OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 22 September 2022 commencing at 10.00 am and finishing at 2.40 pm

Present:

Voting Members:	Councillor Jane Hanna OBE – in the Chair
	District Councillor Paul Barrow (Deputy Chair) Councillor Imade Edosomwan Councillor Damian Haywood Councillor Dr Nathan Ley Councillor Freddie van Mierlo City Councillor Jabu Nala-Hartley District Councillor David Turner Jean Bradlow Barbara Shaw
Other Members in Attendance:	Councillor Mark Lygo Councillor Jenny Hannaby Councillor Tim Bearder
By Invitation:	Emily Lewis-Edwards, Chief Executive of Community First Oxfordshire Rosalind Pearce, Executive Director, Healthwatch Oxfordshire Martin Chester, Clinical Operations Manager, South Oxfordshire, SCAS Will Hancock, Chief Executive Officer, SCAS Mike Murphy, Director of Strategy and Governance, SCAS Tom Stevenson, Comms and Engagement Lead for the SCAS Improvement Programme Kirsten Wells-Drewitt, Head of Operations in Oxfordshire, SCAS.
Officers: Whole of meeting:	Eddie Scott, Health Scrutiny Officer Tom Hudson, Clerk
Part of meeting	Ansaf Azhar, Corporate Director for Public Health Derys Pragnell, Consultant in Public Health Katharine Eveleigh, Health Improvement Practitioner David Munday, Consultant in Public Health Karen Fuller, Interim Director for Adults and Housing

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.

52/22 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Cllrs Champken-Woods, Leverton and Poskitt. Cllr Nala-Hartley sent word that she would be late to the meeting.

53/22 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Cllr Hanna noted her position as Chief Executive of SUDEP Action.

Cllr Van Mierlo declared an interest on the basis of working as an independent consultant for companies making medicinal products for lung cancer.

54/22 MINUTES
(Agenda No. 3)

The minutes of the HOSC meeting held on 14 July were **AGREED** as an accurate record subject to the following amendments:

1) That reference be made to Cllr Turner's request to Oxford Health in item 43/22 for information concerning what had happened to those residents of South Oxfordshire who had been assessed for palliative care and not been able to access beds in Wallingford. No answer to this question had been received.
2) That reference in item 43/22 be made to the Working in partnership with people and communities: Statutory guidance, specifically in respect of communities who had been worked with, and understood the history of change.

55/22 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

None

56/22 OXFORDSHIRE TOBACCO CONTROL STRATEGY
(Agenda No. 5)

Cllr Mark Lygo, Cabinet Member for Public Health and Equalities, Ansaf Azhar, Director of Public Health, Derys Pragnell, Consultant in Public Health, and Katharine Eveleigh, Health Improvement Practitioner, attended to present a report to the Committee in respect of the work already achieved as part of the Tobacco Control Strategy, and the reconfiguration of the Strategy, post-pandemic.

Cllr Lygo, Cabinet Member for Public Health and Equalities explained the context of the report. Smoking was the leading cause of preventable death in the UK, and the single greatest modifiable risk factor in cancer, COPD, miscarriages, still-births and

birth anomalies. To tackle this, in March 2020 the Council adopted a five-year Smoke Free Strategy with the ambition of reducing the prevalence of smoking to below 5% by 2025. Owing to the pandemic, progress towards this goal had been slower than originally envisaged.

Ansaf Azhar, Director of Public Health, noted that the health impacts of smoking were disproportionately experienced by those experiencing disadvantage in society. For instance, whilst Oxfordshire's prevalence at the launch of the strategy was below the national average at between 10-11% those experiencing problems with serious mental health were at around 30%, likewise social housing tenants, and manual workers over 20%. The Council's approach, therefore, needed to be targeted rather than universal. The Council had had the efficacy of different interventions independently assessed to identify the most effective ones for inclusion within the strategy. Evidence showed that a focus broader than simply smoking cessation services was required to underpin the ability of the majority of smokers to quit. This breadth was enabled by the strategy being a partnership document, signed by all the local councils, as well as local health partners, with specific actions for each partner. The effect of Covid was to put a complete stop to many of these actions for over two years. As a consequence, reaching the 5% target would be significantly more challenging. Nevertheless, not all actions had been stopped, and the importance of reducing smoking numbers meant it was important to keep on striving to meet the target on schedule. Looking from a national perspective, the Khan Review's recommendations provided much greater impetus for smoking cessation than previously, and it was important to keep up the momentum in order to capture as much benefit from the Khan Review interventions as possible.

