly dependent on geographical accessibility and awareness. Where provision is uneven—for example, concentrated in urban centres—its system-wide impact is diminished. The Committee's recommendation to address gaps in Safe Haven coverage therefore aligns with the evidence base: without equitable distribution, these services risk reinforcing, rather than mitigating, existing inequalities.

Additionally, at a policy level, the recommendation is fully aligned with the statutory role of Integrated Care Systems (ICSs). ICSs were explicitly established to improve population health and reduce inequalities in access, experience and outcomes[10]. National bodies such as NHS England have reinforced this through programmes like Core20PLUS5, which require systems to prioritise the most disadvantaged populations[11].

However, evidence suggests that many systems struggle to operationalise this aspiration. The Care Quality Commission (CQC) has found that while ICSs recognise inequalities as a priority, they do not always sufficiently understand or address population-level variation in need and access[12]. This gap between ambition and implementation underscores the importance of scrutiny bodies in setting clear expectations and holding systems to account.

[8] A qualitative investigation of crisis cafés in England: their role, implementation, and accessibility | BMC Health Services Research | Springer Nature Link

[9] [link.springer.com] / [pmc.ncbi.nlm.nih.gov]

[10] [kingsfund.org.uk]

[11] [kingsfund.org.uk]

[12] Integrated care systems - Care Quality Commission

The academic literature further supports the role of integrated neighbourhood teams in addressing inequalities, provided they are designed with local specificity, adequate resourcing, and strong community engagement. Evidence indicates that locally sensitive approaches, co-located services, and trust-building with marginalised communities are critical to reducing disparities[13]. These principles directly reinforce the Committee's emphasis on ensuring neighbourhood models deliver equitable benefit.

Examples from across England illustrate how systems can operationalise this approach. In Wakefield, for instance, integrated care partners have worked with housing services to address the social determinants of mental health, linking individuals to support earlier and reducing downstream demand on crisis services[14]. Such initiatives demonstrate that addressing inequality requires coordination beyond traditional clinical services, particularly in areas such as housing, employment and community support.

Similarly, the broader IAPT (Improving Access to Psychological Therapies) programme illustrates how targeted expansion of access can significantly increase uptake and recovery, but also highlights that improvements in overall access do not automatically eliminate disparities between groups[15]. This reinforces the need for ongoing, targeted action.

Therefore, the recommendation that equity of access be treated as a core performance objective is therefore both evidence-based and strategically necessary. Mental health inequalities are deeply embedded and shaped by structural determinants; they cannot be resolved through uniform service provision alone. Instead, they require:

- active identification of variation at neighbourhood level,
- targeted intervention where gaps are identified, and
- deliberate adaptation of services to meet the needs of different communities.

In this context, addressing gaps in crisis alternatives such as Safe Havens, ensuring rural and deprived communities benefit equally from neighbourhood models, and embedding equity within system performance frameworks are not optional enhancements—they are essential conditions for delivering a fair and effective mental health system.

By articulating this expectation clearly, the Committee is not simply requesting further analysis; it is asserting that equity must move from an aspirational principle to an operational priority, embedded across commissioning, delivery and performance management.

[13] What works: How can integrated neighbourhood teams reduce inequalities in health and health care? - Health Equity Evidence Centre

[14] [england.nhs.uk]

[15] [pmc.ncbi.nlm.nih.gov]

**Recommendation 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.*

***Treating co-production as a core performance objective for the development and delivery neighbourhood mental health centres:*** The JHOSC recognises that modern mental health systems cannot deliver effective, equitable and sustainable outcomes through top-down models alone; rather, they must be shaped in partnership with the communities they serve, including local authorities, voluntary sector organisations, and people with lived experience.

Co-production in health and care goes beyond consultation. It involves service users, families, communities and local stakeholders participating as equal partners in decision-making, design and delivery. National policy increasingly frames this as essential to tackling inequalities and improving outcomes. NHS England's strategy on advancing mental health equalities emphasises the need to improve access, experience and outcomes by working meaningfully with communities and people with lived experience to shape services[16].

The report submitted to the Committee for this item already acknowledges the importance of co-production, highlighting the role of voluntary, community and social enterprise (VCSE) partners and the embedding of peer workers and experts by experience within service delivery. This reflects a strong foundation. However, the Committee's recommendation seeks to move co-production from a supporting principle to a core performance expectation. This is significant: it implies that co-production should not be episodic or optional, but systematically embedded in how neighbourhood mental health centres are developed and operated.

This shift is particularly important in the context of neighbourhood-based models. While localisation offers opportunities for more responsive and integrated care, it also risks replicating existing service assumptions unless local voices are genuinely incorporated. As academic commentary on neighbourhood health systems has noted, defining and delivering services at a neighbourhood level raises critical questions about whose needs are prioritised and how variation is understood across different communities[17].

The case for co-production is particularly strong when considered through the lens of health inequalities. Mental health need is shaped by

[16] https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/
[17] https://bjgp.org/content/76/764/102

a complex interplay of social determinants, including housing, income, isolation, and community cohesion. Research demonstrates that these determinants vary significantly across local populations and are deeply embedded within neighbourhood contexts. For example, the Mental Health Foundation identifies key drivers of inequality such as financial insecurity, loneliness and access to services, noting that these factors are interconnected and must be addressed holistically[18].

Neighbourhood-level co-production provides a mechanism for surfacing these local realities. It allows services to be shaped by those who understand the lived experience of mental health within specific communities, including the barriers to access that may not be visible in aggregate data. Academic research on neighbourhood-based interventions supports this view, highlighting that improvements in mental health outcomes are closely linked to factors such as social cohesion, trust in local services, and community participation[19].

Without co-production, there is a risk that neighbourhood mental health centres become geographically decentralised but conceptually centralised—replicating standardised models rather than tailoring services to local need. The Committee's recommendation directly addresses this risk by requiring the inclusion of local councils, elected members, and community organisations working alongside families and individuals with lived experience.

The inclusion of local councils and the voluntary sector within co-production arrangements is not simply desirable; it is essential. Integrated Care Systems (ICSs) were established to bring together NHS organisations, local authorities and community partners to improve population health and reduce inequalities[20]. In practice, however, evidence suggests that achieving genuinely integrated working remains challenging, particularly where governance structures are complex and operational pressures dominate.

The voluntary sector plays a particularly critical role in bridging the gap between formal services and communities. In Oxfordshire, organisations such as Mind, Restore and Response are already delivering crisis support, housing, and recovery services, often grounded in community knowledge and lived experience. Nationally, evidence shows that such organisations are often better placed to engage marginalised communities, build trust, and provide culturally appropriate support.

