Notice of Meeting

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 11 September 2025 at 10.00 am

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

If you wish to view proceedings, please click on this Live Stream Link.
However, that will not allow you to participate in the meeting.

Membership

Chair:	Councillor Jane Hanna OBE		
Deputy Chair:	District Councillor Dorothy Walker		
Councillors:	Ron Batstone	Judith Edwards	Emma Garnett
	Imade Edosomwan	Gareth Epps	Paul-Austin Sargent
District Councillors:	Paul Barrow	Elizabeth Poskitt	
	Katharine Keats-Rohan	Louise Upton	
Co-Optees:	Sylvia Buckingham	Barbara Shaw	
Date of Next Meeting:	*20 November 2025*		

For more information about this Committee please contact:

Committee Officer: *Scrutiny Team*

Email: *Email: scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

September 2025

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer no later than 9 am on the working day before the date of the meeting.**

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Minutes (Pages 1 - 16)

To approve the minutes of the meeting held on 05 June 2025, and to receive information arising from them.

4. Speaking to or Petitioning the Committee

Members of the public who wish to speak on an item on the agenda at this meeting, or present a petition, can attend the meeting in person or 'virtually' through an online connection.

Requests to speak must be submitted no later than 9am three working days before the meeting, i.e. Friday 05 September 2025

Requests should be submitted to omid.nouri@oxfordshire.gov.uk and scrutiny@oxfordshire.gov.uk.

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9am on the day of the meeting. Written submissions should be no longer than 1 A4 sheet.

5. Response to HOSC Recommendations (Pages 17 - 36)

The Committee has received Acceptances and Responses to recommendations made as part of the following item(s):

1. Musculoskeletal Services in Oxfordshire
2. Audiology Services in Oxfordshire
3. Cancer Services in Oxfordshire
4. Oxfordshire as Marmot Place
5. Oxfordshire System Pressures

The Committee is recommended to **NOTE** the responses.

6. **Chair's Update** (Pages 37 - 76)

The Chair will provide a verbal update on relevant issues since the last meeting.

There are TWO reports in the agenda papers for this item, containing recommendations from the Committee on: Oxfordshire System Pressures, and on Oxfordshire as a Marmot Place.

A letter was sent on behalf of the Committee to the Chief Executive of the BOB Integrated Care Board, requesting further information on a recent Oxfordshire Neighbourhood Health Bid.

There are TWO documents attached to this item:

1. The letter that was sent to the ICB Chief Executive on behalf of the Committee.

2. The application Oxfordshire Place-based Partnership recently submitted in response to the national neighbourhood health implementation programme (NNHIP).

The response received by the Committee is as follows:

"The Oxfordshire application is intended to accelerate the benefits of neighbourhood working in Oxfordshire:

- *Specifically, for some of the most vulnerable and deprived residents:*
- *To build on progress to date relating to care being delivered and coordinated by INTs.*
- *To further explore and mature primary care at scale delivery.*

The application required sign off from a wide variety of statutory organisations including CEOs from both the ICB and OCC. We also including other non-statutory organisations like Healthwatch and OCVA organisations hopefully demonstrating the extent stakeholders involved in developing the application.

For the purposes of the application, resident involvement was limited due to a short turnaround time in holiday season. However, Oxfordshire has held multiple neighbourhood health and care workshops with broad representation (including statutory organisations, Healthwatch, VCFSE orgs, Patient Participation Groups. The full impact on primary care is unknown at this stage, but the Oxfordshire Neighbourhood Health Steering Group is chaired by the Chair of Oxfordshire GP Leadership Group, with further representation form GPLG and PCNs. The broader neighbourhood agenda is intended to further enhance primary and community care.

Planning guidance has recently been published, this will help inform local processes that will of course require input across sectors, organisations and residents. Dr Ben Riley is senior responsible officer for the ICB and we expect neighbourhood working to be driven and delivered large by collaborations at Place. All 3 Places in BOB have applied and we expect to hear back which proposal will be taken forward towards the end of this month. Oxfordshire's proposal focussed on Oxford City and part of Banbury and Bicester covering areas we already have developed Integrated

Neighbourhood Teams and 9 out of the 10 most deprived wards in Oxfordshire."

The Committee is recommended to **Note** the Chair's update having raised any relevant questions.

7. General Practice Access and Estates (Pages 77 - 88)

Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire - Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board) has been invited to present a report on General Practice Access and Estates in Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

8. Oxfordshire Eyecare Services (Pages 89 - 96)

Matthew Tait (Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board) has been invited to present a report on Eyecare services in Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

9. Healthwatch Oxfordshire Update (Pages 97 - 108)

Veronica Barry has been invited to present the Healthwatch Oxfordshire Update report.

The Committee is invited to consider the Healthwatch Oxfordshire update and **NOTE** it having raised any questions arising.

There are TWO documents attached to this item:

1. The main Healthwatch Oxfordshire Update report.

2. Appendix 1: A document developed by Healthwatch Oxfordshire, outlining the future of Healthwatch and independent scrutiny.

10. Adults Autism and Attention Deficit Hyperactivity Disorder services (Pages 109 - 122)

Matthew Tait (BOB Integrated Care Board Chief Delivery Officer) has been invited to present a report on Adults Autism and Attention Deficit Hyperactivity Disorder services in Oxfordshire.

The Committee is invited to consider the report, raise any questions and **AGREE** any recommendations arising it may wish to make.

11. **Forward Work Plan** (Pages 123 - 124)

The Committee is recommended to **AGREE** to the proposed work programme for its upcoming meetings.

12. **Actions and Recommendations Tracker** (Pages 125 - 142)

The Committee is recommended to **NOTE** the progress made against agreed actions and recommendations having raised any questions.

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.

Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests

Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:

Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

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 .....

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Musculoskeletal Services in Oxfordshire

Lead Cabinet Member(s) or Responsible Person:

- Matthew Tait (Chief Delivery Officer-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Neil Flint (Associate Director of Planned Care-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Tony Collett (Connect Health)
- Mike Carpenter (Connect Health)
- Suraj Bafna (Connect Health)

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Tuesday 3rd June 2025.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to report:

Thank you for the Joint Health Overview and Scrutiny Committee (HOSC) report on Musculoskeletal Services in Oxfordshire following the public meeting on 06 March 2025. Following review of the report we have detailed a few points of clarification below as well as specific responses to the three recommendations made in the report.

Points of clarification

"Diagnostic physiotherapists"

- The MSK care pathway spans from primary care, through community and into secondary care. A significant number of MSK conditions can be successfully managed in primary care and onward referral is not always required. To support the primary care team with MSK condition-specific management, the role of MSK First Contact Physiotherapist (FCP) was introduced in 2019[1] , and this role is what is referred to as "diagnostic physiotherapists" in the HOSC report. The remit of the FCP role is to provide the initial MSK assessment in primary care to support optimal primary care self-management for MSK disorders and support appropriate and judicious onward referrals when needed. The role is one of assessment, rather than of providing ongoing therapy input (if this is required, then patients would be referred into the community MSK service to obtain this). FCPs in Oxfordshire are employed by the primary care network and are not directly employed through the community MSK service. As such, some GP practices chose to employ FCPs whilst others do not, meaning there is variance across the county in FCP provision. Since the commencing delivery of the community MSK service, Connect Health have worked to engage with FCP groups and primary care networks to collaborate between care settings for an optimal patient pathway across primary, community and secondary care regardless of whether a GP practice has an FCP service or not. We provide FCP clinicians to one PCN in Oxfordshire.

  [1] https://www.england.nhs.uk/wp-content/uploads/2019/05/elective-care-high-impact-interventions-first-contact-practitioner-msk-services-specification.pdf

Direct referral to MSK Specialists

- Part of the remit of the community MSK service is to determine if any incoming referral requires direct opinion in the secondary care setting. Given a significant number of MSK conditions do not require surgical management, a large volume do not need to be referred into the secondary care setting. Incoming referrals are therefore triaged by Advanced Practice (AP) MSK clinicians to assess if onward direct referral to the surgical teams is required. Currently about 12% of referrals from primary care are triaged directly onto orthopaedics. There are clear guidelines from the ICB with regards to the prior approval criteria [2] that need to be met in order for optimal management related to a range of orthopaedic procedures and these have been shared in a previous newsletter with all GP practices. The community MSK service support optimisation of holistic care in fulfilment of these criteria to ensure that all onward referrals are compliant with the commissioning guidelines.

[2] https://www.bucksoxonberksw.icb.nhs.uk/clinical-commissioning-policy-statement-categories/musculoskeletal-msk/

Use of digital appointments

- These are already widely used across the service with a telephone appointment being the default first point of contact for all Tier 1 MSK appointments (unless not an appropriate modality for the patient) which speeds up access to timely advice, reduces travel time & expenses and minimises the time patients might need to take off from work or other responsibilities for their appointment.
- We utilise a digital triage tool called PhysioNow[3] which supports in clinical safety netting and stratification as part of self-referral helping to ensure patients that need a more urgent appointment get one. 84% of patients that are offered PhysioNow complete it. The other 16% of patients are called after 3-days of not completing the digital tool to ensure there is no delay to their care or inequity in service provided to those who may not be able to access digital care platforms.
- We have recently piloted FLOK which is an AI-tool to support management of back pain which has been successfully used elsewhere and are currently awaiting the final analysis and report on this pilot. Initial data shows that of about 750 eligible patients 68% opted to use the FLOK tool[4] and of these 75% were fully managed within the FLOK system.

[3] https://www.connecthealth.co.uk/physionow/

[4] https://news.nhslothian.scot/2024/07/12/uks-first-ai-physio-clinic-trialled-by-nhs-lothian/

Primary Care Collaboration & Training

- Since January 2025 we have published and circulated to all GP practices via email a monthly MSK newsletter to support primary care in understanding and navigating MSK pathways. This newsletter consistently emphasises our willingness to attend GP practices to provide further training on management of MSK conditions to support appropriate first line management.
- In partnership with the ICB we have identified the 10 GP practices with the lowest referral rates and engaged with them to understand reasons for this and whether there are barriers to access that need addressing. A full report detailing this project has been shared with the ICB. The primary finding was that these practices had a young patient population with a higher proportion of students who therefore tend to have less need for the MSK services.
- As identified in the HOSC report one of the big challenges in healthcare is the number of clinical systems in use and often the lack of visibility across the system of shared records which remains a challenge in the Oxfordshire MSK system as we have no access to GP or hospital records. However, we have recently been successful in improving our access to diagnostic test results ordered in primary care meaning that we can now directly see imaging and blood test results via our clinical systems and so are no longer reliant on primary care remembering to include the reports in their referrals. This has greatly

reduced the administrative burden on both primary care and our service and leads to a better patient experience with more information directly available at the point of care.

Pelvic Health Service

- The Oxfordshire MSK Pelvic Health service accepts referrals for a wide range of pelvic health conditions including:
  - Bladder & bowel dysfunction, pregnancy related pelvic girdle pain, persistent pelvic pain, vaginal & rectal prolapse and diastasis rectus abdominis.
- The service is staffed by specialist MSK professionals (physiotherapists & osteopaths) with additional training and experience in the management of pelvic health conditions. The four areas of treatment outlined in the HOSC report of: Pelvic floor exercises, healthy diet and hydration, maintaining a healthy weight and proper lifting technique are all core treatment strategies alongside patient education and other more specialist modalities in the pelvic health service.
- Pregnancy related pelvic girdle pain (PGP) is considered a priority condition and so referrals for this are triaged and offered an initial telephone appointment within 2-weeks of accepting the referral. In addition, we have created a bespoke PGP video which is sent to patients to support them with understanding what PGP is and how best to manage it.
- With regards to the quality of service provided by our pelvic health team they are consistently one of the highest performing service lines when it comes to patient satisfaction questionnaires. Over the past 6-months 178 responses have been received to the Friends & Family test from patients who have been under the pelvic health service and of these 94% would recommend or highly recommend the service to a friend or family member.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. To address variances around the county, with a view to residents being able to access local MSK services more swiftly.	Partially accepted.	Review of the estates footprint against demand is completed on a bi-annual basis and the latest review showed that the capacity across the County met the demand. We do, however, understand that there are challenges for those residing in more rural locations and by August 2025 we will complete a full review of demand in the South of Oxfordshire, split by service line. We have 4 sites in the South of Oxfordshire; Henley on Thames, Wallingford, Didcot and Wantage. Once we have the information to identify specific demand vs. capacity for the South region, we can make recommendations based on capacity per service line. There is no additional funding available to mobilise new permanent sites. For context, the service is funded by a block arrangement with part of the finances linked to a performance based local incentive scheme which includes access metrics. The service currently receives 10% more referrals than the contractual indicative activity plan with no additional funding. The increase in demand equates to an additional 6000 patients a year. The service has put in innovative pathways, such as one stop shops, to maintain and improve wait times within KPIs and to meet the growing demand in the absence of growing funding to support this. If the review of south provision highlights that there is a need to increase capacity in the South, then we will liaise with existing community and voluntary groups to discuss the option of us doing specialist outreach clinics. It is worth noting, that where clinically appropriate, we offer telephone and video appointments for patients who do not have the ability to travel.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

2. To continue to develop further collaboration with GPs and other services to improve MSK services. It is recommended that efforts are made to reduce the number of steps (and time) required to access MSK services.	Partially Accepted	Ongoing work to help patients & primary care teams understand the best ways to access and navigate the MSK pathways in Oxfordshire including: 1. Monthly newsletter to all GP practices with a spotlight on understanding a different MSK pathway each month. 2. Ongoing high-quality MSK triage to ensure referrals are sent to the most appropriate service for the first MSK appointment. Continued engagement via the newsletter and attending GP meetings to support primary care teams in understanding the thresholds for direct referral to secondary care services and any relevant commissioning guidelines that need to be satisfied. 3. GP/FCP engagement project in partnership with the ICB in which we have identified the 10 lowest referring GP practices and then contacted them to better understand the causes behind. 4. Continuing to attend various public health engagement events to promote awareness of the service across the county and particularly that self-referral is available for those >18 years old. Self-referral is available online via the physionow digital triage tool or via the telephone and 84% of patients that are offered physionow as a route into the service accept it. 5. We are named attendees at the North Oxfordshire Network Group which meets on a quarterly basis and helps maintain a working relationship and dialogue with primary care services in North Oxfordshire
3. For efforts to be made to create improvements to pelvic health outcomes. It is recommended that there is engagement with the	Accepted	The Pelvic Partnership is a charity that advocates for timely treatment of pregnancy-related pelvic girdle pain which would be consistent with our pathway to manage this as a priority condition.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Pelvic Partnership around support for those who are waiting for support.		They also look to offer support groups and information for people suffering with PGP. We have asked our pelvic health team to review their website in order to check that it is compliant with best practice recommendations and research. If so, we will look at how best we can signpost to and collaborate with them to further support people with PGP.

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Response to Audiology Recommendations for HOSC

Further to HOSC presentation and discussion on the 6th March 2025, 3 recommendations were made. Below represents the ICB's response to these.

Recommendation 1: *For further information to be provided around the level of need for audiology services (including amongst children), and on supply at the local and acute levels. It is recommended that further resourcing is sought to tackle waiting lists and prioritisation, particularly around Community Diagnostic Centres.*

The ICB is currently supporting a national review of audiology services for paediatric patients. Therefore, we are requesting the information relating to demand, service delivery and capability come from that independent report once published. This avoids any prejudice of information. However, participating in this review, it included a visit OUH as well as the other NHS Trusts. Notably, a proposal has been developed to improve access, capacity and resourcing for these services. This would affect both adult services and paediatric services. Therefore, we ask this information is shared once an outcome from the proposal has been reached.

In addition, the ICB has supported the OUH in bidding for capital funds that would provide key estate and equipment capabilities, necessary to improving access and capacity for paediatric services.

Furthermore, the ICB is currently working with community providers and the OUH to support a safe clinical model where some more patients could be supported by community providers and increase overall capacity while also reducing waiting times for such services in the hospital. This is being led by the OUH and supported by the ICB as well as community providers.

Recommendation 2: *For improvements to be made around communications with the wider public to increase awareness of available support from audiology services.*

The ICB support this recommendation and is liaising with all its. We are working with providers to engage with primary care colleagues and support any local marketing they may do to inform and support patients, including making information accessible to all. However, we are also mindful as to not cause an aggressive marketing scheme that drives inappropriate use of services.

Recommendation 3: *That Community Audiology is brought onto the same Electronic Patient Record system as the rest of Oxford University Hospitals NHS Foundation Trust.*

The ICB has considered this and supports the intention and recommendation. However, this is not viable as many providers have autonomy to use their own system – both NHS Trusts and independent providers. The demand for providers in Oxfordshire to opt to the OUH system, would be at the risk to the rest of their provision nationally and to other systems.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

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Issue: Cancer Services in Oxfordshire

Lead Cabinet Member(s) or Responsible Person:

- Matthew Tait (Chief Delivery Officer-Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board).
- Felicity Taylor Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust).
- Andy Peniket (Clinical Director for Oncology & Haematology, Oxford University Hospitals NHS Foundation Trust).

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Tuesday 3rd June 2025.

Response to report:

Enter text here.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
1. For further detail to be shared on outcomes across different cancer types, and how that compares nationally and regionally.	Accepted	Benchmarking analysis at tumour site level across the three cancer standards will be provided for the next HOSC meeting.
2. For there to be clear communications with cancer patients who cannot speak in English (or who struggle to communicate in general), and for mechanisms to be in place to help with advocacy for such patients.	Partially	We use a robust interpreter service in these circumstances to mitigate challenges some patients may find with the English language Clinical staff are supported through training and the Cancer Lead Nurse has agreed to arrange some further sessions for clinical nurse specialists accordingly to mitigate any gaps. Cancer Management Team are exploring any digital solutions that may support this further.
3. For Oxford University Hospitals NHS Foundation Trust to collaborate with the Oxfordshire County Council's Public Health team on awareness campaigns with communities with low take-ups of cancer screening.	Accepted	

Health Overview & Scrutiny Recommendation Response Pro forma

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This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: **Oxfordshire as a Marmot Place**

Lead Cabinet Member(s) or Responsible person: Ansaf Azhar, Director of Public Health
Kate Holburn, Deputy Director of Public Health

Deadline for Response: 29th July 2025

Response to report:

Enter optional text here

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)
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 timely development of specific indicators for	Accepted	Transparency will be achieved through regular updates at the Health and Wellbeing Board and other partnership boards which are most relevant to the focus principles. Updates will be ongoing through the year. Indicators, which will be developed as plans mature, will be aligned with Health and Wellbeing Board indicators, but not limited to these.

Health Overview & Scrutiny Recommendation Response Pro forma

the purposes of evaluating collective system-level efforts to achieve this, and that these must include rural inequalities.		
2. To explore further avenues of funding for the purposes of supporting the work to making Oxfordshire a Marmot Place.	Accepted	Investment from different sources will be sought to support the achievement of Marmot outcomes to address inequalities in access to work.
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 with a view to any future working in their neighbourhood being done with the community. 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.	Accepted	The rural inequalities indicators will be developed with the communities and will reflect feedback from local knowledge and activities to address inequalities.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Oxfordshire system pressures

Lead Cabinet Member(s) or Responsible Person:

- Dan Leveson- Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) Director of Places and Communities.
- Lily OConnor- Oxfordshire Urgent Emergency Care Director.
- Karen Fuller- Director of Adult Social Care, Oxfordshire County Council.
  (on behalf of Oxfordshire System Partners)

It is requested that a response is provided to each of the recommendations outlined below:

Deadline for response: Wednesday 6th August

Response to report:

Enter text here.

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Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale.
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.	Accepted	Oxfordshire is actively working towards a plan to meet the recommendations of Healthwatch's recent report (June 2025). An audit of local, and neighbouring, provider websites has been completed to review what information is currently available on Urgent and Emergency Care (UEC) services. We are working with the Integrated Care Board (ICB) Communications and Engagement Team to explore how this web audit could inform discussions with our system-wide partner organisations to improve consistency in public signposting. We will also seek support to identify how information can be best presented to ensure our local population can easily access the guidance they need, when they need it. The outcomes will be reviewed at System Urgent Care Delivery Group - attended by all Oxfordshire system partners – to ensure a collaborative and proportionate response to what the local population have asked for. The first draft is expected in September 2025.
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	Partially accepted: Accept the principle but already in place in Oxfordshire	In progress: Timescale March 2026: - Out of Area Patients (OAPs) reduction program plan (improving flow, reducing Length of stay (LOS); reducing delays; targeted action on for those with LOS of over 60/90 days) - Inpatient Improvement program (Trust wide) - Crisis Team expansion to full countywide 24/7 service - Mental Health (MH) service improvement program (as part of new 10-year contract for MH services in Oxfordshire.

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alternative community-based settings and local crisis responses.		In place: - 24/7 Crisis Team - partial coverage countywide (City, North East Oxon, North &West Oxon) - 24/7 MH Helpline embedded within 111/999 - 24/7 MH text service introduced Spring 2025 - Safe Havens in Oxford and Banbury (in partnership with Oxfordshire Mind (Mind is a charity supporting people with MH conditions) They provide an emergency environment for people for a short time. This provides people with the space and time that they require on a short-term basis.
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.	Accepted	1. Major efforts have been made to highlight and unapologetically dedicate additional resource to these priority areas and populations. Community Profiles have been developed to better understand the strengths and needs of these communities through an asset-based community development (ABCD) model. 2. Community Health Development Officers (CHDOs) in priority areas foster community engagement, support local health initiatives and implement action plans and recommendations from the Community Insight Profiles. 3. The Well Together Programme is a £1million grants programme, funded by BOB ICB, which recognises the essential role Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations play in addressing health inequalities at a local level, funding is available for new and existing organisations and projects in the 10 priority areas. Alongside the financial benefit, Well Together has supported organisations to gather stories and collect data to measure impact of activities. It has also helped people to reach a wider

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		audience, develop ongoing collaboration and signpost to further networks and support. 4. Oxfordshire Neighbourhood Voices is a structured twelve-month partnership, where senior leaders will be paired with community members from the most deprived neighbourhoods. Engagement will occur within existing community structures such as faith groups and grassroots networks minimising burden and maximising authenticity. Each pair will meet at least monthly, with interactions tailored to their context and grounded in mutual respect and openness.
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).	Partially accepted: Accept the principle but already in place in Oxfordshire	Determination of medically optimised for discharge (or the Discharge Ready Date (DRD)) is based on the definition of the 'criteria to reside' within the government's Hospital discharge and community support guidance. One of these criteria to be considered is a review of the patient's NEWS score. All patients should be given an Estimated Date of Discharge (EDD) within 24 hours of admission, which is reviewed daily during board and ward rounds. A patient's condition can fluctuate so their EDD and DRD will flex accordingly. We will therefore continue to use this nationally agreed criteria.
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	Partially accepted	Oxfordshire has a whole system neighbourhood development group which is in the process of scoping out all services and local groups. The group meets weekly and reports monthly to Place Based partnership board. We have a workshop organised for 8th August 2025, with Health, Social Care and the voluntary sector to design the geography of neighbourhoods within Oxfordshire.

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).		Each Neighbourhood will utilise data from many sources, all providers, Public Health and social care. The local population is divided into groups, to identify adults with multiple long-term conditions and those at rising risk. Data can be analysed at system, place, PCN, and practice level to support proactive, targeted intervention. Neighbourhood teams involved in direct care can access identifiable patient lists to deliver tailored support. The detail of how we will integrate the services within and across neighbourhoods needs further work. There is no additional funding available to the Oxfordshire system so we will make sure we maximise the available funding to meet the outcomes of Oxfordshire residents.

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OXFORDSHIRE COUNTY COUNCIL

Cllr J Hanna OBE

Chair, Oxfordshire Health Overview and Scrutiny Committee

29 August 2025

Dear Nick Broughton,

Seeking information on recent Neighbourhood bid:

I am writing to you on behalf of the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC). I understand that the local NHS has recently initiated a neighbourhood health bid, and I am seeking further information regarding this development.

Specifically, the Committee would appreciate your clarification on the following points:

- *The Nature of the Bid*: Could you please outline the aims, scope, and objectives of the recent neighbourhood health bid? We are eager to understand how this initiative aligns with the broader strategic priorities of the Integrated Care Board and other local system partners, and the anticipated outcomes for Oxfordshire's neighbourhoods and communities.

- *Funding Allocation*: Is there any plan for further funding to be allocated to neighbourhoods as part of this bid or as follow-on support?

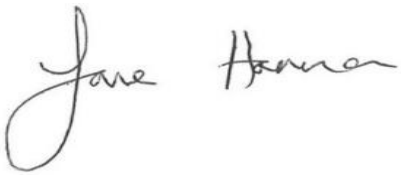
- *Stakeholder Engagement*: Have key stakeholders—including the County Council, local residents, primary care providers, or voluntary organisations been engaged during the formulation and submission of this bid? Are there any plans to ensure their continued involvement in neighbourhood health?

- *Impacts on Primary Care*: What (if any) potential effects could this neighbourhood health bid have on the delivery and sustainability of primary care services within Oxfordshire?

We would greatly appreciate any insights you can provide regarding the above queries, as well as any supporting documentation or plans that may be available for public review. In light of the pace required of the NHS for sign off of 5 year plans this year, we would be grateful for as much transparency as possible of any developing timelines and planned engagement.

Thank you for your attention to our request. I look forward to your response and to learning more about how the Integrated Care Board is working to enhance health services in our communities and neighbourhoods.

Yours sincerely,



Cllr Jane Hanna OBE

Chair, Oxfordshire Joint Health Overview Scrutiny Committee

Department of Health & Social Care

NHS

Application to take part in the National Neighbourhood Health Implementation Programme

All fields in this document should be completed. THE QUESTIONS AND YOUR ANSWERS CONSTITUTE THE CRITERIA UPON WHICH YOUR APPLICATION WILL BE JUDGED

Applications should be emailed to england.neighbourhoodhealthserviceteam@nhs.net by 8 August 2025.

