OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 5 June 2025 commencing at 10.01 am and finishing at 3.57 pm.

Present:

Chair:	Councillor Jane Hanna OBE
Deputy Chair:	District Councillor Dorothy Walker
Councillors:	Ron Batstone Imade Edosomwan Judith Edwards Gareth Epps Emma Garnett Paul-Austin Sargent
District Councillors:	Paul Barrow Katharine Keats-Rohan Elizabeth Poskitt Louise Upton
Co-Optees:	Sylvia Buckingham
Other Members in Attendance:	Cllr Kate Gregory, Cabinet Member for Public Health & Inequalities
Officers:	Stephen Chander, Executive Director for People Ansaf Azhar, Director of Public Health and Communities Karen Fuller, Director of Adult Social Care Kate Holburn, Deputy Director of Public Health Dr Rob Bale, Interim Chief Operating Officer for Mental Health and Learning Disability Veronica Barry, Executive Director of Healthwatch Oxfordshire Sue Butt, Oxford Health NHSFT Transformation Director Anne Carlile, BOB ICB Head of Urgent Emergency Care Programme Angie Fletcher, Deputy Chief Nurse, and Emma Leaver, Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care Jenna Gilkes, BOB ICB Urgent Emergency Care Programme Manager Louise Johnson, OUH Deputy Director Urgent Emergency Care Britta Klinck, Chief Nurse Emma Leaver, Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care Dan Leveson, BOB ICB Director of Place and Communities

Lily O'Connor, Oxfordshire Urgent Emergency Care Director
Sally Steele, Head of Hospitals
Felicity Taylor-Drewe, OUH Chief Operating Officer
Kirsten Willis-Drewett, South Central Ambulance Service Assistant Director of Operations
Omid Nouri, Health Scrutiny Officer

The Council considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and decided as set out below. Except insofar as otherwise specified, the reasons for the decisions are contained in the agenda and reports, copies of which are attached to the signed Minutes.

28/25 ELECTION OF CHAIR FOR THE 2025/26 COUNCIL YEAR
(Agenda No. 1)

Cllr Hanna, was nominated by Cllr Batstone and seconded by Cllr Edosomwan.

There being no other nominations, Cllr Hanna was elected Chair for the 2025/26 municipal year.

29/25 ELECTION OF DEPUTY-CHAIR FOR THE 2025/26 COUNCIL YEAR
(Agenda No. 2)

D/Cllr Walker, was nominated by Cllr Epps and seconded by D/Cllr Keats-Rohan.

There being no other nominations, D/Cllr Walker was elected Deputy Chair for the 2025/26 municipal year.

30/25 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Apologies were received from Barbara Shaw.

31/25 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

Sylvia Buckingham declared that she was also a Patient Safety Partner with Oxford University Hospitals NHS Foundation Trust (OUH), and a Trustee for Healthwatch Oxfordshire.

Cllr Sargent declared a personal interest as that their partner works for Adult Social Care for Oxfordshire County Council.

Cllr Garnett declared that they were employed by the Department of Primary Healthcare at the University of Oxford.

Cllr Hanna declared an interest as an employee of SUDEP Action.

32/25 MINUTES

(Agenda No. 5)

The Chair requested an amendment to the minutes of the 6th March 2025 meeting. The Committee **AGREED** to update the wording around epilepsy services to reflect positive changes, including the new Medicines and Healthcare products Regulatory Agency (MHRA) policy and the distribution of patient safety leaflets in 30 languages. However, it also noted the lack of progress on medication access for girls and women. Additionally, the Committee was still awaiting information on whether the capacity risks to the epilepsy service had been addressed.

The Committee **APRROVED** the minutes of the meeting held on 6th March 2025, subject to the above amendment.

33/25 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 6)

Joan Stuart, from Oxfordshire Keep Our NHS Public, raised concerns about private eye clinics performing most cataract surgeries, which she felt risked NHS eye care departments. She cited a Sunday Times investigation revealing potential fraud, unnecessary operations, poor post-surgery care, and Accident & Emergency (A&E) visits for complications. Research indicated that private clinics funded by the NHS made significant profits, with much of the budget not spent on patient care, destabilising NHS hospitals. Joan questioned the effectiveness of the ICB's referral process and called for a full investigation into Oxfordshire's eye care services, urging the Committee to address the issue.