In Wakefield, for example, integrated care partners have worked with housing and community services to address the wider determinants of mental health, linking individuals to support earlier and preventing crisis escalation. This joint working has demonstrable impacts on both

[18] https://www.mentalhealth.org.uk/explore-mental-health/blogs/mental-health-inequalities-uk
[19] https://academic.oup.com/eurpub/article/30/5/964/5671760
[20] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained

individual outcomes and system pressures[21]. These kinds of models rely on close collaboration between statutory and voluntary partners, underpinned by shared ownership of outcomes. By embedding co-production as a performance objective, the Committee is effectively strengthening these relationships and ensuring that they are consistently applied at neighbourhood level.

Moreover, a further justification for this recommendation lies in the growing evidence that services designed with lived experience input are more effective. Individuals and families with lived experience bring insights that cannot be replicated through professional knowledge alone. This is particularly relevant in mental health, where stigma, trust, and personal relationships play a central role in engagement with services. Research on crisis cafés and Safe Haven models illustrates this point clearly. These services, which are often co-produced and delivered with significant voluntary sector involvement, are designed specifically to provide accessible, non-clinical environments for people in crisis. Studies show that they can improve access to support, offer alternatives to emergency departments, and provide a more person-centred experience[22].

However, these benefits are not automatic; they depend on services being responsive to the needs of the communities they serve. Co-production ensures that services remain grounded in lived experience over time, rather than drifting towards standardised, institutionally driven models.

While the benefits of co-production are clear, it is not without challenges. Evidence from integrated care systems suggests that meaningful co-production requires:

- sufficient time and resources to support participation,
- genuine sharing of power and decision-making, and
- clear structures for accountability and feedback.

Research on integrated neighbourhood teams highlights that successful models are those that are locally sensitive, well-resourced, and built on trust between services and communities[23]. Without these conditions, there is a risk that co-production becomes tokenistic.

For meaningful coproduction and development of improved mental health within neighbourhoods, there needs to be a shift from hospital to community, but one that is grounded in relationship with the voluntary sector; local communities and which recognises the cultural

[21] https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities/

[22] https://link.springer.com/article/10.1186/s12913-024-11662-0 ; https://pmc.ncbi.nlm.nih.gov/articles/PMC12647224/

[23] https://www.heec.co.uk/resource/what-works-how-can-integrated-neighbourhood-teams-reduce-inequalities-in-health-and-health-care/

understanding, trust, deep local knowledge necessary to connect seamlessly with public services, and amplify the existing networks of people and assets within communities.

The Committee's recommendation implicitly addresses these risks by framing co-production as a core performance objective. This elevates it to the same level of importance as access, quality and outcomes, ensuring that it is embedded within governance, commissioning and service development frameworks. In essence, the recommendation that co-production be treated as a core performance objective in neighbourhood mental health services is both timely and necessary. It reflects a recognition that effective mental health systems must be:

- rooted in the realities of local communities,
- responsive to lived experience, and
- delivered in partnership across organisational boundaries.

In the Oxfordshire context, where strong foundations of partnership and co-production already exist, this recommendation does not represent a radical departure but rather a natural progression—moving from good practice in parts of the system to consistent, system-wide expectation. It builds on the support for this approach by the JHOSC since 2021 on Marmot; Neighbourhoods, and local examples like the coproduction with Wantage Town Council on hospital to community services.

The neighbourhood shift will require consideration of networked governance structures enabling sharing of power and decision-making; governance focusing on systems convening that fosters collaboration, generative conflict, removing barriers and collective learning; enable community leadership and shared accountability. Data and evidence requires value to detailed neighbourhood-level data used with communities to inform place specific decisions and value to the wisdom of practice to recognise capable communities. Scaling requires national guidance that values principles and indicators of system health, local variability and place-based implementation. Funding requires flexible place-based portfolios that allow pooled funding and adaptive allocation. Outcomes need to be co-defined and connected to locally defined indicators aligned with community priorities and system wide learning goals with monitoring of relationship quality and learning rigour, short feedback to enable adjustment in real-time. Accountability and responsibility is essentially multi-directional.

At a minimum it requires funding of a convening role, an independent local patient voice, involvement of local leaders and local scrutiny. This is necessary to stop extending institutional models into neighbourhoods rather than building around what already exists so that services sit within communities and have a relationship with it, and so that communities can support prevention of crisis and early identification and advocacy for those in need of crisis support from public services.

More broadly, this jhosc recommendation aligns with national policy, academic evidence, and emerging best practice across integrated care systems. By embedding co-production at neighbourhood level and ensuring the involvement of local councils, elected members, the voluntary sector and lived experience families, the system is better positioned to deliver services that are not only accessible, but meaningful, equitable and effective. Ultimately, this recommendation recognises that sustainable improvement in mental health outcomes cannot be delivered to communities—it must be developed with them.

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

***Ensuring quality of outcomes, not just speed of access, to mental community mental health services:*** The recommendation being made by the JHOSC, that access standards for adult community mental health services must be applied in a clinically meaningful way—reflects a growing recognition across the NHS and academic literature that performance targets, if poorly designed or implemented, can unintentionally distort care delivery. In particular, the emphasis within the recommendation on safeguarding therapeutic continuity, ensuring consistent data definitions, and prioritising quality over speed speaks directly to the central tension in contemporary mental health policy: how to expand access without undermining the effectiveness and integrity of care.

Over the past decade, national mental health policy has increasingly prioritised access standards, with the aim of reducing waiting times and improving responsiveness. This shift has been widely seen as necessary, particularly given historic under-provision and long delays in accessing care. The expansion of programmes such as Improving Access to Psychological Therapies (IAPT) demonstrates the benefits of this approach: significantly increased numbers of people receiving treatment and improved overall recovery rates[24]. However, the same evidence also highlights a critical limitation—improved access does not automatically translate into improved quality or equitable outcomes.

Within the Oxfordshire Performance and Assurance Oversight Board Report submitted to the Committee (Annex 1), the introduction of interim access standards for adult community mental health services—such as the "two meaningful contacts within 28 days" metric—illustrates this evolving policy landscape. The report also highlights the use of statistical process control (SPC) charts and data quality indicators to monitor variation and assurance. While these tools represent important advances

[24] https://pmc.ncbi.nlm.nih.gov/articles/PMC8381091/

in performance monitoring, they also underline the complexity of interpreting access metrics meaningfully. The definition of a “meaningful contact” is inherently subjective, and inconsistencies in interpretation across teams risk undermining the reliability of reported performance. The Committee’s recommendation directly addresses this issue by emphasising the need for consistent and clinically grounded definitions. Without this, access standards risk becoming detached from clinical reality, creating a situation where performance appears strong on paper while underlying care quality is variable.

Furthermore, one of the most significant risks associated with narrowly defined access targets is that they may prioritise speed of initial contact over continuity of care. In mental health services, therapeutic continuity is not simply a desirable feature; it is central to effective treatment. Longitudinal relationships with clinicians enable trust, engagement and sustained recovery, particularly for individuals with severe or enduring mental illness.

