

Notice of Meeting



Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 11 June 2026 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:	To be elected		
Deputy Chair:	To be elected		
Councillors:	Jane Hanna OBE Ron Batstone Jenny Hannaby	David Hingley Emma Garnett	Mark Lygo Paul-Austin Sargent
District Councillors:	Katharine Keats-Rohan Elizabeth Poskitt	Val Shaw Louise Upton	David Rodgers
Co-Optees:	Sylvia Buckingham	Barbara Shaw	Dr Alan Cohen
Date of Next Meeting:	10 September 2026		

For more information about this Committee please contact:

Committee Officer: *Scrutiny Team*
Email: *Email: scrutiny@oxfordshire.gov.uk*

Martin Reeves
Chief Executive

June 2026

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. **Election of Chair for the 2026/27 Council Year**
2. **Election of Deputy-Chair for the 2026/27 Council Year**
3. **Apologies for Absence and Temporary Appointments**
4. **Declarations of Interest - see guidance note on the back page**
5. **Minutes** (Pages 11 - 30)

To **APPROVE** the minutes of the meeting held on 16 April 2026 and to receive information arising from them.

6. **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 present a petition must be submitted no later than 9am ten working days before the meeting.

Requests to speak must be submitted no later than 9am three working days before the meeting, i.e. 08/06/2026.

Requests should be submitted to the Scrutiny Officer at 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.

7. JHOSC Cooptee Appointment (Pages 31 - 34)

The purpose of this item is for the Committee to **AGREE** to the appointment of a Coopted member.

The Committee is **RECOMMENDED** to:

1. **NOTE** the requirement to fill one vacant co-opted post on the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) and the work undertaken to fill this post.
2. **AGREE** to Dr Alan Cohen's appointment as a co-opted member of the JHOSC (subject to full completion and submission of a Register Of Interests form).

8. Interim Update Report from the JHOSC Primary Care Access and Estates Working Group (Pages 35 - 102)

The purpose of this item is to provide the Committee with an interim update on the ongoing work and activities of the JHOSC Primary Care Access and Estates Working Group.

PLEASE NOTE: There are TWO main reports attached to this item:

1. Cover Report.
2. Annex 1- Main Interim Report of the Oxfordshire JHOSC Primary Care Access and Estates Working Group.

Please also note: The Annex 1 Main Interim Report of the working group has its own set of annexes labelled A-E (all of which are also attached in the agenda papers for this item).

The Committee is **RECOMMENDED** to:

- a) **RECEIVE** and **NOTE** the Joint Health Overview and Scrutiny Committee (JHOSC) primary care and estates working group interim report found in Annex 1.
- b) **AGREE** to the appointment of an additional working group member (whilst adhering to the principle of political balance) given that Cllr Gareth Epps is no longer a member of the Committee.
- c) **AGREE** to receive a final report with findings and recommendations from the working group in the September 2026 JHOSC meeting, so as to allow for:
 - The final planned working group session to take place with representatives of the Thames Valley Integrated Care Board (ICB) on the use of digital tools and models in primary care services.
 - Conducting site visits to GP practices in both rural and urban areas.
 - Inclusion of further findings from the working group's inquiry on the national backdrop of General Practice, and on the case studies of the Great Western Park and Bicester Health Centre.

9. Response to HOSC Recommendations (Pages 103 - 118)

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

1. Maternity Services in Oxfordshire.
2. Oxfordshire Learning Disability Plan.

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

10. Chair's Update (Pages 119 - 196)

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

Three reports containing Recommendations from the Committee were sent on behalf of the JHOSC as part of the following areas/items:

1. Adult and Older Adult Mental Health Services.
2. All-Age Autism Strategy.
3. Director of Public Health Annual Report.

All these reports are published in the agenda papers for this item.

A letter was sent on behalf of the Committee to the Chief Executive of the Thames Valley ICB. It relates to the Committee being alerted to a critical situation relating to delayed payments to adult social care providers for the provision of Continuing Health Care services (CHC). The wording of this letter is as outlined below:

Dear Nick

The Committee has been alerted to a critical situation relating to delayed payments to adult social care providers for the provision of Continuing Health Care services (CHC)

Given that many providers are operating on tight margins, delayed payments on the scale that we have been alerted to is deeply alarming because of the obvious dependency of many of our most vulnerable residents on these services.

In light of the urgency I have discussed with Omid Nouri (Health Scrutiny Officer). It would be helpful for reassurance purposes if the ICB provided the Committee with a written response on how it is tackling this situation as soon as possible. A written response would be reassuring at this time if it included how much money is owed; what is this as a percentage of overall spend on CHC and, if also affected, Funded Nursing Care; how many clients are supported through this route and how many providers have been and are being affected by delays in payment. The public and residents who depend on provider services would be reassured by a clear timescale for resolving these delayed payments urgently; how many provider accounts are currently up to date and settled, and what actions are being taken to avoid these delays in the future.

It will also be important that the Committee can be reassured at our next JHOSC meeting on 11th June 2026, and we would request that the ICB representative be able to report a brief update at that time.

Kind regards

Jane Hanna

Chair, Oxfordshire JHOSC

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

11. Oxford University Hospitals NHS Foundation Trust Quality Account (Pages 197 - 444)

Oxford University Hospitals NHS Foundation Trust has been invited to present the Trust's Annual Quality Account for this year.

The Committee is **RECOMMENDED** to:

- a) **AGREE** to provide feedback on the Trust's Quality Account.
- b) **AGREE** to finalise the wording of the feedback subsequent to and outside this meeting, and to submit the feedback to the Trust prior to the publication date for the Quality Account at the end of June 2026.

PLEASE NOTE: There are TWO documents attached to this item:

- 1. A Cover Letter submitted to the Committee by Oxford University Hospitals NHS Foundation Trust for this item.
- 2. The full draft Oxford University Hospitals NHS Foundation Trust quality account.

12. Dentistry Services in Oxfordshire (Pages 445 - 470)

Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire, Thames Valley Integrated Care Board) has been invited to present a report providing an update on Dentistry Services in Oxfordshire.

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

13. Healthwatch Oxfordshire Update (Pages 471 - 480)

Veronica Barry (Executive Director, Healthwatch Oxfordshire) has been invited to present the Healthwatch Oxfordshire Update.

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

14. South Central Ambulance Service CQC Improvement Journey Update (Pages 481 - 494)

Paul Jefferies (Divisional Director-Thames Valley, South Central Ambulance Service NHS Foundation Trust) and Andrew Battye (Head of Operations for Oxfordshire, South Central Ambulance Service NHS Foundation Trust) have been invited to present a report providing an update on the SCAS Care Quality Commission Improvement Journey.

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

15. Oxford Health NHS Foundation Trust Quality Account (Pages 495 - 572)

Oxford Health NHS Foundation Trust has been invited to present the Trust's Annual Quality Account for the year 2025-2026.

The Committee is **RECOMMENDED** to:

- a) **AGREE** to provide feedback on the Trust's Quality Account.
- b) **AGREE** to finalise the wording of the feedback subsequent to and outside this meeting, and to submit the feedback to the Trust prior to the publication date for the Quality Account at the end of June 2026.

16. Forward Work Plan (Pages 573 - 574)

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

17. Actions and Recommendations Tracker (Pages 575 - 580)

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, 16 April 2026 commencing at 10.00 am and finishing at 3.28 pm.

Present:

Chair: Councillor Jane Hanna OBE

Deputy Chair: District Councillor Dorothy Walker

Councillors: Ron Batstone Gareth Epps Paul-Austin Sargent
Imade Edosomwan Emma Garnett

District Councillors: Katharine Keats-Rohan Louise Upton
Elizabeth Poskitt

Co-Optees: Sylvia Buckingham
Barbara Shaw

Officers:

- Dr Lola Martos (Consultant old age psychiatrist and Clinical Director Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate, Oxford Health NHS Foundation Trust).
- Catherine Sage (Associate Director, Adult & Older Adult Mental Health and Partnerships Oxford Health NHS Foundation Trust).
- Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust).
- Jess Wilshire Jess Willsher (CEO, Oxfordshire Mind)
- Matthew Tait (Executive Delivery Officer, Thames Valley ICB).
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council)
- Bhavana Tank (Head of Joint Commissioning Live Well).
- Donna Husband (Head of Public Health Programmes – Start Well – public Health, Oxfordshire County Council)
- Mark Chambers (Head of Children's Community Services Community Health Services, Dentistry and Primary Care Directorate | Oxford Health NHS Foundation Trust)
- Emma Leaver (Chief Operating Officer for Community Health Services, Dentistry & Primary Care, Oxford Health NHS Foundation Trust)
- Taylor Nicola (Senior Clinical Lead for Public Health)
- Ansaf Azhar (Director of Public Health, Oxfordshire County Council).

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.

14/26 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies for absence were received from Councillor Judith Edwards.

15/26 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Councillor Garnett declared a personal interest as an employee of the University of Oxford, Primary Health Care Department.

Barbara Shaw declared a personal interest as Chair of Healthwatch Oxfordshire (HWO) and as a Patient Safety Partner at Oxford University Hospitals NHS Foundation Trust (OUH).

Sylvia Buckingham declared a personal interest as a Patient Safety Partner and a Trustee of Healthwatch Oxfordshire.

The Chair declared her standing interest as an employee of a national epilepsy and sudden unexpected death in epilepsy (SUDEP) charity.

No further declarations were made.

The Committee **NOTED** the declarations of interest.

16/26 MINUTES OF THE PREVIOUS MEETING
(Agenda No. 3)

The Committee considered the minutes of the meeting held on 29 January 2026.

The Committee **AGREED** that: the minutes of 29 January 2026 be amended, where necessary, following checking against the meeting recording to capture aspects of what a member of the public raised regarding eyecare services; and that the final amended version be treated as a true and accurate record once those checks had been completed.

17/26 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Three members of the public had registered to address the Committee.

Dr Andrew Johnson (retired Consultant Surgeon):

Dr Johnson spoke on maternity services at Horton General Hospital; due to technical issues he could not join live, so a written statement was read to the Committee.

He said removing consultant-led maternity in 2016 reduced local access and reassurance for families, and raised concerns about capacity and quality at the John Radcliffe, citing a CQC “requires improvement” rating. He argued workforce pressures could be mitigated by reinstating a consultant-led Horton unit using rotational staffing from the John Radcliffe, noting similar models elsewhere.

The Committee **NOTED** that maternity services remained an ongoing focus of the Committee’s scrutiny work.

Joan Stewart (Keep Our NHS Public):

Ms Stewart said long waits and limited theatre capacity at Oxford Eye Hospital persisted, with reliance on leased theatres and constrained consultant availability. She warned delays were driving patients to the independent sector, undermining NHS training, workforce sustainability and financial viability. She also raised concerns about a lack of data on A&E presentations with complications after independent-sector surgery, arguing this reduced transparency and effective contract management.

The Committee was asked to continue scrutinising eye care services and to investigate further.

Jane Southworth (Member of Public):

Ms Southworth described being moved onto an unexplained “virtual clinic” pathway at Oxford Eye Hospital despite longstanding glaucoma and awaiting surgery, with no in-person ophthalmologist and scans reviewed remotely weeks later. She said criteria and safeguards were unclear, the model was difficult for older/frail patients, and she requested Eye Hospital senior managers attend a future Committee meeting to explain the changes and the impact on the hospital’s teaching role.

In response, the Chair thanked Ms Southworth and confirmed that the Committee took these concerns seriously.

The Committee **NOTED** the public representations.

18/26 RESPONSE TO HOSC RECOMMENDATIONS

(Agenda No. 5)

The Committee considered written responses received to previous recommendations issued by the Committee, including responses relating to:

- Oxfordshire Neighbourhood Health Plan.
- Adult Autism and ADHD Services.

The Committee **NOTED** the responses to previous recommendations.

19/26 CHAIR'S UPDATE

(Agenda No. 6)

The Chair provided a comprehensive verbal update on activity since the Committee's previous meeting in January.

- The Chair advised that a report containing the Committee's recommendations on maternity services had been submitted to Oxford University Hospitals NHS (OUH) Foundation Trust on behalf of the Committee. The report was included within the agenda papers for transparency.
- A letter had been sent on behalf of the Committee to the Chief Executive and Chair of OUH seeking clarification in relation to errors identified in data presented to the Committee at its January public meeting item on maternity. The letter had also requested further information regarding engagement with families affected by maternity service concerns. A response had since been received from the Trust's Chief Executive, which was published as an addendum to the agenda.
- Correspondence from the Committee had continued with families affected by OUH maternity services since January, and the Committee had taken the unusual step of offering to facilitate an initial process-planning discussion between families and the Trust to help establish an engagement approach that might be acceptable to all parties. The offer remained open and families had also been reminded of the standard routes through which they could continue to address the Committee directly in public meetings.
- The Chair updated Members on developments relating to joint health scrutiny arrangements. She reported that the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee (BOB JHOSC) had met on 17 March 2026, and that, following the establishment of the new Thames Valley Integrated Care Board on 1st April 2026 with an expanded geography, proposals would be brought forward to formally dissolve the BOB JHOSC and to establish a new Thames Valley JHOSC. Recommendations

made by the BOB JHOSC remained available to Members and the public via the published minutes of its last meeting.

- There was currently one vacant cooptee position on the Committee. A recruitment exercise would be initiated with the aim of appointing an additional co-opted member ahead of the Committee's June meeting.
- The Chair reported on the work of the Primary Care Working Group, which had met four times since January, including sessions with officers of the Integrated Care Board, the Chair of the Local Medical Committee, and district council officers. She highlighted that scrutiny had focused in particular on primary care estates, including progress on the Didcot Great Western Park health facility, where a developer had now been appointed. She confirmed that further scrutiny, including visits to GP practices and additional working group sessions on estates in Didcot, Bicester and Wallingford, was planned, with findings to be reported back to the Committee in due course.
- Regarding the Substantial Change Working Group focusing on the redevelopment of Wantage Community Hospital; the Chair explained that, although negative media coverage had referenced delays, the working group's scrutiny had identified that the primary cause related to asbestos and iron issues identified during surveys. She advised that these issues had now been addressed and that completion was anticipated in late summer or early autumn 2026.
- On eye care services, the Chair reminded Members that the Committee had previously written to the Department of Health and Social Care to express concern about the impact of independent sector provision on NHS ophthalmology services. In addition to ongoing local scrutiny, Freddie van Mierlo MP had offered to pursue a response at national level on the Committee's behalf. Eyecare remained a live issue for the Committee's future work programme.

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

20/26 MENTAL HEALTH MOTION FROM COUNCIL (Agenda No. 7)

The Committee considered a report by the Health Scrutiny Officer relating to a motion passed by Oxfordshire County Council at its meeting on 9 December 2025. The motion requested that the Health and Wellbeing Board invite the Joint Health Overview and Scrutiny Committee to investigate and report on how mental health services provided by Oxford Health NHS Foundation Trust and wider system partners

were addressing the rising prevalence and impact of poor mental health among adults and children in Oxfordshire.

The Chair outlined the context to the motion, explaining that it had been debated late in the Full Council agenda and had received cross-party support, reflecting the shared recognition of the scale of mental health need locally and nationally. She advised that, due to time constraints at Full Council, it had not been possible for the Committee to explain that substantial scrutiny of children's emotional wellbeing and mental health services had already been completed in November 2025, resulting in a detailed report with multiple recommendations, the formal response to which was still awaited.

The Chair explained that the Committee's agreed work programme already included scrutiny of adult and older adult mental health services, scheduled for the current meeting, including consideration of transition issues between children's and adult services. She therefore proposed that the Committee formally note the request arising from the Full Council motion, reaffirm its existing and ongoing scrutiny of mental health services across the age spectrum, and incorporate its findings into its next Annual Report to Council.

The Chair confirmed that mental health was already a recurring theme across the Committee's work programme, and that future scrutiny items, including sessions with the ambulance service and other providers, would provide further opportunities to explore system-wide impacts. She further proposed that, as part of its formal response to the motion, the Committee could write to the Secretary of State for Health and Social Care, summarising key findings from its scrutiny of children's and adult mental health services and highlighting relevant national context.

Following discussion, the Committee indicated that it was content with this approach.

The Committee **AGREED** to:

- **NOTE** the request arising from the Full Council motion.
- **CONFIRM** that it had already undertaken scrutiny of children's mental health services and was undertaking scrutiny of adult and older adult mental health services at the current meeting.
- Incorporate its findings and observations into its next Annual Report to Council.
- Write to the Secretary of State for Health and Social Care to highlight key findings and concerns identified through its mental health scrutiny work.

21/26 ADULT AND OLDER ADULT MENTAL HEALTH SERVICES IN OXFORDSHIRE

(Agenda No. 8)

Dr Lola Martos (Consultant old age psychiatrist and Clinical Director Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate, Oxford Health NHS Foundation Trust); Catherine Sage (Associate Director, Adult & Older Adult Mental Health and Partnerships Oxford Health NHS Foundation Trust); Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust); Jess Wilshire (Chief Executive, Oxfordshire Mind); Matthew Tait (Executive Delivery Officer, Thames Valley ICB); Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); and Bhavna Taank (Head of Joint Commissioning Live Well); were invited to attend in order to present a report with an update on Adult and Older Adult Mental Health services in Oxfordshire.

The Chair welcomed the officers and set out the context for the item, noting that it formed part of the Committee's agreed work programme and responded directly to the motion passed by Full Council in December 2025, requesting further scrutiny of mental health services.

The Oxford Health NHS Foundation Trust (OH) Chief Operating Officer for Mental Health and Learning Disability outlined the national and local context, explaining that adult mental health services continued to experience sustained increases in demand, rising clinical complexity, and significant workforce pressures. Referrals to adult mental health services had increased year-on-year, with a growing proportion of people presenting with complex trauma, co-existing substance misuse, neurodivergence and social needs such as housing instability. These pressures had affected flow through services and contributed to challenges in meeting waiting-time expectations in some pathways.

The Associate Director for Adult and Older Adult Mental Health and Partnerships provided further detail on community services and access. The Community Mental Health Transformation Programme had been central to current service redesign and aimed to strengthen multidisciplinary working, improve access, and embed voluntary and community sector support within neighbourhood-based models. While investment had supported the development of new roles such as peer support workers, officers noted that recruitment and retention of experienced mental health professionals, including nurses and consultant psychiatrists, remained challenging and continued to place pressure on teams.

Members queried waiting times for assessment and treatment, particularly for adults with serious mental illness and for older adults accessing memory services and dementia pathways. The OH Consultant Old Age Psychiatrist and Clinical Director acknowledged that demand for older adult mental health services, including memory assessment, had increased substantially, reflecting demographic change and greater awareness. She advised that this had led to longer waits in some areas, but

emphasised that work was under way to streamline diagnostic pathways, strengthen links with primary care, and ensure that people received meaningful support while awaiting formal diagnosis.

The Committee explored the operation of crisis services, including crisis resolution and home treatment teams. Officers explained that crisis services were under sustained pressure, with high demand and increasing acuity, but that the Trust remained committed to supporting people safely in the community wherever possible. The Executive Delivery Officer for the Integrated Care Board highlighted the importance of system-wide coordination, noting that pressures in mental health services had impacts across the wider urgent and emergency care system. Partners were working together to manage demand, improve flow, and reduce the need for admission where safe alternatives existed.

Members raised concerns about inpatient capacity and delayed discharges, particularly for older adults with mental health needs and dementia. Officers confirmed that delayed discharge was often linked to wider system factors, including availability of social care, appropriate housing, and community support. The Head of Joint Commissioning – Live Well explained that joint commissioning arrangements sought to address these challenges by strengthening community provision and improving alignment between health and social care, but acknowledged that progress was constrained by workforce availability and funding pressures.

The Committee asked how the experiences of older adults and carers were being reflected in service design. The Chief Executive Officer of Oxfordshire Mind described the voluntary sector's role in supporting people and carers to navigate the mental health system and highlighted feedback consistently received from carers about fragmentation and the difficulty of understanding who to contact at different points in a person's care. She emphasised the importance of integrated, person-centred pathways and of recognising carers as partners in care.

Workforce wellbeing and sustainability were then discussed. Officers described ongoing efforts to support staff through supervision, training and flexible working, while recognising that sustained pressure had an impact on morale and retention. Members emphasised the importance of ensuring that staff wellbeing was treated as integral to service quality and safety, rather than as a secondary consideration.

Members also questioned how inequalities in access and outcomes were being addressed, particularly for people living in rural areas or from disadvantaged communities. Officers confirmed that identifying and tackling inequalities was a core focus of service development and commissioning, with data used to highlight variation in access and outcomes and voluntary sector partners playing a key role in reaching underserved groups.

The Chair specifically raised the issue of the Warneford Hospital redevelopment project, noting its importance to the future configuration of adult and older adult mental health services in Oxfordshire. The Committee asked for clarity on the current

status of the project, its relationship to wider mental health strategy and service transformation, and whether there continued to be risks or uncertainty that might impact patients, staff or service planning.

In response, the Chief Operating Officer for Mental Health and Learning Disability explained that the Warneford redevelopment remained a live project within the Trust's estates and capital planning framework. He advised that the redevelopment was intended to support modern, therapeutic models of inpatient care and to bring ageing facilities up to required standards, but acknowledged that progress had been affected by national capital constraints, wider construction pressures and the complexity inherent in redeveloping a live clinical site.

The Executive Delivery Officer for the Integrated Care Board added that the Integrated Care Board remained engaged with the Trust on the Warneford project at a system level. The redevelopment formed part of broader system planning for mental health infrastructure and that assurance processes continued through established governance routes. While recognising Members' concerns about timescales, he emphasised that capital decisions were subject to national processes and affordability considerations and that these factors were outside local control.

The Associate Director for Adult and Older Adult Mental Health and Partnerships confirmed that, in the meantime, services at the Warneford continued to operate safely and that interim mitigations and maintenance arrangements were in place. Clinical risk and patient safety were kept under regular review and that service planning did not assume early delivery of the redevelopment until formal approvals were secured.

Members welcomed the clarification but stressed the importance of transparency and ongoing communication with the Committee, given the Warneford's strategic role in Oxfordshire's mental health system and its significance to staff morale, recruitment and service user confidence.

Discussion returned to crisis and inpatient services more broadly. Officers described sustained pressure on crisis pathways and inpatient beds, noting that high acuity and complexity were increasing length of stay and affecting flow. The Head of Joint Commissioning – Live Well explained that joint commissioning efforts focused on strengthening community alternatives and improving discharge pathways, but acknowledged that system-wide capacity constraints continued to present challenges.

Concluding the item, the Chair reflected that the session had illustrated both the scale of the challenges facing adult and older adult mental health services and the importance of sustained, system-wide action. Members agreed that continued scrutiny would be essential, particularly in relation to waiting times, workforce capacity, crisis provision and the experience of older adults and carers.

The Committee **AGREED** to issue the following recommendations subject to any necessary minor amendments by the Chair and the Health Scrutiny Officer offline:

1. That system partners treat equity of access as a core performance objective, with explicit action taken where neighbourhood-level variation is identified, including: addressing gaps in crisis alternatives and Safe Haven coverage, and ensuring that any neighbourhood-based models benefit rural and more deprived communities as effectively as urban areas.
2. That system partners treat co-production as a core performance objective for development and delivery neighbourhood mental health centres. It is recommended that there is an inclusion of local councils, local members and local voluntary sector working with lived experience families at any neighbourhood level included in the work programme.
3. That access standards for adult community mental health services are applied in a clinically meaningful way. It is recommended that there are clear safeguards to ensure that: early contact does not displace therapeutic continuity, that data definitions are consistent across teams, and that performance management reinforces quality and outcomes, not just speed of access.
4. For collaboration amongst system partners to identify what is needed locally for the implementation of the new government guidance on key workers/named worker for personalised care and on implementation of the Patient and Carer Race Equality Framework.
5. For collaboration amongst system partners on reducing/preventing out of area placements to include independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient. It is also recommended that there is a review that includes patients, families, and the voluntary sector to determine whether community placements are working well as a safe and conducive home setting protective against worst outcomes.
6. For any performance targets for access to physical health checks for mentally ill patients to be met. It is recommended that there are timely and regular physical health checks for those with comorbidities, and to also include a check-up of their long-term conditions.
7. For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a community mental health centre in every community; for mental health investment to be placed on a statutory footing; and for there to be support for expansion of section 75 agreements for pooled budgets or other clear mechanisms and levers for the local integration and shared ownership needed. It is recommended that local system partners call

for national support to move to multi-year funding for commissioning of the voluntary sector, and that there be clear timely arrangements for the delivery of the Modern Service Framework for mental health.

8. For collaboration among system partners to ensure that transitions from children's to adult's mental health services are as smooth and supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions.

22/26 UPDATE ON THE DEVELOPMENT OF THE ALL-AGE AUTISM STRATEGY (Agenda No. 9)

Karen Fuller (Corporate Director - Adult Social Care); Bhavna Taank (Head of Joint Commissioning – Live Well – Housing, Education and Social Care); Dee Nic Sitric (Chief Executive- Autism Champions and Expert by Experience); and Matthew Tait (Executive Delivery Officer, Thames Valley Integrated Care Board); attended to present and discuss the draft All-Age Autism Strategy for Oxfordshire and the strategy's ongoing development.

The Chair introduced the item by noting that the strategy remained in draft and that the Committee welcomed the opportunity to provide scrutiny at this stage of its development prior to its sign off at the Health and Wellbeing Board.

The Corporate Director – Adult Social Care described the strategy as having been “on quite a journey” and stressed that, while it remained draft, it represented a significant shift in approach and language. The strategy had been co-produced across multiple organisations and that the drafting process had required repeated pauses, reflection and revision, particularly where language and framing risked reinforcing a deficit narrative.

The Chief Executive of Autism Champions and Expert by Experience provided a detailed account of lived experience and, critically, the lived experience of participating in co-production itself. She described co-production as a term that was frequently used but often misunderstood, and explained that meaningful co-production required autistic people and the autistic community to be involved from the beginning and throughout delivery, rather than being consulted at the end. The experience of attending and waiting through an extended agenda had been anxiety-provoking even though she had supportive “anchors” in the room and prior experience of attending. Small acts of reassurance (such as being approached and acknowledged in a supportive manner by the Health Scrutiny Officer), constituted practical “reasonable adjustments” and were often more impactful than large, formal interventions.

The Chief Executive of Autism Champions and Expert by Experience then addressed the broader content and direction of the strategy. She described autism as frequently “invisible” in ways that made system engagement harder, noting that autism could not be reliably inferred by appearance and that autistic presentation varied widely across

individuals. She described the challenge of engaging key stakeholders and seldom-heard voices, particularly non-speaking autistic people, emphasising that engaging non-speakers required time, relational practice and specialist expertise that were often difficult to secure within tight drafting timetables and constraints.

A significant part of the discussion focused on the difficulty of system engagement during the strategy's development. The Chief Executive of Autism Champions and Expert by Experience explained that securing the right stakeholders "in a room" had been extremely difficult and described this as a recurring barrier, despite some successful engagement activity. A major engagement session at the King's Centre had attracted high attendance from autistic people and which had been led effectively by autistic members of the working group, but she stressed that engagement remained one of the hardest aspects of delivery because the system often struggled to understand or prioritise autism as a cross-cutting issue.

The Committee explored the strategy's language, particularly around the framing of "treatment". The Chief Executive of Autism Champions and Expert by Experience challenged the implication that autism itself required treatment, noting that autism was an identity and a way of being human, not an illness. The system should instead focus on reducing stigma and removing barriers created by services and environments, so that autistic people were not pressured to fit into narrow expectations that served others' comfort rather than their own wellbeing.

Members and contributors also linked autism to wider system issues discussed earlier in the meeting, including mental health and transitions. The Chief Executive of Autism Champions and Expert by Experience stated that autism "pervaded" mental health pathways and that distress caused by unmet reasonable adjustments could present as mental health symptoms. She also stressed that autistic children became autistic adults and that the system must not allow people to "fall off a cliff" at transition points.

The Committee also heard reflections on education. The Chief Executive of Autism Champions and Expert by Experience described education as feeling separate from health, social care and mental health even though Education, Health and Care Plans were inherently multi-system. The complexity created by differing statutory responsibilities, including that education provision was the only statutory "surface" within Education, Health and Care Plans, despite the fact that many determinants of outcomes lay in health, social care and system integration. She noted difficulties engaging some education settings and highlighted the political and structural complexity of securing system-wide alignment.

Lisa Lyons (Director of Children's Services, Oxfordshire County Council) joined the meeting at this point.

The Director of Children's Services reinforced the need to keep the strategy both accessible and deliverable. Strategies should not raise expectations with commitments that could not realistically be delivered, because failure to deliver would

erode trust further. Work would continue to produce a children and young people's version in a concise, accessible format, with young people supported to shape an appropriate version of the strategy and to place it within the local offer. The role of the Parent Carer Forum was formally recognised as instrumental in organising workshops and supporting the work to reach its current draft form.

The Committee then moved into detailed scrutiny of governance and accountability. It was queried as to how much authority and "teeth" the Autism Improvement Board would have to hold partners to account if delivery stalled. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care responded that the Autism Improvement Board was co-chaired jointly with lived experience leadership and included representation from partner organisations and lived experience groups. Six implementation groups would sit beneath the Board, corresponding to six key areas within the strategy, and that each group would report up with outcome measures and Key Performance Indicators (KPIs). Where delivery was not occurring, the Board chairs would have the ability to contact relevant organisations, pursue resolution, and escalate. Escalation routes existed through wider system governance, including relevant ICB boards, joint commissioning executive arrangements and place-based partnership structures where system partners were present.

In response, the Corporate Director – Adult Social Care distinguished between youth justice and the broader criminal justice landscape, clarifying accountability and offering assurance that children in youth justice settings were entitled to enhanced service provision, including screening and specialist support. When children were remanded they became entitled to enhanced support as children in care, and that this included screening for autism and ADHD alongside other needs, making this area potentially a "good news story" to incorporate into the strategy more explicitly.

Returning to implementation arrangements, the Head of Joint Commissioning – Live Well – Housing, Education and Social Care explained that an engagement event had been held on 4 December 2025 and that invitations to participate had been issued openly. Names were being compiled across statutory partners, lived experience communities and voluntary sector organisations, acknowledging that membership would not be perfect at the outset and would need to evolve as gaps were identified.

The Committee then discussed future-proofing in the context of local government reorganisation and potential disaggregation. Members asked how the strategy would be protected from being lost or reset if council structures changed. The Corporate Director – Adult Social Care responded that the local authority would continue to have a legal duty to maintain an autism strategy, regardless of structural changes, and that caveats would be included as appropriate. Disaggregation could create challenges for voluntary sector organisations' ability to operate across multiple authorities, and that hosting arrangements and mechanisms to preserve the learning and legacy of work would need to be considered actively.

The Committee examined financial modelling and asked when financial modelling would be completed, what budgets and partner organisations would be in scope, and how affordability would be assured before final approval. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care explained that much of the intended improvement should be cost-neutral, rooted in changes to practice, communication, training and pathway working rather than new-funded provision. However, implementation planning could surface areas of genuine cost, and that financial modelling would then consider existing budgets within pooled arrangements, local authority and ICB resources and other sector contributions, with the potential to divert existing funding and seek grant funding where appropriate. Officers emphasised that the system had no additional overall money and that affordability would therefore depend on realistic scoping and prioritisation of what could be delivered.

Finally, the discussion returned to outcomes and evaluation. The Committee asked how the system would know whether the strategy was actually achieving change beyond diagnostic waiting times, particularly in relation to reasonable adjustments, accessibility and “enabling” outcomes. The discussion linked this to the intent that an implementation plan would be reviewed annually, with actions being converted into business as usual where achieved and new KPIs set for subsequent cycles, supported by listening activity and ongoing feedback from autistic people and families.

The Committee expressed that the draft strategy represented a significant step forward, but that delivery would depend on clear governance, true co-production in implementation (including reaching beyond representative organisations), realistic financial scoping, and a robust outcomes framework capturing both quantitative and qualitative experience.

The Committee **AGREED** to issue the following recommendations subject to any necessary amendments offline by the Chair and Health Scrutiny Officer:

1. That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including: how partner organisations are held to account for delivery of agreed actions; how under performance or delay will be escalated; and how assurance will be reported to the Health and Wellbeing Board and shared with scrutiny.
2. That co production principles are explicitly embedded in delivery, not only strategy development, including: a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities, sequencing actions and reviewing progress within the implementation plan; and clarity on how lived experience feedback will directly influence commissioning, service redesign and system decisions.

3. That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope; the balance between new investment and reconfiguration of existing resources; and the affordability and sustainability of priority commitments.
4. For a clear outcomes and performance framework to be developed. It is recommended that any outcomes and performance frameworks include diagnostic waiting times and access to support while waiting; consistency and effectiveness of reasonable adjustments across services; experiences of transitions; and lived experience and qualitative outcomes, not solely access metrics.
5. For system partners to work toward the development a children's version of the Autism Strategy.

23/26 HEALTHWATCH OXFORDSHIRE UPDATE (Agenda No. 10)

Veronica Barry (Executive Director, Healthwatch Oxfordshire) was invited to present the Healthwatch Oxfordshire Update Report.

Healthwatch's ongoing statutory role in gathering and representing patient and public experience across Oxfordshire's health and social care system was explained to the Committee. Healthwatch's continued engagement with a range of partnership boards and system forums was also highlighted.

Members noted the publication of a number of recent Healthwatch reports and pieces of community research. These included a report on experiences of musculoskeletal services, which identified persistent concerns around communication, appointment availability, cancellations, referral pathways and waiting times, alongside some positive feedback once care was accessed. The Committee noted that recommendations had been issued and that responses had been received from commissioners and the provider.

The update also highlighted community research activity, including work with the Sunrise Multicultural Centre in Banbury on cancer awareness and barriers to access, and engagement with rural communities as part of wider work on health inequalities. Members noted that these findings were intended to complement formal system performance data.

The Committee received an update on Enter and View activity, including visits to Katharine House Hospice and Ashurst Ward at Littlemore Hospital, and the publication of an Enter and View report relating to St Leonard's Ward at Wallingford Community Hospital. Members noted that all reports, including provider responses, were publicly available.

Healthwatch Oxfordshire also reported on recent and forthcoming public engagement activity, including a March 2026 webinar on Oxfordshire's work as a Marmot Place and a planned webinar providing an opportunity for public input into the Oxford Health NHS Foundation Trust strategy.

Members noted recurring themes from Healthwatch intelligence, including difficulties accessing GP and dental services, administrative barriers, and challenges navigating complaints processes. It was also noted that some forthcoming Healthwatch reports would be published after the local elections in line with Purdah guidance.

The Committee **NOTED** the Healthwatch Oxfordshire Update.

24/26 HEALTH VISITOR SERVICES IN OXFORDSHIRE (Agenda No. 11)

Donna Husband (Head of Public Health Programmes – Start Well – Public Health, Oxfordshire County Council); Mark Chambers (Head of Children's Community Services Community Health Services, Dentistry and Primary Care Directorate | Oxford Health NHS Foundation Trust); Emma Leaver (Chief Operating Officer for Community Health Services, Dentistry & Primary Care, Oxford Health NHS Foundation Trust); and Taylor Nicola (Senior Clinical Lead for Public Health) were invited to present a report on Health Visitor Services in Oxfordshire.

Officers outlined the extent of organisational change following the establishment of the integrated 0–19 Children's Community Public Health Service, which had brought together health visiting, school nursing, and related services within locality-based teams operating under a single point of access. This model had been informed by learning from the COVID-19 period, evidence on widening inequalities across Oxfordshire, and the County's commitment to the Marmot principles.

Members questioned reported performance against mandated contacts, particularly delayed new birth and early years reviews, and sought clarity on how such delays arose and how risks were mitigated. The statutory window for new birth visits was extremely narrow and that apparent "misses" often reflected legitimate clinical and social circumstances, including prolonged hospital stays, overlapping midwifery involvement, parental choice to stay with family out of county, or non-attendance at clinic appointments.

Officers stressed that recorded performance metrics did not fully reflect the extent of follow-up activity undertaken by teams. Examples were provided of families who had initially failed to attend scheduled appointments but were subsequently followed up through home visits, enabling practitioners to assess both the child and the home environment. The Committee was reassured that delayed contacts did not equate to withdrawal of support and that persistence, professional curiosity, and escalation were embedded in practice.

Members expressed concern that families who did not engage might be those most at risk, particularly in more deprived or vulnerable circumstances. Officers described

clear escalation policies, including structured records review, checks against GP and safeguarding databases, and liaison with other universal and specialist services. Health visitors did not work in isolation but as part of multidisciplinary arrangements designed to ensure that no child became “invisible” to services.

The Committee explored arrangements for transition from maternity to health visiting care. Officers described close operational integration with midwifery services, including daily birth notifications, shared vulnerability scoring, and regular local and strategic meetings. The introduction of improved digital systems was noted to have strengthened information flow, although challenges remained around county borders, private births, and families moving shortly after delivery.

Members were advised that vulnerability assessments were dynamic rather than static and were reviewed throughout the antenatal and early postnatal period, enabling proactive targeting of additional support where risk increased. Officers clarified that reported data focused on face-to-face contacts, even where telephone contact or hospital-based engagement had occurred, creating a risk that activity was under-represented in headline figures.

Members referred to sections of the report describing increasing acuity, safeguarding activity, and complexity within caseloads, and questioned how this was reflected in staffing models. Officers explained that locality team sizes were intentionally uneven, weighted for deprivation, vulnerability, geography, and travel time, rather than population size alone. The service delivered a very high volume of mandated contacts each month across the county and that workforce modelling had been explicitly designed to protect universal provision while enabling targeted intervention.

Officers advised that a comprehensive demand-and-capacity review was underway, including a time-and-motion study to reassess whether assumptions made at the start of the contract remained valid. The Committee welcomed the dynamic nature of this approach but emphasised the need for continued assurance that safeguarding demands were not crowding out preventative activity.

Members returned repeatedly to the balance between statutory safeguarding responsibilities and universal preventative work. Officers described the use of a skill-mixed workforce, with clinic-based provision supporting efficient universal delivery and enabling health visitors to focus on more complex cases. The integrated 0–19 model was cited as enabling a more coherent lead professional role for families with children of different ages, reducing duplication and hand-offs between services.

Members explored the principle of continuity in detail, including references in the report to visits being delayed to preserve continuity with the same practitioner. Officers explained that continuity was valued by families, supported trust, and enhanced safeguarding judgement by allowing practitioners to recognise changes over time. This approach could affect reported performance against strict timeframes, but officers argued that clinical value outweighed the marginal impact on metrics.

The Committee welcomed the extension of health visiting involvement beyond age five for families with ongoing needs, describing this as a significant development that helped bridge the gap between early years and school-age services. Members noted the introduction of additional pre-school reviews and their relevance to school readiness.

Members raised concerns about food insecurity, temporary accommodation, and material deprivation affecting families with babies and young children. Officers described how such issues were escalated through appropriate channels and addressed in partnership with housing, voluntary sector, and other statutory services. Health visitors acted as system-navigators and advocates rather than sole problem-solvers.

The Committee explored links to the Best Start in Life programme, Family Hubs development, and Marmot priorities, and was assured that Health Visitor Services were a core component of whole-system planning for early years outcomes.

The discussion also covered immunisation uptake, infant feeding, breastfeeding, obesity prevention, screen time, and speech and language development. Officers described an extensive health promotion offer, including local groups, digital support through ChatHealth, infant feeding hubs, and enhanced feeding support. The Committee welcomed evidence of improved breastfeeding continuation rates and the proactive sharing of safeguarding intelligence arising from hospital data to inform age-appropriate prevention messaging.

Members questioned the robustness of digital systems and data integration, particularly following previous cyber incidents affecting NHS organisations. Officers outlined strengthened cyber security standards, business continuity planning, and the benefits of alignment with GP clinical systems. While acknowledging that data consistency across the system remained a work in progress, the Committee welcomed progress toward more integrated intelligence to support early identification of need.

The Committee noted the scale of transformation undertaken by the service, the complexity of current demand, and the central role of health visiting in prevention, safeguarding, and early years outcomes.

The Committee **AGREED** to issue the following recommendations subject to any necessary amendments required by the Chair and Health Scrutiny Officer offline:

1. That health visitors are integrated into whole system planning in the community. It is recommended for integration of HV services within Best Start in Life, with improvements to information to babies, children and families.
2. For Health visitor services to continue to focus away from crisis management to core health functions including addressing the impacts of health inequalities on families.

3. For Health visitor services to continue to work on promoting specific issues such as health immunisation uptake and breastfeeding.
4. For there to be an assessment/review of workforce capacity; to ensure safe management of caseloads and to provide essential early intervention for families.
5. To continue to prioritise continuity of the Health Visitors visiting families as well as the Four Year Visits.

25/26 FORWARD WORK PLAN (Agenda No. 12)

The Committee considered its Forward Work Programme.

The Committee **AGREED** the proposed Forward Work Programme for the June 2026 meeting, and to delegate authority to the Chair and Health Scrutiny Officer to make necessary adjustments to the programme should circumstances require changes between meetings.

26/26 ACTIONS AND RECOMMENDATIONS TRACKER (Agenda No. 13)

The Committee **NOTED** the Actions and Recommendations Tracker.

..... in the Chair

Date of signing

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

11 JUNE 2026

Coopted Members of the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC)

Report by Director of Law and Governance and Monitoring Officer

RECOMMENDATION

1. The Committee is **RECOMMENDED** to:
 - a) **NOTE** the requirement to fill one vacant co-opted post on the Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) and the work undertaken to fill this post.
 - b) **AGREE** to Dr Alan Cohen's appointment as a co-opted member of the JHOSC (subject to full completion and submission of a Register Of Interests form).

Executive Summary:

2. Pursuant to Part 6.1B (3) of the Council's Constitution, in addition to Councillors, the Joint Health Overview & Scrutiny Committee shall, in order to assist it in its work, include in its membership up to three non-voting co-opted members. Co-opted members can be appointed because of the personal contribution they would make to the work of the Committee or to represent health related interests as determined by the Committee from time to time.
3. Following the need to fill one vacant co-opted member post of the JHOSC, the Health Scrutiny Officer has coordinated a recruitment exercise. Following this recruitment exercise, the Committee is asked to agree to the appointment of Dr Alan Cohen.

Please note: a biography for Dr Alan Cohen is available in Annex 1 of this report below:

Background and work undertaken to date:

4. Part 6.1B (3) of the Council's Constitution allows for up to three co-opted members to sit on the Joint Health Overview and Scrutiny Committee (JHOSC). Co-opted Members are normally to serve for a period of 2 years and that period may be extended for up to a further term of two years.

5. An advert for the vacancy for the vacant co-optee post was launched publicly on the Oxfordshire County Council website from Thursday 23 April 2026 until Friday 01 May 2026. During this time, Dr Alan Cohen and one other applicant applied for this post, and both were subsequently interviewed by a panel comprising the Health Scrutiny Officer, Chair and Deputy-Chair of the JHOSC on Tuesday 05 May 2026.
6. The outcome of the interview was a unanimous decision by the panel members to recommend to the Committee that Dr Alan Cohen be appointed as a co-opted member of the JHOSC.
7. The interview panel is therefore recommending Dr Alan Cohen for appointment to the vacant role as a co-opted member having fully considered his extensive experience across primary care, mental health services, and national health policy, together with his proven understanding of health overview and scrutiny through his previous service on the JHOSC between 2017 and 2022. The panel considered that Dr Cohen's combination of clinical expertise, system-level insight and voluntary sector leadership would add significant value to the Committee's scrutiny of health and care services across Oxfordshire.

Legal implications:

8. Co-opted members are formal members of the Committee and are therefore bound by the Members' Code of Conduct. Any appointment is subject to agreeing to comply with the Member Code of Conduct and declaring interests.
9. Under Part 6.1b (3) of the Constitution, co-optees have no voting rights.
10. The Committee's power to appoint co-optees arises from Part 6.1b of the Council's constitution. There are no further direct implications arising from this report.

Legal Comments Checked By:
Jay Akbar – Head of Legal & Governance

Financial implications:

11. The costs of appointing an additional co-optee are negligible, and these can be met from existing budgets within Democratic Services.

Financial Comments Checked By:
Bick Nguyen-McBride - Finance Business Partner

Anita Bradley
Director of Law and Governance and Monitoring Officer

Annex 1: Biography of Dr Alan Cohen (below)

Other Documents: None.

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June 2026

ANNEX 1: Biography of Dr Alan Cohen

Dr Alan Cohen MBBS, BSc, DCH, FRCGP is a retired General Practitioner with over 40 years' experience across clinical practice, national health policy, mental health services, and health system leadership. He served as a GP principal for more than 20 years in South London, during which time he was involved in developing and leading training and teaching practices and held a range of local primary care leadership roles.

From 2005, Dr Alan Cohen worked at a national level as Senior Primary Care Adviser to the Department of Health's Care Services Improvement Partnership and as National Primary Care Lead for the Improving Access to Psychological Therapies (IAPT) programme. He also served as Honorary Associate Director of Primary Care at the Department of Health and held senior roles within the Sainsbury Centre for Mental Health, chairing regional development centres and leading national guideline development work, including NICE guidelines on anxiety and contributions to guidance on depression and severe mental illness.

Between 2011 and 2015, Dr Alan Cohen was Director of Primary Care at West London Mental Health Trust, overseeing the provision of physical healthcare services for people with severe and enduring mental illness, including those in high-secure and forensic settings. Since retiring from clinical practice, he has continued to contribute through teaching, research, policy development and publication in the field of primary care mental health and integrated care.

Dr Alan Cohen previously served as a co-opted member of the Oxfordshire Joint Health Overview and Scrutiny Committee between 2017 and 2022, participating fully in the Committee's work and contributing to Task and Finish Groups focusing on musculoskeletal services and community services. He has also held senior voluntary sector leadership roles locally, including serving as Chair of the Board of Oxfordshire Mind until September 2025, further strengthening his understanding of the relationship between statutory services, the voluntary sector and community-based provision.

Dr Alan Cohen brings extensive experience of health policy, primary and community care, mental health services and lived experience of healthcare to support the Committee in its statutory scrutiny role.

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

11 JUNE 2026

Update Report from the Joint Health Overview and Scrutiny Committee Primary Care Access and Estates Working Group

Report by Director of Law and Governance and Monitoring Officer

RECOMMENDATIONS

1. The Committee is **RECOMMENDED** to:
 - a) **RECEIVE** and **NOTE** the Joint Health Overview and Scrutiny Committee (JHOSC) primary care and estates working group interim report found in Annex 1.
 - b) **AGREE** to the appointment of an additional working group member (whilst adhering to the principle of political balance) given that Cllr Gareth Epps is no longer a member of the Committee.
 - c) **AGREE** to receive a final report with findings and recommendations from the working group in the September 2026 JHOSC meeting, so as to allow for:
 - The final planned working group session to take place with representatives of the Thames Valley Integrated Care Board (ICB) on the use of digital tools and models in primary care services.
 - Conducting site visits to GP practices in both rural and urban areas.
 - Inclusion of further findings from the working group's inquiry on the national backdrop of General Practice, and on the case studies of the Great Western Park and Bicester Health Centre.

Executive Summary:

2. This report introduces the Committee to the work and the interim findings and recommendations of the JHOSC Primary Care Access and Estates Working Group (Annex 1).
3. The working group was established to support the Committee's scrutiny of primary care access and the condition, capacity and suitability of the primary care estate across Oxfordshire, including how system partners are responding to pressures in access and premises and what plans are in place for improvement.
4. Annex 1 sets out the group's latest update, key themes emerging from its work, and its interim findings and recommendations for the Committee to consider.