David Rogers discussed the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) operating model and primary care. He emphasised funding and expanding primary care through developer contributions, especially in Cherwell, which was predicted to grow significantly. He mentioned that around £21 million could aid primary care expansion, including infrastructure and digital services. Rogers requested the Committee support the ICB by ensuring prompt consultation on local plans to secure these contributions. He stressed the importance of a plan for primary care expansion, incorporating digital systems, and the need to inform practices about available funding. He also recommended monitoring progress to ensure primary care services developed to meet the population's needs.

Jenny Hannaby, Chair of the Wantage Town Council Health Committee, expressed her appreciation for the Committee's oversight of the Wantage Community Hospital redevelopment project. She described the history of the hospital's temporary closure and the unsuccessful engagement between the Clinical Commissioning Group (CCG) and the town, leading to a coproduction effort with various stakeholders. Jenny outlined the plans for refurbishing the hospital in 2024, including digital upgrades and a £1 million investment. She emphasised the hospital's importance in addressing rural health disparities and reducing travel to Oxford City. Jenny sought the Committee's support in communicating the project's significance to OUH’s new leadership.

34/25 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 7)

The Committee **NOTED** the responses to its recommendations on:

1. Oxfordshire Healthy Weight.
2. Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board Operating Model.
3. Health and Wellbeing Strategy Outcomes Framework.
4. Support for Patients Leaving Hospital.
5. Oxford Health NHS Foundation Trust People Plan.
6. Director of Public Health Annual Report.

35/25 NHS REFORMS UPDATE

(Agenda No. 11)

Dan Leveson, BOB ICB Director of Place and Communities, introduced an update on the NHS Reforms. The BOB ICB Director of Place and Communities sent the apologies of Matthew Tait, BOB ICB Chief Delivery Officer.

Stephen Chander, Executive Director for People, attended to take the Committee's questions on the NHS Reforms update, with Cllr Kate Gregory, Cabinet Member for Public Health & Inequalities, also attending online. Veronica Barry, Executive Director of Healthwatch Oxfordshire, also attended as a guest of the Committee.

The BOB ICB Director of Place and Communities announced that the government required Integrated Care Boards (ICBs) to cut costs by 50%, targeting £18 per head. He highlighted areas like strategic commissioning and population health management, reducing performance activities. Southeast's ICBs reduced from six to four, with BOB ICB possibly merging with East Berkshire. Rapid changes were planned, with stakeholder engagement in June and July, a new model agreed by September, staff consultation in October, and formalisation by April 2026 or 2027. A transition executive oversaw the reorganisation.

The Executive Director for People acknowledged there were significant proposed changes without clear details on their impact. He highlighted Oxfordshire's strong integrated work and viewed reforms as an opportunity for a local solution. The Place Based Partnership met in July to discuss Oxfordshire's offer to the ICB, aiming to mitigate risks and identify opportunities. He emphasised understanding the impact on services and the Committee's scrutiny role.

The Chair mentioned that as the Chair of the BOB HOSC, they have requested that the BOB HOSC be convened, with all the Committees across the three-county area in place, and further actions were to be considered.

Members asked if the ICB was required to make a 50% cut in addition to the cuts made last year or if it is a 50% reduction on top of the most recent changes to the operating model. The BOB ICB Director of Place and Communities clarified that the 50% reduction was on top of the previous 30% cuts made last year. The target is to

reduce the total cost to about £19 per head of population. This involves further reductions in staff and an expansion of geographical boundaries.

Members enquired whether further restructuring would reduce Place staff and if there was a commitment to a place-based convener role. The BOB ICB Director of Place and Communities noted that workforce reductions were anticipated but the exact impact on Place staff was undetermined. He affirmed the importance of Place in the new operating model and committed to collaborating with Place-based partnerships. The concept of a Place-based convener role was still being considered.

The Committee asked about the implications of changes to the provider oversight role on monitoring and evaluation. The BOB ICB Director clarified that the new model aimed to minimise duplication and emphasise collaboration. The oversight and assurance role would evolve to focus on understanding performance, evaluating needs, and reducing unwarranted variation. The central team would handle regulation and performance management, allowing local teams to concentrate on needs assessment and evaluating effective practices.