The importance of continuity is widely supported in the literature. Evidence from integrated care and primary care research demonstrates that continuity of clinician is associated with improved outcomes, reduced hospital admissions, and greater patient satisfaction. In the context of mental health, where stigma, vulnerability and complexity are often present, these relationships are particularly critical.

However, the introduction of short-term access targets can create unintended pressures on services to prioritise initial appointments over ongoing care. For example, services may reallocate clinician time towards meeting access standards, potentially reducing availability for follow-up or longer-term therapeutic work. The Committee’s recommendation therefore rightly calls for safeguards to ensure that early contact does not displace therapeutic continuity. This is not an argument against access standards, but rather a recognition that they must be implemented within a broader framework that values long-term outcomes.

Moreover, a further key element of the recommendation is the need for consistent data definitions across teams. Annex 1 submitted to the Committee explicitly identifies data quality as a critical component of performance reporting, with indicators assessing whether data are valid, complete and supported by appropriate processes. This reflects a broader challenge within health systems: performance metrics are only as robust as the data on which they are based.

Academic research reinforces this point. Studies of health system performance measurement have repeatedly shown that variation in data collection methods and definitions can lead to misleading comparisons and inappropriate conclusions[25]. In mental health services, where

[25] https://pmc.ncbi.nlm.nih.gov/articles/PMC8381091/

interventions are often complex and multifaceted, this challenge is particularly acute. For example, what constitutes a "meaningful contact" may vary depending on clinical context, patient need, and service model. The Committee's recommendation therefore recognises that consistency is not merely a technical issue, but a prerequisite for meaningful performance management. Without shared definitions and robust data standards, access metrics risk becoming a distorted signal, reflecting variations in recording practices rather than actual service performance.

Perhaps the most significant aspect of the recommendation is its insistence that performance management should reinforce quality and outcomes, not just speed of access. This aligns closely with national policy and academic evidence, both of which increasingly emphasise outcomes as the ultimate measure of service effectiveness. The King's Fund has highlighted that inequalities in mental health care are not limited to access, but extend to experience, quality and outcomes, with different population groups experiencing markedly different results from treatment[26]. This suggests that focusing solely on access risks overlooking the deeper structural issues that shape mental health outcomes.

Similarly, research into integrated care systems has shown that improving population health requires a shift from activity-based performance measures towards outcomes-based approaches, including recovery, wellbeing and social functioning[27]. In this context, access metrics should be understood as necessary but insufficient; they are a means to an end, not an end in themselves.

The Oxfordshire data further illustrates this tension. While access indicators may show strong performance, other metrics—such as recovery rates in Talking Therapies or physical health outcomes for people with severe mental illness—indicate ongoing challenges. This underscores the importance of a balanced performance framework that integrates access, quality and outcomes.

Experience from other areas of the country reinforces the importance of applying access standards in a clinically meaningful way. In some systems, the rapid expansion of early access targets has led to unintended consequences, including increased service fragmentation and reduced continuity of care. Conversely, areas that have successfully balanced access and quality—often through integrated neighbourhood models—have done so by embedding clinical judgement and local flexibility within performance frameworks.

For example, NHS England case studies highlight the value of integrated, cross-sector approaches that address wider determinants of health and

[26] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-inequalities
[27] https://www.health.org.uk/sites/default/files/upload/publications/2026/ICS%20report_Final.pdf

support continuity of care across pathways[28]. These models demonstrate that effective care cannot be reduced to a single metric; it requires coordination, relationship-building and a focus on long-term outcomes.

Academic work on neighbourhood health systems also emphasises the need for locally sensitive approaches that combine accessibility with continuity and trust[29]. This reinforces the Committee's position that access standards must be applied in a way that reflects the realities of clinical practice rather than imposing rigid, uniform targets.

Therefore, this recommendation represents a nuanced and evidence-based approach to performance management in mental health services. It acknowledges the importance of improving access while recognising the risks of over-reliance on speed-based metrics. By calling for safeguards to protect therapeutic continuity, ensure data consistency, and prioritise quality and outcomes, the Committee is advocating for a more balanced and clinically meaningful application of access standards. In doing so, the recommendation aligns with both national policy direction and academic evidence, which increasingly emphasise the need for integrated, outcome-focused approaches to mental health care. It also reflects the realities observed within the Oxfordshire system, where strong performance on access metrics must be understood within a broader context of demand, complexity and variability.

Ultimately, the recommendation asserts that access standards should serve the goal of better care—not replace it. Ensuring that they are applied in a clinically meaningful way is therefore not simply a technical adjustment, but a fundamental requirement for delivering safe, effective and sustainable mental health services.

**Recommendation 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.*

***Importance of collaboration among system partners on implementation of government guidance on the Patient and Carer Race Equality Framework:*** The JHOSC's recommendation that system partners collaborate to identify local requirements for implementing government guidance on named workers and the Patient and Carer Race Equality Framework (PCREF) reflects a key insight within contemporary mental health policy: that improving outcomes depends not only on service provision, but on how care is coordinated, personalised and made equitable across populations. The recommendation recognises

[28] https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities/
[29] https://bjgp.org/content/76/764/102

that both the named/key worker model and PCREF represent transformative national policy directions—but that their success depends fundamentally on local system adaptation, cross-partner collaboration and effective implementation.

The concept of a named or key worker sits at the heart of the shift towards personalised care within the NHS. Personalised care has been established as a central component of the NHS Long Term Plan, with the aim of ensuring that care is based on "what matters" to people, rather than a one-size-fits-all model[30]. This approach recognises the growing complexity of mental health needs, particularly among adults and older adults with multiple conditions, social vulnerabilities and long-term support requirements[31].

Within this context, the named worker model provides a practical mechanism for translating personalised care into everyday service delivery. NICE guidance explicitly highlights that having a named worker—acting as a single point of contact—can improve coordination, increase engagement, and lead to better outcomes and experiences of care[32]. This is particularly important in mental health systems, where care pathways often involve multiple services and professionals across health, social care and the voluntary sector[33].

The report submitted to the Committee for this item, in outlining the complexity of local mental health provision and the breadth of services involved—from community mental health teams to crisis response and voluntary sector provision—implicitly demonstrates why coordination is critical. Without a clear, identifiable professional responsible for overseeing an individual's care journey, there is a risk of fragmentation, duplication and disengagement.

