OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 29 January 2026 commencing at 10.01 am and finishing at 3.30 pm.

Present:

Chair: Councillor Jane Hanna OBE
Deputy Chair: District Councillor Dorothy Walker

Councillors: Ron Batstone, Gareth Epps, Imade Edosomwan, Emma Garnett

District Councillors: Katharine Keats-Rohan, Val Shaw, Elizabeth Poskitt, Louise Upton

Co-Optees: Barbara Shaw

Officers:
Ansaf Azhar, Director of Public Health and Communities (Oxfordshire County Council)
Karen Fuller, Director of Adult Social Care (Oxfordshire County Council)
Alex Wheeler, Senior Joint Commissioning Officer
Bhavna Taank, Head of Joint Commissioning - Live Well
Clair Taylor, My Life My Choice Project Co-ordinator
Fiona Ruck, Health Improvement Practitioner
Kate Austin, Public Health Principal
Kumudu Perera, My Life My Choice Expert by Experience
Matthew Tait, BOB ICB Chief Delivery Officer
Professor Dr. Andrew Brent, Chief Medical Officer Oxford University Hospitals
Veronica Barry, Executive Director of Healthwatch Oxfordshire
Yvonne Christley, Chief Nurse Oxford University Hospitals NHS Foundation Trust
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.

1/26 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Cllr Sargent, Cllr Edwards, and Sylvia Buckingham.

The Committee sent their best wishes to Cllr Sargent.

2/26 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

Barbera Shaw declared her interest as the Chair of Healthwatch Oxfordshire.

Cllr Hanna declared her interest as an employee of SUDEP action.

3/26 MINUTES

(Agenda No. 3)

The Committee **APPROVED** the minutes of the meeting held on 20 November 2025 as a true and accurate record.

4/26 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Roseanne Edwards (Banbury Guardian) urged the committee to address ongoing problems with maternity care at John Radcliffe Hospital and its impact on the Horton General Hospital. She claimed that a PowerPoint presentation was withheld from the Keep the Horton General group for nine months, which undermined their case. Roseanne argued that reported improvements did not solve space limitations, staff shortages, or high birth rates, and called for engagement on restoring two obstetric units in Oxfordshire.

Joan Stuart (Keep our NHS Public) warned of long-term risks to Oxford Eye Hospital, mainly due to profit-driven NHS-funded eye clinics. She explained that capping private sector profits could lead to a £45 million loss and withdrawal from cataract services. Fee cuts would impact NHS departments by ignoring their wider roles, while higher tariffs for complex surgeries might push private clinics to take over work now done by NHS hospitals, endangering future financial stability.

Emma Henrion (Keep our NHS Public) discussed concerns about the future of two NHS LIFT schemes in Oxford, with leases expiring in 2031. She explained that the ownership and accountability of these sites were unclear, as the company holding the leases lacked local health stakeholders. Emma warned that similar issues could arise with future health centres under public-private partnerships. She requested the Committee seek clarity from the ICB on site ownership, decision-making processes, and the ICB’s relationship with the leaseholder.

5/26 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 5)

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

- Eyecare Services in Oxfordshire
- GP Access & Estates

The Committee expressed concern that the response to the Committee's recommendation on Eyecare services did not address the intended issue of tracking specific problems escalated to the Eye Hospital. They emphasised the need for a system to identify trends and sources of issues, particularly from private providers, for effective contract management.

6/26 JHOSC SUBSTANTIAL CHANGE WORKING GROUP UPDATE REPORT

(Agenda No. 6)

The Committee received an update on the JHOSC Substantial Change Working Group and its ongoing scrutiny of the project to redevelop Wantage Community Hospital.

The Chair updated the Committee on the substantial change working group, noting its ongoing scrutiny of the redevelopment project for Wantage Community Hospital. They explained that the hospital, serving a large local population, had been temporarily closed for many years, and the working group had identified local needs and inequalities. Progress had been made with building works underway, and the Chair recommended that the Committee supports the working group's continuation for another year and to appoint three new members to replace those who had left.

The Committee **NOTED, CONFIRMED,** and **AGREED** to the recommendations in the update.

7/26 CHAIR'S UPDATE

(Agenda No. 7)

The Chair provided a verbal update on the following issues since the previous OJHOSC meeting.

Cllr Garnett joined the meeting at this stage.

A detailed deep dive into children's emotional wellbeing and mental health services had already taken place in November, with further scrutiny on adult mental health, including transition issues, scheduled for April 2026. -dive into children's emotional wellbeing and mental health services had already taken place in November, with further scrutiny on adult mental health, including transition issues, scheduled for April

A report containing the Committee's recommendations on the Oxfordshire Neighbourhood Health Plan had been submitted to system partners.

Another report was submitted on behalf of the Committee containing recommendations to system partners on Children's Emotional Wellbeing and Mental Health.