Concerns were expressed regarding the impact of budget cuts on disease prevention, the distribution of burden, and the existence of a document detailing 'must-dos' for local systems. The Director acknowledged the challenge of balancing prevention efforts with high service demand and financial constraints. He reiterated the ongoing commitment to prevention and reducing health inequalities despite these challenges and mentioned an extensive list of statutory responsibilities guiding their actions.

Concerns were raised about the NHS app's functionality and consistency across surgeries. The BOB ICB Director of Place and Communities acknowledged these challenges, explaining that multiple systems and information governance requirements complicated improvements in digital technology use. There was a commitment to enhancing interoperability and consistency, with further discussions on oversight needed.

Members asked about accommodating Oxfordshire's growth and primary access support. The Director stated that the ICB worked with local planning departments to address primary care needs using Section 106 and CIL funds. Despite complexities in developing primary care estates, they focused on modernising general practice and expanding roles through the Additional Role Reimbursement Scheme. Neighbourhood health and care services were developed to support primary care amid demand and capacity challenges.

The Executive Director of Healthwatch Oxfordshire queried the ICB's plans to communicate and engage the public regarding remote versus local services amidst access challenges. The BOB ICB Director of Place and Communities acknowledged the need to involve communities despite potential communication resource reductions. He emphasised their statutory obligation to engage the public and committed to delivering the best services by organising care around different populations' needs.

The Chair inquired about the Didcot project's planning, funding status, and any immediate barriers. The BOB ICB Director of Place and Communities confirmed the Didcot project's priority, working through the final stages of the business case focusing on value for money and economic viability. He assured continued focus on priority projects like Didcot despite reorganisation.

The Committee enquired about the transparency of the new ICB operating model and whether early input from both the Committee and the public was possible. The BOB ICB Director of Place and Communities confirmed plans to engage stakeholders, including local authorities, starting from June, assuring maximum transparency due to sensitive impacts on staff and employment.

The Committee then raised concerns regarding the 50% budget cuts on the ICB amid the challenging healthcare environment and sought understanding of management plans for such reductions. The Director acknowledged the substantial challenge of the cuts and the prevailing sense of "not again" among staff given recent reorganisations. He stressed the importance of collaboration, avoiding isolated efforts, and focusing on opportunities for integration and collective action to improve population health despite difficulties.

The Committee **AGREED** to write a letter to the Chief Executive of the BOB ICB to ask if there was any support that could be provided from the Committee around the recent NHS reforms and the ongoing changes to the ICB's operating model.

36/25 SYSTEM PRESSURES UPDATE

(Agenda No. 12)

Karen Fuller, Director of Adult Social Care, introduced the system pressures update, along with Lily O'Connor, Oxfordshire Urgent Emergency Care Director.

They were joined by:

- Cllr Kate Gregory, Cabinet Member for Public Health & Inequalities;
- Ansaf Azhar, Director of Public Health and Communities;
- Veronica Barry, Executive Director of Healthwatch Oxfordshire;
- Dan Leveson, BOB ICB Director of Places and Communities;
- Anne Carlile, BOB ICB Head of Urgent Emergency Care Programme;
- Jenna Gilkes, BOB ICB Urgent Emergency Care Programme Manager;
- Sally Steele, Head of Hospitals;
- Felicity Taylor-Drewe, OUH Chief Operating Officer;
- Louise Johnson, OUH Deputy Director Urgent Emergency Care;
- Emma Leaver, Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care;
- Sue Butt, Oxford Health NHSFT Transformation Director;
- Kirsten Willis-Drewett, South Central Ambulance Service (SCAS) Assistant Director of Operations.

The Director of Adult Social Care emphasised the early discussion of system pressures and noted strong organisational collaboration. She cited many representatives as evidence of effective urgent and emergency care efforts. The

Oxfordshire Urgent Emergency Care Director stated that despite challenges, Oxfordshire performed well compared to neighbouring counties during the previous winter. She identified gaps in care pathways and highlighted initiatives to reduce duplication, improve continuity, and enhance access to same-day emergency services. Successes in Banbury and Oxford City were noted, particularly in managing patients at home to improve outcomes.