Place details

1. **Current ICS your Place is part of:**

   Buckinghamshire, Oxfordshire and Berkshire West (BOB)

2. **Full name of the Place on which the project will focus:**

(please include details on footprint including population size, local authority alignment and number/configuration of any integrated neighbourhood teams):

Oxfordshire has a GP registered population of 828,209 across five district councils and one upper-tier county council, with a mix of rural and urban areas. Oxfordshire has:

- 21 PCNs
- 63 GP Practices
- 118 Dentists
- 68 Opticians
- 99 Pharmacies

This application will predominantly focus on:

- Oxford City (6 PCNs covering GP registered population of 242,000), where there are 6 of the most deprived wards in the county, 2 mature INTs, and at scale primary care, Oxford City Primary Care (OCPC), well placed to progress as a multi-neighbourhood provider.
- Banbury and Bicester (GP registered population of 94,000), led by Principal Medical Limited (PML), a longstanding membership and at scale provider organisation, and there are 3 of the most deprived wards in the county and 3 mature INTs.

It will further progress existing efforts to prioritise and focus on areas of Oxfordshire that are home to people facing some of the greatest health inequalities. Nine out of the ten most deprived wards in Oxfordshire are situated within Oxford City and Banbury, there is a 15 year gap in life expectancy for men living in one of these wards, compared with Oxfordshire's most affluent.

Within these areas, health and social care provision is advancing in line with the key components of neighbourhood health, for example:

- Established and effective multi-disciplinary integrated neighbourhood teams, coordinating and delivering care to some of the most complex and vulnerable 1-2% of the population.
- Primary care delivering services at scale, including urgent neighbourhood services, with ambitions to further develop multi neighbourhood provider models.
- Advanced approached to community development.

There are five mature and embedded Integrated Neighbourhood Teams (INTs), the first of which was developed in 2021, with others following in subsequent years. The five teams, covering Bicester, OX3, City East and Banbury (2) came about through population health management approaches. Health and social care leaders agreed key data packs that would enable them to identify populations that would most benefit from multidisciplinary working and more joined up care. Key characteristics included those aged over 65, residing in areas of high deprivation and categorised as 10 or 11 in the Johns Hopkins Adjusted Clinical Groups (ACG).

Those in receipt of care coordinated and/or delivered by INTs are experiencing positive outcomes, so much so that three further INTs are in development. Commitments from key health and social care providers have been made. Population cohorts have been identified, these range from High Intensity Users (HIU), Long Term Conditions (LTC), Children and Young People (CYP) and Frailty. Mobilisation is underway to ensure care is coordinated and delivered in the most effective way to improve outcomes.

Alongside the development of INTs, there are currently three primary care providers delivering services at scale:

1. Principal Medical Limited (PML) - mainly operating in north Oxfordshire.
2. Oxford City Primary Care (OCPC) – operating in and around Oxford City.
3. Oxford Health NHS Foundation Trust (OHFT) – county wide out of hours and district nursing.

3. Neighbourhoods within the Place

(please include whether each neighbourhood has a clinical lead, managerial lead and admin)

PCNs	Clinical lead	Managerial lead	Admin
• Healthier Oxford Network • Oxford Central	Yes	Yes	Yes
• OX3+	Yes	Yes	Yes
• Spires • SeOxHA • East Oxford	Yes	Yes	Yes
• Banbury Cross	Yes	Yes	Yes
• Bicester	Yes	Yes	Yes

4. ICB Chief Executive and Local Authority Chief Executive who will act as the co-sponsors:

(full name, title and contact details)

As a requirement of this application, systems will be expected to:

- fund a co-ordination function for each neighbourhood (named clinical lead, managerial and administrative support)
- provide essential backfill for staff and similar expenses (travel, accommodation, venues) to participate in the National Neighbourhood Health Implementation Programme
- provide enabling support to progress Neighbourhood Health e.g. analytical support (see FAQs)
- provide a Neighbourhood Health implementation coach and project lead

Martin Reeves Chief Executive Oxfordshire County Council Martin.reeves@oxfordshire.gov.uk	Dr Nick Broughton Chief Executive BOB ICB Nick.broughton1@nhs.net

5. Mayoral combined authorities

If you are in a mayoral combined authority, please confirm that the mayor is aware of and supportive of your proposal.

N/A

6. Neighbourhood Health implementation coach and project lead:

(full name, current role and contact details)

Each Place will need to supply a person who has existing improvement, collaboration and leadership skills and is able to work with their own initiative (see role description in the FAQs). They will be assigned full time for 12 months to act as the local Place coach, as part of the national network of Neighbourhood Health project leads, supported by the national team.

Neighbourhood Health Coach: Chris Wright Associate Director of Place BOB ICB c.wright29@nhs.net	Project Leads Dr Joe McManners Co-Clinical Director Ox3+ PCN Joe.mcmanners@nhs.net Dr Toby Quartley Co-Chair PML Toby.quartley@nhs.net

Place background information

7. Does your Place have a devolved budget from the ICB? If so, how is this organised and what scope of services does it cover? (max 150 words)

Oxfordshire has a devolved budget via a Section 75 agreement between OCC and BOB ICB with a pooled budget of £560m. BOB ICB also delegated responsibility for Urgent and Emergency Care and Health Inequalities budgets, alongside the Better Care Fund (BCF) enabling us to prioritise investments in neighbourhood working, prevention, primary care and voluntary sector. Much INT progress to date has been funded via the BCF and targets deprived areas.

The Joint Commissioning Executive is an executive level board accountable for the deployment of pooled funds. It is co-chaired by OCC and ICB, membership includes NHS Acute, Community, and Mental Health provider representation.

Oxfordshire's Health, Education and Social Care joint commissioning team, hosted by OCC and established in 2021/22, is a key enabler and commissions across the life course:

- **Start Well** – Children and Young People.
- **Live Well** – Adult mental health, learning disabilities, autism.
- **Age Well** – Community services, prevention, addressing inequalities.

150 words

8. Do you have existing data sharing agreements between the constituent statutory organisations in this application, and if so, what do they cover? (max 150 words)

NHS organisations within Oxfordshire have signed up to and are covered by the Regional Health and Social Care Information Sharing Agreement (RegISA). Work is progressing with Oxfordshire County Council to sign them up to this agreement also. This is an overarching agreement which allows constituent organisations to agree to share specific sets of information with other constituent organisations.

For example, the agreement permits:

- Sharing of information from NHS and Social Care into the electronic Shared Care Record which covers BOB.
- Creation and usage of linked patient-level Population Health dataset covering BOB and usable for segmentation.

There are opportunities to further optimise this agreement to support additional sharing required to support neighbourhood working.

There are areas where all GP surgeries and secondary care providers have access to shared instances of the Electronic Patient Record (EPR). This will be further optimised and scaled to support additional sharing to benefit neighbourhood working.
149 words

9. Do you have a risk stratification tool rooted in primary care data that would enable you to identify the adults with multiple long-term conditions and rising risk within the Place that will be the focus of this early work? Please describe (including if you have a section 251 agreement for use of linked patient level data for population health i.e. for both direct care and secondary use)? (max 150 words)

Neighbourhoods utilise the Johns Hopkins ACG Patient Need Groups via the Population Health Management (PHM) platform, Connected Care. This tool segments the population into 11 groups, which can be filtered by clinical indicators to identify adults with multiple long-term conditions and those at rising risk. Data can be analysed at system, place, PCN, and practice level to support proactive, targeted intervention. Neighbourhood teams involved in direct care can access identifiable patient lists to deliver tailored support.

The tool has been effectively used at system level for example, combining ACG segmentation with cardiovascular risk indicators to help practices identify and manage cohorts at rising risk of CVD. Linked patient-level data is shared locally through the Regional Health and Social Care Information Sharing Agreement. As this does not include NHS England data, and all identifiable data is used for direct care, advice has confirmed Section 251 approval is not required.
148 words

10. Describe any existing forum for CEOs of the different statutory organisations and partners (e.g. VCSE, providers) in your Place that meets regularly to support Neighbourhood Health (ways of working, function, responsibilities, frequency). (max 150 words the implementation of)

The Oxfordshire Place-Based Partnership (PBP) is a forum for senior leaders across health, care, and community sectors to drive integration, improve outcomes, and reduce inequalities. It meets monthly to align strategy, oversee delivery, and coordinate resources across the system, bringing together CEOs and executives from:

- NHS providers (OUH, OHFT)
- BOB ICB
- Oxfordshire County, City, and District Councils (including Public Health)
- Primary Care
- VCSE sector and Healthwatch
- Oxfordshire Association of Care Providers

Oxfordshire PBP prioritises neighbourhood working, prevention, and better value care. A Community and Primary Care Board will oversee neighbourhood delivery and report to Oxfordshire PBP.A dedicated steering group has been established, chaired by the Chair of the Oxfordshire GP Leadership Group, with the OHFT CEO as Co-Chair, supported by a Professor at Oxford University who is an expert in systems change. The NNHIP accelerator will report through these arrangements to ensure progress is made and learnings shared.
148 words

Your application in local context

Please specify the following on this application form **(strictly no attachments or presentations)**.

11. Describe existing examples of integrated working in your Place or Neighbourhood and the results obtained. (max 500 words)

Oxfordshire has longstanding integrated commissioning arrangements and pooled budgets. There is strong experience of developing integrated working through teams across multiple providers, generally in sub-place or neighbourhood footprints.

Integrated Neighbourhood Teams (INTs) have been developed with GP based Proactive Care Teams working with secondary care (acute, community and mental health) services, social care, and the VCFSE sector to coordinate care for higher need complex patients, especially older people and those with medical problems in social need. This has reduced crisis care, empowered patients and improved satisfaction of patients and carers.

There is an advanced **Hospital@Home** service which is increasingly finding ways to integrate with INTs. Alongside positive outcomes for patients and families, there are efficiencies and avoided costs through reduced reliance on inpatient care.

Working with communities and VCSFEs is foundational to neighbourhood working. The CORE20plus5 framework has been used to prioritise actions in the most deprived areas of Oxfordshire, building networks, trust and connections and improving health outcomes through programmes like Well Together, Move Together and Equal Start. Health inequalities funding has been used to pump prime VCSFE groups to tackle social and health needs.

Priority populations have been identified and supported through multi agency working. For example, people with complex learning disabilities have been effectively supported to avoid unnecessary admissions. Homeless people have been supported to access housing, with a commitment to ensure nobody is discharged back to the streets.
There are three active and successful pilots of Community Health and Wellbeing Workers in three of the most deprived areas, linking residents, health and communities.

The Oxford and Banbury **Urgent Treatment Centres (UTCs)** are Primary Care services delivered by OCPC and PML offering same day urgent appointments, co-located on acute hospital sites. They deliver in excess of 1,000 same day appointments per month and have the infrastructure to expand to support further as needed.

Neighbourhood work will also draw on learning across Oxfordshire, in Wantage £1m was received through the Community Investment Levy (CIL) to increase the number of clinic/consultation rooms as a potential future **neighbourhood health centre,** similar opportunities and approaches will be pursued.

Jointly funded **key system roles** in urgent care leadership, the transfer of care hub that co-ordinates hospital discharges, Home First, joint commissioning and dedicated business intelligence.

During 2024 there was a large focus on **Home First,** supporting people in their communities and reducing delays in hospitals, providing wraparound support in partnership between NHS, Local Authority, VCFSE and independent care providers resulting in:

- Reducing average length of stay in numerous bed-based settings.
- Increasing proportion of people (from 69% to 76%) returning to full independence.
- Reducing the number of nursing home beds for discharge from 95 to 37.

During 2024, the Mental Health Leadership comprising NHS providers and commissioners, VCFSE, Local Authority with experts by experience awarded a 10-year integrated contract building on the previous **outcomes-based contract**. This includes six Keystone Mental Health Hubs operating from non-stigmatising and accessible venues, some of which are co-located with a social enterprise such as a shop or café.

500 words

12. What do you hope to achieve from being part of the National Neighbourhood Health Implementation Programme? (max 150 words)

The NNHIP aligns to existing local strategies and plans, these ambitions of improving the health and wellbeing of our residents by joining up care and improving outcomes will be accelerated by accessing national experts, guidance and other opportunities.

Building on the culture of improvement and learning that health and social care leaders in Oxfordshire have, the NNHIP would enable participants to identify transferable and scalable solutions from elsewhere, especially to tackle inequalities and work upstream in health pathways.

There is a strong and developing culture of integrated working and working with Local Authorities, participating in this programme would catalyse this and help spread this culture locally.
Oxfordshire is keen to progress ambitions of further developing multi neighbourhood providers and learning needs to be in place to achieve this. The NNHIP offers a national platform that would formalise and enhance these collaborations, adding structure, peer learning, and shared accountability across sectors.
150 Words

13. What will you contribute to the National Neighbourhood Health Implementation Programme that other Places can learn from? Please provide details of the specific interventions that have delivered results. (max 200 words)

Oxfordshire will share experience of delivering integrated neighbourhood working and proactive care for the highest need patients, and build evidence for the impact on outcomes, especially the reduction in crisis care and targeting of groups and areas facing the greatest health inequalities.

System prioritisation of BCF, UEC and Health Inequalities funding has resulted in dedicated prevention and primary/community funding.

Oxfordshire is a Marmot County, which builds our approach to community development to tackle social determinants.

There have been significant improvements in reducing the number of delayed discharges and increasing care in people's home. This was achieved through partnership working between statutory, voluntary and independent health and care providers.

Oxfordshire has examples of shifting provision closer to communities; such as the Community Gynaecology service delivered in partnership between PML and OUH.

There are many local partnerships with academic, biotech and health policy institutions. The focus has not yet been on neighbourhood health but there is increasing interest from the unique network around Oxfordshire and the potential for collaboration and national impact is significant.

Experts and leaders from Oxfordshire are involved with many relevant national working groups and strategies, (e.g. NHSE GP at scale) creating opportunities for further influence and collaboration.
199 words

14. How will you share learning within your System? (max 200 words)

The BOB Neighbourhood Health programme is coordinated across system and delivered at place, bringing together the strengths and value of Place and Neighbourhood-led work and maximising impact with enablers that a wider system can offer. A system wide Community of Practice (CoP) for Neighbourhood Health development will be put in place to support Place-led delivery. The CoP will provide a platform for places to update wider stakeholders on progress, share learning and address challenges collaboratively, membership of the CoP will be broad and inclusive. Best practice will be shared at the BOB Neighbourhood Health Collaborative Leadership Group, a collaboration of ICS Partners, Senior Leads and SROs. Additionally, an online platform will be utilised to share information, documentation and case studies with system partners.

Throughout Oxfordshire there will be shared learning opportunities, including the development of a fast follower approach to support developments elsewhere in the county.

There are many sharing / learning opportunities throughout BOB, including:

- BOB VCSE Health Alliance.
- The configuration of secondary care NHS providers across place / county borders.
- A “BBO” Local Medical Committee.
- GP Leadership Groups from each county come together on a regular basis, Oxfordshire GPLG includes leaders who are champions of Neighbourhood working.

199 words

15. How will you reach, engage and improve outcomes for the 20% most deprived population as identified by the Index of Multiple Deprivation (IMD)? (max 200 words)

Oxfordshire is very diverse; there is a 15-year gap in life expectancy between men residing in some areas of the county, and those in the least deprived. It has some of the most vulnerable and deprived neighbourhoods, 10 wards in Oxfordshire are in the most deprived 20% in England, despite Oxfordshire containing wealthier areas and high value sectors.

We will:

1. Highlight and dedicate resources to priority areas and populations. Community Profiles help better understand strengths and needs of communities through an asset-based community development (ABCD) model.
2. Community Health Development Officers (CHDOs) and Local Area Coordinators in priority areas foster community engagement, support local health initiatives and implement action plans and recommendations from the Community Insight Profiles.
3. The Well Together Programme is a £1million grants programme funding community-led initiatives to address health inequalities. Funding is available for grassroots organisations and projects in the 10 priority areas.
4. Oxfordshire Health and Homelessness Inclusion Service funded by BCF supports a multi-disciplinary team including social workers, housing officers and psychologists to help people experiencing, or at risk of, homelessness. It supports people moving from hospital into accommodation.

2 and 3 are being evaluated by University of Oxford, with promising preliminary findings.
200 words

16. Please tell us about any other enablers you have implemented or are progressing to support sustaining or scaling neighbourhood working. For example, shared digital patient record, pooling of resources or estates, supporting GPs to work at scale and the development of neighbourhood and multi-neighbourhood providers, left shift of funding, training and development, Neighbourhood Health approaches with other specific population cohorts. We would be grateful if you could provide specific information on any local assets you have already that could support meeting the commitment to have a Neighbourhood Health Centre in every community, as set out in the 10 Year Health Plan. (max 300 words)

There are a range of enablers in-place or under development that will support and scale neighbourhood working:

- **Community Health and Wellbeing Workers (CHWW)** focussing on all ages and targeting high priority streets in some of the greatest areas of deprivation.
- There are examples of emerging **primary care at scale models** that can support neighbourhood development in an inclusive way, supported by the GP practices.
- Through **Connected Care**, shared care records are enhancing, alongside the development of functionality and culture for population health management. Oxford City is one of very few places in England whereby Primary and Community Care all use the same EPR.
- Track record and several years' real-world experience of **designing and delivering INTs**.
- **Oxfordshire PBP** is developing good relationships that is routinely measured using a maturity matrix. There are ambitions to become a formal accountable board for planning and funding neighbourhood working.
- Longstanding **S.75 Agreement** and **pooled budget** provide a platform to further increase delegation and accept responsibility for budgets aligned with BCF to further leverage our collective resources and sharing risks.
- The **joint commissioning team** and executive is a collaboration that includes providers, acting as a commissioner and transformation team for Place.
- Systemwide **inclusive, transparent planning** with partners to agree and align funding priorities and increase funding in prevention and primary and community care.
- Experience delivering largescale services in partnership with VCSFE such as the mental health **outcomes-based contract**.
- Through CHDO, Well Together and other programmes, strong **connections with communities** have been built, especially in deprived areas.
- Develop more ways to **involve communities in a culturally appropriate** way, such as Neighbourhood Voices where senior leaders will be paired with community members from the most deprived neighbourhoods, promoting shared learning, cultural humility, and inclusive leadership.

287 words

17. Please list any other national pilots or initiatives you are involved in. (max 150 words)

- BOB ICB is part of a CVD Champions pilot to increase case find people with risk factors for CVD on an opportunistic basis.
- Oxfordshire works in partnership with Thames Valley Cancer Alliance to deliver the priorities outlined in the national cancer programme plan which includes initiatives linked to prevention and screening, optimising the cancer pathway, building on community diagnostic centres, deployment of the Lung Cancer Screening Programme and piloting pancreatic cancer case findings.
- Oxfordshire is 1 of approximately 50 Marmot Places in Great Britain.
- Oxfordshire is the only place in the country outside of London with two Biomedical Research Centres (BRCs); 1) Oxford BRC, 2) Oxford Health BRC.
- CYP with type 1 diabetes.

113 words

18. Please identify any particular aspects of Neighbourhood Health (in addition to the initial shared priority of adults with LTCs and risking risk) that you are particularly interested in developing or contributing to (either specific population cohorts, or enabling agendas such as financial flows, digital, workforce, estates, supporting GPs to work at scale and the development of neighbourhood and multi-neighbourhood providers). (max 150 words)

Oxfordshire would seek to:

- Develop the most effective approach to address gaps in health needs in neighbourhoods, identified through the Oxfordshire voice programme.
- Expand the effective working of INT MDTs into further developing neighbourhoods, especially closer working with social care and housing.
- Further establish and utilise an evidence base for achieving better outcomes through proactive, anticipatory community-based care.
- Support the development of children and young people with family hubs, exploring learning to effectively focus on holistic prevention and early interventions to improve school attendance, reduce childhood obesity and improve mental health and wellbeing.
- Further progress primary care working at scale, building on OCPC and PML who currently deliver at scale services (e.g. visiting services, UTC).
- Explore financial flow mechanisms that are fair and transparent, truly enabling the “three shifts”.
- Build on examples that shift care out of hospital, into community settings, such as the Community Gynaecology service.

150 words

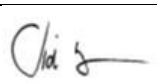
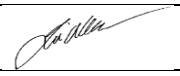
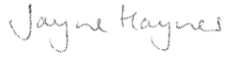
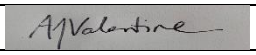
Declaration

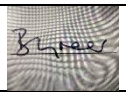
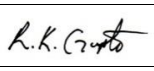
This is to be completed by all CEOs (or equivalent) and PCN clinical directors in each constituent organisation in your Place.

We collectively agree to:

- endorse this application to join the National Neighbourhood Health Implementation Programme
- support the Place team to deliver the objectives of the programme
- contribute to nationwide learning, sharing and capability building for Neighbourhood Health

We commit to the continued implementation of Neighbourhood Health, including assisting other Places in subsequent phases of the work.

Constituent Organisation	BOB ICB
Name and Role	Dr Nick Broughton
Signature	
Date	08/08/2025
Constituent Organisation	Oxfordshire County Council
Name and Role	Martin Reeves, CEO
Signature	
Date	07/08/2025
Constituent Organisation	Oxford University Hospitals NHS FT
Name and Role	Simon Crowther, CEO
Signature	
Date	07/08/2025
Constituent Organisation	Oxford Health NHS FT
Name and Role	Emma Leaver, Interim COO - Community, Dentistry & Primary Care
Signature	
Date	07/08/2025
Constituent Organisation	Community First Oxfordshire (VCFSE infrastructure organisation)
Name and Role	Emily Lewis-Edwards, Co-CEO
Signature	E Lewis-Edwards (verified electronically)
Date	07/08/2025
Constituent Organisation	PCN - OX3+
Name and Role	Dr Joe McManners, Co-Clinical Director
Signature	
Date	07/08/2025
Constituent Organisation	PCN - Healthier Oxford Network
Name and Role	Dr Jayne Haynes, PCN Clinical Director
Signature	
Date	07/08/2025
Constituent Organisation	PCN – Oxford Central
Name and Role	Dr Andrew Valentine, PCN Clinical Director
Signature	

Date	07/08/2025
Constituent Organisation	PCN - Spires
Name and Role	Dr Alison Maycock, PCN Co-Clinical Director
Signature	Alison Maycock (verified electronically)
Date	07/08/2025
Constituent Organisation	PCN - SeOxHa
Name and Role	Dr Bridget Greer, PCN Co-Clinical Director
Signature	
Date	07/08/2025
Constituent Organisation	PCN - East Oxford
Name and Role	Dr Rohit Kotnis and Dr Samantha Line, PCN Co-Clinical Directors
Signature	
Date	07/08/2025
Constituent Organisation	PCN – Bicester
Name and Role	Dr Jonathan Holt, PCN Clinical Director
Signature	
Date	07/08/2025
Constituent Organisation	PCN – Banbury Cross
Name and Role	Dr Rajesh K Gupta, PCN Clinical Director
Signature	
Date	07/08/2025

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

Oxfordshire System Pressures

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

Report to:

- Dan Leveson- Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) Director of Places and Communities.
- Lily OConnor- Oxfordshire Urgent Emergency Care Director.
- Karen Fuller- Director of Adult Social Care, Oxfordshire County Council.

(on behalf of Oxfordshire System Partners)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report providing an update on the pressures being experienced by the Oxfordshire Health and Care system during its public meeting on 05 June 2025.

2. The Committee would like to thank Dan Leveson (BOB ICB Director of Places and Communities); Lily OConnor (Oxfordshire Urgent Emergency Care Director); Anne Carlile (Head of Urgent Emergency Care Programme, BOB ICB); Jenna Gilkes (Urgent Emergency Care Programme Manager, BOB ICB); Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); Victoria Baran (Deputy Director of Adult Social Care, Oxfordshire County Council); Sally Steele (Head of Hospitals); Felicity Taylor-Drewe (Chief Operating Officer, Oxford University Hospitals NHS Foundation Trust [OUH]); Louise Johnson (Deputy Director Urgent Emergency Care, OUH); Emma Leaver (Chief Operating Officer, Oxford Health NHS Foundation Trust [OH]); Sue Butt (Transformation Director, OH); Kirsten Willis-Drewett (South Central Ambulance Service [SCAS]); for attending the meeting on 05 June and for answering questions from the Committee in relation to the pressures experienced by the Oxfordshire system.

3. The Committee had received reports of some of the challenges and pressures experienced by Oxfordshire's health and care partners; particularly in the wake of rising demand for health services and an ageing population. The Committee routinely urges Oxfordshire's system partners to work closely toward identifying key areas of pressures early on, and to work collaboratively to address these. The Committee was also keen to receive insights into the initial plans and measures adopted by system partners in light of increased demand as well as likely shortages of resources and funding.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the Council and its partners to not only deliver services promptly and efficiently, but to also invest time and resource into averting significant

pressures on the provision of health and care services for Oxfordshire's population. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

- The key service areas that have been impacted by increased pressures.
- What were the underlying causes of the pressures experienced by system partners.
- Whether the NHS reforms (which include plans to cut ICB costs by fifty percent) would add further pressures to the system's planning, coordination, and delivery of Urgent and Emergency Care Services?
- Details of any specific outcome measures being utilised to determine the efficacy of Urgent and Emergency Care Services.
- Details of the work of Neighbourhood Multidisciplinary Teams in the Community.
- Attendance patterns and wait times in Emergency Departments.
- How discharged patients will receive appropriate support in the context of rising pressures.

SUMMARY

5. During the 05 June 2025 meeting, 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.

6. 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.

7. 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.

8. Concerns were raised and discussed 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.

9. 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.

10. 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.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

11. This section highlights five key observations and points that the Committee has in relation to pressures experienced by the Oxfordshire health and care system. These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Transparency and public engagement: In the healthcare landscape, Urgent and Emergency Care Services play a vital role in safeguarding the health and wellbeing of the public. Providing prompt and efficient medical attention during emergencies can mean the difference between life and death. However, a key aspect often overlooked is the engagement and reassurance provided to the public regarding these services. Effective communication about the outcomes and broader system working is essential to foster trust and ensure that individuals receive the urgent care they need.