The Committee was asked to **NOTE** the formal response received from the Department of Health and Social Care via Anneliese Dodds MP, regarding future arrangements for an independent patient voice after the imminent abolition of Healthwatch by government legislation.

The Chair also referenced a recent Oxfordshire County Council motion requesting scrutiny of both children's and adult mental health services.

An update was also given on interactions between the Chair and Health Scrutiny Officer with the Buckinghamshire, Oxfordshire, and Berkshire West Joint Health Overview Scrutiny Committee (BOB JHOSC) Vice Chair and the Buckinghamshire Council Scrutiny Manager as part of preparations for the establishment of a new Thames Valley JHOSC.

The Committee was also informed of a private meeting held with its members and with Oxford University Hospitals NHS Foundation Trust on 22 December 2025, to receive an update on maternity services.

Another meeting was also held between the Chair, the Health Scrutiny Officer, Dan Leveson, BOB ICB (Integrated Care Board) Director of Place and Communities, and Julie Dandridge, BOB ICB Associate Director for Primary Care, which had enabled concerns about primary care (including in Didcot) and local practice closures to be raised.

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

8/26 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2025/26

(Agenda No. 8)

Ansaf Azhar, Director of Public Health and Communities (Oxfordshire County Council), Kate Austin (Public Health Principal), and Fiona Ruck (Health Improvement Practitioner), were invited to present the Director of Public Health Annual Report.

The Committee received a presentation on the Director of Public Health's Annual Report, which took the form of an interactive web-based publication designed to make health information more engaging and accessible. The Public Health Principal and Health Improvement Practitioner demonstrated the platform's features, noting its use of bold visual design, clear navigation tiles and intentionally concise text to help users explore themes such as local data, lived experience, health inequalities and community voice. Offices highlighted that the new format builds on the direction set by the 2020 report, "Some Are More Equal Than Others", by showing progress in several areas of deprivation and showcasing community-led initiatives that have developed despite significant financial pressures across the system.

The Committee heard that the digital report incorporates videos, case studies, blogs and toolkits, including contributions from Professor Sir Michael Marmot and local community health workers. These materials aimed to demonstrate the real-life impacts of health inequalities and highlight the positive outcomes achieved by communities themselves. Officers explained that the toolkit had been designed to help local groups access and interpret data at the most appropriate geographic level, and where possible at parish level, to support targeted action in both urban and rural contexts. They highlighted how the toolkit could provide granular detail at parish level, supporting tailored action in both rural and urban communities.

Officers discussed how the report and associated tools address the specific challenges faced by residents in affluent rural areas, where isolation, poor transport links and hidden deprivation can hinder access to services. They emphasised the importance of integrating local insight with the NHS ten-year plan to ensure that community experience influences future commissioning. The wide geography of the Thames Valley ICB was acknowledged as a further challenge, reinforcing the need for strong partnership working and a consistent focus on inequalities. The overarching intention of the new digital format is to foster dialogue, empower isolated individuals and enable community narratives to shape future public health priorities and service development. Importantly, they underlined the report's aim to foster dialogue, empower isolated individuals, and ensure community voices influence future health services and tangible health improvements.

Members sought clarity on the level of granularity available in the forthcoming toolkit and digital data platform. Officers explained that while users can already explore detailed data for the ten priority wards, equivalent parish-level information was not yet available county-wide due to national data limitations. Some indicators could be broken down more locally than others, and qualitative community insight was currently published for the fourteen areas where Community Insight Profiles had been completed. The long-term ambition was to extend this model across Oxfordshire, but data gaps, particularly in rural settings where small populations can mask need, prevented a fully consistent approach. Officers stressed that the new toolkit would support communities to undertake their own profiling, and demonstrations could be provided to any area wishing to use it.

Officers described how the initial focus on the ten most deprived wards had expanded as evidence of rural inequalities grew. Newer insight profiles already included areas outside the original list, such as Bicester-area communities and parts of West Oxfordshire. Rural deprivation, they noted, was complex to measure and often concealed within overall affluence, making mixed-method approaches essential. Work had therefore begun on a rural inequality dashboard that combined indicators such as transport access, housing and availability of services. This would support more precise identification of localised issues and guide tailored recommendations for market towns, villages and isolated communities. The long-term ambition was to extend the community insight model countywide, allowing tailored recommendations for market towns, villages and isolated communities.

The Committee explored how lived experience could be incorporated into the public health dashboard. Officers confirmed that including stories, videos and examples of community-led work was both feasible and desirable. Qualitative insight had always been central to the Community Insight Profiles, and Officers expect community-generated material to become increasingly important, particularly where quantitative data remain inconsistent. The forthcoming toolkit was intended to support community groups in collecting, structuring and sharing their insights.