The Committee inquired about improving outcomes, redesignating minor injuries units, public engagement strategies, and primary patient outcomes. The Oxfordshire Urgent Emergency Care Director clarified that the redesignation was mainly for reporting and might not occur, with services remaining unchanged. Simplifying information for the public was emphasised to guide them based on their symptoms. Key patient outcomes included better quality of life, reduced morbidity and mortality, and continuity of care, especially in deprived areas. The Director of Adult Social Care added that understanding urgent care options was crucial for timely and appropriate patient care.

The Executive Director of Healthwatch Oxfordshire requested details on recent developments and service functions, referring to the Healthwatch report. The Urgent Emergency Care Director explained that a detailed list of services, opening times, and functions had been compiled, with plans to provide comprehensive information to the public via the Oxfordshire Live Well website and Google searches.

Members discussed the 111 service, noting delays and initial contact with non-clinical staff. The Urgent Emergency Care Director and SCAS Assistant Director of Operations described the 111 service as integrated and effective, directing patients through care pathways using a directory of services. Non-clinical staff triaged calls, escalating them to clinicians, if necessary, with the ambulance service responding if a clinical response was needed within 30 minutes.

The SCAS Assistant Director of Operations explained that ambulance delays were managed through a triage system categorising calls from life-threatening to less urgent. Patients with worsening conditions were re-triaged to higher priorities. The Oxfordshire Urgent Emergency Care Director noted that delays were caused by inappropriate calls, multiple ambulances arriving simultaneously, and ensuring safe handover. Efforts were made to free up ambulances quickly for critical cases.

Members inquired about Oxfordshire's ambulance service performance compared to other UK regions. The SCAS Assistant Director of Operations reported South Central Ambulance Service ranked second or third nationally, with improvements in handover delays at Oxford University Hospitals showing strong performance.

The Interim Chief Operating Officer for Community Health Services stated urgent community response teams consisted of specialist practitioners providing immediate care. To manage increasing workloads, they aimed to reduce service duplication and improve capacity within specific areas, ensuring appropriate clinical response and managing expectations.

The Committee asked which services were most impacted by workforce and funding limits. The Oxfordshire Urgent Emergency Care Director explained that the issue was

not just staff numbers but also skills, which take years to develop. Despite more funding, workforce availability remained challenging. Efforts are ongoing to reduce inefficiencies and ensure appropriate treatment settings to avoid unnecessary hospital admissions, aiming to align resources with demand and improve services. When asked if teams were available countywide, the Director confirmed they were, ensuring consistency and avoiding postcode disparities while addressing health inequalities in deprived areas.

Ansaf Azhar, Director of Public Health, arrived at this stage.

The Committee inquired about fiscal constraints affecting neighbourhood teams' deployment across the county and their impact on reducing hospital costs. The Oxfordshire Urgent Emergency Care Director explained that these teams bridged the gap between hospital discharge and primary care for high-risk patients, focusing on Banbury and Oxford City due to limited funding. Weekly multidisciplinary team reviews aimed to manage high-risk patients elsewhere. The BOB ICB Director emphasised that developing neighbourhood teams was part of a 10-year plan to identify populations benefiting from a multidisciplinary approach to improve access to services and support independent living at home, ultimately reducing hospital costs.

Members asked about addressing the mental health crisis and pathways for children and youth. The Oxfordshire Urgent Emergency Care Director noted Oxford Health's 24/7 crisis response, which reduced waiting times using successful models like Fleetwood's integrated neighbourhood teams for early intervention, starting in Blackbird Leys and expanding to Abingdon. Collaboration with schools and voluntary groups aimed to offer comprehensive support. Emma Leaver stressed managing patient and family expectations and ensuring proper clinical responses to lessen CAMHS's burden through early community interventions.

The Committee asked if redirecting patients from emergency departments to appropriate settings required more resources or better pathways. The Oxfordshire Urgent Emergency Care Director noted that South Central Ambulance Service (SCAS) effectively assessed patients at home while they waited for an ambulance, reducing hospital visits and admissions. Due to resource constraints, this service was available only at certain times, with plans to expand it. Collaboration between SCAS and other partners was key to their success, and SCAS performed well nationally in patient diversion efforts.

Concerns have been raised regarding Thames Valley Police frequently encountering individuals experiencing mental health crises, with crisis teams advising the public to contact the police. The Director of Adult Social Care acknowledged this issue but clarified that such advice was not standard practice. County Council and Oxford Health staff operated around the clock to manage acute mental health crises, coordinating Mental Health Act assessments as necessary. Kirsten noted a shift in policing practices, categorising mental health issues under healthcare, with the ambulance service responsible for acute situations and the police providing support only when there was a risk of harm to first responders.

