OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 18 April 2024 commencing at 10.00 am and finishing at 3.50 pm

Present:

Voting Members:	Councillor Jane Hanna OBE – in the Chair
	District Councillor Elizabeth Poskitt (Deputy Chair) Councillor Jenny Hannaby Councillor Nick Leverton Councillor Michael O'Connor District Councillor Paul Barrow City Councillor Sandy Douglas District Councillor Katharine Keats-Rohan Councillor Lesley McLean
Co-opted Members:	Barbara Shaw
	Councillor (for Agenda Item)
By Invitation:	Julie Dandridge, BOB ICB Lead for Primary Care across Oxfordshire Dan Leveson (BOB ICB Place Director, Oxfordshire) Hugh O'Keefe BOB ICB Senior Programme Manager – Pharmacy, Optometry and Dental Services Dr Veronica Barry, Executive Director Healthwatch Oxfordshire Terry Roberts Chief People Officer, Oxford University Hospitals NHS Foundation Trust
Officers:	Ansaf Azhar, Director of Public Health

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting [, together with a schedule of addenda tabled at the meeting/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

23/24 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies had been received from the following:

- Cllr Nigel Champken-Woods
- Cllr Mark Lygo.

24/24 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

The following interests were declared:

- Cllr Jane Hanna declared that she worked for SUDEP Action.
- Barbara Shaw declared that she was a chair of a cardiovascular charity.

25/24 MINUTES

(Agenda No. 3)

The minutes of the committee's meeting on 8 February 2024 were assessed for their accuracy.

The Committee **AGREED** the minutes as an accurate record of proceedings and that the Chair should sign them as such.

26/24 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Liz Peretz addressed the Committee on behalf of Oxfordshire Keep Our NHS Public.

She expressed deep concerns about the Primary Care Model, which she, along with the BOB Local Medical Committee, Oxford Patient Network, and others, opposed. Their concerns were:

- NHS England had not made this model mandatory, and if adopted, it could be much more expensive and potentially lead to worse health outcomes than the current system.

- If implemented, it could end the concept of the family doctor and risk the crucial connection between a local surgery and the population it served.

- The proposed two-tier system, distinguishing between users of Same Day Hubs and Neighbourhood Teams for the 'chronically sick', did not make sense. In this system, a patient who had not needed the doctor for years would be diverted to far less trained staff.

- The Primary Care Model had not been tried and tested. It was not a system tested to destruction by strong research, simply an idea put forward in the Fuller Stocktake report.

- The Committee was encouraged to speak up against the 'roll out' by their ICB of the new Primary Care Model. Instead, she asked for support for the GPs in their Primary

Care Networks to come up with their own solutions to the current crisis, and to listen when they said adequate funding and flexibility in how to use it was what they needed.

27/24 CHAIR'S UPDATE

(Agenda No. 5)

The Chair outlined the following points to update the Committee on developments since the previous meeting:

- A report (containing recommendations from HOSC) had been submitted to the Oxford University Hospitals NHS Foundation Trust regarding the South Central Ambulance Service's CQC Improvement Journey, which was discussed during the 08 February 2024 HOSC meeting
.
- A HOSC report containing recommendations from the Committee on the Director of Public Health Annual Report could also be found in the agenda papers.

- The Chair and the Health Scrutiny Officer had requested a written briefing for the Committee relating to the temporary closure of the ADHD referral list, with a view to understanding the reasoning behind the closure as well as the potential impact it could have on those affected.

- The Committee had requested a briefing from Oxford University Hospitals NHS Foundation trust on the recent CQC maternity inspection at the Horton.

- The Committee made recommendations to the Integrated Care Board (ICB) and the parliamentary House Select Committee regarding a new policy issued by the medicines regulator. This policy pertained to anti-seizure medication and medication used for individuals with bipolar disorder called Valproate. As an update to that, the ICB established a task force comprising consultants, specialist nurses, medicines safety officers, representatives from charities and patients with lived experiences. The impact report outlined that there were unavoidable consequences, and current services were ill-equipped to handle the implementation of phase one of the medicines regulatory policy. Specifically, it was anticipated that approximately 2,855 outpatient appointments would be lost due to the new requirements.
  The report further predicted that reduced access would lead to increased mortality and greater morbidity, including emergency situations arising from uncontrolled epilepsy. Notably, this assessment did not encompass the impacts and risks associated with phase two of the policy, which could be even more significant.

- The Chair also paid tribute to the Senior Patient Safety Manager at the ICB for his leadership of this taskforce, and the Committee offered their condolences to his family and colleagues.