Discussion then turned to rural access to GP services. Officers acknowledged that limited transport, dispersed populations and reliance on voluntary schemes left many residents effectively cut off from primary care. The community insight work had already highlighted these barriers, and the rural inequality framework aimed to map them more systematically. Officers emphasised the importance of using public health evidence to shape broader decisions about housing, transport and place-shaping so that access to GPs becomes a proactive consideration rather than a reactive one. Innovation in rural areas, they said, would require stronger collaboration between councils, the NHS and local community groups.

Members asked how the Community Insight Profiles aligned with the NHS ten-year plan. Officers explained that the profiles were designed as a shared system resource rather than a standalone public health exercise. They already fed into neighbourhood-level planning and commissioning decisions led by the ICB, supporting a preventative approach that complemented clinical priorities. By embedding insight on wider determinants, the profiles helped to guide decisions about service locations, resource deployment and targeted interventions. Strong collaboration across the system was essential to retain this alignment.

Concerns were raised about whether the newly expanded Thames Valley ICB might dilute the focus on local inequalities. The BOB ICB Chief Delivery Officer outlined that senior leadership appointments had been confirmed and that staff consultation on organisational structures would begin in February, after which clearer operating models would be defined. He emphasised that the ICB remained committed to prevention and reducing inequalities, and highlighted successful joint programmes already under way, including Well Together and learning disability initiatives. Officers reiterated the importance of ensuring that the needs of rural and vulnerable communities continued to shape decision-making despite the larger geographic footprint.

Members also discussed how the community voice would continue to shape public health and wider system commissioning. Officers emphasised that community insight informed not only public health work but programmes such as school readiness and joint NHS–council evaluation projects. Stories, feedback and co-produced recommendations were expected to play a growing role in shaping prevention work and wider determinants of health across the system.

Officers noted that epilepsy, which affects about a quarter of people with learning disabilities, had been raised through recent LEADER findings. Further detailed information had been sought from health partners and fed through the Health and Wellbeing subgroup to inform ongoing planning.

Members sought reassurance on the accessibility of the new interactive website, particularly for people with visual impairments, limited digital literacy or unreliable internet connectivity. Officers confirmed that accessibility considerations would be built into the next development phase and that feedback would be passed to the communications team. Features such as text-to-speech and clearer navigation were being explored, and the team was considering the publication of a technical report or alternative formats alongside the online version.

Finally, the Committee asked about monitoring progress against the report's recommendations. Officers explained that impacts would continue to be overseen through existing governance structures, primarily the Health and Wellbeing Board, with relevant issues returning to HOSC as appropriate. They emphasised that the report aims to shape long-term system priorities, so monitoring will focus on broader prevention and inequality outcomes rather than short-term activity measures.

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

1. To embed Community Insight Profiles (CIP) into routine commissioning and service design, ensuring decisions explicitly reference CIP findings and community led priorities.

2. To ensure that neighbourhood working includes public health leadership and community voice structures. It is recommended that there is a systemwide roadmap for neighbourhood maturity, resourcing, and integration with the existing voluntary and community sector and council assets.

3. For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes, including Well Together and physical activity pathways.

4. To move Community Health Development Officer, Well Together roles and community led programmes onto multiyear funding cycles, given that short funding cycles undermine sustainability. It is recommended that there is a best value review and prioritisation of funding continuity to avoid regression of gains in areas with improving Index of Multiple Deprivation deciles.

5. To prioritise Oxfordshire-wide rural areas that are experiencing a regression on the Multiple Deprivation deciles of inequalities. It is recommended that the capability of rural communities is explored by the development of the Neighbourhood offer to Towns and parishes; and to give consideration for a contextualised offer to support an independent voice, local members, and to enhance community capabilities.

City Cllr Upton left the meeting at this stage.

9/26 OXFORDSHIRE LEARNING DISABILITY PLAN

(Agenda No. 9)

Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); Bhavna Taank (Head of Joint Commissioning - Live Well); Clair Taylor (My Life My Choice Project Co-ordinator); Kumudu Perera (My Life My Choice Expert by Experience); Alex Wheeler (Senior Joint Commissioning Officer); and Matthew Tait, (BOB ICB Chief Delivery Officer), were invited to present a report on the Oxfordshire Learning Disability Plan.

The Director of Adult Social Care highlighted the strong foundations of co-production that had shaped the plan and emphasised the positive atmosphere surrounding its development. She noted that the plan had recently been discussed at Cabinet, where its formal signing and subsequent media coverage had been warmly received, reflecting a strong endorsement of the work undertaken.

The Head of Joint Commissioning – Live Well and the My Life My Choice Expert by Experience then presented the Oxfordshire Learning Disability Plan in detail. They explained that the plan represented a ten-year, dynamic strategy that had been co-produced with people with learning disabilities, their families, carers and professionals across the system. Four central themes shaped the strategy: having a good life, health and wellbeing, a place to live, and homes not hospitals. These themes were supported by cross-cutting elements including transitions, workforce, technology and inclusion. They emphasised that the plan had been informed by extensive engagement involving more than 200 participants, whose contributions had centred on communication, access to activities and the importance of meaningful relationships.