5. The Committee is asked to receive and note the working group's update report and to consider the interim findings and recommendations within Annex 1. The Committee is also asked to extend the timescale of the working group to enable planned site visits to GP practices in urban and rural parts of the County to take place (this is due to the working group awaiting confirmation from the ICB and individual GP practices as to when they can host such visits).

Background and work undertaken to date:

6. The JHOSC Primary Care Access and Estates Working Group was established by the Committee to undertake detailed work on issues relating to access to general practice and primary care estates, and to report back to the Committee with findings and recommendations.
7. The working group's remit includes understanding the current position on access (including variation across localities and groups of patients), reviewing the capacity and condition of primary care premises, and considering the plans of system partners to improve access and address estates constraints. The group has gathered evidence through engagement with relevant NHS partners and by reviewing available performance and estates information.
8. Since its formation, the working group has continued its programme of evidence-gathering and discussion on primary care access and estates, supported by officers.
9. The update report in Annex 1 contains some key interim findings of the working group and summarises the key themes emerging from the group's work to date, including issues raised in relation to access routes and patient experience, and the constraints and opportunities associated with the primary care estate.
10. Annex 1 also sets out the working group's interim recommendations on GP services and estates matters for the Committee to consider and, when finalised in its report to the Committee in September 2026, to submit these to the Thames Valley Integrated Care Board.

Legal implications:

11. The establishment of this working group has been undertaken pursuant to Part 6.1B of Oxfordshire County Council's Constitution which states that: 'Appointments to such Working Groups will be made by the Committee, ensuring political balance as far as possible. Such panels will exist for a fixed period, on the expiry of which they shall cease to exist.'
12. There are no other direct legal implications arising from this report relating to the existence of this working group or its interim report and recommendations to the wider Committee.

Legal Comments:

Jay Akbar – Head of Legal & Governance

Financial implications:

13. There are no direct financial implications arising from the existence of this working group or its interim report and recommendations to the wider Committee.

Comments checked by:

Bick Nguyen-McBride

Finance Business Partner

bick.nguyen-mcbride@oxfordshire.gov.uk

Anita Bradley

Director of Law and Governance and Monitoring Officer

Annex 1: Interim Report of the Oxfordshire JHOSC Primary Care Access and Estates Working Group.

Please note: The Interim Report of the working group has its own set of annexes labelled A-E.

Contact Officer:

Dr Omid Nouri

Health Scrutiny Officer

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Tel: 07729081160

June 2026

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Interim Report of the JHOSC Primary Care Access and Estates Working Group

Working Group Membership: Cllr Jane Hanna (Chair), City Cllr Louise Upton, Cllr Gareth Epps (until appointed to Cabinet May 2026), Cllr Paul-Austin Sargent, Cllr Ron Batstone, District Cllr Katherine Keats-Rohan.

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

Report to:

- Nick Broughton- Chief Executive, Thames Valley ICB.
- Julie Dandridge- Strategic Lead for Primary Care for Oxfordshire.
- Daniel Leveson- Director of Places & Communities, Thames Valley Integrated Care Board.

INTRODUCTION AND OVERVIEW

1. Long-standing issues of concern with GP services in Oxfordshire have received regular scrutiny by the JHOSC over the past few years. The Committee held a primary care Workshop on 17 October 2022 which examined demand, capacity, and activity in General Practice, alongside primary care estate development and availability. (Please see link to the agenda of the November 2022 JHOSC meeting which contains a report of the findings of this workshop as well as an annex detailing the number of patients registered per GP practice in Oxfordshire from 2014-2022: [Agenda for Oxfordshire Joint Health Overview & Scrutiny Committee on Thursday, 24 November 2022, 10.00 am | Oxfordshire County Council](#)).
2. This topic also received significant attention in a deep-dive of JHOSC scrutiny of GP services in 2023 which resulted in:
 - The creation of a dedicated GP estates role within the Integrated Care Board (ICB).
 - Didcot Great Western Park being prioritised for ICB capital funding for a new GP estate.
 - Formal correspondence from the Committee to the Secretary of State for Health and Social Care, calling for primary care estate to be delivered ahead of major housing developments in Oxfordshire, alongside action on national workforce shortages.
3. The Primary Care Access and Estates Working Group was established by the Oxfordshire Joint Health Overview and Scrutiny Committee following its public meeting on 11 September 2025. At that meeting, the Committee considered the increasing pressures facing general practice in Oxfordshire and agreed that a more detailed examination of the systemic issues affecting primary care delivery was required. The GP Access and Estates scrutiny held in the JHOSC's September 2025 public meeting highlighted significant variation in access, challenges in

recruiting and retaining staff, and delays to major estate projects such as Didcot Great Western Park and Bicester Health Centre.

4. In the context of this item in September, the Committee identified the following system-wide concerns:
 - Access to GP appointments varies significantly across Oxfordshire.
 - Workforce pressures continue, including difficulties recruiting GPs, nurses and administrative staff.
 - Delays to key estate projects are limiting service expansion.
 - Estate constraints are preventing practices from increasing capacity even when workforce funding is available.
 - Areas experiencing large housing growth face the greatest pressure on GP buildings.
 - The above dynamics are having significant impacts on residents and on professionals working in primary care.
5. During the September 2025 meeting, the Committee recommended for there to be:
 - Stronger engagement between the ICB and local planning authorities.
 - Clearer ownership of estate strategy at local, place level.
 - Assurance that estate constraints will not undermine commitments on access, workforce resilience or neighbourhood-based models of care.
6. The ICB responded to and accepted the JHOSC's recommendations, noting constraints relating to national capital funding, policy and regulatory frameworks. The Committee therefore agreed that these issues require continued and intensive scrutiny. Case studies needed to be central to this (e.g. Didcot Great Western Park), where regular updates on progress such as the most recent appointment of a developer and the start of building works continue to be crucial to the Committee as well as the local MP.
7. As a result of this scrutiny in September 2025 and the concerns identified with GP services in Oxfordshire, and the Committee therefore resolved to create a time-limited working group to undertake a more focused "deep dive" into matters relating to primary care access, workforce pressures and estate capacity across the county.
8. The establishment of the working group was formally confirmed by the Committee at its meeting on 20 November 2025, at which point the Committee also agreed the proposed membership of the working group and its scope and methodology. The working group was tasked with developing a clearer understanding of the underlying drivers of access challenges in general practice, identifying structural and system-level barriers, and exploring potential solutions that could be pursued by the Integrated Care Board and its partners.
9. The agreed membership of the working group comprised elected members drawn from the Joint Health Overview and Scrutiny Committee and district councils, reflecting the cross-system nature of the issues under consideration. Membership included Cllr Jane Hanna, City Cllr Louise Upton, Cllr Gareth Epps, Cllr Paul-Austin

Sargent, Cllr Ron Batstone, and District Cllr Katharine Keats-Rohan. Officer support was provided by the Health Scrutiny Officer, with input and attendance at evidence sessions from representatives of the NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, Healthwatch Oxfordshire and other relevant stakeholders as appropriate.

10. In agreeing the scope of the working group, the Committee made clear that its focus should extend beyond short-term performance metrics and consider the wider factors influencing access to GP services. The agreed remit therefore included examination of primary care capacity and access arrangements, workforce sustainability and workload, the adequacy and delivery of primary care estates, and the interaction between population growth, housing development and health infrastructure planning. Particular emphasis was placed on understanding how these issues interact at system level and the implications for patients, practices and local communities across Oxfordshire.
11. The working group was also asked to consider relevant national policy and guidance, alongside local data and patient experience evidence, in order to contextualise Oxfordshire's challenges within the broader NHS policy framework. The Committee requested that the working group report back on its activities (including any interim findings and proposed recommendations) by June 2026.

Stakeholder Engagement Undertaken:

12. The working group had engaged with (and expresses thanks to) a range of stakeholders to produce a review that is inclusive and comprehensive. These include:
 - NHS Thames Valley ICB (including estates, workforce, and commissioning leads). This includes Dan Leveson (BOB ICB Director of Places & Communities) and Julie Dandridge (Strategic lead for primary care across Oxfordshire).
 - Healthwatch Oxfordshire; including Veronica Barry (Executive Director of Healthwatch Oxfordshire) and Barbara Shaw (Chair of Healthwatch Oxfordshire).
 - South and Vale District council planning and estates officers.
 - Individuals representing General practitioners (including Dr Michelle Brennan, Dr Richard Wood, Dr Peter Burkner, and Dr James McNally).
 - Local councillors (including District Cllr David Rodgers).
13. Engagement was conducted through online Microsoft Teams meetings, written submissions, and site visits. The working group also received written submissions including:
 - GP Appointment data and registered patient list sizes per practice from January 2023-December 2025 (labelled Annex A).

- GP Appointment trends data month by month from January 2025-December 2025 (labelled Annex B).
- GP Patient Survey data as of the most recent collection in January 2025 (labelled Annex C).
- GP workforce data (labelled Annex D).
- Report submission to the working group from the Buckinghamshire, Oxfordshire, and Berkshire West Local Medical Committee on *Demand, Capacity & Activity in General Practice*. (labelled Annex E).
- The Healthwatch Oxfordshire report on what Healthwatch has heard about GP services in Oxfordshire from April 2025-March 2026 (this will be published on the Healthwatch Oxfordshire website at the end of May).
- A written submission from Cherwell District Cllr David Rodgers on his views and understanding of primary care services.
- NHSE publication on the *Red Tape Challenge; recommendations and next steps*.
- NHSE guidance on *Bridging the interface between primary and secondary care, mental health and community services*.
- The Royal College of General Practitioners Study on Uncovering the drivers and costs of unnecessary GP workload.
- The GP services update report submitted to the JHOSC as part of the Committee's public meeting item on GP services in its September 2025.

14. Further academic and policy-based sources have been independently utilised as part of informing the findings and recommendations of the working group on the current state of GP services.

Summary of working group activity and sessions:

15. This section provides an overview of the sessions that the working group had, including a summary of who the sessions were with, and the themes that were discussed in each session.

16. Below is a table which provides a summary at a glance of the sessions, followed by a breakdown of what was discussed in each session.

Date	Who with	Main focus
13 Feb 2026	Thames Valley ICB	GP access and workforce pressures
23 Feb 2026	BOB Local Medical Committee	GP staffing, workload and access
10 Mar 2026	Thames Valley ICB	Workforce and demand data
18 Mar 2026	South & Vale District Council officers	Planning and GP estates (Didcot GWP)
21 Apr 2026	Healthwatch Oxfordshire	Patient experience and access
23 Apr 2026	Thames Valley ICB	Primary care estates and infrastructure

17. Breakdown of Working Group Meetings and Evidence Gathered:

1. ICB Session – Access to GP Services, Workforce Sustainability and Quality survey from Patients

13 February 2026 – Julie Dandridge and Dan Leveson (ICB)

This initial session with the Integrated Care Board focused on the overall accessibility of GP services in Oxfordshire and the sustainability of the primary care workforce, establishing a system-level context for the working group's work. ICB officers outlined the scale of demand pressures, noting sustained growth in registered patient numbers driven by housing development, population change, and increasing clinical complexity within the community.

A significant part of the discussion centred on workforce supply, including difficulties recruiting and retaining GPs and other clinical staff, and the reliance on short-term schemes to stabilise services. Members explored how workforce shortages translated into practical access issues for patients, including reduced appointment availability and pressures on continuity of care. The working group also questioned how far national workforce initiatives were delivering tangible local benefit and whether current planning assumptions adequately reflected Oxfordshire's rate of population growth.

While estates were not the principal focus, the discussion explicitly linked workforce capacity to physical estate limitations, with ICB officers acknowledging that constrained or outdated premises often prevented practices from expanding staffing or service offer even where demand and funding existed. This meeting helped frame access and workforce as interdependent system issues, rather than isolated challenges. The session was also helpful in exploring publicly available data links and the limits of usability of these for the working group; and securing agreement from the ICB to produce Oxfordshire focused tables for use in the next session.

2. BOB Local Medical Committee session – Practice-Level Perspective on Access, Workforce and Capacity

23 February 2026 – Dr Richard Wood (Chief Executive, BOB Local Medical Committee)

The session with the Local Medical Committee provided a front-line general practice perspective, complementing ICB data with lived organisational experience. Discussion concentrated on the operational reality of delivering access under sustained pressure, including the cumulative effect of workforce shortages, administrative burden, and increasing patient expectations.

The LMC described wide variation between practices in their ability to respond to demand, influenced by workforce stability, estate size, and local population characteristics. Particular emphasis was placed on how administrative workload and contractual requirements were consuming clinical time, limiting the extent to which practices could increase face-to-face capacity even where workforce numbers appeared stable on paper.

The working group explored how estate constraints exacerbated workforce pressures, with small or poorly-configured premises restricting recruitment of additional staff, limiting multidisciplinary working, and constraining modern models of care. The discussion reinforced the link between estates, workforce sustainability and access, and highlighted the risk that practices operating at the margins could become increasingly fragile without structural intervention.

3. ICB Session – Data on Demand, Workforce and Access Trends

10 March 2026 – Julie Dandridge and Dan Leveson (ICB)

This meeting focused on quantitative data underpinning the working group's enquiry, allowing members to scrutinise trends in demand and capacity in detail. ICB officers presented data on registered patient list growth, GP workforce numbers, appointment volumes and utilisation patterns, including seasonal fluctuation and local variation.

The working group examined how increases in registered populations compared with workforce growth, and discussed the implications for future access if current trends continued. Members explored the limitations of headline workforce figures and probed how factors such as part-time working, portfolio roles and sickness absence affected real-world capacity. The discussion also addressed variation between localities, highlighting areas experiencing particularly acute pressure.

Attention was given to how data was used by the ICB to inform commissioning and prioritisation decisions, and whether existing mechanisms were sufficiently responsive to rapid population growth linked to new housing developments. This session strengthened the evidence base for the working group's findings by grounding narrative concerns about access in objective trend data.

Attention was also given to the capacity of the ICB (given its reorganisation into a Thames Valley ICB), and on what the associated impact would be on support by the ICB to practices that were struggling, and the capacity of the ICB to work in a timely way with district councils on primary care estate. This has been a critical theme from the BOB JHOSC as well as the Oxfordshire JHOSC for many years, constituting a priority concern.

4. Oxfordshire District Councils Session – Planning Systems and Primary Care Estates

18 March 2026 – South Oxfordshire and Vale of White Horse District Council planning and estates Officers

This meeting examined the local planning context influencing delivery of primary care infrastructure, with a particular focus on the interface between local authorities and the NHS. District officers explained how planning obligations, including Section 106 agreements and Community Infrastructure Levy funding, were negotiated and the constraints affecting their deployment for health infrastructure.

A detailed case study of Didcot Great Western Park illustrated longstanding challenges in aligning housing growth with GP estate capacity. Discussion explored issues such as funding viability, land ownership, timing mismatches between development and NHS capital approval, and the complexity arising from multiple organisations holding different parts of the delivery responsibility.

Very detailed attention was given to the particular barriers existing at every stage along the timeline; from before the approval of local housing estate provision and the building of the estate, and the consequences including funding implications as well as GP estate implications for a local population. The increased housing developments resulted in delays in registering patients at local practices.

The working group scrutinised whether existing planning and funding mechanisms were sufficiently robust to support timely primary care expansion, particularly in high-growth areas. Members also considered how earlier and more structured engagement between district councils and the NHS might mitigate delays and improve outcomes. This session was central in evidencing that primary care access is shaped by planning and infrastructure decisions well beyond the NHS.

4. Healthwatch Oxfordshire Session – Patient Experience and Inequalities of Access

21 April 2026 – Healthwatch Oxfordshire

This session focused on patient experience of accessing GP services, ensuring that resident perspectives informed the working group's analysis. Healthwatch shared themes arising from its engagement work, including persistent difficulties securing appointments, challenges navigating digital systems, and concerns about continuity of care.

The discussion explored how digital access requirements were affecting different population groups, particularly older residents without carers or advocates, those with limited digital confidence, and people with learning difficulties or other additional needs. Healthwatch also highlighted how variations in practice responsiveness contributed to perceived inequality between communities.

The working group considered how patient experience should be used alongside quantitative access metrics, recognising that measures of availability alone did not always reflect the quality or equity of access. This meeting reinforced the importance of embedding patient voice within recommendations on GP service design and access improvement.

The discussion included the existing local model which included an independent patient voice and what would be lost without that. (Future digital models will be explored in a future dedicated session that the working group will have with the ICB on digital models for primary care).

5. ICB Session – Primary Care Estates, Infrastructure and Strategic Planning

23 April 2026 – Julie Dandridge and Dan Leveson (ICB)

The most recent ICB session focused in-depth on primary care estates capacity, drawing together themes from earlier meetings. Officers outlined the current condition and distribution of GP premises across Oxfordshire, the constraints affecting expansion, and the impact of organisational restructuring on estates capability within the ICB.

The discussion examined in depth three specific estate case studies, Great Western Park, Bicester Health Centre, and Wallingford Medical Centre, considering progress to date, remaining barriers, and lessons for future developments. Members explored how estate limitations restricted workforce growth, constrained service transformation, and limited the ability to deliver more integrated models of care.

The working group also discussed longer-term approaches, including neighbourhood health hubs, and questioned how future estate planning could better align with population growth and service redesign. This session clearly demonstrated how estates underpin the working group's core themes of access, workforce sustainability and service resilience.

18. Therefore, in line with its original scope, these meetings collectively allowed the working group to:

- Examine access to GP services from system, practice and patient perspectives.
- Assess workforce sustainability using both data and front-line insight.
- Understand how estate capacity and planning systems constrain service expansion.
- Start exploring digital access and patient experience, including inequality impacts.

- Identify structural issues requiring coordinated action across the NHS and local authorities.

19. In terms of its next steps, the working group will:

- Hold an additional session with the representatives of the Thames Valley ICB on the use of digital tools and models in primary care services.
- Conduct site visits to GP practices in both rural and urban areas.
- Consider its findings against the backdrop of knowledge of evolving national NHS and local government reforms.

Key snapshot extrapolations from Primary Care Data provided to the group:

20. The working group was provided with a comprehensive set of quantitative and qualitative datasets by the Integrated Care Board, covering GP appointment activity, patient list growth, workforce capacity and patient experience (Annexes A–D). When considered together, these datasets provide a clear picture of how demand, capacity and access interact across Oxfordshire’s primary care system.

21. A key overarching extrapolation is that high activity does not equate to sufficient or equitable access. The GP appointment and registered patient list data (Annex A), alongside monthly appointment trend data for 2025 (Annex B), demonstrate that practices across Oxfordshire are delivering consistently high volumes of appointments against a background of sustained list growth. The data does not suggest a system experiencing short-term pressure or seasonal fluctuation; rather, it points to a structural demand–capacity imbalance, particularly in areas of population growth. This indicates that access challenges are not driven by under-delivery of appointments but by demand that continues to rise faster than underlying capacity.

22. A second key extrapolation is that workload intensity within general practice is increasing even where appointment numbers are stable or rising. Workforce data (Annex D), considered alongside appointment trends (Annex B), suggests that growth in activity has not been matched by a proportional increase in full-time equivalent GP capacity. This implies that the marginal increase in demand is being absorbed through intensified workload rather than expanded capacity. The working group noted that this aligns with national evidence showing that appointment data alone significantly under-represents the total volume and complexity of work undertaken in general practice.

23. Patient experience evidence provides an important contextual layer to this picture. The GP Patient Survey results (Annex C) show that while many patients report positive experiences once they secure care, difficulties in contacting practices, obtaining timely appointments and seeing a preferred clinician persist. When viewed alongside Annexes A, B and D, this suggests that access problems are not primarily about willingness or effort within practices, but about constrained capacity and system design. High appointment delivery is therefore compatible with ongoing patient frustration, particularly where continuity of care and flexibility are reduced.

24. A further extrapolation is that access pressures are unevenly distributed, even when aggregate data appears stable. Combining list growth data (Annex A) with patient experience findings (Annex C) indicates that practices serving fast-growing areas, rural communities or populations with additional access barriers are more likely to experience acute pressure. The working group noted that this reinforces the need to treat access inequality as a structural issue rather than a side-effect of individual practice performance.
25. Finally, when workforce, activity and patient experience data are read together, they point to a system operating close to capacity with limited resilience. High baseline activity leaves little headroom to absorb additional demand, service change or workforce attrition. This helps explain why relatively small disruptions—such as staff absence, delayed estate development or interface failures elsewhere in the system—can have disproportionate effects on patient access.

Summary Table: What Each Dataset Tells the Working Group

Dataset	What the Data Shows	Key Extrapolation for the Working Group
Annex A – GP appointments and registered patient list sizes (2023–2025)	Sustained list growth and high appointment delivery across practices	Demand is structurally rising; access issues are not explained by low activity
Annex B – Monthly appointment trends (2025)	Consistently high activity throughout the year	Pressure is continuous rather than seasonal; limited slack in the system
Annex C – GP Patient Survey (Jan 2025)	Mixed patient experience, with persistent access barriers	High throughput does not automatically result in good access or continuity
Annex D – GP workforce data	Limited growth in GP capacity relative to demand	Increasing workload intensity and reduced resilience within practices

KEY POINTS OF OBSERVATION:

26. This section highlights five key observations and points that the working group has in relation to GP services in Oxfordshire. These five key points of observation have been informed by the evidence received by the group from its sessions as well as from written submissions/data supplied. These points of observation have been used to determine the recommendations being made by the working group which are outlined below:

Importance of an integrated approach to improving access to general practice (ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole): The evidence considered by the working group demonstrates that access to general practice in Oxfordshire is shaped by the combined effects of population growth, workforce capacity, estate constraints and the design of access routes, rather than by any single factor in isolation. The working group therefore concluded that meaningful and sustainable improvements in access can only be delivered through a single, integrated approach, in which workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole.

Analysis of GP appointment activity and registered patient list sizes between January 2023 and December 2025 (Annex A) shows that practices across Oxfordshire are serving a growing registered population, with significant variation in list size growth between areas. While the data demonstrates that practices are collectively delivering very high volumes of appointments, it also highlights substantial differences in demand pressure at practice level. In particular, practices serving areas of rapid housing growth have experienced disproportionate increases in registered patients without corresponding increases in clinical capacity or physical space. The working group noted that, under such conditions, additional appointments alone cannot resolve access issues where workforce availability and estate capacity are already fully stretched.

This is reinforced by the month-by-month GP appointment trend data for January to December 2025 (Annex B). The data indicates that appointment volumes fluctuate seasonally but remain consistently high throughout the year, reflecting sustained demand rather than short-term pressure. However, the working group observed that delivery of high appointment numbers has not translated into a uniform improvement in patient experience. This supports national evidence that appointment counts do not capture the full range of work undertaken in general practice, nor the intensity and complexity of consultations now required. The working group therefore concluded that reliance on appointment data as a proxy for access risks obscuring underlying capacity constraints.

Patient experience evidence, as captured in the most recent GP Patient Survey (January 2025, Annex C), provides further context. While many patients reported positive experiences once they were able to secure an appointment, results relating to ease of contact, waiting times and choice of appointment type showed considerable variation. The working group noted that these findings align with feedback gathered by Healthwatch Oxfordshire, which highlights that improvements implemented through digital and triage-based access models have not been experienced equally across all population groups. This reinforces the conclusion that changes to access routes, when implemented separately from workforce and estates planning, can unintentionally widen inequalities rather than reduce them.

Workforce data (Annex D) was central to the working group's analysis. Although Oxfordshire has benefited from the introduction of additional roles through multidisciplinary teams, the data shows that growth in full-time equivalent GP capacity has not kept pace with increasing demand and list sizes. Moreover, the distribution of workload within practices has changed significantly, with GPs increasingly managing higher-complexity cases alongside supervision, triage and administrative responsibilities. National research demonstrates that a substantial proportion of GP time is absorbed by work that sits outside direct face-to-face consultations, including tasks generated at the interface between primary and secondary care¹. The working group therefore concluded that workforce planning, if considered independently of system design and workload drivers, cannot deliver sustainable access improvements.

The interaction between workforce limitations and estate constraints is particularly significant. Evidence reviewed by the working group shows that practices operating from constrained or outdated premises face limits on the number and type of clinical staff they can accommodate, restricting both appointment capacity and the development of neighbourhood-based, multidisciplinary working. National analyses show that many primary care estates were not designed to support modern service models, with limited flexibility to expand or reconfigure space². In Oxfordshire, this challenge is intensified in areas of population growth where estate delivery has lagged behind housing development, resulting in persistent access pressure despite high clinical effort.

The working group also considered how digital access and neighbourhood models interact with these pressures. Evidence from the GP Patient Survey (Annex C) demonstrates that while digital routes may improve convenience for some patients, they are not a substitute for sufficient clinical capacity or appropriate physical infrastructure. National Healthwatch evidence consistently highlights that digital-first approaches, when introduced without adequate support and alternative

¹ [RCGP, Uncovering the GP workload burden](#)

² [Institute for Government](#)

routes, risk disadvantaging digitally excluded populations³. The working group concluded that digital access must therefore be planned alongside workforce availability and estate suitability, rather than deployed as a stand-alone solution.

Experience from other parts of the country reinforces this conclusion. Integrated care systems that have aligned workforce strategy, estates investment and service redesign—such as North Central London and Hertfordshire and West Essex—demonstrate that access improvements are more sustainable when these elements are considered together⁴. Conversely, where initiatives have progressed in isolation, systems have struggled to convert activity growth into improved patient experience.

The Committee's examination of GP services in its September 2025 public meeting focused appropriately on understanding activity, performance and programmes underway. The working group's subsequent analysis, drawing on detailed appointment, population, workforce and patient experience data (Annexes A–D), shows that the primary challenge now facing Oxfordshire is not the absence of initiatives, but the absence of a coherent framework linking them. Without such integration, gains in one area—such as increased appointment delivery or expanded digital access—are repeatedly constrained by workforce, estates or system-generated workload pressures elsewhere.

For these reasons, the working group concluded that the Integrated Care Board should adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. This approach provides the clearest route to sustainable improvements in access, more equitable patient experience, and a transparent basis for future scrutiny by the Oxfordshire Joint Health Overview and Scrutiny Committee.

Recommendation 1: *For the Integrated Care Board to adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. It is also recommended that variation between localities and communities is supported in this process. The ICB needs to enhance its own capacity to work with local authorities and communities to expand capacity of primary care services in light of increases in demand.*

Taking active steps to reduce avoidable GP Workload: The working group concluded that active steps to reduce avoidable, system-generated workload on general practice are essential to protecting clinical capacity and improving patient access in Oxfordshire. This conclusion arises from a consistent theme across the evidence considered by the working group: that pressures on access are not

³ [Healthwatch England](#)

⁴ [North Central London Infrastructure Strategy](#)

primarily explained by a lack of effort or productivity within general practice, but by the cumulative burden of work generated by the wider health system that falls to GPs by default.

Local appointment activity and registered patient list data (Annex A) show that general practices across Oxfordshire are delivering very high volumes of appointments against a backdrop of sustained population growth. Registered list sizes increased markedly between January 2023 and December 2025, particularly in growth areas, placing additional demand on practices without a commensurate increase in clinical or administrative capacity. Month-by-month appointment trends for 2025 (Annex B) demonstrate that activity remains consistently high throughout the year rather than being driven by short-term seasonal spikes. Despite this, patient experience data (Annex C) indicates that many patients continue to report difficulties in accessing care, particularly in contacting practices and securing timely appointments. The working group concluded that this apparent contradiction—high activity alongside persistent access problems—cannot be adequately explained by appointment supply alone.

A central explanation lies in how GP time is consumed. Workforce data (Annex D) confirms that while Oxfordshire has benefited from growth in wider primary care roles, growth in full-time equivalent GP capacity has not kept pace with demand and complexity. This mirrors national trends, where GPs are increasingly required to manage complex, multi-morbid patients, provide supervision within multidisciplinary teams, and absorb additional tasks generated elsewhere in the system. National analysis by the *British Medical Association* highlights that workload growth in general practice has significantly outstripped workforce growth over the past decade, undermining sustainability and access despite record appointment delivery⁵.

Evidence submitted by the BOB Local Medical Committee (Annex E) was particularly influential in shaping this recommendation. The LMC highlighted that a substantial proportion of GP workload arises not from patient-initiated demand, but from tasks transferred—formally or informally—from secondary care, community services and wider public systems. This includes follow-up investigations, onward referrals, medication queries, care coordination and administrative work that does not require GP-level expertise but nonetheless consumes clinical time. This finding aligns closely with national research by the Royal College of General Practitioners, which estimates that “unnecessary” and hidden workload costs practices over £400 per GP per day and contributes directly to burnout, reduced retention and loss of clinical capacity⁶.

The working group’s evidence sessions reinforced these findings. In sessions with NHS representatives, members repeatedly heard that poorly designed interfaces between primary and secondary care

⁵ [BMA – Pressures in General Practice](#)

⁶ [RCGP, Uncovering the GP workload burden](#)).

continue to generate avoidable workload for general practice. Tasks such as incomplete discharge information, inappropriate test result follow-up and unclear referral pathways were identified as routine sources of additional work. National guidance published through the NHS England Red Tape Challenge explicitly recognises these interface failures as a major driver of GP workload and calls for integrated care boards to take active steps to reduce bureaucracy rather than allowing work to default to general practice⁷. Complementary guidance from the Getting It Right First Time programme sets out clear standards for improving processes between primary, secondary, mental health and community services, with the explicit aim of relieving pressure on GPs and improving patient flow⁸.

Patient experience evidence further supports the working group's conclusion. The GP Patient Survey (Annex C) and Healthwatch Oxfordshire's engagement between April 2025 and March 2026 consistently show that patients' frustration with access often reflects delays created by system processes rather than unwillingness or inefficiency within practices. Healthwatch evidence points to confusion about care pathways, repeated contacts generated by unresolved administrative issues, and increased demand for GP intervention when other services are difficult to access. National Healthwatch reporting echoes these themes, warning that failure to address access barriers across the system risks entrenching inequality and driving patients back to general practice as the "service of last resort"⁹.

The working group also drew on learning from other parts of the country. Integrated care systems that have actively addressed system-generated workload—by standardising referral processes, clarifying responsibilities at discharge and investing in interface roles—have demonstrated improvements in GP capacity and patient flow. For example, Cheshire and Merseyside's work on implementing standardised interface principles has been cited nationally as good practice in reducing avoidable GP workload and improving system efficiency¹⁰.

Academic literature published in the *British Journal of General Practice* also highlights that measuring access purely through appointment numbers obscures the "hidden labour" of general practice, much of which is driven by system design rather than patient need¹¹.

The GP services update item considered by the Committee in its September 2025 meeting rightly focused on understanding activity levels and programmes underway. However, the working group's subsequent scrutiny, informed by detailed data (Annexes A–D), professional evidence (Annex E) and national research, demonstrates that further improvements in access cannot be achieved simply by increasing appointment counts or introducing new access routes. Without

⁷ [NHS England – GP Red Tape Challenge](#)

⁸ [GIRFT – Bridging the interface](#)

⁹ [Healthwatch England](#)

¹⁰ [RCGP – Red Tape Challenge response](#)

¹¹ [BJGP editorial](#)

addressing avoidable, system-generated workload, any additional clinical capacity released will continue to be absorbed by inefficiencies elsewhere in the system.

Therefore, the working group concluded that active steps must be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system. This is not a request for further information, but a call for systemic action by the Integrated Care Board to protect scarce clinical capacity, improve sustainability within general practice and deliver meaningful improvements in patient access across Oxfordshire.

Recommendation 2: *For active steps to be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system, in order to protect clinical capacity and improve patient access. It is recommended that there is collaboration with local General Practice leaders (as well as patient representative bodies) to explore ways to reduce excessive administrative non-clinical work for qualified GPs; and that there is national escalation when this excessive work is owed to national constraints.*

Ensuring Sustainable Workforce Models in General Practice: The working group concluded that improving access to general practice in Oxfordshire cannot be achieved through a narrow focus on workforce headcount alone. Instead, the evidence considered by the working group demonstrates that long-term sustainability depends on how workload is distributed, how continuity of care is supported, and whether experienced GPs are able and willing to remain in practice. For this reason, the working group recommends that the Integrated Care Board ensures workforce models explicitly address workload intensity and retention, rather than relying primarily on increases in staffing numbers.

Local data on registered patient lists and appointment activity between January 2023 and December 2025 (Annex A) shows sustained and, in many areas, accelerating growth in demand for general practice. Registered list sizes have increased unevenly across Oxfordshire, reflecting housing growth and demographic change, with some practices absorbing significantly higher patient-to-GP ratios than others. While overall appointment volumes have risen, the working group noted that list growth increases not only the number of consultations but also the complexity of work, as larger lists inevitably contain greater numbers of older patients and people with multiple long-term conditions.

Month-by-month appointment trends for 2025 (Annex B) reinforce this picture. Appointment delivery remains consistently high throughout the year, suggesting that general practice is already operating near the limits of its available capacity. However, the working group observed that sustained appointment volume does not equate to sustainable workload. National research demonstrates that appointment counts capture only a portion of the work undertaken in general practice and do not reflect the cognitive, administrative and coordination burden that increasingly

characterises GP roles¹². As a result, workforce models based primarily on appointment throughput risk masking intensifying pressures on individual clinicians.

Workforce data (Annex D) was central to the working group's analysis. While Oxfordshire has seen growth in wider primary care roles, including those funded through multidisciplinary team arrangements, growth in fully qualified, experienced GPs—particularly on a full-time equivalent basis—has been limited. Evidence consistently shows that GP workload intensity has risen faster than the GP workforce, contributing to reduced job satisfaction, increased part-time working, and early retirement¹³. The working group therefore concluded that workforce sustainability cannot be assured through recruitment alone, without parallel action to manage workload and support retention.

The submission from the BOB Local Medical Committee (Annex E) strongly reinforced this conclusion. The LMC highlighted that workload intensity—rather than absolute staffing numbers—is a key determinant of GP retention. Experienced GPs are increasingly choosing to reduce sessions or leave practice altogether due to cumulative workload pressures, including administrative burden and system-generated tasks that detract from direct patient care.

Evidence from the working group's sessions with NHS partners further demonstrated that workload intensity is closely linked to system design. Poorly defined interfaces between primary and secondary care routinely shift work to GPs, increasing complexity and time pressure without corresponding resource transfer. The NHS Red Tape Challenge similarly identifies excessive administrative burden as a driver of poor workforce sustainability and reduced continuity of care¹⁴.

Continuity of care emerged as a critical theme linking workforce sustainability and patient experience. GP Patient Survey results from January 2025 (Annex C) show that patients place high value on seeing a preferred or familiar clinician, particularly those managing long-term or complex conditions. Healthwatch Oxfordshire's engagement work between April 2025 and March 2026 on GP services in Oxfordshire reinforces this, highlighting patient frustration when continuity is disrupted by high staff turnover, reliance on locums, or fragmented workforce models (the outcome report will be published on the Healthwatch Oxfordshire website by June 2026). Academic research, including from the King's Fund, also consistently demonstrates that continuity of care is associated with improved patient outcomes, reduced hospital admissions, and higher professional satisfaction among GPs, all of which contribute to workforce retention¹⁵.

¹² [British Journal of General Practice](#)

¹³ [BMA – Pressures in General Practice](#)).

¹⁴ [NHS England – Red Tape Challenge](#)

¹⁵ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice>

The working group noted that models which prioritise workforce flexibility without protecting continuity risk undermining both patient experience and staff retention. Evidence from other parts of the country indicates that systems investing in smaller, stable clinical teams and protecting experienced GPs' roles within them see better retention outcomes than those relying heavily on short-term staffing solutions. For example, integrated care systems that have explicitly linked retention strategies to workload reduction and continuity—such as parts of Greater Manchester and Cheshire and Merseyside—have been cited by national bodies as demonstrating more sustainable general practice models¹⁶.

The GP services update item discussed by the Committee in September 2025 appropriately focused on understanding activity levels and workforce initiatives underway. However, the working group's subsequent, deeper scrutiny demonstrates that a focus on staffing numbers alone risks obscuring the factors that determine whether clinicians remain in practice. Without addressing workload intensity, continuity of care and the working conditions experienced by senior GPs, increases in workforce supply may result only in churn rather than sustainable capacity.

Hence, the working group concluded that the Integrated Care Board must ensure workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs. This approach recognises that experienced clinicians are a finite and valuable resource, and that protecting their capacity and wellbeing is essential to improving access, maintaining quality, and ensuring the long-term resilience of general practice across Oxfordshire.

Recommendation 3: *That the Integrated Care Board ensures that workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs, rather than focusing solely on staffing numbers.*

Prioritising the reduction of inequalities in access to GP Services:

The working group concluded that improving access to GP services in Oxfordshire must be accompanied by a deliberate and sustained focus on reducing inequalities in access. Evidence considered by the working group demonstrates that improvements in headline access metrics do not translate evenly across population groups or geographies, and that without targeted action, existing disparities risk being entrenched or widened. For this reason, the working group recommends that the Integrated Care Board prioritises action to ensure that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth.

¹⁶ [RCGP – Continuity and Retention](#)

Analysis of GP appointment data and registered patient list sizes between January 2023 and December 2025 (Annex A) shows significant variation across Oxfordshire in both list size growth and demand pressure. Practices serving areas of rapid housing development have seen disproportionate increases in registered patients over a short period, often without a corresponding expansion in workforce or estate capacity. The working group noted that such areas face particular challenges in maintaining timely access, as increased list size translates directly into higher baseline demand. Month-by-month appointment trends during 2025 (Annex B) show that while practices collectively deliver high volumes of appointments throughout the year, this activity does not resolve uneven access where underlying capacity constraints and population change are not evenly distributed.

Patient experience data highlights how these pressures translate into inequality. Results from the January 2025 GP Patient Survey (Annex C) show marked variation in patients' ability to contact their practice, secure appointments and see a preferred clinician. While many respondents report good experiences once an appointment is obtained, the working group noted that ease of access remains a persistent challenge for particular groups. Healthwatch Oxfordshire's engagement work on GP services between April 2025 and March 2026 reinforces this finding, with access to GP services remaining one of the most common issues raised by residents (the outcome of this study will be published on the Healthwatch Oxfordshire website by June 2026). Healthwatch evidence points to consistent barriers faced by rural residents, people with limited digital skills, and those living in areas undergoing rapid population growth, particularly where existing services have not expanded at the same pace.

Rural inequality emerged strongly in both the data and the working group's sessions. Rural practices often serve geographically dispersed populations, with fewer alternative providers nearby and greater reliance on a small number of clinicians. Workforce data (Annex D) shows that such practices can be more vulnerable to staffing gaps and fluctuations, with limited ability to absorb sudden increases in demand. National research confirms that rurality is associated with lower GP-to-patient ratios and longer travel times, compounding access issues even where appointment availability appears comparable on paper¹⁷. The working group concluded that policies aimed at improving access must explicitly recognise rural context, rather than assuming uniform delivery models are appropriate across the county.

Digital exclusion was another recurring theme (this will be covered in more depth in a future dedicated session with the Thames Valley ICB). While digital access routes can improve efficiency and convenience for some patients, evidence reviewed by the working group shows that these benefits are not universal. GP Patient Survey data (Annex C) indicates

¹⁷ [RCGP – Health inequalities](#)).

that a proportion of patients struggle with online access or prefer telephone or face-to-face contact. Healthwatch Oxfordshire also reported that older residents, people with disabilities, those on low incomes and individuals with limited English proficiency are disproportionately disadvantaged by digital-first models when alternative routes are constrained. This mirrors national findings from Healthwatch England, which has repeatedly warned that digital transformation in general practice risks widening inequalities unless supported by inclusive design and sufficient analogue access¹⁸.

Moreover, workload pressures amplify these inequalities. Evidence from the BOB Local Medical Committee (Annex E) highlights that system-generated workload reduces the capacity of practices to offer flexible, responsive access, particularly in high-pressure areas. Nationally, the Royal College of General Practitioners has demonstrated that unnecessary and hidden workload consumes significant clinical time that could otherwise be directed towards patient access, with a disproportionate impact on practices serving more complex or deprived populations¹⁹. The working group concluded that unless workload pressures are addressed, practices in high-need areas will be least able to improve access, thereby exacerbating inequality.

Evidence from the working group's sessions with NHS organisations reinforced the importance of system coordination. Members heard that interfaces between primary, secondary and community services often generate additional demand for GP intervention, particularly where access to other services is limited. National NHS England guidance on bridging the interface between services recognises the role of poor system design in diverting patients back to general practice, disproportionately affecting areas with fewer alternative access routes²⁰. Similarly, the NHS Red Tape Challenge acknowledges that bureaucratic burdens and unclear responsibilities reduce system efficiency and have uneven impacts across communities²¹.

In addition, the written submission to the working group from Cherwell District Councillor David Rodgers illustrated how these issues intersect in areas of rapid growth. The submission highlighted the gap between housing delivery and primary care capacity, with new residents placing additional demand on already-stretched practices before new infrastructure is delivered.

National policy literature, including from the *Institute for Government's* work on GP estates, consistently identifies this mismatch as a driver of access inequality, particularly where local planning systems and healthcare commissioning are insufficiently aligned²². The working group

¹⁸ [Healthwatch England – GP access](#)

¹⁹ [RCGP – Unnecessary workload study](#)

²⁰ [GIRFT – Bridging the Interface](#)

²¹ [NHS England – Red Tape Challenge](#)

²² [Institute for Government – GP estates](#)

concluded that populations affected by rapid growth are at particular risk of deteriorating access if inequality is not explicitly addressed.

Learning from other parts of the country reinforces the need for a targeted approach. Integrated care systems that explicitly prioritise equity—such as Greater Manchester and parts of London—have used population health data to tailor access initiatives to specific communities, combining workforce support, outreach and flexible access routes. Evaluations from these systems demonstrate that access improvements are more likely to be sustained, and inequalities reduced, when services are designed around local need rather than uniform targets²³.

Therefore, the working group's analysis demonstrates that aggregate improvement does not guarantee equitable improvement. Drawing on detailed data (Annexes A–D), professional evidence (Annex E) and patient experience, the working group concluded that reducing inequalities in access requires explicit prioritisation and sustained action by the Integrated Care Board.

For the above reasons, the working group recommends that the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. This approach recognises that equitable access is not a by-product of general improvement but a core objective that must be actively pursued if the benefits of investment and reform are to be shared fairly across the county.

Recommendation 4: *That the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. It is recommended that local patient voices and the scrutiny function have meaningful input into the design and commissioning of GP services.*

Treating primary care estates capacity as a critical determinant of access: The working group concluded that capacity within primary care estate is a fundamental determinant of access to GP services in Oxfordshire. Evidence reviewed by the working group demonstrates that workforce growth, appointment delivery and service transformation are all constrained by the availability, suitability and timing of primary care infrastructure. Where estate provision fails to keep pace with population growth and changing models of care, access pressures emerge that cannot be resolved through short-term operational measures. For these reasons, the working group recommends that the Integrated Care Board treats primary care estates capacity as a critical system issue and

²³ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/tackling-health-inequalities>

ensures that planning, delivery and expansion of infrastructure are proactively aligned with housing development and population change. Local GP appointment and registered patient list data between January 2023 and December 2025 (Annex A) illustrates the scale of demand growth across Oxfordshire and its uneven geographical distribution. Practices serving areas of significant housing development have experienced rapid increases in registered list sizes over a relatively short period, often without corresponding increases in consulting space, clinical rooms or supporting facilities. While practices have continued to deliver high volumes of appointments, the working group noted that physical estate limitations place a limit on the number of clinicians who can be accommodated and the range of services that can be delivered. Appointment trends for 2025 (Annex B) show sustained activity across the year, reinforcing the conclusion that access challenges in growth areas are structural rather than seasonal.

The relationship between estates and workforce capacity was explored in depth through workforce data (Annex D) and evidence sessions held by the working group. The data shows that even where funding is available to recruit additional staff, practices operating from constrained premises are often unable to expand their workforce. National analysis confirms that inadequacies in GP premises are a significant barrier to recruitment and retention, particularly where buildings are outdated, inflexible or too small to support multidisciplinary teams²⁴. The working group therefore concluded that estate capacity directly limits the effectiveness of workforce initiatives intended to improve access.

Evidence submitted by the BOB Local Medical Committee (Annex E) reinforced this assessment. The LMC highlighted that estate constraints contribute to workload intensity by restricting opportunities to redesign services, share workload across roles, or co-locate community services. Nationally, the Royal College of General Practitioners has also emphasised that unsuitable premises increase administrative inefficiency and contribute to unnecessary workload, reducing the time available for direct patient care²⁵. The working group concluded that estate limitations therefore exacerbate both access problems and workforce sustainability challenges.

Patient experience evidence further underlines the importance of estates provision. GP Patient Survey results from January 2025 (Annex C) show variation in access and satisfaction that correlates with capacity pressures at practice level. Healthwatch Oxfordshire's engagement between April 2025 and March 2026 consistently highlights difficulty in securing timely appointments in fast-growing communities, alongside frustration where practices are perceived to be "over capacity". Healthwatch evidence mirrors national findings that access problems are particularly acute where population growth outstrips infrastructure

²⁴ [Institute for Government – Delivering a general practice estate fit for purpose](#)

²⁵ [RCGP – Uncovering the drivers and costs of unnecessary GP workload](#)

delivery²⁶. The working group concluded that patients' experience of access is shaped not only by appointment systems, but by whether physical infrastructure has expanded in line with need.

The issue of delayed or misaligned estate delivery was a recurring theme in the working group's sessions with NHS partners and local authority representatives. Members heard evidence of cases where GP premises were delivered years after housing completion, leaving practices to absorb new residents without additional space or facilities. The written submission from Cherwell District Councillor David Rodgers provided a local illustration of this challenge, highlighting how gaps between housing delivery and health infrastructure place sustained pressure on existing practices and undermine public confidence in access to services. National policy analysis from the Institute for Government and elsewhere identifies this misalignment as a systemic issue arising from fragmented responsibilities between planning authorities, developers and healthcare commissioners²⁷.

National NHS policy increasingly recognises the need for proactive and integrated estate planning. NHS England guidance on neighbourhood health centres emphasises that primary care infrastructure must be planned as a long-term enabler of service delivery, integrated with workforce and service models, and aligned with local growth strategies²⁸. Similarly, guidance produced through the Getting It Right First Time programme highlights the inefficiencies that arise where primary care infrastructure is delivered retrospectively, forcing general practice to compensate for wider system shortcomings²⁹.

Learning from other parts of the country reinforces the working group's conclusions. Integrated care systems such as North Central London and parts of Greater Manchester have demonstrated that early, structured engagement with planning authorities and developers enables primary care estates to be delivered alongside housing growth, rather than lagging behind it. These systems have shown that proactive estate planning supports workforce recruitment, service integration and more equitable access³⁰. By contrast, areas where estate planning is reactive continue to report persistent access challenges despite high clinical effort.

The GP services update item considered by the Committee in September 2025 focused appropriately on service activity and improvement initiatives. However, the working group's subsequent scrutiny demonstrates that without treating estate capacity as a core determinant of access, such initiatives are constrained in their impact. Evidence from Annexes A–E, combined with patient experience and national research,

²⁶ [Healthwatch England – GP access](#)

²⁷ [Institute for Government](#)

²⁸ [NHS England – Neighbourhood health centre guidance](#)

²⁹ [GIRFT – Bridging the interface](#)

³⁰ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice>

indicates that once access pressures have emerged due to inadequate infrastructure, they are difficult and costly to reverse.