Derys Pragnell, Consultant in Public Health, presented the data as known at the time, which owing to Covid, was a little further out of date than would be expected. Smoking rates overall were declining, but with very significant spikes amongst a number of demographics, including those with serious mental health problems, routine manual workers and social housing tenants. Country of birth had a significant impact, with those born in Eastern Europe also displaying high rates. Following its habit of reviewing its strategy in light of new guidance, the Tobacco Control Alliance, made up of the County and District Councils, and health partners had recently begun co-producing interventions to help social housing tenants stop their smoking habits. Additional work was being undertaken with Trading Standards to reduce under-age sales of e-cigarettes. Key areas of focus for the coming year were expected to include enhancing the integration of smoking cessation services with the maternity pathway and early years, a review of provision for young people, developing smoke-free areas, improved enforcement and a Stoptober campaign about mental health and wellbeing.

The Committee explored ability of stigma to reduce smoking, but also its impact in preventing people from coming forward for treatment for smoking-related diseases. Ansaf Azhar confirmed that the focus on the Strategy was not to build additional stigma but to enable smokers to give up. Katharine Everleigh, Health Improvement Practitioner noted that the Council and system partners followed nationally-recognised good practice in the form of evidence-based questioning which was designed not to cause stigma.

E-cigarettes were a complex issue for the Committee, specifically the tension between their usefulness as a tool for smoking cessation amongst tobacco smokers, and the 'gateway' effect of younger people taking up vaping without having previously smoked. Ansaf Azhar recognised the importance of e cigarettes in helping existing smokers quit, and their dangers as a gateway to nicotine consumption. The Committee was informed that a national review had concluded that whilst not absolutely safe, e-cigarettes were 95% safer than tobacco cigarettes. It was important, therefore, that their use as a tool to help tobacco smokers quit was not undermined, but it was also recognised that the work was necessary to prevent young people taking up vaping, particularly with the mistaken view that doing so was risk-free. This was being undertaken in conjunction with schools via anti-addiction training and work by School Health Nurses, as well as existing programmes from the Fire Service and Trading Standards but the need for more work, particularly focusing on the harm of addition rather than direct health harms, was necessary. It was requested and agreed that feedback on this additional work with children and young people would be provided to the HOSC.

The challenge of developing coordinated policy across all schools within a fragmented educational context which allowed academies to set their own policies was explored. Cllr Lygo drew attention to the fact smoking was not allowed by law in any school but that the Council was working with schools to try and develop smoke-free school gates. If HOSC members had particular concerns about specific schools the topic should be raised with the relevant Head Teachers. In the longer-run, however, the Tobacco Control Alliance would review recently-changed advice from NICE on the most effective approaches to working with schools and parents before embarking on specific actions to address these issues.

In view of the cost of living crisis and the growth in demand for illegal tobacco it would engender, the adequacy of the £6000 of fines issued by the Council for selling illegal tobacco was queried. It was recognised by Ansaf Azhar that with enforcement forming one of the four pillars to the strategic approach, more needed to be done and would be looked into on the back of Scrutiny's challenge. Equally however, it was noted that other alliance members, such as the districts, also were involved in issuing fines through their licensing inspections.

The Committee also queried the degree to which the Council was building on the opportunities afforded by the cost of living crisis to develop relationships with stakeholders, such as advice centres and food banks, and through them with members of key disadvantaged communities. Though work was being undertaken with social housing providers, the suggestion of food banks was recognised as valuable and would be looked into as part of an assessment as to which services were being accessed and how every contact could be made to count.

More information was sought in relation to the actual nature of the work being undertaken with social housing providers. Given that it had only recently begun, to date it included training of housing officers around smoking cessation conversations, and a review of the information available to tenants. However, a key element of work which was yet to be undertaken was co-production with tenants. The outcome of this would heavily inform the work undertaken in the future.