The My Life My Choice Expert by Experience described the empowerment gained through the co-production process and illustrated how lived experience had helped frame the plan's priorities. The Officers explained that the plan aligned closely with both local frameworks and wider national policy.

The discussion moved into the structure of future reviews, and Officers explained that although the plan had originally been designed for formal reviews at three-, five- and seven-year points, this structure had been amended following feedback gathered through the World Café engagement event. People with learning disabilities had expressed a preference for an earlier review to ensure timely reflection and the ability to respond more dynamically to changing needs.

Officers confirmed that each review would draw on renewed engagement, likely employing a similar World Café-style format, ensuring that lived experience continued to guide the plan's evolution. Oversight of progress sat with the Learning Disability Improvement Board, which would assess whether developments in services, new data or emerging concerns required earlier revisions. They stressed that the plan had been deliberately structured as a dynamic document that any subgroup or partner could request to revisit if significant issues, changes in need or new evidence came to light.

Attention then turned to risk management, and Officers explained that oversight of risk sat with the Learning Disability Improvement Board, comprising health, social care, voluntary sector representatives and experts by experience. This structure provided continuous scrutiny and challenge. Officers added that the extensive co-production process itself helped to mitigate risks by ensuring that actions within the plan reflected real need and were grounded in lived experience rather than assumptions. Engagement mechanisms such as World Café events had been intentionally built into the plan's governance, helping to surface potential difficulties early and ensuring alignment with the priorities of people with learning disabilities. They emphasised that regular monitoring, open communication across partners and the ability to trigger early adjustments formed essential components of long-term risk mitigation.

Consideration was then given to the measures that would be used to assess alignment with wider frameworks, such as the NHS Long Term Plan, the Oxfordshire Way and national learning-disability guidance. Officers explained that thematic subgroups would develop their own Key Performance Indicators (KPIs) linked to the "what needs to happen" section of the plan, ensuring clear metrics for progress and alignment. These KPIs would be reported to and overseen by the Learning Disability Improvement Board, which included experts by experience and system partners responsible for formal check-and-challenge. Officers added that governance and reporting arrangements would be refined further, recognising that various responsibilities sat with system partners beyond the Council and would require continued development and coordination.

Discussion then shifted to system-wide commitments, particularly in relation to the pact signed between Oxfordshire County Council and My Life My Choice. Officers confirmed that the Council took pride in having signed the pact, which contained practical commitments shaped directly through lived experience. These included promoting access to work, supporting good housing and facilitating independence. Some commitments, such as improving recruitment into social care, were already being advanced through joint work with advocacy groups. However, Officers recognised that wider system commitments, including those shared across health, social care and voluntary organisations, required further development. They highlighted the goal of strengthening integration between health and care and ensuring that commissioning decisions, service planning and housing alignment were conducted transparently and in line with the needs of people with learning disabilities.

The early priorities for addressing inequalities were then discussed in detail. Officers explained that the initial focus within the first one to three years would be on the most significant and well-evidenced inequalities disproportionately affecting people with learning disabilities. These included poorer access to healthcare, higher prevalence of co-existing conditions such as epilepsy and sensory impairments, and persistent barriers experienced by people from ethnic minority communities. They emphasised the importance of improving access to and quality of annual health checks, addressing disparities in life expectancy and tackling negative experiences within NHS settings. Subgroups had already begun examining data relating to dentistry, pain management, health checks and wider health inequalities to establish baseline measures. Officers confirmed that KPIs were being developed and would continue to evolve as new insights and lived-experience contributions emerged.

Plans to expand the number of "safe places" for people with learning disabilities were outlined. Officers clarified that the ambition related to the national Safe Places scheme and that the goal, though challenging, was to ensure that safe places were located within a five-minute walk for residents by December 2026. Some community support services and libraries already formed part of the scheme, and the "Having a Good Life" subgroup would lead further work to expand it. Although this subgroup was still developing its programme, Officers explained that they intended to work with district councils, community organisations and established networks such as dementia-friendly schemes to broaden coverage. They welcomed offers from

Members to help encourage local organisations to join the scheme, stating that community involvement was essential to its success.

Further discussion centred on annual health checks for people aged over 14 with a learning disability. Officers clarified that these checks were an NHS-commissioned responsibility delivered through GP practices and constituted an essential tool for improving health outcomes and preventing avoidable hospital admissions. It was acknowledged that uptake and quality varied considerably, both locally and nationally, underscoring the need for improvement. The Committee noted the importance of the checks as a bridge between health and social care, particularly given the vital supporting role often played by carers. Officers agreed that stronger integration at neighbourhood level would be required to improve the process and confirmed that they would seek further updates from health partners. They noted that epilepsy, affecting around one in five people with learning disabilities, had already been identified as an area requiring additional attention, and confirmed that updates would be brought into the Health and Wellbeing subgroup and future workplans.