Therefore, the Primary Care Access and Estates Working Group recommends that the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, ensures early and structured engagement with local planning authorities and developers, and secures the timely delivery of adequate, fit-for-purpose primary care facilities as communities expand. This proactive approach is essential to protecting access, supporting workforce sustainability and ensuring that the benefits of growth and development in Oxfordshire are matched by timely and equitable provision of primary care services.

Recommendation 5: That the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, and ensures that the planning, delivery and expansion of primary care infrastructure in Oxfordshire is proactively aligned with population growth and housing development. It is recommended that there is early/structured engagement with local planning authorities and developers; and a timely delivery of adequate, fit-for-purpose primary care facilities as communities expand, rather than responding retrospectively once access pressures have already emerged.

Legal Implications

27. 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.
28. 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'.
29. 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.

LIST OF ANNEXES:

- Annex A – GP Appointment data and registered patient list sizes per practice from January 2023-December 2025.
- Annex B - GP Appointment trends data month by month from January 2025-December 2025 (labelled Annex B).
- Annex C- GP Patient Survey data as of the most recent collection in January 2025.
- Annex D- GP workforce data.
- Annex E- Report submission to the working group from the Buckinghamshire, Oxfordshire, and Berkshire West Local Medical Committee on *Demand, Capacity & Activity in General Practice*.

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June 2026

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Month	GP Name	PCN Name	List Size - Jan 2023	List Size - Jan 2025	List Size-Growth	Appointments	Appointments Per 1,000 Patients
Dec-2025	THE HART SURGERY	HENLEY SONNET PCN	10,669	10,457	-1.99%	7,741	740.3
Dec-2025	DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,296	19,634	1.75%	8,563	436.1
Dec-2025	ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	6,482	7,032	8.49%	3,312	471.0
Dec-2025	DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,870	13,312	3.43%	6,800	510.8
Dec-2025	EYNHAM MEDICAL GROUP	EYNHAM & WITNEY PCN	15,468	16,314	5.47%	10,160	622.8
Dec-2025	TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,318	8,447	1.55%	4,563	540.2
Dec-2025	CHALGROVE & WATLINGTON SURGERIES	THAME PCN	7,404	8,052	8.75%	4,186	519.9
Dec-2025	HEDENA HEALTH	CITY - OX3+ PCN	29,273	26,904	-8.09%	8,367	311.0
Dec-2025	BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,087	9,076	-0.12%	4,094	451.1
Dec-2025	SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	18,782	19,305	2.78%	7,895	409.0

Dec-2025	ST BARTHOLOMEW S & HOLLOW WAY MED CENTRE	SPIRES PCN	21,473	29,231	36.13%	9,022	308.6
Dec-2025	MORLAND HOUSE SURGERY	THAME PCN	11,317	11,320	0.03%	4,323	381.9
Dec-2025	NETTLEBED SURGERY	HENLEY SONNET PCN	4,301	3,961	-7.91%	1,680	424.1
Dec-2025	BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	17,267	23,484	36.01%	9,502	404.6
Dec-2025	WINDRUSH MEDICAL PRACTICE	EYNHAM & WITNEY PCN	20,057	21,385	6.62%	7,729	361.4
Dec-2025	NEWBURY STREET PRACTICE	WANTAGE PCN	15,741	15,967	1.44%	7,565	473.8
Dec-2025	SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,844	9,841	-0.03%	4,335	440.5
Dec-2025	BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	10,462	9,979	-4.62%	2,471	247.6
Dec-2025	BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	5,612	6,300	12.26%	4,469	709.4
Dec-2025	WINDRUSH SURGERY	BANBURY ALLIANCE PCN	8,816	9,072	2.90%	4,506	496.7

Dec-2025	OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,453	12,502	0.39%	4,099	327.9
Dec-2025	MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	17,296	15,104	-12.67%	7,608	503.7
Dec-2025	BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	41,600	42,002	0.97%	13,500	321.4
Dec-2025	CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,661	15,326	-2.14%	8,940	583.3
Dec-2025	THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	11,451	12,420	8.46%	7,033	566.3
Dec-2025	BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,597	9,926	3.43%	3,829	385.8
Dec-2025	CHURCH STREET PRACTICE	WANTAGE PCN	17,585	20,349	15.72%	10,459	514.0
Dec-2025	CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,429	3,388	-1.20%	1,656	488.8
Dec-2025	THE BELL SURGERY	HENLEY SONNET PCN	10,281	10,979	6.79%	5,198	473.4
Dec-2025	MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,484	5,961	8.70%	2,435	408.5
Dec-2025	WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	18,116	19,108	5.48%	8,714	456.0

Dec-2025	MONTGOMERY HOUSE SURGERY	BICESTER PCN	17,093	16,398	-4.07%	6,741	411.1
Dec-2025	MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	12,956	14,631	12.93%	6,724	459.6
Dec-2025	WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,346	9,661	3.37%	4,062	420.5
Dec-2025	WOODLANDS MEDICAL CENTRE	DIDCOT PCN	16,329	18,841	15.38%	10,460	555.2
Dec-2025	MANOR SURGERY	CITY - OX3+ PCN	19,459	26,616	36.78%	14,146	531.5
Dec-2025	GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,354	7,371	0.23%	3,873	525.4
Dec-2025	WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,181	6,239	0.94%	2,718	435.6
Dec-2025	BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,131	7,939	11.33%	4,936	621.7
Dec-2025	THE RYCOTE PRACTICE	THAME PCN	12,921	13,778	6.63%	6,924	502.5
Dec-2025	WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	17,499	19,373	10.71%	8,795	454.0
Dec-2025	BICESTER HEALTH CENTRE	BICESTER PCN	16,216	20,173	24.40%	8,070	400.0

Dec-2025	THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	17,589	19,963	13.50%	8,162	408.9
Dec-2025	DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	12,003	12,194	1.59%	4,116	337.5
Dec-2025	CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	4,702	5,218	10.97%	3,022	579.1
Dec-2025	BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	8,154	8,050	-1.28%	3,746	465.3
Dec-2025	HIGHTOWN SURGERY	BANBURY ALLIANCE PCN	12,062	12,396	2.77%	6,954	561.0
Dec-2025	ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	5,710	6,159	7.86%	2,990	485.5
Dec-2025	WOODLANDS SURGERY	BANBURY ALLIANCE PCN	8,320	9,963	19.75%	4,066	408.1
Dec-2025	COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	11,007	12,013	9.14%	3,309	275.5
Dec-2025	SIBFORD SURGERY	UNALLOCATED	3,041	3,255	7.04%	998	306.6
Dec-2025	LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	443	515	16.25%	892	1,732.0
Dec-2025	GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,528	10,481	-0.45%	6,142	586.0

Dec-2025	NUFFIELD HEALTH CENTRE	EYNESHAM & WITNEY PCN	12,133	11,721	-3.40%	6,618	564.6
Dec-2025	BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	11,771	12,331	4.76%	5,343	433.3
Dec-2025	JERICHO HEALTH CENTRE	OXFORD CENTRAL PCN	10,177	12,343	21.28%	2,303	186.6
Dec-2025	LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,628	9,282	-3.59%	4,618	497.5
Dec-2025	NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	6,018	13,563	125.37%	4,921	362.8
Dec-2025	THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	13,176	12,739	-3.32%	5,805	455.7
Dec-2025	KES@NORTHGATE	OXFORD CENTRAL PCN	6,381	6,714	5.22%	1,653	246.2
Dec-2025	THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,484	5,335	-2.72%	3,561	667.5
Dec-2025	ALCHESTER MEDICAL GROUP	BICESTER PCN	21,297	21,482	0.87%	5,890	274.2
Dec-2025	COGGES SURGERY	EYNESHAM & WITNEY PCN	7,914	8,561	8.18%	3,557	415.5
Dec-2025	OAK TREE HEALTH CENTRE	DIDCOT PCN	11,045	10,985	-0.54%	4,404	400.9

GP Name	PCN Name	List Size - Jan 2023	List Size - Jan 2025	List Size-Growth	31/01/25	28/02/25	31/03/25	30/04/25	31/05/25	30/06/25	31/07/25	31/08/25	30/09/25	31/10/25	30/11/25	31/12/25	Average Appointments Per 1,000 Patients
THE HART SURGERY	HENLEY SONNET PCN	10,669	10,457	- 1.99 %	8599	7356	8132	7473	7456	7725	7904	6774	8169	9548	7939	7,741	755.60
DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,296	19,634	1.75 %	8099	7396	8292	7641	7511	7549	8161	6979	8195	11374	8886	8,563	418.69
ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	6,482	7,032	8.49 %	3671	3583	3633	3597	3477	3664	3598	3204	4024	4544	3325	3,312	517.06
DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,870	13,312	3.43 %	6945	5791	6068	5835	5575	5929	6619	5286	6421	8114	5830	6,800	470.83
EYNSHAM MEDICAL GROUP	EYNSHAM & WITNEY PCN	15,468	16,314	5.47 %	12628	10723	11143	10665	9945	9964	10706	9337	10484	12889	9934	10,160	656.79

TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,318	8,447	1.55 %	49 17	4969	5020	4535	4633	4725	531 8	4394	5246	6074	4545	4,563	581.46
CHALGROVE & WATLINGTON SURGERIES	THAME PCN	7,404	8,052	8.75 %	36 07	3213	3585	3046	3339	3694	373 8	3019	3810	4912	3971	4,186	456.62
HEDEN HEALTH CENTRE	CITY - OX3+ PCN	29,273	26,904	- 8.09 %	11 62 1	10869	12108	10594	10426	10785	8492	7516	8875	10073	8834	8,367	367.23
BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,087	9,076	- 0.12 %	50 47	4709	5011	4338	4471	4369	471 0	3926	4669	5454	4361	4,094	506.45
SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	18,782	19,305	2.78 %	88 21	8067	8465	8193	8143	8228	877 9	6862	7913	10125	8395	7,895	431.17
ST BARTHOLOMEWS & HOLLOW	SPIRES PCN	21,473	29,231	36.13 %	96 53	8948	9341	8968	8793	9014	938 2	8340	10500	12509	9584	9,022	325.15

WAY MED CENTRE																	
MORLAND HOUSE SURGERY	THAME PCN	11,317	11,320	0.03 %	5196	4390	4486	4750	4568	4814	4987	3931	4787	7057	4505	4,323	425.46
NETTLEBED SURGERY	HENLEY SONNET PCN	4,301	3,961	- 7.91 %	1785	1583	1697	1545	1537	1651	1840	1609	1746	1948	1716	1,680	427.86
BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	17,267	23,484	36.01 %	12077	10762	11672	11030	11312	11446	11436	9218	10096	9966	9904	9,502	455.70
WINDRUSH MEDICAL PRACTICE	EYNHAM & WITNEY PCN	20,057	21,385	6.62 %	9224	7816	8506	7943	8226	8558	9024	7968	8712	8711	7979	7,729	391.22
NEWBURY STREET PRACTICE	WANTAGE PCN	15,741	15,967	1.44 %	8314	7073	7773	7240	7179	7664	8057	6671	7260	8026	7173	7,565	469.69
SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,844	9,841	- 0.03 %	5067	4446	4504	4271	4312	4569	4919	3633	4254	5794	4043	4,335	458.52
BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY	10,462	9,979	- 4.62 %	3077	2790	2882	2762	2672	2733	2754	2321	2699	3306	2609	2,471	276.21

	NETWORK PCN																
BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	5,612	6,300	12.26 %	4892	4312	4915	4335	4356	4737	4652	3988	4650	5023	4191	4,469	721.16
WINDRUSH SURGERY	BANBURY ALLIANCE PCN	8,816	9,072	2.90 %	5537	4831	5339	5053	4971	4914	5510	4590	5461	6451	5432	4,506	574.98
OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,453	12,502	0.39 %	4762	4328	4523	4306	4444	4264	4559	3774	4408	6158	4279	4,099	359.30
MALTRUS E SURGERY	ABINGDON CENTRAL PCN	17,296	15,104	- 12.67 %	8452	7621	8510	7387	6918	7943	8677	6453	7966	9810	8219	7,608	527.26
BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	41,600	42,002	0.97 %	17853	14235	15129	14073	12354	14869	15458	12023	15295	15889	15931	13,500	350.40
CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDS HIRE RURAL ALLIANCE (NORA) PCN	15,661	15,326	- 2.14 %	8360	7626	8494	7708	7602	7557	8341	6996	7150	11005	8800	8,940	536.01

THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	11,451	12,420	8.46 %	8111	7259	7465	6808	6717	7203	7551	6278	7280	9056	7506	7,033	592.24
BARTLEMA S SURGERY	CITY - EAST OXFORD PCN	9,597	9,926	3.43 %	3601	3248	3258	2968	3110	3471	3727	3099	3751	4082	3922	3,829	353.16
CHURCH STREET PRACTICE	WANTAG E PCN	17,585	20,349	15.72 %	11094	9632	10079	9523	9948	10103	11772	9232	10806	12427	10375	10,459	513.74
CLIFTON HAMPTON SURGERY	ABINGDO N AND DISTRICT PCN	3,429	3,388	- 1.20 %	1911	1540	1878	1712	1822	1910	1874	1561	1753	2253	1611	1,656	528.36
THE BELL SURGERY	HENLEY SONNET PCN	10,281	10,979	6.79 %	5878	4776	5562	4904	4960	5027	5604	4625	5349	5746	5546	5,198	479.51
MILL STREAM SURGERY	WALLING FORD & SURROU NDS PCN	5,484	5,961	8.70 %	2789	2596	2900	3040	2528	2713	2919	2251	2854	4172	2814	2,435	475.47
WALLINGF ORD MEDICAL PRACTICE	WALLING FORD & SURROU NDS PCN	18,116	19,108	5.48 %	9898	8931	9505	8176	8318	8936	9651	7952	9460	12919	9409	8,714	487.88

MONTGOMERY HOUSE SURGERY	BICESTER PCN	17,093	16,398	- 4.07 %	8893	8085	8266	7738	8236	8667	8911	7794	8824	9316	8019	6,741	505.60
MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	12,956	14,631	12.93 %	8119	7116	7161	6859	6750	7188	7252	6342	6803	7573	6583	6,724	481.11
WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,346	9,661	3.37 %	4556	4080	4015	4734	4228	4489	4502	3362	4945	5620	4579	4,062	458.65
WOODLANDS MEDICAL CENTRE	DIDCOT PCN	16,329	18,841	15.38 %	10886	9040	10262	8956	9375	9032	10712	8536	10478	13308	10714	10,460	538.54
MANOR SURGERY	CITY - OX3+ PCN	19,459	26,616	36.78 %	15708	13770	15165	14782	13684	14553	15789	13412	15022	16614	14045	14,146	553.21
GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,354	7,371	0.23 %	4236	3936	4070	3992	3653	3937	4073	3315	3901	6020	4193	3,873	556.22

WYCHWOOD SURGERY	NORTH OXFORDS HIRE RURAL ALLIANCE (NORA) PCN	6,181	6,239	0.94 %	31 35	2871	3038	3237	2792	2845	292 2	2603	2808	4199	2901	2,718	481.77
BURFORD SURGERY	RURAL WEST OXFORDS HIRE PCN	7,131	7,939	11.33 %	55 77	4739	5115	4634	4582	5103	488 1	4251	4960	6274	4916	4,936	629.47
THE RYCOTE PRACTICE	THAME PCN	12,921	13,778	6.63 %	74 05	6404	6828	6610	6607	6872	720 7	6470	7326	9727	6980	6,924	516.28
WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	17,499	19,373	10.71 %	10 35 7	8942	9763	8414	7965	9158	968 6	7741	9642	1339 5	1014 1	8,795	490.37
BICESTER HEALTH CENTRE	BICESTER PCN	16,216	20,173	24.40 %	76 58	7939	8470	8560	7694	8194	857 9	6969	8046	1016 4	8892	8,070	409.93
THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	17,589	19,963	13.50 %	88 45	7536	8502	8459	7458	8364	830 5	6942	8503	1178 6	8102	8,162	421.46
DEDDINGTON HEALTH CENTRE	NORTH OXFORDS HIRE RURAL ALLIANCE	12,003	12,194	1.59 %	47 32	4257	4684	4511	4126	4482	450 6	4100	4379	6740	3991	4,116	373.30

	(NORA) PCN																
CROPREDY SURGERY	NORTH OXFORDS HIRE RURAL ALLIANCE (NORA) PCN	4,702	5,218	10.97 %	30 48	2913	3165	2928	2839	3192	340 9	2670	3061	4594	2967	3,022	603.81
BLOXHAM SURGERY	NORTH OXFORDS HIRE RURAL ALLIANCE (NORA) PCN	8,154	8,050	- 1.28 %	37 01	3275	3661	3403	3574	3590	397 0	3558	3713	5412	3750	3,746	469.49
HIGHLOW N SURGERY	BANBURY ALLIANCE PCN	12,06 2	12,39 6	2.77 %	68 95	6153	7079	6332	6481	6565	714 7	5789	6934	8265	7090	6,954	549.13
ST. CLEMENT' S SURGERY	CITY - EAST OXFORD PCN	5,710	6,159	7.86 %	33 71	3292	3244	3161	2926	3053	335 9	2605	3149	3794	3097	2,990	514.71
WOODLAN DS SURGERY	BANBURY ALLIANCE PCN	8,320	9,963	19.75 %	45 58	4405	4535	4430	4117	4133	473 3	3874	4495	5768	4239	4,066	446.26
COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	11,00 7	12,01 3	9.14 %	36 02	3373	3736	3255	3213	3185	340 2	2583	3310	4324	3438	3,309	282.54

SIBFORD SURGERY	UNALLOCATED	3,041	3,255	7.04 %	1165	1035	1162	1033	975	1070	1075	912	997	1756	985	998	336.99
LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	443	515	16.25 %	1173	1107	1077	922	904	1003	1120	898	1142	1238	1141	892	2,041.59
GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,528	10,481	- 0.45 %	6727	6003	6836	6426	5869	6094	6738	5550	6050	7541	7164	6,142	613.33
NUFFIELD HEALTH CENTRE	EYNHAM & WITNEY PCN	12,133	11,721	- 3.40 %	7612	6670	6693	5962	5571	5722	6500	5449	6280	7619	6576	6,618	549.38
BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	11,771	12,331	4.76 %	6776	6000	6231	5724	5410	5309	5471	4091	4952	7022	5753	5,343	460.10
JERICO HEALTH CENTRE	OXFORD CENTRAL PCN	10,177	12,343	21.28 %	2358	2254	2450	2077	2017	2396	2110	1768	2122	2941	2396	2,303	183.59
LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,628	9,282	- 3.59 %	5564	4348	4819	4374	4522	4825	4965	4032	5154	6172	4953	4,618	523.83
NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	6,018	13,563	125.37 %	6467	5759	6043	5162	5590	5968	5751	4472	5143	7078	5678	4,921	418.00

THE KEY MEDICAL PRACTICE	KIDLINGT ON, ISLIP, WOODST OCK & YARNTON (KIWY) PCN	13,17 6	12,73 9	- 3.32 %	71 50	6157	6574	6117	6154	6339	672 6	5065	6176	8112	6114	5,805	500.36
KES@NOR THGATE	OXFORD CENTRAL PCN	6,381	6,714	5.22 %	19 67	1990	2045	1791	2019	2006	184 4	1439	1847	2500	2239	1,653	289.69
THE CHARLBUR Y MEDICAL CENTRE	RURAL WEST OXFORDS HIRE PCN	5,484	5,335	- 2.72 %	36 47	3075	3557	3595	3172	3078	363 6	2945	3207	4895	3262	3,561	650.27
ALCKSTE R MEDICAL GROUP	BICESTER PCN	21,29 7	21,48 2	0.87 %	64 53	5864	6109	5352	5003	5421	559 2	4714	5823	8475	6184	5,890	274.96
COGGES SURGERY	EYNSHA M & WITNEY PCN	7,914	8,561	8.18 %	36 82	3344	3747	3222	3478	3459	364 6	3109	3703	4426	3867	3,557	420.90
OAK TREE HEALTH CENTRE	DIDCOT PCN	11,04 5	10,98 5	- 0.54 %	49 37	4754	5205	4857	4438	4393	461 3	4012	5068	6307	4526	4,404	436.31

GP Name	PCN Name	List Size - Jan 2025	GP Patient Survey - Overall Experience	% I phoned the practice	% Online, using the practice website	% Online, using the NHS App	% Online, using a different website or app	% Another way
THE HART SURGERY	HENLEY SONNET PCN	10,457	91%	29%	61%	5%	1%	*
DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,634	58%	66%	10%	4%	*	3%
ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,032	92%	84%	5%	1%	1%	3%
DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	13,312	73%	77%	3%	3%	*	5%
EYNHAM MEDICAL GROUP	EYNHAM & WITNEY PCN	16,314	82%	36%	35%	7%	1%	1%
TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,447	78%	66%	10%	7%	0%	3%
CHALGROVE & WATLINGTON SURGERIES	THAME PCN	8,052	92%	80%	1%	4%	1%	4%
HEDENA HEALTH	CITY - OX3+ PCN	26,904	77%	35%	37%	14%	1%	2%

BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,076	62%	74%	4%	0%	2%	0%
SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	19,305	74%	65%	12%	14%	2%	2%
ST BARTHOLOMEWS & HOLLOW WAY MED CENTRE	SPIRES PCN	29,231	68%	64%	14%	6%	5%	0%
MORLAND HOUSE SURGERY	THAME PCN	11,320	94%	73%	4%	10%	2%	0%
NETTLEBED SURGERY	HENLEY SONNET PCN	3,961	88%	68%	8%	5%	0%	0%
BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	23,484	80%	59%	16%	6%	2%	7%
WINDRUSH MEDICAL PRACTICE	EYNHAM & WITNEY PCN	21,385	79%	37%	33%	15%	3%	3%
NEWBURY STREET PRACTICE	WANTAGE PCN	15,967	68%	38%	29%	24%	*	1%
SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,841	86%	67%	2%	14%	5%	4%
BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	9,979	84%	72%	6%	9%	2%	7%
BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	6,300	96%	71%	7%	11%	0%	3%

WINDRUSH SURGERY	BANBURY ALLIANCE PCN	9,072	57%	76%	11%	2%	4%	*
OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,502	77%	60%	10%	16%	0%	0%
MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	15,104	64%	54%	16%	9%	7%	1%
BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	42,002	62%	63%	16%	14%	1%	2%
CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,326	78%	70%	4%	4%	2%	1%
THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,420	66%	54%	20%	8%	0%	0%
BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,926	82%	75%	5%	7%	0%	5%
CHURCH STREET PRACTICE	WANTAGE PCN	20,349	77%	42%	35%	12%	2%	2%
CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,388	80%	71%	8%	9%	1%	1%
THE BELL SURGERY	HENLEY SONNET PCN	10,979	93%	82%	8%	2%	2%	2%
MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,961	94%	82%	3%	5%	0%	2%

WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	19,108	91%	77%	4%	11%	0%	3%
MONTGOMERY HOUSE SURGERY	BICESTER PCN	16,398	57%	47%	35%	2%	2%	2%
MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	14,631	78%	72%	17%	2%	2%	2%
WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,661	74%	63%	15%	6%	3%	0%
WOODLANDS MEDICAL CENTRE	DIDCOT PCN	18,841	62%	52%	28%	5%	1%	6%
MANOR SURGERY	CITY - OX3+ PCN	26,616	92%	51%	28%	9%	0%	*
GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,371	83%	47%	24%	8%	1%	2%
WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,239	97%	88%	1%	0%	1%	0%
BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,939	87%	85%	3%	2%	0%	1%
THE RYCOTE PRACTICE	THAME PCN	13,778	88%	67%	12%	7%	3%	1%
WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	19,373	70%	34%	37%	20%	3%	*

BICESTER HEALTH CENTRE	BICESTER PCN	20,173	88%	65%	13%	7%	8%	2%
THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	19,963	79%	64%	4%	10%	2%	2%
DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	12,194	77%	36%	37%	19%	0%	0%
CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	5,218	93%	83%	3%	5%	1%	0%
BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	8,050	86%	92%	0%	1%	1%	0%
HIGHTOWN SURGERY	BANBURY ALLIANCE PCN	12,396	80%	72%	11%	5%	1%	2%
ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	6,159	90%	67%	11%	4%	5%	5%
WOODLANDS SURGERY	BANBURY ALLIANCE PCN	9,963	81%	87%	3%	3%	0%	0%
COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	12,013	84%	74%	3%	*	0%	3%
SIBFORD SURGERY	UNALLOCATED	3,255	92%	86%	3%	1%	0%	3%
LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	515	95%	79%	0%	0%	0%	0%

GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,481	79%	29%	48%	6%	1%	1%
NUFFIELD HEALTH CENTRE	EYNHAM & WITNEY PCN	11,721	79%	73%	4%	3%	0%	0%
BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	12,331	68%	81%	2%	0%	*	1%
JERICO HEALTH CENTRE	OXFORD CENTRAL PCN	12,343	85%	82%	2%	3%	2%	4%
LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,282	78%	33%	53%	7%	3%	1%
NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	13,563	81%	76%	5%	8%	2%	2%
THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	12,739	74%	61%	6%	4%	3%	0%
KES@NORTHGATE	OXFORD CENTRAL PCN	6,714	89%	72%	5%	5%	3%	3%
THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,335	67%	77%	6%	3%	0%	0%
ALCHESTER MEDICAL GROUP	BICESTER PCN	21,482	71%	69%	16%	3%	1%	4%
COGGES SURGERY	EYNHAM & WITNEY PCN	8,561	84%	78%	3%	8%	0%	1%
OAK TREE HEALTH CENTRE	DIDCOT PCN	10,985	66%	47%	43%	5%	2%	*

Month	GP Name	PCN Name	List Size - Jan 2025	Admin/Non-Clinical staff	Direct Patient Care staff	GP staff	Nurses	Admin/Non-Clinical staff per 1000 patients	Direct Patient Care staff per 1000 patients	GP per 1000 patients	Nurses per 1000 patients
Jul-2025	THE HART SURGERY	HENLEY SONNET PCN	10,457	12.85	6.21	6.88	2.17	1.23	0.59	0.66	0.21
Jul-2025	DIDCOT HEALTH CENTRE PRACTICE	DIDCOT PCN	19,634	18.41	4.53	10.62	3.37	0.94	0.23	0.54	0.17
Jul-2025	ISLIP SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,032	10.14	5.32	6.41	1.71	1.44	0.76	0.91	0.24
Jul-2025	DONNINGTON MEDICAL PARTNERSHIP	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	13,312	13.84	1.53	7.13	4.07	1.04	0.12	0.54	0.31
Jul-2025	EYNHAM MEDICAL GROUP	EYNHAM & WITNEY PCN	16,314	22.13	19.17	14.39	2.95	1.36	1.18	0.88	0.18
Jul-2025	TEMPLE COWLEY HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	8,447	10.13	2.00	3.40	2.85	1.20	0.24	0.40	0.34

Jul-2025	CHALGROVE & WATLINGTON SURGERIES	THAME PCN	8,052	8.64	4.15	5.12	2.00	1.07	0.51	0.64	0.25
Jul-2025	HEDENA HEALTH	CITY - OX3+ PCN	26,904	29.68	8.53	11.07	4.57	1.10	0.32	0.41	0.17
Jul-2025	BAMPTON SURGERY	RURAL WEST OXFORDSHIRE PCN	9,076	7.03	3.39	2.74	1.91	0.77	0.37	0.30	0.21
Jul-2025	SUMMERTOWN HEALTH CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	19,305	20.31	4.07	9.28	4.65	1.05	0.21	0.48	0.24
Jul-2025	ST BARTHOLOMEWS & HOLLOW WAY MED CENTRE	SPIRES PCN	29,231	31.44	10.05	13.74	2.57	1.08	0.34	0.47	0.09
Jul-2025	MORLAND HOUSE SURGERY	THAME PCN	11,320	7.74	1.49	7.07	0.57	0.68	0.13	0.62	0.05
Jul-2025	NETTLEBED SURGERY	HENLEY SONNET PCN	3,961	6.69	1.31	2.43	2.37	1.69	0.33	0.61	0.60
Jul-2025	BEAUMONT ELMS PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	23,484	29.87	15.70	16.37	4.15	1.27	0.67	0.70	0.18
Jul-2025	WINDRUSH MEDICAL PRACTICE	EYNHAM & WITNEY PCN	21,385	38.63	12.04	15.44	6.21	1.81	0.56	0.72	0.29
Jul-2025	NEWBURY STREET PRACTICE	WANTAGE PCN	15,967	17.16	4.33	7.12	3.56	1.07	0.27	0.45	0.22
Jul-2025	SONNING COMMON HEALTH CTR	HENLEY SONNET PCN	9,841	13.58	0.35	12.77	2.19	1.38	0.04	1.30	0.22

Jul-2025	BANBURY ROAD MEDICAL CENTRE	HEALTHIER OXFORD CITY NETWORK PCN	9,979	8.48	1.25	2.61	1.00	0.85	0.13	0.26	0.10
Jul-2025	BERINSFIELD HEALTH CENTRE	ABINGDON AND DISTRICT PCN	6,300	4.79	0.80	8.40	1.17	0.76	0.13	1.33	0.19
Jul-2025	WINDRUSH SURGERY	BANBURY ALLIANCE PCN	9,072	8.19	1.33	6.43	2.44	0.90	0.15	0.71	0.27
Jul-2025	OBSERVATORY MEDICAL PRACTICE	OXFORD CENTRAL PCN	12,502	13.01	3.89	7.41	1.87	1.04	0.31	0.59	0.15
Jul-2025	MALTHOUSE SURGERY	ABINGDON CENTRAL PCN	15,104	19.44	8.05	6.87	4.29	1.29	0.53	0.45	0.28
Jul-2025	BANBURY CROSS HEALTH CENTRE	BANBURY CROSS PCN	42,002	59.54	22.05	19.85	18.82	1.42	0.52	0.47	0.45
Jul-2025	CHIPPING NORTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	15,326	24.41	7.61	7.71	4.01	1.59	0.50	0.50	0.26
Jul-2025	THE LEYS HEALTH CENTRE	SOUTH EAST OXFORD HEALTH ALLIANCE (SEOXHA) PCN	12,420	13.69	1.36	6.08	2.39	1.10	0.11	0.49	0.19
Jul-2025	BARTLEMAS SURGERY	CITY - EAST OXFORD PCN	9,926	12.51	2.72	8.02	1.00	1.26	0.27	0.81	0.10
Jul-2025	CHURCH STREET PRACTICE	WANTAGE PCN	20,349	18.81	7.84	11.40	6.93	0.92	0.39	0.56	0.34

Jul-2025	CLIFTON HAMPDEN SURGERY	ABINGDON AND DISTRICT PCN	3,388	6.99	0.69	2.21	0.77	2.06	0.20	0.65	0.23
Jul-2025	THE BELL SURGERY	HENLEY SONNET PCN	10,979	8.47	1.45	8.03	2.69	0.77	0.13	0.73	0.24
Jul-2025	MILL STREAM SURGERY	WALLINGFORD & SURROUNDS PCN	5,961	6.87	1.32	4.21	0.53	1.15	0.22	0.71	0.09
Jul-2025	WALLINGFORD MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	19,108	10.96	5.88	12.99	4.01	0.57	0.31	0.68	0.21
Jul-2025	MONTGOMERY HOUSE SURGERY	BICESTER PCN	16,398	21.73	6.57	8.91	4.53	1.32	0.40	0.54	0.28
Jul-2025	MARCHAM RD FAMILY HEALTH CENTRE	ABINGDON AND DISTRICT PCN	14,631	0.00	0.00	13.12	2.79	0.00	0.00	0.90	0.19
Jul-2025	WOODSTOCK SURGERY	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	9,661	12.99	2.95	4.41	1.91	1.34	0.31	0.46	0.20
Jul-2025	WOODLANDS MEDICAL CENTRE	DIDCOT PCN	18,841	18.11	4.78	11.00	2.95	0.96	0.25	0.58	0.16
Jul-2025	MANOR SURGERY	CITY - OX3+ PCN	26,616	34.96	13.13	21.31	7.01	1.31	0.49	0.80	0.26
Jul-2025	GOSFORD HILL MEDICAL CENTRE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	7,371	10.81	1.43	4.64	1.43	1.47	0.19	0.63	0.19

Jul-2025	WYCHWOOD SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	6,239	6.16	9.35	6.93	1.35	0.99	1.50	1.11	0.22
Jul-2025	BURFORD SURGERY	RURAL WEST OXFORDSHIRE PCN	7,939	8.07	3.67	3.27	2.41	1.02	0.46	0.41	0.30
Jul-2025	THE RYCOTE PRACTICE	THAME PCN	13,778	13.64	6.52	10.21	5.31	0.99	0.47	0.74	0.39
Jul-2025	WHITE HORSE MEDICAL PRACTICE	WHITE HORSE PCN	19,373	18.34	13.45	10.81	3.79	0.95	0.69	0.56	0.20
Jul-2025	BICESTER HEALTH CENTRE	BICESTER PCN	20,173	22.29	9.25	13.12	6.53	1.10	0.46	0.65	0.32
Jul-2025	THE ABINGDON SURGERY	ABINGDON CENTRAL PCN	19,963	17.28	2.19	11.53	3.45	0.87	0.11	0.58	0.17
Jul-2025	DEDDINGTON HEALTH CENTRE	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	12,194	18.17	6.68	7.43	1.80	1.49	0.55	0.61	0.15
Jul-2025	CROPREDY SURGERY	NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	5,218	6.11	4.16	4.82	3.07	1.17	0.80	0.92	0.59
Jul-2025	BLOXHAM SURGERY	NORTH OXFORDSHIRE RURAL	8,050	13.59	1.71	5.01	2.78	1.69	0.21	0.62	0.35

		ALLIANCE (NORA) PCN									
Jul-2025	HIGHTOWN SURGERY	BANBURY ALLIANCE PCN	12,396	20.25	5.12	6.91	4.07	1.63	0.41	0.56	0.33
Jul-2025	ST. CLEMENT'S SURGERY	CITY - EAST OXFORD PCN	6,159	6.97	5.43	4.37	0.79	1.13	0.88	0.71	0.13
Jul-2025	WOODLANDS SURGERY	BANBURY ALLIANCE PCN	9,963	11.44	1.20	4.48	0.93	1.15	0.12	0.45	0.09
Jul-2025	COWLEY ROAD MEDICAL PRACTICE	CITY - EAST OXFORD PCN	12,013	11.73	0.64	6.16	1.88	0.98	0.05	0.51	0.16
Jul-2025	SIBFORD SURGERY	UNALLOCATED	3,255	4.00	0.29	0.99	0.40	1.23	0.09	0.30	0.12
Jul-2025	LUTHER STREET MEDICAL PRACTICE	HEALTHIER OXFORD CITY NETWORK PCN	515	3.80	0.00	2.89	3.41	7.38	0.00	5.61	6.63
Jul-2025	GORING & WOODCOTE MEDICAL PRACTICE	WALLINGFORD & SURROUNDS PCN	10,481	14.69	0.27	7.64	2.20	1.40	0.03	0.73	0.21
Jul-2025	NUFFIELD HEALTH CENTRE	EYNHAM & WITNEY PCN	11,721	20.40	2.43	10.32	3.00	1.74	0.21	0.88	0.26
Jul-2025	BROADSHIRES HEALTH CENTRE	RURAL WEST OXFORDSHIRE PCN	12,331	11.69	3.36	6.02	5.57	0.95	0.27	0.49	0.45
Jul-2025	JERICO HEALTH CENTRE	OXFORD CENTRAL PCN	12,343	3.85	0.40	4.87	1.20	0.31	0.03	0.39	0.10
Jul-2025	LONG FURLONG MEDICAL CENTRE	ABINGDON AND DISTRICT PCN	9,282	8.40	1.13	4.17	2.37	0.90	0.12	0.45	0.26

Jul-2025	NORTHGATE HEALTH CENTRE	OXFORD CENTRAL PCN	13,563	15.20	5.48	6.44	2.35	1.12	0.40	0.47	0.17
Jul-2025	THE KEY MEDICAL PRACTICE	KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	12,739	15.05	4.68	7.71	2.05	1.18	0.37	0.60	0.16
Jul-2025	KES@NORTHGATE	OXFORD CENTRAL PCN	6,714	4.79	1.27	2.69	1.10	0.71	0.19	0.40	0.16
Jul-2025	THE CHARLBURY MEDICAL CENTRE	RURAL WEST OXFORDSHIRE PCN	5,335	7.36	4.63	3.35	1.24	1.38	0.87	0.63	0.23
Jul-2025	ALCHESTER MEDICAL GROUP	BICESTER PCN	21,482	20.07	9.48	9.65	3.77	0.93	0.44	0.45	0.18
Jul-2025	COGGES SURGERY	EYNHAM & WITNEY PCN	8,561	8.95	3.24	5.89	1.33	1.05	0.38	0.69	0.16
Jul-2025	OAK TREE HEALTH CENTRE	DIDCOT PCN	10,985	10.97	2.00	3.84	4.07	1.00	0.18	0.35	0.37

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Author: Dr Richard Wood, CEO BBOLMC

16 Feb 2026

Report for HOSC: Demand, Capacity & Activity in General Practice in BBO. The BBOLMC SitRep

Methodology

The BBOLMC collects data from participating practices across several different measures, including:

- The **number of medical record entries** made by the practice each week within EMIS (the medical records system) and which type of staff member made those entries.
- The **number of in-coming telephone calls** each week. Practices are asked to also include into this total count the number of e-consults (online form submissions) and other contact points (such as walk-ins).
- The **number of GPs** they have in the practice each week.
- How much protected (ring-fenced) **admin time** a GP is given per week, outside of direct patient care.

This local data is used for two purposes:

1. To provide a Situation Report (“SitRep”) on measures of demand, capacity, and activity in General Practice
2. To generate an *Operational Pressures Escalation Level* (“OPEL”) score for each practice. OPEL scores are mathematically derived, based on the data submitted by the organisation. They have been used by hospital trusts for many years as a method of declaring operating pressures. The BBOLMC OPEL system was the first of its kind for General Practice. Below, we provide an OPEL score in two domains: demand-vs-capacity, and admin workload.

A methodology paper is available on request which gives greater detail about data collection, derived conclusions, and the many assumptions that potentially confound the data below.

Participation

Participating is voluntary for practices. It is a manual process which takes approximately 5-10 minutes of practice time each week. Uptake is limited. Out of approximately 200 practices in Berkshire, Buckinghamshire and Oxfordshire (BBO), Approximately 20-30 submit data on a weekly basis, which covers a (non-contiguous) population footprint of c.325,000 patients. Approximately 15 of the submitting practices are from Oxfordshire, which covers a footprint of c.195,000 patients.

We do not audit practice submissions for data quality. Practice contributions are not necessarily consistently done on a weekly basis. There was also a significant increase in the number of participating practices from April 2023 (prior to that, it was only c.13 practices across BBO). Thus, interpretation of the data should be done with caution.

BBOLMC is the data controller. Practices participate under a confidentiality agreement which specifies that BBOLMC will never release granular practice-level data without the practice’s express prior consent.

Results

Demand

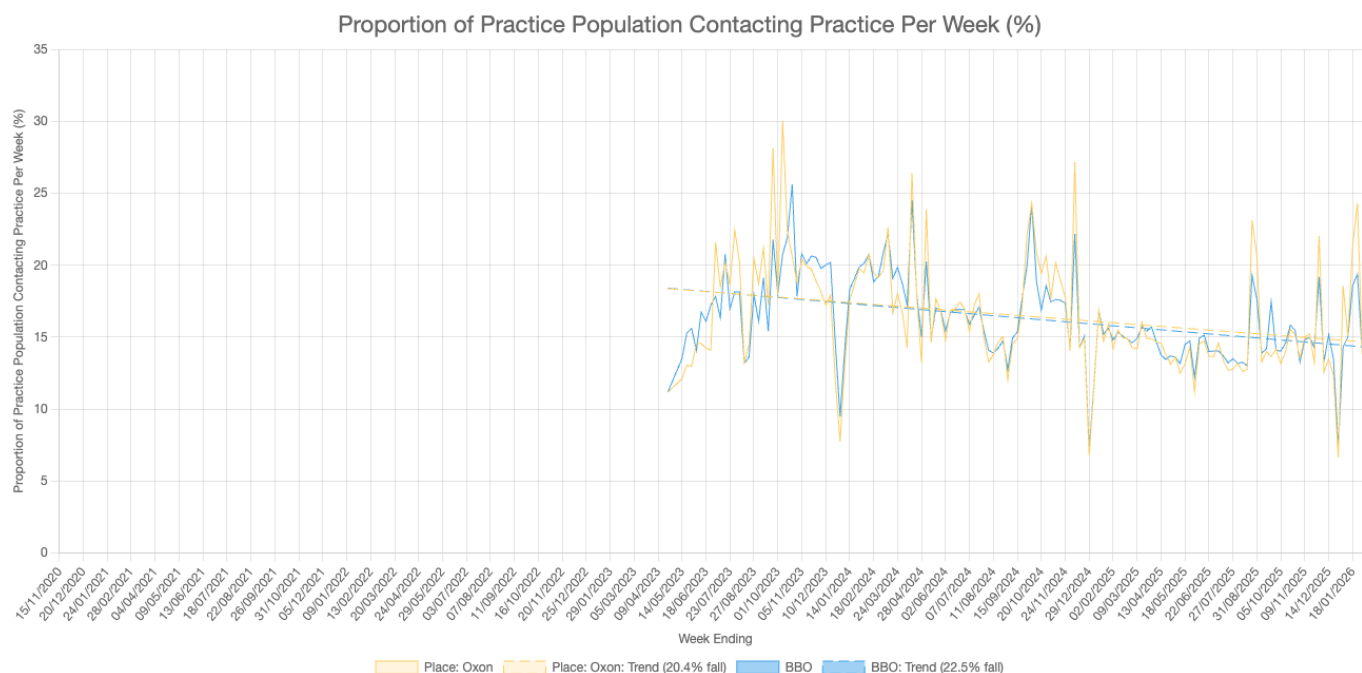


Chart 1: The proportion of Practice Population Contacting Practice Per Week (%). The blue line is all BBO; and the yellow line is for Oxfordshire practices specifically.

Data collection for incoming demand started in April 2023.

Chart 1 shows the proportion of Practice Population Contacting Practice Per Week (%). This summates gross income telephone call numbers + e-consults + walk-ins + any other contact points the practice is able to capture and report to us, per week. This total figure is divided into the practice population size to give us an estimate of the total % of the population calling weekly. As telephone lines are open 5 days per week, dividing the weekly figure by 5 will give an average daily demand figure.

The weekly average is c.15%. This means the equivalent of **1 in 7 of every person in the population contacts their practice each week**. The estimated daily average is 3% of the population. Of course, some patients will contact their practice many times, and some not at all (the figures are an average across the population).

Of note, the number of contacts into the practice has fallen steadily from April 2023 until now – a 20% decline for Oxfordshire. Reasons for this decline are not clear but may include:

- Patient health may theoretically be improving (we have no data to support this)
- Patients are giving up (chimes with anecdotal experience)
- It may be artefactual: From October 2024, GP contract changes triggered a shift away from telephone calls into the practice and towards online submissions to practices, and this *may* not be captured by the data submitted by practices which had priorly put a lot of emphasis on counting telephone contacts.

Capacity

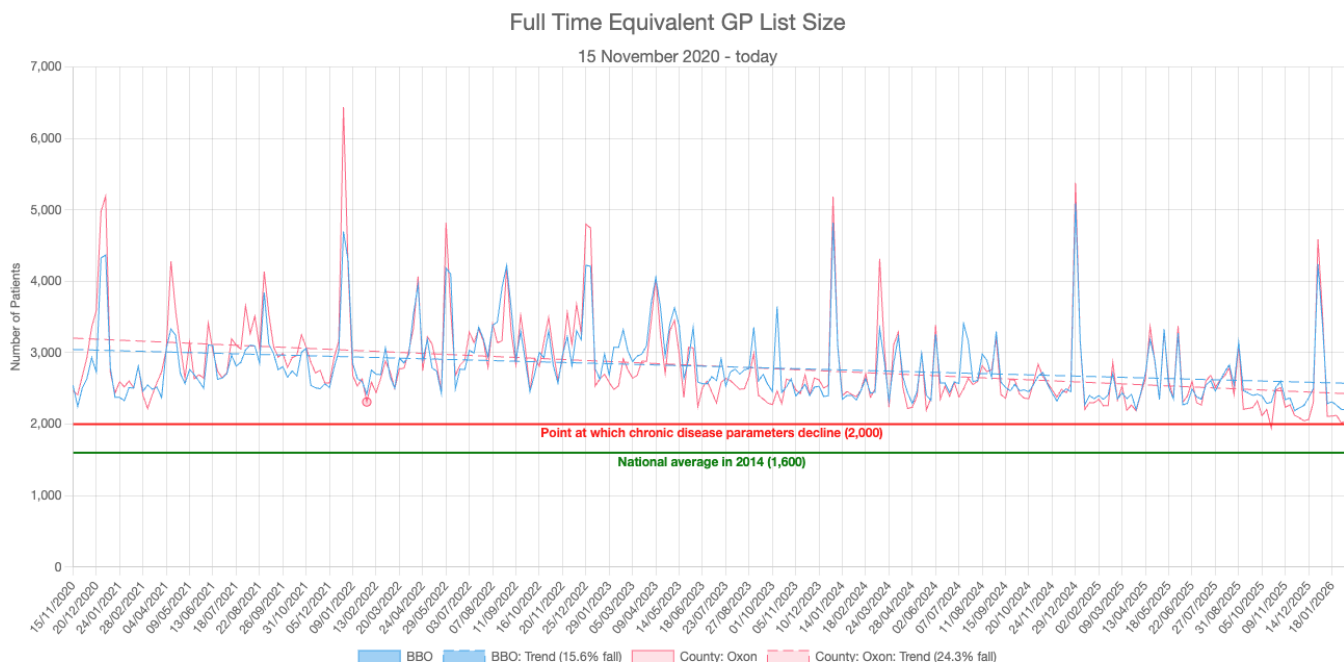


Chart 2: Full time equivalent GP list size over time in BBO (blue) and Oxon (pink).

Chart 2 shows Full time equivalent patient list size with two benchmarks:

1. comparison with national averages from 2014 [using national data sources] – the green horizontal line; and
2. the point at which international published research from developed healthcare systems shows that chronic disease parameters are known to decline (a full-time-equivalents GP list size of 2000ⁱ) – the red horizontal line.

The local FTE list size is calculated by taking the number of GP sessions available in the practice per week, and dividing that into the practice population (to give GP list size per session) and then multiplying that by 9 to arrive at a FTE (a full time GP is 9 sessions). "GP sessions" includes principals, salarieds, locums, and trainees (but not medical students). It also includes admin and business sessions - viz., all GP sessions contracted by the practice per week. It is a dynamic measure of GP "bums on seats" on a weekly basis. This data is not publicly available elsewhere at local and national level.