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

The Committee **AGREED** the following actions:

1. For the Committee to **DELEGATE** to the Chair and Health Scrutiny Officer to write to the Health Secretary (and copying in the Parliamentary Health Select Committee) to bring the likely impacts of the Valproate Pregnancy Prevention policy to their attention, and to request that until the likely impacts and risks of phase 1 of the policy are assessed and safely addressed, that they allow local systems to delay implementation.

2. For the Committee to **AGREE** to the establishment of a four member HOSC Working Group, for the purposes of engaging in ongoing scrutiny of the NHS's Oxford Community Health Hubs Project.

3. For the Committee to convene a public meeting item on medicine shortages, in line with increasing reports of such shortages across the board.

4. For the Committee to **AGREE** to **DELEGATE** to the Chair and Health Scrutiny Officer the responsibility to determine an approach to ongoing scrutiny of Oxford University's Hospital's Plan B for the expansion of Horton Hospital.

28/24 GP PROVISION IN OXFORDSHIRE

(Agenda No. 6)

Julie Dandridge (BOB ICB Lead for Primary Care across Oxfordshire) and Dan Leveson (BOB ICB Place Director, Oxfordshire) presented a report on GP provision in Oxfordshire.

The BOB ICB Lead for Primary Care across Oxfordshire introduced the report. Addressing an item on which the Committee had previously received a briefing, the partners at Botley Medical Centre had handed back their contract the previous year and the ICB worked with the residents and the Patient Participation Group around Botley Medical Centre and with local providers to find two new practices willing to take on the patients. The draft Primary Care Strategy had been co-produced with a number of stakeholders and the feedback was being collated into a final version, to be signed off by the ICB Board in May. There was a recognition of the increase in GP appointments, but also an acknowledgment that patients and the public were still having difficulty getting through to GPs by phone to get an appointment. There had been much progress in improving primary care estates. Some things were unfortunately beyond the control of the ICB, but work was continuing with GP leaders to try and improve access for patients.

The Committee asked in what respects had the National Recovery and Access to Primary Care Programme funded, influenced, and shaped the decisions and measures taken around GP provision in Oxfordshire. The BOB ICB Lead for Primary Care explained that the national primary care access and recovery. had come with some funding to support it. This funding was partly for practices to have time to implement what they called modern general practice, which involved assessing how and by whom patients should be seen. All their practices had submitted plans on how they would do this at the primary care network level. There was also funding for IT, specifically to ensure that all their practices had functioning cloud-based telephony and to drive forward other innovations in IT.

The Committee queried the extent to which the development of the Primary Care Strategy involved adequate levels of public and stakeholder engagement. The BOB ICB Lead for Primary Care had stated that engaging everyone was challenging. They had co-produced the draft strategy with GP leaders and Primary Care Network clinical directors, and held webinars and sessions for the public and professional colleagues. A detailed public engagement report was available, and Healthwatch had been used to disseminate information and hold seminars. Feedback received from public engagement indicated a need for more co-production of communications. The strategy would only work if the public was taken along, their concerns understood, and if they helped to drive it forward. Engagement on the strategy had closed as they wanted to get a final strategy out and ready. The strategy was put in place to help with the challenges faced by GPs and the public in terms of access. None of the components in the strategy were going to be mandated but were suggestions to colleagues in general practice on how to progress to enable better access for patients. There were good examples of where some of the integrated neighbourhood teams and acute same-day hubs really worked and made a real difference to patients and access, but it was not going to be universal. In terms of further engagement, this would now take place locally as they defined and shaped it for every local footprint.

The Committee asked for more information about the development of proactive and personalized care in the community setting for people with complex health needs.
The BOB ICB Lead for Primary Care emphasised the importance of the development of care closer to home, with services being moved out of hospitals into the community for easier patient access. Integrated neighbourhood teams were brought together, uniting experts in care to move things forward in a unified direction. This was part of developing a patient-focused approach, which had been implemented in some cases, but not optimally across all areas. Resources included NHS staff in the community and staff in general practice. The goal was to join up and streamline processes, using the same records to release capacity for personalized care for those who needed it most. There were many teams that needed to be brought together to drive this forward, and good work was being done across Oxfordshire to achieve this in certain places.

The Committee enquired as to whether any extensive progress had been made for the ICB to work closely with District Councils to enhance GP access and services and deal with primary care estate issues. The BOB ICB Lead for Primary Care had explained that their town planner was actively participating in the district councils' planning discussions, building relationships, and driving things forward in a more organised manner. The engagement with individual councillors was primarily through the officers rather than direct interactions with the councillors themselves.