The Committee explored whether the community-basis of much of the work to stop smoking would translate to funding from the BOB ICS coming to Council services. It was noted that the Chair of the BOB ICS was Javid Khan, the author of the Khan review, an individual keen to see the entire BOB ICS area become smoke-free. The Inequality Forum of the BOB ICS was prioritising smoking cessation but it was felt that interventions when people were entering into the healthcare service for elective surgeries, mental health or maternity would likely be more effective than community-based services.

The Committee questioned how much, in light of Covid, individuals who were vulnerable owing to smoking-related health conditions were getting the support they needed. This, it was explained, would be a key part of the BOB's ICP strategy, but more immediately increased numbers of health checks were being made available.

Finally, the realism of the modelled reductions in smoking were challenged. It was accepted that the models had been developed prior to Covid, meaning possibly some disruption. However, the models would be kept under review, and as a counter-balance to the negative impacts of Covid, a lot effort was being invested nationally and locally into smoking cessation, efforts which would reasonably be expected to show clear reductions in smoking.

The Committee **AGREED** to:

1) Give its support to the proposed amended actions to the Smoke Free Strategy Action Plan
2) Recommend to the Health and Wellbeing Board that work to consider how the smoke-free agenda could be progressed further in light of the cost of living crisis be undertaken, as well as work with younger people around the addictive potential of e-cigarettes.
3) To emphasise to the Health and Wellbeing Board the importance of meaningful co-production in service and strategy planning, as well as the avoidance of stigmatisation as a tool for smoking cessation.

57/22 HEALTH INEQUALITIES IN RURAL AREAS

(Agenda No. 6)

Cllr Mark Lygo, Cabinet Member for Public Health & Equality, Ansaf Azhar, Director of Public Health, and David Munday, Consultant in Public Health provided a brief presentation and report as a precursor to the November report relating to the same topic.

David Munday, Consultant in Public Health broached the importance of population movements through changing birth and death rates, housing growth and migration in planning suitable health services for future demand. The Oxfordshire Joint Strategic Needs Assessment was the primary tool used by the Council for understanding these changes. Provisional data from the 2021 census indicated that population growth across the County over the last decade had been 11%, but that that growth had not been experienced equally across the County, with Vale of the White Horse experiencing the greatest. The fastest growing age groups within the County were people in their fifties and over 65. More granular, sub-district level data, would be

available in the future release tranches of the 2021 census. The newest JSNA would be published in early October.

The Committee asked for more information regarding the process for the provision of primary care services in areas experiencing new housing growth. Though known to be an ICB responsibility, the exact process was not known and the issue was identified as one requiring fuller unpacking at the November meeting. Councillors agreed, given their own experience of the difficulties caused for residents when the process did not run smoothly. District members on Planning Committees suggested that there was not an equivalence between the concern accorded to the provision of education and that accorded to healthcare, and it was necessary to know who within the NHS could knowledgeably address this imbalance.

The Committee discussed the importance of recognising that rural inequalities stemmed partially from the inherent challenges of rural topography, but also from policy which meant that they were expected to take on more new housing than urban areas. A key issue the former of these challenges was ambulance waiting times, which in rural areas were necessarily higher simply owing to the greater distances needing to be travelled. For those without access to transport, access to primary care services in rural areas was also very challenging. Another area of concern in parts of the County was that of access to maternity services, and it was requested that data be provided on where future demand for such services would be required. In response, it was noted, however, that birth rates in localities were not the only determinant of demand for maternity services. Ethnicity, for example, was an important consideration in terms of access to maternity services, obesity rates during pregnancy and breast feeding rates were all core contributors to the outcomes for baby and mother in maternity services, and would also therefore impact where supply was located as much as simple levels of demand.

Jean Bradlow and Cllr Haywood were put forward to join the Chair and Vice-Chair in scoping the November report more fully.

58/22 HEALTHWATCH UPDATE

(Agenda No. 7)

Rosalind Pearce, Executive Director, Healthwatch Oxfordshire and Emily Lewis-Edwards, Chief Executive of Community First Oxfordshire presented the Healthwatch update, which focused on a report developed by Community First Oxfordshire on behalf of Healthwatch Oxfordshire on rural isolation.