Across all data going back to November 2020, the FTE GP list size for BBO is c. **2,877**. For Oxfordshire specifically it is **2,724**. These figures are significantly above 'safe' levels associated with optimal management of chronic disease (the red line). (NB: this internationally specified 'safe level' of a list size of 2000 pts per full time GP was published prior to the diversification of the General Practice workforce as part of the PCN DES additional roles scheme).

The FTE GP list size has decreased steadily, indicating more GPs for the population. The reason for this may be:

- Changes in the GP contract in April 2024 which allowed specific ring-fenced PCN workforce funds to be allowed to employ newly qualified GPs.
- Artefactual: there was a significant increase in the number of participating practices from April 2023.

Activity

ⁱ Cited in Van Den Homberg & Campbell (2013). *Is 'practice size' the key to quality of care?* British Journal of General Practice, September 2013; 459-460

Berkshire LMC Chair
Dr Mark Green

Buckinghamshire LMC Chair
Dr Stefan Kuehner

Oxfordshire LMC Chair
Dr Gareth Evans

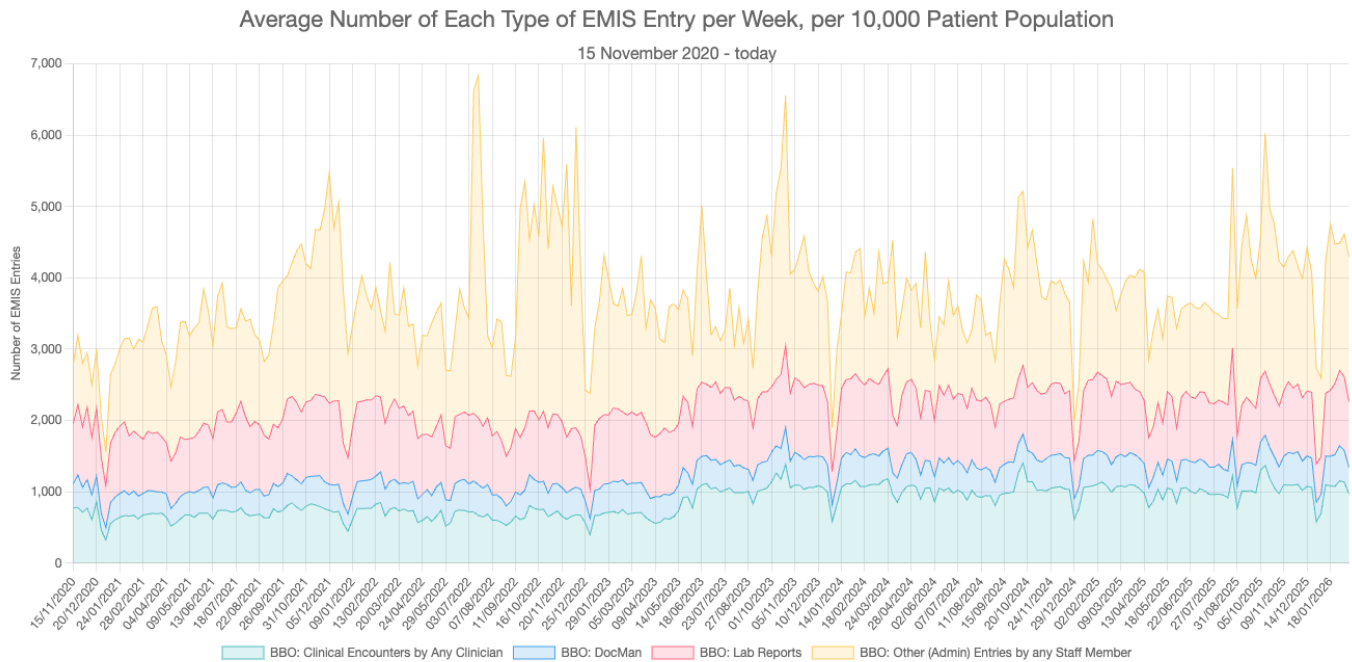


Chart 3: the average number of medical record entries made by a typical practice each week. Green is clinical entries (contacts with a patient). The remainder are admin-related.

Chart 3 shows the average number of medical record entries made by a typical practice each week. The types of medical records entries are subdivided into:

- **clinical encounters** (green: records of a consultation with a patient)
- **docman** (letters read by a practice member of staff and filled into the notes, such as hospital clinic letters)
- **lab reports** (red; results of tests received from the lab, read by the clinician, and filed into the notes)
- **All other** EMIS entries being created weekly within the practice

Data is shown using a denominator of a practice population of 10,000.

The medical record entry counts do NOT include medical record entries that are "externally generated" (such as OOH entries into EMIS, or Covid vaccination programme entries), or SMS/email messages between practice and patient. So, it only counts medical record entries generated manually, internally within the practice.

The data shows that only 25% or less of medical record entries are from consultations with patients. The remaining **75% of all medical record entries are admin-related**.

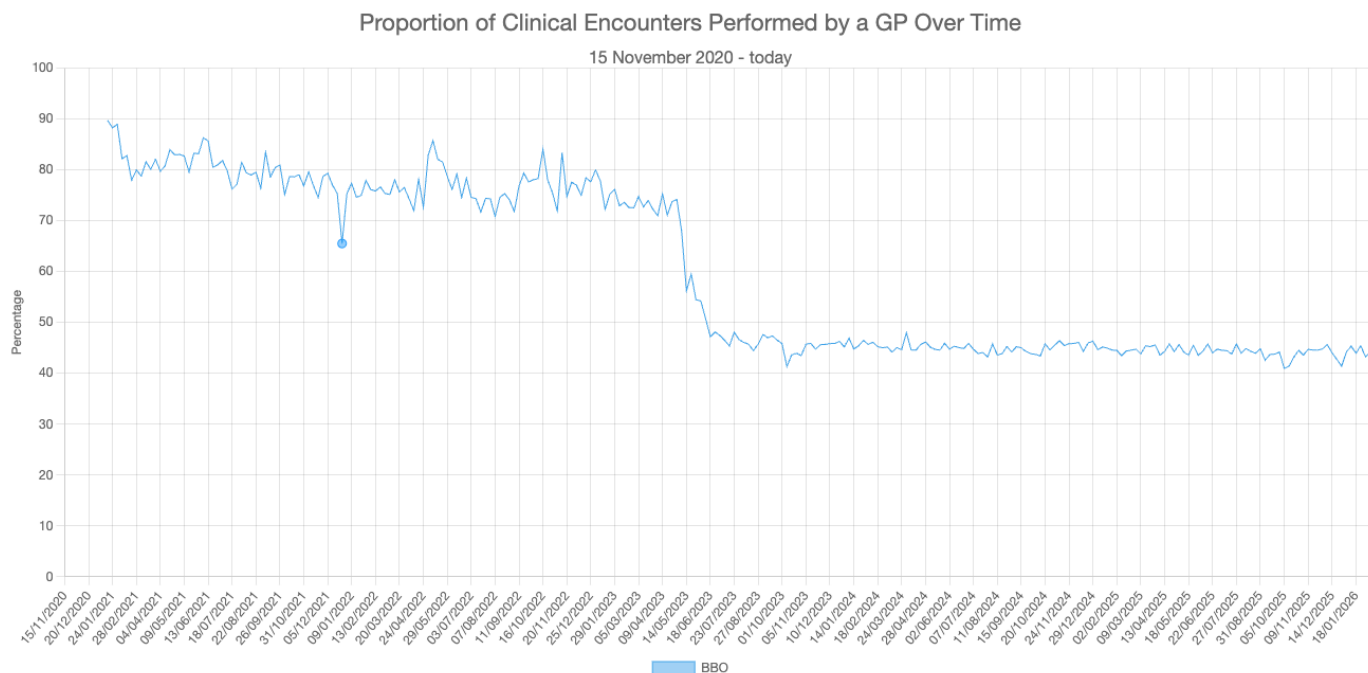


Chart 4: The proportion of clinical encounters that are conducted by a GP, as opposed to another patient-facing allied health professional.

Chart 4 shows the proportion of clinical encounters that are conducted by a GP, as opposed to another patient-facing allied health professional. Which AHPs are included depends on the practice's 'clinical user group' settings specified in EMIS but, as a general rule, it includes Nurses (any type), advanced nurse practitioners, paramedics, pharmacists, health visitors, physiotherapists, phlebotomists, physician assistants, and Midwives, but not healthcare assistants.

55% of all clinical consultations in the practice are now delivered by a non-GP.

The steep drop in April 2023 corresponds to the point at which the pilot phase ceased, and data collection was rolled out across all BBO so may be artefactual. However, the imposed GMS contract for the year 2023-24 showed continued significant real-time cuts to general practice and this drop may therefore have reflected practices cutting back their finances by employing AHPs (funded by the PCD DES additional roles reimbursement scheme) rather than GPs (funded from practice income).

Demand-Capacity Matching

In 2021 Oxfordshire Healthwatch performed a surveyⁱⁱ of patients contacting their practice in the previous month and asked them the reason for their contacting their practice. From this data we extrapolated that approximately 56% of all patient contacts to a practice ideally required a consultation with a GP *specifically* (rather than an allied health professional, or administrative staff).

If we apply this % figure to the total amount of contacts per week for a given practice, we can estimate how many GP appointments each participating practice needs per week. For example, if a practice receives 1000 contacts from a practice per week, 560 will ideally need a GP appointment.

Participating practices tell us how many GP 'bums on seats' they have per week (reported as how many 'GP sessions – or clinics - available per week. A clinic is assumed to be half a day). We can use this figure to answer the following question: *with the number of GPs a practice has available per week, how many patients would each GP need to see per clinic to meet the incoming demand?* For example, using the above worked example,

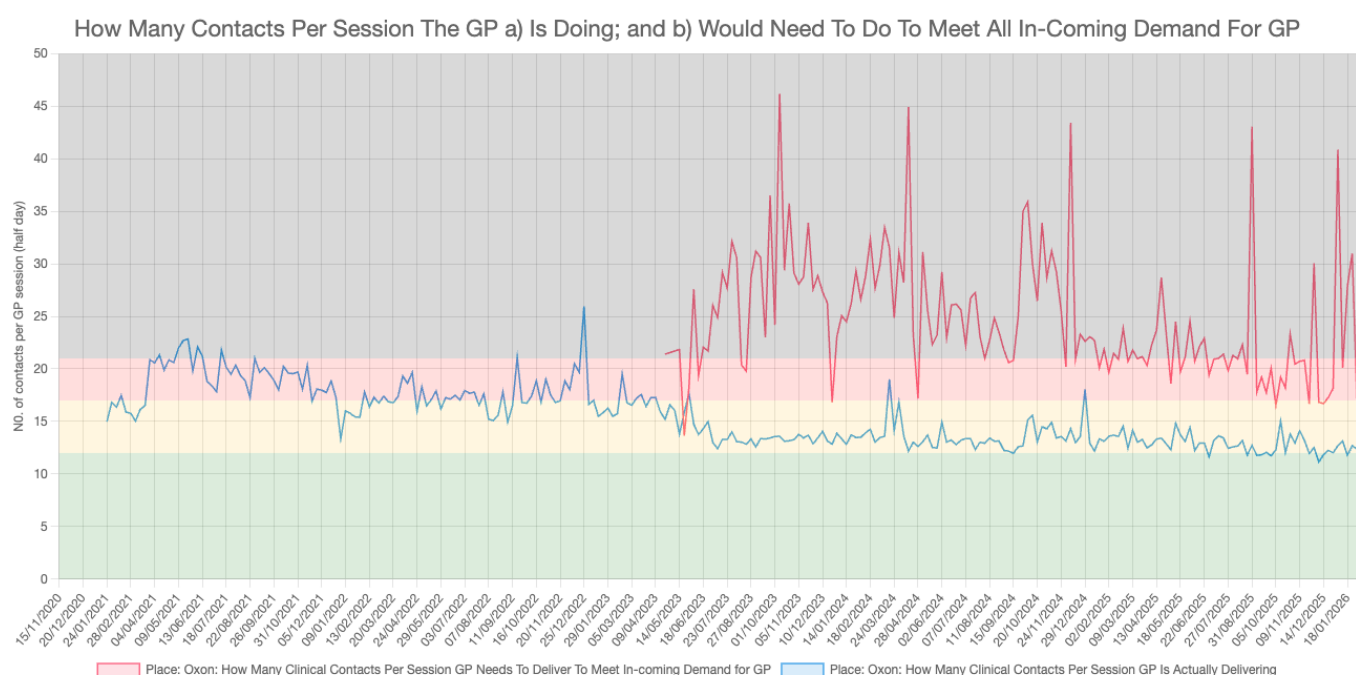
ⁱⁱ https://healthwatchoxfordshire.co.uk/wp-content/uploads/2022/05/20220504_GP-report_final.pdf

if there were 560 patient requests for a GP in a week, and 10 GP sessions/clinics available that week in the practice, each GP would need to see 56 patients per clinic to meet that demand.

We can then apply “BMA safe-working limits” to this activity. The BMA, in collaboration with the European GP Committee of the EU, has published safe working limits for the number of patient contacts a GP can safely manage in one dayⁱⁱⁱ. The further a GP goes above this limit, the more unsafe their working. The limits are as follows:

- **Safe:** 12 patient contacts per session (25 per day). For the purpose of assigning an OPEL level to the practice, we classify this as working at **OPEL 1**.
- **Pressured Working:** 13-17 patient contacts per session (26-34 per day). We classify this as working at **OPEL 2**.
- **Unsafe working:** 18 – 21 patient contacts per session (36 – 42 contacts per day). We classify this as working at **OPEL 3**.
- **Off the scale:** >21 contacts per session (>42 contact per day). We classify this as working at **OPEL 4**.

Chart 5, below, displays the data in graph form for Oxfordshire specifically. The Y-axis is the number of contacts per GP session. The **blue line** is the number of contacts per session each GP in the practice is *actually* delivering per session. The **red line** is the number of contacts each GP would *need* to deliver per session if the practice were to meet all the demand for a GP coming in that week. The coloured background bands are the BMA safe working bands (OPEL 1 – OPEL 4):



- An increasing number of “simple” presentations being consulted by allied health professionals (chart 4) means that only the more complex presentations are left for GPs to see. This necessarily takes more time, necessitating a drop in the total number a GP can see per session.

The **red line** in the chart is the number of contacts per session each GP would need to see if it were to meet all the demand for a GP coming into the practice. This would put GP working predominantly into OPEL 4 – unacceptable working conditions for GPs and their patients.

The difference between the blue line and the red line is the mismatch between demand for GPs and GP capacity. In reality, this mismatch is managed by directing patients to allied health professionals, or other services in an attempt to meet their needs as best as can be done.

It is of note that the drive to have more patients seen by allied health professionals rather than their GP is a central tenet of both the *PCN DES* and the *NHS 10 Year Plan*. It is an attempt to increase the availability of a diversified – and often cheaper – workforce. It does, however, pose an existential challenge to the *raison d’être* of a GP. Many GPs in practices went into the profession wishing to ‘follow the patient and not the disease’ – viz., to provide continuity of care for the patient, which means seeing the ‘simple’ things as well as the complex. The current direction of travel in our workforce, however, is to restrict what the GP sees to only the most complex. This reduces continuity of care and is likely to have adverse outcomes for patients in the long run. It also has the potential to reduce GP morale and work satisfaction.

Admin Burden

How little admin time is too little? The BMA safe working publications previously estimated that one GP clinical session of three hours was associated with one hour of required admin time. If we assume a BMA session to be 12 patient contacts, then then this equates to 5 minutes of admin time required per patient seen.

Because we know from our data collection the number of patient contacts a GP has per session on average, we can work out how much admin time they need: *5 mins x number of patients seen*. Practices tell us how much protected admin time each GP has per week on average. We can therefore compare how much GPs get on average with how much they need. The greater the disparity between the two, the greater the admin burden. To quantify this, we revert to the same BMA thresholds as above (chart 5) and create *admin OPEL levels* for each practice:

OPEL 1: Receiving BMA “safe” amount of time (5 mins per clinical encounter)

OPEL 2: Receiving up to 60% of BMA “safe” amount of time (3 mins per clinical encounter)

OPEL 3: Receiving up to 20% BMA “safe” amount of time (1 min per clinical encounter)

OPEL 4: Receiving less than 20% of BMA “safe” amount of time (<1 min per clinical encounter)

Chart 6 below reports the proportion of practices at each admin OPEL level in Oxfordshire.

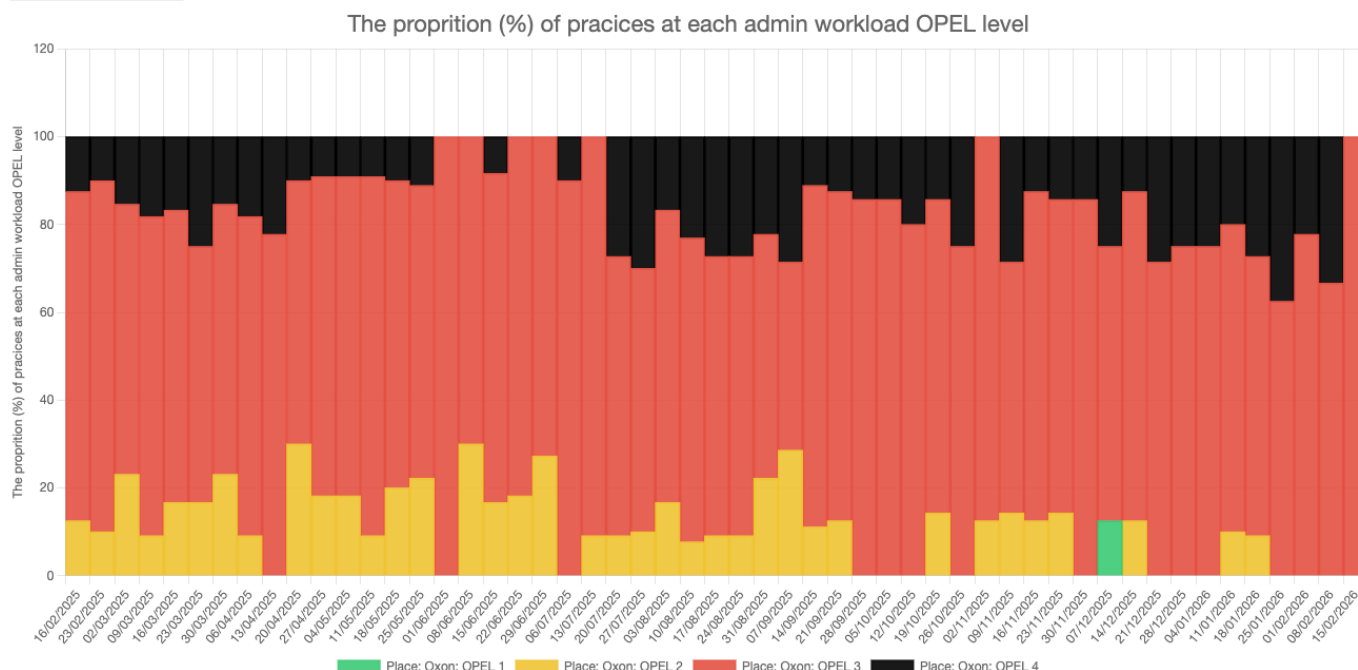


Chart 6: Admin burden: The proportion of practices at each admin OPEL.

Chart 6 shows that the majority of practices (>80%) can only ring-fence 20% or less of the admin time required for GPs (**OPEL 3**). Safe levels of adequate admin time (**OPEL 1**) are a rare event.

Conclusions

- The equivalent of 1 in 7 of every person in the population contacts their practice each week.
- the FTE GP list size for BBO is c.2,877. For Oxfordshire specifically it is 2,724. These figures are significantly above 'safe' levels associated with optimal management of chronic disease
- 75% of all medical record entries are admin-related.
- 55% of all clinical consultations in the practice are now delivered by a non-GP.
- Most practices are now delivering safe levels of patient contacts per session (12 contacts per clinic). Where they to meet all the demand for a GP coming into the practice, they would need to operate at dangerous levels of activity.
- Most practices (c.85%) receive only 20% or less of the admin time they need.

-END-

Agenda Item 9

Please note that a range of academic studies and cases from other areas around the country have been utilised and referenced to inform the observations and recommendations contained in this report.

You will find that the report contains some key observation points and recommendations around the following areas:

1. To implement a Trust wide maternity communication standard covering: listening, 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 within 28 days, and how it plans to align with the NHS England maternity bundle section on epilepsy.

Response to Health Scrutiny Committee Recommendations

Oxford University Hospitals NHS Foundation Trust – Maternity Services

Oxford University Hospitals NHS Foundation Trust (OUH) welcomes the recommendations from the Health Scrutiny Committee and recognises the importance of transparency, learning and continuous improvement in rebuilding confidence in maternity services. The Trust is committed to delivering safe, equitable and compassionate care. It has set out below its response to each recommendation, including actions already taken and those planned.

Rec	Trust response	What we are doing (assurance)	How we will measure impact	Governance / reporting
1	Accept	Implement and embed a Trust-wide Maternity Communication Standard (listening, clarity/timing, translation/accessibility, expectations at key points of care), co-designed with service users; deliver staff training and updated information resources.	Patient experience (Friends and Family Test and targeted feedback), complaints themes, interpreter offer/uptake, audit of documentation/communication touchpoints.	Maternity governance via Perinatal Quality and Outcomes Meeting and the national patient-facing Perinatal Quality Oversight monthly report; escalated via the maternity quality dashboard to Trust Board.
2	Accept	Publish a quarterly public-facing learning and improvement report (themes, experience of complaints process, actions/ownership, independent review involvement in baby deaths, evidence of impact).	Timeliness of publication; completion of actions; service-user feedback on transparency; trends in repeat themes and complaint handling metrics.	Reviewed through Perinatal Quality and Outcomes Meeting and reported to Trust Board; published on Trust website.
3	Partially accept	Implement a standard evaluation framework for Equal Start Oxford and wider outreach/translation programmes, with commitment to publish outcomes; expansion beyond OX4 is subject to sustainable funding/commissioning decisions.	Uptake/reach (by locality and demographics), experience/satisfaction, equity indicators, and selected outcome measures (access, timeliness, continuity).	Quarterly review through maternity governance; shared with partners/commissioners; escalated to Trust Board via the maternity assurance route.

4	Accept	Set out how tariff, demand modelling and Birthrate Plus inform staffing establishment and burnout mitigation; maintain an explicit workforce risk and mitigation plan.	Workforce indicators (vacancy/retention/sickness), acuity/activity trends, escalation frequency, staff survey/pulse, and wellbeing indicators.	Coordinated finance/workforce review; maternity risk register and Perinatal Quality and Outcomes Meeting; Trust Board reporting.
5	Accept	Provide written update to HOSC within 28 days and align local pathway to NHS England maternity bundle epilepsy section; strengthen audit, data reporting, and training.	Bundle compliance, audit findings, and actions; timeliness of referral to MMC; completion of personalised plans; training completion.	Maternity Clinical Governance Committee, Perinatal Quality and Outcomes Meeting and Trust Board reporting; Maternal Medicine Network collaboration.

1. Trust wide maternity communication standard - Accept Recommendation Response and progress

OUH has developed and is implementing a Trust wide Maternity Communication approach co-designed with service users through the Oxfordshire Maternity and Neonatal Voice Partnership. This work has been shaped directly by feedback from listening events, complaint themes, focus groups with families from seldom heard communities and feedback from staff. As a result, the approach is structured around four core communication priorities:

- Listening and empathy, including trauma-informed practice and validation of lived experience.
- Timing and clarity of information, ensuring information is delivered proactively and revisited during care.
- Accessible communication, including compliance with the Accessible Information Standard, routine offer of translation and interpretation services, and culturally appropriate information.
- Expectations at key points of care, including induction of labour, intrapartum care, and postnatal care, with standardised explanations to reduce uncertainty and anxiety.

The approach is being embedded through a clear implementation plan, including:

- Updated maternity information resources and digital content.
- Staff education via mandatory training and induction.
- Local leadership oversight through matrons, Deputy/Head of Midwifery, Director of Midwifery and Trust Patient Experience Team.
- Monitoring via patient feedback, Friends and Family Test and complaint themes. This is reported through the Patient Engagement and Experience Strategic Committee.
- Oversight provided at Board level, including input from Non-Executive Director safety champions.

- External 'critical friend' scrutiny from the Oxfordshire Maternity and Neonatal Voices Partnership, contributing independent service user perspectives.

Assurance: By the end of Q2 2026/27 we will have (1) refreshed induction and mandatory training materials, (2) updated core patient information and key explanations at induction of labour/intrapartum/postnatal touchpoints, and (3) implemented a monthly monitoring pack (Friends and Family Test, complaints themes and accessibility/translation metrics) reviewed through maternity governance.

Progress and compliance with the communication standard will be reported through maternity governance, including the national patient-facing monthly Perinatal Quality Oversight report, and escalated to Trust Board via the maternity quality dashboard. The Patient Engagement and Experience Committee also provides a route to the Board for oversight.

2. Quarterly public facing learning report - Accept Recommendation Response and progress

The Trust is implementing a quarterly, public facing maternity learning and improvement report to increase transparency and the public's confidence in the service. This builds on existing governance processes and responds directly to service user feedback requesting greater visibility of learning.

Each report will include:

- High-level themes emerging from complaints and concerns, with anonymised exemplars.
- Feedback on service users' experience of the complaints process, informed through follow-up engagement.
- Actions taken and learning implemented, with clear ownership and timescales.
- Compliance with national guidance, including the percentage of cases involving an independent reviewer in any baby death, aligned to the Perinatal Mortality Review Tool (PMRT) requirements.
- Evidence of impact, including changes to pathways, practice, or outcomes.

Reports will be published on the Trust website and reviewed through the Trust's governance structure, with formal oversight via the Perinatal Quality and Outcomes Meeting (PQOM) and Trust Board reporting to ensure accountability and assurance.

3. Evaluation framework for Equal Start Oxford and outreach programmes - Partially Accept Recommendation

Response and progress

OUH partially accepts this recommendation. The Trust agrees that a robust and consistent evaluation framework is required for Equal Start Oxford and for its wider outreach and translation activity and confirms that this will be implemented. However, expansion of the Equal Start Oxford model to additional localities, including Didcot and Banbury, is dependent on funding and commissioning decisions. OUH will continue to work with system partners to support this where possible.

Equal Start Oxford is a cross-sector partnership between Oxford University Hospitals NHS Foundation Trust and Flo's – The Place in the Park, established in 2022 to address entrenched health inequalities affecting pregnant women and young families in Oxford's OX4 area. As a place-based, community-led early intervention model focused on the first 1001 days of life, Equal Start Oxford demonstrates how collaboration across healthcare, community organisations, and lived-experience leadership can improve health equity.

Equal Start Oxford's current evaluation framework, supported by NIHR ARC, charts uptake of programme offers and includes capture of service user feedback (summarised below), further detailed breakdown is available on request. There is a plan for expanded impact measurement reflecting a commitment to understanding both immediate and long-term outcomes for mothers, families, and communities.

The Equal Start Oxford programme delivers holistic, culturally responsive support that tackles the social determinants of health and improves access to maternity care. Its integrated approach combines health justice casework, tailored antenatal education, peer-led groups, English language provision, and early years support. Qualitative evaluation demonstrates how close working between community partners and OUH maternity services has been central to building trust among underserved populations, improving access to care, and empowering women to navigate complex systems. Service user and professionals feedback indicates improved wellbeing, more positive care experiences, and reduced pressure on maternity teams—highlighting the system-wide benefits of coordinated cross-sector working.

Equal Start Oxford's impact is strengthened by its emphasis on community capacity-building. Initiatives such introduction to community interpreter training programmes enable women to gain skills, confidence, and agency while supporting others. User feedback shows that multilingual, community-informed OUH EDI Midwife- led antenatal education classes improve understanding of pregnancy, birth, and newborn care, leading to greater preparedness and engagement with services. In the ESO health justice casework, Equal Start Oxford maternity advocates have supported 87 new referrals from maternity with over 1,100 actions in the past year addressing issues with housing, welfare entitlements, food insecurity, and immigration issues.

Equal Start Oxford illustrates that cross-sector, community-rooted approaches are essential to improving health equity by aligning services, addressing social need, and strengthening the capabilities and resilience of the communities they serve.

OUH agrees with the recommendation to strengthen evaluation and has developed an evaluation framework for:

- Equal Start Oxford expansion to Didcot and Banbury.
- Support for asylum seekers and underserved groups.
- Translation, advocacy, and outreach programmes.

The framework has been co-designed with service users, community partners and maternity advocates and includes:

- Uptake and reach (e.g. demographic profile, geographical coverage).

- Impact on experience and outcomes, including continuity of care and access to services.
- Service user satisfaction, using qualitative and quantitative feedback.
- Measures to address equity, aligned with known maternity inequalities.

Evaluation findings will be reviewed quarterly by the service, and partners as stated above, and reported through maternity governance and the Trust Board to demonstrate impact and value, supporting continuous improvement and commissioning decisions. This approach builds on the work described in previous HOSC reporting on Equal Start Oxford and planned expansion.

Equality, Diversity, and Inclusion (EDI) – Evaluation Summary

Response and progress

To provide assurance on the impact and evaluation of Equality, Diversity, and Inclusion (EDI) activity within Oxfordshire Maternity Services, with a focus on reducing health inequalities, improving access, and enhancing experience and outcomes for women facing the greatest barriers to care.

Analysis of 8,474 women booked into maternity services demonstrates a diverse population with significant social and health complexity, including:

- 31% women from Black, Asian, Mixed or Other ethnic backgrounds
- 17% with a primary language other than English; 4.7% requiring interpreter support
- High prevalence of mental health needs (33%), recent migration (7%), and other social vulnerabilities.

This data underpins targeted, proportionate EDI interventions.

Improving Access to Care

- Targeted outreach (e.g. maternity immunisation hubs) showed improved engagement among ethnic minority women when clinics were delivered locally with interpreters and senior clinical presence. Qualitative staff feedback supports improved reach and acceptability, leading to extension of this model to additional localities.
- Migrant focused multidisciplinary clinics (ROSE and ISIN RUA) demonstrated strong qualitative impact, with women reporting reduced anxiety, improved understanding and high satisfaction with holistic, joined up care. Evaluation to date is predominantly service user feedback, with further quantitative work planned.
- The “Book by 10” campaign addressed late booking into maternity care, particularly among Black and Chinese women. Baseline audit identified delays occurring prior to system entry. Screening lead feedback indicates an observed >10% increase in booking by 10 weeks; formal re-audit is scheduled in 2026.

Improving Experience and Engagement

- SAPLINGS community-based support (Banbury) combined clinical care, therapy, parent education, and peer support for women with complex socio-economic needs. Evaluation is qualitative, with consistent reports of

reduced isolation, increased confidence, and improved engagement with services.

- Translated antenatal education and unit tours, delivered through community partnerships, supported over 100 women. Women reported increased confidence, reduced fear of childbirth and improved understanding of care pathways. Attendance and feedback data demonstrate strong engagement, with repeat participation.

Tackling Structural Barriers

- Digital inclusion support mitigated digital exclusion risks following implementation of a fully digital maternity record. Over 70 women were supported through provision of phones or data-enabled SIM cards, improving safeguarding, engagement, and access to urgent care. Evaluation focuses on reach and access rather than longer-term outcomes.
- Improved ethnicity data quality was achieved through regular leadership reminders and incorporation of ethnicity discussions into mandatory Active Bystander training. A sustained reduction in “unknown/not stated” ethnicity recording has been observed, strengthening inequality monitoring, though impact has not been formally evaluated.

Workforce Culture and Capability

- Active Bystander Training evaluation (27 respondents) showed improvements in staff confidence (78%), motivation (96%), and self-reported intervention behaviour (70%). Opportunity barriers remain (time, hierarchy, reporting clarity), highlighting the need for organisational systems to reinforce learning.

Summary

- EDI activity is data driven, targeted and proportionate, aligned to local population needs.
- Evaluations demonstrate clear improvements in access, experience, and staff capability, particularly for migrant women and those facing social, language and digital barriers.
- Evidence is strongest where community partnership and co-production models are used.
- Further formal quantitative evaluation is planned to strengthen assurance, alongside continued use of qualitative service user feedback.

4. Alignment of maternity tariff, demand modelling, and staffing sustainability - Accept recommendation

Response and progress

The Trust recognises the national constraints associated with the maternity payment model and the increasing acuity and complexity of care. OUH provides assurance that staffing decisions and risk mitigations are explicitly aligned to demand and safety by triangulating national funding assumptions with local activity/acuity intelligence and Birthrate Plus workforce methodology, and by escalating sustainability risks through formal governance.

National maternity tariff assumptions

Maternity services across England are largely commissioned by the Integrated Care Boards (ICBs). The payment model for Maternity services is based on fixed payment made to the Trust, designed to cover the expected annual costs for service. This means that any increase in activity across the service is not reflected in income given to the Trust. The fixed payment is split between obstetric and midwifery care and broken down to reflect levels of complexity and types of deliveries. However, the payment amount is based on national data and does not reflect specific populations' needs. Hence the Trust receives same funding however complex or extensive the care needed

In recent years, this is particularly challenging in relation to increase number of elective c- sections. While there is a set amount of money dedicated to the Trust to cover that type of activity, it does not match the recent demand on the service.

There will be a marginal increase of overall fixed element for Maternity from 1st April 2026- to be agreed. The increase will reflect inflation and will not accommodate specific changes to activity types or levels.

- Local demand modelling
- Birthrate Plus workforce projections
- Staff wellbeing and burnout risks

This is overseen through a coordinated workforce and finance approach, with:

- Regular review of Birthrate Plus data to inform staffing establishment.
- Measurement of triage and Maternity Assessment Unit (MAU) contacts and attendances, including analysis of trends and demographic breakdowns.
- Ongoing review and consultation regarding community on-call requirements versus available capacity to ensure safe and responsive service delivery.
- Escalation of workforce risks, including fatigue and burnout, via the maternity risk register and PQOM.
- Targeted workforce investment and wellbeing initiatives, including retention, support, and flexible working.
- Transparent reporting to Trust Board on workforce sustainability and risk.

This alignment ensures staffing decisions are evidence based and responsive to demand, while prioritising staff wellbeing as essential to patient safety.

Assurance: During 2026/27 the Trust will publish (via the maternity assurance route) an updated demand-and-capacity narrative summarising tariff context, local activity/acuity trends, Birthrate Plus conclusions and agreed establishment, and the associated burnout/fatigue mitigations. Workforce risks will remain explicit on the maternity risk register with defined actions, owners and review dates, and exceptions will be escalated via PQOM to Trust Board.

- Access to mental health support — 24/7 mental health services, counselling, and occupational health pathways to provide timely professional support.

- Flexible working options — Remote working arrangements, flexible scheduling, and autonomy over work patterns to reduce stress and improve work–life balance.

5. Epilepsy pathway update and alignment with NHS England maternity bundle - Accept recommendation

Response and progress

OUP confirms that a full written update on epilepsy in maternity care will be submitted to HOSC within 28 days, in line with the previously accepted recommendation. This summary provides an overview of current progress, alignment with national standards, and governance arrangements.

The recent Epilepsy Maternity Self-Assessment (April 2026) demonstrates strong foundations in several areas:

- Established preconception pathways, including epilepsy specific input and comprehensive risk-based counselling.
- Named clinical leads for obstetrics and neurology/epilepsy.
- A functioning epilepsy pregnancy MDT, including neurology, maternal medicine, and obstetric medicine.
- Robust emergency escalation, with automatic obstetric/midwifery review for PWE attending ED.

Areas requiring further development include:

- Consistent referral of all pregnant PWE to the Maternal Medicine Centre within two weeks.
- Universal provision of personalised care plans, birth plans, and intrapartum seizure plans by 37 weeks.
- Strengthening postnatal review, particularly timely specialist review after ASM changes.
- Embedding epilepsy-specific audit, data reporting, and governance processes.

OUP is aligned with several core elements of the national bundle:

- Multidisciplinary leadership is in place and accessible.
- Comprehensive preconception information is routinely provided.
- 24-hour maternity advice is consistently available.
- Seizure management plans are routinely included in care.

Further work is underway to:

- Ensure personalised care planning is consistent for all PWE.
- Strengthen escalation pathways into Maternal Medicine Centre for first seizures in pregnancy.
- Improve partner facing information and discharge planning documentation.
- Expand training and competency assessment for maternity and neurology teams.

The self-assessment highlights the need to formalise epilepsy specific governance:

- Annual audit of epilepsy maternity care is not yet embedded.
- Service user review of the epilepsy pathway is not currently undertaken.
- Data reporting to the Maternal Medicine Network is inconsistent.
- Epilepsy training is included in mandatory training every three years, but training needs analysis is not routinely completed.

OUH will implement:

- Annual epilepsy maternity audit covering the full pathway.
- A structured service user review process.
- Quarterly reporting through maternity governance.
- Clear risk register entries for identified gaps.
- Strengthened data flows to the Maternal Medicine Network.

This work is overseen through established maternity governance structures, including:

- Maternity Clinical Governance Committee
- Perinatal Quality and Outcomes Meeting (PQOM)
- Trust Board reporting through the Maternity Assurance Framework
- Maternal Medicine Network collaboration

These structures will ensure ongoing monitoring, compliance with the NHS England Maternity Care Bundle, and continuous improvement.

Conclusion

OUH welcomes the Health Scrutiny Committee's recommendations and provides assurance that they are being implemented through a clear programme of work, with defined deliverables, measurable impact, and Board-level oversight. The Trust accepts recommendations 1, 2, 4 and 5 in full and partially accepts recommendation 3. OUH will implement a robust evaluation framework for Equal Start Oxford and wider outreach/translation activity, while recognising that any expansion to additional localities is dependent on sustainable funding and commissioning decisions.

Over 2026/27 the Trust will evidence progress by: embedding the Maternity Communication Standard (including accessibility/translation metrics) and implementing routine monitoring via patient feedback, Friends and Family Test and complaints themes; publishing a quarterly public-facing learning and improvement report; maintaining an explicit workforce sustainability and burnout risk plan informed by demand modelling and Birthrate Plus; and submitting the epilepsy pathway update to JHOSC within 28 days alongside implementation of strengthened audit, training and data reporting. Delivery will be tracked through the maternity risk register and PQOM, with escalation through the maternity quality dashboard to Trust Board. This governance approach, alongside ongoing co-design with service users through OMNVP, underpins the Trust's commitment to transparency, equity and continuous improvement and supports the restoration of confidence in OUH maternity services.

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 Learning Disability Plan

Lead Cabinet Member(s) or Responsible Person:

- Karen Fuller (Director of Adult Social Care).
- Bhavna Taank (Head of Joint Commissioning - Live Well).
- Clair Taylor (My Life My Choice Project Co-ordinator).
- Alex Wheeler (Senior Joint Commissioning Officer).

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

Deadline for response: Wednesday 13th May 2026.

Response to report:

Thank you for your report and recommendations for the Oxfordshire Learning Disability Plan 2025 – 2035.

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. That partners at place consider an anniversary event to share progress and good practice.	Accepted	Partners will deliver a co-produced anniversary-style event to share progress and good practice in relation to the Learning Disability Plan. This event will be designed with people with lived experience and partner organisations and will provide an opportunity to reflect on outcomes, learning and areas for improvement. The anniversary event will be aligned with Learning Disability Week in June 2027 and will reinforce partners' commitment to meaningful co-production and shared learning. As part of the Learning Disability Plan Pledge, partners have also committed to producing an annual report on progress and outcomes, with the first report due in 2027. The annual report will help inform the content of the anniversary event and provide a clear account of progress against the Plan. A working group will be set up to support with organising the event. This combined approach will ensure that progress and good practice are shared in ways that are co-produced with partners.
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	Accepted	Outcome measures will be developed for all planned deliverables within the Oxfordshire Learning Disability Plan and will be prepared for scrutiny by the Joint Health Overview and Scrutiny Committee in 2027.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

level on their roles and contributions to LD services, and on what has supported and hindered collaboration.		A data dashboard is currently being developed to support evidence of progress against the key outcomes in the Plan. Outcome measures are being developed and refined through the ongoing development of the themed, dynamic work plans, which are co-produced with partners, including people with lived experience, and aligned with relevant national and local policy. Progress against the Plan, including achievements, risks, issues and challenges, is reported and discussed quarterly at the Learning Disability Improvement Board, providing regular oversight and assurance. As part of the 2027 report to JHOSC, partners at place level will set out their respective roles and contributions to learning disability services, including reflections on what has supported effective collaboration and what barriers have been identified.
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.	Accepted	Annual Health Checks and associated Health Actions Plans are delivered through Primary Care and are nationally specified by NHS England. GP practices are required to make reasonable adjustments to support people with learning disabilities to participate meaningfully in their annual review. The Oxfordshire Learning Disability Plan supports this national framework by promoting accessible information, sharing learning from lived experience, and encouraging people with learning disabilities and carers to prepare in advance of an Annual Health Check. This approach supports greater empowerment and helps to improve the quality and usefulness of annual reviews within existing national arrangements.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		Oxford Health have links available on their website to accessible information which also includes a checklist Annual health check - Oxford Health NHS Foundation Trust Oxfordshire Family Support Network (OxFSN) also provide information on their website covering All About Health All About Health Oxford Health Learning Disability Team are working with GP surgeries on a pilot project covering breast screening and updates are shared at the Learning Disability Improvement Board. The Quality Improvement Team in HESC Commissioning work with Supported Living Support Providers. Health Checks are discussed, and people will be asked to share good practice, which can help with empowering others and enhancing quality and people's experiences.
4. For there to be further engagement with people with a Learning Disability/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.	Accepted	The Learning Disability Plan recognises the importance of engagement with people with learning disabilities, including those with epilepsy, as well as relevant voluntary sector organisations and experts by lived experience. Relevant information within the Plan's facts and figures section will be explored further through Theme 2 and areas of learning as part of the Physical Health Strategy. Work identified through this process will involve appropriate engagement with experts by experience and voluntary sector partners. This will support shared learning, including contributions to communities of practice and understanding opportunities to prevent avoidable hospital admissions and early deaths.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

		A Champion will be identified for this area to ensure people's stories and experiences are captured and to ensure open communication between all relevant stakeholders.

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

Adult & Older Adult Mental Health in Oxfordshire

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

Report to:

- Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust).
- Dan Leveson (Director for Places and Communities- Thames Valley ICB).
- Matthew Tait (Executive Delivery Officer, Thames Valley ICB).
- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on adult and older adult mental health services in Oxfordshire in its public meeting on 16 April 2026.
2. The Committee would like to thank Dr Lola Martos (Consultant old age psychiatrist and Clinical Director Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate, Oxford Health NHS Foundation Trust); Catherine Sage (Associate Director, Adult & Older Adult Mental Health and Partnerships Oxford Health NHS Foundation Trust); Dr Rob Bale (Consultant Psychiatrist and Chief Operating Officer for Mental Health and Learning Disability Oxford Health NHS Foundation Trust); Jess Wilshire Jess Willsher (CEO, Oxfordshire Mind); Dan Leveson (Director for Places and Communities- Thames Valley ICB); Matthew Tait (Executive Delivery Officer, Thames Valley ICB); Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); and Bhavana Tank (Head of Joint Commissioning Live Well); for attending the meeting and answering questions from the Committee.
3. Mental health services for adults is of significant interest and concern to the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by Oxfordshire's system partners to tackle declining mental health and to improve the support available for adults living with ill mental health. In line with the recent Oxfordshire County Council motion on mental health, the Committee was also keen to investigate the degree of prevention work amongst system partners to ensure that support is not only provided at the point of actual mental health crisis.

4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:
- An assessment of demand and capacity for mental health services.
 - An overview of current service models.
 - Information on existing care pathways.
 - System-Wide KPIs for Serious Mental Illness.
 - Waiting times and access.
 - The experiences of mental health service users.
 - Funding, workforce and resource sustainability for mental health services.
 - The degree of efficacy of multi-Agency working and system integration.
 - How residents/patients with co-occurring or complex needs are supported.
 - Details on crisis care, emergency response and inpatient provision.
 - Details on inpatient bed capacity and out of county placements.
 - An update on mental health estates, including on the Warneford hospital redevelopment and any other critical estate challenges.
 - The degree to which prevention work is being adopted and evaluated.
 - Details around transitions from children's to adult services; including how young people with complex or long-term conditions are identified early for transition planning, and the degree of local adherence to national transition guidance.

SUMMARY

5. During the 16 April 2026 meeting, the Chair set out the context for the item, noting that it formed part of the Committee's agreed work programme and responded directly to the motion passed by Full Council in December 2025, requesting further scrutiny of mental health services. The Committee had already undertaken scrutiny of Children's emotional wellbeing and mental health (including CAMHS services) and issued several recommendations as part of this deep-dive into children's mental health services.
6. The Oxford Health NHS Foundation Trust (OH) Chief Operating Officer for Mental Health and Learning Disability outlined the national and local context, explaining that adult mental health services continued to experience sustained increases in demand, rising clinical complexity, and significant workforce pressures. Referrals to adult mental health services had increased year-on-year, with a growing proportion of people presenting with complex trauma, co-existing substance misuse, neurodivergence and social needs such as housing instability. These pressures had affected flow through services and contributed to challenges in meeting waiting-time expectations in some pathways.
7. The Associate Director for Adult and Older Adult Mental Health and Partnerships provided further detail on community services and access. The Community Mental Health Transformation Programme had been central to current service redesign and aimed to strengthen multidisciplinary working, improve access, and embed voluntary and community sector support within neighbourhood-based models. While investment had supported the

development of new roles such as peer support workers, officers noted that recruitment and retention of experienced mental health professionals, including nurses and consultant psychiatrists, remained challenging and continued to place pressure on teams.

8. Members queried waiting times for assessment and treatment, particularly for adults with serious mental illness and for older adults accessing memory services and dementia pathways. The OH Consultant Old Age Psychiatrist and Clinical Director acknowledged that demand for older adult mental health services, including memory assessment, had increased substantially, reflecting demographic change and greater awareness. She advised that this had led to longer waits in some areas, but emphasised that work was under way to streamline diagnostic pathways, strengthen links with primary care, and ensure that people received meaningful support while awaiting formal diagnosis.
9. The Committee explored the operation of crisis services, including crisis resolution and home treatment teams. Officers explained that crisis services were under sustained pressure, with high demand and increasing acuity, but that the Trust remained committed to supporting people safely in the community wherever possible.
10. Members raised concerns about inpatient capacity and delayed discharges, particularly for older adults with mental health needs and dementia. Officers confirmed that delayed discharge was often linked to wider system factors, including availability of social care, appropriate housing, and community support. The Head of Joint Commissioning – Live Well explained that joint commissioning arrangements sought to address these challenges by strengthening community provision and improving alignment between health and social care, but acknowledged that progress was constrained by workforce availability and funding pressures.
11. The Committee asked how the experiences of older adults and carers were being reflected in service design. The Chief Executive Officer of Oxfordshire Mind described the voluntary sector's role in supporting people and carers to navigate the mental health system and highlighted feedback consistently received from carers about fragmentation and the difficulty of understanding who to contact at different points in a person's care. She emphasised the importance of integrated, person-centred pathways and of recognising carers as partners in care.
12. Workforce wellbeing and sustainability were then discussed. Officers described ongoing efforts to support staff through supervision, training and flexible working, while recognising that sustained pressure had an impact on morale and retention. Members emphasised the importance of ensuring that staff wellbeing was treated as integral to service quality and safety, rather than as a secondary consideration.
13. The Committee specifically raised the issue of the Warneford Hospital redevelopment project, noting its importance to the future configuration of adult

and older adult mental health services in Oxfordshire. Members asked for clarity on the current status of the project, its relationship to wider mental health strategy and service transformation, and whether there continued to be risks or uncertainty that might impact patients, staff or service planning. The Chief Operating Officer for Mental Health and Learning Disability explained that the Warneford redevelopment remained a live project within the Trust's estates and capital planning framework. The redevelopment was intended to support modern, therapeutic models of inpatient care and to bring ageing facilities up to required standards.