Furthermore, academic research reinforces the importance of care coordination and continuity in this regard. Evidence indicates that continuity of care is associated with reduced hospital admissions, fewer emergency presentations and improved long-term outcomes for people with severe mental illness[34]. Moreover, studies have found that coordination across professionals and services improves user satisfaction and recovery outcomes, particularly for those with complex needs[35].
However, the existence of national guidance alone is insufficient. The implementation of named worker models varies significantly between systems, with differences in role definition, caseload expectations and

[30] https://www.england.nhs.uk/personalisedcare
[31] [england.nhs.uk]
[32] https://www.nice.org.uk/guidance/qs140/chapter/Quality-statement-4-Named-worker
[33] [nice.org.uk]
[34] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/longterm-efficacy-of-a-continuityofcare-treatment-model-for-patients-with-severe-mental-illness-who-transition-from-inpatient-to-outpatient-services/CEC0763E0D11CEFC279899FC0DF1D8CF
[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357

integration across services. As noted in NHS practice discussions, there is often “no real definition” of the key worker role, leaving systems to interpret and operationalise it locally[36]. This variability reinforces the Committee’s conclusion that system partners must collaboratively determine what the model should look like in Oxfordshire, rather than relying on generic national assumptions. The implementation of guidance will also be dependent on the workforce plan. There is also a need for national clarity for local systems on how the additional responsibilities and administration for the new role will be funded and supported.

The second element of the recommendation—the implementation of the Patient and Carer Race Equality Framework—addresses a longstanding and well-evidenced issue within mental health services: persistent racial inequalities in access, experience and outcomes. Research demonstrates that individuals from ethnically minoritised backgrounds, particularly Black communities, are more likely to experience coercive interventions, longer hospital stays and poorer engagement with services[37].

PCREF represents a national response to these disparities. Introduced by NHS England as a mandatory anti-racism framework, it requires all mental health providers to take structured action to reduce inequalities, including through improved data collection, governance, and patient engagement[38]. Importantly, PCREF emphasises that change must be co-produced with communities, ensuring that interventions are grounded in lived experience and local context rather than imposed centrally.

The Care Quality Commission has reinforced the importance of this framework by integrating it into inspection processes, making it a key component of how service quality is assessed[39]. Failure to implement PCREF effectively can therefore have direct implications for organisational ratings and regulatory oversight.

In Oxfordshire, the report (submitted to the Committee’s) emphasis on partnership with voluntary and community organisations, as well as the involvement of experts by experience, aligns strongly with the principles of PCREF. However, this JHOSC recommendation reflects the recognition that formal compliance with the framework is not sufficient. To be effective, PCREF must be translated into locally meaningful action, informed by the specific demographic profile, community relationships and service pressures within the county.

Examples from other NHS Trusts illustrate how this can be achieved. East London NHS Foundation Trust, for instance, has implemented PCREF through partnership working with local authorities, community

[36] https://www.merseycare.nhs.uk/role-key-worker
[37] https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1053502/full
[38] https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref
[39] https://www.cqc.org.uk/guidance-providers/nhs-trusts/brief-guides-inspection-teams/pcref

organisations and service users to co-design culturally responsive services[40]. Similarly, Avon and Wiltshire Mental Health Partnership Trust has used PCREF to identify barriers to access and develop targeted interventions in collaboration with local communities[41]. These examples demonstrate that successful implementation requires sustained collaboration across system partners, including health services, local authorities and the voluntary sector.

In essence, the central justification for the Committee's recommendation lies in the recognition that neither personalised care nor race equality can be delivered by individual organisations acting in isolation. Mental health care is inherently multi-agency, involving NHS providers, local authorities, housing services, voluntary organisations and community networks. As such, the implementation of named workers and PCREF must be approached as system-wide initiatives, rather than discrete organisational responsibilities.

Moreover, academic research on care coordination highlights that fragmented systems—where roles, responsibilities and communication pathways are unclear—lead to poorer outcomes and increased burden on both service users and carers[42]. Conversely, effective collaboration across agencies supports continuity, improves communication, and enables more responsive and personalised care[43].

This is particularly relevant when considering the intersection between the two policy areas addressed in the recommendation. Named workers provide a mechanism for coordination and continuity, while PCREF provides a framework for ensuring that care is equitable and responsive to diverse communities. When implemented together, they have the potential to transform both the structure and the culture of mental health services. However, this integration can only be achieved through deliberate collaboration.

This recommendation by the JHOSC is therefore grounded in both evidence and policy. It recognises that the introduction of named workers and the implementation of PCREF are not merely technical changes, but fundamental shifts in how mental health services are organised and delivered. These shifts require:

- clear role definition and coordination across complex systems,
- meaningful engagement with communities and lived experience, and,
- alignment between national policy and local context.

[40] https://www.elft.nhs.uk/information-about-elft/equity-diversity/patient-and-carer-race-equality-framework-pcref
[41] https://www.awp.nhs.uk/about-us/news/stories/trust-implements-new-approach-reducing-racial-inequalities
[42] https://academic.oup.com/book/59497/chapter/501514189
[43] [academic.oup.com]

By emphasising collaboration among system partners to identify what is needed locally, the Committee is addressing the critical implementation gap that often undermines national policy initiatives. It is asserting that success depends not just on adopting frameworks, but on translating them into coherent, locally grounded practice. In doing so, the recommendation reflects a broader principle: that effective mental health services are not simply delivered through structures and targets, but through relationships, coordination and a sustained commitment to equity.

**Recommendation 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.*

***Preventing out of area placements through including the use of independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient:*** The Committee's recommendation that system partners collaborate to reduce and prevent out-of-area placements (OAPs), incorporate independent clinical reviews, and embed patient and family input into decisions about long-term placement reflects a significant and justified concern within modern mental health care: that institutionalisation, geographical dislocation, and fragmented discharge pathways can undermine recovery, safety and dignity. This recommendation is grounded not only in the local evidence presented in the report and Annex 1 submitted to the Committee for this item, but also in a robust national and academic evidence base which demonstrates that OAPs and long-term institutional care are associated with poorer outcomes unless carefully managed through coordinated, person-centred approaches.

Out-of-area placements arise when patients are admitted to mental health beds outside their local area, often due to capacity constraints, complex needs, or lack of suitable community provision. While occasionally necessary, their long-term use has been widely criticised within national policy and research due to their impact on continuity of care, patient experience and recovery and impact on families.

The Oxfordshire Performance and Assurance Oversight Board Report submitted to the Committee highlights this tension clearly. While snapshot measures suggest a reduction in the number of OAPs, the persistence of high bed-day usage indicates that patients continue to spend prolonged periods away from their communities. This distinction between point-in-time counts and cumulative bed use is critical: it shows that the issue is not only about how many people are placed out of area, but how long they remain there. The narrative accompanying the data further identifies delays in discharge linked to challenges in securing

appropriate accommodation or community placements, reflecting a broader systems issue rather than an isolated operational problem. Nationally, it is well established that there are over 2,000 people with learning disabilities or autism that are placed in psychiatric hospitals without a formal mental health diagnosis. One recent example was the NHS England Clive Treacey Independent Review, which found his needs were for specialised physical health care, a stable routine and expert seizure management but instead and despite not having a treatable mental illness he was repeatedly sectioned under the Mental Health Act and kept in hospital for a decade because of the lack of a community package of care.