The Committee queried whether the Great Western Park project in Didcot was going according to plan. The BOB ICB Lead for Primary Care stated that they had made significant progress with the Great Western Park development. This progress was marked by the ICB's agreement and the extension of the Section 1 agreement that was already in place with the developer. The council was preparing to receive the land and the fund. Despite the complexity of the legal agreement involving three or four parties, they were on the right path and intended to maintain the momentum. The next steps, which included finalising the legal agreements and submitting a planning application, were clearly in sight.

The Committee enquired as to whether there was any record keeping of ‘failed service requests’, and whether this was followed up. The BOB ICB Lead for Primary Care had responded that, at that time, the only method of testing was through the GP patient survey. Nationally, from October, call data would be collected. They acknowledged the existence of a significant amount of unmet need and emphasised the importance of reaching those individuals who might be deterred from accessing their GP if they failed to get through. Regarding how to assist these patients, more work needed to be done on the ground with patients, including working with support groups, to ensure these individuals could access the necessary services.

The Committee asked whether the ICB monitored each practice against requests for online and urgent appointments being closed. The BOB ICB Lead for Primary Care explained that the Primary Care Strategy was initiated to address the need for capacity in general practice. The ICB was aware and captured details about practices that struggled to remain open due to a lack of capacity and appointments. The default solution was to use the 111 service, which could perform early triage and determine the urgency of a patient's need to be seen, but efforts were being made to assist practices that regularly had to switch to the 111 service.

The Committee queried whether the ICB was reviewing the number of GPs and number of additional primary care roles per practice. The BOB ICB Lead for Primary Care acknowledged that there was variation across GPs. They utilised several data sets, including the Patient Access Survey, which consistently ranked practices and provided a clear indication of where they needed to focus on. This was something they constantly monitored and provided support to a number of practices for.

The Committee asked how the ICB was anticipating future housing developments and population increases. The BOB ICB Lead for Primary Care explained that their town planner played a crucial role. The planner was meeting with officers to review upcoming plans and submit requests for support for general practice primary care infrastructure. There were plans in place in some locations, for example they had strategies to increase provision across Bicester and Kidlington using developers' contributions. The planner was aiming to look ahead, to create long-term plans rather than reactive ones.

The Committee asked whether the ICB thought there was a need to explore more strategically the potential to partner with the local authorities in provision of new primary care premises. The BOB ICB Lead for Primary Care mentioned a Section 2 agreement for working in collaboration with local authorities and councils, which was a significant opportunity for general practice on the ground. They acknowledged that the ICB had no capital, and their only source of funding was through revenue. They saw potential opportunities in collaborating with local authorities and expressed a strong interest in exploring them.

The Committee asked why the initial focus was on prevention around cardiovascular disease. The BOB ICB Lead for Primary Care responded that they believed there was still significant room for improvement in cardiovascular disease. They acknowledged the substantial benefits this could have, not only for patients but also for the system and resources. They confirmed that cardiovascular prevention had

been agreed upon as a BOB system priority. However, they had also received feedback suggesting that prevention should not be limited to just cardiovascular disease but should also encompass areas such as oral health and children's preventative health. The ICB did not want their strategy to be so broad that it encompassed everything and ended up delivering nothing, which was why they narrowed their focus to one area. However, they anticipated that other aspects of prevention would be broader than just cardiovascular disease.

The BOB ICB Place Director for Oxfordshire added that cardiovascular disease was identified as the leading cause of premature death and noted a significant inequality in its occurrence, which explained their focus on it. The BOB ICB Place Director and the Director of Public Health chaired the Prevention Health Inequalities Forum and were examining better access to and advertisement of NHS health checks, and had made significant investments promoting activity. They emphasised that there was a lot to do, and that they needed to preserve with prevention and inequality work, as the positive impact from this would be more visible in the long term.

The Committee enquired as to how the GP retainer scheme would help to enhance the retention of GPs. The BOB ICB Lead for Primary Care explained that there was a 'new to practice' GP fellowship that provided support to new GPs and the implementation and delivery of the Primary Care Strategy could attract new GPs. The introduction of innovative ways of working with patients was thought to help retain GPs and the developments to roles were found to be very rewarding for the staff.

The Committee asked whether administrative staff received appropriate training in being able to support clinicians and patients. The BOB ICB Lead for Primary Care responded that the receptionist had traditionally been the first point of contact for someone trying to access a GP appointment. They were upskilling those receptionists to become care navigators so that they could direct the right patients to the right place. The reception staff were trained to understand what the important questions were so that they could point patients to the right clinician; whether that be a pharmacist, a physiotherapist, or the GP. There was a national training program for receptionist care navigators and most practices had their own training in place as well. All NHS staff, including administrative staff, were bound by confidentiality. The ICB was committed to work with the public to help shape what information they needed to participate and feel confident in the range of staff that were now working in general practice.