14. Crisis and inpatient services more broadly were also discussed. Officers described sustained pressure on crisis pathways and inpatient beds, noting that high acuity and complexity were increasing length of stay and affecting flow. The Head of Joint Commissioning – Live Well explained that joint commissioning efforts focused on strengthening community alternatives and improving discharge pathways, but acknowledged that system-wide capacity constraints continued to present challenges.

KEY POINTS OF OBSERVATION:

15. This section highlights eight key observations and points that the Committee has in relation to adult and older adult mental health services in Oxfordshire. These eight key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Treating equity of access as a core performance objective: The JHOSC's recommendation that system partners treat equity of access as a core performance objective in adult and older adult mental health services reflects a fundamental principle of modern health policy: that equal provision does not necessarily produce equal outcomes. Instead, systems must actively identify and address variation in access, experience, and outcomes across different communities. This is particularly critical in mental health, where disparities are both entrenched and multifactorial. The Health and Social Care Committee report into Community Mental Health Services 2026 found that timely access to mental health care is a matter of safety, dignity, and equity; with delays in care leading to preventable crisis, greater distress, poorer outcomes, and higher costs to the system. The severity gap, where people fall between high and low intensity services is a national system failing.

A substantial body of evidence also demonstrates that mental health need is not distributed evenly across populations, and neither is access to care. Research consistently shows that people living in the most deprived communities experience significantly higher levels of mental ill-health, yet are less likely to access or benefit from timely and effective support. For example, analysis by the Mental Health Foundation highlights that individuals in the most deprived areas of England are 64%

more likely to experience common mental disorders, while systemic barriers continue to shape access to services¹.

Similarly, the King's Fund identifies persistent inequalities in access to care, with certain groups—particularly ethnic minorities, older adults, and those in deprived areas—under-represented relative to their level of need². These patterns are not incidental; they reflect wider structural determinants such as housing, employment, social isolation, and service configuration. As such, expecting equity to emerge organically from uniform service provision is unrealistic. It must be actively pursued³.

Within the Oxfordshire context of local delivery, the report submitted to the Committee emphasises that neighbourhood-based delivery and increasing demand illustrates both an opportunity and a risk. While localisation of services has the potential to improve accessibility and responsiveness, it can also create what is often described in the literature as a “postcode lottery” if variation between neighbourhoods is not actively monitored and addressed. Academic commentary on neighbourhood health services explicitly warns that localisation must be accompanied by deliberate mechanisms to ensure equitable access across settings, particularly between urban and rural populations⁴.

Furthermore, the Committee's focus on ensuring that neighbourhood models benefit rural and more deprived communities as effectively as urban areas is especially well-founded. Rural mental health inequalities are both under-recognised and deeply embedded. The Centre for Mental Health highlights that rural populations face distinctive barriers including physical isolation, limited service visibility, reduced transport options, and digital exclusion, all of which restrict timely access to support⁵.

Parliamentary evidence has similarly identified concerns about the adequacy and accessibility of mental health provision in rural areas, particularly following wider reductions in local services and social infrastructure⁶. These disparities are further compounded by socioeconomic deprivation, which intersects with geography to create cumulative disadvantage⁷.

From a systems perspective, this means that a model designed primarily around urban density and infrastructure—such as centrally located crisis hubs or services clustered around acute hospitals—may be inherently less accessible to dispersed or marginalised populations unless deliberate adaptations are made. The Committee's recommendation

¹ [source](#) / [\[mentalhealth.org.uk\]](https://www.mentalhealth.org.uk)

² [Mental Health 360 | Inequalities | The King's Fund](#)

³ [\[kingsfund.org.uk\]](https://www.kingsfund.org.uk)

⁴ [\[bjgp.org\]](https://www.bjgp.org)

⁵ [\[centreform...lth.org.uk\]](https://www.centreformentalhealth.org.uk)

⁶ [Rural Mental Health - Environment, Food and Rural Affairs Committee](#)

⁷ [\[publicatio...liament.uk\]](#)

therefore reflects a recognition that equity requires differentiated delivery, not uniform distribution.

Moreover, the recommendation being made by the JHOSC also highlights specific concern regarding the coverage and accessibility of crisis alternatives, including Safe Havens. This is an important area for scrutiny, as crisis services often represent the most immediate interface between individuals in acute distress and the health system.

Evidence on crisis cafés and Safe Haven models demonstrates their potential to provide accessible, non-clinical alternatives to emergency departments, offering early intervention and emotional support in less stigmatising environments. Qualitative research has identified their key functions as including diversion from A&E, improved access to crisis care, and provision of safe spaces for individuals in distress⁸. A broader scoping review similarly found that such services can reduce emergency department use and alleviate social isolation, although challenges remain around consistency and equitable access⁹.

Crucially, however, the effectiveness of crisis alternatives is highly dependent on geographical accessibility and awareness. Where provision is uneven—for example, concentrated in urban centres—its system-wide impact is diminished. The Committee's recommendation to address gaps in Safe Haven coverage therefore aligns with the evidence base: without equitable distribution, these services risk reinforcing, rather than mitigating, existing inequalities.

Additionally, at a policy level, the recommendation is fully aligned with the statutory role of Integrated Care Systems (ICSs). ICSs were explicitly established to improve population health and reduce inequalities in access, experience and outcomes¹⁰. National bodies such as NHS England have reinforced this through programmes like Core20PLUS5, which require systems to prioritise the most disadvantaged populations¹¹.

However, evidence suggests that many systems struggle to operationalise this aspiration. The Care Quality Commission (CQC) has found that while ICSs recognise inequalities as a priority, they do not always sufficiently understand or address population-level variation in need and access¹². This gap between ambition and implementation underscores the importance of scrutiny bodies in setting clear expectations and holding systems to account.

⁸ [A qualitative investigation of crisis cafés in England: their role, implementation, and accessibility | BMC Health Services Research | Springer Nature Link](#)

⁹ [\[link.springer.com\]](#) / [\[pmc.ncbi.nlm.nih.gov\]](#)

¹⁰ [\[kingsfund.org.uk\]](#)

¹¹ [\[kingsfund.org.uk\]](#)

¹² [Integrated care systems - Care Quality Commission](#)

The academic literature further supports the role of integrated neighbourhood teams in addressing inequalities, provided they are designed with local specificity, adequate resourcing, and strong community engagement. Evidence indicates that locally sensitive approaches, co-located services, and trust-building with marginalised communities are critical to reducing disparities¹³. These principles directly reinforce the Committee's emphasis on ensuring neighbourhood models deliver equitable benefit.

Examples from across England illustrate how systems can operationalise this approach. In Wakefield, for instance, integrated care partners have worked with housing services to address the social determinants of mental health, linking individuals to support earlier and reducing downstream demand on crisis services¹⁴. Such initiatives demonstrate that addressing inequality requires coordination beyond traditional clinical services, particularly in areas such as housing, employment and community support.

Similarly, the broader IAPT (Improving Access to Psychological Therapies) programme illustrates how targeted expansion of access can significantly increase uptake and recovery, but also highlights that improvements in overall access do not automatically eliminate disparities between groups¹⁵. This reinforces the need for ongoing, targeted action.

Therefore, the recommendation that equity of access be treated as a core performance objective is therefore both evidence-based and strategically necessary. Mental health inequalities are deeply embedded and shaped by structural determinants; they cannot be resolved through uniform service provision alone. Instead, they require:

- active identification of variation at neighbourhood level,
- targeted intervention where gaps are identified, and
- deliberate adaptation of services to meet the needs of different communities.

In this context, addressing gaps in crisis alternatives such as Safe Havens, ensuring rural and deprived communities benefit equally from neighbourhood models, and embedding equity within system performance frameworks are not optional enhancements—they are essential conditions for delivering a fair and effective mental health system.

By articulating this expectation clearly, the Committee is not simply requesting further analysis; it is asserting that equity must move from an aspirational principle to an operational priority, embedded across commissioning, delivery and performance management.

¹³ [What works: How can integrated neighbourhood teams reduce inequalities in health and health care? - Health Equity Evidence Centre](#)

¹⁴ [\[england.nhs.uk\]](https://england.nhs.uk)

¹⁵ [\[pmc.ncbi.nlm.nih.gov\]](https://pmc.ncbi.nlm.nih.gov)

Recommendation 1: *That system partners treat equity of access as a core performance objective, with explicit action taken where neighbourhood-level variation is identified, including: addressing gaps in crisis alternatives and Safe Haven coverage, and ensuring that any neighbourhood-based models benefit rural and more deprived communities as effectively as urban areas.*

Treating co-production as a core performance objective for the development and delivery neighbourhood mental health centres:

The JHOSC recognises that modern mental health systems cannot deliver effective, equitable and sustainable outcomes through top-down models alone; rather, they must be shaped in partnership with the communities they serve, including local authorities, voluntary sector organisations, and people with lived experience.

Co-production in health and care goes beyond consultation. It involves service users, families, communities and local stakeholders participating as equal partners in decision-making, design and delivery. National policy increasingly frames this as essential to tackling inequalities and improving outcomes. NHS England's strategy on advancing mental health equalities emphasises the need to improve access, experience and outcomes by working meaningfully with communities and people with lived experience to shape services¹⁶.

The report submitted to the Committee for this item already acknowledges the importance of co-production, highlighting the role of voluntary, community and social enterprise (VCSE) partners and the embedding of peer workers and experts by experience within service delivery. This reflects a strong foundation. However, the Committee's recommendation seeks to move co-production from a supporting principle to a core performance expectation. This is significant: it implies that co-production should not be episodic or optional, but systematically embedded in how neighbourhood mental health centres are developed and operated.

This shift is particularly important in the context of neighbourhood-based models. While localisation offers opportunities for more responsive and integrated care, it also risks replicating existing service assumptions unless local voices are genuinely incorporated. As academic commentary on neighbourhood health systems has noted, defining and delivering services at a neighbourhood level raises critical questions about whose needs are prioritised and how variation is understood across different communities¹⁷.

The case for co-production is particularly strong when considered through the lens of health inequalities. Mental health need is shaped by

¹⁶ <https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/>

¹⁷ <https://bjgp.org/content/76/764/102>

a complex interplay of social determinants, including housing, income, isolation, and community cohesion. Research demonstrates that these determinants vary significantly across local populations and are deeply embedded within neighbourhood contexts. For example, the Mental Health Foundation identifies key drivers of inequality such as financial insecurity, loneliness and access to services, noting that these factors are interconnected and must be addressed holistically¹⁸.

Neighbourhood-level co-production provides a mechanism for surfacing these local realities. It allows services to be shaped by those who understand the lived experience of mental health within specific communities, including the barriers to access that may not be visible in aggregate data. Academic research on neighbourhood-based interventions supports this view, highlighting that improvements in mental health outcomes are closely linked to factors such as social cohesion, trust in local services, and community participation¹⁹.

Without co-production, there is a risk that neighbourhood mental health centres become geographically decentralised but conceptually centralised—replicating standardised models rather than tailoring services to local need. The Committee’s recommendation directly addresses this risk by requiring the inclusion of local councils, elected members, and community organisations working alongside families and individuals with lived experience.

The inclusion of local councils and the voluntary sector within co-production arrangements is not simply desirable; it is essential. Integrated Care Systems (ICSs) were established to bring together NHS organisations, local authorities and community partners to improve population health and reduce inequalities²⁰. In practice, however, evidence suggests that achieving genuinely integrated working remains challenging, particularly where governance structures are complex and operational pressures dominate.

The voluntary sector plays a particularly critical role in bridging the gap between formal services and communities. In Oxfordshire, organisations such as Mind, Restore and Response are already delivering crisis support, housing, and recovery services, often grounded in community knowledge and lived experience. Nationally, evidence shows that such organisations are often better placed to engage marginalised communities, build trust, and provide culturally appropriate support.

In Wakefield, for example, integrated care partners have worked with housing and community services to address the wider determinants of mental health, linking individuals to support earlier and preventing crisis escalation. This joint working has demonstrable impacts on both

¹⁸ <https://www.mentalhealth.org.uk/explore-mental-health/blogs/mental-health-inequalities-uk>

¹⁹ <https://academic.oup.com/eurpub/article/30/5/964/5671760>

²⁰ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained>

individual outcomes and system pressures²¹. These kinds of models rely on close collaboration between statutory and voluntary partners, underpinned by shared ownership of outcomes. By embedding co-production as a performance objective, the Committee is effectively strengthening these relationships and ensuring that they are consistently applied at neighbourhood level.

Moreover, a further justification for this recommendation lies in the growing evidence that services designed with lived experience input are more effective. Individuals and families with lived experience bring insights that cannot be replicated through professional knowledge alone. This is particularly relevant in mental health, where stigma, trust, and personal relationships play a central role in engagement with services. Research on crisis cafés and Safe Haven models illustrates this point clearly. These services, which are often co-produced and delivered with significant voluntary sector involvement, are designed specifically to provide accessible, non-clinical environments for people in crisis. Studies show that they can improve access to support, offer alternatives to emergency departments, and provide a more person-centred experience²².

However, these benefits are not automatic; they depend on services being responsive to the needs of the communities they serve. Co-production ensures that services remain grounded in lived experience over time, rather than drifting towards standardised, institutionally driven models.

While the benefits of co-production are clear, it is not without challenges. Evidence from integrated care systems suggests that meaningful co-production requires:

- sufficient time and resources to support participation,
- genuine sharing of power and decision-making, and
- clear structures for accountability and feedback.

Research on integrated neighbourhood teams highlights that successful models are those that are locally sensitive, well-resourced, and built on trust between services and communities²³. Without these conditions, there is a risk that co-production becomes tokenistic.

For meaningful coproduction and development of improved mental health within neighbourhoods, there needs to be a shift from hospital to community, but one that is grounded in relationship with the voluntary sector; local communities and which recognises the cultural

²¹ <https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities/>

²² <https://link.springer.com/article/10.1186/s12913-024-11662-0> ;
<https://pmc.ncbi.nlm.nih.gov/articles/PMC12647224/>

²³ <https://www.heec.co.uk/resource/what-works-how-can-integrated-neighbourhood-teams-reduce-inequalities-in-health-and-health-care/>

understanding, trust, deep local knowledge necessary to connect seamlessly with public services, and amplify the existing networks of people and assets within communities.

The Committee's recommendation implicitly addresses these risks by framing co-production as a core performance objective. This elevates it to the same level of importance as access, quality and outcomes, ensuring that it is embedded within governance, commissioning and service development frameworks. In essence, the recommendation that co-production be treated as a core performance objective in neighbourhood mental health services is both timely and necessary. It reflects a recognition that effective mental health systems must be:

- rooted in the realities of local communities,
- responsive to lived experience, and
- delivered in partnership across organisational boundaries.

In the Oxfordshire context, where strong foundations of partnership and co-production already exist, this recommendation does not represent a radical departure but rather a natural progression—moving from good practice in parts of the system to consistent, system-wide expectation. It builds on the support for this approach by the JHOSC since 2021 on Marmot; Neighbourhoods, and local examples like the coproduction with Wantage Town Council on hospital to community services.

The neighbourhood shift will require consideration of networked governance structures enabling sharing of power and decision-making; governance focusing on systems convening that fosters collaboration, generative conflict, removing barriers and collective learning; enable community leadership and shared accountability. Data and evidence requires value to detailed neighbourhood-level data used with communities to inform place specific decisions and value to the wisdom of practice to recognise capable communities. Scaling requires national guidance that values principles and indicators of system health, local variability and place-based implementation. Funding requires flexible place-based portfolios that allow pooled funding and adaptive allocation. Outcomes need to be co-defined and connected to locally defined indicators aligned with community priorities and system wide learning goals with monitoring of relationship quality and learning rigour, short feedback to enable adjustment in real-time. Accountability and responsibility is essentially multi-directional.

At a minimum it requires funding of a convening role, an independent local patient voice, involvement of local leaders and local scrutiny. This is necessary to stop extending institutional models into neighbourhoods rather than building around what already exists so that services sit within communities and have a relationship with it, and so that communities can support prevention of crisis and early identification and advocacy for those in need of crisis support from public services.

More broadly, this jhosc recommendation aligns with national policy, academic evidence, and emerging best practice across integrated care systems. By embedding co-production at neighbourhood level and ensuring the involvement of local councils, elected members, the voluntary sector and lived experience families, the system is better positioned to deliver services that are not only accessible, but meaningful, equitable and effective. Ultimately, this recommendation recognises that sustainable improvement in mental health outcomes cannot be delivered to communities—it must be developed with them.

Recommendation 2: *That system partners treat co-production as a core performance objective for design, development and delivery neighbourhood mental health centres. It is recommended that there is an inclusion of local councils, local members and local voluntary sector working with lived experience families at any neighbourhood level included in the work programme.*

Ensuring quality of outcomes, not just speed of access, to mental community mental health services: The recommendation being made by the JHOSC, that access standards for adult community mental health services must be applied in a clinically meaningful way—reflects a growing recognition across the NHS and academic literature that performance targets, if poorly designed or implemented, can unintentionally distort care delivery. In particular, the emphasis within the recommendation on safeguarding therapeutic continuity, ensuring consistent data definitions, and prioritising quality over speed speaks directly to the central tension in contemporary mental health policy: how to expand access without undermining the effectiveness and integrity of care.

Over the past decade, national mental health policy has increasingly prioritised access standards, with the aim of reducing waiting times and improving responsiveness. This shift has been widely seen as necessary, particularly given historic under-provision and long delays in accessing care. The expansion of programmes such as Improving Access to Psychological Therapies (IAPT) demonstrates the benefits of this approach: significantly increased numbers of people receiving treatment and improved overall recovery rates²⁴. However, the same evidence also highlights a critical limitation—improved access does not automatically translate into improved quality or equitable outcomes.

Within the Oxfordshire Performance and Assurance Oversight Board Report submitted to the Committee (Annex 1), the introduction of interim access standards for adult community mental health services—such as the “two meaningful contacts within 28 days” metric—illustrates this evolving policy landscape. The report also highlights the use of statistical process control (SPC) charts and data quality indicators to monitor variation and assurance. While these tools represent important advances

²⁴ <https://pmc.ncbi.nlm.nih.gov/articles/PMC8381091/>

in performance monitoring, they also underline the complexity of interpreting access metrics meaningfully. The definition of a “meaningful contact” is inherently subjective, and inconsistencies in interpretation across teams risk undermining the reliability of reported performance. The Committee’s recommendation directly addresses this issue by emphasising the need for consistent and clinically grounded definitions. Without this, access standards risk becoming detached from clinical reality, creating a situation where performance appears strong on paper while underlying care quality is variable.

Furthermore, one of the most significant risks associated with narrowly defined access targets is that they may prioritise speed of initial contact over continuity of care. In mental health services, therapeutic continuity is not simply a desirable feature; it is central to effective treatment. Longitudinal relationships with clinicians enable trust, engagement and sustained recovery, particularly for individuals with severe or enduring mental illness.

The importance of continuity is widely supported in the literature. Evidence from integrated care and primary care research demonstrates that continuity of clinician is associated with improved outcomes, reduced hospital admissions, and greater patient satisfaction. In the context of mental health, where stigma, vulnerability and complexity are often present, these relationships are particularly critical.

However, the introduction of short-term access targets can create unintended pressures on services to prioritise initial appointments over ongoing care. For example, services may reallocate clinician time towards meeting access standards, potentially reducing availability for follow-up or longer-term therapeutic work. The Committee’s recommendation therefore rightly calls for safeguards to ensure that early contact does not displace therapeutic continuity. This is not an argument against access standards, but rather a recognition that they must be implemented within a broader framework that values long-term outcomes.

Moreover, a further key element of the recommendation is the need for consistent data definitions across teams. Annex 1 submitted to the Committee explicitly identifies data quality as a critical component of performance reporting, with indicators assessing whether data are valid, complete and supported by appropriate processes. This reflects a broader challenge within health systems: performance metrics are only as robust as the data on which they are based.

Academic research reinforces this point. Studies of health system performance measurement have repeatedly shown that variation in data collection methods and definitions can lead to misleading comparisons and inappropriate conclusions²⁵. In mental health services, where

²⁵ <https://pmc.ncbi.nlm.nih.gov/articles/PMC8381091/>

interventions are often complex and multifaceted, this challenge is particularly acute. For example, what constitutes a “meaningful contact” may vary depending on clinical context, patient need, and service model. The Committee’s recommendation therefore recognises that consistency is not merely a technical issue, but a prerequisite for meaningful performance management. Without shared definitions and robust data standards, access metrics risk becoming a distorted signal, reflecting variations in recording practices rather than actual service performance.

Perhaps the most significant aspect of the recommendation is its insistence that performance management should reinforce quality and outcomes, not just speed of access. This aligns closely with national policy and academic evidence, both of which increasingly emphasise outcomes as the ultimate measure of service effectiveness. The King’s Fund has highlighted that inequalities in mental health care are not limited to access, but extend to experience, quality and outcomes, with different population groups experiencing markedly different results from treatment²⁶. This suggests that focusing solely on access risks overlooking the deeper structural issues that shape mental health outcomes.

Similarly, research into integrated care systems has shown that improving population health requires a shift from activity-based performance measures towards outcomes-based approaches, including recovery, wellbeing and social functioning²⁷. In this context, access metrics should be understood as necessary but insufficient; they are a means to an end, not an end in themselves.

The Oxfordshire data further illustrates this tension. While access indicators may show strong performance, other metrics—such as recovery rates in Talking Therapies or physical health outcomes for people with severe mental illness—indicate ongoing challenges. This underscores the importance of a balanced performance framework that integrates access, quality and outcomes.

Experience from other areas of the country reinforces the importance of applying access standards in a clinically meaningful way. In some systems, the rapid expansion of early access targets has led to unintended consequences, including increased service fragmentation and reduced continuity of care. Conversely, areas that have successfully balanced access and quality—often through integrated neighbourhood models—have done so by embedding clinical judgement and local flexibility within performance frameworks.

For example, NHS England case studies highlight the value of integrated, cross-sector approaches that address wider determinants of health and

²⁶ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-inequalities>

²⁷ https://www.health.org.uk/sites/default/files/upload/publications/2026/ICS%20report_Final.pdf

support continuity of care across pathways²⁸. These models demonstrate that effective care cannot be reduced to a single metric; it requires coordination, relationship-building and a focus on long-term outcomes.

Academic work on neighbourhood health systems also emphasises the need for locally sensitive approaches that combine accessibility with continuity and trust²⁹. This reinforces the Committee's position that access standards must be applied in a way that reflects the realities of clinical practice rather than imposing rigid, uniform targets.

Therefore, this recommendation represents a nuanced and evidence-based approach to performance management in mental health services. It acknowledges the importance of improving access while recognising the risks of over-reliance on speed-based metrics. By calling for safeguards to protect therapeutic continuity, ensure data consistency, and prioritise quality and outcomes, the Committee is advocating for a more balanced and clinically meaningful application of access standards. In doing so, the recommendation aligns with both national policy direction and academic evidence, which increasingly emphasise the need for integrated, outcome-focused approaches to mental health care. It also reflects the realities observed within the Oxfordshire system, where strong performance on access metrics must be understood within a broader context of demand, complexity and variability.

Ultimately, the recommendation asserts that access standards should serve the goal of better care—not replace it. Ensuring that they are applied in a clinically meaningful way is therefore not simply a technical adjustment, but a fundamental requirement for delivering safe, effective and sustainable mental health services.

Recommendation 3: *That access standards for adult community mental health services are applied in a clinically meaningful way. It is recommended that there are clear safeguards to ensure that: early contact does not displace therapeutic continuity, that data definitions are consistent across teams, and that performance management reinforces quality and outcomes, not just speed of access.*

Importance of collaboration among system partners on implementation of government guidance on the Patient and Carer Race Equality Framework: The JHOSC's recommendation that system partners collaborate to identify local requirements for implementing government guidance on named workers and the Patient and Carer Race Equality Framework (PCREF) reflects a key insight within contemporary mental health policy: that improving outcomes depends not only on service provision, but on how care is coordinated, personalised and made equitable across populations. The recommendation recognises

²⁸ <https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities/>

²⁹ <https://bjgp.org/content/76/764/102>

that both the named/key worker model and PCREF represent transformative national policy directions—but that their success depends fundamentally on local system adaptation, cross-partner collaboration and effective implementation.

The concept of a named or key worker sits at the heart of the shift towards personalised care within the NHS. Personalised care has been established as a central component of the NHS Long Term Plan, with the aim of ensuring that care is based on “what matters” to people, rather than a one-size-fits-all model³⁰. This approach recognises the growing complexity of mental health needs, particularly among adults and older adults with multiple conditions, social vulnerabilities and long-term support requirements³¹.

Within this context, the named worker model provides a practical mechanism for translating personalised care into everyday service delivery. NICE guidance explicitly highlights that having a named worker—acting as a single point of contact—can improve coordination, increase engagement, and lead to better outcomes and experiences of care³². This is particularly important in mental health systems, where care pathways often involve multiple services and professionals across health, social care and the voluntary sector³³.

The report submitted to the Committee for this item, in outlining the complexity of local mental health provision and the breadth of services involved—from community mental health teams to crisis response and voluntary sector provision—implicitly demonstrates why coordination is critical. Without a clear, identifiable professional responsible for overseeing an individual’s care journey, there is a risk of fragmentation, duplication and disengagement.

Furthermore, academic research reinforces the importance of care coordination and continuity in this regard. Evidence indicates that continuity of care is associated with reduced hospital admissions, fewer emergency presentations and improved long-term outcomes for people with severe mental illness³⁴. Moreover, studies have found that coordination across professionals and services improves user satisfaction and recovery outcomes, particularly for those with complex needs³⁵.

However, the existence of national guidance alone is insufficient. The implementation of named worker models varies significantly between systems, with differences in role definition, caseload expectations and

³⁰ <https://www.england.nhs.uk/personalisedcare>

³¹ [\[england.nhs.uk\]](https://www.england.nhs.uk)

³² <https://www.nice.org.uk/guidance/qs140/chapter/Quality-statement-4-Named-worker>

³³ [\[nice.org.uk\]](https://www.nice.org.uk)

³⁴ <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/longterm-efficacy-of-a-continuity-of-care-treatment-model-for-patients-with-severe-mental-illness-who-transition-from-inpatient-to-outpatient-services/CEC0763E0D11CEFC279899FC0DF1D8CF>

³⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357>

integration across services. As noted in NHS practice discussions, there is often “no real definition” of the key worker role, leaving systems to interpret and operationalise it locally³⁶. This variability reinforces the Committee’s conclusion that system partners must collaboratively determine what the model should look like in Oxfordshire, rather than relying on generic national assumptions. The implementation of guidance will also be dependent on the workforce plan. There is also a need for national clarity for local systems on how the additional responsibilities and administration for the new role will be funded and supported.

The second element of the recommendation—the implementation of the Patient and Carer Race Equality Framework—addresses a longstanding and well-evidenced issue within mental health services: persistent racial inequalities in access, experience and outcomes. Research demonstrates that individuals from ethnically minoritised backgrounds, particularly Black communities, are more likely to experience coercive interventions, longer hospital stays and poorer engagement with services³⁷.

PCREF represents a national response to these disparities. Introduced by NHS England as a mandatory anti-racism framework, it requires all mental health providers to take structured action to reduce inequalities, including through improved data collection, governance, and patient engagement³⁸. Importantly, PCREF emphasises that change must be co-produced with communities, ensuring that interventions are grounded in lived experience and local context rather than imposed centrally.

The Care Quality Commission has reinforced the importance of this framework by integrating it into inspection processes, making it a key component of how service quality is assessed³⁹. Failure to implement PCREF effectively can therefore have direct implications for organisational ratings and regulatory oversight.

In Oxfordshire, the report (submitted to the Committee’s) emphasis on partnership with voluntary and community organisations, as well as the involvement of experts by experience, aligns strongly with the principles of PCREF. However, this JHOSC recommendation reflects the recognition that formal compliance with the framework is not sufficient. To be effective, PCREF must be translated into locally meaningful action, informed by the specific demographic profile, community relationships and service pressures within the county.

Examples from other NHS Trusts illustrate how this can be achieved. East London NHS Foundation Trust, for instance, has implemented PCREF through partnership working with local authorities, community

³⁶ <https://www.merseycare.nhs.uk/role-key-worker>

³⁷ <https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1053502/full>

³⁸ <https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref>

³⁹ <https://www.cqc.org.uk/guidance-providers/nhs-trusts/brief-guides-inspection-teams/pcref>

organisations and service users to co-design culturally responsive services⁴⁰. Similarly, Avon and Wiltshire Mental Health Partnership Trust has used PCREF to identify barriers to access and develop targeted interventions in collaboration with local communities⁴¹. These examples demonstrate that successful implementation requires sustained collaboration across system partners, including health services, local authorities and the voluntary sector.

In essence, the central justification for the Committee's recommendation lies in the recognition that neither personalised care nor race equality can be delivered by individual organisations acting in isolation. Mental health care is inherently multi-agency, involving NHS providers, local authorities, housing services, voluntary organisations and community networks. As such, the implementation of named workers and PCREF must be approached as system-wide initiatives, rather than discrete organisational responsibilities.

Moreover, academic research on care coordination highlights that fragmented systems—where roles, responsibilities and communication pathways are unclear—lead to poorer outcomes and increased burden on both service users and carers⁴². Conversely, effective collaboration across agencies supports continuity, improves communication, and enables more responsive and personalised care⁴³.

This is particularly relevant when considering the intersection between the two policy areas addressed in the recommendation. Named workers provide a mechanism for coordination and continuity, while PCREF provides a framework for ensuring that care is equitable and responsive to diverse communities. When implemented together, they have the potential to transform both the structure and the culture of mental health services. However, this integration can only be achieved through deliberate collaboration.

This recommendation by the JHOSC is therefore grounded in both evidence and policy. It recognises that the introduction of named workers and the implementation of PCREF are not merely technical changes, but fundamental shifts in how mental health services are organised and delivered. These shifts require:

- clear role definition and coordination across complex systems,
- meaningful engagement with communities and lived experience, and,
- alignment between national policy and local context.

⁴⁰ <https://www.elft.nhs.uk/information-about-elft/equity-diversity/patient-and-carer-race-equality-framework-pc-ref>

⁴¹ <https://www.awp.nhs.uk/about-us/news/stories/trust-implements-new-approach-reducing-racial-inequalities>

⁴² <https://academic.oup.com/book/59497/chapter/501514189>

⁴³ [\[academic.oup.com\]](https://academic.oup.com/)

By emphasising collaboration among system partners to identify what is needed locally, the Committee is addressing the critical implementation gap that often undermines national policy initiatives. It is asserting that success depends not just on adopting frameworks, but on translating them into coherent, locally grounded practice. In doing so, the recommendation reflects a broader principle: that effective mental health services are not simply delivered through structures and targets, but through relationships, coordination and a sustained commitment to equity.

Recommendation 4: *For collaboration amongst system partners to identify what is needed locally for the implementation of the new government guidance on key workers/named worker for personalised care and on implementation of the Patient and Carer Race Equality Framework.*

Preventing out of area placements through including the use of independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient: The Committee's recommendation that system partners collaborate to reduce and prevent out-of-area placements (OAPs), incorporate independent clinical reviews, and embed patient and family input into decisions about long-term placement reflects a significant and justified concern within modern mental health care: that institutionalisation, geographical dislocation, and fragmented discharge pathways can undermine recovery, safety and dignity. This recommendation is grounded not only in the local evidence presented in the report and Annex 1 submitted to the Committee for this item, but also in a robust national and academic evidence base which demonstrates that OAPs and long-term institutional care are associated with poorer outcomes unless carefully managed through coordinated, person-centred approaches.

Out-of-area placements arise when patients are admitted to mental health beds outside their local area, often due to capacity constraints, complex needs, or lack of suitable community provision. While occasionally necessary, their long-term use has been widely criticised within national policy and research due to their impact on continuity of care, patient experience and recovery and impact on families.

The Oxfordshire Performance and Assurance Oversight Board Report submitted to the Committee highlights this tension clearly. While snapshot measures suggest a reduction in the number of OAPs, the persistence of high bed-day usage indicates that patients continue to spend prolonged periods away from their communities. This distinction between point-in-time counts and cumulative bed use is critical: it shows that the issue is not only about how many people are placed out of area, but how long they remain there. The narrative accompanying the data further identifies delays in discharge linked to challenges in securing

appropriate accommodation or community placements, reflecting a broader systems issue rather than an isolated operational problem. Nationally, it is well established that there are over 2,000 people with learning disabilities or autism that are placed in psychiatric hospitals without a formal mental health diagnosis. One recent example was the NHS England Clive Treacey Independent Review, which found his needs were for specialised physical health care, a stable routine and expert seizure management but instead and despite not having a treatable mental illness he was repeatedly sectioned under the Mental Health Act and kept in hospital for a decade because of the lack of a community package of care.

Academic literature strongly supports the importance of addressing this. Continuity of care is widely regarded as a cornerstone of effective mental health provision, and studies have shown that disruptions—such as those caused by being treated far from home—are associated with poorer outcomes, including higher readmission rates and reduced engagement⁴⁴. The concept of “continuity of care” itself extends beyond access to services, encompassing relational stability, coordinated pathways and sustained engagement, all of which are undermined when individuals are placed far from their support networks⁴⁵.

The Committee’s recommendation for independent clinical review of patients in out-of-area or long-term placements reflects an understanding that institutionalisation is not a neutral state. Over time, patients may become embedded in care pathways that are difficult to exit, particularly where clinical risk aversion, system pressures and the absence of suitable alternatives converge.

Independent clinical review provides a mechanism to challenge these dynamics. It introduces external scrutiny into decision-making, ensuring that ongoing placement is justified not simply by convenience or system limitations, but by clear clinical need. Research into care coordination and service fragmentation highlights the importance of clearly defined roles, accountability and oversight in improving outcomes for people with complex mental health needs⁴⁶. Without such oversight, there is a risk that responsibility becomes diffused across organisations, leading to inertia and prolonged institutionalisation.

In practice, several systems across England have already adopted structured review processes for OAPs. For example, mental health trusts

⁴⁴ <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/longterm-efficacy-of-a-continuity-of-care-treatment-model-for-patients-with-severe-mental-illness-who-transition-from-inpatient-to-outpatient-services/CEC0763E0D11CEFC279899FC0DF1D8CF>

⁴⁵ <https://journals.sagepub.com/doi/pdf/10.1177/070674370404900805>

⁴⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357>

operating under the Community Mental Health Framework have introduced multidisciplinary review panels—often involving commissioners, clinicians and care coordinators—to assess whether placements remain appropriate and to actively plan for repatriation. These models demonstrate that systematic review, when embedded within governance structures, can reduce unnecessary bed days and support transitions back to community care.

A defining feature of the Committee’s recommendation is the emphasis on including patient and family input in decisions about long-term placement and institutionalisation. This reflects a wider shift in mental health policy towards co-production and personalised care, recognising that individuals and their networks hold critical insight into what constitutes meaningful recovery and safe discharge.

The NHS personalised care agenda explicitly emphasises that care should be based on “what matters” to individuals, and that families and carers are integral to planning and delivering support⁴⁷. In the context of OAPs and long-term placements, this means that decisions should not be made solely on clinical or operational grounds, but should incorporate the lived experience of patients and those who support them.

Academic research reinforces this perspective. Studies on care coordination for people with severe mental illness highlight that involving caregivers and families improves navigation of complex systems, strengthens support networks, and enhances long-term outcomes⁴⁸. In contrast, exclusion of these perspectives can lead to decisions that are technically appropriate but practically unworkable, particularly when considering discharge into the community.

The report submitted to the Committee’s emphasis on integrated working with social care and the voluntary sector further supports the importance of this approach. Social workers, housing providers and voluntary organisations often have a more holistic understanding of individuals’ needs, including accommodation, social support and local connectivity. Their involvement is therefore critical in determining whether a placement is sustainable and conducive to recovery.

Moreover, the second component of this JHOSC recommendation—the need for system-wide review of community placements—addresses an equally important issue: the risk that discharge from inpatient or out-of-area care does not necessarily result in effective community integration. Poorly designed or under-resourced community placements

⁴⁷ <https://www.england.nhs.uk/personalisedcare/>

⁴⁸ <https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1473235/full>

can lead to instability, readmission and, ultimately, a cycle of institutionalisation.

Evidence suggests that successful community-based care depends on more than simply providing accommodation. It requires coordinated, multidisciplinary support, stable relationships with care professionals, and integration with wider services such as primary care, social care and the voluntary sector. Research on integrated care systems emphasises that collaboration across sectors is essential to achieving sustainable outcomes and reducing reliance on hospital-based care⁴⁹.

Examples from other areas illustrate how this can be achieved in practice. In Wakefield, for instance, partnerships between health services, housing providers and community organisations have been used to address barriers to discharge and prevent readmission, demonstrating both improved outcomes for individuals and reduced system pressure⁵⁰. These approaches rely on continuous evaluation of placements, ensuring that they remain appropriate and supportive over time.

In addition, the inclusion of voluntary sector perspectives within such reviews is particularly important. Voluntary organisations often provide services that extend beyond statutory provision, including peer support, community integration and culturally appropriate care. Their insights can therefore help identify whether community placements are genuinely meeting individuals' needs, or whether additional support is required.

Therefore, the Committee's recommendation represents a comprehensive and evidence-based approach to addressing one of the most complex challenges in adult and older adult mental health services: the balance between inpatient care, out-of-area placements and sustainable community provision. By emphasising collaboration, independent clinical review, and the inclusion of patient, family and voluntary sector perspectives, it reflects an understanding that reducing OAPs is not simply a matter of increasing capacity, but of transforming how decisions are made and how care is delivered.

At its core, the recommendation recognises that mental health services must move beyond reactive responses to immediate pressures and instead adopt a proactive, system-wide approach to care planning and review. This includes:

⁴⁹ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained>

⁵⁰ <https://www.england.nhs.uk/integrated-care/resources/case-studies/integrated-care-in-action-health-inequalities>

- ensuring that placements are clinically justified and regularly reviewed,
- involving those with lived experience in shaping decisions, and
- continuously evaluating whether community settings provide safe, stable and meaningful environments for recovery.

In doing so, the recommendation aligns with both local evidence and national policy direction, and supports the development of a mental health system that is not only efficient, but also humane, equitable and recovery-focused.

Recommendation 5: *For collaboration amongst system partners on reducing/preventing out of area placements to include independent clinical reviews, and family/patient input on sustainability of long-term institutionalisation for every patient. It is also recommended that there is a review that includes patients, families, and the voluntary sector to determine whether community placements are working well as a safe and conducive home setting protective against worst outcomes.*

Importance of meeting performance targets for access to physical health checks for mentally ill patients, and ensuring timely and regular physical health checks for those with comorbidities: The Committee's recommendation that performance targets for physical health checks for people with mental illness must be met—and that these checks should be timely, regular, and inclusive of long-term conditions—addresses a longstanding and well-evidenced disparity within health systems: the systematic neglect of physical health needs among people with mental illness. This recommendation is both locally justified, based on the evidence presented within the report and Annex 1 submitted to the Committee, and strongly supported by national policy and academic research, which consistently demonstrate the urgent need to close the gap between mental and physical health outcomes.

People living with severe mental illness (SMI) experience significantly poorer physical health outcomes than the general population, including higher rates of cardiovascular disease, diabetes, respiratory illness and premature mortality. This disparity is widely recognised as one of the most persistent health inequalities in the UK. Research underpinning national policy has shown that individuals with serious mental illness die 15–20 years earlier on average than the wider population, largely due to preventable physical health conditions.

The Patient and Carer Race Equality Framework (PCREF) literature reinforces this point when describing broader mental health inequalities. It highlights that individuals from marginalised groups—particularly those already vulnerable—experience poorer access, outcomes and engagement with services, including in areas such as physical health monitoring⁵¹. This aligns with findings in the report submitted for this item,

⁵¹ <https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1053502/full>

where physical health checks for people with SMI were recorded as being significantly below national targets.

The implication is clear: without systematic intervention, people with mental illness—especially those with complex or enduring conditions—are less likely to have their physical health needs identified and managed in a timely manner. The Committee’s recommendation therefore reflects an urgent need to ensure that performance targets are not merely aspirational, but actively delivered in practice.

At the core of the recommendation is the requirement that physical health checks are both timely and regular. This reflects an understanding that physical health deterioration in people with mental illness often occurs gradually and may go undetected without structured monitoring.

National frameworks on personalised care emphasise that care should be continuous, proactive and centred on individual needs, rather than reactive or episodic⁵². This principle is particularly relevant for individuals with comorbidities—such as diabetes or cardiovascular disease—where routine monitoring is essential to prevent complications.

Academic evidence supports this approach. Studies of continuity of care demonstrate that regular engagement with health services, including structured monitoring, is associated with improved clinical outcomes, reduced emergency admissions and better long-term management of chronic conditions⁵³. For patients with mental illness, this is especially important because symptoms such as low motivation, cognitive impairment or social isolation may act as barriers to engaging with primary care services. Without proactive outreach and structured check-ups, these individuals are at greater risk of falling through gaps in care. The Oxfordshire data reflecting underperformance in SMI physical health checks therefore highlights not only a metric shortfall, but a systemic risk: that individuals with the greatest need are not receiving consistent, preventive care.

The Committee’s explicit inclusion of long-term condition management within physical health checks is particularly significant. Mental and physical health are closely interconnected, with strong evidence demonstrating that people with mental illness are more likely to develop chronic physical conditions, and that these conditions are often more difficult to manage. Research on care coordination highlights that individuals with complex needs require integrated, multi-disciplinary support to manage both mental and physical health effectively⁵⁴. Where this integration is lacking, there is a risk that physical and mental health are treated separately, leading to fragmented care and poorer outcomes.

⁵² <https://www.england.nhs.uk/personalisedcare>

⁵³ <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/longterm-efficacy-of-a-continuityofcare-treatment-model-for-patients-with-severe-mental-illness-who-transition-from-inpatient-to-outpatient-services/CEC0763E0D11CEFC279899FC0DF1D8CF>

⁵⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357>

In practical terms, this means that physical health checks should not be limited to basic screening, but should include:

- ongoing monitoring of established long-term conditions,
- coordination with primary care and specialist services, and
- active management plans tailored to individual needs.

Examples from NHS systems across England illustrate the value of this approach. In several integrated care systems, multidisciplinary teams—including GPs, mental health clinicians and specialist nurses—have been used to deliver joint physical and mental health reviews, resulting in improved detection of long-term conditions and better management of risk factors such as obesity and hypertension. These models demonstrate that when care is coordinated and comprehensive, outcomes improve.

Furthermore, a key element of the recommendation is the insistence that performance targets for physical health checks must be met. This reflects an important distinction between measurement and action. While performance frameworks have increasingly incorporated indicators for SMI physical health checks, evidence suggests that these targets are not always achieved in practice, and where they are achieved, the quality and consistency of checks may vary.

NHS England has emphasised the need for improved data collection and monitoring as part of efforts to reduce health inequalities, including ensuring that key indicators—such as physical health checks—are consistently recorded and acted upon⁵⁵. However, the presence of data alone does not guarantee improvement; it must be linked to accountability and quality assurance processes.

The Oxfordshire performance data submitted to this Committee for this item, which highlights gaps in meeting national standards, illustrates this challenge. It suggests that while systems may have the infrastructure to measure performance, additional effort is required to translate this into reliable delivery at scale.

This raises a broader point about performance targets being more effective if they are embedded within a wider system of clinical governance, workforce capacity and integrated delivery. Without this, there is a risk that targets are either unmet or met in ways that prioritise compliance over quality.

Improved physical health outcomes for people with SMI can be achieved by taking a proactive, integrated approach. This can include:

- shared care models between primary care and mental health services,

⁵⁵ <https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref>

- dedicated physical health clinics within community mental health teams, and
- targeted outreach to individuals at highest risk.

The success of any of these approaches would lie in their ability to align performance targets with clinical practice, ensuring that checks are not only completed, but are meaningful and lead to intervention.

The Oxfordshire system, with its emphasis on neighbourhood-based care and integrated working—as described in the HOSC report—is well positioned to build on these models. However, the Committee’s recommendation highlights that this will require sustained focus, clear accountability and collaboration across system partners.

The recommendation that physical health check targets for people with mental illness must be met—and that these checks should be timely, regular and inclusive of long-term conditions—is both necessary and justified. It reflects a recognition that improving mental health outcomes cannot be achieved in isolation from physical health, and that the current system continues to underserve a population with significant and complex needs.

By emphasising regular monitoring, integration with long-term condition management and accountability for performance, the Committee is advocating for a shift from reactive, fragmented care to proactive, coordinated support. This aligns with both national policy and academic evidence, which consistently demonstrate that better physical health care for people with mental illness leads to improved outcomes, reduced inequalities and greater system sustainability. Ultimately, the recommendation underscores a fundamental principle: that parity of esteem between mental and physical health must be delivered in practice, not just policy—and that doing so requires both robust performance management and meaningful clinical engagement.

Recommendation 6: *For any performance targets for access to physical health checks for mentally ill patients to be met. It is recommended that there are timely and regular physical health checks for those with comorbidities, and to also include a check-up of their long-term conditions.*

For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a community mental health centre in every community; and for mental health investment to be placed on a statutory footing: The Oxfordshire Joint Health Overview and Scrutiny Committee’s recommendation that system partners collaboratively call for a strengthened national framework—encompassing a clear strategy for neighbourhood mental health centres, statutory investment, expanded use of pooled budgets, multi-year funding for the voluntary sector, and timely delivery of the Modern Service Framework—reflects a sophisticated understanding of the structural constraints currently limiting progress in adult and older adult mental health services. This recommendation is grounded in the

evidence emerging from the report and Annex 1 submitted to the Committee for this item, which collectively illustrate that while local systems are innovating and improving performance in areas such as community access and crisis response, their ability to transform services at scale remains constrained by national policy, funding instability, and fragmented commissioning arrangements.

At the centre of the recommendation is the call for a clear national strategy to enable delivery of a community mental health centre in every community. This aligns directly with the strategic direction of NHS reform, which emphasises a shift from hospital-based care to localised, community provision. Integrated Care Systems (ICSs) were explicitly designed to support this transformation, with the aim of improving outcomes and tackling inequalities through place-based, collaborative working⁵⁶.

However, academic and policy analysis suggests that delivering this vision requires more than structural reform; it requires clarity of national direction and sustained investment. The Health Foundation has highlighted that while ICSs aim to shift care into communities and improve prevention, their success is dependent on consistent policy support and alignment between national ambitions and local delivery mechanisms⁵⁷.

The report submitted to the Committee reflects this tension. It describes a system that is increasingly focused on community-based provision—through neighbourhood teams, crisis alternatives, and voluntary sector partnerships—but also highlights ongoing pressures on inpatient capacity, workforce, and funding. These pressures limit the extent to which local partners can fully realise the ambition of a comprehensive, community-based mental health system. The Committee's recommendation therefore recognises that without a clear national framework—defining expectations, funding, and delivery models—local systems will continue to develop unevenly.