The Committee is aware of the numerous pressures being faced by Oxfordshire system partners, and agrees with the Director of Adult Social Care's emphasis of the importance of early discussions of these pressures. To that effect, there should be transparent and open discussion not only amongst system partner organisations themselves

to determine how to navigate through these pressures, but also amongst key stakeholders and the wider public within Oxfordshire. This involves the importance of sharing specific outcome and performance measures with the wider public in as transparent a manner as possible. Whilst system partners may have been undertaking public engagements around some of the important system work around discharging, it is crucial that engagements also revolve around the topic of key pressures faced by the County Council and its NHS partners. For instance, in late 2024 to early 2025, health and care partners in Surrey, including the County Council and the ICB and lead NHS providers, launched public engagement efforts and events with the public so as to communicate some of the pressures in the system and to reassure the public of ensuing plans[1].

Public engagement is crucial in the realm of Oxfordshire's Urgent and Emergency Care Services for several reasons. Firstly, it can build trust between the healthcare commissioners/providers and the community. When the public is informed about the quality and outcomes of care, they are more likely to have confidence in the services provided. Secondly, engagement could help in alleviating anxiety and uncertainties that individuals may have when faced with emergencies. Providing clear and transparent information reassures the public that they are in capable hands.

To enhance public engagement, assurance, and trust, it is important for Oxfordshire's system partners to communicate specific outcome measures related to Urgent and Emergency Care Services. These measures can include:

- *Successful Outcomes:* Highlighting instances where patients received timely and effective care can demonstrate the efficiency of the services. Success stories and case studies can be shared to illustrate the positive impact of urgent care.

- *Unsuccessful Outcomes:* While it may seem counterintuitive, sharing information about unsuccessful outcomes is also important. Transparency about challenges and areas for improvement shows that the system is committed to learning and evolving. It is essential to handle this communication sensitively to maintain public trust.

- *Whole System Working:* Explaining how different components of the health and care system work together ensures a cohesive approach to urgent care. This includes the coordination between emergency departments, ambulance services, and other healthcare providers. By showcasing the interconnectedness of the system, the public gains a comprehensive understanding of how their care is managed.

[1] March 2025 highlight report | Healthy Surrey

A key case in point is from the Cheshire and Merseyside region; where local system partners, including the NHS and local authorities, launched a public engagement campaign to communicate some of the system's key outcome measures to the population, as well as how system partners planned to work collaboratively[2].

To increase public engagement, the Committee recommends that Oxfordshire system partners employ various communication strategies including through the use of:

- *Regular Updates:* Providing regular updates about the performance and outcomes of Urgent and Emergency Care Services keeps the public informed. These updates can be disseminated through newsletters, social media, and community meetings.

- *Visual Aids:* Using visual aids such as infographics and videos can make complex information more accessible. These tools can be used to explain statistics, processes, and success stories in a visually engaging manner.

- *Public Forums:* Organizing public forums and Q&A sessions allows for direct interaction between healthcare providers and the community. These events provide a platform for addressing concerns, answering questions, and gathering feedback from the public.

- *Collaboration with Local Media:* Collaborating with local media outlets ensures that information reaches a wider audience. Press releases, interviews, and features in local newspapers and radio stations can help spread important messages about Urgent and Emergency Care Services.

A good example where all these aforementioned public engagement strategies played out was in Sussex, where local NHS bodies and local authorities worked closely with both local Healthwatch's and Voluntary Sector organisations to drive transparency around Urgent and Emergency Care strategies and outcomes[3].

Increasing engagement with the public is essential in providing reassurance about the quality and outcomes of Urgent and Emergency Care Services. Transparency, regular communication, and the use of effective strategies can build trust and ensure that individuals receive the care they need with confidence. By fostering a strong relationship between healthcare providers and the community, we can create a more informed and reassured public, ultimately leading to better health outcomes for all.

[2] draft-nhs-cm-public-engagement-framework.pdf
[3] Working-with-people-and-communities-report-2024-IAG-draft.pdf

Recommendation 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.*

Mental health crises can present a significant challenge to healthcare systems. To ensure effective and compassionate care, it is imperative to focus on comprehensive planning, robust support mechanisms, and adequate resourcing. Inpatient mental health settings, while essential in certain cases, can be inappropriate and costly, often exacerbating the distress of patients. A 2016 study in the Journal of *World Psychiatry* found that many individuals experiencing a mental health crisis may benefit more from interventions within their community, where they can remain connected to their support networks[4].

The Committee is aware of the 24/7 crisis response provided by Oxford Health NHS Foundation Trust, and how this can and has been reducing waiting times using successful interventions through integrated neighbourhood teams (particularly in Blackbird Leys and Abingdon). Collaboration with schools and voluntary groups can also help in offering comprehensive support for both adults and children's mental health.

Indeed, there are some key challenges with regard to providing support via inpatient settings including:

- *Cost:* Inpatient care can often be expensive, both for the healthcare system as well as for patients and their families. This is particularly the case for families who may have to travel long distances or find suitable accommodation to be close to their loved ones who remain in hospital.

- *Appropriateness:* Not all patients experiencing a mental health crisis require hospitalisation. Many of these patients often need immediate, localised support within their community. One study published in the *Journal of Mental Health* found that patients often preferred being treated in community settings, and that they felt that they could develop a better rapport with local healthcare and support workers in their local communities[5].

- *Isolation:* Hospital settings can isolate patients from their communities, which can potentially hinder their recovery. This is particularly the case if they are hospitalised in locations far from their homes/residential area.

[4] Community mental health care worldwide: current status and further developments - Thornicroft - 2016 - World Psychiatry - Wiley Online Library
[5] Professionals' performance in community mental health settings: A conceptual exploration: Journal of Mental Health: Vol 9, No 1

Therefore, there are sone key benefits to care being provided and received in the Community for mental health patients. Local crisis responses are more accessible and can provide immediate intervention. In addition, there is a point about patients receiving continuity of care, where they can maintain contact with familiar healthcare providers and support networks at the local level; this would also allow for care that is as personalised as possible.

For a successful transition to community-based mental health crisis interventions, there are five steps that could be adopted. Firstly, Integrated Care Models should be developed and implemented. Integrated care models that combine physical, mental, and social health services would help to ensure a holistic response to mental health crises. The Committee believes that there is potential for this to mature through Integrated Neighbourhood Teams. Secondly, there should be comprehensive training and support for health and care providers on crisis intervention techniques and community-based care. This training should include recognising crisis signs, de-escalation techniques, and appropriate referral processes. A good example of this is in Surrey, where most health and care providers received professional training on how to handle a mental health crisis and on how to patients can access long term mental health support[6]. Thirdly, it is vital to strengthen community resources by invest in community mechanisms such as crisis intervention teams, mobile crisis units, and mental health hotlines. These resources can provide immediate support and reduce the need for inpatient care. The Committee understands that this is somewhat being adopted by system partners, although more could be undertaken around determining whether resource levels are adequate or not. Fourthly, fostering partnerships between healthcare providers, community organisations, and local authorities to create a cohesive support network for individuals experiencing a mental health crisis is also crucial. In the Cambridgeshire and Peterborough region, a mental health partnership between the local authorities and the local ICB and NHS providers had been erected for children's mental health, and this enabled extensive collaborative work to tale place with the development of multidisciplinary support teams at the community level[7]. Finally, it is pivotal that a system is implemented for continuous evaluation of crisis intervention strategies to identify areas for improvement and ensure that community-based responses are effective and responsive to patient needs.

Therefore, transitioning to a system focused on community-based mental health crisis interventions requires concerted efforts in planning, support, and resourcing. The Committee understands that Oxfordshire's system partners are working toward this. By reducing reliance on costly and often inappropriate inpatient settings, the local healthcare system can provide more effective, compassionate, and personalised care for individuals experiencing a mental health crisis. This strategic approach would not

[6] Mental Health Practitioner (MHP) : Surrey Training Hub
[7] Cambridgeshire and Peterborough Mental Health Support Team

only benefit patients, but would also enhances the efficiency and sustainability of mental health services in Oxfordshire.

Recommendation 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.*

Importance of coproduction: The continual development of Urgent Emergency Care Services is a crucial aspect of our healthcare system. Part of ensuring the success of these services, it is essential to engage in coproduction continuously. Coproduction would be an important collaborative process where Oxfordshire's health and care providers on the one hand, and service users on the other, can work together to design, develop, and deliver services. This approach would help to ensure that Oxfordshire's Urgent Emergency Care services are tailored to meet the needs of the community and that the users' voices are heard and valued.

The Committee is aware that system partners have already embarked on public engagements to raise awareness of Urgent Emergency Care services and the relevant support available for residents. Nonetheless, more specifically, it is vital that Urgent Emergency Care services are as coproduced as possible. With the system's development of the new Integrated Improvement Programme, there is an opportunity to engage in coproduction with key stakeholders and the wider public as part of the design and launch of this programme.

Engaging in continuous coproduction of Urgent Emergency Care Services is vital for the following reasons:

- *Enhancing Service Quality:* Continuous engagement would allow for regular feedback from service users, which helps in identifying areas of improvement and ensuring that Urgent Emergency Care services provided are of the highest quality.

- *Building Trust and Relationships:* Regular engagement would fosters trust between service providers and users. It could help build strong relationships between system partners and the public, making it easier to implement changes and improvements.

- *Ensuring Relevance:* Healthcare needs and challenges are dynamic. Continuous engagement could ensure that Urgent Emergency Care services remain relevant and adaptable to the changing needs of local communities in Oxfordshire.

Indeed, the NHS England Urgent and Emergency Care (UEC) plan for 2025/26, published on 6 June 2025, emphasised the importance of coproduction and a community-centric approach. This should be used as

impetus to help shape an agenda and culture of continuous coproduction of Oxfordshire's Urgent Emergency Care Services[8].

In the specific context of the Integrated Improvement Programme, coproduction could play a role in:

- *Identifying key areas for improvement:* Through coproduction, users and providers can identify critical areas within the Urgent Emergency Care Services that need enhancement. This collaborative effort ensures that the improvements are user-centred. For instance, in the Lancashire region, the local NHS Integrated Care Board worked closely the County Council and other system partners to develop a Urgent Emergency Care five-year strategy initiating in 2024. This strategy kickstarted a process of coproduction where the public and key stakeholders and community representatives were provided opportunities to have input into determining how such services could be improved[9].

- *Developing Solutions:* Coproduction allows for the brainstorming and development of innovative solutions to address the identified issues. By involving users in the process, the solutions are more likely to be effective and well-received.

- *Implementing Changes:* With the users' input, the implementation of changes becomes smoother. Their involvement ensures that the changes are practical and beneficial.

- *Monitoring and Evaluation:* Continuous engagement allows for ongoing monitoring and evaluation of the implemented changes. This ensures that the improvements are sustainable and continue to meet the users' needs.

Continuous engagement in coproduction is essential for the successful development of Urgent Emergency Care Services. By integrating coproduction into the Integrated Improvement Programme, the system can ensure that the services are of high quality, relevant, and user-centred.

Recommendation 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.*

Determinations for discharging: Determining whether a patient is medically fit to be discharged from the hospital is a multifaceted process that requires careful consideration of various factors, including clinical assessments, patient preferences, and the involvement of carers. One critical component of this determination is the inclusion of specific

[8] The Urgent & Emergency Care Plan 2025/26: Evolution, Promise & Challenges NHS UEC Plan 2025/26: Critical Analysis & Key Changes

[9] LSC Integrated Care Board :: Urgent and emergency care five-year strategy 2024-2029

national frameworks, such as the National Early Warning Score (NEWS), which can provide valuable insights into the patient's condition and readiness for discharge.

The National Early Warning Score is designed to standardise the assessment of acute illness severity and detect deterioration in adult patients. It is composed of several clinical parameters including respiratory rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness, and temperature. According to a 2015 study in the Journal of *Resuscitation*, this is a cumulative score helps healthcare professionals identify patients at risk of deterioration, enabling timely and appropriate interventions[10].

When considering a patient's discharge, the NEWS framework provides valuable insights into their current health status. A low NEWS score suggests stability, whereas a high score indicates potential risks that need addressing before discharge. Integrating NEWS into fit-to-discharge assessments ensures that decisions are based on comprehensive and standardised criteria.

Effective communication with patients and their carers is essential for successful discharge planning. Patients and carers should be actively involved in discussions about the NEWS and what it means for the patient's current condition and post-discharge care. This collaborative approach would help to foster understanding and ensures that everyone (including patients and their families/carers) is aware of the health indicators being considered.

The Committee is aware that NEWS scores may be utilised in some way or another in Oxfordshire when considering when/how to discharge patients. Nonetheless, the crucial part is that NEWS scores considerations ought to be discussed and considered in a transparent manner with patients as well as their families/carers.

Each discharge plan should be personalised, taking into account the patient's NEWS, their specific needs, and the support available from their carers. Healthcare professionals should explain the significance of the NEWS score and how it impacts the decision to discharge. According to a study published in the *BMC Public Health Journal*, by involving patients and carers, the discharge process becomes more transparent and tailored to the patient's circumstances, improving the experience and satisfaction of patients and their families and carers[11]. The NEWS system is being utilised at both Guy's and St. Thomas' and King's College Hospital NHS Foundation Trusts as a new standardised system to help determine when or how patients should be discharged, and these determinations are being made alongside patients and their families. The

[10] Factors affecting response to National Early Warning Score (NEWS) - ScienceDirect
[11] Using the National Early Warning Score (NEWS/NEWS 2) in different Intensive Care Units (ICUs) to predict the discharge location of patients | BMC Public Health

Trusts have also been providing training to staff on how to utilise the NEWS system in a manner that improves patient outcomes as well as satisfaction[12].

Recommendation 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).*

Resourcing for the Neighbourhood Model: The Neighbourhood model and Multi-Disciplinary Teams (MDTs) are pivotal in creating a holistic, community-focused approach to healthcare and social support. To ensure the effectiveness of these models, it is crucial to evaluate whether there is sufficient investment and to provide evidence of sufficiency or insufficiency. A comprehensive system mapping exercise that includes Town and Parish Councils with local knowledge is recommended by the Committee to support this evaluation.

Investment in the Neighbourhood model and MDTs is essential for several reasons. Firstly, it can ensure that resources are adequately allocated to meet the diverse needs of communities. Secondly, sufficient investment can support the integration of various services, fostering collaboration among Oxfordshire's health and care providers, social workers, and other community stakeholders. This integration is vital for addressing the complex health and wellbeing issues comprehensively throughout the County.

The Committee is yet to receive specific evidence as to any mapping exercises being undertaken to determine the level of need as well as resourcing for the neighbourhood model in Oxfordshire. Whilst there is a profound commitment to this model by Oxfordshire's system partners, further clarity is required over the steps being taken to understand and secure necessary resource levels. To determine whether the current investment levels are sufficient, it is recommended to conduct a detailed analysis of funding allocations as well as outcomes. This includes examining the financial resources dedicated to MDTs, the availability of essential infrastructure, and the adequacy of staffing levels. Additionally, gathering data on community health outcomes can provide insights into the effectiveness of current resource levels.

The Committee understands that the neighbourhood model is one that is incrementally maturing, not only within Oxfordshire but nationally also. Therefore, there are very little exemplars to look toward. Nonetheless, a whole system mapping exercise can be crucially used for understanding the broader context within which the Neighbourhood model and MDTs can operate. This exercise should involve:

- *Town and Parish Councils*: Leveraging their local knowledge of community projects, initiatives, and stakeholder engagement.

[12] National Early Warning Score (NEWS)

- *Community Stakeholders:* Engaging with local organisations, community groups, and residents to gather insights on community needs and existing support structures.

- *Healthcare Providers:* Collaborating with primary care providers, hospitals, and specialised services to ensure a comprehensive understanding of the healthcare landscape.

This mapping exercise could be adopted as an initial step to help determine the levels of resourcing that are available or that may be required. The inclusion of Town and Parish Councils and local stakeholders in the mapping exercise is vital for supporting risk reduction and a whole population approach. These entities have valuable insights into community dynamics, potential risks, and opportunities for intervention. By involving them in the planning process, it is possible to develop more targeted and effective strategies for addressing health and social challenges.

Recommendation 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).*

Legal Implications

12. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  Power to scrutinise health bodies and authorities in the local area
  Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
  Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

13. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

14. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

15. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Imade Edosomwan
Councillor Judith Edwards
Councillor Gareth Epps
Councillor Emma Garnett
Councillor Paul-Austin Sargent
District Councillor Paul Barrow
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
City Councillor Louise Upton
Sylvia Buckingham

Annex 1 – Scrutiny Response Pro Forma

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July 2025

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

Oxfordshire as a Marmot Place

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

Report to:
- Ansaf Azhar– Director Public Health & Communities.
- Kate Holburn –Deputy Director of Public Health.

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report providing an update on the work around making Oxfordshire a Marmot Place during its public meeting on 05 June 2025.

2. The Committee would like to thank Ansaf Azhar (Director Public Health & Communities) and Kate Holburn (Deputy Director of Public Health); for attending the meeting on 05 June and for answering questions from the Committee in relation to Oxfordshire becoming a Marmot Place.

3. The Committee had received reports of some of the challenges experienced by residents (in both urban and rural areas) around health inequalities; particularly in the wake of and as a result of the covid-19 pandemic, as well as rising demand for health services and an ageing population. The Committee routinely urges Oxfordshire's system partners to work closely toward improving services and tackling such inequalities. The Committee was also keen to gain insights into the initial measures taken as part of the initiative around making Oxfordshire a Marmot Place.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the Council and its partners to not only deliver services promptly and efficiently, but to also invest time and resource in identifying where key health inequalities and challenges lie, and how to collaboratively address these. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

   - What were the specific goals and objectives for Oxfordshire becoming a Marmot Place?

   - How would these goals align with the broader health and prevention agendas being articulated both nationally and locally?

   - Who would be the key stakeholders involved in the planning and implementation of this initiative?

- Who would be leading on what as part of the Marmot Place initiative in Oxfordshire?

- How would system partners be assessing the social determinants of health locally?

- How would it be determined how far Oxfordshire has come in tackling health inequalities?

- Would the government's Local Government Reforms and Devolution plans impact the work around Oxfordshire becoming a Marmot Place?

- How would accountability and transparency remain at the heart of the Marmot Place initiative?

SUMMARY

5. During the 05 June 2025 meeting, 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.

6. The Committee asked why three out of eight Marmot principles had been selected. The Deputy Director of Public Health explained that 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.

7. It was discussed 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 input from the Committee, ensuring thorough involvement. The Marmot team offered independent expertise to enhance initiatives and identify areas for improvement.

8. 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.

9. In response to the Committee's enquiries regarding how the Marmot initiative will be evaluated in a transparent manner, it was outlined that the initiative aligned with existing health strategy indicators that will be 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.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

10. This section highlights three key observations and points that the Committee has in relation to Oxfordshire becoming a Marmot place. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Transparency and evaluation of the Marmot initiative: The endeavour to transform Oxfordshire into a Marmot Place is a critical initiative aimed at reducing health inequalities and improving the wellbeing of its residents. The Committee is highly supportive of the Marmot initiative and believes it could generate significant benefits for Oxfordshire's residents in the long run. Nonetheless, to ensure transparency and measure the progress and impacts of this initiative on the local level, it is essential to develop specific indicators that can evaluate the collective system-level efforts.

The Committee was keen to gain an understanding of the governance and accountability around the Marmot initiative. However, further clarity could be provided around the degree to which structures such as the Marmot Advisory Board (headed by Michael Marmot) would help to achieve effective governance, transparency, and accountability around the initial steps being taken as part of the Marmotisation. The Committee were also informed that a steering group including representatives from various organisations would be involved in the governance of this initiative; it is therefore crucial that this steering group includes representation from various local system partners, organisations, and stakeholders. According to a *Local Government Association* publication, Oxfordshire's unique mix of rural and urban areas presents distinct challenges[1]. This complex amalgam of rural and urban areas/communities necessitates clear frameworks for planning and evaluating any steps taken to address specific types of inequalities unique to specific types of localities around the County.

Indicators would serve as vital tools for monitoring and evaluating the effectiveness of policies and interventions. They could allow for measurable data that can inform decision-making, guide resource allocation, and demonstrate accountability. For Oxfordshire's transition to a Marmot Place, these indicators will be crucial in tracking improvements in the social determinants of health, health outcomes, and overall quality of life.

Whilst it is understandable that proxy indicators can be developed in the initial stages of Marmotisation in Oxfordshire, it is crucial that there

[1] Building Fairer Towns, Cities, and Regions: Insights from Marmot Places | Local Government Association

is a plan to develop more longer-term indicators that can be used to help instil a culture of transparency, accountability and governance. This could be achieved in the following ways:

- *Stakeholder involvement:* The development and implementation of these indicators should involve a wide range of stakeholders, including Oxfordshire County Council, Oxfordshire's two NHS healthcare providers, educational institutions (including Oxfordshire's universities), community organizations, and residents. Their input will ensure that the indicators are relevant, comprehensive, and reflective of community needs. A key case in point is Manchester City Council, which is amongst the early local authorities to adopt the Marmot initiative, where significant engagements with key local stakeholders were used to determine what the key priorities for the City should be around Marmotisation[2]. The Committee has championed the recognition of rural inequalities through its recommendations since 2021, and is pleased to see that rural as well as urban inequalities are at the centre of the initiative. The Committee's work has included facilitating co-production between whole system partners and a local population through partnership with Wantage Town Council; including indicators to tackle rural inequalities. The mapping of existing initiatives in rural areas would be an important piece of work that could be facilitated by Town and parish councils and County Councillors who are local members.

- *Data collection and analysis:* Robust data collection and analysis methods are essential for the accurate measurement of indicators. This includes regular data collection, the use of reliable data sources, and advanced analytical techniques to interpret the results. A good inspirational example of this is from the Cheshire and Merseyside region, where the region's nine local authorities worked alongside the local NHS Integrated Care Board and other local partners to gather data to determine what the priorities should be for local Marmotisation, and to be able to evaluate these moving forward[3].

- *Regular reporting and transparency:* To maintain transparency, it is important to regularly report on the progress towards achieving the indicators. This can be done through public reports, community meetings, and digital platforms that provide accessible and understandable information to all stakeholders. To use the Cheshire and Merseyside example again, each of the region's local authorities would regularly produce reports to their respective Full Council meetings on progress achieved around the local Marmot indicators and targets[4].

[2] Making Manchester Fairer | Making Manchester Fairer | Manchester City Council
[3] Building back fairer: Cheshire and Merseyside's Marmot Community launch event | Champs Public Health Collaborative
[4] Appendix Two All Together Fairer Final Recommendations 010422.pdf

The Committee understands that data and community engagement will be utilised to address local inequalities in Oxfordshire, with an initial focus on children's welfare, fair employment, and healthy living standards. Therefore, efforts should be made to ideally create indicators for each of these three areas of priority work. For children's welfare, indicators could revolve around children's mental health, school readiness, educational attainment, and school attendance, but also children and parent involvement with the Marmot project. For fair employment, indicators could include close examination of the percentage of Oxfordshire's population that is employed, groups that are underrepresented in employment e.g. disabilities, as well as household income levels.

The Committee notes that tackling rural inequality is less developed within Marmot. Developing indicators at the neighbourhood level with Towns and parishes; their population and local community organisations is key. Understanding the indicators that may already be in use will be important. Exemplars may include isolation; length of public transport and car journeys to vital services, facilities, and opportunities.

Furthermore, the Committee is aware that another key mechanism through which to evaluate the health inequalities work around Marmotisation is via the Health and Wellbeing Board and its strategy. Whilst the board provides a positive avenue through which to evaluate this work, it is crucial that there is not an exclusive reliance on the board and its strategy as being the key avenue through which to evaluate the Marmot initiative. Whilst there may be parallel themes between Marmot indicators and those of the health and wellbeing strategy, clear indicators should also be developed that are unique to the work around Marmotisation. Having said that, duplication in the work and evaluation around Marmotisation and the health and wellbeing strategy should be avoided inasmuch as possible.

In essence, developing specific indicators for evaluating Oxfordshire's transition to a Marmot Place is a critical step in ensuring the initiative's success. These indicators will provide valuable insights into the impact of collective efforts on the part of Oxfordshire's system partners, helping to guide future actions and ensuring accountability. By focusing on key indicators that may be unique to Marmotisation or that may run parallel to the work around the health and wellbeing strategy (including around children's welfare, fair employment, and healthy living standards), Oxfordshire can effectively measure and achieve its goals of reducing health inequalities and improving the quality of life for all residents.

Recommendation 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 timely development of specific indicators for the purposes of evaluating collective system-level efforts to achieve this, and that these must include rural inequalities.*

Funding and resource: The Marmot Place initiative aims to address health inequalities and improve the overall wellbeing of communities by adopting the recommendations of the Marmot Review. Oxfordshire has embarked on this ambitious journey, recognising the importance of equitable health and social outcomes. To ensure the successful implementation and sustainability of this initiative, exploring various funding avenues is crucial.

The first and most immediate steps that relevant system partners should take is to determine (based on the three priority areas of work on Marmotisation mentioned above) whether existing funding and workforce is sufficient for the purpose of advancing this work. Without undertaking this exercise, system partners risk pursuing Marmotisation in the absence of knowing where and how resource should be allocated. One source of funding that could be available is through any potential current or future government grants and funding programmes. The government's Ten Year Plan aims to focus on health prevention. This therefore presents an opportunity for Oxfordshire's Marmot initiative to be presented to government as a genuine commitment by the County to pursue this national ambition.

Additionally, the Committee understands that £141,575 of funding has been allocated from Oxfordshire County Council's Public Health Wider Determinants budget as payments to University College London's Institute of Health Equity to help support the Marmot work. However, further funding from this budget or elsewhere should ideally be allocated to fund other additional research projects (potentially with local Oxfordshire universities) that could help contribute to understanding where inequalities lie and how to develop strategies and policies to tackle these. Engagement with policymakers and presenting the long-term benefits of the Marmot Place initiative can also help secure substantial financial support.

Moreover, it is also important to consider approaching philanthropic foundations and trusts that are dedicated to funding health and social equity projects. Such organisations often look for initiatives that promise measurable impact and sustainability. Identifying and approaching foundations that align with the goals of the Marmot Place initiative is a critical step. In addition, several large corporations allocate a portion of their profits to Corporate Social Responsibility (CSR) programmes, which are funding initiatives that benefit public health and community well-being. Engaging with corporations operating in or around Oxfordshire and proposing partnerships could also lead to significant financial support. Approaching local businesses and larger corporations with a clear value proposition and opportunities for positive publicity can foster mutually beneficial relationships. Highlighting how supporting the Marmot Place initiative aligns with their CSR objectives can encourage their investment.