The Committee asked what could be done to alleviate the pressures in community pharmacy. The BOB ICB Lead for Primary Care replied that Pharmacy First had launched on the 31st of January and it was welcomed by the profession and by community pharmacists. As Pharmacy First developed and as more conditions became available for pharmacists to treat, it brought more income into the community pharmacy, which was really welcomed by their pharmacies, especially smaller independents.

It was **AGREED** that the BOB ICB Lead for Primary Care would provide the Committee with a breakdown of how funds from the National Recovery and Access to Primary Care Programme were being spent.

It was also **AGREED** that the BOB ICB Lead for Primary Care would liaise with the ICB Director of Comms and Engagement to respond to the Committee's question on what prevented the ICB and the local managers from taking on board the scrutiny committee feedback about engagement.

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

1. To ensure continuous stakeholder engagement around the Primary Care Strategy and its implementation, and for the ICB to provide evidence and clarity around any engagements adopted and on key feedback themes that were received from within Oxfordshire. It is also recommended that there is a clear implementation plan to be developed as part of the Primary Care Strategy, and for this to be shared with HOSC and key stakeholders.

2. To continue to work on prevention of medical and long-term conditions besides cardiovascular disease.

3. To review ICB capacity to ensure adequacy, with a view that the ICB can work in a timely way with all District Councils across Oxfordshire on the securement and spending of infrastructure funding.

4. That an expected date for the signing of the legal agreement on Didcot Western Park is provided to the JHOSC, so there can be reassurance about the likely timescale for the tendering process.

5. That the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons; and that there is a communication with the public to provide improved clarity and communication about the statistics concerning access to appointments.

6. For there to be clarity and transparency around the use of any competency frameworks and risk assessments around the role of non-medical staff who are involved in triaging or providing medical treatment to patients.

29/24 DENTISTRY PROVISION IN OXFORDSHIRE

(Agenda No. 7)

Hugh O'Keefe (BOB ICB Senior Programme Manager – Pharmacy, Optometry and Dental Services), Dan Leveson (BOB ICB Place Director, Oxfordshire) had been invited to present a report on Dentistry Provision in Oxfordshire. Ansaf Azhar (Director of Public Health) was also in attendance.

The BOB ICB Senior Programme Manager for Pharmacy, Optometry and Dental Services explained that the report included an update on the progress made since the last HOSC meeting they attended the previous year. They had been dealing with continuous issues related to dental practices leaving the NHS, which had become a serious concern, and the report covered their actions in response to these departures.

The Committee asked whether there was any indication as to the geographical spread of practices in Oxfordshire that had not met the minimum target contracted activity required for NHS dentists to avoid financial recovery, and what the reason

was for Oxfordshire's inferior performance to Buckinghamshire and West Berkshire. The BOB ICB Senior Programme Manager explained that contract delivery before the pandemic used to run at about 90% in Oxfordshire, and there had been more of an impact from the pandemic in the longer term in Oxfordshire. It could not be said that there was a particular area in Oxfordshire that was doing much better than others, although West Oxfordshire and the Vale of the White Horse were seeing slightly lower levels of provision.

As the distance from the capital increased, challenges arose, particularly in more rural areas. Similar patterns were observed in Buckinghamshire and the West of Oxfordshire, but not so much in West Berkshire. These areas, especially the West of Oxfordshire, faced significant challenges, with numerous practices deciding to leave the NHS and go private. This trend was more prevalent in this county than in other parts of the system. Since 2021, about 5% of the capacity was lost, with approximately three-quarters of that loss occurring in Oxfordshire. About half of the loss was specifically in the West of Oxfordshire as practices in these rural areas were making decisions to leave the NHS.

The Committee enquired as to the challenges facing patients trying to access local NHS dental services. The BOB ICB Senior Programme Manager clarified that, in contractual terms, dentists were only responsible for patients while conducting the course of treatment, so they were not registered. Due to the pandemic, many patients discovered that they had not attended for more than two years and when they then called back in to the dentist they appeared as new patients.
The recovery of access was fairly rapid early on in 2022. Since then, it had been slowing, and the report discussed some of the issues including gaps in treatment, leading to worse oral health, meaning those treatment plans were taking longer to complete. Thus, the backlog was taking time to clear because of the needs that were presenting.