The call for mental health investment to be placed on a statutory footing responds to a longstanding concern about the variability and fragility of mental health funding. Although recent years have seen increased investment in mental health services, this funding has often been subject to competing pressures and short-term planning cycles.

National evidence demonstrates that demand for mental health services continues to grow, with an estimated one in five adults affected by common mental health conditions and rising levels of unmet need⁵⁸. These pressures are reflected locally in Oxfordshire, where Annex 1

⁵⁶ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained>

⁵⁷ https://www.health.org.uk/sites/default/files/upload/publications/2026/ICS%20report_Final.pdf

⁵⁸ <https://www.gov.uk/government/news/key-target-hit-with-8500-extra-mental-health-workers-in-the-nhs>

highlights consistently high demand across community and urgent care pathways.

The absence of statutory protection for mental health funding creates a risk that investment is diluted or redirected in response to immediate system pressures. In contrast, placing investment on a statutory footing would provide greater certainty and accountability, enabling long-term planning and sustained service development. This is particularly important for community mental health transformation, which requires upfront investment in workforce, estates and infrastructure before benefits are realised.

Moreover, a further key element of the recommendation is the expansion of Section 75 (s75) agreements and other mechanisms for pooled budgets. These arrangements allow NHS bodies and local authorities to combine resources and share responsibility for commissioning and delivering services. In practice, they are one of the most effective tools for enabling integrated, person-centred care.

The importance of such arrangements is well supported by both policy and research. Integrated care models are based on the principle that collaboration across organisational boundaries is essential to addressing complex needs and delivering better outcomes⁵⁹. However, integration is frequently undermined by fragmented funding streams and misaligned incentives. The report submitted to the JHOSC illustrates this challenge, particularly in areas such as discharge planning, housing and community support, where responsibilities span health, social care and the voluntary sector. The persistence of issues such as delayed discharges and out-of-area placements reflects structural barriers that cannot be resolved within single organisational budgets. Expanding pooled budgets through s75 agreements would help to align incentives, enable joint decision-making, and support shared ownership of outcomes. Evidence from integrated care case studies demonstrates that such arrangements can improve coordination, reduce duplication, and support more effective use of resources⁶⁰.

Furthermore, the recommendation's emphasis on multi-year funding for the voluntary sector reflects another critical constraint within the current system. Voluntary, community and social enterprise (VCSE) organisations play a central role in mental health provision, particularly in areas such as crisis prevention, peer support, and community engagement. The report submitted for this item highlights this contribution, noting the involvement of organisations such as Mind and Restore in delivering key services. However, despite their importance, many VCSE organisations operate on short-term contracts, often renewed annually or even more frequently. This creates instability, limits workforce development, and restricts the ability to invest in long-term

⁵⁹ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained>

⁶⁰ <https://www.england.nhs.uk/integratedcare/resources/case-studies/integrated-care-in-action-health-inequalities>

service improvement. Research on integrated care systems has identified this as a key barrier to effective collaboration, with voluntary sector partners often lacking the financial security needed to participate fully in system transformation⁶¹.

Multi-year funding arrangements would address this issue by providing stability and enabling organisations to plan, invest and innovate. This would not only strengthen the voluntary sector itself, but also enhance the overall resilience and responsiveness of the mental health system.

Finally, the recommendation being issued by the JHOSC also calls for clear and timely arrangements for delivering the Modern Service Framework for mental health. While national frameworks provide important direction, their impact depends on effective implementation at local level. Delays, ambiguity or lack of alignment between policy and practice can undermine progress and create uncertainty among system partners. The Oxfordshire evidence suggests that local systems are ready to engage with these reforms, but require clearer timelines, expectations and support. This is consistent with broader findings that policy implementation in complex systems is often hindered by gaps between national ambition and local capacity. Academic research on care coordination underscores the importance of clear roles, shared objectives and effective communication in delivering system-wide change⁶². In the absence of these, even well-designed frameworks can fail to achieve their intended outcomes.

In essence, this recommendation represents a strategic and forward-looking response to the challenges identified within both local and national evidence. It recognises that while local systems such as Oxfordshire are making progress in transforming mental health services, their ability to deliver at scale is constrained by factors that lie beyond their direct control.

This JHOSC recommendation is also supported by the findings and recommendations of the detailed inquiry and report of the Parliamentary Health and Care Committee's into Community Mental Health. The Committee welcomed the emphasis that the Government has placed on the potential for community based mental health centres model and the £472 million funding for mental health services and new guidance on a 'named worker', but has expressed disappointment that their recommendations for the extension of pilots (that had shown emerging evidence of reductions in A and E, crisis and need for inpatients); putting the Mental Health Investment Standard on a statutory footing; and expanding the use of s75 arrangements across the NHS and local authorities were not accepted. The Committee also sought clarity on accountability arrangements for the Modern Service Framework for Mental Health that would be the main vehicle for decisions on further

⁶¹ <https://www.mentalhealth.org.uk/our-work/policy-and-advocacy/planning-prevention-unlocking-potential-integrated-care-systems-create-mentally-healthy-society>

⁶² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247357>

recommendations such as waiting time standards. The workforce that would be needed to implement the ten year plan would need specific detail in the ten year Workforce plan on staff working in community mental health services and key professional groups such as mental health social workers.

By calling for a clear national strategy, statutory investment, expanded pooled budgets, multi-year funding for the voluntary sector, and effective implementation of national frameworks, the Committee is advocating for the structural changes needed to enable sustained, system-wide improvement. These measures are not merely desirable; they are essential for delivering a mental health system that is integrated, equitable and capable of meeting the needs of a growing and increasingly complex population. In doing so, the recommendation reflects a broader understanding that meaningful transformation in mental health care requires alignment between national policy and local delivery—and that collaboration across system partners must be supported by equally robust and coherent national frameworks.

Recommendation 7: *For collaboration amongst system partners to call for a clear national strategy to enable local systems to deliver a co-produced community mental health centre in every community; for mental health investment to be placed on a statutory footing; and for there to be support for expansion of s75 agreements for pooled budgets or other clear mechanisms and levers for the local integration and shared ownership needed. It is recommended that local system partners call for national support to move to multi-year funding for commissioning of the voluntary sector, and that there be clear timely arrangements for the delivery of the Modern Service Framework for mental health.*

For collaboration among system partners to ensure that transitions from children's to adults mental health services are as smooth and supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions: The recommendation that system partners collaborate to ensure that transitions from children's to adult mental health services are as smooth, supportive and needs-led as possible reflects a critical and well-documented challenge within mental health systems. The transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) represents a key point of vulnerability in the care pathway, and one which has historically been associated with discontinuity, disengagement and worsening outcomes. The Committee's emphasis on collaboration and patient-centred care is therefore both necessary and strongly supported by local evidence, national policy direction and academic research.

Transitions from CAMHS to AMHS are not simply administrative processes; they involve a profound shift in how care is conceptualised and delivered. CAMHS services tend to be family-oriented, developmentally focused and supportive, whereas adult services are often more medically focused and expect higher levels of individual

autonomy. This divergence in service models creates structural challenges for young people moving between them.

The report submitted to the Committee highlights the development of programmes such as the 18–25 transitions pathway, reflecting recognition within the system that traditional transition arrangements are insufficient. This is consistent with national evidence, which shows that transition is frequently poorly managed and inadequately coordinated. A major study published in the *British Journal of Psychiatry* found that fewer than 5% of young people experienced an “optimal transition”, defined as involving planning, joint working, information transfer and continuity of care⁶³. This finding underscores the scale of the issue: most transitions are not only suboptimal, but actively detrimental to continuity of care.

The consequences of inadequate transitions are significant. Disruption of care during this period can lead to disengagement from services, deterioration in mental health, and increased reliance on crisis interventions. Research consistently shows that young people are at risk of being “lost in transition” due to poor communication, lack of planning and unclear accountability between services. A qualitative study of young people’s experiences found that transitions were often characterised by confusion, anxiety and insufficient support, with many participants reporting negative experiences both before and after transfer to adult services⁶⁴. Similarly, a study published in the *British Journal of General Practice* found that young people frequently experienced disjointed care and unmet needs, particularly when continuity between services was poorly managed⁶⁵. Additionally, these findings are reinforced by systematic reviews which demonstrate that transition is a high-risk period for disengagement and declining service use, with mental health service utilisation dropping sharply as young people age out of CAMHS⁶⁶. The implications for policy and practice are clear: failure to manage transitions effectively can undo the benefits of earlier intervention and create long-term risks for individuals and the system.

The Committee’s recommendation places collaboration at the centre of addressing these challenges. This reflects the reality that transitions span multiple services and organisational boundaries, including CAMHS, AMHS, primary care, social care, education and the voluntary sector. No single organisation can deliver effective transitions in isolation. National guidance from NHS England explicitly recognises this, stating that integrated care boards and providers must jointly develop transition models and ensure shared accountability for delivery across services⁶⁷. This guidance also emphasises that transition should be a planned and

⁶³ <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/process-outcome-and-experience-of-transition-from-child-to-adult-mental-healthcare-multiperspective-study/7E7201DFDB1C81F467B9C679080870A5>

⁶⁴ <https://www.tandfonline.com/doi/pdf/10.2989/17280583.2025.2533162>

⁶⁵ <https://bjgp.org/content/72/719/e413>

⁶⁶ <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/wps.20266>

⁶⁷ <https://www.england.nhs.uk/long-read/supporting-young-people-to-transition-into-adolescent-and-adult-services/>

coordinated process, involving preparation, transfer and ongoing support.

Academic research supports this approach, highlighting that effective mental health transitions require strong interprofessional collaboration, clear communication and shared responsibility between services⁶⁸. In the absence of such collaboration, fragmented care pathways and inconsistent communication are likely to persist, leading to poorer outcomes.

The Oxfordshire system's emphasis on partnership working—evident in its integration of NHS, local authority and voluntary sector services—provides a strong foundation for delivering these improvements. However, the Committee's recommendation indicates that further alignment and coordination are required to ensure consistent implementation.

Moreover, a defining feature of the recommendation is its emphasis on ensuring that patient need is at the heart of transition arrangements. This reflects a broader shift towards personalised, developmentally appropriate care, recognising that transitions occur during a critical life stage characterised by psychological, social and physical change. Research consistently shows that transitions are more successful when they are tailored to individual needs and actively involve the young person and their family. Evidence from co-produced transition programmes demonstrates that preparation, information sharing and emotional support can significantly improve outcomes and experiences⁶⁹. Similarly, NICE guidance highlights the importance of having a named worker to coordinate care during transition, providing a consistent point of contact and ensuring that support is aligned with individual needs⁷⁰. The Oxfordshire report's focus on ensuring continuity and integration across pathways aligns with these principles, but the Committee's recommendation makes explicit that this must be consistently applied across all transitions.

Across England, there is growing recognition of the need to reform transition pathways, with several systems developing innovative models to address the challenges identified above. These include:

- 0–25 service models, which remove the artificial boundary between CAMHS and AMHS and provide continuous support through adolescence into adulthood,
- joint clinics and multidisciplinary teams, enabling parallel care from both child and adult services during transition, and
- transition coordinators or key workers, ensuring continuity and personalised care.

⁶⁸ <https://pmc.ncbi.nlm.nih.gov/articles/PMC8976965>

⁶⁹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC5397792>

⁷⁰ <https://www.nice.org.uk/guidance/qs140/chapter/Quality-statement-4-Named-worker>

The Royal College of Psychiatrists has advocated for such approaches, emphasising the need for flexible age boundaries, integrated workforce models and improved coordination across services to deliver better outcomes for young people⁷¹. These models provide practical examples of how the Committee's recommendation can be implemented at a system level.

The recent Parliamentary inquiry into Community mental health found that nationally, there were severe gaps with a 'cliff-edge' for young people. The Government accepted the Health and Social Care Committees recommendation that an 18th birthday should not act as an artificial cut-off of care. The Committee's scrutiny of Children's mental wellbeing and services found that in Oxfordshire, action had been taken to make additional appointments available to children coming up to their 18th birthday and the Committee strongly supports this priority to support smooth transitions.

Therefore, this recommendation being issued by the JHOSC is both timely and well-founded. It reflects a clear understanding that transitions between children's and adult mental health services are a critical point in the care pathway, where poor coordination can lead to disengagement and worsening outcomes. By emphasising collaboration among system partners and the centrality of patient need, the Committee is advocating for a more integrated, person-centred approach to transition.

The evidence from both the Oxfordshire system and the wider literature indicates that effective transitions require:

- coordinated planning and communication across services,
- involvement of patients and families in decision-making,
- continuity of care and consistent relationships with professionals, and
- flexible, developmentally appropriate service models.

Without these elements, the risk remains that young people will continue to experience fragmented care and fall through gaps in the system. With them, transitions can become an opportunity to strengthen engagement, improve outcomes and support long-term recovery. In this context, the recommendation does not simply address a specific operational issue; it articulates a broader principle: that mental health services must be designed around the lived experience and developmental needs of individuals, and that collaboration is essential to delivering this vision in practice.

Recommendation 8: *For collaboration among system partners to ensure that transitions from children's to adults mental health services are as smooth and*

⁷¹ https://www.rcpsych.ac.uk/docs/default-source/members/faculties/child-and-adolescent-psychiatry/child-and-adolescent-psychiatry-faculty-delivering-better-outcomes-for-children-and-young-adults.pdf?sfvrsn=2041138f_5

supportive as possible, with a view to ensure that patient need is at the heart of any support provided in the context of transitions.

Legal Implications

16. 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.
17. 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'.
18. 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.
19. 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 Gareth Epps
 - Councillor Emma Garnett
 - Councillor Imade Edosomwan
 - District Councillor Katharine Keats-Rohan
 - District Councillor Elizabeth Poskitt
 - District Councillor Val Shaw
 - City Councillor Louise Upton
 - Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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June 2026

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

Development of the All-Age Autism Strategy for Oxfordshire

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

Report to:

- Karen Fuller (Director of Adult Social Care, Oxfordshire County Council).
- Ian Bottomley (Deputy Director, Integrated Commissioning).
- Bhavna Taank (Head of Joint Commissioning [Life Course] – Live Well)
- Dan Leveson (Director for Places and Communities- Thames Valley ICB).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on the development of an All-Age Autism Strategy for Oxfordshire in its public meeting on 16 April 2026.
2. The Committee would like to thank Karen Fuller (Director of Adult Social Care, Oxfordshire County Council); Bhavna Taank (Head of Joint Commissioning [Life Course] – Live Well); Matthew Tait (Executive Delivery Officer, Thames Valley Integrated Care Board); and Dee Nic Sitric (Chief Executive– Autism Champions, and Expert by Experience) for attending the meeting and answering questions from the Committee.
3. The topic of Autism and the services available to support autistic residents for all ages is of significant interest and concern to the JHOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by Oxfordshire's system partners to address some of the challenges that residents with autism can experience, both as a result of the challenges associated with autism as well as in relation to the services/support available.
4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:
 - The extent to which this is a system-wide strategy, and whether there is clarity on the role of each system partner in delivering its aims and objectives.
 - How the strategy was developed to ensure inclusion of all key stakeholders and seldom heard voices.
 - How the strategy aims to improve access and support through school, Further Education, and employment.
 - How the strategy will support appropriate, timely support across the lifespan.

- The extent to which community awareness raising and stigma reduction will be supported by the strategy.
- The degree to which people with autism will receive person-centred support (focusing on strengths, independence and quality of life and improved life expectancy).
- The relationship between epilepsy and autism.
- How the strategy identifies and supports care pathways for people with autism at risk of suicide.
- Details of any family and carer support that will be supported by the strategy including– navigation, respite, information, and early help.
- How autism services will become more accessible through helping to removing barriers, improving pathways, and simplifying navigation.
- How partners will track improvements in quality of life, access, employability, education, transitions, and early support.
- How delivery will be sequenced and resourced across Oxfordshire County Council, the NHS, schools, district councils, and community partners.
- Details for wait times for diagnosis and treatment (including support provided whilst families are on waiting lists).
- How the strategy will support other major strategies & programmes at place.
- Details of recruitment and retention for staff involved in providing services for autistic residents.

SUMMARY

5. During the 16 April 2026 meeting, the Director of Adult Social Care described the strategy as having been “on quite a journey” and stressed that, while it remained draft, it represented a significant shift in approach and language. The strategy had been co-produced across multiple organisations and that the drafting process had required repeated pauses, reflection and revision, particularly where language and framing risked reinforcing a deficit narrative.
6. The Chief Executive of Autism Champions and Expert by Experience provided a detailed account of lived experience and, critically, the lived experience of participating in co-production itself. She described co-production as a term that was frequently used but often misunderstood, and explained that meaningful co-production required autistic people and the autistic community to be involved from the beginning and throughout delivery, rather than being consulted at the end.
7. A significant part of the discussion focused on the difficulty of system engagement during the strategy’s development. The Chief Executive of Autism Champions and Expert by Experience explained that securing the right stakeholders “in a room” had been extremely difficult and described this as a recurring barrier, despite some successful engagement activity.
8. The Committee heard reflections on education. The Chief Executive of Autism Champions and Expert by Experience described education as feeling separate from health, social care and mental health even though Education, Health and Care Plans were inherently multi-system. The complexity created by differing

statutory responsibilities, including that education provision was the only statutory “surface” within Education, Health and Care Plans, despite the fact that many determinants of outcomes lay in health, social care and system integration.

9. The Director of Children’s Services reinforced the need to keep the strategy both accessible and deliverable. Strategies should not raise expectations with commitments that could not realistically be delivered, because failure to deliver would erode trust further. Work would continue to produce a children and young people’s version in a concise, accessible format, with young people supported to shape an appropriate version of the strategy and to place it within the local offer.
10. The Committee then moved into detailed scrutiny of governance and accountability. It was queried as to how much authority and “teeth” the Autism Improvement Board would have to hold partners to account if delivery stalled. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care responded that the Autism Improvement Board was co-chaired jointly with lived experience leadership and included representation from partner organisations and lived experience groups. Six implementation groups would sit beneath the Board, corresponding to six key areas within the strategy, and that each group would report up with outcome measures and Key Performance Indicators (KPIs). Where delivery was not occurring, the Board chairs would have the ability to contact relevant organisations, pursue resolution, and escalate. Escalation routes existed through wider system governance, including relevant ICB boards, joint commissioning executive arrangements and place-based partnership structures where system partners were present.
11. The Committee examined financial modelling and asked when financial modelling would be completed, what budgets and partner organisations would be in scope, and how affordability would be assured before final approval. The Head of Joint Commissioning – Live Well – Housing, Education and Social Care explained that much of the intended improvement should be cost-neutral, rooted in changes to practice, communication, training and pathway working rather than new-funded provision. However, implementation planning could surface areas of genuine cost, and that financial modelling would then consider existing budgets within pooled arrangements, local authority and ICB resources and other sector contributions, with the potential to divert existing funding and seek grant funding where appropriate. Officers emphasised that the system had no additional overall money and that affordability would therefore depend on realistic scoping and prioritisation of what could be delivered.

KEY POINTS OF OBSERVATION:

12. This section highlights five key observations and points that the Committee has in relation to the development of the All-Age Autism strategy for Oxfordshire. These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including how partner organisations are held to account for delivery of agreed actions: The recommendation being made by the JHOSC—that the role, authority and escalation mechanisms of the Autism Improvement Board should be clearly articulated in the final All-Age Autism Strategy and/or its implementation plan—reflects a fundamental principle of effective governance in complex, multi-agency systems. At its core, the recommendation recognises that the success of any system-wide strategy is not determined solely by the clarity of its vision or the ambition of its priorities, but by the robustness of the governance structures that translate those ambitions into coordinated, accountable and deliverable action.

The draft Oxfordshire All-Age Autism Strategy explicitly positions the Autism Improvement Board as the central oversight mechanism responsible for driving implementation across a wide array of partners, including local authority services, NHS organisations, education providers, and the voluntary and community sector. However, while the strategy sets out the existence of this Board and describes its collaborative ethos, it is less explicit about the formal mechanisms through which accountability will be exercised, performance managed, and risks escalated. This gap is precisely what the JHOSC recommendation seeks to address.

From the perspective of public administration and governance theory, this recommendation is well-founded. Accountability is widely recognised in the academic literature as a cornerstone of effective public sector governance, ensuring that organisations entrusted with public resources are “answerable to the public” and subject to mechanisms that require them to justify performance and outcomes¹. Similarly, research in public administration emphasises that accountability is multifaceted—encompassing vertical accountability (to elected bodies and scrutiny), horizontal accountability (between organisations), and social accountability (to service users and communities)². In the context of an all-age autism strategy, all three forms are relevant: the Autism Improvement Board must coordinate partners (horizontal accountability), report into formal governance structures such as the Health and Wellbeing Board (vertical accountability), and remain responsive to autistic people and their families (social accountability).

The need for clearly defined governance structures is even more acute in integrated health and care systems. The Health and Care Act 2022 established Integrated Care Systems (ICSs) precisely to bring together disparate organisations to plan and deliver services collaboratively.

¹ <https://www.europeanproceedings.com/article/10.15405/epsbs.2023.11.77>

² <https://journals.sagepub.com/doi/pdf/10.1177/00208523231211751>

However, the parliamentary Health and Social Care Committee has observed that such partnership arrangements create inherent risks of blurred accountability if roles and responsibilities are not clearly articulated³. In this context, the JHOSC recommendation aligns closely with national policy expectations: without clear lines of responsibility and oversight, “patients risk falling through the cracks of a system that is already under pressure”⁴.

The Oxfordshire strategy reflects many of the characteristics of a mature ICS-aligned approach: it is system-wide, co-produced, and reliant on shared delivery across organisational boundaries. However, the very features that make it ambitious also create risks. The strategy includes commitments relating to diagnostic waiting times, workforce capability, reasonable adjustments, transitions, housing, and employment—areas that span multiple organisations with different statutory duties and funding streams. Without explicit clarity on “who is accountable for what,” there is a well-documented risk that responsibility becomes diffused, leading to delays, inconsistent delivery, or failure to act.

The importance of defined escalation mechanisms is particularly significant. In healthcare governance literature, escalation pathways are identified as a critical component of effective oversight, ensuring that risks and under-performance are not only identified but acted upon in a timely way⁵. In practice, this means that governance bodies must not only receive performance information, but also have agreed processes for responding when progress is insufficient—whether through targeted support, intervention, or escalation to higher-level decision-making bodies. The NHS Oversight Framework, for example, is predicated on a “consistent and transparent approach to assessing performance” and taking “quick action” where organisations are not delivering⁶. Translating this principle into the local autism context reinforces the need for a clear escalation framework within the Autism Improvement Board’s remit.

Evidence from other local authority areas further illustrates the importance of robust governance arrangements in autism strategies. In Gateshead, for example, delivery of the local autism strategy is explicitly overseen by a multi-agency autism board that reports into the Health and Wellbeing Board, with governance identified as a central component of implementation⁷. Similarly, the London Borough of Bromley has established an All-Age Autism Board which brings together senior leaders, professionals, and people with lived experience to influence

³ <https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/587/report.html>

⁴ <https://mtg.org.uk/wp-content/uploads/2025/12/Rebuilding-Accountability-in-the-NHS-A-Review-of-ICB-Leadership-Innovation-and-Patient-Outcomes.pdf>

⁵ <https://impact-guru.co.uk/blogs/news/governance-structures-and-accountability-in-autism-services>

⁶ <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/>

⁷ <https://democracy.gateshead.gov.uk/documents/s43016/Autism%20Strategy-%20Health%20and%20Wellbeing%20Board.pdf>

service change, with an emphasis on ensuring that the Board is not merely advisory but has real impact on decision-making⁸. These examples demonstrate that where governance structures are clearly articulated and empowered, they can act as effective vehicles for system-wide improvement; conversely, where governance is ambiguous, strategies risk becoming aspirational rather than operational.

This recommendation being made by the JHOSC also reflects wider principles of good governance identified in health care and public sector literature. Effective governance frameworks are characterised by clarity of roles, defined decision-making authority, transparency in reporting, and mechanisms for assurance and review⁹. These principles are directly relevant to the Autism Improvement Board. For example, clarity of roles ensures that no aspect of the strategy is left without a responsible owner; transparency in reporting enables scrutiny bodies, such as the JHOSC, to assess progress; and defined assurance mechanisms ensure that the Health and Wellbeing Board can fulfil its statutory role in overseeing the health and wellbeing strategy for the area¹⁰.

Crucially, the recommendation is not simply a technical request for governance detail; it is a substantive intervention aimed at safeguarding delivery, accountability and public confidence. Autism strategies, by their nature, seek to address entrenched inequalities, fragmented services, and long-standing gaps in provision. These challenges are complex and cross-cutting, and they require sustained, coordinated action over time. Without a governance framework that specifies how partners will be held to account, how progress will be monitored, and how issues will be escalated, there is a significant risk that these systemic challenges will persist despite the presence of a well-articulated strategy.

The emphasis on reporting to the Health and Wellbeing Board and sharing assurance with scrutiny is also particularly significant. Health and Wellbeing Boards are intended to provide strategic oversight and ensure alignment across local priorities, while scrutiny committees play a critical role in holding the system to account on behalf of the public. By recommending that assurance mechanisms are clearly defined, the JHOSC is reinforcing the importance of maintaining democratic oversight within a system that increasingly relies on partnership governance rather than hierarchical control.

Thus, the recommendation being issued by the JHOSC is both proportionate and necessary. It reflects established principles of public sector governance, aligns with national policy expectations for integrated care systems, and responds directly to the risks inherent in delivering a

⁸ <https://www.local.gov.uk/case-studies/london-borough-bromley-all-age-autism-board>

⁹ <https://academic.oup.com/intqhc/article/35/3/mzad046/7210365>

¹⁰ <https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance>

complex, multi-agency autism strategy. By seeking clarity on accountability, escalation and assurance, the Committee is not merely requesting additional detail; it is strengthening the conditions for the strategy's successful implementation. In doing so, it ensures that the ambition of the All-Age Autism Strategy is matched by a governance framework capable of delivering meaningful, measurable change for autistic people and their families across Oxfordshire.

Recommendation 1: *That the role, authority and escalation mechanisms of the Autism Improvement Board are clearly articulated in the final strategy and/or implementation plan, including: how partner organisations are held to account for delivery of agreed actions; how under performance or delay will be escalated; and how assurance will be reported to the Health and Wellbeing Board and shared with scrutiny.*

That co-production principles are explicitly embedded in delivery, not only strategy development, including a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities: The Oxfordshire JHOSC recommendation that co-production principles must be explicitly embedded in delivery, not only in strategy development—goes to the heart of whether the all-age autism strategy becomes a living programme of change or remains a well-intentioned statement of ambition. The draft strategy repeatedly frames itself as a partnership strategy and states that it has been co-produced with autistic people, with experts by experience continuing to shape, guide and influence the work going forward. The accompanying report submitted to the Committee similarly emphasises that co-production has been central to development through consultations, countywide events, and ongoing working groups, and it highlights that the Autism Improvement Board includes autistic people and experts by experience.

Yet the point of scrutiny is not simply to recognise that co-production occurred during drafting; it is to ensure that co-production is not “front-loaded” and then diluted when difficult decisions arise—particularly decisions about prioritisation, sequencing, resource trade-offs, and accountability for implementation. That is why the recommendation appropriately focuses on embedding co-production in the implementation plan, and on specifying exactly how lived experience feedback will influence commissioning, service redesign, and system decisions.

A substantial body of evidence in public service research supports the Committee's concern. Co-production is not merely consultation; it is a model of service planning and delivery in which professionals and citizens share power and responsibility, producing better-fitting services and mobilising knowledge and resources that organisations cannot generate alone. In a widely cited framework, co-production is understood as shifting relationships from one-way service delivery towards

negotiated, reciprocal arrangements in which service users and communities are not passive recipients but active contributors to outcomes. Systematic reviews of co-creation and co-production in public services reinforce that the conditions of co-production (including clarity of roles, resourcing, and genuine influence on decisions) matter as much as the aspiration to collaborate; without these, “co-production” risks becoming a label applied to practices that do not redistribute influence.

The draft strategy itself implicitly highlights why co-production must extend into delivery. It explains that each of the six priority areas will be accompanied by an action plan structured around broad “We will” commitments and that the governance structure includes an Autism Improvement Board and task-and-finish groups. Notably, it also states that the “We will” statements may appear broad, intentionally covering multiple actions, with the action plan providing the granularity. If the detailed action plan is where prioritisation and sequencing decisions will be made, then it is at precisely that point—where commitments are translated into deliverables, timelines, and owner organisations—that autistic people and experts by experience must have a clear, protected role. Otherwise, co-production is confined to the less contentious phase (drafting principles and vision) and excluded from the phase where power is exercised (deciding what happens first, what is funded, what is deprioritised, and what constitutes “progress”).

The Committee’s emphasis on involving autistic people “of all ages” and experts by experience “from the entire community” is also justified by the strategy’s Equality Impact Assessment (EIA) that was also submitted to the JHOSC. The Strategy’s EIA explicitly recognises risks that stakeholders may not feel thoroughly included, and it notes barriers to engagement and access (including limited internet access and language barriers), with mitigations such as detailed stakeholder mapping and alternative formats. This matters because co-production that relies only on established organisations or those already “in the room” can inadvertently reproduce inequality—over-representing people with time, confidence, digital access, and existing connections, while under-representing people in rural communities, deprived areas, people from minoritised ethnic communities, and autistic people who are undiagnosed or less connected to services. The EIA’s acknowledgment of these risks reinforces the Committee’s call for delivery-phase co-production to be explicitly designed to reach beyond the most visible stakeholders, ensuring that the “experts by experience” function is not limited to a narrow subset of the autistic community.

National guidance also supports making co-production a delivery requirement rather than an optional ethos. NHS England defines co-production as an equal partnership with people and communities from the earliest stages of service design through development and evaluation, and it situates co-production as distinct from informing, consulting, or engaging. This is important because it anchors the expectation that co-production should run “from start to finish,” not stop

at publication of a strategy¹¹. Likewise, NHS England's operational guidance on all-age autism assessment pathways sets out principles for pathway design and specifically includes the expectation that services are "co-designed by clinicians and people who access the services," reinforcing that lived experience involvement is integral to commissioning and evaluation, not a discretionary add-on. When local systems in England are being asked nationally to reduce variation and inequality in autism pathways, Oxfordshire's approach to embedding lived experience influence into delivery becomes a matter of both quality and equity, not simply good practice¹².

This JHOSC recommendation is also supported by practice examples from other areas that have sought to formalise how lived experience influences delivery decisions. A particularly relevant example is the London Borough of Bromley: All-Age Autism Board case study, which describes a governance arrangement that brings together autistic individuals, parent/carer representatives, the voluntary sector, and local authority professionals to influence change, and emphasises creating a board that is not merely "top-down" but structured to grow autistic community voice¹³. Bromley's own local offer page further explains that priorities were chosen through feedback and that an action plan is reviewed through board arrangements, with engagement opportunities open to people without requiring a formal diagnosis—an explicit attempt to widen "experts by experience" participation beyond organisational representation¹⁴. The Improving support for children with autism and their families using a 100 day challenge framework article also illustrates how structured collaboration with families can shift local systems from repeated discussion of problems to action-oriented change, highlighting the role of parent participation in shaping interventions¹⁵. These examples do not provide a one-size-fits-all template for Oxfordshire, but they demonstrate a shared lesson: co-production is most resilient when it is built into delivery machinery—boards, action plans, review cycles, and open engagement routes—rather than treated as a completed stage of drafting.

A central feature of the JHOSC recommendation is its insistence on clarity about how lived experience will influence commissioning and service redesign. That emphasis is well-founded because commissioning decisions determine what is funded, what is specified in contracts, what is measured, and what incentives shape provider behaviour. Oxfordshire's all-age autism strategy includes commitments that touch multiple commissioning domains—education, health and care, housing, employment, and criminal justice—each with distinct decision forums and resource constraints. Without explicit routes for lived experience input into commissioning cycles, co-production risks being

¹¹ [\[england.nhs.uk\]](https://www.england.nhs.uk)

¹² [\[thinklocal...nal.org.uk\]](https://thinklocal...nal.org.uk) [\[england.nhs.uk\]](https://www.england.nhs.uk), [\[nice.org.uk\]](https://www.nice.org.uk)

¹³ [Local Government Association case study](#).

¹⁴ [Bromley Council overview of the BAAB and engagement](#)

¹⁵ [BMJ opinion piece](#)

confined to narrative feedback rather than becoming a decision-shaping force. The co-production evidence base in social care is particularly clear that co-production must be more than “a change in words”; it requires organisational culture, structure and practice changes, and it warns that if co-production is not clearly defined and resourced, its meaning is diluted and its transformative potential reduced¹⁶. The same literature distinguishes between descriptive, compliance-focused approaches to co-production and more transformative models that redistribute power and shape service priorities—directly relevant to the Committee’s insistence on co-production in the implementation plan’s sequencing and review.

Finally, this recommendation’s focus on review and progress monitoring reflects a practical truth about autism strategies: implementation takes place in a changing landscape of demand pressures, workforce constraints and interdependent programmes. The Oxfordshire report notes that the implementation plan is still being developed and will be taken forward through partnership structures, which means the most consequential decisions are still to come. Co-production embedded into delivery creates a disciplined feedback loop: lived experience informs what “good” looks like, influences how actions are prioritised, and then tests whether changes are actually experienced on the ground. This aligns with NIHR guidance on co-production, which stresses the importance of shared power, joint ownership of key decisions, and continuous reflection throughout a programme—not only at the outset¹⁷. It also aligns with the NHS England framing that co-production is an “equal partnership” from design through evaluation, guarding against tokenism and ensuring decisions remain person-centred¹⁸.

In summary, this JHOSC recommendation targets the precise point at which co-production too often fails: the transition from writing a strategy to delivering it. Oxfordshire’s documents already declare a commitment to co-production and recognise inclusion risks, but scrutiny is right to require explicit delivery-phase mechanisms that ensure autistic people of all ages—alongside a genuinely representative range of experts by experience—shape priorities, sequence actions, and review progress, with clear routes for their feedback to influence commissioning and system decisions. The academic literature, national guidance, and practical examples from other areas converge on the same conclusion: co-production produces its greatest value when it is operationalised as shared decision-making over time, rather than treated as a one-off consultation exercise¹⁹.

Recommendation 2: *That co production principles are explicitly embedded in delivery, not only strategy development, including: a clear role for autistic people (of all ages) and experts by experience (from the entire community) in shaping priorities,*

¹⁶ [SCIE guide on co-production in social care](#)

¹⁷ [NIHR guidance on co-producing a project](#)

¹⁸ [\[england.nhs.uk\]](#)

¹⁹ [\[local.gov.uk\]](#), [\[livingautism.com\]](#)

sequencing actions and reviewing progress within the implementation plan; and clarity on how lived experience feedback will directly influence commissioning, service redesign and system decisions.

That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope: The recommendation made by the Committee—that financial modelling for the All-Age Autism Strategy should be developed as far as possible, including clarity on budgets, funding sources, partner contributions, and the balance between new investment and reconfiguration—addresses one of the most critical determinants of whether the strategy will achieve its intended outcomes. While the draft strategy document presented to the Committee sets out a clear and ambitious vision, it also explicitly acknowledges that the financial implications of delivery have not yet been fully modelled, and that further work is required to establish affordability and sustainability. This acknowledgement is important, but it also exposes a material risk: without robust financial planning, the strategy may struggle to move from ambition to implementation.

The strategy itself identifies a wide range of system-wide changes, including reducing diagnostic waiting times, strengthening education and transitions, improving workforce capability, and expanding support in housing and employment. These commitments are inherently resource-dependent. They span multiple organisational boundaries and funding streams—local authority, NHS, voluntary sector and community provision—each subject to different budgetary pressures and governance frameworks. In this context, the JHOSC recommendation is not procedural; it is fundamental to ensuring that the strategy is deliverable within the real constraints of the Oxfordshire system.

Public sector and healthcare governance literature strongly supports the Committee's position. Evidence consistently shows that effective strategy implementation depends on alignment between strategic goals, resource allocation, and financial planning. NHS England's commissioning framework emphasises that integrated care systems must align long-term strategies with resource allocation and continuous evaluation of outcomes, ensuring that plans are grounded in affordability and value for money²⁰. Similarly, the NHS Oversight Framework highlights the expectation that systems operate within financial constraints and establish clear mechanisms for assessing performance and sustainability, with rapid intervention where delivery is not viable²¹. These national expectations reinforce the principle that strategic ambition must be accompanied by a credible financial model.

²⁰ <https://www.openaccessgovernment.org/nhs-england-launches-strategic-commissioning-framework-for-integrated-care-boards/201060>

²¹ <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26>

At a theoretical level, this aligns with broader public administration research, which identifies financial sustainability and accountability as core principles of good governance. Studies of public sector accountability emphasise that organisations must be able to demonstrate how public resources are allocated and used to achieve defined outcomes, and that such transparency underpins trust, effectiveness and long-term system stability²². In complex, multi-agency systems such as integrated care partnerships, this becomes even more critical: without a shared financial understanding, organisations may pursue individual priorities that undermine collective delivery.

The Oxfordshire context further underlines the need for clarity. The main report submitted to the Committee explicitly references system pressures, fragmented services and growing demand, all of which create constraints on available resources. In such an environment, strategy delivery cannot rely on implicit assumptions about funding growth or capacity expansion. Instead, it must explicitly address the trade-offs between:

- investing in new services or interventions;
- reconfiguring or redeploying existing resources; and
- prioritising among competing demands.

This is precisely what the JHOSC recommendation seeks to achieve by requiring clarity on the balance between new investment and reconfiguration. Evidence from social care and health reform demonstrates that strategies which fail to articulate this balance risk becoming “aspirational documents” without a realistic pathway to delivery. The Social Care Institute for Excellence, for example, emphasises that transformation in care systems must consider the economics of co-production and service redesign, including how resources are redistributed rather than simply expanded²³.

Examples from other areas illustrate both the necessity and the benefits of financial clarity. In Gateshead, the All-Age Autism Strategy was explicitly supported by a governance framework in which delivery planning, including financial considerations, was overseen by a multi-agency autism board, ensuring that priorities were aligned with available resources and partner contributions²⁴. Similarly, in Nottinghamshire, the autism strategy is explicitly embedded within the Integrated Care System’s broader commissioning and planning framework, ensuring alignment between strategic priorities and system-level funding and accountability structures²⁵. These examples demonstrate that where financial planning is integrated into strategy development, implementation is more coherent and measurable.

²² <https://www.europeanproceedings.com/article/10.15405/epsbs.2023.11.77>

²³ <https://timebanking.org/wp-content/uploads/2020/05/Coproduction-in-Social-Care-Scie.pdf>

²⁴ <https://democracy.gateshead.gov.uk/documents/s43016/Autism%20Strategy-%20Health%20and%20Wellbeing%20Board.pdf>

²⁵ <https://www.nottinghamshire.gov.uk/policy-library/112571/all-age-autism-strategy-2022-2025>

The JHOSC recommendation also highlights the importance of identifying which partner organisations and funding pots are in scope. This is particularly important in integrated care systems, where funding is distributed across multiple organisations rather than held centrally. NHS England guidance emphasises that Integrated Care Boards and partners must take collective responsibility for delivery of system improvements and financial sustainability, rather than relying on individual organisations acting independently²⁶. Without clarity on which organisation is contributing what resource to each priority, there is a risk of duplication, gaps, or misalignment in delivery.

The Equality Impact Assessment (EIA) further strengthens the case for robust financial modelling. The EIA identifies a range of inequalities affecting autistic people, including barriers to access and variations in experience across different groups. Addressing these inequalities—whether through improved diagnostic pathways, culturally appropriate services, or targeted support—will require targeted resource allocation. Without financial modelling, there is a risk that equality objectives remain aspirational rather than embedded in delivery. National guidance similarly emphasises that resource allocation must be explicitly linked to reducing inequalities in outcomes and access²⁷.

Another key dimension of the recommendation is sustainability. The strategy is intended to operate over a multi-year period, and many of its ambitions—such as improving workforce capability or developing preventative pathways—require sustained investment rather than one-off funding. Healthcare governance literature stresses that short-term, project-based funding can undermine long-term outcomes, particularly in areas requiring cultural and system change²⁸. By requiring an assessment of affordability and sustainability, the JHOSC recommendation ensures that the strategy considers not only whether actions can be initiated, but whether they can be maintained over time.

Furthermore, financial modelling creates the conditions for effective performance management and scrutiny. A clear understanding of costs and funding allows the system to assess:

- whether investment is delivering expected outcomes;
- whether resources are being used efficiently; and
- whether adjustments are needed in response to changing demand or performance.

This aligns with the Committee's wider role in ensuring that recommendations are actionable, measurable and capable of scrutiny, rather than simply aspirational. It also supports transparency, enabling

²⁶ <https://www.england.nhs.uk/long-read/guidance-on-good-governance-and-collaboration>

²⁷ <https://www.england.nhs.uk/long-read/guidance-on-good-governance-and-collaboration>

²⁸ <https://academic.oup.com/intqhc/article/35/3/mzad046/7210365>

both the Health and Wellbeing Board and the public to understand how resources are being used to achieve outcomes for autistic people.

In conclusion, the draft Oxfordshire All-Age Autism Strategy sets out a comprehensive vision for improving the lives of autistic people across the county, but its success will depend on the extent to which that vision is underpinned by a realistic, clearly articulated financial framework. The evidence from national policy, academic literature, and practice in other areas all point to the same conclusion: without clear financial planning, accountability and sustainability, even the most well-designed strategies are unlikely to deliver meaningful change. By insisting on clarity around funding, resource allocation and affordability, the Committee is strengthening the foundations for delivery, ensuring that the strategy is not only ambitious but also achievable and sustainable in practice.

Recommendation 3: *That financial modelling for the All-Age Autism Strategy is developed as much as is possible, including: any budgets/funding pots and partner organisations in scope; the balance between new investment and reconfiguration of existing resources; and the affordability and sustainability of priority commitments.*

For a clear outcomes and performance framework to be developed:

The Committee's recommendation that a clear outcomes and performance framework be developed for the All-Age Autism Strategy reflects a critical principle of effective public service reform: that strategies must not only set direction, but must also establish how success will be defined, measured and scrutinised. In the absence of such a framework, there is a significant risk that even well-intentioned and co-produced strategies fail to deliver meaningful change for service users, particularly in complex, multi-agency systems such as autism services.

The reports submitted to the Committee clearly articulate a shared ambition to improve outcomes for autistic people across Oxfordshire, and they emphasise co-production, partnership working and system-wide transformation. The strategy identifies key areas for improvement, including diagnostic pathways, education and transitions, health and care access, and wider determinants such as employment and housing. However, while these priorities are clearly set out, the documentation provides limited detail on how delivery will be measured in practice, beyond broad commitments to monitoring progress and using data and lived experience to inform improvement. This creates a gap between strategic ambition and operational accountability—precisely the gap that the JHOSC recommendation seeks to address.

The need for a comprehensive outcomes framework is well-established in both policy and academic literature. Public administration research consistently emphasises that effective governance requires not only setting objectives but also establishing clear performance indicators and feedback loops, enabling organisations to assess whether interventions are achieving their intended impact. Without such mechanisms,

accountability becomes diffuse, and improvement efforts risk being driven by activity rather than outcomes. As noted in broader governance studies, accountability in the public sector depends on the ability of institutions to provide “regular updates on performance” and demonstrate how actions translate into outcomes for citizens²⁹.

This principle is particularly important in the context of autism services, where outcomes are often complex, longitudinal and highly individualised. National guidance reinforces the need for outcome-focused approaches. NHS England guidance on co-production and service design stresses that services should be developed and evaluated in partnership with people who use them, ensuring that measurement frameworks reflect real-world experiences and impacts, not just administrative outputs³⁰. This aligns directly with the Committee’s emphasis on including lived experience and qualitative outcomes, rather than relying solely on access metrics.

The specific components identified in the JHOSC recommendation—diagnostic waiting times, access to support while waiting, reasonable adjustments, transitions, and lived experience—are particularly appropriate given the evidence base on autism services. Diagnostic waiting times are a widely recognised system pressure, with national and local evidence indicating significant delays between referral and diagnosis. The report submitted to the JHOSC highlights long waits as a key issue affecting autistic people and their families. Measuring waiting times is therefore essential, but it is not sufficient in itself. As NHS policy increasingly recognises, the experience of waiting—the availability of support, information and interim interventions—is just as important as the duration of the wait. This justifies the inclusion of “access to support while waiting” as a distinct outcome measure.

Similarly, the Committee’s focus on reasonable adjustments across services reflects a growing body of evidence that autistic people often face systemic barriers in accessing healthcare and other services, even where those services are nominally available. NHS England’s operational guidance on autism pathways emphasises that services must be designed to be accessible and responsive, including through adjustments to communication, environments and processes³¹. Measuring whether such adjustments are consistently implemented is therefore critical to understanding whether the system is genuinely inclusive, rather than simply compliant at a formal level.

Furthermore, the inclusion of transitions as a key outcome area is also strongly supported by both the strategy and wider evidence. Transitions—from childhood to adulthood, from education to employment, or between services—are consistently identified as points

²⁹ <https://www.europeanproceedings.com/article/10.15405/epsbs.2023.11.77>

³⁰ <https://www.england.nhs.uk/always-events/co-production>

³¹ <https://www.england.nhs.uk/long-read/operational-guidance-to-deliver-improved-outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards>

of vulnerability for autistic people, often associated with discontinuity of support and poorer outcomes. NICE guidance on autism services highlights the importance of coordinated, multi-agency approaches to transitions and recommends that systems monitor how effectively transitions are managed across organisational boundaries³². Including transitions in the outcomes framework therefore ensures that the strategy addresses not only isolated service components, but also the integration between them.

The Committee's emphasis on lived experience and qualitative outcomes is particularly significant. Traditional performance frameworks in health and social care have often relied heavily on quantitative indicators such as activity levels, waiting times and throughput. While these metrics are important, they do not capture the quality or impact of services from the perspective of users. Academic literature on co-production and public service design highlights that user experience is an essential dimension of service quality, and that involving service users in defining and assessing outcomes leads to more responsive and effective services³³. This aligns closely with the Oxfordshire All-Age Autism strategy's commitment to using lived experience to drive improvement, but the JHOSC recommendation rightly insists that this commitment must be operationalised through the performance framework, rather than remaining an aspirational statement.

Moreover, examples from other areas reinforce the importance of embedding outcomes frameworks within autism strategies. In Nottinghamshire, for instance, the autism strategy is closely linked to the Joint Strategic Needs Assessment and broader system performance monitoring, ensuring that outcomes such as access, inequalities and service experience are tracked and reviewed at system level³⁴. Similarly, the Bromley All-Age Autism Board oversees delivery through a structured action plan, with priorities informed by lived experience and reviewed regularly through governance processes³⁵. These examples demonstrate that where outcomes are clearly defined and monitored, strategies are more likely to drive sustained and measurable improvement.

In addition, the Equality Impact Assessment (submitted to the JHOSC as Annex 2) further strengthens the case for a comprehensive outcomes framework. It identifies a range of inequalities affecting autistic people, including barriers to access and variation in experience across different groups. Addressing these inequalities requires not only targeted interventions but also the ability to measure differential outcomes across populations, ensuring that improvements are equitably distributed.