Members inquired about the persistent rise in emergency department admissions despite initiatives aimed at reducing them. The Oxfordshire Urgent Emergency Care

Director explained that some individuals relied on emergency departments as their primary healthcare due to difficulties accessing other services. Frequent emergency department attendees often overlap with regular GP practice visitors. Education and appropriate service responses are essential to addressing this issue. Projects targeting high-intensity users and individuals prone to falls are ongoing, yet visits following falls continue to increase. This situation underscores the need for improved public education and consistent service availability.

The Committee discussed the emergency department waiting times, asking about solutions involving staff or better assessment, and patient transfers. The OUH Deputy Director of Urgent Emergency Care explained that increased patient numbers required efficiency improvements, not more staff, due to skill and funding limits. Efforts included streamlining pathways, directing patients to appropriate care outside the ED, early senior doctor assessments, and quick specialist transfers to avoid delays.

The Committee sought information on smooth hospital discharge processes and clinical measures discussed with patients. The OUH Deputy Director of Urgent Emergency Care explained that daily discussions about discharge dates occurred with patients and were updated based on their progress. Before discharge, an assessment confirmed the patient no longer required hospital care and their early warning scores were within normal ranges for safe home management, possibly with additional services like acute hospital at home.

Members asked if there were plans to expand visiting services, virtual wards, and engagement outside traditional healthcare settings. The Oxfordshire Urgent Emergency Care Director stated they were reviewing visiting services in one area of Oxfordshire to identify duplication and unmet health needs. This involved collaboration with residents to understand their perspectives and requirements.

Members inquired about coproduction involvement in urgent and emergency care. The Oxfordshire Urgent Emergency Care Director clarified that coproduction had been extensively integrated, especially in developing integrated neighbourhood teams. This collaboration included working with local councils and community groups to address specific needs of different areas. Projects in Barton and Banbury highlighted significant input from local residents, shaping services to meet each area's unique requirements.

Further inquiries were made regarding optimising digital technology and data to alleviate pressures on urgent and emergency care services. The Director explained that they had invested in personnel for data optimisation. Comprehensive data collected by GP practices, encompassing emergency admissions, reasons for admissions, age demographics, and more, were updated monthly. Collaboration with the Public Health Director's team aimed to focus on areas of deprivation and identify unmet health needs, developing a model to interpret primary care data more effectively.

The Committee **AGREED** to issue the following recommendations subject to minor amendments to the wording offline:

1. To increase engagement with the public to provide reassurances as to any specific outcome measures around Urgent and Emergency Care Services, including successful/unsuccessful outcomes and whole system working more broadly. It is recommended that there is communication to help people receive the urgent care they need.

2. To ensure that there is sufficient planning, support, and resourcing for supporting patients experiencing a mental health crisis. It is recommended that the whole system focuses on the reduction of inappropriate and costly mental health inpatient settings, with a view to improving alternative community-based settings and local crisis responses.

3. To ensure that you continue to engage in coproduction as part of the development of Urgent Emergency Care Services, including around the Integrated Improvement Programme.

4. To ensure that determinations of medically fit-to-discharge include consideration with the patient and their carer of specific national frameworks such as the meaning of the patient's National Early Warning Score (NEWS).

5. For there to be sufficient investment in the Neighbourhood model and Multi-Disciplinary Teams, and for evidence to be provided as to whether there is sufficient or insufficient investment. It is recommended that there is a whole system mapping exercise that includes Town and parish councils with local knowledge of community projects and stakeholders (who can also contribute at a neighbourhood level to support reduction of risks and a whole population approach).

37/25 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 13)

Veronica Barry, Executive Director of Healthwatch Oxfordshire, provided a brief summary of the Healthwatch Oxfordshire update report.

The Executive Director of Healthwatch Oxfordshire reviewed key initiatives. GP access had been a major concern due to appointment scheduling and digital access issues. An upcoming Urgent Care Report, based on feedback from nearly 200 individuals, would address urgent care navigation. A video highlighted the importance of patient involvement in prevention and primary care models. A discussion event examined the Marmot Review with around 100 community representatives expected. A menopause webinar featured an Oxford community champion. Collaboration continued with Lilly O'Connor on developing integrated neighbourhood teams. Supporting the voluntary and community sector during these changes was emphasised.