In answer to the Committee's query about the low NHS pay to dentists, the BOB ICB Senior Programme Manager explained that when the NHS contract was introduced, it was argued that it would have a 'swings and roundabouts effect', as dentists would only need to see some patients for a short period of time for a check-up while other patients would need longer treatment. There had always been a recognition that there was some cross-subsidisation with private work in dentistry, as even if a dentist had a substantial NHS contract, they nearly always had private work that went with it. The problem was that this contracting model was impacted by COVID and dentists were tending to see patients with more complex needs, so the swings and roundabouts effect was not working as well. Some of the national changes aimed to adjust the pricing and bring in a new minimum price, as the pricing used for the dental contract was based on activity carried out in a reference year in 2004/5.
The dental contract had been introduced in 2006 and pilots for a different type of contract had been run since then, however they had an impact on access. Practices that took part in these schemes devoted more time to seeing patients, which led to a fall in access and patient charge revenues.

The Committee enquired about the basis of the NHS contract and the effect on dentists that did not meet their targets. The BOB ICB Senior Programme Manager elaborated that the contract provided unit payments based on treatment bands, and

dentists were paid units of dental activity (UDAs) based on the numbers of treatment bands they did in a given year, within a capped allocation. Some practices opted to leave due to the risk associated with delivering these units, especially when dealing with patients with more complex needs that required more treatment, but only represented a fixed unit payment. The introduction of flexible commissioning was partly to help patients who had been struggling to get into the system, with practices participating in the scheme opening up to see these patients. It also helped practices reduce their business risk by converting a portion of their activity target to access sessions, allowing them to receive the same amount of money without having to hit as high an access target.

The Committee asked whether any efforts were being made by ICB or NHSE to influence the government to increase financial uplifts applied to dental contracts.
The BOB ICB Senior Programme Manager explained that there were contract changes in 2022 and 2024, and when these changes were considered collectively, there were benefits to dental practices. A new patient premium was introduced to incentivise dental practices to take on new patients. There was talk about a new contract in 2025, but there was a financial barrier to introducing a new contract, as the dental system was heavily dependent on patient charges, which in turn depended on patient attendance. There was a significant risk to financial stability if substantial changes were made, therefore previous changes have been incremental.

The Committee enquired about progress on ensuring that new dentist trainees were registered swiftly. The BOB ICB Senior Programme Manager answered that arrangements had been made for overseas dentists to be added to the performer list more quickly, as previously, they had to undergo an examination process before they could start working on the NHS.

The Committee asked what was being done to help those patients from dental surgeries that had handed their contracts back. The BOB ICB Senior Programme Manager explained that a programme had been implemented, which involved approaching local practices to try to replace the activity that had been lost due to contract hand backs. In Oxfordshire, there had been some success and about another 20,000 units of dental activity (UDAs) had been commissioned, the equivalent of 3 1/2 surgeries. However, there were still significant gaps, and it was recognised that the flexible commissioning was an interim solution. The next stage was to go out to formal market procurement with the aim of seeking new practices to come into the areas where capacity had been lost.

The Committee queried how the ICB made sure that patients were being given correct and accurate information about where they can go to access the NHS dentists. The BOB ICB Senior Programme Manager highlighted that flexible commissioning had been helping with the access issue. When the scheme was started, practices were nervous about widely publicising their access because they feared being inundated with patients due to limited access. As a result, a requirement was introduced in the contract for practices to update their information. More practices were opening up in Oxfordshire, which was an early sign that the extra activity being put into the system was helping practices.

The Committee asked whether the ICB would be commissioning new contracts, particularly in those areas with no NHS dentists and what the time scale was for opening new practices in areas that expressed interest. The BOB ICB Senior Programme Manager acknowledged that in the past, seeking expressions of interest in very rural areas could yield no responses, and recognised that it was not enough to commission without ensuring this could be delivered. However, expressions of interest had been received in some of these areas in Oxfordshire with little NHS provision. There was a timeline from the start of procurement to opening of about 18 months to two years. Finding and obtaining planning permission for premises represented the majority of that time.

The Committee enquired whether having patients on their books prevented dentist surgeries from taking on new patients. The BOB ICB Senior Programme Manager replied that a significant portion of the capacity was being utilised by patients who were regular attenders. The ICB had been attempting to restore this capacity as swiftly as possible, enabling practices to move beyond merely recalling individuals who had previously been in the system. They had suggested extending recall times, as it was not clinically indicated that everyone needed to attend as frequently as every six months. This could also create additional capacity for new patients.