³² <https://www.nice.org.uk/guidance/qs51/resources/developing-a-multiagency-local-team-122806333>

³³ <https://www.seemescotland.org/media/7284/beyond-engagement-and-participation.pdf>

³⁴ <https://www.nottinghamshireinsight.org.uk/research-areas/jsna/adults-and-vulnerable-adults/autism-2025>

³⁵ <https://www.local.gov.uk/case-studies/london-borough-bromley-all-age-autism-board>

Without such measurement, there is a risk that overall performance appears to improve while inequalities persist or even widen.

Crucially, an outcomes framework also underpins effective scrutiny. For the JHOSC to fulfil its statutory role, it must be able to assess whether the strategy is delivering on its objectives and to challenge the system where it is not. This requires clear, agreed indicators and regular reporting, enabling the Committee to move beyond anecdotal evidence and engage in robust, evidence-based scrutiny. The recommendation therefore not only supports delivery but also strengthens democratic accountability.

In conclusion, the Oxfordshire All-Age Autism Strategy sets out a strong vision and a comprehensive set of priorities, but without a detailed framework for measuring progress and impact, there is a risk that these ambitions will not translate into meaningful change. By specifying key areas such as diagnostic waiting times, support while waiting, reasonable adjustments, transitions and lived experience, the Committee is ensuring that the strategy remains focused on the outcomes that matter most to autistic people and their families. Supported by national guidance, academic research, and examples from other areas, this recommendation strengthens the foundations for delivery, accountability and continuous improvement across the Oxfordshire system.

Recommendation 4: *For a clear outcomes and performance framework to be developed. It is recommended that any outcomes and performance frameworks include diagnostic waiting times and access to support while waiting; consistency and effectiveness of reasonable adjustments across services; experiences of transitions; and lived experience and qualitative outcomes, not solely access metrics.*

Developing a children's version of the autism strategy: The recommendation by the Committee—that system partners should work towards developing a children's version of the All-Age Autism Strategy—is rooted in a clear and well-established principle of public policy and service design: that policies must be accessible, meaningful and responsive to the people they affect, including children and young people. In the context of an all-age autism strategy, this is particularly significant, because autistic children and young people are not only recipients of services but also individuals with distinct experiences, needs, rights and perspectives that differ from those of adults.

The draft All-Age Autism Strategy is explicitly framed as a strategy for “everyone”, recognising that autistic people are present in all areas of community life and that inclusion is a shared responsibility. However, while the strategy includes commitments relating to education, transitions and young people's pathways, it is primarily written in a general, system-focused format, intended for professionals, commissioners and partner organisations. It does not currently function as a document that autistic children and young people themselves can easily access, understand or use to navigate services or hold the system

to account. The recommendation for a children's version therefore seeks to address a clear gap between the intended beneficiaries of the strategy and its accessibility to them.

This principle is strongly supported by national practice. The UK Government's National strategy for autistic children, young people and adults 2021 to 2026 includes an Easy Read version specifically designed to communicate the strategy in accessible language, explaining what the strategy means, what will happen, and how progress will be monitored³⁶. Such documents are not merely simplified summaries; they are a recognition that accessibility is a fundamental requirement of inclusive policy, especially in relation to autism, where communication differences are a central consideration. The same national strategy deliberately extends its scope to children and young people for the first time, reflecting the importance of ensuring that support is available "as early as possible and across their lifetime"³⁷. This reinforces the need for local strategies, such as Oxfordshire's, to ensure that children and young people can engage with and benefit from the strategy in their own right.

Across the UK, there are numerous examples of local areas producing child-friendly or easy-read versions of autism strategies, recognising that accessibility is a key component of effective delivery. For instance, North Yorkshire has produced an "easy read version" of its strategy for children and young people with autism, designed to ensure that children and families can understand the services available and how they will be supported³⁸. Similarly, Greater Manchester and Norfolk have developed simplified or accessible strategy documents to ensure broader understanding and engagement with planning and delivery priorities. These examples demonstrate that producing accessible or child-focused versions of strategies is not an optional enhancement but an established element of good practice in autism policy³⁹.

However, the justification for a children's version extends beyond accessibility alone. It is also grounded in the growing recognition that children and young people have a right to participate in decisions that affect their lives, including the design and evaluation of public services. The Local Government Association emphasises that councils have responsibilities under the United Nations Convention on the Rights of the Child (UNCRC) to ensure that children are able to express their views and that those views are taken seriously in policy development⁴⁰. Similarly, UK Government guidance on youth voice in policymaking states that policies affecting young people should incorporate their input

³⁶ <https://assets.publishing.service.gov.uk/media/60d2e20fe90e0743a210e00f/national-strategy-for-autistic-children-young-people-and-adults-easy-read.pdf>

³⁷ <https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026>

³⁸ https://cyps.northyorks.gov.uk/sites/default/files/SEND/Autism/Easy_Read_Autism_Strategy.pdf

³⁹ cyps.northyorks.gov.uk [autismgm.org.uk]

⁴⁰ <https://www.local.gov.uk/topics/children-and-young-people/engaging-young-people-policy-development>

“throughout the whole policy cycle,” from design through to implementation and evaluation⁴¹.

Academic literature reinforces this position. Research on children’s participation highlights that including children’s voices in policy leads to more accurate, nuanced and effective policy outcomes, as it grounds decision-making in lived experience rather than assumptions⁴². Studies in inclusive education similarly emphasise that learners’ voices are often marginalised in policy debates, despite being essential to understanding barriers and improving systems⁴³. In the field of autism specifically, participatory research approaches underline the importance of involving autistic individuals—including children—in shaping decisions about services, in order to reduce the disconnect between policy and lived experience⁴⁴.

A children’s version of the strategy is therefore not simply about simplifying language; it is about creating a platform through which children and young people can engage with, understand and influence the system that affects them. It can serve as a tool for:

- explaining what support they are entitled to receive;
- helping them and their families navigate services;
- enabling schools and professionals to communicate expectations clearly; and
- supporting accountability by making commitments visible and understandable.

The Equality Impact Assessment provides additional justification for this approach. It recognises the importance of inclusion, accessibility and engagement with different groups, highlighting that barriers to communication and engagement must be addressed if the strategy is to be effective for all. In the context of children and young people—particularly those with autism, who may have additional communication needs—this underscores the necessity of producing materials that are not only accessible but designed specifically with their needs in mind. Producing a children’s version of the strategy is a practical way of ensuring that equality considerations are translated into tangible action.

Moreover, the recommendation supports one of the strategy’s central aims: improving outcomes across the life course, particularly in areas such as education and transitions to adulthood. These are areas where children and young people are the primary stakeholders. A strategy that cannot be understood or engaged with by those stakeholders risks

⁴¹ <https://www.gov.uk/government/publications/youth-voice-in-policymaking/getting-ready-to-involve-young-people-in-policy>

⁴² <https://repository.gchumanrights.org/server/api/core/bitstreams/fe94c7ca-e097-46ff-bf30-b48e81cb1b27/content>

⁴³ <https://files.eric.ed.gov/fulltext/EJ1317916.pdf>

⁴⁴ https://warwick.ac.uk/fac/sci/psych/research/autism/creative-approaches-participatory-research-toolkit/fpsyg_12_713982.pdf

limiting its impact. By contrast, a child-friendly version can reinforce continuity across the life course by helping young people understand what support to expect now and in the future.

Additionally, there is also an important cultural dimension. Research on child and youth-friendly governance demonstrates that where children are not included in decision-making, policies risk becoming ineffective or misaligned with real needs, and young people may lose trust in public institutions⁴⁵. Conversely, involving children and making policy accessible to them contributes to more responsive, legitimate and trusted systems. This aligns closely with the co-production principles underpinning the Oxfordshire's All-Age Autism strategy, which emphasise partnership and lived experience as drivers of improvement.

Therefore, this JHOSC recommendation responds directly to the challenges identified in the Oxfordshire documents, aligns with national policy and guidance, and is strongly supported by academic evidence and practice across other local areas. By ensuring that autistic children and young people can access, understand and engage with the strategy, system partners will not only improve inclusivity but also strengthen delivery, accountability and long-term outcomes. In doing so, they will move beyond a strategy that is merely about children and young people, to one that is meaningfully shaped with and for them.

Recommendation 5: *For system partners to work toward the development a children's version of the Autism Strategy.*

Legal Implications

13. 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.
14. 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'.
15. 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

⁴⁵ <https://childfriendlygovernance.org>

whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

16. 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 Gareth Epps
Councillor Emma Garnett
Councillor Imade Edosomwan
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
District Councillor Val Shaw
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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June 2026

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

Director of Public Health Annual Report

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

Report to:

- Ansaf Azhar- Director of Public Health, Oxfordshire County Council.
- Kate Austin- Public Health Principal, Oxfordshire County Council.
- Fiona Ruck- Health Improvement Practitioner, Oxfordshire County Council.

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered the draft Director of Public Health (DPH) annual report in its public meeting on 29 January 2026.
2. The Committee would like to thank Ansaf Azhar (Director of Public Health, Oxfordshire County Council); Kate Austin (Public Health Principal, Oxfordshire County Council); and Fiona Ruck (Health Improvement Practitioner, Oxfordshire County Council); for attending the meeting and answering questions from the Committee.
3. The DPH annual report is of significant interest and concern to the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by Oxfordshire County Council's public health team to improve public health services for residents in Oxfordshire of all ages. The DPH annual report provides a strong indications into some of the steps being taken by the public health team in this regard.
4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:
 - The nature of this year's DPH annual report and the themes/topics that will be covered within it.
 - The format of this year's annual report, and whether there have been changes in its format in line with what some other local authority Directors of public health have embarked on.
 - Whether any coproduction is involved as part of the development of this year's DPH annual report.

- The degree to which there is collaboration with key system partners in the development of (or public health commitments found within) this year's annual report.

SUMMARY

5. During the 29 January 2026 meeting, 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. It was 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.
6. 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.
7. It was discussed how the report and associated tools address the specific challenges faced by residents in 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.
8. 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.
9. 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.

10. 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.
11. 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.

KEY POINTS OF OBSERVATION:

12. This section highlights five key observations and points that the Committee has in relation to the commitments and themes highlighted in this year's DPH annual report. (and associated services more broadly). These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Embedding CIPs into routine commissioning and service design:

The Director of Public Health Annual Report 2025/26 makes clear that Oxfordshire has moved beyond deficit-focused, data-only approaches towards a richer, more nuanced understanding of place, lived experience, and the wider determinants of health. However, the full value of this investment will only be realised if the insights generated through Community Insight Profiles (CIP) are systematically embedded into decision-making processes across the health and care system, rather than being treated as supplementary or optional evidence.

The DPH Annual Report explicitly recognises that traditional datasets, including statutory indicators and aggregate health outcomes, are insufficient on their own to explain why inequalities persist in specific communities or how services should respond to them. The report describes how CIPs were developed precisely to bridge this gap, combining epidemiological data with qualitative insight, asset mapping, and community-led priorities to create a more actionable understanding of local need. This aligns closely with established public health theory on the limitations of technocratic planning approaches that privilege what is

measurable over what is meaningful, particularly for marginalised populations¹.

Embedding CIPs into routine commissioning therefore represents a shift from episodic consultation towards structurally embedding community voice within the “rules of the system”. Without such embedding, there is a risk that CIP findings remain influential only where individual commissioners, clinicians or officers choose to engage with them, rather than shaping service models consistently across Oxfordshire. The Annex 1 Content Framework submitted to the committee illustrates how CIP insights have already influenced delivery decisions in areas such as community mental wellbeing support, physical activity pathways, access to food, and social connection. These examples demonstrate not only improved alignment with local priorities but also increased trust between communities and statutory partners – a critical precondition for effective preventive work².

From a commissioning perspective, embedding CIPs means more than “having regard” to local insight. It requires that business cases, service specifications, options appraisals and evaluation frameworks explicitly reference relevant CIP findings and explain how community-identified priorities have shaped proposed interventions. This approach is consistent with best practice in outcomes-based commissioning and with the NHS’s increasing emphasis on place-based and neighbourhood health models, as articulated in the NHS 10-Year Plan and national neighbourhood health guidance³. The DPH Annual Report highlights that neighbourhood working will only succeed if services are designed around people’s lived realities, including transport barriers, housing conditions, social isolation and access to trusted local services – all core components of CIP analysis.

There is strong precedent elsewhere in England for the systematic use of similar place-based insight within commissioning frameworks. In Greater Manchester, for example, locality-level intelligence drawn from community research has been embedded into Integrated Care System commissioning through “locality plans” that must demonstrate alignment with community priorities identified through qualitative insight and participatory engagement⁴. Evaluations of this approach have shown improved service take-up, better targeting of preventive resources, and greater legitimacy of commissioning decisions in communities that have historically experienced disempowerment.

Similarly, the “Neighbourhood Health” and “Thriving Places” programmes in Bradford have embedded community insight into service co-design and commissioning processes, particularly in areas of ethnic diversity and high deprivation. Independent evaluation demonstrated that services

¹ <https://www.instituteofhealthequity.org/resources-reports>

² <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

³ <https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/>

⁴ <https://www.greatermanchester-ca.gov.uk/what-we-do/health-and-social-care/>

designed using community-led intelligence were more effective at addressing trust, cultural appropriateness and access, particularly in maternal and early years services and long-term condition management⁵. These findings echo wider academic literature on co-production and participatory public health, which consistently shows that interventions designed with communities are more likely to be effective, equitable and sustainable⁶.

The Annex 1 Content Framework submitted to the Committee also highlights the role of Community Health Development Officers (CHDOs) in translating insight into action. While these roles have been instrumental in delivery, the DPH Annual Report is clear that reliance on individual posts is not sufficient to embed learning system-wide. Commissioning processes themselves must institutionalise CIP use so that learning survives changes in personnel, organisational structures, or funding cycles. This is particularly important given the risks identified in the report around funding instability, system reform, and local government reorganisation, all of which can disrupt progress if insight is not embedded structurally.

Embedding CIPs also strengthens accountability. When commissioning decisions explicitly reference CIP findings, it becomes possible for scrutiny bodies such as the JHOSC to assess not only whether engagement took place, but whether it meaningfully influenced outcomes. This responds directly to longstanding concerns nationally about “consultation fatigue” and tokenistic engagement, where communities are asked for views that do not translate into changed decisions⁷. Making CIP references a routine requirement creates a clear audit trail linking insight, decision, and impact.

Finally, this recommendation being made by the Committee is fully aligned with the Marmot principles underpinning Oxfordshire’s ambition to become a Marmot Place. Professor Sir Michael Marmot’s work consistently emphasises that reducing inequalities requires proportionate, place-sensitive action informed by the lived experiences of those most affected⁸. Embedding CIPs into commissioning operationalises these principles, ensuring that investment decisions systematically prioritise those populations and neighbourhoods facing the greatest disadvantage, rather than relying solely on county-level averages that can obscure deep local inequalities.

In summary, the recommendation to embed Community Insight Profiles into routine commissioning and service design is not an optional enhancement but a necessary step if Oxfordshire is to convert high-quality insight into sustained reductions in inequality. The DPH Annual Report and its accompanying framework demonstrate the value

⁵ <https://www.bradfordhealthpartners.org/>

⁶ <https://www.tandfonline.com/doi/full/10.1080/09581596.2020.1717511>

⁷ <https://www.health.org.uk/publications/long-reads/community-engagement-for-health>

⁸

of CIPs as an evidence base. Embedding them formally within commissioning processes ensures that this value is realised consistently, transparently, and at scale, supporting better outcomes for communities and stronger accountability for the system as a whole.

Recommendation 1: *To embed CIPs into routine commissioning and service design, ensuring decisions explicitly reference CIP findings and community led priorities.*

Ensuring neighbourhood working includes Public Health Leadership and Community Voice Structures: the case for a System-wide Roadmap on Maturity, Resourcing and Integration:

The DPH Annual Report 2025/26 positions Oxfordshire's recent progress as rooted in partnership working, hyper-local insight and engagement with the wider determinants of health. The accompanying cover report submitted to the Committee explicitly frames the Annual Report as a tool to inform future service delivery and commissioning decisions, highlighting the new interactive format of this year's DPH Annual Report as a mechanism for improving accessibility, engagement and ongoing learning. The Annex 1 Content Framework reinforces this framing by emphasising prevention, place-based approaches and the need to consolidate progress through sustained, system-wide action, rather than discrete or time-limited initiatives. Taken together, these documents provide a strong local rationale for ensuring neighbourhood working is led by public health principles and meaningfully shaped by community voice.

Neighbourhood working requires public health leadership to succeed. Nationally, neighbourhood working has been positioned as the primary vehicle for delivering the "shift" from hospital to community, and from reactive treatment to prevention. However, experience across England demonstrates that neighbourhood models risk becoming overly clinical or narrowly focused on managing high-need cohorts unless they are explicitly grounded in population health intelligence and inequalities analysis. The Government's Neighbourhood Health Framework is explicit that neighbourhood health can only succeed as a joint endeavour between the NHS and local government, with shared outcomes, common metrics and enabling governance structures⁹. Similarly, NHS England's Neighbourhood Health Guidelines for 2025/26 stress the importance of system-wide population health management, partnership with local authorities and integration with voluntary and community sector partners, rather than viewing neighbourhoods solely as units for multidisciplinary clinical teams¹⁰.

The DPH Annual Report reflects this understanding locally. Annex 1 submitted to the Committee repeatedly highlights that what shapes health and wellbeing are the "building blocks of health" – income, housing, education, transport, social connection and access to resources

⁹ <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

¹⁰ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/>

– factors that sit largely outside traditional healthcare delivery. The report also includes explicit warnings about the careful interpretation of deprivation data, noting that indicators such as the Index of Multiple Deprivation must be contextualised and triangulated to avoid over-claiming progress or misdirecting resources. This analytical discipline is a core public health function and illustrates why neighbourhood working that lacks public health leadership risks being poorly targeted and potentially misleading in its assessment of impact. Academic evaluations of integrated care and community-based models reinforce this point. National evaluation work on community-based multidisciplinary teams in England found that while local integration can improve coordination, success depends on strong system enablers, including shared objectives, governance, data capability and leadership that extends beyond individual services¹¹. Public health leadership provides exactly this system-level perspective, ensuring neighbourhood priorities are aligned with inequalities intelligence and prevention objectives, rather than responding primarily to short-term service pressures.

The second pillar of the recommendation – embedding community voice structures within neighbourhood working – reflects both Oxfordshire’s own learning and a substantial national and international evidence base. Annex 1 of the DPH Annual Report describes in detail how Community Insight Profiles (CIPs) were developed to combine quantitative data with lived experience, local knowledge and asset mapping. Importantly, it also records how communities challenged partners with the question “So what?”, prompting a shift from insight-gathering towards tangible action and delivery. This experience demonstrates that engagement alone is insufficient; communities must also have a route to influence decisions, priorities and resource allocation.

The academic literature is clear that sustained community participation improves relevance, trust and equity, particularly when communities are involved throughout the full policy and commissioning cycle. A recent scoping review of co-creation in public health found that while community participation is often present in design and implementation, it is frequently weak or absent in governance and evaluation, limiting long-term impact¹². UK-focused research into commissioning and co-production similarly identifies commissioning complexity, power imbalances and organisational culture as structural barriers to meaningful co-production, unless community voice is embedded deliberately within decision-making frameworks¹³.

This evidence aligns closely with policy analysis from The King’s Fund, which cautions that neighbourhood health means different things in different places and that success depends on collaboration, leadership and investment, including genuinely community-led approaches rather

¹¹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC12423453/>

¹² <https://pmc.ncbi.nlm.nih.gov/articles/PMC10094395/>

¹³ <https://onlinelibrary.wiley.com/doi/pdf/10.1111/hex.14053>

than technocratic service redesign¹⁴. Without defined voice structures, neighbourhood working risks becoming something that is done to communities rather than with them, undermining legitimacy and long-term sustainability.

The call for a system-wide roadmap is therefore critical here. Neighbourhood working is not a single intervention but a complex capability that develops over time. Without a roadmap, neighbourhoods will mature unevenly: some benefiting from strong leadership, data and community infrastructure, while others remain under-resourced and poorly connected to wider system priorities. The DPH Annual Report's interactive format is intended to support ongoing learning and adaptability, but this flexibility increases the need for a stable implementation framework that sets out expectations for neighbourhood maturity, resourcing and accountability.

National policy increasingly reflects this logic. The Neighbourhood Health Framework explicitly refers to the need for clear archetypes, shared outcomes and enabling infrastructure to avoid a fragmented approach¹⁵. NHS England's guidance similarly emphasises progression over time and integration with wider public sector reform, including collaboration with the voluntary, community, faith and social enterprise sector¹⁶.

Evidence from other areas reinforces the importance of a structured, system-wide approach. In Bradford District and Craven, the Reducing Inequalities in Communities programme established a defined neighbourhood-scale programme supported by embedded research capability through the Bradford Inequalities Research Unit, enabling robust evaluation and learning over time¹⁷. In Wigan, the "Wigan Deal" demonstrated how an explicit, borough-wide framework for asset-based working and community partnership could reshape public services and reduce demand, but only because the approach was underpinned by leadership, culture change and sustained commitment across the system¹⁸.

Similarly, the Bromley by Bow Centre illustrates how community-anchored institutions can integrate primary care, social support and community development when supported by outcomes frameworks derived from what matters to local people¹⁹. Emerging evaluations of community health and wellbeing worker models show that these roles can be highly effective in building trust and connecting

¹⁴ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

¹⁵ <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

¹⁶ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/>

¹⁷ <https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/>; https://borninbradford.nhs.uk/wp-content/uploads/2024/11/BIRU-Final-Report_v2.0_Jan24.pdf

¹⁸ <https://centreforpublicimpact.org/public-impact-fundamentals/the-wigan-deal/>;

<https://www.kingsfund.org.uk/insight-and-analysis/projects/lessons-wigan-deal>

¹⁹ <https://www.health.org.uk/funding-and-fellowships/projects/practitioner-led-evidence-at-bromley-by-bow>; https://knowledge.lancashire.ac.uk/id/eprint/3386/1/Bromley_by_Bow_Centre_Report.pdf

services, but only when supported by clear infrastructure, governance and funding arrangements – again pointing to the need for a system-level roadmap rather than isolated pilots²⁰.

Therefore, the JHOSC recommendation to ensure neighbourhood working includes public health leadership, formal community voice structures and a system-wide roadmap for maturity, resourcing and integration is firmly grounded in both Oxfordshire's own learning and national and academic evidence. It recognises that neighbourhood health will only deliver on its promise if it remains anchored in prevention and inequalities intelligence, if communities have meaningful influence over priorities and design, and if progress is supported through clear expectations and sustained investment across the system.

If Oxfordshire is to protect and build on the achievements set out in the DPH Annual Report – and if neighbourhood working is to become a durable platform for reducing health inequalities rather than a transient reform narrative – then the development of such a roadmap is not an optional enhancement. It is the mechanism through which a compelling public health vision can be translated into consistent, accountable and equitable practice across all neighbourhoods in the county.

Recommendation 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.*

For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes: While Oxfordshire has made tangible progress in mobilising community-led and system-wide prevention initiatives, this progress will only be sustained and scaled if it is accompanied by transparent, regular and system-level reporting. In this sense, the recommendation is not simply about producing another report; it is about embedding prevention within the governance, accountability and learning architecture of the local health and care system.

The Director of Public Health (DPH) Annual Report 2025/26 positions prevention and the reduction of health inequalities as central to Oxfordshire's strategic direction. The cover report describes how the Annual Report draws together hyper-local insight, community-led action and partnership working to inform future service delivery, and explicitly highlights the role of interactive, accessible reporting in supporting shared understanding across the system. The Annex 1 content framework reinforces this narrative by setting out the development and impact of prevention programmes such as Community Insight Profiles, Well Together, the Community Health Development Officer model, and

²⁰ <https://napc.co.uk/a-comparative-case-study-process-evaluation-of-three-community-health-and-wellbeing-worker-pilots-in-england/>; <https://arc-swp.nihr.ac.uk/research/projects/evaluation-of-the-cornwall-community-health-and-wellbeing-worker-chww-service/>

whole-system approaches to physical activity, while also underlining the fragility of progress if investment, coordination and shared ownership are not maintained. Taken together, these documents implicitly point to the need for a mechanism that can track, evidence and communicate prevention progress year-on-year beyond a single DPH Annual Report cycle.

Prevention programmes differ fundamentally from acute or treatment-focused interventions. Their impacts are often cumulative, diffuse and realised over longer timeframes, and they frequently span multiple sectors, funding streams and delivery partners. Without regular, system-wide reporting, prevention risks becoming invisible in comparison with more immediate operational pressures, despite being repeatedly recognised in national policy as essential to long-term sustainability. NHS England's Neighbourhood Health Guidelines for 2025/26 emphasise the need for integrated care systems and partners to strengthen prevention and population health management, while also acknowledging that progress requires consistent system oversight and learning²¹. Similarly, the Government's Neighbourhood Health Framework highlights the importance of shared outcomes, metrics and transparency if prevention is to be embedded rather than displaced²².

The Annex 1 (submitted to the Committee) section on the Prevention and Health Inequalities Forum makes clear that PHIF was established to provide strategic leadership across partners, particularly to secure commitment from organisations with substantial financial leverage and to align investment with prevention and equity priorities. Yet leadership without visible accountability can struggle to maintain momentum over time. Annual system-wide reporting provides a practical mechanism through which PHIF can demonstrate collective progress, identify gaps, and reinforce the shared responsibility of all partners in delivering prevention outcomes.

Academic literature strongly supports the value of transparent, regular reporting in advancing health equity and prevention. Research on prevention science and health equity consistently emphasises that system-level action requires mechanisms to track progress, make methodological choices explicit and support accountability to communities and decision-makers²³. Similarly, public health scholars argue that measuring and communicating progress on health inequalities is a necessary step in mobilising action and sustaining political and organisational commitment²⁴. Without such reporting, prevention initiatives risk being perceived as peripheral or discretionary, particularly in financially constrained environments.

²¹ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/>

²² <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

²³ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10227139/>

²⁴

The Well Together programme, described in Annex 1 as a flagship community-led prevention initiative, provides a compelling example of why annual, system-wide reporting is needed. Well Together is funded through the Thames Valley Integrated Care Board and delivered in partnership with voluntary and community sector organisations to address health inequalities in priority areas. Its design explicitly recognises that wellbeing is created collectively and that trusted, grassroots organisations are essential to engaging residents who are often least well served by traditional services²⁵.

Evaluation evidence from Oxfordshire and elsewhere demonstrates that such programmes generate value well beyond their immediate outputs, including improvements in trust, social connection and engagement with wider health services. Phase 1 evaluation of Community Health Development Officer and Well Together programmes, led by the University of Oxford, highlights the importance of continuity, embedded roles and sustained relationships for achieving impact²⁶. However, these forms of impact are unlikely to be fully appreciated or protected unless they are routinely reported at a system level, alongside more conventional activity data.

National experience reinforces this point. In Bradford District and Craven, the Reducing Inequalities in Communities programme embedded routine reporting and evaluation as part of its prevention strategy, enabling the system to understand which interventions were delivering impact and why, and to adapt accordingly²⁷. The lesson for Oxfordshire is not to replicate Bradford's model wholesale, but to recognise that annual, system-wide reporting is a key enabler of learning, credibility and sustained investment in prevention.

Moreover, the Annex 1 content framework submitted to the Committee describes Oxfordshire's whole-system approach to physical activity as a nationally recognised example of partnership working, with demonstrable outcomes for individuals, communities and the wider system. This aligns closely with a substantial academic evidence base showing that physical activity is most effectively promoted through whole-system approaches that address environmental, social and service-level factors, rather than isolated behaviour change interventions²⁸.

NHS England has repeatedly emphasised that physical activity is one of the most powerful tools available to health systems for preventing long-term conditions, supporting mental wellbeing and reducing demand on services²⁹. Yet experience shows that physical activity initiatives can

²⁵ <https://www.equalhealthoxon.org.uk/initiative/well-together-programme>;
<https://communityfirstoxon.org/community-action/community-health-wellbeing/wt/>

²⁶

²⁷ <https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/>; https://borninbradford.nhs.uk/wp-content/uploads/2024/11/BIRU-Final-Report_v2.0_Jan24.pdf

²⁸ <https://pmc.ncbi.nlm.nih.gov/articles/PMC4920841>

²⁹ <https://www.england.nhs.uk/ourwork/public-health/harnessing-the-benefits-of-physical-activity>

be fragmented or short-lived unless responsibility for oversight and reporting is clearly located. Annual PHIF reporting would provide a forum through which progress on physical activity pathways can be assessed across partners, including health, local government, sport and the voluntary sector, and through which inequalities in access and outcomes can be explicitly monitored.

Whole-system reporting also aligns with the growing national emphasis on structural and accountability measures in public health and healthcare. The Health Foundation has argued persuasively that prevention will only be prioritised if systems can clearly identify, track and communicate what they are investing in and what difference it is making³⁰. Annual reporting on prevention programmes provides a practical vehicle for doing exactly that at a local system level.

The recommendation that PHIF should lead this annual reporting is also significant. PHIF is positioned, in Annex 1 submitted to the Committee, as a forum that brings together partners across sectors and uses its convening power to influence investment, align strategy and embed a prevention lens. By publishing an annual system-wide progress update, PHIF can reinforce its role not only as a strategic body but also as a steward of shared narrative and learning. This is particularly important at a time when system leaders face competing priorities and when prevention gains risk being eclipsed by short-term pressures.

International and national reporting frameworks consistently show that transparency and public accountability help sustain focus on equity and prevention. The World Health Organisation's 2025 report on social determinants of health equity underscores that progress on these complex challenges requires sustained attention, measurement and communication, not one-off initiatives³¹. Annual PHIF reporting would situate Oxfordshire's prevention work within this wider context and provide a clearer basis for scrutiny, challenge and support.

Therefore, in recommending that the Prevention and Health Inequalities Forum publish annual, system-wide progress on prevention programmes such as Well Together and physical activity pathways, the Oxfordshire JHOSC is advancing a proportionate and evidence-based response to the realities of prevention work. The recommendation recognises that prevention delivers its greatest value when it is visible, shared and accountable across the whole system. It also reflects learning from the DPH Annual Report and Annex 1 framework, which demonstrate both the achievements and the vulnerabilities of Oxfordshire's prevention agenda. Annual PHIF reporting would strengthen accountability, support learning, and help protect prevention investment at a time of significant system pressure. Critically, it would ensure that prevention and health inequalities remain firmly on the agenda not just as strategic aspirations,

³⁰ <https://www.health.org.uk/reports-and-analysis/briefings/counting-what-matters-how-to-classify-account-and-track-spending-for-prevention>

³¹ <https://www.who.int/news/item/06-05-2025-health-inequities-are-shortening-lives-by-decades>

but as measurable, reviewable and collectively owned commitments across Oxfordshire's health and care system.

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

Securing Prevention Gains Through Multi-Year Funding: The Case for Sustainability, Best Value and Avoiding Regression: The Committee's recommendation to move Community Health Development Officer (CHDO) roles, the Well Together programme and wider community-led initiatives onto multi-year funding cycles reflects a critical insight into how health inequalities are reduced in practice. It recognises that short-term funding, while often administratively convenient, fundamentally undermines the sustainability, effectiveness and value for money of prevention programmes. In the context of the Director of Public Health (DPH) Annual Report 2025/26, which highlights encouraging signs of improvement in some Index of Multiple Deprivation (IMD) indicators while also warning of the fragility of these gains, this recommendation addresses a central strategic risk: that progress achieved through long-term, trust-based community work may be lost through funding instability.

The DPH Annual Report cover report presents Oxfordshire's recent prevention journey as one characterised by sustained partnership working, hyper-local insight and community-led action. It explicitly notes that progress since the 2019/20 DPH report has been driven by programmes that build local capacity, relationships and trust over time, rather than by short-lived interventions. The Annex 1 content framework reinforces this message, particularly in its discussion of the Community Insight Profile (CIP) programme, CHDO roles and Well Together. These initiatives are consistently described as relational, place-based and cumulative in nature, relying on continuity and local knowledge to translate insight into meaningful and sustained change. The same framework also identifies a key risk: that without sustained investment, gains achieved in priority areas could stall or reverse, especially in a context of wider funding constraints and system reform.

Prevention and community development do not operate on the same timelines as acute service delivery. Academic and policy literature repeatedly demonstrates that short funding cycles distort behaviour, weaken partnerships and erode institutional memory. A scoping review published in the Community Development Journal found that embedding community development approaches within local systems is consistently hindered by short-term funding arrangements, which make it difficult to build trust, retain skilled staff and sustain local participation³². The review highlights that community-centred approaches are most effective when

³² <https://academic.oup.com/cdj/article/58/4/699/7332008>

they are treated as long-term system assets, rather than time-limited projects.

This evidence aligns closely with Oxfordshire's local experience. Annex 1 submitted to the Committee describes how CHDOs act as connectors, brokers and trusted local figures, supporting delivery partners, convening relationships and ensuring recommendations from CIPs are implemented in ways that make sense locally. These roles are effective precisely because they are embedded, visible and sustained over time. Short funding cycles undermine this model by creating uncertainty for staff, reducing continuity in relationships and incentivising short-term outputs over long-term outcomes. Evaluation evidence from Oxfordshire's own CHDO and Well Together programmes reinforces this point, noting that continuity and "being there over time" are essential to building trust and enabling meaningful engagement, particularly in communities that have historically experienced disengagement from public services³³.

The Well Together programme exemplifies the same dynamic. Well Together is explicitly designed around community-led, grassroots activity in priority areas, with an emphasis on trust, accessibility and building social infrastructure that supports wellbeing³⁴. Many of the organisations involved are small or emerging groups embedded in their communities, for whom short-term funding creates disproportionate administrative burden and existential risk. From a best-value perspective, repeatedly onboarding, funding and then losing such organisations due to funding uncertainty represents poor stewardship of public resources.

Furthermore, a particularly important element of the JHOSC recommendation is the explicit reference to avoiding regression in areas showing improving IMD deciles. Annex 1 of the DPH Annual Report provides a careful and nuanced discussion of Oxfordshire's IMD 2025 results, emphasising both encouraging signs of progress and the need for caution in interpretation. The report stresses that IMD is a relative, point-in-time measure, and that apparent improvements can be fragile, particularly if the underlying drivers of inequality are not addressed consistently over time.

This fragility is well documented in the wider literature. The World Health Organization's 2025 report on social determinants of health equity highlights that gains in health equity are often reversible when investment is withdrawn or when structural supports are weakened, especially in disadvantaged communities³⁵. Similarly, prevention science research shows that discontinuity in preventive interventions disproportionately

³³ <https://data.oxfordshire.gov.uk/wp-content/uploads/2025/04/ohh-chdowt-evaluation-phase1-full-report.pdf>

³⁴ <https://www.equalhealthoxon.org.uk/initiative/well-together-programme;>
<https://communityfirstoxon.org/community-action/community-health-wellbeing/wt/>

³⁵ <https://www.who.int/news/item/06-05-2025-health-inequities-are-shortening-lives-by-decades>

affects populations already experiencing disadvantage, widening inequalities rather than narrowing them³⁶.

In this context, moving to multi-year funding cycles is not merely about organisational stability; it is about safeguarding population-level gains. For areas that have begun to move up IMD deciles, often after years of targeted effort, the withdrawal or fragmentation of community-based prevention support risks undoing progress and wasting prior investment. A best-value review that explicitly considers the cost of regression – in terms of increased demand on health services, reduced community capacity and widening inequalities – would provide a more accurate assessment of value than short-term cost savings alone.

Experience from other parts of England provides strong support for this approach. In Bradford District and Craven, the Reducing Inequalities in Communities (RIC) programme was established as a multi-year initiative precisely to allow sufficient time for prevention interventions to bed in, be evaluated and refined. The programme was supported by the Bradford Inequalities Research Unit, enabling longitudinal learning and adaptation³⁷. A key lesson from Bradford has been that short-term pilots rarely deliver system-level change, whereas longer-term commitments enable both effectiveness and accountability.

Similarly, the “Wigan Deal” offers a powerful example of how sustained, multi-year investment in community-centred approaches can deliver both improved outcomes and reduced demand on public services. Wigan Council’s shift towards asset-based working and long-term partnership with the voluntary and community sector was underpinned by a deliberate move away from short-term practices³⁸. Importantly, evaluations have shown that the financial benefits of this approach were only realised over time, reinforcing the argument that prevention represents best value when funded on a multi-year basis.

The Bromley by Bow Centre in Tower Hamlets provides further evidence of the value of continuity. Over several decades, sustained investment has enabled the development of an integrated model combining primary care, social prescribing, community development and enterprise. Long-term evaluation shows that this model’s effectiveness lies in its stability, local credibility and ability to retain skilled staff and trusted relationships³⁹. These are precisely the attributes undermined by short funding cycles.

³⁶ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10227139>

³⁷ <https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/>; https://borninbradford.nhs.uk/wp-content/uploads/2024/11/BIRU-Final-Report_v2.0_Jan24.pdf

³⁸ <https://centreforpublicimpact.org/public-impact-fundamentals/the-wigan-deal/>; <https://www.kingsfund.org.uk/insight-and-analysis/projects/lessons-wigan-deal>

³⁹ https://knowledge.lancashire.ac.uk/id/eprint/3386/1/Bromley_by_Bow_Centre_Report.pdf; <https://www.health.org.uk/funding-and-fellowships/projects/practitioner-led-evidence-at-bromley-by-bow>

Furthermore, the Committee's recommendation for a best-value review alongside multi-year funding is therefore crucial. Best value in prevention should be understood in terms of long-term outcomes, system resilience and inequality reduction, not simply annual budget containment. The Health Foundation has argued that prevention spending is often undervalued because it is poorly measured and insufficiently tracked over time, calling for more systematic approaches to classifying and reporting preventive investment⁴⁰. Applying this logic locally, a best-value review that explicitly prioritises funding continuity for high-impact community programmes would align financial decision-making with Oxfordshire's stated ambitions on prevention and health equity.

The Prevention and Health Inequalities Forum, described in Annex 1 as bringing together partners with significant financial influence, is well placed to sponsor or oversee such a review. By doing so, it could help shift the system away from reactive, short-term funding decisions and towards a more strategic, prevention-led allocation of resources that protects prior investment and maximises returns over time.

In essence, the JHOSC recommendation to move CHDO, Well Together and community-led programmes onto multi-year funding cycles, supported by a best-value review and prioritisation of funding continuity, is firmly grounded in local evidence, national experience and academic research. It reflects an understanding that prevention works through sustained relationships, trust and cumulative impact, and that short funding cycles actively undermine these mechanisms.

In the context of the DPH Annual Report's findings – particularly the warning that improving IMD indicators remain fragile – this recommendation is also a statement about risk management. Without funding continuity, Oxfordshire risks losing hard-won gains and incurring higher downstream costs as inequalities widen once again. Multi-year funding is therefore not a luxury, but a prerequisite for delivering lasting value, protecting progress and ensuring that prevention genuinely contributes to a fairer, healthier Oxfordshire over the long term.

Recommendation 4: *To move Community Health Development Officer, Well Together roles and community led programmes onto multi-year 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.*

Prioritising Oxfordshire-wide rural areas that are experiencing a regression on the Multiple Deprivation deciles of inequalities: The JHOSC's recommendation to prioritise rural areas experiencing regression on the Index of Multiple Deprivation (IMD) deciles represents a necessary and timely recalibration of how inequalities are/should be

⁴⁰ <https://www.health.org.uk/reports-and-analysis/briefings/counting-what-matters-how-to-classify-account-and-track-spending-for-prevention>

understood and addressed across the county. While Oxfordshire is often characterised as relatively affluent, this aggregate picture masks deep and growing inequalities within rural towns, villages and parishes. The Director of Public Health (DPH) Annual Report 2025/26 explicitly cautions against complacency, noting that improvements in deprivation indicators are uneven and, in some areas, fragile or reversing. In this context, the recommendation responds to a critical strategic risk: that rural inequalities remain under-recognised, under-resourced and structurally disadvantaged within systems primarily designed around urban or population-dense neighbourhoods.

The Annex 1 content framework submitted to the Committee is clear that health inequalities are shaped by the wider determinants of health, including transport, access to services, housing affordability, employment security and social connection. These determinants manifest differently in rural contexts. Sparse populations, limited public transport, digital exclusion and declining local infrastructure combine to create a distinct pattern of disadvantage that is not always captured by headline statistics. National evidence consistently shows that rural deprivation is more likely to be “hidden”, spatially dispersed and experienced alongside isolation, making it harder for systems to identify need and target support effectively⁴¹.

The IMD is a valuable tool, but it is a relative, place-based snapshot that can obscure emerging rural decline. As highlighted in Annex 1 of the DPH Annual Report, changes in IMD deciles must be interpreted carefully, particularly where improvements in one area may be offset by decline elsewhere or by worsening conditions in comparators. Rural areas are especially vulnerable to this methodological limitation, because small changes in income, housing costs or access to services can push communities into worse deprivation bands with little public visibility.

Academic research reinforces this point. Studies of rural health inequalities demonstrate that deprivation in rural areas is often underestimated and that service access barriers amplify the impact of poverty and disadvantage⁴². The Health Foundation has similarly noted that rural communities frequently face “double disadvantage”: poorer access to services combined with policy narratives that prioritise urban inequality⁴³.

In Oxfordshire, where housing affordability pressures, insecure work and transport dependency disproportionately affect rural residents, the risk of regression is real. The JHOSC recommendation therefore reflects an evidence-based recognition that rural inequality requires explicit

⁴¹ <https://www.gov.uk/government/publications/health-inequalities-in-rural-and-coastal-areas/health-inequalities-in-rural-and-coastal-areas>

⁴² <https://academic.oup.com/heapol/article/35/6/653/5859896>

⁴³ <https://www.health.org.uk/news-and-comment/charts-and-infographics/inequalities-in-rural-and-urban-areas>

prioritisation, rather than being assumed to improve automatically as part of county-wide progress.

A central element of this JHOSC recommendation is to explore rural community capability through the development of the Neighbourhood offer to towns and parishes. The Annex 1 content framework submitted to the Committee situates neighbourhood working as the future model for integrated, preventive and place-based delivery, aligned with national direction through neighbourhood health and the NHS 10-Year Plan. However, neighbourhood models have largely developed around urban geographies, Primary Care Networks, or densely populated estates. Without adaptation, rural towns and parishes risk being structurally excluded from the benefits of neighbourhood working.

National policy increasingly acknowledges this challenge. NHS England's neighbourhood health guidance emphasises that neighbourhood models must be locally defined and responsive to place, rather than imposed uniformly⁴⁴. The King's Fund similarly highlights that neighbourhood health must reflect how people live, travel and connect in different contexts, warning against urban-centric assumptions⁴⁵.

Extending the Neighbourhood offer to towns and parishes therefore requires a flexible, contextualised approach. In rural settings, neighbourhoods may not be contiguous estates but networks of villages, market towns and service hubs. Local assets may include parish councils, village halls, faith groups, libraries, volunteer drivers, and informal support networks. Recognising and legitimising these as part of the Neighbourhood offer is essential if rural communities are to benefit from system investment in prevention and integration.

Moreover, the recommendation's emphasis on supporting an independent voice and local members is particularly significant in rural settings. Rural communities often rely heavily on councillors, parish representatives and volunteers to advocate for local needs, yet these voices can struggle to influence system-level decision-making dominated by larger organisations and urban priorities. The DPH Annual Report and Annex 1 repeatedly stress the value of community voice in shaping effective responses to inequality, drawing on the experience of Community Insight Profiles and community-led programmes.

Academic literature on co-production and community capability underscores that meaningful participation requires infrastructure and resourcing, not just consultation. A systematic review of community co-creation in public health found that without sustained support, community voice risks being tokenistic or confined to narrow engagement exercises⁴⁶. This is particularly acute in rural contexts, where individuals

⁴⁴ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26>

⁴⁵ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

⁴⁶ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10094395>

often participate in multiple roles and where capacity can be easily overstretched.

Supporting an independent rural voice may therefore require different mechanisms than those used in urban neighbourhoods. This could include dedicated facilitation, support for parish-level collaboration, or investment in rural anchor organisations that can convene communities across dispersed geographies. The experience of rural community development programmes in counties such as North Yorkshire and Cumbria demonstrates that tailored support for parish networks and local leadership can significantly enhance community resilience and service access⁴⁷.

Examples from elsewhere reinforce the case for a differentiated rural approach. In Cornwall, where deprivation is widespread but dispersed, the development of community-led health and wellbeing models has relied on recognising parish-level identity and investing in trusted local connectors, rather than assuming neighbourhoods mirror urban patterns⁴⁸. Evaluations show that rural outreach is most effective when it builds on existing local structures and supports community capability over time.

Similarly, in Lincolnshire, place-based health inequality work has increasingly focused on rural market towns as hubs, combining local authority, voluntary sector and NHS effort around defined rural catchments⁴⁹. These models underline that rural neighbourhood working must be designed deliberately, not retrofitted from urban templates.

Furthermore, at the heart of this JHOSC recommendation is a recognition that community capability is itself a protective factor against inequality. The Marmot Review and subsequent Institute of Health Equity work emphasise that giving communities greater control and strengthening social infrastructure are essential components of reducing health inequalities⁵⁰. In rural areas, where statutory services are often distant or limited, community capability becomes even more critical.

The DPH Annual Report reflects this logic by highlighting community-led programmes as key drivers of progress since 2019/20. Extending this approach to rural areas experiencing IMD regression aligns with both evidence and equity principles. It recognises that prevention is not simply about service provision, but about enabling communities to shape solutions, access resources and sustain improvement over time.

Conclusion

⁴⁷ <https://www.localtrust.org.uk/insights/research-insights/community-power-in-rural-areas>

⁴⁸ <https://arc-swp.nihr.ac.uk/research/projects/evaluation-of-the-cornwall-community-health-and-wellbeing-worker-chww-service>

⁴⁹ <https://www.nhsconfed.org/publications/place-based-partnerships-rural-and-coastal>

⁵⁰ <https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

Overall, the JHOSC's recommendation to prioritise rural areas experiencing regression in deprivation, to extend a contextualised Neighbourhood offer to towns and parishes, and to support independent voice and community capability is a proportionate, evidence-based response to a long-standing blind spot in inequality policy. It reflects learning from the DPH Annual Report, which shows that progress is uneven and fragile, and that rural disadvantage requires explicit attention. Without such a focus, Oxfordshire risks entrenching a two-tier approach to neighbourhood working, where urban areas benefit from system investment while rural communities could risk fall further behind. By contrast, developing a rural-appropriate Neighbourhood offer, strengthening local voice and investing in community capability would align Oxfordshire's prevention strategy with national direction, academic evidence and the lived realities of rural residents. In doing so, it would ensure that the ambition to reduce health inequalities truly extends across the whole county, not just its most visible places.

Recommendation 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.*

Legal Implications

13. 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.
14. 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'.
15. 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.

16. 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 Gareth Epps
Councillor Emma Garnett
Councillor Imade Edosomwan
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
District Councillor Val Shaw
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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June 2026

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22 May 2026

Dear Omid,

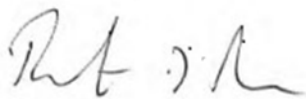
Please find enclosed our draft Quality Account for 2025/26 to be tabled at HOSC alongside this covering letter on 11th June 2026.