System-wide collaboration was then explored further, with officers emphasising that the Learning Disability Plan had been developed jointly across health, social care and the voluntary sector. This collaborative approach created valuable opportunities to improve pathways such as annual health checks, early intervention and community support. Officers highlighted the role of joint commissioning teams, which operated across organisational boundaries and allowed for better alignment of priorities and monitoring. The Learning Disability Improvement Board would review progress, enabling system partners and experts by experience to challenge inconsistencies and identify any gaps in delivery. Officers reiterated that consistent improvement, particularly in areas such as epilepsy management or the avoidance of unnecessary hospital admissions, depended on strong, integrated governance, shared data and the sustained use of lived experience to inform decisions.

The plan's proposals for an information platform for activities and support groups were discussed next. Officers explained that the platform would be hosted through the Oxfordshire County Council website and the Live Well Oxfordshire portal, with layout, usability and content shaped by subgroup input. They described early findings showing that information across the county was scattered across multiple sources, and a key early task would be consolidating this into a clearer, more accessible system. Accessible design principles would guide the work, with lived-experience feedback central to refining its structure. A dedicated workstream had begun mapping out how information would be collected, validated and regularly refreshed. Officers mentioned that visual inclusivity indicators such as logos were being considered, although they emphasised the need to avoid unintentionally excluding groups who were not yet using such markers.

Employment support for adults with learning disabilities formed another major theme. Officers explained that the Oxfordshire Employment Service already supported many people with additional needs to secure and sustain employment. They also noted the launch of the national Connect to Work programme, which had gone live locally in January and aimed to help people with learning disabilities access employment and training opportunities. The importance of wellbeing and empowerment within employment pathways was highlighted, with advocacy groups such as My Life My

Choice providing workplace readiness, confidence-building and practical peer-led support. Officers confirmed that benefits advice and guidance formed routine parts of social care and advocacy support, helping individuals make informed decisions without fear of losing essential support.

Further emphasis was placed on ensuring that adults with learning disabilities felt genuinely empowered when seeking employment, particularly where employment might affect their benefits. Officers explained that empowerment formed a central principle of the plan and that a wide range of existing support, including workplace coaching, advocacy services and detailed benefits advice, helped to ensure people made informed, confident decisions. They described how advocacy organisations offered travel training, peer support and guidance tailored to individual needs, while social care teams regularly assisted with navigating the benefits system as part of transition planning. This approach was designed to ensure people felt supported and informed throughout their employment journey.

Training across the system was then considered, particularly the Oliver McGowan Mandatory Training. Officers explained that the training had become a statutory requirement and that monitoring mechanisms were being established across local organisations. The County Council had already begun delivering the training internally, while broader system-wide monitoring frameworks, especially those involving NHS and ICB governance, were still being clarified as part of the new operating model. Officers agreed to take away an action to produce a more detailed update and emphasised that robust oversight was essential, given that the training aimed to improve safety, communication and reasonable adjustments for people with learning disabilities.

There was also a discussion of supported living and risks relating to choice, continuity and quality. Officers explained that the Council and ICB had already undertaken significant work to strengthen the provider market, including establishing a specialist framework ensuring providers had the right expertise for varying levels of need. While acknowledging risks such as market fragility and the need for stable specialist provision, officers explained that current evidence did not support establishing a fully in-house service. The council lacked the infrastructure needed to directly deliver care services, and previous scoping had revealed substantial financial and operational barriers. Instead, resilience was being strengthened through mixed approaches, such as the council purchasing properties while external providers delivered care, enabling increased stability without requiring full in-house provision.

Finally, Officers outlined how assistive technology was being used to support adults with learning disabilities. They explained that assistive technology was already widely embedded in practice, forming part of the standard equipment offer. Tools such as movement sensors, bed sensors, medication reminders and devices like Alexa were routinely used to promote safety, support independence and strengthen the quality of assessments. Sufficient resources were available through the council’s equipment budget, and use of technology was expanding across both learning-disability and dementia services. Officers noted that the technology market continued to evolve quickly and that a dedicated officer monitored developments and collaborated with Innovate Oxfordshire to explore emerging opportunities. Although no standalone strategy existed, assistive technology was considered business as usual and an essential element of future service development.

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

1. That partners at place consider an anniversary event to share progress and good practice.

2. For outcome measures to be developed on all due deliverables, and for this to be prepared for scrutiny by the JHOSC in 2027. It is recommended that there is a statement from all partners at place level on their roles and contributions to LD services, and on what has supported and hindered collaboration.