Academic literature strongly supports the importance of addressing this. Continuity of care is widely regarded as a cornerstone of effective mental health provision, and studies have shown that disruptions—such as those caused by being treated far from home—are associated with poorer outcomes, including higher readmission rates and reduced engagement[44]. The concept of "continuity of care" itself extends beyond access to services, encompassing relational stability, coordinated pathways and sustained engagement, all of which are undermined when individuals are placed far from their support networks[45].

The Committee's recommendation for independent clinical review of patients in out-of-area or long-term placements reflects an understanding that institutionalisation is not a neutral state. Over time, patients may become embedded in care pathways that are difficult to exit, particularly where clinical risk aversion, system pressures and the absence of suitable alternatives converge.

Independent clinical review provides a mechanism to challenge these dynamics. It introduces external scrutiny into decision-making, ensuring that ongoing placement is justified not simply by convenience or system limitations, but by clear clinical need. Research into care coordination and service fragmentation highlights the importance of clearly defined roles, accountability and oversight in improving outcomes for people with complex mental health needs[46]. Without such oversight, there is a risk that responsibility becomes diffused across organisations, leading to inertia and prolonged institutionalisation.

In practice, several systems across England have already adopted structured review processes for OAPs. For example, mental health trusts

[44] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/longterm-efficacy-of-a-continuityofcare-treatment-model-for-patients-with-severe-mental-illness-who-transition-from-inpatient-to-outpatient-services/CEC0763E0D11CEFC279899FC0DF1D8CF
[45] https://journals.sagepub.com/doi/pdf/10.1177/070674370404900805
[46] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357

operating under the Community Mental Health Framework have introduced multidisciplinary review panels—often involving commissioners, clinicians and care coordinators—to assess whether placements remain appropriate and to actively plan for repatriation. These models demonstrate that systematic review, when embedded within governance structures, can reduce unnecessary bed days and support transitions back to community care.

A defining feature of the Committee's recommendation is the emphasis on including patient and family input in decisions about long-term placement and institutionalisation. This reflects a wider shift in mental health policy towards co-production and personalised care, recognising that individuals and their networks hold critical insight into what constitutes meaningful recovery and safe discharge.

The NHS personalised care agenda explicitly emphasises that care should be based on "what matters" to individuals, and that families and carers are integral to planning and delivering support[47]. In the context of OAPs and long-term placements, this means that decisions should not be made solely on clinical or operational grounds, but should incorporate the lived experience of patients and those who support them.

Academic research reinforces this perspective. Studies on care coordination for people with severe mental illness highlight that involving caregivers and families improves navigation of complex systems, strengthens support networks, and enhances long-term outcomes[48]. In contrast, exclusion of these perspectives can lead to decisions that are technically appropriate but practically unworkable, particularly when considering discharge into the community.

The report submitted to the Committee's emphasis on integrated working with social care and the voluntary sector further supports the importance of this approach. Social workers, housing providers and voluntary organisations often have a more holistic understanding of individuals' needs, including accommodation, social support and local connectivity. Their involvement is therefore critical in determining whether a placement is sustainable and conducive to recovery.

Moreover, the second component of this JHOSC recommendation—the need for system-wide review of community placements—addresses an equally important issue: the risk that discharge from inpatient or out-of-area care does not necessarily result in effective community integration. Poorly designed or under-resourced community placements

[47] https://www.england.nhs.uk/personalisedcare/
[48] https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473235/full

can lead to instability, readmission and, ultimately, a cycle of institutionalisation.

Evidence suggests that successful community-based care depends on more than simply providing accommodation. It requires coordinated, multidisciplinary support, stable relationships with care professionals, and integration with wider services such as primary care, social care and the voluntary sector. Research on integrated care systems emphasises that collaboration across sectors is essential to achieving sustainable outcomes and reducing reliance on hospital-based care[49].

Examples from other areas illustrate how this can be achieved in practice. In Wakefield, for instance, partnerships between health services, housing providers and community organisations have been used to address barriers to discharge and prevent readmission, demonstrating both improved outcomes for individuals and reduced system pressure[50]. These approaches rely on continuous evaluation of placements, ensuring that they remain appropriate and supportive over time.

In addition, the inclusion of voluntary sector perspectives within such reviews is particularly important. Voluntary organisations often provide services that extend beyond statutory provision, including peer support, community integration and culturally appropriate care. Their insights can therefore help identify whether community placements are genuinely meeting individuals' needs, or whether additional support is required.

Therefore, the Committee's recommendation represents a comprehensive and evidence-based approach to addressing one of the most complex challenges in adult and older adult mental health services: the balance between inpatient care, out-of-area placements and sustainable community provision. By emphasising collaboration, independent clinical review, and the inclusion of patient, family and voluntary sector perspectives, it reflects an understanding that reducing OAPs is not simply a matter of increasing capacity, but of transforming how decisions are made and how care is delivered.

At its core, the recommendation recognises that mental health services must move beyond reactive responses to immediate pressures and instead adopt a proactive, system-wide approach to care planning and review. This includes:

[49] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained
[50] https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities

- ensuring that placements are clinically justified and regularly reviewed,
- involving those with lived experience in shaping decisions, and
- continuously evaluating whether community settings provide safe, stable and meaningful environments for recovery.

In doing so, the recommendation aligns with both local evidence and national policy direction, and supports the development of a mental health system that is not only efficient, but also humane, equitable and recovery-focused.

**Recommendation 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.*

***Importance of meeting performance targets for access to physical health checks for mentally ill patients, and ensuring timely and regular physical health checks for those with comorbidities:*** The Committee's recommendation that performance targets for physical health checks for people with mental illness must be met—and that these checks should be timely, regular, and inclusive of long-term conditions—addresses a longstanding and well-evidenced disparity within health systems: the systematic neglect of physical health needs among people with mental illness. This recommendation is both locally justified, based on the evidence presented within the report and Annex 1 submitted to the Committee, and strongly supported by national policy and academic research, which consistently demonstrate the urgent need to close the gap between mental and physical health outcomes.

People living with severe mental illness (SMI) experience significantly poorer physical health outcomes than the general population, including higher rates of cardiovascular disease, diabetes, respiratory illness and premature mortality. This disparity is widely recognised as one of the most persistent health inequalities in the UK. Research underpinning national policy has shown that individuals with serious mental illness die 15–20 years earlier on average than the wider population, largely due to preventable physical health conditions.

The Patient and Carer Race Equality Framework (PCREF) literature reinforces this point when describing broader mental health inequalities. It highlights that individuals from marginalised groups—particularly those already vulnerable—experience poorer access, outcomes and engagement with services, including in areas such as physical health monitoring[51]. This aligns with findings in the report submitted for this item,

[51] https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1053502/full

where physical health checks for people with SMI were recorded as being significantly below national targets.