Meaningful co-production at a neighbourhood level including local members, Town and parish Councils, and community organisation stakeholders can not only build the evidence for funding from external sources, but co-production can generate identification of funding sources and additional value. An example would be the Wantage hospital to community project for children and adults which is funded by Community Infrastructure Levy and by a legacy that was discovered through co-production. This was enabled by local members and the Wantage Town Council, and a committed network of local organisations and businesses that are supporting and adding value.

In essence, securing diverse funding streams is essential for the success and sustainability of Oxfordshire's Marmot Place initiative. By exploring government grants, philanthropic foundations, CSR programmes, and academic partnerships, the initiative can obtain the necessary financial support to drive impactful change for the County. A strategic and coordinated approach to funding will ensure that Oxfordshire can achieve its vision of becoming a Marmot Place, where health equity and community wellbeing are at the forefront of local development. The Committee appreciates that the Marmot initiative in its in early stages, and therefore urges that system partners work toward identifying and allocating adequate sources of funding and resource to support this work.

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

Supporting local initiatives for tackling rural inequalities: The issue of rural inequalities in Oxfordshire has become a pressing concern that requires a strategic and comprehensive approach. Recognising the unique challenges faced by rural communities, it is imperative to develop specific indicators that can accurately measure and address these inequalities. The Committee understands that Oxfordshire County Council and its partners are committed to tackling inequalities more broadly as part of the Marmot initiative. However, the Committee urges that as part of the early stages of the Marmot project, there is a clear framework for tackling inequalities that are unique to rural areas. Within this, it is important to identify the inequalities that are unique to the specific rural areas within the County (each of which could embody their own characteristics, population groups, and public health priorities).

The Committee has made previous recommendations around tackling rural health inequalities in its scrutiny of the Health and Wellbeing Strategy, and urges that there is a continued commitment to this by system partners as part of the Marmot work. Local members, Town and Parish councils are crucial stakeholders in the effort to tackle rural inequalities. These councils possess a wealth of local knowledge and experience that can provide valuable insights into the specific needs and challenges of their communities. It is recommended that these councils be invited to contribute to the development of specific indicators by sharing their observations, any data within their possession, and

suggestions. This collaborative approach will help to ensure that rural inequalities indicators are rooted in the realities of rural life and are tailored to address the most pressing issues affecting local communities in Oxfordshire. Tackling such inequalities in Oxfordshire would require greater specificities as opposed to the adoption of a "one size fits all" approach. Therefore, the Macro frameworks and objectives of the Marmot approach should be blended with local Place and community-based intelligence and dynamics. For instance, within the Cheshire and Merseyside region, there were extensive collaborations with local Parish Councils around the work to identify inequalities unique to local areas and communities; this helped with intelligence gathering as well as transparency[5].

Local Councillors as well as voluntary and community organisations can play an essential role in identifying and addressing rural inequalities in Oxfordshire. Their firsthand experiences and understanding of local dynamics make them invaluable contributors to the development of indicators for rural inequalities. By inviting local members and voluntary and community organisations to participate in discussions and provide input, we can ensure that indicators reflect the diverse perspectives and needs of the community. This inclusive approach fosters a sense of ownership and commitment among local representatives and stakeholders, enhancing the effectiveness of the measures implemented as part of the Marmot initiative.

In Oxfordshire, numerous projects and organisations are already working diligently to combat rural inequalities. These initiatives range from educational programmes to healthcare services provided by system partners, to efforts undertaken by voluntary and community organisations and support networks. It is recommended that these existing efforts are acknowledged and supported. By recognising the achievements and challenges faced by these initiatives, we can build on their successes and avoid duplication of efforts to tackle rural inequalities throughout the County.

According to a study in the *Critical Public Health Journal*, voluntary and local community organisations are often the frontline defenders against rural inequalities. Their proximity to the communities they serve allows them to respond swiftly and effectively to emerging issues[6]. It is therefore essential to provide these organisations with the necessary resources and support to continue their work. This can include financial assistance, training opportunities, and access to relevant data and research. Empowering these organisations can strengthen the collective effort to reduce inequalities and foster more resilient rural communities.

[5] Cheshire and Merseyside features as a case study in new LGA tackling health inequalities report | Champs Public Health Collaborative

[6] Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland: Critical Public Health: Vol 20, No 1

Furthermore, the first step in developing specific indicators for rural inequalities is to identify the key areas where inequalities exist. According to research published in the *Journal of Rural Studies*, this can include access to healthcare, education, employment opportunities, housing, transportation, and social services[7]. By pinpointing these areas, we can create targeted measures that address the root causes of disparities. Once these key areas are identified, the next step is to develop measurable indicators that can track progress and outcomes. These indicators should be clear, concise, and based on reliable data. Examples of potential indicators include the percentage of rural residents with access to primary healthcare services, educational attainment of rural students, the unemployment rate in rural areas, and the availability of affordable housing. Effective indicators require robust data collection and analysis. It is recommended that Oxfordshire's system partners work collaboratively to gather data from various sources, including surveys, official records, and community feedback. This data should be analysed to identify trends, patterns, and areas of improvement. Regular reporting and review of the indicators will ensure that the measures remain relevant and effective.

It is noteworthy that as mentioned above, rural communities in Oxfordshire are diverse, with unique characteristics and needs. It is essential to adapt the indicators to reflect these local contexts. This can involve customising the measures to suit the specific demographics, geography, and economic conditions of each area. By tailoring the indicators, system partners can ensure that they are meaningful and impactful for the communities they are designed to serve.

Essentially, developing specific indicators for rural inequalities in Oxfordshire is a vital step towards creating a more equitable and inclusive society. By engaging local councils and members, recognising existing efforts, and supporting voluntary and community organisations, system partners can build a comprehensive framework to address these disparities. Through careful identification, measurement, and analysis, these indicators will provide the necessary tools to track progress around the Marmot initiative and drive positive change in rural communities.

Recommendation 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 with a view to any future working in their neighbourhood being done with the community. 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.*

[7] The assessment of rural development: Identification of an applicable set of indicators through a Delphi approach - ScienceDirect

Legal Implications

11. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

12. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

13. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

14. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Imade Edosomwan
Councillor Judith Edwards
Councillor Gareth Epps
Councillor Emma Garnett
Councillor Paul-Austin Sargent
District Councillor Paul Barrow
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
City Councillor Louise Upton
Sylvia Buckingham

Annex 1 – Scrutiny Response Pro Forma

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July 2025

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Oxfordshire Joint Health Overview and Scrutiny Committee

Date of meeting: 11 September 2025	**Paper no:**

Title of paper: General Practice access and estates in Oxfordshire

Paper is for:	**Discussion**	✓	**Agreement**		**Information**	✓

Purpose of paper:
The paper sets out the key aspects of access to General Practice services in Oxfordshire. It includes access data as well as reference to Oxfordshire practice workforce and estates.

It is an update to the report provided in April 2024

Recommendations

Members of HOSC are invited to note the contents of this update paper.

Authors:	Julie Dandridge. Associate Director of Primary Care Infrastructure Associate Director of Pharmacy, Optometry and Dentistry, NHS Buckinghamshire, Oxfordshire and Berkshire West ICB

Date of paper: 21 August 2025

General Practice access and estates in Oxfordshire

1. Introduction

This report is provided to the Joint Health Overview and Scrutiny Committee for information and discussion. The paper sets out the key aspects of delivery in the provision of primary care services in Oxfordshire, specifically general practice services. It provides an update to the paper presented in May 2022 and April 2024.

2. Context

As of 1 August 2025, Oxfordshire has 64 General Practices providing general medical services to between 3,300 and 42,000 individuals. The reduction in the number of practices follows two separate practice mergers in Oxford City – 27@Northgate and 28@Northgate: St Bartholomew's Medical Centre and Hollow Way Medical Practice in April 2024. In both cases there was no change to the provision or location of services. Merging of two practices can often strengthen the resilience of smaller practices and allow more services to be provided. Following consultation Hedena Health closed their branch surgery at the Marston Pharmacy site. Patients will continue to access services via their main site or the Barton Surgery branch site.

3. Modern General Practice

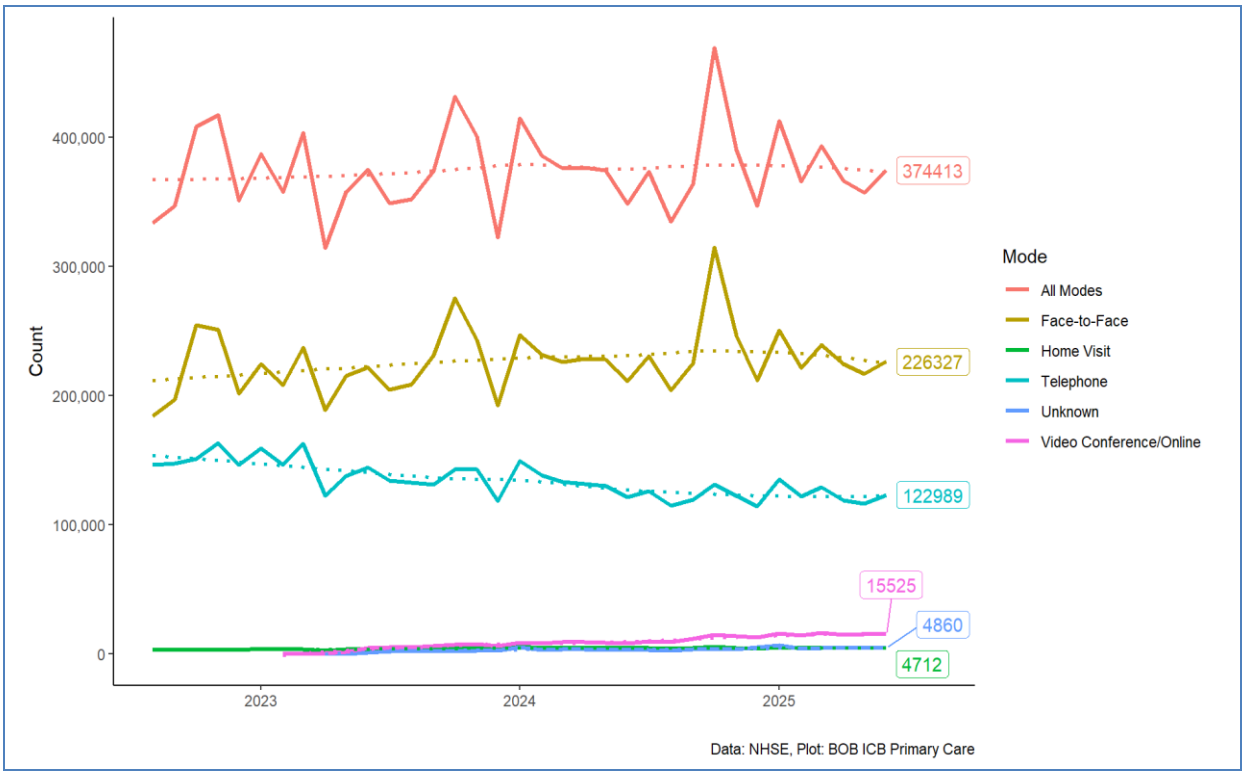
Modern General Practice was a concept introduced in 2024 to be the foundation of transformation within primary care to better align capacity with need, improve patient experience and improve the working environment for general practice staff: The fundamental components are:

- *Optimising contact channels*; offering patient choice of access channel (telephone, online and in person) via highly usable and accessible practice websites, online consultation tools and improved telephone systems.
- *Structured information gathering* at the point of patient contact (regardless of how the contact is made) to understand what is being asked of the service.
- *Using care navigation* and workflow process across all access channels to assess and prioritise need safely and fairly, and to efficiently get patients to the right healthcare professional or service, in the appropriate timeframe (including consideration of continuity of care) moving away from a 'first come first served' approach.
- *Better allocating existing capacity to need,* making full use of a multi-professional primary care team, community services and 'self access' options where appropriate and helping GPs and practice staff to optimise use of their time where it's needed most.
- *Building capability* in general practice teams to work together and to access, understand and use data, digital tools and shared knowledge to lead, plan, implement, improve and sustain change.

The ICB is working with practices to support the implementation of Modern General Practice. Funding and incentives are included as part of a system wide delivery plan, which also includes expansion of community pharmacy services, digital solutions and improvements across the primary and secondary care interface.

4. GP Appointments

Appointment numbers in General Practice are collected and reported nationally each month[1]. The graph below sets out the appointments which have remained steady since 2023 although there have been seasonal variations.

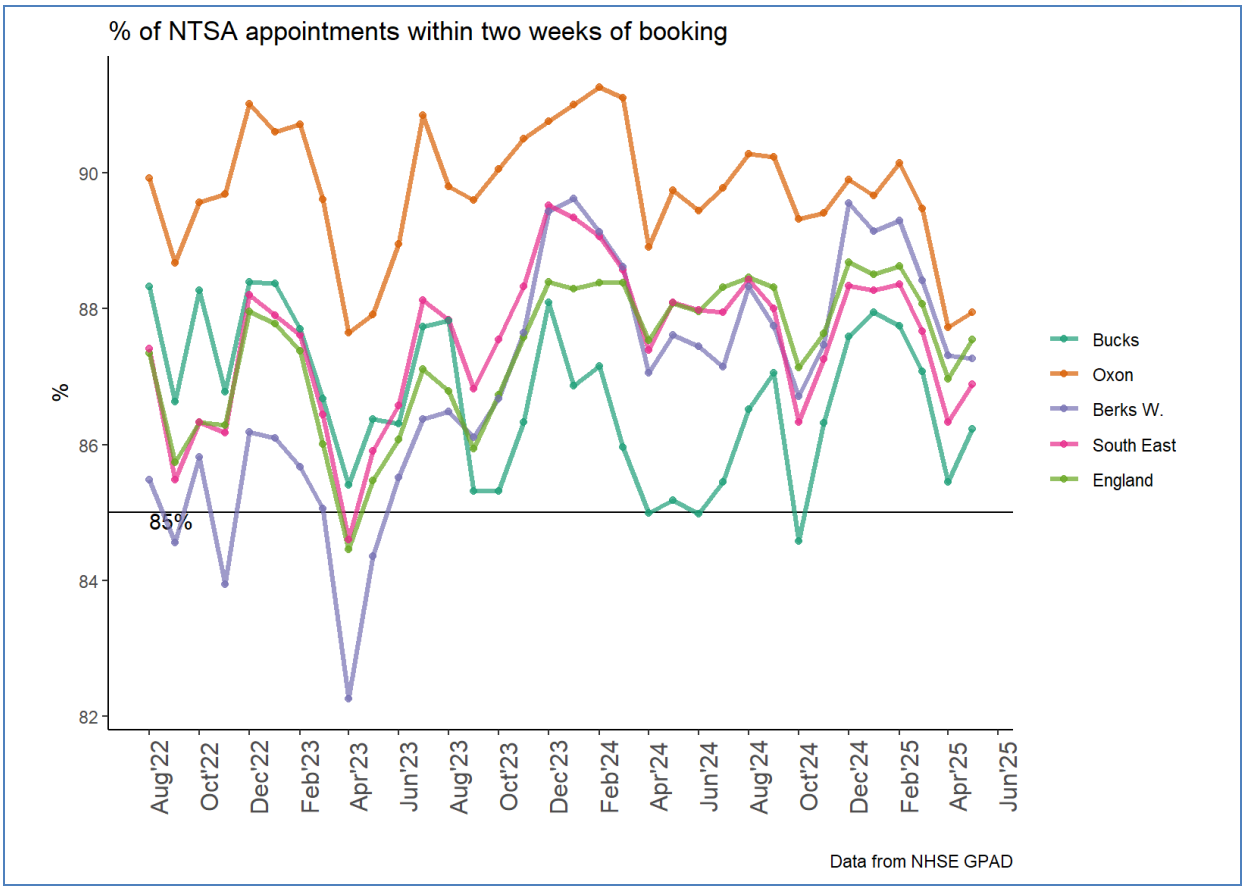


Graph 1 General Practice appointments by mode

In Oxfordshire appointment levels have been sustained at pre pandemic numbers since September 2020 with the number of appointments being delivered remaining steady. The appointment patterns follow the seasonal trends seen in previous years and the majority of appointments are delivered face to face. Of the 374,000 appointments offered in June 2025, 48.6% were offered by a GP.

A recent focus has been to ensure that those patients that need an appointment with their GP practice gets an appointment within 2 weeks where appropriate and that those who contact their practice urgently are assessed the same day or next day according to clinical need. 88% of Oxfordshire patients are seen within 2 weeks of contacting their practice which compares favourably with the national position of 86% and 55.5% of patients have a same day appointment (compared to 54.3% for England)

[1] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice



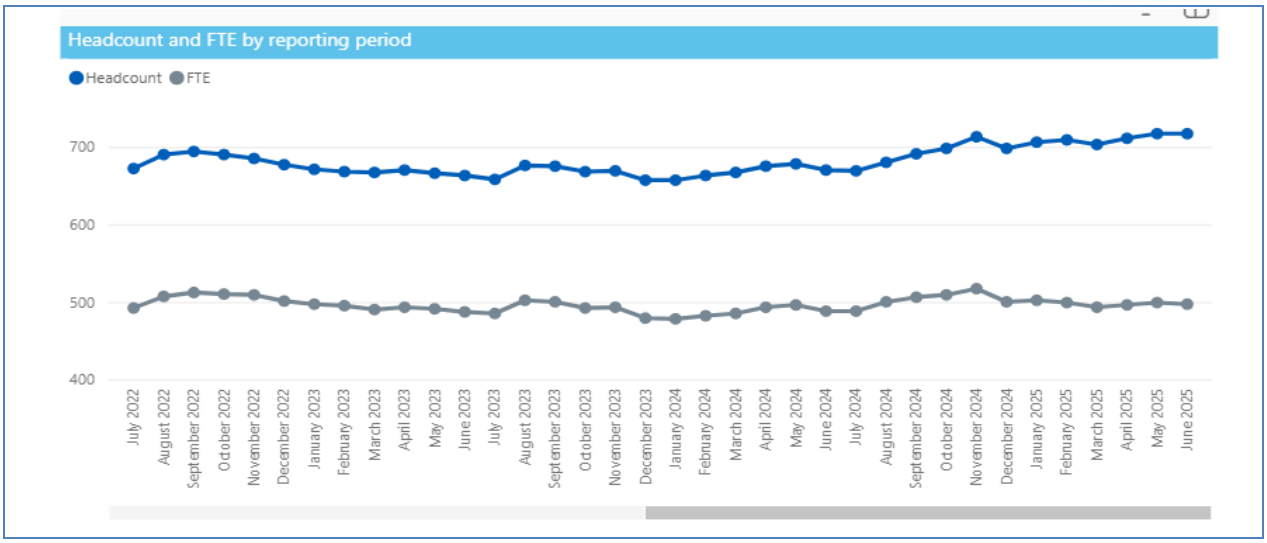
Graph 2 General Practice appointments not typically scheduled in advance (NTSA) scheduled within 2 weeks of booking

5. General Practice workforce

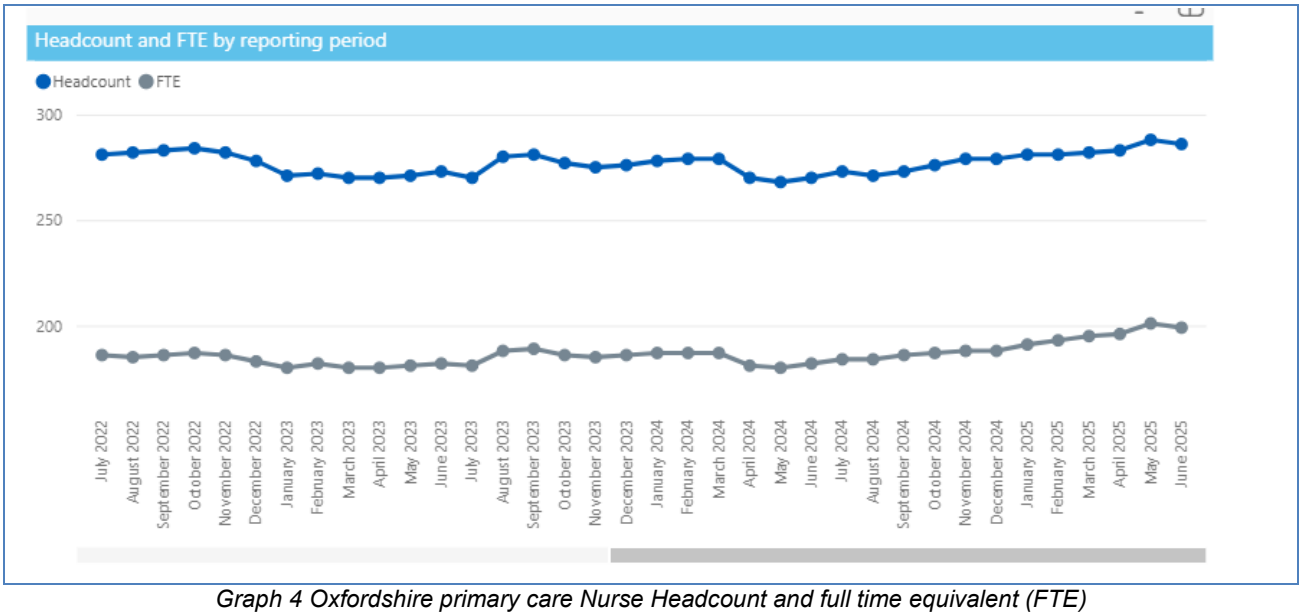
5.1. GPs

Practices are individual businesses and as such can decide on the number and type of staff that they employ. Data shows that Oxfordshire has slightly more GPs per 10,000 patients than the national average but slightly less nurses. The number of GPs have been slowly increasing over time[2].

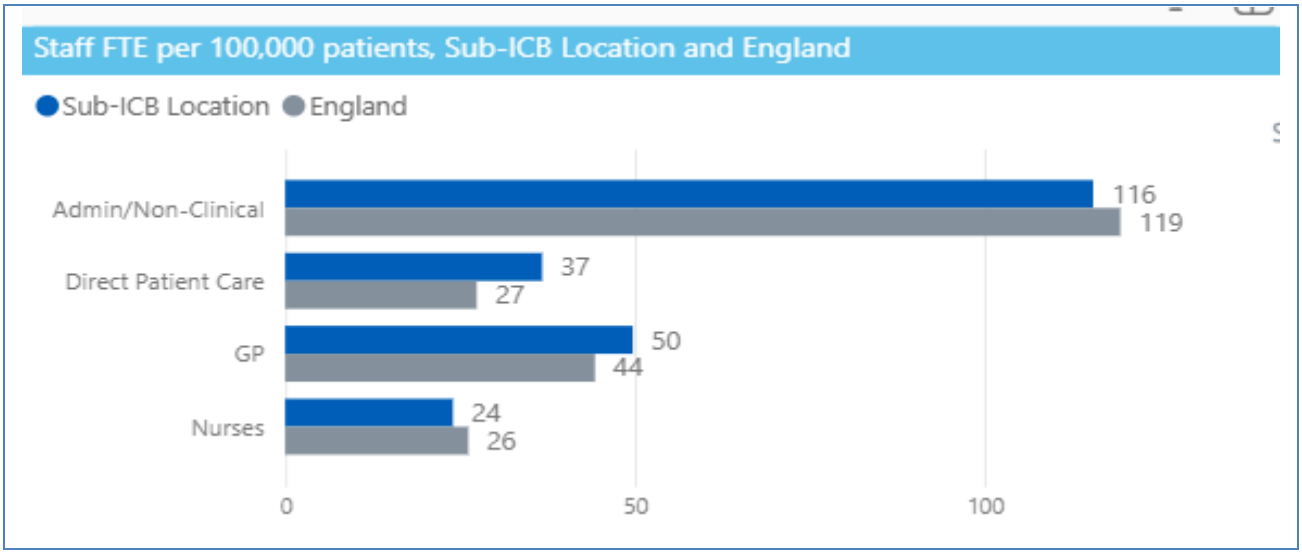
[2] General Practice Workforce, 31 July 2025 - NHS England Digital



Graph 3 Oxfordshire GP Headcount and full time equivalent (FTE)



Graph 4 Oxfordshire primary care Nurse Headcount and full time equivalent (FTE)



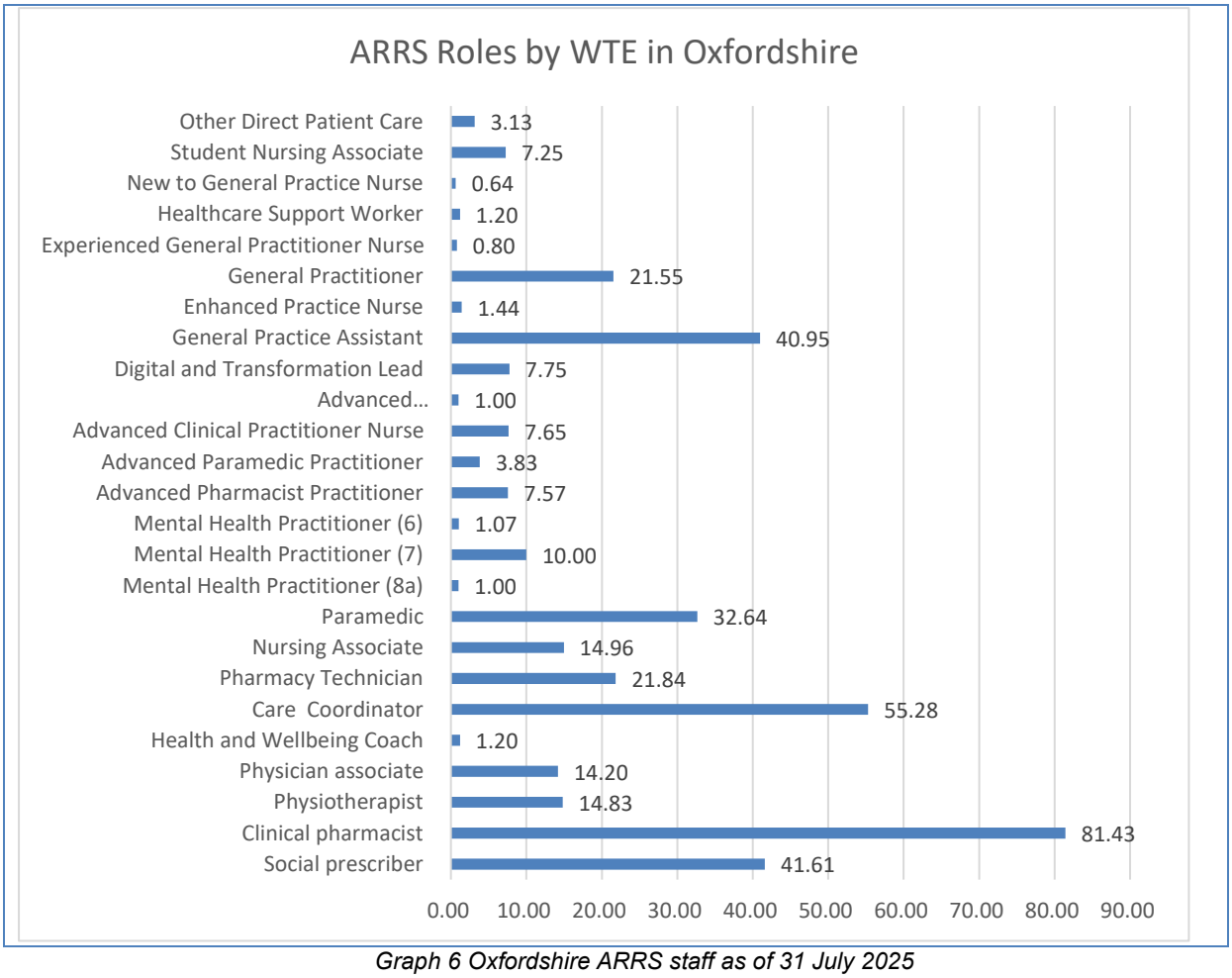
Graph 5 Oxfordshire primary care staff per 100,000 pts

There are several schemes in place to support and improve recruitment and retention of general practice staff including:

- GP retainer scheme which provides more flexibility and training support for those GPs thinking of leaving the profession to remain in post
- new to general practice fellowship scheme open to newly qualified doctors to support them transition to their first role in general practice.
- community of practice for personalised care roles to learn from each other and collectively improve their knowledge and skills to enhance patient care.
- Continuing Professional Development funding for nurses and allied health professionals
- Training and support for practice managers in various elements of running a practice such as HR, finance.