Emily Lewis-Edwards highlighted Community First Oxfordshire's historical links with rural issues as a driver for the report, but also noted the more immediate driver of Covid and the exclusionary effect for some of the move towards digital provision. In total, 528 people took part in surveys, focus groups or interviews. Overall, the feedback was that people knew their neighbours, had and used the internet, and owned their own private vehicle. However, in all three categories small numbers of exceptions existed, for whom their lack of neighbour support, internet or transport was highly problematic. Indeed, even amongst those owning private vehicles, lack of public transport was a contributor to isolation. Time, confidence or lack of physical

capacity tended to be the reasons why individuals reported not getting involved in community activities, which were identified as crucial in challenging isolation. The key conclusions drawn were that any solutions to rural isolation should be multifaceted. Nevertheless, given the weight given to issues of transport, community activities and access to information full consideration should be given to how these needs could be met within a specific community.

In response to the presentation, the Committee explored a number of issues. These included the degree to which the issues raised were specifically rural issues or actually universal ones. In response it was recognised that physical distance was more of an issue for rural areas, but that many of the problems of access were the same in disadvantaged communities in rural or urban areas. Another issue explored concerned the means of collecting the underlying data, whether it itself by being primarily online was exclusionary. The limitations were recognised, but so was the fact that some aspects were online at the request of participants, and that feedback from those who were spoken to in person correlated with the responses received by those submitting their views online. The Committee welcomed the way in which the report shone a light on the needs of individuals in a more granular way than the Joint Strategic Needs Assessment could, giving voice to those minorities in villages where the majority were generally managing.

Cllr Lygo, Cabinet Member for Health and Equalities, expressed the wish to see the work extended to more 'on the ground' consultation in relevant areas. Linking in with stakeholders relating to specific areas of focus, such as transport, would likely prove fruitful.

Rosalind Pearce also provided a verbal update relating to Healthwatch's activity. Healthwatch had held a round-table on access to dentistry. Access to dentist for routine appointments was reported to be very challenging for those not already registered with a dentist. Out of hours demand for those without a dentist often provided a stop-gap but not permanent solutions. At the round-table commissioners, dentists and public health officials agreed that local commissioning could, over time, rise to meet demands. Dentists were facing difficulties with recruiting staff, as well as the level of payments for dental services. In the short term these difficulties were likely to persist. A similar round table was due to be held around pharmacy provision.

59/22 SOUTH CENTRAL AMBULANCE SERVICE

(Agenda No. 8)

Will Hancock, Chief Executive Officer of South Central Ambulance Service, and Martin Chester, Clinical Operations Manager, South Oxfordshire, made a presentation to the Committee on the service provided by South Central Ambulance Service (SCAS), performance and the Care Quality Commission (CQC) improvement programme. They were supported by Tom Stevenson, Comms and Engagement Lead for the SCAS Improvement Programme, Mike Murphy, Director of Strategy and Governance at SCAS, and Kirsten Wells-Drewitt, Head of Operations in Oxfordshire at SCAS.

Will Hancock, SCAS Chief Executive introduced the report. The August report from the CQC, giving SCAS an 'inadequate' rating, was a significant departure from the

organisation's pre-pandemic trajectory, where it had been moving towards an 'outstanding' rating. The Board was disappointed to see the change in direction, but were committed to addressing the issues raised as a matter of urgency. The key issue of concern focused on emergency and urgent care, and an improvement plan had been developed to address the areas of concern highlighted by the CQC. A comprehensive governance structure was in place to hold the organisation to account, as well as ensure planned activities complemented other areas of the health care system. Broadly, the improvement plan focused on four key areas: culture and wellbeing, governance, patient safety and experience, and performance recovery. A number of priority actions had already been undertaken as part of the improvement programme, including increasing capacity in safeguarding teams, ambulance crews and amongst call-centre staff, enhanced equipment checks and provision, staff-support measures and a governance review. The CQC report did note some areas of outstanding work, highlighting the pride and hard work of staff, the kindness shown by staff, and the level of innovation shown. The organisation's improvement plan needed to be delivered in the face of significant national pressures around recruitment and retention, as well as increasing demand for services. In terms of performance, SCAS was performing below the national for category 1 calls (the most severe) but was exceeding it in categories 2-4.