The implication is clear: without systematic intervention, people with mental illness—especially those with complex or enduring conditions—are less likely to have their physical health needs identified and managed in a timely manner. The Committee's recommendation therefore reflects an urgent need to ensure that performance targets are not merely aspirational, but actively delivered in practice.

At the core of the recommendation is the requirement that physical health checks are both timely and regular. This reflects an understanding that physical health deterioration in people with mental illness often occurs gradually and may go undetected without structured monitoring.

National frameworks on personalised care emphasise that care should be continuous, proactive and centred on individual needs, rather than reactive or episodic[52]. This principle is particularly relevant for individuals with comorbidities—such as diabetes or cardiovascular disease—where routine monitoring is essential to prevent complications.

Academic evidence supports this approach. Studies of continuity of care demonstrate that regular engagement with health services, including structured monitoring, is associated with improved clinical outcomes, reduced emergency admissions and better long-term management of chronic conditions[53]. For patients with mental illness, this is especially important because symptoms such as low motivation, cognitive impairment or social isolation may act as barriers to engaging with primary care services. Without proactive outreach and structured check-ups, these individuals are at greater risk of falling through gaps in care. The Oxfordshire data reflecting underperformance in SMI physical health checks therefore highlights not only a metric shortfall, but a systemic risk: that individuals with the greatest need are not receiving consistent, preventive care.

The Committee's explicit inclusion of long-term condition management within physical health checks is particularly significant. Mental and physical health are closely interconnected, with strong evidence demonstrating that people with mental illness are more likely to develop chronic physical conditions, and that these conditions are often more difficult to manage. Research on care coordination highlights that individuals with complex needs require integrated, multi-disciplinary support to manage both mental and physical health effectively[54]. Where this integration is lacking, there is a risk that physical and mental health are treated separately, leading to fragmented care and poorer outcomes.

[52] https://www.england.nhs.uk/personalisedcare

[53] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/longterm-efficacy-of-a-continuityofcare-treatment-model-for-patients-with-severe-mental-illness-who-transition-from-inpatient-to-outpatient-services/CEC0763E0D11CEFC279899FC0DF1D8CF

[54] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357

In practical terms, this means that physical health checks should not be limited to basic screening, but should include:

- ongoing monitoring of established long-term conditions,
- coordination with primary care and specialist services, and
- active management plans tailored to individual needs.

Examples from NHS systems across England illustrate the value of this approach. In several integrated care systems, multidisciplinary teams—including GPs, mental health clinicians and specialist nurses—have been used to deliver joint physical and mental health reviews, resulting in improved detection of long-term conditions and better management of risk factors such as obesity and hypertension. These models demonstrate that when care is coordinated and comprehensive, outcomes improve.

Furthermore, a key element of the recommendation is the insistence that performance targets for physical health checks must be met. This reflects an important distinction between measurement and action. While performance frameworks have increasingly incorporated indicators for SMI physical health checks, evidence suggests that these targets are not always achieved in practice, and where they are achieved, the quality and consistency of checks may vary.

NHS England has emphasised the need for improved data collection and monitoring as part of efforts to reduce health inequalities, including ensuring that key indicators—such as physical health checks—are consistently recorded and acted upon[55]. However, the presence of data alone does not guarantee improvement; it must be linked to accountability and quality assurance processes.

The Oxfordshire performance data submitted to this Committee for this item, which highlights gaps in meeting national standards, illustrates this challenge. It suggests that while systems may have the infrastructure to measure performance, additional effort is required to translate this into reliable delivery at scale.

This raises a broader point about performance targets being more effective if they are embedded within a wider system of clinical governance, workforce capacity and integrated delivery. Without this, there is a risk that targets are either unmet or met in ways that prioritise compliance over quality.

Improved physical health outcomes for people with SMI can be achieved by taking a proactive, integrated approach. This can include:

- shared care models between primary care and mental health services,

[55] https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref

- dedicated physical health clinics within community mental health teams, and
- targeted outreach to individuals at highest risk.

The success of any of these approaches would lie in their ability to align performance targets with clinical practice, ensuring that checks are not only completed, but are meaningful and lead to intervention.
The Oxfordshire system, with its emphasis on neighbourhood-based care and integrated working—as described in the HOSC report—is well positioned to build on these models. However, the Committee's recommendation highlights that this will require sustained focus, clear accountability and collaboration across system partners.

The recommendation that physical health check targets for people with mental illness must be met—and that these checks should be timely, regular and inclusive of long-term conditions—is both necessary and justified. It reflects a recognition that improving mental health outcomes cannot be achieved in isolation from physical health, and that the current system continues to underserve a population with significant and complex needs.

By emphasising regular monitoring, integration with long-term condition management and accountability for performance, the Committee is advocating for a shift from reactive, fragmented care to proactive, coordinated support. This aligns with both national policy and academic evidence, which consistently demonstrate that better physical health care for people with mental illness leads to improved outcomes, reduced inequalities and greater system sustainability. Ultimately, the recommendation underscores a fundamental principle: that parity of esteem between mental and physical health must be delivered in practice, not just policy—and that doing so requires both robust performance management and meaningful clinical engagement.

**Recommendation 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.*

***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; and for mental health investment to be placed on a statutory footing:*** The Oxfordshire Joint Health Overview and Scrutiny Committee's recommendation that system partners collaboratively call for a strengthened national framework—encompassing a clear strategy for neighbourhood mental health centres, statutory investment, expanded use of pooled budgets, multi-year funding for the voluntary sector, and timely delivery of the Modern Service Framework—reflects a sophisticated understanding of the structural constraints currently limiting progress in adult and older adult mental health services. This recommendation is grounded in the

evidence emerging from the report and Annex 1 submitted to the Committee for this item, which collectively illustrate that while local systems are innovating and improving performance in areas such as community access and crisis response, their ability to transform services at scale remains constrained by national policy, funding instability, and fragmented commissioning arrangements.

At the centre of the recommendation is the call for a clear national strategy to enable delivery of a community mental health centre in every community. This aligns directly with the strategic direction of NHS reform, which emphasises a shift from hospital-based care to localised, community provision. Integrated Care Systems (ICSs) were explicitly designed to support this transformation, with the aim of improving outcomes and tackling inequalities through place-based, collaborative working[56].

However, academic and policy analysis suggests that delivering this vision requires more than structural reform; it requires clarity of national direction and sustained investment. The Health Foundation has highlighted that while ICSs aim to shift care into communities and improve prevention, their success is dependent on consistent policy support and alignment between national ambitions and local delivery mechanisms[57].

The report submitted to the Committee reflects this tension. It describes a system that is increasingly focused on community-based provision—through neighbourhood teams, crisis alternatives, and voluntary sector partnerships—but also highlights ongoing pressures on inpatient capacity, workforce, and funding. These pressures limit the extent to which local partners can fully realise the ambition of a comprehensive, community-based mental health system. The Committee's recommendation therefore recognises that without a clear national framework—defining expectations, funding, and delivery models—local systems will continue to develop unevenly.