5.2. Additional Roles Reimbursement Scheme (ARRS)

The Additional Roles Reimbursement Scheme (ARRS) was introduced as part of the Primary Care Network contract in July 2019. The aim of the funding was to expand the primary care workforce by funding additional multi-disciplinary roles. Since the implementation of the PCN contract the number of ARRS roles has expanded. Oxfordshire now has 394.84 whole time equivalent ARRS staff split across 25 separate roles.



Graph 6 Oxfordshire ARRS staff as of 31 July 2025

5.3. ARRS GPs

In October 2024, the scheme was adjusted to include funding for recently qualified GPs with a separate allocation of funding to support this employment. To qualify for the funding GPs must have qualified in the past two years and not held a substantive post within general practice.

In Oxfordshire the funding for PCNs was just over £1m for the six months from 1 October 2024 to 31 March 2025. Appointing suitable individuals proved difficult due to the short-term nature of the funding but Oxfordshire practices appointed an additional 21.55 whole time equivalent GPs. Recently qualified GPs are now part of the ARRS.

5.4. Physician Associates/Assistants

Physician Associates (PAs) have been included as part of ARRS funding since April 2023. Concerns were raised regarding patient safety, role clarity, and the rapidly expanding presence of PAs which resulted in an independent review of the roles being undertaken - The Leng Review[3]. The purpose of the review was to assess the safety and effectiveness of PAs in healthcare settings. The outcome of the review was published in July 2025 with key points being:

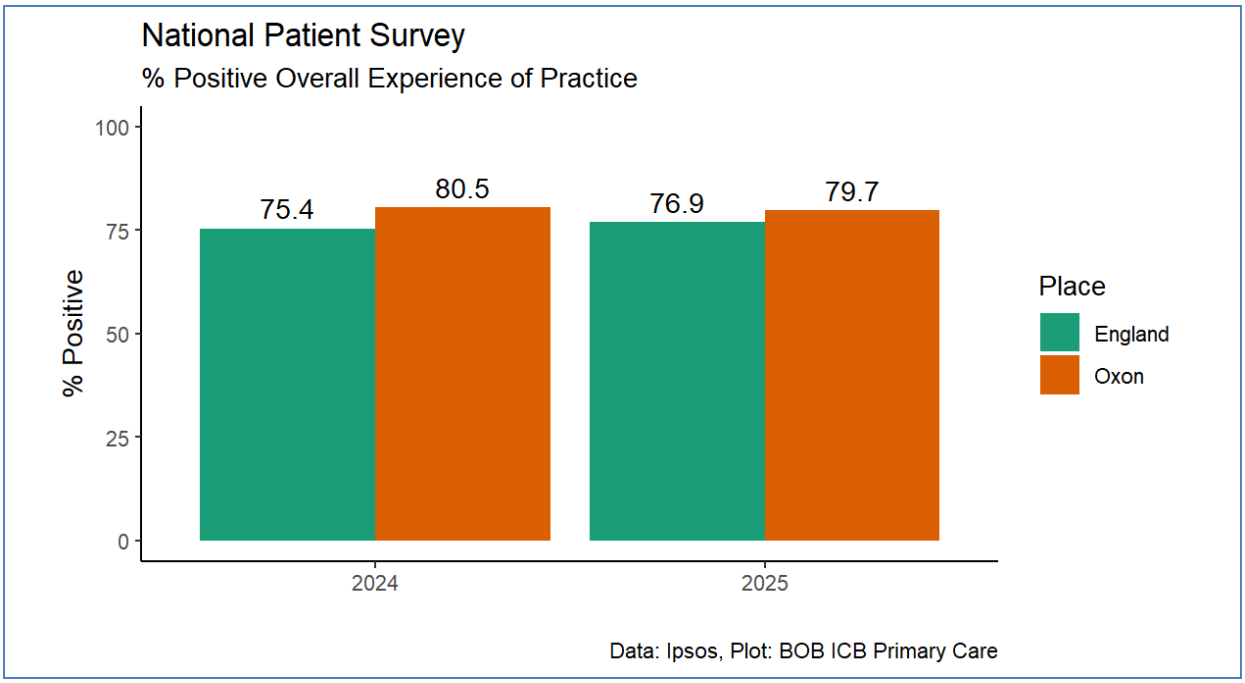
- Physician associates should be called "physician assistants" to emphasize their supportive function.
- New physician assistants should gain at least two years of experience in secondary care before working in primary care or mental health.
- Physician assistants should be part of a structured team led by a senior clinician, with a designated doctor as their line manager and supervisor.
- A permanent faculty should be created for professional leadership, with training and credentialing standards set by relevant medical bodies.
- General Medical Council (GMC) requirements for physician assistants should be presented separately from those for doctors to clarify the differences in their roles.

The numbers of PAs have not decreased in Oxfordshire as a result of the concerns and the publication of the Leng Review. At financial year end (31 March 2025) the whole time equivalent for Physician Assistants in Oxfordshire was 11.25. The position at end of Q1 2025/26 was 14.2 whole time equivalent. The ICB has worked with practices using PAs to ensure that they have appropriate safeguards in place.

[3] The Leng review: an independent review into physician associate and anaesthesia associate professions - GOV.UK

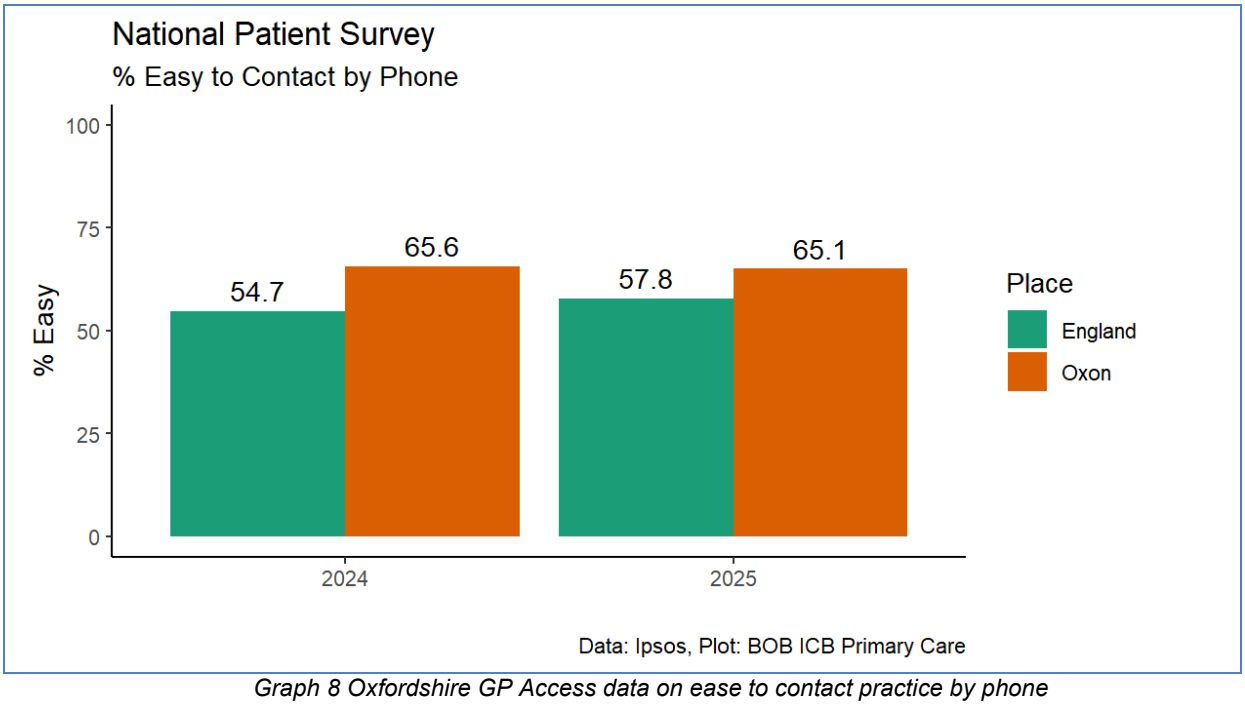
6. Patient Access Survey

The GP Patient Survey is an independent annual survey run by Ipsos on behalf of NHS England. The survey is sent out to over two million people registered with GP practices in England. The results show how people feel about their GP practice. Oxfordshire remains above the England average for overall experience of their GP practice. However there was a slight decrease when compared to 2024 survey results



Graph 7 Oxfordshire GP access survey on overall experience of practice

Those that report *ease of getting through on the phone* is significantly greater than the England average. The ICB is currently rolling out a new online consultation tool as more patients are looking to contact their doctor through an online portal.



Graph 8 Oxfordshire GP Access data on ease to contact practice by phone

Detailed information at practice and PCN level can be found GP Patient Survey .

The NHS Friends and Family Test (FFT) is a contractual requirement for primary care. The last data available is for January 2025. The percentage of patients rating experience as positive in Oxfordshire practices was 93%, which is in line with the average for BOB practices and SE Region and above the national figures. This has increased by 3% since the same time period in 2024.

7. Schemes to support general practice access

7.1. Pharmacy first

Pharmacy First schemes are further being promoted to remove reliance on general practice for some health tasks. This includes the initiation and continuation of oral contraception, blood pressure monitoring and treatment of minor illness including 7 common conditions where Pharmacists can issue antibiotics and other prescription medication according to agreed pathways. Further information can be found Pharmacy - Stay Well

7.2 Urgent dental appointments

The ICB has also commissioned an Urgent and Non-Urgent Unscheduled Care Dental Access Appointments Scheme.

- *Urgent unscheduled care*: patients who may need clinical care within 24 hours or as soon as practically possible, unless the condition worsens; or
- *Non-urgent unscheduled care*: patients requiring dental care within 7 days, unless the conditions worsens.

The ICB has agreed with 36 practices across BOB to provide this service in 2025-26. Details of the practices taking part in the scheme and of the days they are providing these sessions have been forwarded to NHS 111. Patients should contact 111 in the first instance if they need dental care. NHS 111 will signpost to urgent or unscheduled care at these practices.

8. Primary care Estate

8.1. Current context

It is recognised that many GP premises across BOB need additional capacity and modernisation, due to the mix of house conversions or older purpose-built surgery buildings not designed for modern day healthcare. There are currently 154 practices across BOB operating out of 223 practice sites. Very few have room to expand which means practices have outgrown their existing space.

Whilst the ICB recognise the importance of primary care estate, the many constraints including a lack of capital, high rental costs and lack of suitable options make investment and improvement in primary care estates difficult.

Despite this across Oxfordshire there are two major projects to improve primary care estate which includes a new surgery building in Great Western Park in Didcot and expansion of Bicester Health Centre into space vacated by Oxford Health NHS Foundation trust to increase the number of consulting rooms available.

8.2. Health service planning

The ICB is a duty-to-cooperate prescribed body under the Town and Country Planning (Local Planning) (England) Regulations 2012 and as such local planning authorities and county councils are under a duty to cooperate with the ICB on health matters that cross administrative boundaries. As a result, the ICB has regular meetings with local Council planning authorities in Oxfordshire to ensure that primary healthcare is considered in planning.

The ICB is also invited to attend Planning Advisory Group meetings, which is organised by Future Oxfordshire Partnership (now known as Oxfordshire Leaders Joint Committee) to set out the challenges of primary care estates.

In 2024/2025, the ICB reviewed more than 10 Oxfordshire draft local plan and/or neighbourhood plan documents and made formal representation to 7 consultations including both local plans, neighbourhood plans and infrastructure delivery plans (IDPs), which have implications for primary healthcare in the local area, including:

- Littlemore Neighbourhood Plan Public Consultation
- Wallingford Neighbourhood Plan Review Consultation
- Thame Neighbourhood Plan Review Consultation

Despite the ICB not being a statutory consultee in planning applications the ICB is proactively working with local Council partners to ensure appropriate primary healthcare mitigation is identified for those strategic and major developments within Oxfordshire. Mitigation may include the provision of land and/or a new facility and/or financial contributions towards primary care estate projects of existing premises.

In August 2024, the ICB issued a letter to all Heads of Planning to set out the types of planning applications to be consulted and the use of Community Infrastructure Levy (CIL) to support primary care estates projects. Currently, the ICB is responding to those major developments (10 or more units) or have significant impact on a local Primary Care Network (PCN). The ICB has also made representations in appeals to reinstate the ICB position in securing necessary primary care mitigations if necessary.

In 2024/2025, ICB has provided comments on 66 planning applications including pre-applications in Oxfordshire.

8.3. Developers Contributions

The ICB considers many requests for expansion/extension of GP premises some of which can be funded or part funded by housing developer contributions through the

Town Planning system. However, these contributions are not generally easily allocated nor sufficient to fund major new build projects in areas of significant population growth.

Healthcare has been allocated 20% of the infrastructure proportion of Community Infrastructure Levy (CIL) funding from South Oxfordshire District Council and Vale of White Horse District Council for primary healthcare projects supported by ICB.

These contributions have been approved for extensions to two existing practice estate in Abingdon as well as for the Great Western Park development with plans emerging for other areas.

8.4 Project Initiation Documents

The ICB receives many project initiation documents (PIDS) which set out practice proposals for increase in space. The ICB has a prioritisation matrix which it uses to assess the priority of requests with housing growth, lack of current space, available capital and strategic fit being key parameters. Unfortunately, many of the schemes are not deemed value for money by the district valuer as the costs of building do often not make the projects viable.

Solutions such as use of developer's contributions especially through Community Infrastructure Levy which has less constraints can be helpful.

8.5 Utilisation and Modernisation Fund

The Primary Care Utilisation and Modernisation Fund was announced during the 2024 Spending Review and provides new national capital funding of £102 million in 2025 to 2026 to support improvements in the primary care estate.

The fund aims to:

- enhance the use of existing infrastructure
- create additional capacity for the GP and practice workforce
- enable additional patient appointments

The ICB has put forward 8 GP schemes for Oxfordshire although not all of them will progress. Many are small schemes whereby admin space will be converted to more clinical space.

9. Next steps

The 'Fit for the Future- 10 Year Health Plan for England'[4] published in July 2025 sets out the UK Government vision for the next ten years of the health service. As care shifts from the hospital to the community, General practice will be at the heart of the new Neighbourhood Health Service. This will bring together skilled professionals into patient centred teams, provide personalised care and deliver care into local communities.

[4] NHS England » Fit for the Future: 10 Year Health Plan for England

Digital tools can provide a way of streamlining processes for both the patient and the practice although it is recognised that not all individuals will wish to use a digital/online route. All practices now offer online registration when a patient wants to register with a practice. The ICB will continue to promote the use of the NHS app as its functionality increases (including ability to track prescription requests between a GP practice and a community pharmacy and being able to book appointments through the NHS app). The 10year plan focuses on making the NHS App a world-leading tool for patient choice.

There is already good innovative practice across Oxfordshire such as the Same Day Urgent hub in the southeast of the City, integrated neighbourhood teams in Bicester, Banbury and Headington; use of AI technology to record key points from a consultation direct into the patient notes. The aim will be to spread this good practice across Oxfordshire to improve access to the right care for patients.

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Oxfordshire Eyecare Services
September 2025

Introduction

This paper responds to questions raised by the Health Oversight and Scrutiny Committee regarding eyecare services commissioned in Oxfordshire by Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

1. How eye care services are commissioned and managed

The ICB commissions a range of eyecare services across Oxfordshire to meet the needs of the local population. We have a range of established providers that deliver broadly three tiers of services:

a) Primary care optometry services

NHS funded sight tests are undertaken in community and domiciliary settings. These services are delivered by community optical practices in England ensuring a standardised foundation-level eye healthcare offer across the population.

There is a provision for NHS vouchers to be made to eligible persons to meet or contribute towards the cost incurred for the supply, replacement or repair of optical appliances (glasses and contact lenses), or to contribute towards the cost of a sight test.

NHS funded sight tests are provided under General Ophthalmic Service (GOS) contracts which are commissioned by ICBs on an any qualified provider basis.

The NHS Business Services Authority process GOS contract applications and the South East Commissioning Hub manage the contracts on behalf of all six ICBs in the South East Region.

b) Intermediate care/community eyecare providers

Primary Eye Care Services (PEC)
PEC provide a number of enhanced community eye care services across Oxfordshire. They function as an umbrella organisation for the Optometric Practices in Oxfordshire to administer, recruit and develop services delivered by the practices themselves. The services are:

- Minor Eye conditions (MEC) - provided by 31 Optometry practices in Oxfordshire. This service provides early local assessment, diagnosis and treatment for specified minor eye conditions such as red eye, white eye with visual disturbance, lid swelling and flashers and floaters for all patients registered with an Oxfordshire GP over five years of age. Referrals to the

service are made by GPs, eye casualty or self-presentation by patients with patient experience information regularly collected as part of the contract.

The service works to agreed pathways and guidance to deliver the service with the aim of giving patients access to urgent and routine eye care outside of hospital in a local, easily accessible setting. It reduces reliance on GPs and eye casualty with Optometrists able to refer to eye casualty if necessary. Pharmacy advice is also available for very minor eye conditions.

- Glaucoma Repeat Readings service (GRRS) - provided by 26 Optometry practices across Oxfordshire. The service is for suspected Glaucoma and Ocular hypertension (high pressure within the eye). High pressure within the eye is an indication that Glaucoma may be a possibility.

  GPs and Optometrists are able to refer to the service. Consultants are also able to refer for repeat diagnostics where they need confirmation at the point of triaging a referral. Most referrals come from routine eye tests and the repeat of eye pressure checks and the visual fields to confirm if a referral is required for further investigation or not.

- Hydroxychloroquine Monitoring
  This is for patients at high risk of developing damage to the retina called Retinopathy because they are taking Hydroxychloroquine, a drug frequently used for Rheumatological conditions. The retina is a light sensitive layer at the back of the eye and allows light to be sensed and transmitted to the brain and therefore an image is seen. Sight is impacted if this no longer happens.

  High risk patients are those who have taken hydroxychloroquine for 5 years or longer, take Tamoxifen, have impaired kidney function or have a high dose of the drug.

  The service delivers diagnostics to check that there is no retinopathy developing. It is conducted yearly if required. If retinopathy is detected the patient is referred to secondary care for treatment.

c. <u>Hospital/Secondary eyecare services</u>

The Oxford Eye Hospital, provided by Oxford University Hospital NHS Foundation Trust and located at the John Radcliffe, provides a range of ophthalmology services for both adults and children, including; Glaucoma, Cataracts, Ocular Inflammation, Optometry, Orthoptics and outpatient services (outpatient services are also provided from the Horton Hospital).

There has been an increase in the number of Independent Service Providers (ISPs) offering ophthalmology services in accordance with the national Choice agenda. Within Oxfordshire, ISP providers include SpaMedica and Newmedica and the ICB is in the process of accrediting additional providers.

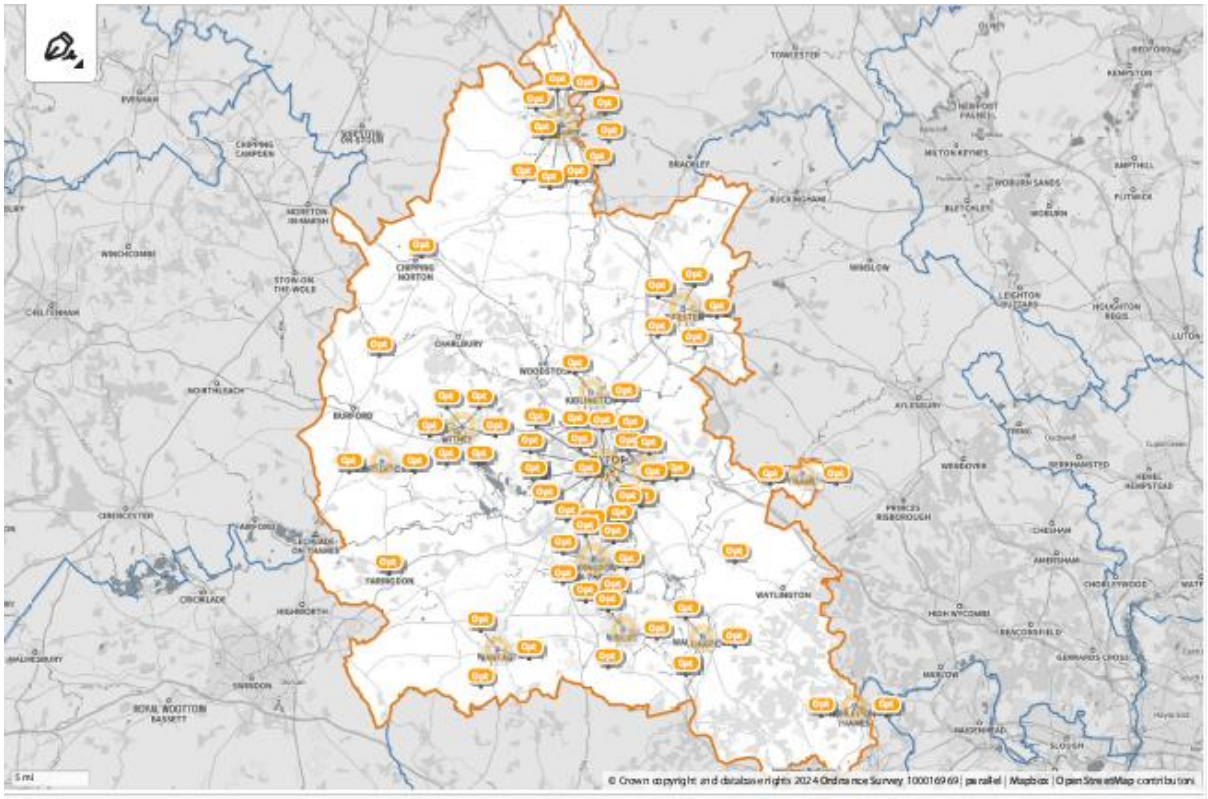
The eye services they offer are limited and commissioned following a strict accreditation process to ensure they are appropriately qualified to deliver the

clinical services provided. These currently include cataracts, glaucoma and Ocular plastics.

All providers are managed through established contract management oversight arrangements which include regular review of delivery against activity plans and meetings with the providers to ensure timely response and resolution to any issues that may emerge.

d. **What is the geographical distribution of eye care facilities in Oxfordshire?**

- Primary Optometry and intermediate care - Primary Optometry and PEC services are distributed across Oxfordshire as illustrated by the below map, with domiciliary services available to eligible patients.



- ISPs - SpaMedica provides services in from their base at Blenheim Office Park, Long Hanborough and Newmedica is located in on the Marcham Road in Abingdon

- Acute/Tertiary Centres - Oxford University Hospital NHS Foundation Trust provider Ophthalmology services from both the John Radcliffe site in Headington and the Horton General Hospital in Banbury

e. **Are there sufficient numbers of eye care professionals (ophthalmologists, optometrists, and support staff) to meet the demand?**

There have been no reported incidents where General Optometry Services contractors have not been provided due to insufficient optometrists.

The ISPs of eyecare services are seeking to deliver a wider range of services as part of the national Choice framework. This enables existing providers to extend their offer and for new providers to enter the market if they meet specific criteria to deliver Consultant led services. Whilst this is positive in providing patients with greater choice and shorter waiting times in some instances, this has had a destabilising impact on trainees and wider NHS Trust Ophthalmology services.

ISPs deliver a service for low complexity cataract surgery, reducing the demand for this type of treatment in NHS Trusts. As a consequence, Trusts have not been receiving the lower acuity cases that would be used to support training which has resulted in the loss of trainees to the system.

This national issue has meant that work that would have been delivered by trainees has needed to be backfilled by more experienced staff, impacting other areas of the department, for example eye casualty.