3. That people with Learning Disabilities, paid and unpaid carers, and health staff undertaking annual reviews, are empowered to improve the quality of annual reviews.

4. For there to be further engagement with people with Learning Disabilities/autism and epilepsy, and that relevant voluntary sector organisations (with their experts by lived experience) are engaged with in a timely way; with a view to understanding what they can contribute to communities of practice and prevention of avoidable and long admissions to hospital and early deaths.

The Committee adjourned for lunch at 12:45, and reconvened at 13:31

10/26 MATERNITY SERVICES

(Agenda No. 11)

Yvonne Christley (Chief Nurse, Oxford University Hospitals NHS Foundation Trust [OUH]) and Professor Dr. Andrew Brent (Chief Medical Officer, OUH), were invited to present the report containing an update on Maternity Services.

The Chair welcomed the Chief Nurse and Chief Medical Officer and invited the Committee to proceed directly to substantive discussion. Members sought clarity on whether the Trust had met families affected by maternity concerns and whether longstanding campaign groups had been meaningfully engaged, particularly in light of previous tensions. The officers reported that groups such as Keep the Horton General had engaged with the Trust at various times, including at listening events, although concerns had persisted about transparency and the handling of information shared by those groups.

The Committee reflected on the private meeting with OUH on 22 December 2025, which had enabled sensitive matters to be raised directly and had provided an opportunity to secure clearer commitments regarding transparency, responsiveness and future engagement. Members underlined the need for renewed dialogue among the Trust, campaigners and affected families, recognising the depth of feeling and the imperative to rebuild confidence.

Attention then turned to the potential for a fresh approach to engagement with campaign groups and the part that Healthwatch could have played as an independent bridge. The officers acknowledged the longstanding nature of concerns within local groups and recognised that earlier engagement had not always built confidence, partly due to misunderstandings and worries about the treatment of information. They supported a renewed, structured model of engagement that brought campaign groups and the Trust together more effectively. They agreed that Healthwatch's independence made it a valuable, community-facing partner, capable of both facilitating dialogue and offering challenge, particularly while national arrangements for patient-voice functions remained uncertain.

The financial environment formed a further line of inquiry. Members explored the implications of NHS tariff changes for maternity services, especially in the context of increasingly complex clinical presentations. The officers noted that national tariff adjustments had been affecting multiple clinical areas. As an illustration, ophthalmology had experienced reduced tariffs for routine activity contrasted with increases for complex procedures, a pattern they considered relevant to maternity. With workloads growing more complex and requiring greater staff time and specialist intervention, the officers questioned whether current tariffs adequately recognised rising acuity. The Trust had already raised these pressures and advocated for sustainable funding models that reflected the real cost of safe, high-quality maternity care. Members warned that tariff misalignment risked worsening workforce and capacity pressures, and the officers confirmed that the matter would remain a focus for continuing scrutiny.

The discussion moved to maternity safety outcomes, with reference to the historic spike in postpartum haemorrhage (PPH) and the measures that had subsequently driven improvement. The officers explained that the increase in PPH had been linked to several factors, including a more complex maternity population and service pressures that had undermined consistency of care. The Trust had conducted a detailed review to understand contributory causes and had implemented a targeted improvement plan. The most effective actions had included strengthening clinical guidelines, improving escalation pathways, enhancing staff training and focusing on the early identification and management of risk during labour and birth. These combined measures had produced a clear improvement in PPH rates and greater consistency in practice across teams, with continued monitoring to sustain progress and embed learning.

In parallel, members examined the newly launched Induction of Labour Improvement Initiative, introduced to address persistent delays. The officers stated that the initiative had been designed to streamline the induction pathway, reduce waiting times and improve outcomes for women needing medical initiation of labour. Although specific process changes were not detailed in the transcript, the officers advised that early signs already indicated reduced delays and better flow through the pathway. Monitoring had continued, with the Trust focused on embedding improvements to deliver safer and more timely inductions over the longer term.

Questions about minimising harm, maintaining safety and responding to shortfalls in outcomes led to further detail on governance. The officers reported that the Trust had strengthened clinical governance procedures through clearer guidelines, rapid escalation routes and closer outcome monitoring. They added that incident reviews had been completed more quickly, making it possible to apply learning sooner. Complaints and concerns had been tracked for themes and fed into service-improvement discussions. The private OUH meeting in December had provided a forum to raise sensitive points directly and to reinforce expectations around transparency and responsiveness. Members stressed the need for consistent application of improvements and for a demonstrably responsive approach when things went wrong.