The call for mental health investment to be placed on a statutory footing responds to a longstanding concern about the variability and fragility of mental health funding. Although recent years have seen increased investment in mental health services, this funding has often been subject to competing pressures and short-term planning cycles.

National evidence demonstrates that demand for mental health services continues to grow, with an estimated one in five adults affected by common mental health conditions and rising levels of unmet need[58]. These pressures are reflected locally in Oxfordshire, where Annex 1

[56] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained
[57] https://www.health.org.uk/sites/default/files/upload/publications/2026/ICS%20report_Final.pdf
[58] https://www.gov.uk/government/news/key-target-hit-with-8500-extra-mental-health-workers-in-the-nhs

highlights consistently high demand across community and urgent care pathways.

The absence of statutory protection for mental health funding creates a risk that investment is diluted or redirected in response to immediate system pressures. In contrast, placing investment on a statutory footing would provide greater certainty and accountability, enabling long-term planning and sustained service development. This is particularly important for community mental health transformation, which requires upfront investment in workforce, estates and infrastructure before benefits are realised.

Moreover, a further key element of the recommendation is the expansion of Section 75 (s75) agreements and other mechanisms for pooled budgets. These arrangements allow NHS bodies and local authorities to combine resources and share responsibility for commissioning and delivering services. In practice, they are one of the most effective tools for enabling integrated, person-centred care.

The importance of such arrangements is well supported by both policy and research. Integrated care models are based on the principle that collaboration across organisational boundaries is essential to addressing complex needs and delivering better outcomes[59]. However, integration is frequently undermined by fragmented funding streams and misaligned incentives. The report submitted to the JHOSC illustrates this challenge, particularly in areas such as discharge planning, housing and community support, where responsibilities span health, social care and the voluntary sector. The persistence of issues such as delayed discharges and out-of-area placements reflects structural barriers that cannot be resolved within single organisational budgets. Expanding pooled budgets through s75 agreements would help to align incentives, enable joint decision-making, and support shared ownership of outcomes. Evidence from integrated care case studies demonstrates that such arrangements can improve coordination, reduce duplication, and support more effective use of resources[60].

Furthermore, the recommendation's emphasis on multi-year funding for the voluntary sector reflects another critical constraint within the current system. Voluntary, community and social enterprise (VCSE) organisations play a central role in mental health provision, particularly in areas such as crisis prevention, peer support, and community engagement. The report submitted for this item highlights this contribution, noting the involvement of organisations such as Mind and Restore in delivering key services. However, despite their importance, many VCSE organisations operate on short-term contracts, often renewed annually or even more frequently. This creates instability, limits workforce development, and restricts the ability to invest in long-term

[59] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained
[60] https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities

service improvement. Research on integrated care systems has identified this as a key barrier to effective collaboration, with voluntary sector partners often lacking the financial security needed to participate fully in system transformation[61].

Multi-year funding arrangements would address this issue by providing stability and enabling organisations to plan, invest and innovate. This would not only strengthen the voluntary sector itself, but also enhance the overall resilience and responsiveness of the mental health system.

Finally, the recommendation being issued by the JHOSC also calls for clear and timely arrangements for delivering the Modern Service Framework for mental health. While national frameworks provide important direction, their impact depends on effective implementation at local level. Delays, ambiguity or lack of alignment between policy and practice can undermine progress and create uncertainty among system partners. The Oxfordshire evidence suggests that local systems are ready to engage with these reforms, but require clearer timelines, expectations and support. This is consistent with broader findings that policy implementation in complex systems is often hindered by gaps between national ambition and local capacity. Academic research on care coordination underscores the importance of clear roles, shared objectives and effective communication in delivering system-wide change[62]. In the absence of these, even well-designed frameworks can fail to achieve their intended outcomes.

In essence, this recommendation represents a strategic and forward-looking response to the challenges identified within both local and national evidence. It recognises that while local systems such as Oxfordshire are making progress in transforming mental health services, their ability to deliver at scale is constrained by factors that lie beyond their direct control.

This JHOSC recommendation is also supported by the findings and recommendations of the detailed inquiry and report of the Parliamentary Health and Care Committee's into Community Mental Health. The Committee welcomed the emphasis that the Government has placed on the potential for community based mental health centres model and the £472 million funding for mental health services and new guidance on a `named worker', but has expressed disappointment that their recommendations for the extension of pilots (that had shown emerging evidence of reductions in A and E, crisis and need for inpatients); putting the Mental Health Investment Standard on a statutory footing; and expanding the use of s75 arrangements across the NHS and local authorities were not accepted. The Committee also sought clarity on accountability arrangements for the Modern Service Framework for Mental Health that would be the main vehicle for decisions on further

[61] https://www.mentalhealth.org.uk/our-work/policy-and-advocacy/planning-prevention-unlocking-potential-integrated-care-systems-create-mentally-healthy-society
[62] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357

recommendations such as waiting time standards. The workforce that would be needed to implement the ten year plan would need specific detail in the ten year Workforce plan on staff working in community mental health services and key professional groups such as mental health social workers.

By calling for a clear national strategy, statutory investment, expanded pooled budgets, multi-year funding for the voluntary sector, and effective implementation of national frameworks, the Committee is advocating for the structural changes needed to enable sustained, system-wide improvement. These measures are not merely desirable; they are essential for delivering a mental health system that is integrated, equitable and capable of meeting the needs of a growing and increasingly complex population. In doing so, the recommendation reflects a broader understanding that meaningful transformation in mental health care requires alignment between national policy and local delivery—and that collaboration across system partners must be supported by equally robust and coherent national frameworks.

**Recommendation 7:** *For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a co-produced community mental health centre in every community; for mental health investment to be placed on a statutory footing; and for there to be support for expansion of s75 agreements for pooled budgets or other clear mechanisms and levers for the local integration and shared ownership needed. It is recommended that local system partners call for national support to move to multi-year funding for commissioning of the voluntary sector, and that there be clear timely arrangements for the delivery of the Modern Service Framework for mental health.*

***For collaboration among system partners to ensure that transitions from children's to adults mental health services are as smooth and supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions:*** The recommendation that system partners collaborate to ensure that transitions from children's to adult mental health services are as smooth, supportive and needs-led as possible reflects a critical and well-documented challenge within mental health systems. The transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) represents a key point of vulnerability in the care pathway, and one which has historically been associated with discontinuity, disengagement and worsening outcomes. The Committee's emphasis on collaboration and patient-centred care is therefore both necessary and strongly supported by local evidence, national policy direction and academic research.