The Committee asked whether the NHS was conducting any work to help increase awareness of the importance of oral health and hygiene. The BOB ICB Senior Programme Manager explained that the oral health promotion service in the area was run by the local authority. However, dentists had played a crucial role in promoting oral health and ensuring access, emphasizing the importance of quickly integrating children into the system. This was to prevent situations where a child's first visit was due to a serious dental problem, which could instigate fear. The ICB had been considering moving beyond just looking at access, which had been a significant focus area, and starting to delve into a more preventative agenda.

The Committee enquired as to what was being done in schools to monitor children's oral health. The Director of Public Health clarified that Oxfordshire was one of the local authorities that still commissioned an oral health needs assessment and conducted an oral health survey. They commissioned the Community Dental Service, which included liaising with school health nurses to influence oral health in children and carry out preventative activities. They tried to incorporate preventative oral health messages through their other physical health services. There was a pathway in place linking with the Community Dental service, for children with oral health needs, and the committee could be provided with more detail on this at a later date.

The Committee asked what steps have been taken to support the oral health of residents with mental illnesses. The BOB ICB Senior Programme Manager replied that there was a community dental service in Oxfordshire that had seen residents with mental illnesses, with dentists who had undergone special care training, and there were numerous ways that patients could access this service.

The Committee enquired as to whether, in evaluation of the programme, they had looked at how people from areas of health inequality had been affected. The BOB ICB Senior Programme Manager clarified that flexible commissioning aimed to identify deprived patient groups like looked after children and asylum seekers. There

was always a cohort of patients who did not attend the dentist and only went when they were in pain, which tended to link to deprivation. The scheme assisted them in getting to the dentist because although it was not designed for urgent treatment, it was picking up on that need in the population to get patients into the system.

The Committee asked what the ICB's position on fluoridating Oxfordshire's water supply was, and whether any consultations were planned around this. The BOB ICB Senior Programme Manager responded that there were no plans at this stage to have consultations about fluoridating the water supply. The information that came from the 2024 contract changes referenced water fluoridation, but it was referencing the schemes that were currently running. The BOB ICB Place Director, Oxfordshire added that this was a Public Health matter and not something the ICB was commissioned to do.

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

1. It is reiterated that underspends should be spent in Oxfordshire, and that priority is given to areas within Oxfordshire that have experienced the worst shortfall in capacity. It is recommended that the ICB prioritises areas within Oxfordshire in light of the increased need within the County relative to other areas under the BOB footprint.

2. To support the creation of new practices within Oxfordshire with urgency, and to explore avenues of funding to support the ICB in developing solutions in this regard.

3. That urgent progress is made in improving the accuracy and the accessibility of information on dentistry services available to people; and that where groups are targeted for help, they can benefit from an effective outreach.

4. For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.

30/24 HEALTHWATCH OXFORDSHIRE UPDATE REPORT

(Agenda No. 8)

Following on from the previous item, Veronica Barry, Executive Director of Healthwatch Oxfordshire, described a visit to asylum refugee hotel accommodations in the Banbury area and where they spoke with several key stakeholders regarding the integration into flexible commissioning in dentistry. Efforts were directed towards collaborating with the welfare office in those specific hotels, as it was observed that their awareness of flexible commissioning was limited.

Additionally, work was undertaken with parents through community connectors in the Banbury area, focusing on oral health. Notably, parents of children with special educational needs were identified as potential users of specialist services. A report detailing these findings is currently in progress. Moving forward, the plan involved partnering with community-based dental services to highlight developmental information specifically for this group of parents. An effort was made to incorporate the voices of the public into the discussion through the appendix. The Executive Director of Healthwatch Oxfordshire reiterated that effective communication with the public was crucial. However, it was acknowledged that the public were currently navigating a complex system with various constraints.

Healthwatch had conducted a Mystery Shopper exercise that simulated patient calls to dental surgeries. This exercise highlighted the time-consuming nature of navigating the system for a member of the public. Despite this, the flexible commissioning scheme was seen as encouraging, although certain groups still lacked clarity on how to access it.

In response to concerns about Patient Participation Groups (PPGs) not being involved in the Primary Care Strategy, the Executive Director of Healthwatch Oxfordshire emphasised that Healthwatch made efforts to promote PPG engagement, including through webinars. An ongoing appraisal of the current state of PPGs revealed a strong need for improved communication around changes. The hope is that Healthwatch's report will enhance support for PPGs, and discussions with the ICB will address communication gaps with these groups.

Additionally, patients had raised the issue of access to ADHD medication to Healthwatch and clarity had been sought from the ICB regarding patient pathways; especially considering changes in national guidelines.

The Committee thanked Healthwatch Oxfordshire for their work and **NOTED** the report.