The Chair enquired about rural deprivation inclusion at Monday's event. The Executive Director clarified that the focus had been on priority urban areas since the Marmot introduction in December. Rural deprivation was being addressed through a separate initiative. The Director of Public Health mentioned ongoing work to develop a dashboard to tackle rural inequalities.

The Committee paused for lunch at 12:50, and commenced at 13:28

38/25 ANNUAL REPORT OF THE OXFORDSHIRE JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE

(Agenda No. 8)

The Committee **AGREED** to the wording of the draft Annual Report, subject to any minor amendments that may be required to be completed by the Health Scrutiny Officer in consultation with the Chair.

39/25 OXFORDSHIRE AS A MARMOT PLACE

(Agenda No. 14)

Ansaf Azhar, Director of Public Health, and Kate Holburn, Deputy Director of Public Health, introduced the Marmot Place report and were prepared to answer questions the Committee had about the process of Marmotisation and its potential impact on Oxfordshire.

The Director of Public Health highlighted health disparities in Oxfordshire, despite its affluence, and recommended the Marmot Place initiative's system-wide approach. This initiative provided a framework for improvement, inspired by Coventry's positive results. The Deputy Director discussed using data and community engagement to address local inequalities, focusing on children's welfare, fair employment, and healthy living standards. She described the governance structure, work streams, and projects like children's services pathways, housing health assessments, and rural inequality mapping, while mentioning collaborations with universities and community engagement plans.

The Committee asked why three out of eight Marmot principles had been selected. The Deputy Director of Public Health explained these principles aligned with ongoing local work and provided a defined focus. This strategy allowed for measurable results and adhered to the Health and Wellbeing Strategy. Although the Institute of Health Equity recommended focusing on two principles, Oxfordshire selected three due to existing initiatives. These principles interconnected with others for a comprehensive approach.

Members queried if the Marmot Place initiative would involve local councils, parishes, and villages. The Director of Public Health confirmed it would, leveraging their knowledge and projects. The engagement process incorporated Committee input, ensuring thorough involvement. The Marmot team offered independent expertise to enhance initiatives and identify areas for improvement.

Members enquired if resources would assist rural groups in gathering data for the Marmot Place initiative. The Deputy Director of Public Health confirmed support for these groups, involving voluntary organisations to collect evidence through surveys, discussions, and focus groups. The Director of Public Health emphasised the need for both quantitative and qualitative data, including community insights, to address rural inequalities.

Members inquired about how rural inequalities were quantified. The Deputy Director of Public Health explained that census measures focused on household-level deprivation across employment, education, health and disability, and household overcrowding. The Director mentioned that qualitative aspects like social isolation and community insights were vital. The initiative included community engagement and lived experiences.

The Committee asked about the prevention of increasing inequalities and the measurement of intervention success. The Director noted that a hierarchy of evidence was used, including community feedback and randomised control trials, but ethical issues prevented control groups without intervention. Instead, a mix of qualitative and quantitative evaluations, including Policy Lab research, assessed intervention effectiveness.

Members enquired about collaboration and coproduction efforts, particularly with Oxford universities, and inclusive examples of patient and public involvement. The Director of Public Health and the Deputy Director of Public Health clarified that coproduction in the Marmot initiative involved community health development officers, focus groups, and partnerships with organisations such as Healthwatch. The engagement process was iterative and adapted to different communities. Regarding Oxford University Collaboration, the Policy Lab—a collaboration with Oxford University and Oxford Brookes University—was a significant component of the initiative, involving students in real-time research projects addressing local policy issues, including health inequalities.

Members inquired about the governance and accountability of the Marmot initiative, particularly regarding the public availability of minutes from the Marmot Advisory Board and steering group meetings, and local governance involvement. The initiative was accountable to the Health and Wellbeing Board, ensuring transparency through structures like the Marmot Advisory Board, led by Michael Marmot, and a steering group with representatives from various organisations. Local projects reported to existing governance frameworks, integrating within systems like Children and Young Person's governance.