The Committee then considered the increase in concerns reported in September 2025, where communication, consent and postnatal care had emerged as dominant themes. The officers confirmed that the spike reflected a cluster of cases in which women and families felt communication had been unclear, consent processes had fallen short of expectations and postnatal support had been inconsistent. Each case had been reviewed, and the resulting learning had been routed through governance to identify and address weaknesses. Targeted work had subsequently reinforced staff training on communication, good practice in shared decision-making and appropriate postnatal follow-up. The officers stated that these themes continued to be monitored closely and that improvements were already being embedded through ongoing quality and safety work in maternity.

Members asked whether longstanding dissatisfaction might have contributed to the heightened reporting observed in September. The officers acknowledged that unresolved distress and breakdowns in communication could have influenced the pattern of concerns and emphasised that complaints were being reviewed individually, with attention to their emotional impact. Regarding the national requirement for independent review of 50% of baby deaths, the officers confirmed that the Trust was working towards compliance and that independent scrutiny formed part of established governance processes. The Committee reiterated the need for sensitive communication, clear support for complainants and sustained transparency in oversight.

Discussion of the complaints process continued. The officers accepted that earlier failings in communication had undermined trust and reported that work was underway to strengthen practice. They explained that each complaint was reviewed on its merits, that themes were captured and fed into governance and that learning informed improvements in communication, consent and postnatal care. The Committee underlined that confidence would only be rebuilt through consistent, timely responses, improved escalation and clearer explanations when outcomes fell short, and that visible follow-through would be essential.

A focus on inequalities prompted questions about how the Trust monitored experience across different groups and reached communities at greater risk. The officers stated that patient-experience feedback, complaint themes and incident reviews informed the understanding of variation in care and allowed earlier, more targeted responses. Strengthening the interface between hospital and community services had been prioritised as neighbourhood health models developed. Better communication, more consistent postnatal support and earlier identification of need were presented as critical to reducing inequalities and improving safety, and the

Committee stressed the importance of tracking lived experience alongside clinical outcomes.

Cllr Garnett left the meeting at this stage.

Historic learning was then revisited, with members requesting details from the 2023 maternity case reviews in Oxford. The officers reported that the dominant themes aligned with those already discussed: the quality of communication with families, the robustness of consent processes and the consistency of postnatal care. These same issues had been visible in the September 2025 increase in concerns, suggesting persistent underlying challenges. The officers confirmed that each 2023 case had been reviewed through governance processes and that learning had been fed back to clinical teams. Improvement efforts therefore continued to prioritise communication standards, shared decision-making and reliable follow-up after birth, with monitoring in place to ensure that learning translated into sustained change.

The Committee asked whether a specific risk cited in discussion was included in the NHS England Maternity Bundle and how national focus translated locally. The officers confirmed that the bundle did contain a section relating to this risk and stated that the Trust’s governance incorporated these expectations into day-to-day practice. The bundle was used to guide monitoring, escalation and improvement, ensuring alignment between national standards and local delivery. Members also sought an update regarding women with epilepsy becoming pregnant. The officers noted the importance of this issue, particularly in the learning-disability population, undertook to obtain a clearer system-level update and confirmed that recent LEADER findings had highlighted epilepsy-related inequalities which would be fed back through the Health and Wellbeing subgroup.

Recent media reporting in the New Statesman and on Channel 4 News was acknowledged. The officers observed that the concerns described in those reports overlapped with issues already discussed: communication, consent and postnatal care. They reiterated that steps had been taken to strengthen governance, escalation and learning processes, and that improvement work was ongoing to address the highlighted areas. The private meeting with OUH on 22 December 2025 had enabled direct examination of sensitive matters and had provided reassurances about transparency and responsiveness. The Committee welcomed these clarifications as useful context for anyone who had viewed the coverage.

The conversation then turned to postpartum injuries and whether the BOB ICB was working toward a standardised approach. The officers recognised the significance of postpartum harm within maternity safety and explained that, while the transcript did not set out a single ICB-wide programme, approaches to perinatal risk and harm, such as postpartum haemorrhage and postnatal care, had been under active review through strengthened governance and shared learning. They added that clinical guidelines, escalation pathways and monitoring mechanisms were being improved locally and that collaboration across the BOB system formed part of the wider improvement agenda. Members reiterated the value of system-wide consistency, and the officers confirmed that cross-ICB alignment would remain a priority.

Workforce planning was examined in light of service pressures and the specific context of Oxfordshire. The officers acknowledged the scale of the challenge, citing rising clinical complexity and sustained demand. They described how workforce planning had been strengthened using national guidance, local activity data and learning from incident reviews, ensuring that staffing models reflected both acuity and capacity. The Trust was refining skill-mix, improving recruitment to specialist roles and focusing on the retention of experienced staff through support and training. The overarching aim was to deliver a flexible, evidence-based workforce aligned with neighbourhood-based care and ongoing maternity improvement work.