In response to the presentation the Committee raised multiple questions. More information was sought regarding the mechanics of how meaningful culture change would be effected. Whilst national surveys indicated that ambulance services were prone to poor cultural practices, the CQC report acted as a conversation starter with staff. Embedding appropriate values within the organisation was a strong component of the organisation's leadership development programme. Taking measures to support the increasing the diversity within the workforce were being taken at staff-level and at Board level. Kirsten Wells-Drewitt, as a Chair of one of the People of Culture boards, confirmed their value in giving voice to staff to feedback on policies and practices, and making the workings of the organisation more transparent.

The Committee questioned whether sufficient financial resource was available to cover the work outlined in the improvement programme. It was confirmed that for the current financial year it was, and additional funding from NHS England meant that future funding was not currently a concern.

The importance of challenge from the Board to senior management and holding them to account was recognised by the Committee and assurance was sought on how this might be improved. An externally-led review was being undertaken by NHS England experts, which would report to the Board. This would especially focus on risk classification and escalation. Actions would need to be determined from the feedback arising from the review. SCAS was also working with exemplars of governance best practice to learn ways to improve.

The Committee sought to know whether the CQC result was a surprise to the Board. It had been recognised that the organisation had been running very thin over Covid, with resources being diverted away from training, coordination and performance management towards simply maintaining front-line services for an extended period. As a consequence, a higher level of risk that performance would eventually drop did exist. The Board were aware of this risk.

It was recognised by the Committee that hearing from staff how the report had been received was incredibly important, and the degree to which structures existed to enable this feedback was raised. The Board had begun to take the opportunity with the reduction in Covid of visiting ambulance stations to hear directly from staff. Overall, however, the feedback was one of a shared frustration across the organisation at the results of the report.

Reported problems for younger and more junior female colleagues were noted by the Committee and the actions taken to address them were challenged. Simply, the reports were accepted to be unacceptable. Awareness and education campaigns were being put into place to challenge bad-but-normalised behaviours towards women across the organisation. Further investment in developing manager understanding of the non-acceptability of behaviour which abused positions of trust and responsibility was also being implemented. Measures to protect particularly vulnerable staff, students in particular, were also underway. It was also reported that long-serving female staff had noted that although there were issues, the trajectory towards the treatment of women was improving, particularly as the numbers grew and more were represented as senior leadership levels. It was recognised that there were areas in the service, however, where female representation at manager and senior manager level was not increasing at the same rate, particularly around Operations, and this had been identified as requiring further work.

Given the impact of the operation of the wider healthcare system on the ambulance service's performance, the working relationship with partners was discussed. The Integrated Improvement Programme would not necessarily be a silver bullet for the ambulance service, but the real-time date provided was expected to make marginal improvements across multiple areas. Overall, relationships and cross-working in Oxfordshire was reported to be extremely well-functioning and were being copied by other localities.

The Committee wished to know more about how non-mandatory recommendations from the CQC report were being prioritised. Many of the non-mandatory recommendations were already in hand given that they matched the organisation's own priorities, but the process was being managed overall using its performance improvement methodologies.

To ensure sufficient staff were working to deliver the service's objectives the Committee asked about support for staff, particularly in relation to stress and mental health. In response, it was noted that ambulance staff face multiple elevated risks to their wellbeing, be it through lifting, infection, shift-pattern induced fatigue or driving-related risks. Relating specifically to mental health, however, the issue was one taken particularly seriously at SCAS, as reflected by Will Hancock's involvement in national-level activity to improve mental health within the ambulance sector. The starting point was trying to reduce stigma and normalise conversations about mental health. The organisation was participating in a number of national campaigns which were promoting multiple conversations. The close relationship with Oxford Health also meant easy access to high quality advice and support for staff.

Finally, clarification was sought on how long the CQC rating would remain without being re-evaluated, given that the Committee was keen to see the trust re-upgraded. Backlogs at the CQC meant the expectation was that a re-inspection was likely to take a frustratingly long time, though no specific timeframe was put forward.

The Committee AGREED that SCAS return to the Committee and give an update on progress in February 2023.