The integrated care strategy aligned health strategies within the ICB footprint, focusing on managing long-term conditions and addressing health determinants. Discussions included integrating broader health policies with the NHS 10-year plan and potential combined or mayoral authorities, emphasising regional collaboration with public health directors.

To evaluate success, the initiative aligned with existing health strategy indicators, monitored over time for progress. Specific indicators for Marmot-aligned projects tracked short-term proxy indicators for early insights and qualitative evaluations to capture the impact on communities and recognise contributions from the voluntary sector.

The Committee **AGREED** to the following recommendations subject to potential minor amendments offline:

1. To ensure that there is sufficient transparency around the steps being taken as well as the impacts being achieved around Oxfordshire becoming a Marmot Place. It is recommended that there is a development of specific indicators for the purposes of evaluating collective system-level efforts to achieve this.

2. To explore further avenues of funding for the purposes of supporting the work to making Oxfordshire a Marmot Place.

3. That specific indicators are developed for rural inequalities, inviting input from Town and Parish councils and local members who can contribute local knowledge of inequalities. It is also recommended that there is support for recognition of existing projects and voluntary and local community organisations (who can act locally) that are tackling these inequalities.

40/25 OXFORD HEALTH NHS FOUNDATION TRUST QUALITY ACCOUNT 2024-2025

(Agenda No. 15)

Britta Klinck, Chief Nurse, Dr Rob Bale, Interim Chief Operating Officer for Mental Health and Learning Disability, Angie Fletcher, Deputy Chief Nurse, and Emma Leaver, Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care, attended to present the quality account report.

The Chief Nurse had presented the quality account report, which was due for public release at the end of the month. The report had supplemented the annual report, highlighting quality priorities and performance. Oxford Health NHS Foundation Trust, a major provider of community and mental health care, had managed services in several regions and community hospitals in Oxfordshire. The Trust had assessed its performance over the past year, set new goals, and aligned with national directives. Despite efficiency challenges, improvements had earned them national recognition. They had prepared for the NHS 10-year plan by aligning with anticipated national priorities.

Members inquired about the Trust's strategy on clinical effectiveness, patient safety, and experience. The strategy focused on staff support, enhancing patient experience and safety, and advancing research. A board committee oversaw quality work, monitored data, and sought improvements. The Trust made progress with 68 peer support workers and established patient forums to include patient voices in decision-making. Continuously evaluating and improving care quality remained a priority.

The Committee requested evidence of measures for staff wellbeing and managing violent behaviour. The Trust implemented conflict resolution training, de-escalation techniques, trauma counselling, and formed a group to reduce violence and aggression, including racial abuse. Campaigns communicated a zero-tolerance policy towards such behaviour. In response to the cost-of-living crisis, they offered financial advice, crisis loans, and support for staff. Improved staff survey results placed the trust among the top ten mental health trusts for supporting, valuing, and engaging staff, and they conducted quarterly surveys for ongoing feedback.

Members also asked about advocating for an Oxford living wage and its recent rejection. Despite acknowledging the high cost of living, the proposal was rejected due to national pay framework constraints and political implications. Nonetheless, the Trust made strides in staffing, particularly through developing nurses from nursing associates and apprenticeships.

Members asked about the effectiveness and uptake of Keystone health and well-being hubs on community mental health. These hubs had high referral levels and were being evaluated for impact using qualitative and quantitative methods. They offered early interventions and guided people to community activities for mental health support, staffed by health professionals, partners, and peer workers who raised awareness and engaged with local communities.

Members also inquired about the Trust's efforts to enhance physical healthcare for those with serious mental illness. The Trust implemented smoking cessation programmes, annual health checks, and physical health clinics within community mental health teams, including home visits if necessary. General nurses in inpatient settings treated patients holistically, acknowledging the link between mental and physical health, and utilised their integrated structure to support both needs, especially in community hospitals.

Members queried the reasons for longer wait times for mental health services, measures taken to improve them, and alternatives for those unable to use digital services. The Trust refined referral processes, eliminated unnecessary steps, and used resources efficiently. Recruitment efforts helped reduce wait times, and they provided face-to-face interventions for those unable to use digital services, ensuring access to services.