31/24 OXFORD UNIVERSITY HOSPITALS NHSFT PEOPLE PLAN

(Agenda No. 9)

Terry Roberts (Chief People Officer, Oxford University Hospitals NHS Foundation Trust) was invited to present a report on the Oxford University Hospital's NHSFT People's Plan. Dan Leveson (BOB ICB Place Director, Oxfordshire) was also in attendance.

The Committee asked for clarification on the Oxford University Hospitals NHS Foundation Trust (OUH) vacancy freeze and whether an impact assessment had been completed to assess its effect. The Chief People Officer clarified that it was not a vacancy freeze, but a vacancy pause. This measure was implemented following instructions from the Integrated Care Board and NHS England, with the aim of balancing their financial books. The pause affected both clinical and non-clinical posts that were Band 8C and above, which included senior roles like managers with a salary of £70,000. Administrative and clerical roles were also paused. OUH still actively recruited to Band 5 and Band 6 nursing vacancies, healthcare support workers, and other direct healthcare roles. The primary goal of this action was to ensure financial stability. A quality impact assessment was conducted not only for the overall programme but also for each post under consideration. Recruitment to posts was not undertaken unless they were fully aware of the potential impact on patient care and their ability to meet constitutional standards.

The Chief People Officer added that OUH was directed to implement these measures. They had been striving to increase productivity and had a significant productivity programme in place for the entire previous year. It was noted that at the end of 2023/24, they finished with a deficit of £10 million. However, this was in the context of achieving £90 million in efficiency savings during the same period.

The Chief People Officer clarified that they did not want to pause the posts, as they were not extra and were indeed needed. However, they had been instructed to review them, a task not unique to Oxford University hospitals. They acknowledged the difficulty of the situation, particularly the administrative burden placed on staff due to the thorough quality impact assessment. They highlighted the financial constraints they were operating under, with a finite budget and a requirement to balance their books. They emphasised that unless key changes were made and tough decisions taken, they would not be able to fund investments to improve both patient and staff experience, as highlighted in the people plan.

The Committee enquired about the effect this could have on staff that were already under strain. The Chief People Officer stated that they were aware of the initiative's impact on their staff. They were constantly monitoring the staff's mood through quarterly staff surveys, a large annual staff survey, retention questionnaires, and regular people plan listening events where they heard directly from the staff. These methods helped them understand the feelings of their staff and were instrumental in developing the people plan.

The BOB ICB Place Director, Oxfordshire acknowledged that their costs, like many systems across the country, had exceeded the allocated funds. The proportion of money spent on staff, was typically between 75% and 80%. They emphasised their responsibility to deliver a balanced budget and considered it absurd to do so without considering how they spent the major proportion of their money. In financially challenging circumstances, one of the first actions they took was vacancy control, as it was something they could control. They ensured that people were still able to staff safely. While doing so, they saw an opportunity to explore different care models that could deliver better value and outcomes at lower costs. They were introducing new integrated models for better value and were considering the introduction of technology. However, they acknowledged the difficulty of these tasks, given the growing cost of care and health demands beyond their resources. Vacancy control was a normal and understandable first action when demonstrating financial control and responsible stewardship of public funds.

The Committee asked how the NHS People Plan influenced the OUH People Plan, and whether the OUH People plan was sufficiently tailored toward any potential specificities for Oxfordshire. The Chief People Officer stated that they had a specific Oxfordshire remit, part of which involved attracting and retaining people from Oxfordshire. They had a scheme to recruit locally for their apprenticeships. They worked on the health inequalities agenda for Oxfordshire and were part of the Anchor Institute. Their goal was to reduce health inequalities and recruit people from local communities into their organization. When they first developed this, they looked at the NHS plan and the ICB people plan, integrating all the key elements from the NHS plan. They conducted extensive engagement to hear what their people thought. Over 75% of the people who worked for them came from Oxfordshire, so they heard what was important for them to live and thrive.

The Committee asked whether there was still a heavy reliance on agency and bank staff and whether cheaper housing for staff would help attract the workforce. The Chief People Officer responded that there was a reliance on agencies due to existing

vacancies and a national shortage of trained nurses and doctors. They had not only depended on agencies and banks but also on overseas recruitment due to the poor supply of trained medical professionals. They had a target to reduce their reliance on banking agencies by 700 whole time equivalents that year and were exploring different ways to achieve this. The cost of living was a factor that made it difficult for people to afford living in Oxford. They had been working with outside agencies to secure cheaper accommodation for their staff, an effort that was ongoing. They appreciated any support that could help them offer low-cost accommodation to their people and key workers. They were also considering the introduction of an Oxford Weighting, similar to the London Weighting received by hospitals in London, given that the cost of living in Oxford was not much lower than in London. They expressed appreciation for any assistance that could be provided in this regard.