60/22 RESPONSES TO PREVIOUS HOSC RECOMMENDATIONS

(Agenda No. 9)

Cllr Tim Bearder, Cabinet Member for Adult Social Care, joined the meeting to discuss the Cabinet's response to the HOSC recommendation made by the Committee at its 09 June 2022 meeting concerning the First 30 Days of the pandemic. The Council's intention to participate in the relevant elements national review was confirmed. The Health Scrutiny Officer had been in contact with the national review to identify those elements and the deadlines for involvement, and it was **AGREED** that this would be shared with the Cabinet member and senior officers in the form of a briefing note to outline how the Council could proactively be involved.

The response to the Committee's recommendation made in relation to the Integrated Improvement Programme was **NOTED**.

61/22 ACTIONS AND RECOMMENDATIONS TRACKER

(Agenda No. 10)

Eddie Scott, Health Scrutiny Officer, updated the Committee on actions from the Committee, drawing attention to the forthcoming Primary Care workshop, and the first meeting of the Integrated Improvement Programme sub group. Progress against the Committee's actions and recommendations was **NOTED**.

The Committee was informed that the Health Scrutiny Officer had spoken with the commissioner responsible for a potential variation to the sexual assault referral centre in Bicester. It was confirmed that the plan was simply to make a change in location, with no change in services. The location change was owing to move to a building with a necessary kite mark for safety. The Committee **AGREED** that a subset of Members would undertake a review to determine whether it was a substantial variation and make a recommendation to the Committee if further work was required.

62/22 CHAIR'S UPDATE

(Agenda No. 11)

Cllr Hanna, Chair of the HOSC, introduced her Chair's update to the Committee.

Cllr Barrow was invited to feed back on the visit undertaken to the Henry Cornish Care Home in Chipping Norton. He, Cllr Poskitt and Barbara Shaw had visited and seen first hand the understanding of infection control and infrastructure in place to support it. However, members were keen to visit a less well-equipped care home to see what experience for patients might be like at care homes which had suffered high mortality in the first wave of the pandemic, and which had suffered repeatedly high

mortality rates across all waves of the pandemic. It was **AGREED** by the Committee that the findings should be submitted as a paper back to the Committee when complete, and submitted as evidence within the Covid-19 national enquiry.

Cllr Hanna informed the Committee that the Covid-19 sub-group was designed to monitor the recovery of elective surgery temporarily closed during the pandemic to inform the focus of the ongoing work programme. Learning would be brought back to the committee.

Eddie Scott, Health Scrutiny Officer, provided an update on the activity of the MSK sub-group, which had met with Connect Health (the new MSK service provider) to discuss their vision, approach and plan for service user engagement and plans for meeting the KPIs set by the ICB. Members who attended were assured of the capacity of the service to provide a service which would meet the needs of users across multiple locations, but that there was room for improvement regarding communication with members around the self-referral pathway and some issues about the fitness for purpose of the website. One outcome was that a place was offered on the service's Service User Engagement sub-group to the HOSC. It was **AGREED** that Barbara Shaw would be the HOSC's representative.

Relating to the Integrated Improvement Programme sub-group, two recommendations were made to the Committee: 1) That members of the sub-group should seek to meet with the Chair of the BOB ICB to seek assurance of the ICB's commitment to the Integrated Improvement Programme, and 2) That the Chair and vice-Chair meet with Sam Foster, from OUH, to discuss plans to reopen currently closed maternity units in Oxfordshire. These recommendations were **AGREED**.

63/22 WORK PROGRAMME

(Agenda No. 12)

Eddie Scott, Health Scrutiny Officer, provided an update to the proposed work programme. The Committee was expected to have a further, more detailed item on Rural Inequalities in November. The February meeting would have an item concerning the MSK service, as well as an update from SCAS regarding the status of their improvement programme.

It was **AGREED** by the Committee that rather than the Committee taking them as items on the work programme, that the Chair would write to the Cabinet member to highlight concerns around the impact of LTNs with regards to access to health services, and maternity services at the Horton and that a written update be provided.

The proposed work programme was **AGREED**.

..... in the Chair

Date of signing 200

(a) FIELD
(b) FIELD_TITLE