Positively, in response to this issue training is now being negotiated locally to be delivered by ISPs in partnership with NHS Trusts, and whilst it has been challenging to mobilise, this will be key to ensuring the number of trainees and availability of qualified Consultants to sustain the delivery of Ophthalmology services going forward.

f. **How long are the waiting times for routine and urgent eye care appointments?**

Emergency conditions are seen in eye casualty on the day. Triage takes place by phone to ensure eye casualty is the most appropriate care setting for the patient's treatment needs. If they have a minor eye condition, they are referred to an Optometrist of choice or Pharmacist service.

MECS provides assessment and treatment for sudden onset, minor eye problems, with patients able to be seen by a specialist within 48 hours.

For routine NHS funded sight testing, there is a mixed economy on the high street ranging from practices who offer walk in appointments to pre-booked appointments.

At speciality level the wait for a first outpatient appointment for ISPs and Acute providers vary, however the length of wait will depend on the clinical urgency, sub-speciality the patient is referred to and whether it is a common or specialist procedure or treatment required.

A common procedure is cataract surgery and indicative waiting times are published on the ICB's website to support patient choice (Cataract surgery - your choices | BOB ICB). Waits currently range from less than 1 month to more than 4 months depending on the provider and complexity of the cataract procedure required.

g. **Are there any barriers to accessing eye services, such as transportation issues, financial constraints, or lack of awareness?**

The eligibility criteria for NHS funded sight tests delivered by General Optometrist Service (GOS) providers is determined nationally, based on for example age, whether the patient receives any benefits and certain medical conditions.

GOS contracts are commissioned on an any qualified provider basis, as a result, provided the applicant meets all the requirements, there is no restriction for entry to the market. In the event a GOS contractor terminates their contract, a check is made for alternative providers within a 10-mile radius and to date, no gaps in service have been identified.

GOS is provided by private businesses who promote routine sight testing (either GOS funded or private) through direct patient communication, in store, or through advertising.

ISP and hospital eyecare services are delivered in accordance with the ICBs Commissioning Policies which set clinical thresholds/criteria for some procedures and treatments which can be found on the ICB's website: Ophthalmology | BOB ICB.

Commissioning Policies are developed with clinical input and reflect NICE and other clinical guidance as appropriate. There are no wider constraints placed on access to eyecare services in Oxfordshire or the wider BOB ICB geography providing a patient is eligible for NHS care.

GPs and Optometrists are well versed in the eye care services available and able to refer patients as necessary with any changes or updates to services communicated through established mechanisms, including the weekly GP Bulletin or Local Optometry Committee. Optometrists are also able to refer directly to secondary care services.

The ICB commissions a Patient Transport Service available to those that meet the national eligibility criteria. If a patient does not meet the eligibility criteria, the Patient Transport Service will signpost the individual to other options that may be available to them, including voluntary sector services.

h. **Are there standard protocols and guidelines in place for the diagnosis and management of eye conditions?**

There are standard pathways, guidelines and supporting referral protocols in place for the management of a range of eyecare conditions across primary, intermediate and secondary care services, including tertiary/specialist services.

i. **How is the quality of care measured and monitored?**

Quality in Optometry (QiO) is a national quality assurance tool to be completed by GOS contractors every three years to assess their compliance with their GOS contracts and to assure, maintain and improve the services they provide.

The toolkit comprises of a compliance checklist. The information collected from this checklist helps the commissioning team to identify which premises should be prioritised for a contract monitoring visit.

The NHS England Policy Book for Eye Heath sets out the assurance framework for GOS mandatory (premises) and additional (mobile/domiciliary) contracts. It sets outs the approach that the Commissioner needs to follow to ensure a consistent approach to contract assurance including:

- the timescale for an information request; and
- the process for a practice visit including premises, equipment, record keeping

GOS contractor visits are conducted with the assistance of clinical advisers. During the three-year contract assurance cycle the following are prioritised the following for visits:

- Practices who have not complied with the data submission, submission of an action plan or complied with an action plan.
- Practices where there are concerns about contract delivery as identified by activity concerns, Key Performance Indicators, or other information.
- Additional contractors selected at random.

The following applications are monitored with follow up of outliers:

- second/spare pair of glasses
- GOS voucher for patients who are non-tolerant of their glasses
- GOS voucher for patients under exceptional circumstances
- same day patient substitutions (domiciliary providers)

Any issues or concerns raised regarding the quality of services commissioned by the ICB are routinely captured and addressed as part of established contract oversight arrangements, drawing on expertise from the ICB Quality and Medical Directorates as required.

j. **What is the level of patient satisfaction with the services provided?**

In September 2024 HealthWatch Oxfordshire published a report setting out the experiences of patients using primary and secondary care eyecare services in Oxfordshire. In summary:

“we heard that people were generally positive about their experiences of appointments at eye care services and slightly less positive about their experiences of travelling to appointments, costs of care, and referrals.

We heard that availability of appointments at the Oxford Eye Hospital was generally good, although people also experienced cancelled appointments, difficulty with transport and attending early appointments, busy waiting areas, and long waits to be seen. Some were frustrated at not being able to receive outpatient eye care at their local health facility.

Feedback on how well eye care professionals explained eye tests and medical procedures was generally positive for both private and NHS providers, but views on how well eye care services worked together to provide treatment were mixed.”

(Source: People's experiences of eye care services in Oxfordshire – September 2024 - Healthwatch Oxfordshire)

A range of recommendations were made to the ICB, Providers and the Local Optometry Committee with a response provided. The ICB is following up these and if possible, will provide an update at the meeting.

Very few complaints are received about GOS contractors. There have been no complaints made to the commissioner about the services provided by GOS contractors on Oxfordshire in the last 3 years.

Any complaints/patient feedback received about local services/providers are routinely investigated and responded to, with any themes addressed with the provider directly as part of contract oversight and management arrangements in place.

k. **What referral pathways exist for patients requiring specialised eye care?**

Oxford University Hospitals NHS Foundation Trust (OUH) is the local specialist centre for eye care services with established referral pathways in place for any eye care requirements that cannot be met through GOS, MECs or ISP provision. OUH would consult with another specialist centre in the rare event they were not able to meet the needs of a patient as part of established network of provision.

l. **Sustainability of NHS eye care departments**

Acute Ophthalmology departments remain challenged due to high demand and the need to continue to reduce waiting times for patients. RTT waiting list for Ophthalmology treatment at Oxford University Hospitals at the end of September 2024 was 6,276 patients, 50.7% waiting within 18 weeks whilst 220 patients were waiting over 52 weeks. At the end of June 2025, the waiting list size had reduced to 5,820 with 54% waiting within 18 weeks and 178 patients waiting over 52 weeks. As part of this work, the Acute Provider Collaborative in BOB, comprising of the three hosted acute NHS Trusts, Oxford University Hospitals NHS Trust, Buckinghamshire Healthcare NHS Trust and Royal Berkshire Hospital NHS Foundation Trust times, have been working together to identify opportunities to better manage demand across the combined resource available, for example consultants working across multiple hospital sites across BOB. Across the Acute Provider Collaborative in BOB the work has resulted in a reduced waiting list for Ophthalmology treatment; at the end of September 2024 was 17,776 patients, 66.4% waiting within 18 weeks whilst 342 patients were waiting over 52 weeks. At the end of June 2025, the waiting list size had reduced to 17,335 with 68.2% waiting within 18 weeks and 215 patients waiting over 52 weeks.

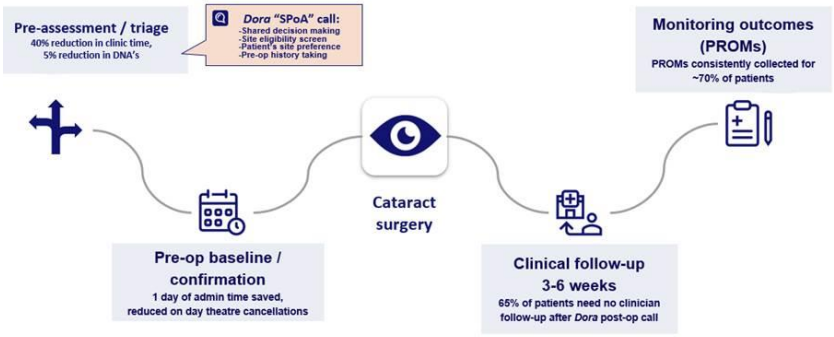
A further example is the instigation of a Single Point of Access (SPoA) for cataract surgery across the BOB System in response to growing demand. The SPoA has been developed using an Artificial Intelligence voice tool called DORA with the software ensuring choice is consistently offered, streaming patients to the right provider based on their eye condition and other health issues.

In excess of 75% of patients requiring cataract surgery can be referred to an ISP provider as they are defined as “high volume low complexity”, for example they have no existing eye conditions, such as Glaucoma or Wet Acute Macular degeneration (AMD) and don’t require the additional expertise of an NHS Trust to complete their procedure.

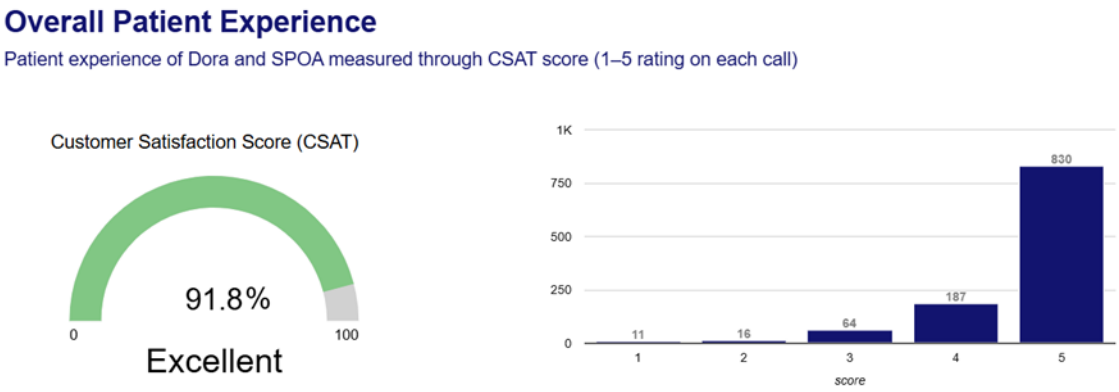
There are however a smaller percentage of patients that have more complex conditions and require specialist expertise, including;

- cataract surgery combined with another ophthalmology procedure,
- bilateral cataract surgery that can only be conducted by NHS Trusts or.
- a need for general anaesthetic and sedation which cannot be delivered by ISP for cataract surgery.

As illustrated below, DORA also supports the pre-operative baseline and post operative call to establish whether the patient would benefit from follow up or if they can be safely discharged from the service. This process is reducing the number of patients needing to come back for follow up by circa 60% and releasing clinical capacity for alternative use.



Patient satisfaction of the DORA SPoA has also been positive with more than 90% of patients rating it “excellent”.



Initiatives like this will be key in supporting the sustainability of NHS eye care departments.

Healthwatch Oxfordshire
Your voice on health and care services

Report to the Oxfordshire Joint Health Overview and Scrutiny Committee

September 2025

Table of Contents

1. Healthwatch Oxfordshire reports to external bodies

For all external bodies we attend our reports can be found online at: https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/

We attended Health and Wellbeing Board, Health Improvement Board and the Children's Trust Board?. We attend **Oxfordshire Place Based Partnership** meetings under Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). We work together with the five Healthwatch groups at place across BOB ICB to give insight into committees at BOB ICB wide level, including BOB ICB Quality Committee, Population and Patient Experience Committee and Prevention and Health Inequalities Committee.

2. Update since the last Health Overview Scrutiny Committee (HOSC) Meeting - June 2025

Healthwatch Oxfordshire reports published to date

The following reports published since the last meeting can be seen here: https://healthwatchoxfordshire.co.uk/reports All reports are available in **easy read**, and word format.

- **Navigating urgent and emergency care in Oxfordshire – June 2025**
- **Using women's health and emergency care services in Oxfordshire – July 2025**

Report	Impact and outcomes
Using women's health services in Oxfordshire July 2025	Between August and October 2024 we heard from 684 women and people who use women's health services in Oxfordshire. This report captures what they told us about accessing and using women's health services, health services more generally, and getting breast or cervical screening. **Impact** – Our report is being used to inform the development of a women's health strategy for Buckinghamshire, Oxfordshire and Berkshire West. *"Healthwatch reports are a key part of our insights that inform strategy and planning. We are currently drafting our women's health strategy for this year and key aspects of this report are included in our priority setting."* Heidi Beddall, Deputy Chief Nursing Officer/Director of

	Quality at NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board – What we heard has also helped to bring about improvements in local services, including a commitment from Oxford University Hospitals NHS Foundation Trust to reduce waiting times for specialist women's health clinics, improve patient information about screening and procedures, and training staff in cultural competency and trauma-informed care. For more details, see the responses from providers, on our report page.
Navigating urgent and emergency care services in Oxfordshire June 2025	This report captured the views and experiences of 322 people of navigating urgent and emergency care (UEC) services in Oxfordshire. **Impact** – We presented this report to the Urgent Care System Delivery Group to inform their planning for winter 2025/26. – Providers are developing a new overarching Oxfordshire Urgent and Emergency online service with clear information, and working to ensure consistency across all providers' websites.

To read more about the **impact** of all our reports, and commissioner and provider responses and actions, see here: https://healthwatchoxfordshire.co.uk/impact/

In July we hosted our **Annual Impact Report** for the year 2024-25 online. The full report and video of our staff presentations about our work can be seen here: https://healthwatchoxfordshire.co.uk/report/healthwatch-oxfordshire-annual-impact-report-2024-25/ Healthwatch Oxfordshire played a pivotal role to develop an event bringing communities from the ten urban priority areas, together to learn about what **Oxfordshire Marmot place** means. We worked with Oxford Community Action, Flo's, AFIUK, as well as Community First Oxfordshire and OCVA to enable this event to be community led and planned. Over 100 grassroots community representatives, and system decision-makers attended. Funding from Public Health supported the event. Notes and insight from the event can be seen here: https://healthwatchoxfordshire.co.uk/news/oxfordshire-marmot-place-tackling-the-health-gap-at-its-roots/

Enter and View Visits

Since the last meeting we made Enter and View visits to the following services:

- Well Pharmacy, Marston
- Blue Outpatient at John Radcliffe

We published the following **Enter and View reports:** (https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/) on our observations from visits to the following services:

- Visits to three sites (Botley, Bicester and Henley on Thames) into services provided by **Connect Health** (August 2025) (now known as Cora Health)

All published Enter and View reports are available here: https://healthwatchoxfordshire.co.uk/our-work/enter-and-view and information https://healthwatchoxfordshire.co.uk/wp-content/uploads/2024/01/Enter-and-View-easy-read-information.pdf

Webinars: Since the last meeting we held two public webinars attended by 42 people - in May 'Livewell in Oxfordshire' and June 'Let's Talk about Menopause'.

To see our webinar programme, zoom links and recordings of all webinars: https://healthwatchoxfordshire.co.uk/news-and-events/patient-webinars/ All welcome.

Our **next webinar** will be:

- **Tuesday 16th September 1 pm** *On the* ***Ten Year Health Plan for England****,* with speakers from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). Zoom link via above.

Our ongoing work:

- **Community research** working with Sunrise Multicultural Centre, Chinese community and others focused on issues important to them.
- Ongoing face-to-face **outreach** to groups and events across the county, including hospital stands (at John Radcliffe), community groups and events e.g. Afrobeat Festival Blackbird Leys, Thame and Oxford Pride Festivals, Play Days across the county, among others. Between April and June we spoke to 579 people during outreach.
- We also attend Patient Participation Group (PPG) meetings across the county, and support PPGs e.g. advice on setting up, running meetings etc. In August we worked together with PPG members from **Charlbury PPG to do on the street**

engagement and insight gathering to support hearing from people about using the NHS App.

3. Key issues we are hearing from the public:

Along with our themed research above, we hear from members of the public via phone, email, online feedback on services (see here for reviews and to leave a review https://healthwatchoxfordshire.co.uk/services), and when out and about. This enables us to raise with health and care providers and commissioners on emerging themes. Below is a brief insight into some of the themes we are hearing public on different issues, and relevant to this HOSC agenda.

The **top services** people contacted us about this quarter were **GP Services -** mainly around barriers access to services in a timely way.

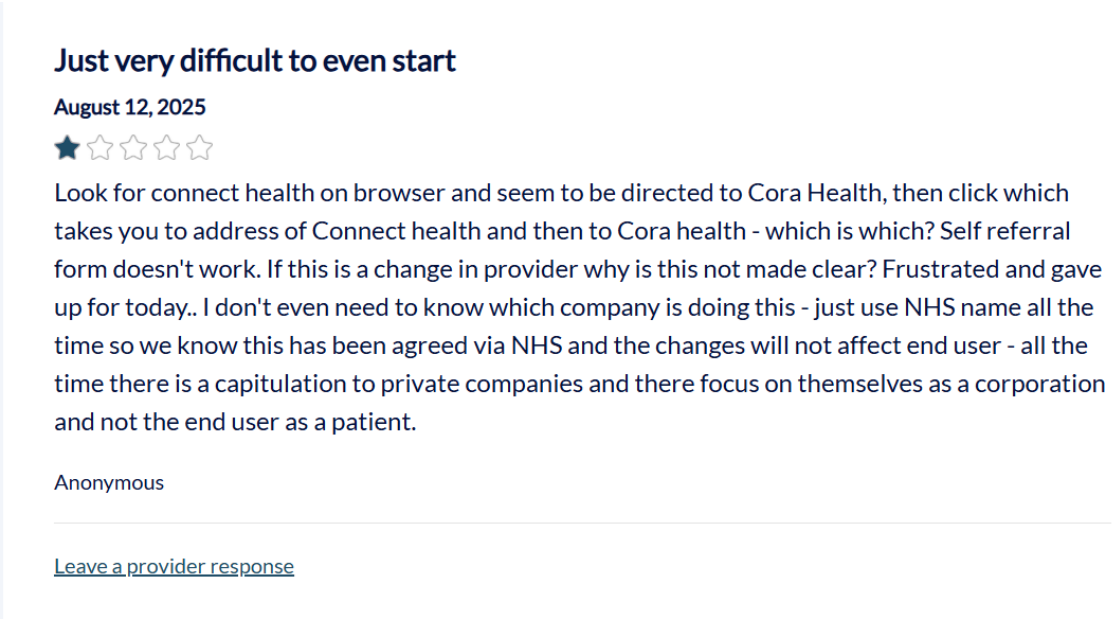
> *"Excellent triage service when needing to speak or see the GP. Medicine treatment excellent."*
>
> "*You just can't get an appointment. If you can't phone up at eight, when I am always at work, you have to use e-consult, but again I'm usually at work when you have to do that. If you do ring first thing you can be on the phone waiting to get through for an hour. It just puts you off making an appointment. If I was poorly now, I'd probably just call 111".*
>
> *"I knew I had an issue with [medical condition] again, so I rang my GP at 8am and by the time I got through at 8.18am there were no appointments left for the day, so they told me to ring 111".*
>
> *"Went to GP surgery at 8am to book an appointment as didn't want to wait on the phone, and was told by the receptionist to call 111 to get a doctor's appointment*".
>
> *"There are never appointments available online anymore, the only way to get one is to phone the surgery. For people that aren't well enough to call (you're often waiting over 30 minutes) it means no healthcare. A new call back system was brought in but this doesn't seem to trigger until you're first in the queue anyway. If you can't wait a month and need to see someone more urgently, you have to be able to call at*

8am and stay on the phone for ages. This means anyone with sleep issues, chronic fatigue, anxiety, memory problems, autism etc is precluded. God help anyone that needs the loo frequently as well, unless you fancy bringing the phone with you!"

"The surgery itself is brilliant with good doctors and all the other staff are very nice and helpful. It's just a shame that you can't get the medical help you need from them."
"Unfortunately their system for online appointments don't let you add extra information they will need so would be great if they phoned patients so they could help them properly. It's no good ringing the practice as it can take ages for them to answer the phone if they even do."

"I find it very difficult to book appointments. I struggle to book appointments online as my computer skill are not good."

Connect Health (muscular skeletal services) has now been absorbed into Cora Health, causing some confusion for patients. We have asked for clear communication for patients about the changes:



Just very difficult to even start

August 12, 2025

★☆☆☆☆

Look for connect health on browser and seem to be directed to Cora Health, then click which takes you to address of Connect health and then to Cora health - which is which? Self referral form doesn't work. If this is a change in provider why is this not made clear? Frustrated and gave up for today.. I don't even need to know which company is doing this - just use NHS name all the time so we know this has been agreed via NHS and the changes will not affect end user - all the time there is a capitulation to private companies and there focus on themselves as a corporation and not the end user as a patient.

Anonymous

Leave a provider response

Using the NHS App

We have just closed our survey focused on the NHS App. We heard from 823 people via face-to-face outreach and an online survey. The report will be published in November. Initial insights show the main reasons for not using the app were preferring to manage their health care in-person, not knowing about the app and lacking digital confidence. Most people said they used the app to order repeat prescriptions and view their GP health records, with less than half managing their appointments via the app. Many people said their health records on the app were incomplete. People from seldom-heard groups have more difficulty using technology and found the app complicated. While acceptance and use of the NHS App appears to be generally high, inequalities are preventing some people from fully accessing the service. Most users perform specific tasks and focused effort is needed if the app is to support transformation of the way people manage their own health and health care.

Illustrative quotes:

"Repeat prescription ordering works well. It is easy and useful to be able to look at your test results."

"Very useful for accessing my health records and finding trustworthy information about health conditions and medication."

"I do try and use the app but I struggle with apps because I have an old phone. I have a lot of health problems so when I do use the app I can order repeat prescriptions."

"I like to see the doctor and I really struggle with IT and would feel very uncomfortable using the app on my phone and would be very scared if I lost my phone knowing people could access my medical records."

Learning disability – feedback we have heard from our work supporting My Life My Choice's Health Voices group includes:

- Issues with getting transport to health appointments, including patient transport for hospital appointments
- Challenges with phone triage, such as difficulty understanding all the options Mixed experiences of using the NHS App – including finding it difficult to navigate
- Difficulties getting prescriptions, including medication shortages, being told to use the NHS app or fill out long forms

- We also heard from a parent carer of an autistic adult about concerns about their hospital treatment, including use of antipsychotic medications despite these being discouraged due to severe side effects, and feeling dismissed by clinical staff
- We also heard from SENDIASS volunteers about long waits for speech and language therapy and occupational therapy for children with SEND.

Winter pressures – see our reports on Navigating Urgent and Emergency Care and Leaving Hospital in Oxfordshire https://healthwatchoxfordshire.co.uk/our-work/research-reports/

- We continue to hear some challenges with the discharge process, including incorrect communication from Royal Berkshire Hospital about post discharge support, delays and gaps in social care provision, and primary capacity to pick up tests for someone leaving hospital. We feed what we hear back to the multi-disciplinary team.

Appendix: The future of Healthwatch and independent scrutiny.

The statutory functions of Healthwatch are set out in Section 221 of the Local Government and Public Involvement in Health Act 2007 as amended by the Health and Social Care Act 2012. The main statutory functions of local Healthwatch are to:

- Promote and support the **involvement of local people** in the commissioning, provision and scrutiny of local care services
- Enable local people to **monitor the standard** of provision of local care services and whether and how local care services could and ought to be improved (e.g. Through 'Enter and View' visits to health and care facilities)
- **Obtain the views of local people**, regarding their needs for, and experiences of, local care services and importantly, to make those views known
- Make **reports and recommendations** about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services.

Local Healthwatch (of which there are 152 across England) are currently funded by and accountable to their local authorities in which they carry out the role.

Healthwatch Oxfordshire is an independent charity and currently delivers the Healthwatch functions for Oxfordshire under a contract with Oxfordshire County Council (to 2028). It receives some additional funding from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), to support our engagement work, representation at ICB level and Place Based Partnership.

Healthwatch Oxfordshire has built trusted relationships over twelve years with communities and residents in Oxfordshire and become an independent partner in the health and care system. It continues its work to reach out and listen to the experiences of Oxfordshire residents and communities, provide advice and support, and to make sure that this voice helps shape local health and social care services.

In 2024-25 we achieved the following:

(See here to read our Annual Report: https://healthwatchoxfordshire.co.uk/report/healthwatch-oxfordshire-annual-impact-report-2024-25/ and here for more details of our impact https://healthwatchoxfordshire.co.uk/impact/impact-of-our-research/)

Healthwatch Oxfordshire continues to work to make sure that we hear from all communities, and develop innovative ways bring this voice to support development of health and social care. The work to pioneer **community research** for example has helped to make sure the voices of less heard communities are brought to the fore. In 2025-26 Healthwatch Oxfordshire continues to focus on its priorities engaging with residents on a range of topics, including neighbourhood health, digital technologies and supporting community research to hear from communities experiencing health inequalities. You can read about our priorities and how we set them at https://healthwatchoxfordshire.co.uk/about-us/our-priorities/

The **Dash Report** on patient safety published for the government in July 2025 outlines the future landscape for patient safety including rationalising pathways for patient voice, action, accountability and response (https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape). It aims to ensure that health and care decision-makers and providers are more accountable, and proactive in response to the voice of people who use services, throughout their systems, and that pathways to bringing that voice are rationalised.

This includes proposed dissolution of Healthwatch England and all local Healthwatch. A Patient Experience Unit will be established in the Department of Health and Social Care into which Healthwatch England functions will be transferred. Local Healthwatch statutory functions will be transferred as follows: Recommendation 5 states (Page 93) "*Bring together the work of Local Healthwatch, and the engagement functions of Integrated Care Boards (ICBs) and providers, to ensure patient and wider community input into the planning and design of services*" and that "*The statutory functions of Local Healthwatch relating to social care should be transferred to local authorities in order to improve the commissioning of social care.*" (See here: https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape

It is envisaged that changes proposed in the Dash Report will be implemented through new Health and Social Care Act legislation, with timelines uncertain, but potentially not until Autumn 2026 or beyond. At present there is limited guidance as to what this means in practice for the future landscape, and to what extent shaping and design for its implementation can be developed at local level. **Until the legislations happens, Oxfordshire County Council remains responsible for ensuring the Healthwatch functions are carried out.**

Healthwatch Oxfordshire are committed to constructive engagement with health and care system partners both at place in Oxfordshire and more widely with the Integrated Care Board. We will actively work collaboratively to explore and contribute to the design of future approaches.