The future configuration of maternity services, particularly the longstanding debate about the Horton and the concentration of obstetric services at the John Radcliffe, was then revisited. The officers stated that current review work was aimed at ensuring services remained resilient, safe and capable of meeting future demand, but they did not indicate any imminent change to the configuration. When asked whether anything other than resources stood in the way of reopening obstetric services at the Horton, the officers explained that decisions of that scale depended on system-wide and national factors, including regulatory requirements, workforce sustainability and formal service-change processes. Previous evaluations had identified significant challenges, notably around staffing sustainability and clinical safety standards, which continued to act as major constraints. The Committee stressed the importance of transparent, ongoing review.

Technology's role in improving safety, communication and clinical effectiveness also formed part of the discussion. The officers stated that digital tools already supported monitoring, decision-making and information-sharing. They indicated that technological improvements were complementing broader maternity-improvement work, particularly in strengthening governance, escalation and learning, and were helping staff to respond more consistently when outcomes fell short. Digital solutions were also being used to streamline pathways such as induction of labour and to improve communication between hospital and community-based teams as neighbourhood health models developed. These tools supported more reliable follow-up and earlier identification of risk, contributing to safer postnatal care, even if no single initiative was presented as transformative.

To close, members asked about experiences at Chipping Norton, Wantage and in home-birth settings, noting that previous discussions had centred on the Horton and the John Radcliffe. The officers confirmed that women had given birth at those locations, as well as at home, although the report they submitted to the Committee did not provide detailed comparative data or outcomes. They emphasised that the broader improvement work, encompassing communication, consent, postnatal care and pathway development, applied across all birth settings, not only acute sites. Strengthening the interface from hospital to community, particularly through neighbourhood health models, had been intended to improve follow-up and ensure consistent support regardless of place of birth. Members welcomed the reassurance that community-based and home-birth services were included in ongoing work and reiterated the importance of monitoring experiences across all birth settings, not just obstetric units

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

1. To implement a Trust wide maternity communication standard covering: timing, clarity and translation of information, as well as expectations during induction, labour and postnatal care.

2. For the Trust to produce a quarterly, public-facing learning report showing: complaint themes, patients' experience of the complaints process, actions taken, percentage achieved of involvement of independent reviewer in any baby death, and evidence of impact. This is to ensure transparency and restore confidence in maternity services.

3. For the Trust to produce an evaluation framework for: Equal Start Oxford's expansion to Didcot and Banbury, general support for asylum seekers and underserved groups, and translation and outreach programmes. It is recommended that such an evaluation framework should include uptake, impact on outcomes, and service user satisfaction.

4. For the Trust to plan and explain how the current national maternity tariff, demand modelling, and BirthRate Plus projections align with staffing expansion and staff burnout.

5. For the Trust to provide a written update on progress on the accepted JHOSC recommendation on epilepsy, and how it plans to align with the NHS England maternity bundle section on epilepsy.

11/26 HEALTHWATCH OXFORDSHIRE UPDATE

(Agenda No. 10)

Veronica Barry, Executive Director of Healthwatch Oxfordshire, was invited to present an update from Healthwatch Oxfordshire.

The Executive Director provided an update on Healthwatch Oxfordshire's recent activities. She reported that Healthwatch had been monitoring issues with new systems, such as improved communication at the Key Medical Centre and ongoing concerns with Quora Health's MSK services, including appointment cancellations and travel difficulties.

Discharge processes, especially in rural areas, continued to be a focus, with follow-ups on previous recommendations. The Executive Director also highlighted increasing concerns about the new non-emergency transport service, noting that Healthwatch was collecting stories and would keep a close watch on developments. All Healthwatch reports and system responses were made available on their website.

A question was raised about whether the Healthwatch research guide addressed the role of towns and parishes in community research, suggesting these institutions would want to be involved when research teams engaged with local populations. Veronica Barry responded that the workshops had included community members in the design process and that the intention was for the report to be relevant to anyone in Oxfordshire wishing to undertake research. The Neighbourhood Planning Alliance had also participated actively.

12/26 FORWARD WORK PLAN

(Agenda No. 12)

Members discussed and prioritised agenda topics for upcoming meetings. They agreed that the 16 April 2026 public meeting would focus on adult and older adult mental health, (including transitions). Consideration was also given to feature updates on neighbourhood health developments, on the South Central Ambulance Service, and on dentistry services in future HOSC meetings.

Members also considered adding items on dementia support, prostate cancer, cancer wait times, and rheumatology.

The Committee **NOTED** that the above items would be placed on a provisional list for future public meetings.

The Committee **AGREED** and emphasised the need to remain flexible, adapting the work programme as partner engagement and system developments evolved.

The Committee also **AGREED** to enable the Chair and Health Scrutiny Officer to make final amendments to the work plan offline.

13/26 ACTIONS AND RECOMMENDATIONS TRACKER

(Agenda No. 13)

The Committee **NOTED** the action and recommendation tracker.

.... in the Chair

Date of signing ....