Transitions from CAMHS to AMHS are not simply administrative processes; they involve a profound shift in how care is conceptualised and delivered. CAMHS services tend to be family-oriented, developmentally focused and supportive, whereas adult services are often more medically focused and expect higher levels of individual

autonomy. This divergence in service models creates structural challenges for young people moving between them.

The report submitted to the Committee highlights the development of programmes such as the 18–25 transitions pathway, reflecting recognition within the system that traditional transition arrangements are insufficient. This is consistent with national evidence, which shows that transition is frequently poorly managed and inadequately coordinated. A major study published in the *British Journal of Psychiatry* found that fewer than 5% of young people experienced an "optimal transition", defined as involving planning, joint working, information transfer and continuity of care[63]. This finding underscores the scale of the issue: most transitions are not only suboptimal, but actively detrimental to continuity of care.

The consequences of inadequate transitions are significant. Disruption of care during this period can lead to disengagement from services, deterioration in mental health, and increased reliance on crisis interventions. Research consistently shows that young people are at risk of being "lost in transition" due to poor communication, lack of planning and unclear accountability between services. A qualitative study of young people's experiences found that transitions were often characterised by confusion, anxiety and insufficient support, with many participants reporting negative experiences both before and after transfer to adult services[64]. Similarly, a study published in the *British Journal of General Practice* found that young people frequently experienced disjointed care and unmet needs, particularly when continuity between services was poorly managed[65]. Additionally, these findings are reinforced by systematic reviews which demonstrate that transition is a high-risk period for disengagement and declining service use, with mental health service utilisation dropping sharply as young people age out of CAMHS[66]. The implications for policy and practice are clear: failure to manage transitions effectively can undo the benefits of earlier intervention and create long-term risks for individuals and the system.

The Committee's recommendation places collaboration at the centre of addressing these challenges. This reflects the reality that transitions span multiple services and organisational boundaries, including CAMHS, AMHS, primary care, social care, education and the voluntary sector. No single organisation can deliver effective transitions in isolation. National guidance from NHS England explicitly recognises this, stating that integrated care boards and providers must jointly develop transition models and ensure shared accountability for delivery across services[67]. This guidance also emphasises that transition should be a planned and

[63] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/process-outcome-and-experience-of-transition-from-child-to-adult-mental-healthcare-multiperspective-study/7E7201DFDB1C81F467B9C679080870A5

[64] https://www.tandfonline.com/doi/pdf/10.2989/17280583.2025.2533162

[65] https://bjgp.org/content/72/719/e413

[66] https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/wps.20266

[67] https://www.england.nhs.uk/long-read/supporting-young-people-to-transition-into-adolescent-and-adult-services/

coordinated process, involving preparation, transfer and ongoing support.

Academic research supports this approach, highlighting that effective mental health transitions require strong interprofessional collaboration, clear communication and shared responsibility between services[68]. In the absence of such collaboration, fragmented care pathways and inconsistent communication are likely to persist, leading to poorer outcomes.

The Oxfordshire system's emphasis on partnership working—evident in its integration of NHS, local authority and voluntary sector services—provides a strong foundation for delivering these improvements. However, the Committee's recommendation indicates that further alignment and coordination are required to ensure consistent implementation.

Moreover, a defining feature of the recommendation is its emphasis on ensuring that patient need is at the heart of transition arrangements. This reflects a broader shift towards personalised, developmentally appropriate care, recognising that transitions occur during a critical life stage characterised by psychological, social and physical change.
Research consistently shows that transitions are more successful when they are tailored to individual needs and actively involve the young person and their family. Evidence from co-produced transition programmes demonstrates that preparation, information sharing and emotional support can significantly improve outcomes and experiences[69]. Similarly, NICE guidance highlights the importance of having a named worker to coordinate care during transition, providing a consistent point of contact and ensuring that support is aligned with individual needs[70]. The Oxfordshire report's focus on ensuring continuity and integration across pathways aligns with these principles, but the Committee's recommendation makes explicit that this must be consistently applied across all transitions.

Across England, there is growing recognition of the need to reform transition pathways, with several systems developing innovative models to address the challenges identified above. These include:

- 0–25 service models, which remove the artificial boundary between CAMHS and AMHS and provide continuous support through adolescence into adulthood,
- joint clinics and multidisciplinary teams, enabling parallel care from both child and adult services during transition, and
- transition coordinators or key workers, ensuring continuity and personalised care.

[68] https://pmc.ncbi.nlm.nih.gov/articles/PMC8976965
[69] https://pmc.ncbi.nlm.nih.gov/articles/PMC5397792
[70] https://www.nice.org.uk/guidance/qs140/chapter/Quality-statement-4-Named-worker

The Royal College of Psychiatrists has advocated for such approaches, emphasising the need for flexible age boundaries, integrated workforce models and improved coordination across services to deliver better outcomes for young people[71]. These models provide practical examples of how the Committee's recommendation can be implemented at a system level.

The recent Parliamentary inquiry into Community mental health found that nationally, there were severe gaps with a `cliff-edge' for young people. The Government accepted the Health and Social Care Committees recommendation that an 18th birthday should not act as an artificial cut-off of care. The Committee's scrutiny of Children's mental wellbeing and services found that in Oxfordshire, action had been taken to make additional appointments available to children coming up to their 18th birthday and the Committee strongly supports this priority to support smooth transitions.

Therefore, this recommendation being issued by the JHOSC is both timely and well-founded. It reflects a clear understanding that transitions between children's and adult mental health services are a critical point in the care pathway, where poor coordination can lead to disengagement and worsening outcomes. By emphasising collaboration among system partners and the centrality of patient need, the Committee is advocating for a more integrated, person-centred approach to transition.

The evidence from both the Oxfordshire system and the wider literature indicates that effective transitions require:

- coordinated planning and communication across services,
- involvement of patients and families in decision-making,
- continuity of care and consistent relationships with professionals, and
- flexible, developmentally appropriate service models.

Without these elements, the risk remains that young people will continue to experience fragmented care and fall through gaps in the system. With them, transitions can become an opportunity to strengthen engagement, improve outcomes and support long-term recovery. In this context, the recommendation does not simply address a specific operational issue; it articulates a broader principle: that mental health services must be designed around the lived experience and developmental needs of individuals, and that collaboration is essential to delivering this vision in practice.

**Recommendation 8:** *For collaboration among system partners to ensure that transitions from children's to adults mental health services are as smooth and*

[71] https://www.rcpsych.ac.uk/docs/default-source/members/faculties/child-and-adolescent-psychiatry/child-and-adolescent-psychiatry-faculty-delivering-better-outcomes-for-children-and-young-adults.pdf?sfvrsn=2041138f_5

*supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions.*

## Legal Implications

16. 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.

17. 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'.

18. 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.

19. 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 Gareth Epps
Councillor Emma Garnett
Councillor Imade Edosomwan
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
District Councillor Val Shaw
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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