It is important that key principles for independent voice are taken into account by the health and care system in planning this transition. Any new model or approach must retain the following core characteristics if public voice is to remain credible and effective:

- Independence from service providers and commissioners building trust
- Built on local presence, relationship and understanding at neighbourhood level, bringing in the voices of everyone including seldom heard communities – to create meaningful change
- Informed by public need, not solely by system priorities
- Focused on integration, and recognising the patient experience which cuts across health and social care boundaries, and wider determinants
- Influential and confident voice acting as a critical friend

These principles are essential to ensuring that public voice continues to contribute meaningfully improving services and reducing health inequalities.

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

NHS Adults Autism and Attention Deficit Hyperactivity Disorder (ADHD) services

Summary report from BOB ICB

1. Purpose of Paper

1.1. This paper provides an update to the Health Overview and Scrutiny Committee on Adults with Autism and Attention Deficit Hyperactivity Disorder (ADHD) who use autism and ADHD services in Oxfordshire.

2. Executive Summary

2.1. Adult Autism and ADHD services in Oxfordshire are experiencing rising demand, long waiting times, and the local NHS service is paused to new referrals due to capacity limits.
2.2. Prevalence and Diagnosis: Around 11,778 adults have autism and 27,714 have ADHD in Oxfordshire, but actual diagnoses, especially for ADHD (10,528 adults), are lower reflecting underdiagnosis, particularly among females and older adults.
2.3. Service Pressure: Waiting lists are long, with autism assessments capped at 110 per year and over 2,200 people waiting for ADHD assessments. Many GPs (about 50%) are reluctant to prescribe ADHD medication, impacting ongoing care.
2.4. Alternative Access: The Right to Choose scheme allows patients to seek assessments from alternative providers when local services are paused, with waits ranging from a few weeks up to 18 months. This does not reflect a financially sustainable model for the ICB
2.5. Service Improvements: A five-year autism strategy is in development, and the Adult ADHD Transformation Programme is underway to streamline care pathways, improve medication management, and better engage GPs.
2.6. Future Plans: The ICB aims to introduce digital tools, involve community support, and collaborate with service users and partners for more accessible, sustainable services.
2.7. This update aims to inform HOSC about the current state of adult autism and ADHD services in Oxfordshire and outline plans to address ongoing challenges.

3. National Policy

3.1. There is a National ADHD taskforce, and the interim report findings are set out below we are expecting the final report to be published in September.

- Better outcomes for everyone: Getting ADHD right isn't just about individuals – it's about reducing school exclusions, easing pressure on mental health services, and helping more people to thrive at home, in work and in society.

- Faster answers for those that need it most: The report calls for a major overhaul of ADHD services, so those that need it most aren't waiting for years for support and diagnosis.
- Support without a diagnosis: The report seeks to reimagine a world that offers practical help (like coaching, classroom tools and parenting advice) to those showing signs of ADHD – even if they're still waiting for diagnosis or don't meet the clinical threshold.
- One joined – up system: The report calls for an end to the confusing patchwork of care, replacing it with clear pathways that work across services and conditions – so no one falls through the cracks.
- Less stress, better lives: The report calls for people to receive quicker support and face fewer barriers, and for families to have to spend less time fighting the system and more time focusing on their child's wellbeing, education, and future.

4. Overview of Population and Prevalence of Autism and ADHD in Oxfordshire

4.1. Population data

4.1.1. NHS data (Patients Registered at a GP Practice, April 2024 - NHS England Digital) shows the population of Oxfordshire in April 2024 was 818,430 based on people registered with a GP. Adults (15+) make up 692,855 of that population.

4.1.2. The autism prevalence in the UK is now estimated to be almost double previous estimates at 1.7%, potentially 1.2 million people in the UK. It is noted that 2.94% of 10-14 yrs were diagnosed autistic, it is recognised that adults aged 20 years and over are less likely to be diagnosed and only 10% of autistic adults aged over 50 are diagnosed. (Getting Real About Autism's Exponential Explosion — NCSA). Based on the data in Paragraph 8 from NHS England Digital, the adult autistic population of Oxfordshire makes up approximately 11,778 calculated using the prevalence figure of 1.7%.

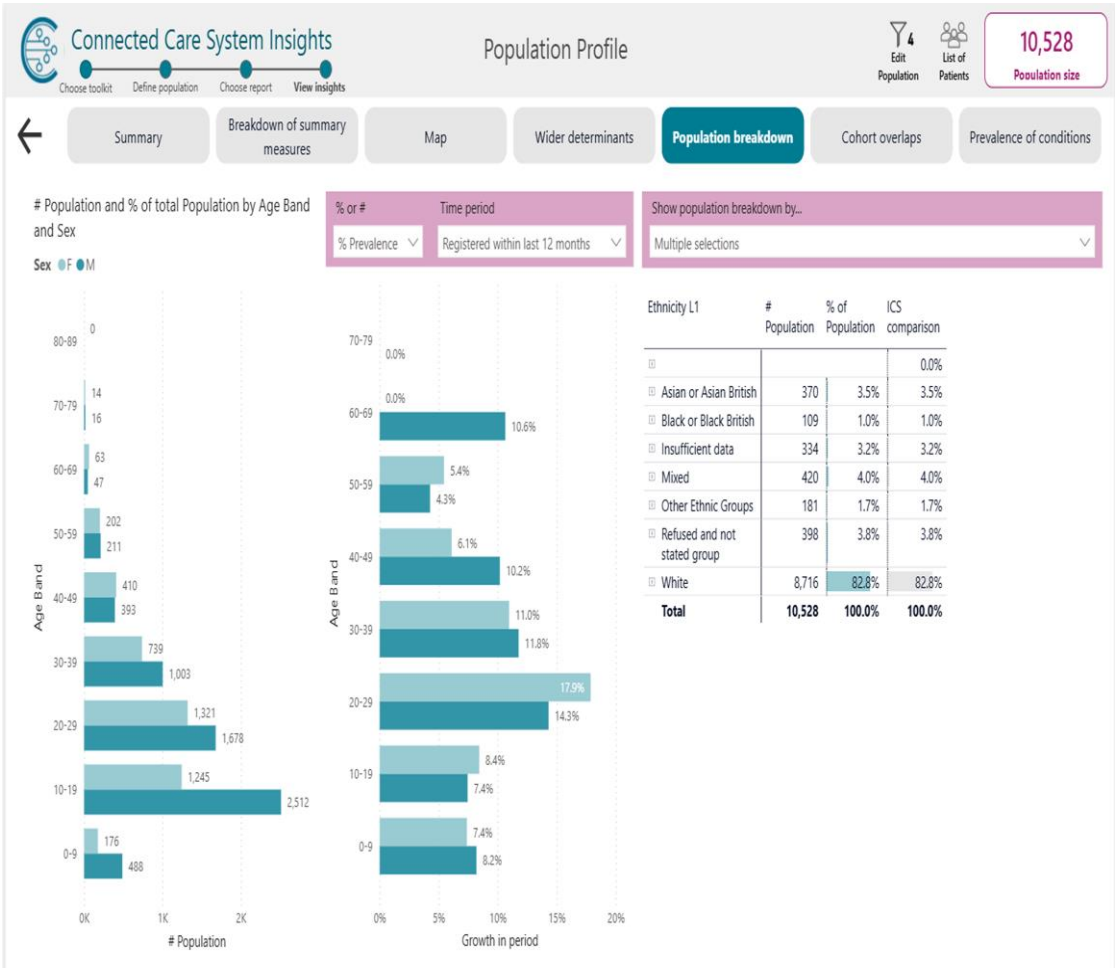
4.1.3. The National Institute for Health and Care Excellence (NICE) reports that the prevalence of ADHD in adults is 5% and, which would suggest the population of adults with ADHD living in Oxfordshire is approximately 27,714. This is inclusive of those who are undiagnosed.

4.1.4. Statistics from the Electronic Medical Information System (EMIS) (a system used primarily by GP practices) show the number of adults diagnosed with ADHD in Oxfordshire are 10,528, which is much lower than the anticipated population according to prevalence. The average age to receive a diagnosis in Oxfordshire is 24. years old. Diagnosis is most commonly recognised males are in education as they typically present with hyperactivity, whilst for females there is under recognition of ADHD presentation. A study by the United Kingdom ADHD Partnership found that females with ADHD often present with differences in their profile of symptoms, comorbidity, and associated functioning compared with males. Girls may struggle with time management,

daydreaming, or being hyperverbal, and are more likely to be diagnosed with the primarily inattentive type of ADHD over the hyperactive type. This can lead to delays in diagnosis, often until adulthood (Why Are So Many More Women Being Diagnosed With ADHD? / Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/ hyperactivity disorder in girls and women | BMC Psychiatry | Full Text)

4.1.5. Below is a snapshot of population data (Figure 1). This shows that the highest rates of diagnosed people are males aged 10-19 years old, which is not surprising, given that males are most commonly diagnosed during their time in education. The data shows almost double the number of males to females have a diagnosis during this age range. We can also see that there has been a 17.9% growth of females aged 20-29 years old obtaining a diagnosis which reinforces the study mentioned earlier that females are often diagnosed in adulthood. There are also figures to demonstrate the ethnic percentages of adults diagnosed with ADHD in Oxfordshire and given the diverse population of Oxfordshire, this will need to be considered when commissioning future services to ensure ethnic minority groups are included in co-producing services to ensure they are designed to be easily accessible for all.

Figure 1 – Population Profile for ADHD



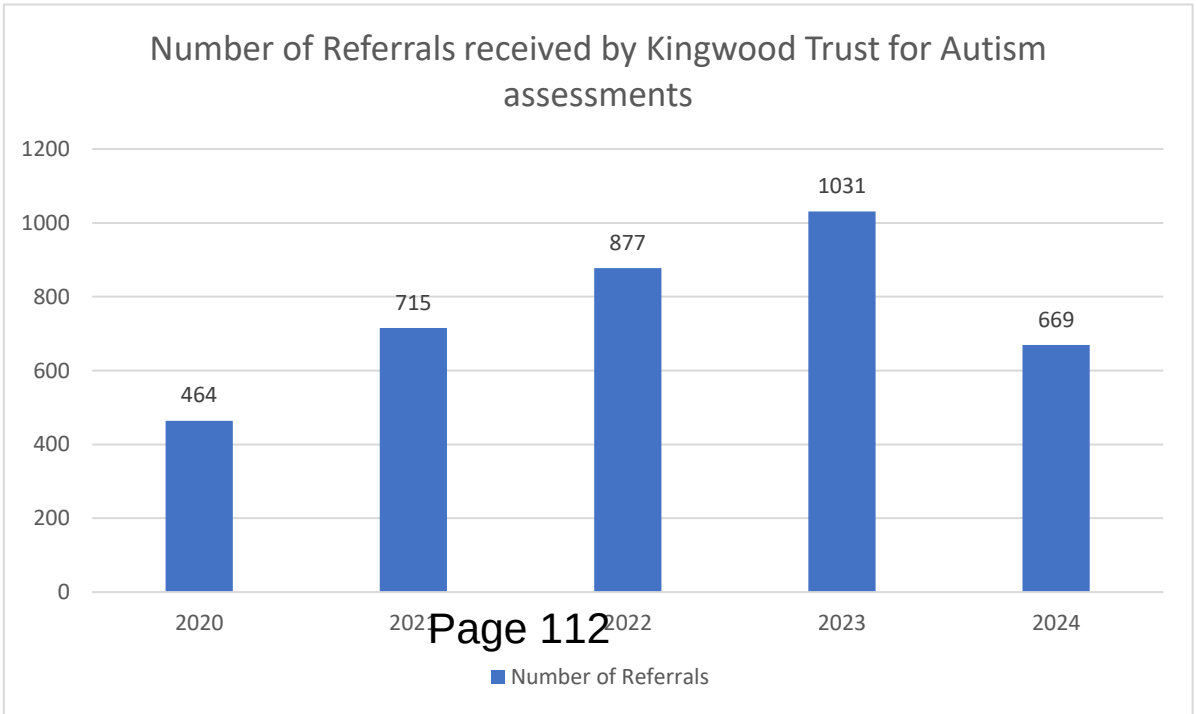
5. Present service provision summary

5.1 Adult ADHD and Autism services have seen significant growth in demand both at a local, region and national level. The waiting list and waiting times in Oxfordshire are not a particular outlier and demonstrate the need for a fundamental review of service provision and pathways to create a sustainable service offer. The ICB is committed to develop these with the Adult ADHD programme already in place and clear commitment to review Autism services driven by the development of a 5 year all age autism strategy. The right to choice model offers an alternative solution where local NHS services are paused and/ or have excessive wating times but do not reflect a financially sustainable model for the Integrated Care Board.

6. Oxfordshire Autism Diagnostic Services for Adults

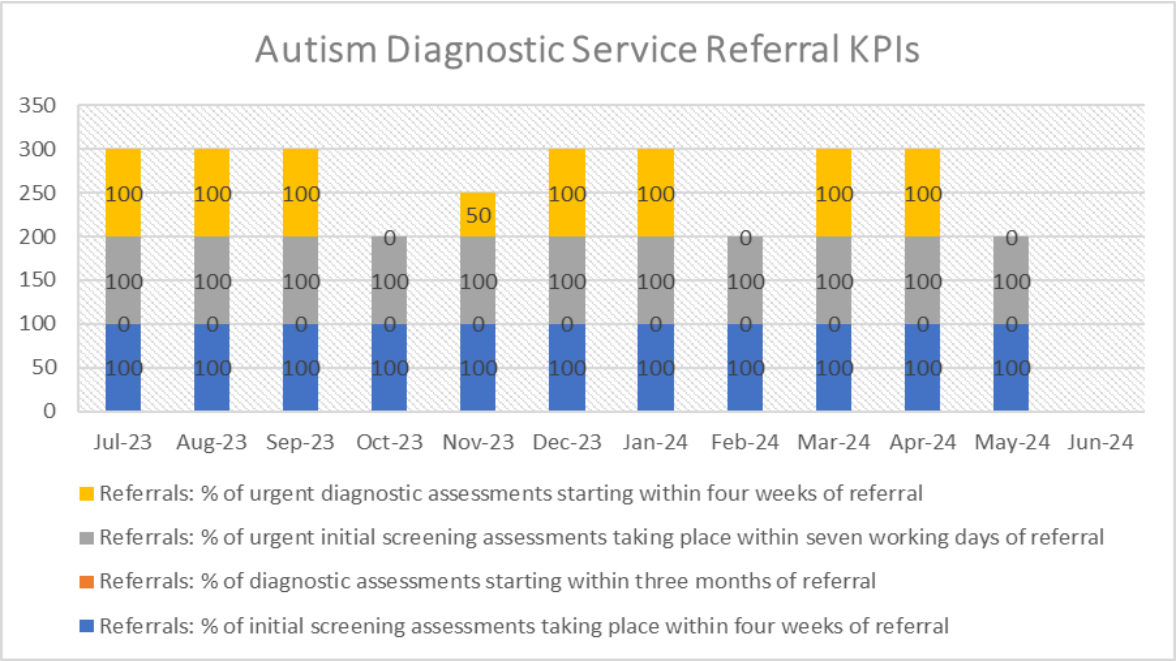
6.1. Kingwood Trust has held a contract with the Integrated Care Board (ICB) for the Adult Autism Diagnostic service and post diagnostic support for 8 years. Awareness of autism has increased nationally, and Kingwood Trust reported that their waiting times had increased year on year with no increase in funding. It was agreed to close the waiting list to new referrals in November 2024 when the waiting time reached 10 years. This decision was made for patient safety and clinical oversight. The demand had exceeded the commissioned capacity of 150 assessments per annum. It was agreed that the contract value would remain at the same and the number of assessments would reduce to 110 per annum and the service was closed to new referrals whilst the backlog of assessments is cleared, however they do continue to deliver services to those that are post diagnosis on what help is available. Table 1 below shows the referrals received by the commissioned Autism assessment service Kingwood Trust. The ICB are committed to continuing dialogue with Kingwood Trust to look at innovation and the contract values to find better solutions than relying on RtC provider. This work will be supported and developed by the action plan for the All-Age Autism Strategy. This action plan will work alongside system partners and community organizations to develop community support provision in Oxfordshire.

Table 1 – Referrals Received by Kingwood Trust 2020 to 2024



6.2. Table 2 below shows the referral Key Performance Indicators (KPIs) for 2023-24 for the Kingwood Trust Adult Autism Diagnostic Contract. The service has consistently delivered above the 95% target for the initial screening assessments; however, they have not reached the 95% target for starting the diagnostic assessment within 3 months, this is due to the high numbers of individuals on the waitlist.

Table 2 – Key Performance Indicators 2023-24 (Adult Autism Diagnostic Contract)



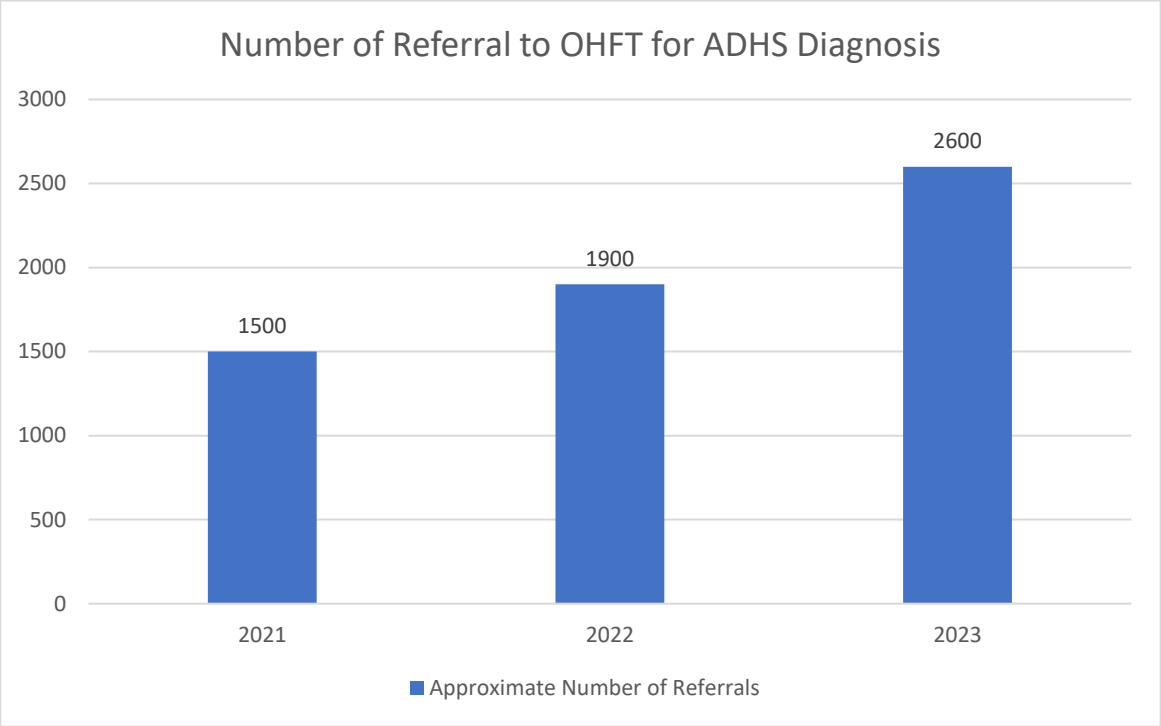
The ICB is establishing a BOB-wide transformation programme for Autism Diagnostic Services for Adults in November 2025. This will address the waiting lists and capacity, and demand issues highlighted above and will continue to assess potential further investment in the service given growth in activity through right to choose providers.

7. Oxfordshire ADHD Diagnostic Services for Adults

7.1. Oxford Health NHS Foundation Trust (OHFT) has held the contract for the Adult ADHD diagnostic service since 2021. With requests for ADHD diagnosis increasing nationally, service waiting times increased to ten years. The service was paused to new patients in February 2024 because patient safety could not be effectively managed. The demand exceeded the commissioned capacity of 200 assessments per annum and the service continues to see patients on the waiting list. Table 3 shows the number of referrals received by Oxford Health NHS Foundation Trust (OHFT) up until February 2024. The 2023 data in the table represents the period

April 2023 to Feb 2024. There is no further data beyond this as referrals are still paused.

Table 3 – Number of Referral received by OHFT up to February 2024



7.2. OHFT is assessing people on the waiting list and the current waiting list has 2,229 people on it. OHFT has completed 126 assessments this year and are offering additional support to those that are transitioning into adulthood.

7.3. One issue affecting patients is that the Shared Care Protocol for Oxfordshire for Adult ADHD requires secondary care to fully transfer patient responsibility to the general practitioner (GP), however 50% of GPs in Oxfordshire are refusing to issue ADHD drugs because of this. There is a full explanation of what Shared Care is at Paragraphs 7.1 to 7.4.

8. Right to Choose (RtC) Providers

8.1. The NHS Right to Choose programme is a legal entitlement in England that allows patients to have more control over where and how they receive care. Patients referred for elective care by a GP, dentist, or optometrist have the legal right to choose the hospital, service provider, and clinical team overseeing their care. This includes private or independent providers with NHS commissioning contracts.

8.2. These services offer a pathway to access Adult ADHD and Autism services for the population where local services are paused or experiencing excessive demands.

8.2.1. Waiting times for adult autism assessment for (RtC) providers vary from a few weeks to over 12 to 18 months but are shorter than local services.

8.2.2. Waiting times for adult ADHD assessment for (RtC) providers vary from six month to 18 months for diagnosis and further waits for titration support and annual reviews

8.3. The ICB has developed a commissioning framework for Adult ADHD contract for RtC providers. The framework will consist of a list of accredited providers which will support more consistency and quality assurance to ensure patients are able to access high quality services.

8.4. RtC expenditure across the BOB ICB geography on all age autism and ADHD service has grown from approx. £1.7m in 2023/24 to £5m in 2024/25 with a potential forecast spend of £11m in 2025/26. Therefore, whilst the model gives access to these services it is not a financially sustainable service model.

9. Reasonable Adjustment Service (RAS)

9.1. This service provides a case consultation resource and clinical interventions in support of the overall care plan to autistic adults accessing mental services in Oxfordshire. The service contract for RAS has been awarded to and delivered by OHFT, which supports both community and inpatient pathways. The team play an important role in delivering autism clinical training to OHFT staff, improving knowledge, understanding and confidence in supporting autistic adults.

9.2. Following the closure of new referrals to Autism at Kingwood – Oxford Adult Autism and Support Service (OAADSS), the RAS created a document of advice to send to those who were seeking a diagnosis, which contained a list of some of the Right to Choose (RtC) providers for both Autism and ADHD, that have been used by the NHS previously.

9.3. The RAS currently has vacancies within the team and the HESC Commissioning Team is supporting OHFT to ensure the service continues to be delivered whilst the recruitment is in progress.

9.4. The RAS service specification has been reviewed and updated under the new overarching 10-year (7-year plus 3-year) contract with Oxford Health. As part of the RAS specification, OHFT will on an annual basis, identify a service improvement initiative and where appropriate do this in a co-produced way with Experts by Experience.

9.5. To bring the experience to life, below is a compilation of positive feedback received from people who have used the RAS and a professional that has attended their training session:

> *"The email you sent beforehand with all the info, and I particularly liked the photo of you so I could recognise you and your name as it was hard to hear on the phone. During the appointment I felt listened to and put at ease (I think I was a bit anxious as I knew it was a one-off appointment, and I wanted to make sure I made the most of it) and I appreciated the effort you went to, to make the environment as calm as possible. The 2 documents were quite useful especially the end of the neuro-inclusion passport about when I get overwhelmed and*

coming up with ideas of how to respond. The documents you have sent over, look good, I haven't had time to click on all the links yet though."

"Small adaptations can make a big difference!"

"The training was exceptional, my colleague and I have been working in the trust for over 20 years, and this was the best and most engaging training we have ever attended, and we think everyone should do it."

10. The role of Shared Care in ADHD pathways

10.1. Shared care protocols (SCP) are mechanisms for GPs to prescribe medications which are initiated within Secondary care, for an area which is thought to be outside a GPs normal knowledge (such as ADHD medication), whereby the GP can prescribe the medication but the decisions about continuing or altering the medication for the condition remains under secondary care consultant. The GP, as they are prescribing, have some responsibility to make sure some elements of physical monitoring is carried out (often but not always including blood test, weight, BP, pulse) and general consideration of side-effects drug interactions etc. An important part of the 'contract' is that secondary care has some overall and ongoing responsibility for the patient, and that they only apply when stable doses are achieved. So, for example, if medication needs to be changed in its entirety or dosage, the consultant will take over responsibility in totality until a stable dose of drug is achieved i.e. the patient is stable on that dose and drug. GPs would not change doses or medication without the say so of the consultant. Therefore, the patient needs to remain open to the consultant. The consultant usually would need to review the patient at least once a year by some mechanism.

10.2. The SCP is a tripartite contract among the patient (who could refuse to be part of a SCP and hence the consultant would need to continue to prescribe and monitor the patient long term), the GP (who could refuse to be part of the process if they have reasonable reason), and the consultant (who may want to retain full control in a complicated case). Any one of these members could refuse a SCP and ALL must agree to it for it to be enacted. Patients must also agree to attending for reviews and having necessary tests done.

10.3. This has been further exacerbated by the requirement within NICE guidance that the person with ADHD and on medication should have an annual review from a person with expertise in ADHD, which is not regarded as a core skill of GPs. Providing these annual reviews within secondary services has diverted commissioned funds from diagnosis and titration to maintenance dose, to carrying out the annual reviews which are required for Shared Care protocols (SCP) to be possible with General Practice. If the annual reviews are not done, then GPs have argued that terms of the SCPs have been broken and therefore if any changes occur to the patients, they are not covered by the medicolegal protection which the SCP provides.