The Committee enquired whether there was any extensive collaboration underway with Oxford University to help support the recruitment of young and talented individuals for employment roles within the trust? The Chief People Officer stated that they regularly met with the university, and they had been exploring creating joint initiatives and developing a joint office. This joint office would focus on joint recruitment for both the university and OUH. This was an ongoing effort that they had been working on for a year but competing demands had prevented an early resolution.

The Committee asked about the protection of staff from abuse and violence and whether there was a whistleblowing policy in place. The Chief People Officer stated that addressing abuse towards their staff was a high priority due to an increase in such incidents. They had a specific group focused on supporting staff in relation to violence, aggression, and sexual harassment. Several initiatives were in place, including body cams for Emergency Department staff, psychological support from their Psychological Medicine service, a poster campaign, and a revisited policy about violence and aggression. They had strengthened their warning system for aggressive or violent patients. They were also encouraging staff not to tolerate abuse, which had sometimes led to staff leaving their jobs. They were working to lower staff tolerance of violence and aggression, even when it came from patients with dementia or other illnesses. They wanted staff to report incidents so they could take action, and were even willing to deliver final warnings to patients at an executive level. They were making progress on this significant agenda, but not as quickly as they would have liked.

The Chief People Officer had confirmed that the majority of the issues were from patients. Upon reviewing the data and staff survey results, they found that incidents involving staff-on-staff were less than half of those involving patients-on-staff.

The Chief People Officer stated that they had a whistleblowing policy encouragement to speak up, however, they believed more needed to be done. As part of their action plan, they were exploring ways to provide psychological safety for people to voice their concerns. They were seeking charity funding to establish an external whistleblowing system, assuring that it would be anonymous and allow people to raise their concerns without fear of being traced. This was aimed at addressing these concerns effectively.

The Committee asked how OUH would be evaluating and measuring the overall effectiveness of the Plan and its tangible outcomes and delivery. The Chief People Officer had responded that they had 15 metrics in their report, that they believed were crucial to measure. The end of Year Three of the People Pan, which was also the end of the financial year, was the time they would measure against all the metrics such as bullying and harassment, time to hire, and vacancy rates. An annual evaluation was conducted to assess their position, and for the second year, they had met the majority of the metrics. The areas they identified as having the most significant gaps were some of the equality and diversity metrics. They also noted the importance of employees taking the majority of their annual leave throughout the year, as it was crucial for rest and recovery. Another concern was the number of people leaving within a year of starting, particularly among admin and clerical and healthcare support workers. This indicated issues with the work environment and the selection process. They found that sometimes, people did not realise the nature of the job they were taking on; and with admin and clerical staff, they could earn the same or more working at Amazon or Tesco. Therefore, they were considering how they paid and how they marketed their non-monetary benefits. These were the key areas they planned to focus on in their third year.

The Committee emphasised the quality of the report and the presentation, and commended the comprehensive metrics and creative solutions being produced.

The Committee **AGREED** to issue the following recommendations to Oxford University Hospitals NHS Foundation Trust:

1. For Oxford University Hospitals NHSFT to provide the Committee with a written briefing around the reasoning behind the pause in recruitment of certain OUH staff, as well as around any risk assessments that have been conducted around the recruitment pause.

2. To ensure that there is ongoing engagement with staff and key stakeholders around the continuing design and delivery of the OUH People Plan.

3. To continue to secure the necessary levels of resources required to deliver on the key objectives of the People Plan.

4. To explore avenues of improving pay for staff in line with the increases in financial hardships generated by the Cost-Of-Living Crisis. It is recommended that the Trust works with relevant system partners to explore the prospect of achieving an Oxford Weighting.

5. To continue to develop clear processes through which to evaluate and measure the effectiveness of the People Plan and its delivery.

32/24 RESPONSES TO HOSC RECOMMENDATIONS

(Agenda No. 10)

The Committee received responses as well as acceptances for the recommendations made as part of the item on the Oxfordshire Place-Based Partnership, which was held during the 23 November 2023 HOSC meeting.

The Committee also received an additional progress update response to the recommendations made as part of the Oxfordshire Healthy Weight item, which was held during the 23 September 2023 HOSC meeting.

The Committee **NOTED** the response and update.

33/24 FORWARD WORK PROGRAMME
(Agenda No. 11)

The Committee **AGREED** the proposed forward work programme.

34/24 ACTIONS AND RECOMMENDATIONS TRACKER
(Agenda No. 12)

The Committee **NOTED** the progress made against agreed actions and recommendations

..... in the Chair

Date of signing .....