The Committee inquired about reduced wait times for children's services in Oxfordshire, the ongoing disparity between demand and capacity, and how the Trust planned to improve timely access, quality, and safety without additional funding. The Trust acknowledged reduced wait times but noted the mismatch between demand and capacity. They aimed to enhance access, quality, and safety through better resource allocation, process improvements, and efficient services, while exploring ways to manage demand within existing resources. They also highlighted the importance of collaborating with the voluntary sector to provide support and manage demand.

Members asked about the Trust's reliance on the voluntary sector and its impact on deprived areas with low community resilience. The Trust acknowledged this challenge and established Keystone hubs, integrated support from both the Trust and the voluntary sector, ensuring necessary services were available even in areas with limited voluntary presence.

The Committee inquired about support for carers, families, and homeless individuals. The Trust had a full-time carers lead who managed activities including care assessments, peer support, and engagement events. Clinicians used the triangle of care approach to involve carers and families in the care process. For those without family support, a key worker was assigned. Crisis services included cafes and a crisis team that carried out home visits and offered round-the-clock support.

Members enquired about minority experiences within the NHS and mental health services, and actions on health inequalities. The Trust applied the Patient and Carers Race Equality Framework (PCREF) to improve ethnic minorities' experiences. They appointed an anti-racism lead to foster an inclusive environment. Recognising that equal treatment did not ensure equity, they tailored support to individual needs. Efforts were ongoing to understand and address barriers to service access, particularly in rural communities, aiming to reduce care disparities.

D/Cllr Poskitt left the meeting at this stage.

Members inquired how the Trust had assessed palliative care services and planned improvements. The trust had set response time targets for family home visits and collected feedback to ensure personalised care. They focused on proactive end-of-life planning and provided clinicians with clear patient and family needs information. Collaboration with care homes had aimed to prevent unnecessary hospital admissions, with district nurses providing regular end-of-life care visits.

Members also asked about the 38 completed reviews and 12 pending ones under the new NHS framework for serious incidents. The pending reviews likely involved ongoing family participation. The Trust aimed to learn from these incidents and enhance safety systems.

The Committee **AGREED** to:

1. Provide feedback on the Trust's quality account.
2. Finalise the wording of the feedback subsequent to and outside the meeting, and to submit the feedback to the Trust prior to the publication date for the quality account at the end of June 2025.

41/25 OXFORD COMMUNITY HEALTH HUBS WORKING GROUP UPDATE

(Agenda No. 9)

The Health scrutiny Officer introduced the Oxford Community health Hubs working group report. Formed in April 2024, the working group group actively tracked the Oxford Community Health Hubs project's progress.

The working group's oversight since its inception was acknowledged. The Committee **AGREED** to:

1. The continuation of the working group's existence and scrutiny of the Community Health Hubs Project.

2. Oxford City Cllr Upton's appointment as a new working group member, replacing former Councillor Michael O'Connor.

A site visit to Murray House (North City hub) was scheduled for 11th June 2025, featuring a project update presentation and a building tour. Committee members were invited, and interested new members were to notify the Health Scrutiny Officer.

42/25 CHAIR'S UPDATE

(Agenda No. 10)

The Chair provided updates on several ongoing and new initiatives, including the Oxford Community Health Hubs Working Group. Volunteers were requested for the Wantage Substantial Change Working Group, with Councillor Batstone volunteering to join. The potential redesignation of minor injuries units and the ophthalmology briefing were also discussed. An ophthalmology briefing was scheduled for September due to public interest.

The Committee **AGREED** to provide feedback offline on the Oxford University Hospitals NHS Foundation Trust quality account, and the Chair also highlighted the importance of engaging with the new Chief Executive of the Trust.

43/25 FORWARD WORK PLAN

(Agenda No. 16)

The Committee discussed organising an online meeting to prioritise the work programme for the rest of the year. They agreed on the importance of GP access and estates, given public interest. A new working group focusing on primary care was suggested to address these issues in depth. The Committee identified GP access and ophthalmology as urgent items to be addressed at the September meeting but expressed concerns about overloading the agenda. They considered holding a workshop for a more focused discussion on primary care.

In conclusion, the Committee **AGREED** to GP access and ophthalmology as being items for the September meeting, and to organise an online meeting to finalise the work programme.

44/25 ACTIONS AND RECOMMENDATIONS TRACKER

(Agenda No. 17)

The Committee **NOTED** the tracker.

..... in the Chair

Date of signing .....