10.4. Currently, GPs are paid for adopting SCPs on prescription for ADHD medication following the general LCS provisions for Near Patient Medicines Management (NPMM) at Level1 BOB_2023-27_LCS_NPMM_Revised_v.1

- Band 1 – is essentially safely prescribing medication only £24.76 per patient per year
- Band 2 – Prescribing plus one listed additional activity £104 per patient per year.
- Band 3 – prescribing plus multiple additional activities £135 per patient per year.

10.5. The commissioning team via the ICB Patient and Liaison Service (PALS) has received a range of complaints from patients, the public, GPs, Councillors and Members of Parliament around the shared care protocol.

10.6. The ICB is reviewing the present model and may consider increases the annual payment to Band 3, however, further work will need to be undertaken to address the Shared Care protocol issue that is specific to Oxfordshire. This is being addressed through the BOB ICB Adult ADHD Transformation Programme which is described in Paragraphs 10.2 to 10.4.

11. Oxfordshire Autism Strategy

11.1. The HESC Joint Commissioning Team is currently co-producing the Oxfordshire All-Age Autism Strategy with experts by experience, local organisations, strategic partners and professionals. The strategy is a 5-year plan running from 2025 to 2030 for the whole Autism system in Oxfordshire. The vision of that strategy includes:

- Inclusive education and employment – Ensuring that autistic individuals have access to appropriate and supportive access to educational opportunities and support to succeed in the workplace.
- Comprehensive health and social care – When required, provide health and social care services that address and support the unique needs of autistic individuals throughout their lives.
- Community awareness – Promoting understanding of Autism within the community to reduce stigma and create a more inclusive society
- Person centred support – Most autistic people will never need services, however when there is a need for support, then individualised support plans will be used to focus on the strengths and needs of each individual, enabling them to live fulfilling lives.
- Family and caregiver support – Provide resources and support for families and caregivers to help them navigate the challenges and celebrate the successes of living with autistic individuals.
- Accessible services – Moving towards ensuring that services are easily accessible and that there are no barriers to receiving the necessary support in a timely manner.
- Lifelong learning and development – Encouraging continuous learning and personal development opportunities for autistic individuals at every stage of life.

11.2. There will be a delivery plan to follow the strategy, which will see local partners work together with experts by experience to improve the quality of autistic people's lives. Focusing on needs led and based services, making support accessible to those who need it.

12. BOB ICB Adult ADHD Transformation Programme

12.1. The ICB is leading on an Adult ADHD Transformation Programme, and the members of the programme group consist of Providers, Experts by Experience (EbE) and Commissioners. There are seven workstreams, each led by a designated workstream lead. The workstream leads, timeline, and impact of their work are outlined in Table 4 below. The Shared Care Protocol issue is being addressed through this programme of work. The findings from the national taskforce have bene incorporated into this programme.

Table 4: Adult ADHD Transformation Programme Workstreams

Workstream	Deliverables	Impact	Status	Date of Completion
Patient Pathway	Produce a document highlighting gaps and challenges in current structures. This needs to include workforce, skillset, investment for inclusion in the business case	Demonstrates current demand and capacity and other key issues and risks for the business case	Completed	
Shared Care	Discussion and agreement with the Local Medical Committee (LMC) around the feasibility of GPs conducting annual health checks and the associated remuneration. A document setting out actions needed to fully implement electronic prescribing and set up teaching sessions for GPs to support Shared Care. Shared Care protocol completed for adult ADHD to be used by RtC providers	GP sign up to the new Shared Care Protocol, which means that patients are offered annual reviews for their ADHD, including medication and ongoing prescribing. Thie results in the improvement of quality and patients' experience. Frees up capacity in all providers	In progress	October 2025
Primary Care Liaison	workforce and their skillset required in primary care. A document with options appraisal for the model for a single point of access (SPA) for primary care to streamline referrals.	Upskill and give confidence to GPs to offer SCP for ADHD	Completed	
Commissioning Framework	Adult ADHD contract for RtC providers	High quality and affordable services available for patients	In progress	6 weeks process

Workstream	Deliverables	Impact	Status	Date of Completion
	Accredited providers, ensuring consistency and quality across the region. Indicative system-wide activity plans (IAP)	Ensuring that using the IAP will enable the ICB to live within its means Eliminating the waiting list time		culminating in October 2025
Comms and Engagement	Comprehensive and effective Communication and Engagement plan	Managing effective communication with stakeholders and moving from defensive to proactive messaging	In progress	September 2025
Access Criteria	New access criteria across all three places in BOB ICB.	Managing demands and ensuring that complex patients are high priority for our local services. Ability to segment to mild, medium and complex categories	In progress	September 2025

12.2. A Lived Experience Workshop was held in July 2025 to inform pathway redesign.

Key themes identified were:

- Challenges in current pathways and processes.
- Strong demand for pre- and post-diagnosis support.
- Opportunities to scale support using digital tools and VCSE partnerships.

12.3. This was followed by a BOB ICS workshop which brought together Providers, EbEs and Commissioners. A new service model has been established, and a business case is in development and is expected to be finalised in October 2025. The new service model will be dependent on new access criteria which will reduce the over-diagnosis of ADHD, reduce the demand for medication by offering a community support service (learning to live with your ADHD approach) and reduce the need to refer to Right to Choose providers. The new model is likely to be driven using digital and AI systems in line with the NHS 10 Year Plan.

13. Conclusion

13.1. In response to the issues and challenges, the ICB is actively developing and implementing the Adult ADHD Transformation Programme to streamline care, improve medication management, and enhance GP engagement. Future plans include leveraging digital tools, strengthening community support, and co-producing solutions with service users and partners to build a more accessible, equitable, and sustainable service model.

13.2. A county-wide Autism Strategy is in development with the objective of local partners working together with experts by experience to improve the quality of autistic people's lives.

13.3. The initiatives described represent a comprehensive programme to enhance care, support, and equitable access across health and community sectors. The adoption of artificial intelligence and digital platforms is poised to improve diagnostic processes and tailor support to individual needs, benefiting both service users and professionals.

13.4. The focus on reasonable adjustments, targeted diagnostic pathways reflect a commitment to inclusive, patient-centred care and to reducing barriers to effective treatment. Collaboration among healthcare providers, educators, technology developers, and individuals with lived experience remains central to the successful implementation of these approaches.

13.5. Continued evaluation and development will be essential to sustain impact and ensure that services remain responsive to the evolving needs of the population. This report highlights the ongoing importance of investment, partnership, and innovation in enabling improved outcomes, greater autonomy, and fuller participation within the community.

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Work Programme 2025/26
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna | Dr Omid Nouri, Health Scrutiny Officer, omid.nouri@oxfordshire.gov.uk

COMMITTEE BUSINESS

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
11 September 2025				
General Practice Access and Estates	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from the BOB Integrated Care Board on measures taken to increase GP access and to secure further primary care estates.	Overview and Scrutiny	
Opthamology Services Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report providing an update on the current state of Opthamology services, this is in line with evidence the Committee has received regarding challenges with these services.	Overview and Scrutiny	
Adult Autism and ADHD Services	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from system partners on services for Adults with Autism, and ADHD.	Overview and Scrutiny	
20 November 2025				
CAMHS Services Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report providing an update on the current state of the CAMHS service for Oxfordshire residents.	Overview and Scrutiny	
School Nurses Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents	To receive a report from Oxford Health NHS Foundation Trust with an update on the role and activities of School Nurses in Oxfordshire.	Scrutiny	

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
Children's Emotional Wellbeing and Mental Health Strategy	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from system partners with an update on the delivery of the Children's Emotional Wellbeing and Mental Health Strategy.	Overview and Scrutiny	
29 January 2026				
South Central Ambulance Service Performance Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from SCAS on its CQC improvement journey and on its performance in Oxfordshire more broadly.	Overview and Scrutiny	
Oxfordshire Learning Disability Plan	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from system partners on the development and launch of the Oxfordshire Learning Disability plan/strategy.	Overview and Scrutiny	
Director of Public Health Annual Report	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive the draft Director of Public Health Annual Report prior to its launch at Oxfordshire's Full Council.	Overview and Scrutiny	

Recommendation Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Omid Nouri, Health Scrutiny Officer, omid.nouri@Oxfordshire.gov.uk

The action and recommendation tracker enables the Committee to monitor progress against agreed actions and recommendations. The tracker is updated with the actions and recommendations agreed at each meeting. Once an action or recommendation has been completed or fully implemented, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker.

KEY	Report due	With Cabinet / NHS	Complete

Recommendations:

Meeting date	Item	Recommendation	Lead	Update/response
06-Mar-25	Musculoskeletal Services in Oxfordshire	1. To address variances around the county, with a view to residents being able to access local MSK services more swiftly.	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	**Partially Accepted (see agenda item 5)**
06-Mar-25	Musculoskeletal Services in Oxfordshire	2. To continue to develop further collaboration with GPs and other services to improve MSK services. It is recommended that efforts are made to reduce the number of steps (and time) required to access MSK services.	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	**Partially Accepted (see agenda item 5)**
06-Mar-25	Musculoskeletal Services in Oxfordshire	3. For efforts to be made to create improvements to pelvic health outcomes. It is recommended that there is engagement with the Pelvic Partnership around support for those who are waiting for support.	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	**Accepted (see agenda item 5)**
06-Mar-25	Cancer Services in Oxfordshire	1. For further detail to be shared on outcomes across different cancer types, and how that compares nationally and regionally.	Matthew Tait; Felicity Taylor; Andy Peniket	**Accepted (see agenda item 5)**

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
06-Mar-25	Cancer Services in Oxfordshire	2. For there to be clear communications with cancer patients who cannot speak in English (or who struggle to communicate in general), and for mechanisms to be in place to help with advocacy for such patients.	Matthew Tait; Felicity Taylor; Andy Peniket	**Partially Accepted (see agenda item 5)**
06-Mar-25	Cancer Services in Oxfordshire	3. For Oxford University Hospitals NHS Foundation Trust to collaborate with the Oxfordshire County Council's Public Health team on awareness campaigns with communities with low take-ups of cancer screening.	Matthew Tait; Felicity Taylor; Andy Peniket	**Accepted (see agenda item 5)**
06-Mar-25	Audiology Services in Oxfordshire	1. For further information to be provided around the level of need for audiology services (including amongst children), and on supply at the local and acute levels. It is recommended that further resourcing is sought to tackle waiting lists and prioritisation, particularly around Community Diagnostic Centres.	Matthew Tait; Neil Flint; Phil Gomersall	**Accepted (see agenda item 5)**
06-Mar-25	Audiology Services in Oxfordshire	2. For improvements to be made around communications with the wider public to increase awareness of available support from audiology services.	Matthew Tait; Neil Flint; Phil Gomersall	**Partially Accepted (see agenda item 5)**
06-Mar-25	Audiology Services in Oxfordshire	3. That Community Audiology is brought onto the same Electronic Patient Record system as the rest of Oxford University Hospitals NHS Foundation Trust.	Matthew Tait; Neil Flint; Phil Gomersall	**Rejected (see agenda item 5)**
05-Jun-25	Oxfordshire as a Marmot Place	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 timely development of specific indicators for the purposes of evaluating collective system-level efforts to achieve this, and that these must include rural inequalities.	Ansaf Azhar; Kate Holburn	**Accepted (see agenda item 5)**
05-Jun-25	Oxfordshire as a Marmot Place	2. To explore further avenues of funding for the purposes of supporting the work to making Oxfordshire a Marmot Place.	Ansaf Azhar; Kate Holburn	**Accepted (see agenda item 5)**

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
05-Jun-25	Oxfordshire as 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 with a view to any future working in their neighbourhood being done with the community. 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.	Ansaf Azhar; Kate Holburn	**Accepted (see agenda item 5)**
05-Jun-25	Oxfordshire System Pressures	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.	Dan Leveson; Lily O'Connor; Karen Fuller	**Accepted (see agenda item 5)**
05-Jun-25	Oxfordshire System Pressures	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.	Dan Leveson; Lily O'Connor; Karen Fuller	**Partially Accepted (see agenda item 5)**
05-Jun-25	Oxfordshire System Pressures	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.	Dan Leveson; Lily O'Connor; Karen Fuller	**Accepted (see agenda item 5)**
05-Jun-25	Oxfordshire System Pressures	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)	Dan Leveson; Lily O'Connor; Karen Fuller	**Partially Accepted (see agenda item 5)**

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
05-Jun-25	Oxfordshire System Pressures	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).	Dan Leveson; Lily O'Connor; Karen Fuller	**Partially Accepted (see agenda item 5)**

Action Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Omid Nouri, Health Scrutiny Officer, omid.nouri@Oxfordshire.gov.uk

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KEY	Delayed	In Progress	Complete

Actions:

Meeting date	Item	Action	Lead	Update/response
No outstanding action items				

Recommendation Update Tracker
Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Omid Nouri, Health Scrutiny Officer, omid.nouri@ocfordshire.gov.uk

The recommendation update tracker enables the Committee to monitor progress accepted recommendations. The tracker is updated with recommendations accepted by Cabinet or NHS. Once a recommendation has been updated, it will be shaded green and reported into the next meeting of the Committee, after which it will be removed from the tracker. If the recommendation will be update in the form of a separate item, it will be shaded yellow.

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	1. To work on developing explicit and comprehensive navigation tools for improving communication and referral for services at the neighbourhood level and within communities. It is recommended that piloting such navigation tools in specific communities may be a point of consideration.	CM Children and Young People	Progress update to be provided
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	2. To ensure adequate co-production with children and their families as part of continuing efforts to deliver the strategy, including considerations of how children and families can be placed at the heart of commissioning. It is also recommended for an early review with the users of the digital offer once this becomes available; to include testing with neurodivergent children and other children known to be at higher risk of mental ill health.	CM Children and Young People	Progress update to be provided
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	3. To continue to explore and secure specific and sustainable sources of funding for the Strategy to be effectively delivered in the long run.	CM Children and Young People	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	4. To ensure that children and young people and their families continue to receive support that is specifically tailored toward their needs. It is recommended that a Needs-Based Approach is explicitly adopted, as opposed to a purely Diagnosis-Based Approach. This could allow for early intervention to be initiated as soon as possible.	CM Children and Young People	Progress update to be provided
30-Jan-24	Children's Emotional Wellbeing & mental Health Strategy	5. That consideration is given to the use of a simple and evidence-based standardised evaluation measure, that is suitable across all services that are working on Children's mental health in community settings.	CM Children and Young People	Progress update to be provided
06-Jul-24	GP Provision	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, to include evidence on key feedback themes and from which groups within Oxfordshire such themes were received from. 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.	Julie Dandridge; Dan Leveson	Progress update to be provided
06-Jul-24	GP Provision	2. To continue to work on Prevention of medical and long-term conditions besides cardiovascular disease.	Julie Dandridge; Dan Leveson	Progress update to be provided
06-Jul-24	GP Provision	4. That the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons, and that it is also checked as to whether/how the public have been communicated with around such closures. It is recommended that there is improved clarity and communication about the statistics concerning access to appointments.	Julie Dandridge; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
06-Jul-24	GP Provision	5. For there to be clarity and transparency around the use of any competency frameworks as well as impact and risk assessments around the role of non-GP qualified medical staff who are involved in triaging or providing medical treatment to patients. The Committee urges that the advocacy needs of patients are considered/provided for, and that patients are clearly informed about the role of the person who is treating them and the reasons as to why this is a good alternative to seeing their GP.	Julie Dandridge; Dan Leveson	Progress update to be provided
06-Jul-24	GP Provision	6. 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.	Julie Dandridge; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	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.	Hugh O'Keefe; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	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.	Hugh O'Keefe; Dan Leveson	Progress update to be provided
12-Sep-24	Dentistry Provision	4. For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.	Hugh O'Keefe; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	1. To ensure that carers receive the necessary guidance as well as support in being able to maximise the support they provide to palliative care patients.	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	2. To secure sustainable sources of funding and resources for the RIPEL project, as well as Palliative Care Services more broadly.	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	3. To secure additional and sufficient resourcing and support for palliative transport services. It is recommended that transport services for palliative care patients are organised in a manner that avoids delay and distress for patients.	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	1. To ensure that adult eating disorder services are personalised in a manner that takes the unique needs and experiences of each individual patient. it is recommended that this service is coproduced with adults with eating disorders as much as possible.	Rachel Corser; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	2. To take adequate measures to tackle loneliness amongst older adults, and to make every effort to reach out to older adults (with lived experience) and to include them in the designing of older adult mental health services. It is recommended that there is liaison with the Oxfordshire Mental Health Partnership to explore avenues to improve coproduction here.	Rachel Corser; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	3. To ensure that patient history is effectively communicated and shared amongst professionals/organisations providing mental health support, and to avert the prospects of patients being or feeling bounced between various mental health services.	Rachel Corser; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	4. That voluntary sector stakeholder organisations who work in Oxfordshire on suicide prevention are invited to register with a VSO suicide prevention stakeholder register. It is also recommended that there is adequate resource, engagement, and a collaborative system inclusive of the VSO registered stakeholders to tackle suicide.	Rachel Corser; Dan Leveson	Progress update to be provided
05-Nov-24	Adult and Older Adult Mental Health in Oxfordshire	5. That there is collaborative system work to develop KPIs on serious mental health to maximise the impact of the existing resource available across Oxfordshire, with a view to prevention and to increase the support available to people and families in distress. It is recommended that there is engagement with the local authority and Region on KPIs relating to patients residing in long-term inpatient settings away from their families.	Rachel Corser; Dan Leveson	Progress update to be provided
26-Nov-24	Medicine Shortages	1. To ensure that policies are in place to recognise and identify patients with cliff-edge conditions, and to ensure that mitigations are in place to reduce the risk of harm to these patients in the event of supply disruptions.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
26-Nov-24	Medicine Shortages	2. To ensure effective communication, coordination, and transparency within and between the local and national levels to help mitigate risks associated with medicine shortages.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
26-Nov-24	Medicine Shortages	3. To work on reducing any prospect of additional excessive workloads on both clinical and administrative staff in the event of medicine shortages, and to provide meaningful support for staff as well as additional resource if need be for the purposes of tackling any additional demand/burdens.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
26-Nov-24	Medicine Shortages	4. To continue to improve sharing of information and transparency, including through a potential digital local database, for helping professionals to easily identify where supply issues exist.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
26-Nov-24	Medicine Shortages	5. To work on improving communication and coproduction with patients and involving those with cliff-edge or long-term conditions, regarding the pharmacy services and the availability of medicines (including through the use of frequently asked questions). It is also recommended that patients are signposted to any support that could be available from pharmacy services and the voluntary sector.	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
16-Dec-24	Epilepsy Services Update	1. For the ICB and Oxford University Hospitals NHSFT to: a. Give priority to patient safety for people with epilepsy and their families in Oxfordshire, and to the welfare of the Oxfordshire epilepsy team, and to set out how that priority will be addressed through their governance and management at a board level. The governance and management of these priorities should also be inclusive of people with lived experience and their charity representatives, as well as their concerns regarding tailored and balanced communications and the use of existing empowerment tools. b. To secure further funding and resource for epilepsy services.	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided
16-Dec-24	Epilepsy Services Update	2. For NHSE Region to give support to the ICB and Oxford University Hospitals NHS Foundation Trust to help achieve the above prioritisations.	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
16-Dec-24	Epilepsy Services Update	3. For OCC Cabinet: For Oxfordshire County Council Cabinet members and senior officers responsible for education and residential care for children and adults with Learning Disabilities and/or autism (who are affected by patient safety concerns), to consider the likely impacts of the valproate policy for the local authority commissioning arrangements and the provision of residential care and out of county placements.	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	1. To ensure that maternity staff receive ongoing training around improving OUHFT Maternity Services. It is recommended that staff are also trained in patient-centred care.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	2. To continue to improve the support for the welfare and wellbeing of maternity staff in the context of improving OUHFT Maternity Services. It is especially crucial that staff are not subjected to undue negative pressure due to their working in maternal services or as part of efforts to improve OUHFT Maternity Services.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	3. To develop a maternity trauma care pathway for ongoing support for mothers (and their partners) to include those who have experienced difficult births, complications, premature babies, and still births and bereavement. It is recommended that this is undertaken in co-production with voluntary organisations that work with families experiencing trauma and who include experts with lived experience. It is crucial to be proactive in reaching out to such patients and their partners in this regard.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	4. To establish robust processes through which to monitor and evaluate the effectiveness of measures aimed at improving OUHFT Maternity Services.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
06-Mar-25	OUHFT Maternity Services in Oxfordshire	5. To ensure that coproduction remains at the heart of the design as well as the improvements of OUHFT Maternity Services. It is also recommended for collaboration amongst relevant system partners, to explore the opportunity for coproduction work to maximise the potential of health checks for supporting women who have given birth, with a view to improve their physical and mental wellbeing and that of their families in the long run.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	6. For there to be clear communication with patients, including in indigenous languages for those who may not be fluent in English.	Yvonne Christley; Rachel Corser; Dan Leveson	Progress update to be provided
05-Jun-25	Oxfordshire Healthy Weight	1. To explore support to local businesses supplying food in the takeaway market to provide healthier offers that meets both business and health needs. It is recommended that effective measures are adopted to address the concerns of local takeaway businesses about losing business in the event of switching to healthier food products	Derys Pragnell	Progress update to be provided
05-Jun-25	Oxfordshire Healthy Weight	2. To support food banks and larders in providing healthier food options; and for there to be further liaison and cooperation between the County Councils' Public Health Team and food larders and banks. It is recommended that there is further celebration of the role of volunteers and voluntary sector organisations in this regard.	Derys Pragnell	Progress update to be provided
05-Jun-25	Oxfordshire Healthy Weight	3. For the development of clear and measurable KPIs so as to evaluate the impacts and progress of the work to promote healthy weight.	Derys Pragnell	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
05-Jun-25	Oxfordshire Healthy Weight	4. For there to be clear communications as soon as possible with residents as to the benefits and risks associated with obesity medications, especially for anyone who has not been encouraged to lose weight by their GP and is considering buying weight loss drugs privately or online without medical supervision.	Derys Pragnell	Progress update to be provided
05-Jun-25	Oxfordshire Healthy Weight	5. For there to be clear mapping and identification of individuals with comorbidities. It is crucial that there is ongoing coproduction of healthy weight services that would include input from those with comorbidities or from vulnerable population groups.	Derys Pragnell	Progress update to be provided
05-Jun-25	Oxfordshire Healthy Weight	6. For system partners to work collaboratively to promote greater physical activity amongst residents of all ages. It is recommended that consideration is given to launching a public event to celebrate good practice in schools around promoting eating well and moving well. This could help to raise awareness of the importance of healthy eating and physical activity for all children.	Derys Pragnell	Progress update to be provided
05-Jun-25	BOB ICB Operating Model Update	1. For the ICB's Executive Sponsor for Oxfordshire and the Director for Places and Communities to meet with the HOSC chair and Health Scrutiny Officer, as well as to meet with local MPs (as part of the national offer for facilitation), to initiate proper engagement with Oxfordshire Place. It is recommended that clear indicators are developed which demonstrate the levels of engagement being undertaken between the ICB and key stakeholders in Oxfordshire Place.	Matthew Tait; Dan Leveson	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
05-Jun-25	Health and Wellbeing Strategy Outcomes Framework	1. To support sustainable funding in the Oxfordshire County Council budget for early years readiness for school.	Cllr Leffman; Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	Progress update to be provided
05-Jun-25	Health and Wellbeing Strategy Outcomes Framework	2. To ensure that rural geographies in Oxfordshire are also at the heart of implementing the priorities and actions of the Health & Wellbeing Strategy.	Cllr Leffman; Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	1. To explore support to local businesses supplying food in the takeaway market to provide healthier offers that meets both business and health needs. It is recommended that effective measures are adopted to address the concerns of local takeaway businesses about losing business in the event of switching to healthier food products.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	2. To support food banks and in providing healthier food options; and for there to be further liaison and cooperation between the County Councils' Public Health Team and food larders and banks. It is recommended that there is further celebration of the role of volunteers and voluntary sector organisations in this regard.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	3. For the development of clear and measurable KPIs so as to evaluate the impacts and progress of the work to promote healthy weight.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
05-Jun-25	Support for People Leaving Hospital	4. For there to be clear mapping and identification of individuals with comorbidities. It is crucial that there is ongoing coproduction of healthy weight services that would include input from those with comorbidities or from vulnerable population groups.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	5. For system partners to work collaboratively to promote greater physical activity amongst residents of all ages. It is recommended that consideration is given to launching a public event to celebrate good practice in schools around promoting eating well and moving well. This could help to raise awareness of the importance of healthy eating and physical activity for all children.	Derys Pragnell; Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
05-Jun-25	Oxford Health NHS Foundation Trust People Plan	1. To work toward reducing reliance on agency staff where possible. It is recommended that processes are in place to ensure that the quality of care provided by agency staff is appropriate and up to standard so as to ensure consistency in the quality of care for patients.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	Progress update to be provided
05-Jun-25	Oxford Health NHS Foundation Trust People Plan	2. To create a positive and supportive work environment for staff, and to foster an environment and processes where staff can easily make complaints or express legitimate grievances.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	Progress update to be provided
05-Jun-25	Oxford Health NHS Foundation Trust People Plan	3. To harness the use of technology to create a better and more efficient working environment for staff. It is also recommended that the Trust takes steps to avert the prospects of future IT outages inasmuch as possible, and to provide evidence of this.	Charmaine Desouza; Zoe Moorhouse; Amelie Bages	Progress update to be provided
05-Jun-25	Director of Public Health Annual Report	1. For the Public Health team to provide details of how system partners will work with schools to improve children's emotional wellbeing and mental health.	Ansaf Azhar; Donna Husband; Frances Burnett	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date (hyperlinked)	Item	Recommendation	Lead	Update
05-Jun-25	Director of Public Health Annual Report	2. For clarity to be provided on who will have responsibility for implementing each of the recommendations being made in the DPH annual report.	Ansaf Azhar; Donna Husband; Frances Burnett	Progress update to be provided
05-Jun-25	Director of Public Health Annual Report	3. For there to be greater collaboration and sharing of ideas between communities for the purposes of improving health and wellbeing at the local community/neighbourhood level.	Ansaf Azhar; Donna Husband; Frances Burnett	Progress update to be provided

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