I would like to emphasise the following please;

- This document remains **in draft** status and has not yet received approval from the Trust Board; as such, its contents may be subject to revision.
- Please note that this version has not been proofread, and some formatting or typographical errors may be present.
- On page 148, Table 17, SUS data for month 12 will not be available until the end of May.

I look forward to presenting our draft Quality Account to members of HOSC on 11 June.

Yours sincerely



Dr Rustam Rea
Deputy Chief Medical Officer
Director of Clinical Improvement

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Oxford University Hospitals

NHS Foundation Trust



Quality Account 2025/26

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Introduction

Interim Chief Executive Officer Overview

Simon Crowther Interim Chief Executive Officer



In our Quality Account we set out how Oxford University Hospitals (OUH) NHS Foundation Trust delivers high quality care through a constant focus on our safety culture, and quality improvement routinely embedding best practice in the care provided to our patients so that avoidable harm is prevented.

Our strategic approach to improving the quality and safety of patient care

Our vision as an organisation is to be an exemplar in healthcare delivery that is compassionate and enabled by the highest levels of research and innovation.

Delivery of this vision remains centred around OUH values of Learning, Respect, Delivery, Excellence, Compassion and Improvement, and builds on the four strategic pillars – People, Patient Care, Performance and Partnerships which underpin our Trust Strategy.

In line with our OUH Trust Strategy, our 5 Year vision for Quality aims to improve the access, quality and experience of care of all our patients; and work with partners to improve the health and wellbeing of our populations, working collaboratively to deliver integrated and sustainable services. We will make OUH a great place to work by delivering the best staff experience and wellbeing for all our people, supported by a sustainable workforce model and a compassionate culture. The [Quality Strategy \(2025- 2030\)](#) encompasses three quality domains which apply to all staff and departments. These are: Patients safety, Patient experience and Clinical effectiveness and outcomes.

Patient Safety Incident Response Framework (PSIRF) and Patient Safety Culture

PSIRF processes have been established since October 2023 and replaced the Serious Incident Framework. The four aims of PSIRF (below) are being met by OUH:

- Compassionate engagement and involvement of those affected by patient safety incidents. OUH has strengthened compassionate engagement by embedding a consistent approach to involving patients, families and staff in investigations,

supported by an expanded group of Patient Safety Partners (PSPs) and Engagement Leads, as well as improved staff support mechanisms.

- Use of a range of system-based approaches to learn from patient safety incidents. OUH has advanced its use of system-based learning through widespread adoption of After Action Reviews (AARs), Learning Multidisciplinary Team Reviews (LMDTRs) and Patient Safety Incident Investigations (PSIIs), enhanced training, and new tools such as the refreshed PSII template and systems-analyst course.
- Considered and proportionate responses to patient safety incidents and safety issues. These have improved through clearer decision-making and streamlined PSII processes.
- Supportive oversight focused on strengthening system functioning and improvement. New quality-assurance mechanisms and the introduction of PSIRF metrics, collectively strengthening the Trust's ability to learn, improve and deliver safer care.

We held a second anniversary summit of PSIRF in November 2025. Representatives from Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB), NHS England, our Patient Safety Partners, Patient Safety colleagues from surrounding Trusts together with our staff were invited. At the summit we launched several initiatives including:

- Our [updated PSIRF plan](#);
- A new PSII template which we and our Patient Safety Partners (PSP) believe provides a better format for patients and their families;
- The introduction of PSIRF metrics; a panel discussion introducing some of our [new PSPs](#);
- Presentation of our new thematic PSIIs by the leads (these are described in our updated PSIRF plan); and a presentation on measuring the quality of our PSIIs using the Healthcare Services Safety Investigations Body (HSSIB) learning response review and improvement tool.

Martha's Rule

Following a successful pilot scheme, [Martha's Rule](#) was rolled out across all inpatient areas at the John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre in Oxford, and the Horton General Hospital in Banbury from 2 March 2026.

Martha's Rule is a national patient safety initiative that enables patients, families, carers and staff to request an urgent clinical review if concerns about a patient's deteriorating condition remain unresolved.

It strengthens the culture of asking, listening and acting when patients or those close to them report worrying changes.

The programme was introduced nationally following the death of 13-year-old Martha Mills, who developed sepsis in hospital. Her case, and others like it, led to the national rollout of Martha's Rule to ensure serious concerns are always heard and acted upon.

Our Quality Priorities

Each year we invite staff, patients and the public – as well as representatives of our key partners and stakeholders – to tell us what matters to them to help inform the development of Quality Priorities which are structured around the three key domains of quality.

Following this quality conversation event and further input from members of the Trust's Clinical Governance Committee and Trust Board members, our [Quality Priorities for 2026/27](#) were approved by the Trust Board in March 2026.

Our patients as partners

At the bi-monthly public meetings of the Trust Board, a patient perspective is shared to enable Board members and others in attendance to hear directly from patients and to strengthen the patient voice.

To ensure wider dissemination and learning, patient perspectives are included in the Trust Board Blogs from the Chair which are published following each public Board meeting – they are emailed to all OUH staff and to all governors, including elected representatives of patients and members of the public.

Patient perspectives are also shared more widely through news stories published on the Trust website and through the Trust's social media channels.

For example, Waqar Taref shared his [story](#) at the Trust Board meeting in March 2026 praising the personalised support he had received from Daley Cross, a Renal and Transplant youth worker over the last six years.

Patients waiting for treatment

We remain committed to seeing more patients, more quickly and to reducing waiting lists. I am grateful to our staff from across the Trust who have continued to focus on improvements to patient pathways, and to our system partners for the collaborative approach to delivering services to our patients.

For a second consecutive year, we successfully maintained a zero position for the number of patients waiting more than two years at the end of March 2026. Focused work has continued on reducing the number of patients waiting more than 65 weeks and 78 weeks; at the end of March 2026, there were 46 patients waiting over 65 weeks compared to 63 in March 2025, and 1 patient waiting over 78 weeks at the end of March 2026 compared to 15 in March 2025. We also increased the number of patients receiving a first outpatient appointment within 18 weeks (68%) against an increasing referral rate and remain committed to further reducing the waiting times for patients requiring elective care.

Quality Improvement (QI)

The Trust continues to invest strongly in quality improvement capability, delivering training for staff, registering more than 1,000 QI projects, and significantly improving project approval times.

In 2025/26 the focus has been on practical, applied improvement through refreshed training offers (Introduction to QI, QI Fundamentals, masterclasses) and national leadership of the new Collaborative QI Practitioner (CQIP) programme.

The Quality Coach Development Programme has expanded Trust-wide coaching capacity, with 39 trained coaches now supporting teams, including early cross-organisation collaboration with Oxford Health.

Organisational learning has been strengthened through regular, accessible QI sharing events and improved dissemination via our QI Zone.

System-wide collaboration across the BOB ICS has deepened, supporting shared learning, co-production with patients and communities, and a growing regional QI network.

New developments

Key developments to improve patient safety, experience and clinical effectiveness, include:

- The [national Cancer Plan](#), launched on World Cancer Day in February 2026, includes our Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) project as a best practice case study. RIPEL enables more people to receive personalised palliative care, including being cared for in their own home at the end of their life if that is their preference.
- The OUH now has an enhanced service for patients with soft tissue and bone tumours at the Horton General Hospital in Banbury, providing faster access to specialist diagnosis and treatment closer to home. [Expanding the musculoskeletal interventional service under general anaesthesia to the Horton General](#) significantly enhances our ability to deliver timely, specialist care while strengthening the Trust's high quality imaging capacity.

- [A new state-of-the-art high intensity focused ultrasound \(HIFU\) machine has been installed at the Churchill Hospital](#) which provides OUH cancer patients access to the latest in this innovative technology. HIFU is a non-invasive treatment that uses ultrasound to heat and destroy targeted tumour cells. Studies in some conditions have found that outcomes for patients with HIFU are similar to surgery with faster recovery and fewer adverse effects.
- [The Kidney Transplant team at OUH marked a significant milestone of completing 5,000 adult kidney transplants since the first procedure in 1975.](#) This achievement reflects decades of dedication, innovation, and collaboration across multi-disciplinary teams, and an unwavering commitment to delivering outstanding patient care.
- Our [Surgical Elective Centre](#) is one of our most significant capital projects for many years. It will provide additional operating theatres to address waiting lists for complex routine procedures, meeting the demands of the growing population across the Thames Valley, when it opens in Autumn 2026.

Excellent outcomes for patients captured in clinical audits

Examples include the following:

- National Ovarian Cancer Audit which showed that the ovarian cancer service performed above national averages on key treatment and survival indicators including lower rates of emergency admissions prior to diagnosis (36% OUH vs 41.1% nationally), higher treatment uptake within recommended timeframes (77% vs 72.7%), and stronger one-year survival (73% vs 69.4%). The audit provides substantial assurance of high-quality care and effective clinical pathways.
- Paediatric Intensive Care Audit Network (PICANet) - OUH Paediatric Intensive Care Unit continues to deliver strong outcomes, with a crude mortality rate of 2% and a standardised mortality ratio below 1, indicating better-than-expected survival rates. The timeframes for mobilisation of the retrieval ambulance and to reach the patient's bedside exceed national averages, along with accidental extubation rates that are significantly lower than national figures.
- Non-Hodkin Lymphoma - OUH demonstrated strong performance in lymphoma care, with one-year survival rates consistently exceeding national averages. Access to a Clinical Nurse Specialist was recorded for >95% of patients, well above national benchmarks.
- Nephrostomy - the British Association of Urological Surgeons Nephrostomy Audit demonstrates that the Trust achieved faster diagnosis and treatment than national averages. OUH achieved a 70% recovery rate, zero mortality, and continues to provide a 24/7 interventional radiology service supporting regional referrals, noting excellent collaboration between services, particularly radiology and urology.

- UK Cystic Fibrosis (CF) Registry – Paediatrics results demonstrated that the service were equal to or exceeding national averages across all of the audit criteria. These include the proportion of patients having an annual review, the recording of lung function and a reduction in treatment burden (i.e. interventions to treat CF such as IV antibiotics).
- Transcatheter Aortic Valve Implantation (TAVI) - the audit demonstrated OUH care was delivered in line with or surpassing all of the national averages across six audit criteria. This includes being in the top 5 Trusts nationally for length of stay (average 2 days vs 3 days); having lower incidence of stroke and major bleeding post-op; and lower rates of vascular complications.

Innovations introduced and the positive impact of research on patient care

OUH is at the heart of a vibrant healthcare research and innovation ecosystem which has a positive impact on the quality and safety of patient care because new innovations and treatments are often introduced first in our hospitals.

We value our partnerships with the University of Oxford and Oxford Brookes University, our role as host organisation of both the Oxford Biomedical Research Centre (BRC) and Health Innovation Oxford and Thames Valley (HIOTV), and our membership of Oxford Academic Health Partners (OAHP).

Examples of recent innovations are:

- The first three patients have undergone revolutionary brain surgery at the John Radcliffe Hospital in Oxford in a bid to treat the chronic pain they have experienced since suffering a stroke. The EPIONE research study, involving Oxford neurosurgeons and engineers, is trialling whether [deep brain stimulation](#) – delivering an electrical pulse into affected areas of the brain – can help to relieve central post-stroke pain, which is experienced by 1 in 12 stroke survivors.
- Pioneering research taking place at the Churchill Hospital in Oxford that is shaping the future of cancer treatment was included in a Channel 4 documentary in November 2025. The first episode of [Cancer Detectives: Finding the Cures](#), produced in partnership with Cancer Research UK, featured the groundbreaking research of Sarah Blagden, Professor of Experimental Oncology at the University of Oxford and Honorary Oncology Consultant at OUH, including the development of cancer vaccines and new drug treatments.
- [Grace Bell became just the second person in the UK to give birth following a womb transplant – and the first following a transplant from a deceased donor.](#) Grace is the first person to have a baby as part of the approved deceased donor womb transplant research programme, initiated and funded by the charity Womb Transplant UK and includes OUH and Imperial College Healthcare NHS Trust as key partners. The womb

transplant programme is jointly led by Isabel Quiroga, a leading consultant transplant and endocrine surgeon at OUH.

- Brain tumour patients being treated at the Churchill Hospital in Oxford are the [first in the UK to benefit from a new way of carrying out MRI scans to plan specialist radiotherapy treatment](#). Thanks to £115,000 of new equipment funded by Oxford Hospitals Charity, this is faster, more precise, and targeted radiotherapy for patients, while also saving valuable time for staff. Initially, 250 patients per year will benefit from the new technology.

Our award-winning teams

We are proud that the commitment of our staff to providing high quality and safe care for patients has been recognised this year:

- [Two senior surgeons from OUH have been recognised with prestigious national awards from the British Association of Oral and Maxillofacial Surgeons \(BAOMS\)](#). Daljit Dhariwal received the Down Surgical Prize, recognising a lifetime of exceptional service to surgery, while Montey Garg won the BAOMS Surgery Prize for surgeons in the first 10 years of consultant practice.
- An app developed by staff at OUH has been [celebrated as an 'outstanding patient resource'](#). Sarah Havord, a VTE Prevention Specialist Nurse Practitioner, and her colleagues won the 'Outstanding patient resource, sharing information about VTE prevention for patients' category at the Thrombosis UK VTE Awards 2025. The [Let's Talk Clots](#) app provides information to patients about blood clots and how to reduce the risk of developing one. Since its launch in November 2023, the app has been downloaded thousands of times.
- Sally Springett, a clinical nurse specialist working in bone marrow transplant research at OUH, won the Game Changer of the Year Award at the [Anthony Nolan Supporter Awards](#) in September 2025.
- The Thames Valley and Surrey Secure Data Environment (TVS SDE) project, a partnership between OUH, Telefónica Tech and Starlight Consulting, was Highly Commended in the 'Data Integration Project of the Year' category at the [Health Service Journal \(HSJ\) Partnership Awards](#) in March 2026.

Performance against some national standards is included in this Quality Account and is discussed in more detail in the Annual Report.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by Oxford University Hospitals NHS Foundation Trust.

ADD SIGNATURE WHEN COMPLETED

Simon Crowther
Interim Chief Executive Officer

xx May 2026

About us and the service we provide

Oxford University Hospitals (OUH) is a world renowned centre of clinical excellence and one of the largest NHS teaching trusts in the UK. We became a Foundation Trust on 1 October 2015.

The Trust is made up of four hospitals –

The [John Radcliffe Hospital](#) (which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre and Women's Centre), the [Churchill Hospital](#) and the [Nuffield Orthopaedic Centre](#), all located in Oxford, and the [Horton General Hospital](#) in Banbury, north Oxfordshire.

We provide a wide range of clinical services including specialised and highly specialised services, medical education, training and research.

Most services are provided in our hospitals, but some are delivered across more than 100 satellite locations across the region, and some in patients' homes.

Our collaboration with the [University of Oxford](#) underpins the quality of the care that is provided to patients, from the delivery of high-quality research, bringing innovation from the laboratory bench to the bedside, to the delivery of high-quality education and training of doctors.

Existing collaborations include the ambitious research programmes established through the [Oxford Biomedical Research Centre \(BRC\)](#) and [Oxford Clinical Research Facility](#), both funded by the [National Institute for Health Research \(NIHR\)](#), and at the [Biomedical Research Unit in musculoskeletal disease](#) at the Nuffield Orthopaedic Centre. These set the standard in translating science and research into new and better NHS clinical care.

More information on OUH and its services is available on the Trust website at [Oxford University Hospitals NHS Foundation Trust Website](#)

Priorities for Improvement and Statements of Assurance from the Board

Priorities for Improvement

Results and achievements for the 2025/26 Quality Priorities (QP)

This section details the Trust's achievements against its quality objectives for 2025/26. While good progress has been made on many of the Quality Priorities for 2025/26, progress on others has been slower than planned due to operational pressures. The Trust continues to support clinical services towards completion of the outstanding objectives. To support ongoing progress, three of the 2025/26 Quality Priorities have been extended into 2026/27, these are: *Excellence also in the basics - reducing variation, improving care through Standard Work, Strengthening Discharges* and *Advance care Planning - End of Life care*.

Patient Safety

Quality Priority 1 System for Electronic Notification and Documentation (SEND)

Why is this a priority?

Why is this a priority?

SEND (System for Electronic Notification and Documentation) was developed in Oxford with support from the National Institute for Health and Care Research (NIHR). It provides an electronic platform for inputting adult inpatient observations, and a clear graphical representation of the patient's observations and National Early Warning Score 2 (NEWS 2). This allows easy identification of trends, early identification of patient deterioration, and escalation recommendations in line with national and local guidance.

The system has faced some challenges leading to reduced use by clinical staff. Issues have included hardware failures, finite technical support, and limited awareness and therefore use among clinicians. The goal is to maximise the opportunity SEND presents to strengthen patient safety by addressing identified hardware issues; embedding equipment checks into standard work; streamlining systems for data entry; and piloting and rolling out the use of SEND for handovers.

Table 1 SEND and Documentation QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 1 (Q1) Monitoring and governance Establish a formal SEND Task and Finish Group responsible for overseeing this	Agreement of Terms of Reference for the group	Complete As we have moved through the year, we have continued to engage with the group and with other key stakeholders to continue to work on issues

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Quality Priority. This group will report to RAID committee and provide updates of these actions		surrounding documentation of observations.
	RAID [1] minutes will highlight progress	Complete - The SEND working group continues to report into the RAID committee. - It is likely this group will merge with and continue to work on this project as part of the Escalation of deteriorating patient QP for the upcoming year.
Objective 2 (Q1-3) Update and roll out education and policies Update the RAID policy (Q1)	RAID Policy finalised, and on the intranet	Complete The RAID policy has been finalised, published and shared on the RAID Share Point page.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Develop a Standard Operating Procedure (SOP) for the documentation of observations and escalation of concerns which links to the Recognising the Acutely Ill and Deteriorating Patient (RAID) Policy (Q1)	When the SOP is signed off, and on the intranet	In Progress SOP has been completed but approval is being sought. Sign off should occur in May/June 2026
Develop SEND online learning resources for (a) the documentation of observations using SEND; and (b) the use of SEND for monitoring observations	SEND learning resources available on My Learning Hub (MLH)	Complete - SEND learning resources are now available on MLH for Midwifery, AHP and Nursing staff. - Sharepoint page for medical staff and shared with incoming doctors at induction - We continue to encourage staff to report equipment issues in a timely manner.
- Update current training materials and roll these out across the organisation supported by education colleagues - Update role-specific user guides	- SEND learning resources included in core clinical induction - Other training materials updated and available on intranet	Complete Sharepoint page for medical staff and shared with incoming doctors at induction

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
		- We have continued to train RAID Assessors 21 members completed RAID assessor training in 2025/26 6 have completed the RAID training and are progressing towards completion. - There are 68 in date RAID assessors across the Trust - We share data with ward managers emphasising the importance of documentation of observations on SEND. - Discussions are continuing with regard the platform for recording of observations. A new vital signs monitor is being trialled in the Trust at present which will support future direction in terms of documentation of observations.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Include SEND in mandatory training for all clinical staff at induction and upload to My Learning Hub. The training undertaken will be appropriate to role and use of SEND (Q1-3)	- Increase in staff training compliance as reported by MLH - Improvement in reporting rates for equipment issues - Improved compliance with observation timeliness	Complete - SEND learning resources are now available on MLH for Midwifery, AHP and Nursing staff. - Sharepoint page for medical staff and shared with incoming doctors at induction - Overall compliance with documentation of observations in SEND for 2025/26 is 60% - This broken down as follows. - Low Risk: NEWS 2 Score of 0-4 Compliance 62% - Low-Medium Risk – NEWS 2 Score of 3 in one parameter- Compliance 47% - Medium Risk – NEWS 2 Score 5-6 – compliance 50% - High Risk- NEWS 2 score of 7 or above or with any clinical concern captured – compliance 51%

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 3 (Q1-3) Pilot and embed the use of SEND for clinical handovers Pilot for a period of 1-3 months; audit the use of SEND for handovers and as part of RAID Huddles	Successful use of SEND at the pilot locations, no issues have been identified, and staff are using and are engaged with its use	In Progress Plan, Do, Study, Act (PDSA) surrounding RAID Huddles is continuing and updates in electronic patient record (EPR) have occurred following initial PDSA cycles.
Following successful pilot, roll out to hospital at night team handovers Trustwide	- Audits will show that clinical handovers and RAID Huddles with SEND are used 80% of the time - Feedback from staff will be positive and any issues will be resolved	In Progress The use of SEND amongst medical staff remains low owing to the need to move between platforms when EPR is predominantly used. We have shared the correct desktop link to SEND with clinical areas to encourage use from computers which also contain EPR.
Q1: Task and Finish Group to agree at least one initial clinical area(s) for the pilot	The Task and Finish Group and RAID are satisfied that the pilot and rollout to hospital at night team handovers has been successful based on feedback and audits and sign off on the rollout	In Progress Uncertainties about the future of SEND and ongoing difficulties in use of the platform by medical staff have slowed progress for Objective 3

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 4 (Q1-4) Access and troubleshooting - Provision and checking/maintenance of the required equipment (part of the Standard Work programme). This will be supported by the Clinical Engineering team - Embed clear processes to ensure ward staff can easily escalate to IM&T and Clinical Engineering any maintenance issues	Ticket turnaround time for SEND maintenance issues from ServiceNow	Complete IM&T colleagues continue to support areas in addressing issues with the SEND platform. The most common issues remain the need to reset tablets and WIFI connectivity. IM&T colleagues are responsive however this remains a source of frustration for ward teams.
- Monitor the rollout of SEND devices to replace other models of machines - Ensure there is a clear and proactive process to issuing licences for staff	Monitor the device registry rollout to ensure up-to-date SEND devices are rolled out across all clinical areas (where appropriate)	Complete Evaluation of new vital signs monitors is complete; they will first be implemented in maternity to allow for further discussion on the future of the SEND platform.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 5 (Q1-4) Maintenance and sustainability Work with Digital Services to resolve any existing issues with the SEND platform	User feedback shows improved user satisfaction with the SEND platform	Complete User feedback is complete and reflects that changes are required but there is lack of capacity in SEND to resolve this therefore other solutions are being reviewed to see what is available.
Work with Digital Services to examine the optimal resource necessary to provide robust technical support for the SEND platform	- Maintenance items are resolved in a timely fashion - An examination has taken place to show the longer-term sustainability of SEND, or another bedside observation workflow	In progress - The continuing issues with the SEND platform have been escalated to the Chief Medical Officer and Chief Digital Information Officer for further review and ongoing discussion about future solutions. - The SEND options appraisal is on pause currently while the digital executive explores their wider EPR strategy

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Work with Digital Services to review options for long-term bedside mobile solutions	Improvement in reporting rates for system issues	Complete Fewer WIFI issues are being reported due to the work undertaken by IM&T colleagues to ensure improved connectivity.
Develop a digital quarterly report to monitor issues with SEND devices. The quarterly report will be presented at the SEND working group for monitoring	Improvement in the metrics in the quarterly report showing fewer maintenance issues with SEND devices	Complete It has been important to listen to staff frustrations with SEND and how this is impacting on documentation in the platform. It is important to look to future options to support clinical teams caring for acutely ill patients. – There is an options appraisals being developed to look at future options for recording adult in patient observations.

^[1] RAID - Recognising the acutely ill and deteriorating patient.

Quality Priority 2: Medicines Reconciliation

Why is this a priority?

A 2018 Cochrane review found that 56% of patients are at risk of medication discrepancies at transitions of care. Published data suggest inadequate reconciliation of medications is estimated to cause 40% of medication errors, 20% of which result in potentially avoidable harm. Avoidable Adverse Drug Events are associated with increased cost and length of stay.

This Quality Priority aims to strengthen medicines reconciliation during the inpatient stay and on discharge; and to link this to a Discharge Medicines Service through which referrals are made to community pharmacy teams. The benefits include improved patient safety and operational and financial efficiency.

Table 2 Medicines Reconciliation QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Objective 1 (Q1) Establish current baseline and ongoing monitoring Establish required dataset for measurement of improvement and cost avoidance by end of Month 1	- Key Performance Indicator (KPI) defined - Estimate financial savings from avoidable harm ± reduced length of stay	Complete - Deep dive reported at Integrated Assurance Committee June 2025 - Dataset has been reviewed and revised. - Able to report performance by ward/first location, and timing of completion at 24/48/72 hours. - Reporting SOP written to confirm inclusions/exclusions in the reporting. Exclusions are minimal (services not using EPR; patients staying <24 hours).

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Establish regular KPIs, including monthly point prevalence audit on errors Identified at reconciliation as KPI and monthly point prevalence audit on patients who have not had admission reconciliation by point of reconciliation on discharge	- Establish monthly point prevalence audit on errors identified at reconciliation - Establish monthly point prevalence audit on patients who have not had admission reconciliation by point of reconciliation on discharge (to take out (TTO))	In Progress - KPI aligned with Shelford organisations as 80% within 24 hours by time stamp. - Point prevalence audit planned for June 2026, incorporating the financial impact of this KPI.
Objective 2 (Q1) Discover and Diagnose Discover and diagnose current barriers to performance at both admission and discharge using QI tools by end of month 2	- Sharing of output e.g. - Fishbone - Driver Diagram - Timed Observations - Process Map of current state - The wider teams understand the barriers to meeting KPI	Complete - The most challenging barrier to performance is workforce capacity. A 94% increase in demand since 2018/19 has not been matched by staffing growth. - Alignment of current workforce to Monday to Friday services results in particularly poor performance for patients admitted Friday or Saturday. - Development of novel pathways via triage, ambulatory and virtual services have not considered processes for

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		medicines reconciliation, resulting in many patients not having medicines reconciled within the desired timeframe.
Objective 3 (Q2-3) Test ideas for improvement A minimum of two Plan-Do-Study-Act (PDSA) cycles and one testing improvement to be completed by end of Q2. Options dependent on QI scoping, but could include redefining responsibilities, embedding 12 noon huddles, GIRFT approach with clerking clinician engagement and robotic processing. Utilise learning for further PDSA cycles in Q3	Summary of learning from PDSA cycle(s) produced	In Progress - A standard work approach has been drafted for consultation by the pharmacy team. - Ideas generated include: - Live oversight dashboard of work outstanding - Acuity scoring to prioritise patients most likely to benefit from MR. - Robotic process automation to pull information from the GP record to appropriate section of EPR. - Progress with digital solutions has been delayed due to competing Trust

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		priorities requiring digital team/ Inicio support.
Improvement idea tested within high frequency admission area(s)	- There is a positive outcome from testing - There are incremental improvements in performance with each PDSA cycle	In Progress Workforce mapped to demand. Planning in place to transition Pharmacist late duty shifts to clinical areas following technician recruitment. Anticipated outcome is support to Emergency Assessment Units (EAUs) and SEU much later in the day i.e. to 8pm to align with admission patterns. The project will require approval of a business case for new technician posts and possible HR consultation; anticipated delivery by end of March 2027.
Objective 4 (Q 1-3) Model capacity and demand with improvements in place	Clear mapping of demand and optimal work patterns to meet this	Complete Modelling complete.

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Model capacity to meet demand (admissions and discharges), test impact of adjusted working patterns. Produce gap analysis and business case if needed to address shortfall via workforce and/or automation: by end of Q3	- Productivity and efficiency gains of 7 days service modelled - A business case has been produced (if required)	Unable to Complete Unable to fund additional hours to test this due to financial controls.
Objective 5 (Q1-4) Facilitate community reconciliation on discharge Embed PharmOutcomes referral tool within EPR to efficiently refer patients to community pharmacy on discharge	1.5% of completed consultant episodes referred (from hospital episode statistics (HES) data) - There should be a reduction in readmissions: assessment against modelling, predicting 100 pa	In Progress. Funding source identified. Business Case presented to CSS Divisional business planning group. Anticipating progression to TME and approval due to significant productivity gains identified. Currently with CSS Divisional leadership team, linked to transfer of other services to Pharmacy. Business case suggests significant potential productivity gain.

Quality Priority 3: Fragility Fracture pathways – including fractured neck of femur pathway

Why is this a priority?

The results of the National Hip Fracture Database (NHFD) demonstrate that at the John Radcliffe (JR) site there is a need to shorten the time taken for hip fragility patients to access surgery.

By contrast, the Horton General Hospital (HGH) continues to deliver care that regularly meets the National Standards.

This Quality Priority aims to combine several quality improvement (QI) workstreams to improve the pathway at the John Radcliffe Hospital and thereby reduce morbidity and mortality.

Table 3 Fragility Fracture pathways – including fractured neck of femur pathway QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Objective 1 (Q1-4) Improving percentage of non-ambulatory fragility fracture (NAFF) patients operated on within 36 hours Q1: Development of a SOP to allow escalation of theatre capacity concerns, and creation of additional emergency trauma capacity in OUH Theatres	Surge capacity procedure in place	Partially Complete Surge capacity: Extra lists at HGH for ambulatory trauma and 3 x 3 session new trauma lists planned at JR as part of Surgical Elective Centre (SEC) planning.

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
- Q2: Change in trauma consultant rota to allow more flexibility to deliver extra lists - Q3: Review of demand and capacity following above changes and understanding opportunities from new theatre build if additional theatre capacity needed	- New trauma consultant rota in place - The additional lists are being used to help with capacity - Demand and capacity modelling available	Complete - New trauma consultant rota in place, rota consultation process continuing - The Trauma capacity group have mapped the requirement for extra capacity and defined working with the JR/West wing Theatre Clinical Director. A strategy to increase capacity for fragility fracture patients at the JR has been developed.
Q4: Expand to a 7-day trauma coordinator service	Business case to deliver 7-day trauma coordinator service submitted to Business Planning Group (BPG)	In Progress - Due to Trust's financial position, business case (BC) for 7-day trauma coordinator service has not progressed. - The Trust financial position means that there has been a delay in the progression of a BC for another GO consultant, which would improve weekend cover.
Q4: Implement Geriatric Orthopaedics (GO) and	Data shows an increase in NAFF patients being operated on within 36 hours	In progress

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
anaesthetic review on day of admission	- Best Practice Tariff (BPT) criterion (a), time to theatre <36 hours, >85% performance - GO review on day of admission – target is 85% of patients seen on day of admission.	- At the JR, the percentages of medically fit enough patients having surgery within 36 hours was 91% in March 2026. - For the National Hip Fracture Database, there is an expectation that patients are reviewed by GO within 72 hours of admission. The JR currently stands at 97% and the Horton is 99%, which are both well above national average. - An 85% local target has been established for GO review on the day of admission, as early medical assessment is associated with improved surgical optimisation and outcomes.
Objective 2 (Q1-4) Improving therapy access to NAFF fracture patients Q1-2: Develop a strong business case to allow 7-day access to therapy services	Business case submitted to Business Planning Group	Complete A Business case has been developed and submitted to OUH Business Planning Group

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Q2-3: Appointment to expanded therapy posts following successful business case	- Improved NHFD metrics (key performance indicator ((KPI) 4). Improved BPT criteria - Reduced acute length of stay - Q4: Improved NHFD KPI 4. Prompt mobilisation after surgery: therapists seeing patients on the day or the day after surgery	Partially Complete - KPI 4: data for JR currently 93% patient mobilised the day after surgery (national average 82%). - The Horton currently stands at 80%. There is a need to increase the % of patients mobilised the day after surgery. Work is ongoing to increase physiotherapy cover at the weekend.
Q4 Implementation of 7-day physiotherapy services to allow all fragility fracture patients to be mobilised on day or day after surgery	- There are fewer complaints about accessing therapy services following NAFF surgery - The acute length of stay has reduced, and patients are not being readmitted	Partially Complete The BC for this service has been developed but has been deprioritised given current good performance, including 93% mobility on day 1 post op at the JR (national average 82%). Work is ongoing to increase physiotherapy cover at the weekend at the Horton where performance against this KPI is 80%.
Objective 3 (Q1-3) Improving multi-specialty working to care for NAFF fracture patients	Daily MDT meeting in theatre	Complete The daily WHO briefing in theatre continues.

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Q1-2: Workforce review to deliver a daily multidisciplinary meeting including theatre teams to facilitate preoperative care and shared decision-making	Data/questionnaires show that daily MDT meetings with theatre staff are occurring and that all staff groups feel that this teamwork has improved overall care for NAFF patients	
Q2-3: Workforce mapping and capacity modelling to deliver equitable orthogeriatric care across all OUH sites and provide 7-day cover	Workforce demand and capacity modelling completed	Partially Complete - There has been more collaborative discussion between anaesthetics, GO and trauma regarding the care of complex NAFF patients. - There has been increased input from anaesthetists including at the trauma screens meeting.
Objective 4 (Q1-4) Improving Cohorting of NAFF patients Q1: Develop pathways/SOPs for cohorting of NAFF patients to facilitate specialist medical/nursing/AHP care	- Q2: Pathways agreed and supported by SOPs. Enacted where possible. Nominated NAFF ward/cohorted beds outside of Trauma Unit footprint in place - The cohorting of NAFF patients is occurring and working well	Partially Complete - NAFF patients are admitted to the trauma unit. This is largely due to the work undertaken by the trauma coordinators. - The ED has led on improving the fragility fracture pathway to hasten the time

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Prioritising initial perioperative care in the Trauma Unit (familiarity of staff, facilitation)		taken for patients to be admitted to the trauma unit.
- Q2: Feasibility study on how to deliver pathways sustainably including a review of demand vs bed capacity to reduce outliers - Admission of all operative NAFF fracture patients to specialist trauma ward from ED with cohorting of NAFF patients for care after the initial perioperative period	- Q2-3: Feasibility study completed - Q4: Number of unnecessary outlier NAFF patients to be minimised outside of Trauma Unit and/or dedicated NAFF ward - Q4: NHFD KPI 0 – over 85% of patients are given a nerve block and admitted to an appropriate orthopaedic or orthogeriatric ward within four hours of presentation	Partially Complete KPI 0 – The JR is still at 3% (national average 10%) on the national hip fracture database. The Horton stands at <u>38% in February 2026</u>. Barriers to admission are being explored but building work adjacent to the trauma unit and works on air conditioning units have meant beds have been closed and some patients cannot be admitted to the trauma unit if they are immuno-compromised.
	That ‘ringfenced’ beds for NAFF patients are available and being used which aids with operating with 36 hours	Complete ‘ring-fenced’ beds for NAFF patients are being used
Objective 5 (Q1-4) Nutrition and fasting process	Q3: Audit of ‘Sip until Send’ administration on EPR/Audit compliance with hip fracture	Complete Sip till send remains adopted by all areas.

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Q1: Introduce 'Sip until Send' policy for non-ambulatory fragility fractures	power plan which includes Ensure juice administration	
	- Q4: Improve Malnutrition Universal Screening Tool (MUST) compliance on NHFD (BPT criteria) - There is compliance with the MUST and there is no evidence of NAFF patients with nutritional issues (there may be unforeseen exceptions even with a completed MUST)	Partially Complete MUST compliance currently stands at 85% for the JR and 100% for HGH. This is for all trauma patients, (not exclusively NAFF patients)
Q2-3: Develop business case for nutritional assistant	Q4: Business case submission to BPG	Not Complete Due to the Trust's financial position, the BC has not progressed regarding nutritional assistance.

Clinical Effectiveness

Quality Priority 4: Standard Work

Why is this a priority?

At OUH, we are committed to delivering the highest quality of care, therefore we are prioritising the implementation of the Standard Work (SW) concept across our services. Drawing from the learning and evidence base from wider industries, this approach is designed to ensure that every patient receives consistent, safe and effective care while supporting our teams in their daily work.

The initial focus for the Standard Work programme has been supporting clinical inpatient teams, working to align with existing structures and reduce duplication and enhance care, for example linking with and understanding the alignment with Care Assure. This provides a frequent opportunity to assess fundamentals of care.

Standard Work is a clear, step-by-step framework that outlines the best way to complete specific tasks based on evidence and expertise. It is about creating reliable processes that support excellence in care. Success will be evaluated through clear metrics, including audit results, staff engagement levels and outcome measures tied to organisational goals.

The overall aim of the Quality Priority is to enable the successful adoption of Standard Work in a structured, measurable and impactful manner on defined priority areas, building forward our culture of excellence and continuous improvement, benefiting patients, staff and the organisation.

This Quality Priority is being rolled over to 2026/27

Table 4 Standard Work QP 2025/26

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
Objective 1 (Q1-4)	Develop standard protocols collaboratively with frontline staff, support adoption of continuous improvement approach and	In Progress

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
Embedding Practice - Embed Standard Work (SW) approach in defined Core Priority Areas of Practice – 25/26 focus on Board Rounds, Equipment Checking, Safe and <i>Secure Storage of Medicines and Safety Huddles</i> - By the end of 2025/26, Standard Work approach will be established in phase one priority areas, demonstrating 80% increase in adherence to defined standards as measured through regular audits	digitisation of results at ward level across identified priorities (e.g. Board Rounds, Equipment Checking, Safe and Secure Storage of Medicines and Safety Huddles) - Capture lessons learnt and case study examples through ‘big room’ to share best practice, scale and spread. - There will be a reduction in variation in practice across selected areas. - Improvements in priority specific defined KPIs	- Blood Glucose Monitoring task and finish (T&F) group overseeing actions, mitigating staffing levels in Biochemistry and maintaining momentum. - T&F Groups established and meeting frequently for all key priority areas except Safety Huddles. Groups have adopted an approach underpinned by QI and continuous improvement. Initially diagnosing and understanding the problem and now working to define clear standards for wards to establish clear processes to achieve. Key standards have been developed or are under development and have been shared with key stakeholders. - Lessons learnt from all task and finish groups captured to support the reduction in variation across wards and are being shared to ensure inclusion in future work and wider Trust approach to standard work.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	Board Rounds: • % compliance to Board Round Policy, including core and enhanced elements	In Progress Board Rounds • Adult ward cohorts 1-6 completed with an overall average increase of 34% improvement (from a baseline average compliance of 54% to a final average compliance of 88%) in compliance to policy. There has also been a sustained reduction in the average length of stay for elective patients within OUH. The reduction in the average length of stay per ward was 12.5 hours. • There has also been an increase in the anticipated date of discharge (ADD) completion within 48 hours of admission from 10% to 50%. • There has been an average increase in the number of discharges before midday per week per ward of 1 and an average increase in discharges per weekend per ward of 1. • Cohort 7 (Paediatrics) – 14 PDSA's have now been completed across Bellhouse Drayson, Horton Children's and Toms wards which will support and inform spread to other Paediatric

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		Wards. The wards have now moved into their 30-60-90 day reviews. • Whiteboard screens are being made operational. Training being planned for staff members where required. Good level of engagement and learning being shared within various forums prior to spread with other children's wards. • An end of Project report for the adult wards and the lessons learnt report have been completed and have been presented at the Standard Work Programme Group as part of governance. • A board round SharePoint page has now been created and live within the QI Zone for staff to refer to for ongoing support. • Sustainability – "holding the gains" - self assessment questions for Board Rounds for all wards now embedded into Ulysses which will have Divisional oversight. This is being completed monthly by all wards. • Board Rounds will now be observed as part of the OxSCA visits.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		- An NHS Impact case study has been completed to share learning from the project and currently planning to disseminate this both internally and externally. In Progress - The revised Board Round policy has been updated following feedback and was presented at the Clinical Policy Group at the beginning of November and was approved. In Progress Equipment Checking - Key priorities for equipment checking includes SEND, Resuscitation and Blood Glucose Monitoring - Task and Finish Groups underway with representation from key services and all Divisions In Progress Resuscitation Checks

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	Equipment Checking: • % compliance of defined standards to check equipment	• First draft standard for resuscitation checks has been completed and will be published using the new OMI template. Rollout and monitoring plan to be agreed with Divisions. • Standard Work for resuscitators in progress and will be tested on the Newborn Care Unit in early 2026. • Key issue has been around consistency of checks and monitoring as resuscitation checks mainly take place over night. • The QI team are linking with the Care Assure team to check and integrate the appropriate questions into the visits linked to the Standard Work document. • Compliance is being measured within My Kit Check and My Assurance Hub. In Progress SEND • Ideas for tests of change for SEND have been developed within the task and finish group as well completion of high-level process maps.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		- The 'one best way' to perform an equipment check for SEND has been documented including photographs and key steps using the new standardised Standard Work Template - Testing is planned at the Horton at the Juniper and Laburnum wards due in early 2026 due to clinical pressures In Progress Blood Glucose Monitoring - Blood Glucose monitoring equipment priority has been progressing with the QI team visiting wards and identified areas to observe their current processes and speaking to staff to gain insights prior to process mapping. - Process map was completed and identified waste in unnecessary ketones checks being carried out within the Trust. The guidance states that ketone checks only need to be carried out once a week, however the meters were prompting staff to undertake a daily check.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		• The prompt could not be changed without changing the frequency of glucose checks. • The Point of Care team undertook an audit of over 10,000 data points and a literature review to determine whether the frequency of the quality checks could be changed. A decision was made to move to weekly checks from the beginning of October and was communicated to all key stakeholders. • The change from daily to weekly checks has projected to save per year: ○ 16,337 clinical hours ○ £30,318 from glucose strips not used. ○ £84,640 from ketone strips not used. • Weekly checks now form part of 'one best way' to perform a quality check. • Use of the Standard Work document for performing internal quality check to be drafted by end of January 2026.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		- The financial savings linked to the change from daily to weekly checks are being calculated at Divisional level and will be shared when ready. In Progress Safe and Secure Storage of Medicines (SSSM) - Task and finish group underway aligned to Medicines Quality Priority and other priorities - Focused observations and stakeholder engagement carried out in Endoscopy, SEU D, CMU A, WW Theatres, JR Theatres, ED and Neonates. Data had been gathered to understand challenges and opportunities in each area using QI methodology to inform work and share learning. 5S (Lean methodology) in planning in conjunction with Standard work being progressed in pilot areas with alignment to planned pharmacy stock reviews. Endoscopy room undertaking tests of change and gathering staff feedback. - Standard work documents for key processes have been agreed within the task and finish

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		group and now being tested. This mainly focuses on the stock handling of pharmacy items, breach escalations and temperature checks which were raised by Pharmacy as key processes that required a standard work approach. • There is clear alignment with the roll out of the digital fridge temperature monitoring solution. • SSSM audits have shown general level of improvement throughout the year in key areas where the QI team had been supporting alongside other priority initiatives in place. • Divisional teams have approached the QI team to review some other areas linked to SSSM following Care Assure visits and other audit results. In progress Safety Huddles • Trust wide clinical questionnaire has been distributed and baseline data available.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	Safe and Secure Storage of Medicines: % increase in compliance measured through Safe and Secure Storage of Medicines audit Safety Huddles: % clinical teams completing safety huddles in alignment with the policy	- Results had shown that discussions were patient centred, responsive and adaptable to departmental requirements. - Feedback from Standard Work Programme Group proposed a principle-based approach rather than a standard would work and will progress with Divisional Leads - QI teams are working with Ophthalmology, a service identified by the Chief Medical Officer, who could benefit from focus into the Standard Work concept, in particular for Safety Huddles.
Objective 2 (Q1-4) Materials Support Materials and Infrastructure for Wider Organisational Adoption of Standard Work	- Define and develop clear branding and approach to language to aid adoption and Trust wide engagement. - Develop Standard Work resources toolkits tailored to organisational need, facilitating the optimisation of current portal for Standard Work for sharing resources wider than defined priority areas.	In progress - Branding for Standard Work has been approved by Chief Officers - Continuation of ad-hoc engagement events with identified services (i.e. maternity, theatres, surgery, endoscopy) as to help staff understand more about standard work following requests within programme group. - Standard Work SharePoint page now available and linked for staff to easily access current

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	• Integrate approach into core Trust business within Divisions with governance enabling scale and spread. • Toolkit and digital platform launched and actively used by staff. • Inclusion of Standard Work in 80% of induction and training programmes • Increased uptake of resources, measured by at least 70% of targeted staff engaging with the toolkit and platform. • Staff report increased confidence and ease in applying Standard Work practices	resources – additional pages under development linked to priority areas to provide specific resources for teams (i.e. Board Rounds and Resuscitation Checks) • Standard Work template for visual display to use in all OUH clinical and non-clinical areas designed by OMI and being shared for use with key teams / services the QI teams are working with at present – once tests of change are complete, the Standard Work documents for the priority processes will be rolled out across the organisation. The document will be instantly recognisable and provide a level of consistency. • Standard Work Masterclass (2 hrs) has been developed and has been tested with identified services. The masterclass was adapted for a one-hour session as part of the BOB ICS Quality Improvement Festival week back in September. • Staff providing feedback through tests of change which is increasing knowledge and confidence of using standard work concept. • Governance / Assurance

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		• Bi-monthly programme meetings in place attended by Divisional leads, task and finish group leads and key stakeholders across the organisation. • Visibility from ward to board, ensuring that compliance is recorded centrally; to allow focus for services and any actions are acted on and changes linked into Care Assure or other groups where required. • Bi-weekly meeting with Accountable Officer in place to help with embedding programme at pace and opportunity to understand any risks and escalations.
Objective 3 (Q2-4) Long-term strategy • Define long-term approach to Trust wide adoption of Standard Work • Engage staff and stakeholders to co-design	• Drafted and approved Trust wide roadmap with Divisional oversight framework • Evidence of measurable improvement in KPIs, e.g. safety, quality, efficiency and patient/staff experience metrics. Case studies sharing best practice to support further adoption	In Progress • Foundation and Engagement – focus has continued establishing standard work programme infrastructure to deliver within defined priorities. • Continued strong engagement across Divisions and wider support services - linked into Standard Work Programme Group.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
a long-term strategy post 2025/26, defining ongoing approach to scale up and integrate into OUH's strategic planning / Quality Management System		• Standard Work Quality Priority agreed to continue into 2026/27 and has been presented to the Quality Conversation Event in December. • National and International Case Studies: Presentation of the Board Rounds project at the Institute for Healthcare Improvement (IHI) International Conference in Utrecht in May. • Submitted application to the Health Service Journal (HSJ) National Awards for the board round project, which was unfortunately not shortlisted, but opportunity to share and gather learning nationwide. It is expected that this will attract national interest as evident when shared in the improvement marketplace at the BOB Southeast Learning Improvement Network event back in May. • NHS Impact Case Study linked to Board Round project has been drafted and shared with key stakeholders internally within OUH. The QI Project Manager is progressing the publication of the case study with NHS Impact as well as the British Medical Journal (BMJ) Open Quality forum.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		Next Steps: • Year two proposal to focus on adopting Standard Work more widely across the organisation as part of a longer-term strategy. • The proposal will also include defining the approach with staff and key stakeholders, embedding it within OUH quality management system, working with selected services to test, adapt and implement changes before wider rollout with Divisional support. • The programme will also include continued work on Safety Huddles and Safe and Secure Storage of Medicines.

Quality Priority 5: Outreach Service from Oxford Critical Care

Why is this a priority?

The aim of the Oxford Critical Care Outreach (CCO) Service is to ensure safe, equitable and quality care for all acutely unwell, critically ill and recovering patients. This service provides two main functions: post-ICU patient follow-up, and early recognition of deterioration and rapid response within main Trust sites.

In-hospital follow-up supports patients during the transition from unit to ward. The aim is that it will better support all patients discharged from critical care, and particularly those discharged out of hours. It has the potential to improve outcomes, including reduction in readmission to ICU, in-hospital mortality, and hospital length of stay. Early recognition of deterioration and intervention can improve patient outcomes and provide timely, expert advice to medical teams. The introduction of Martha's Rule is also likely to advocate a need for 24/7 access to a rapid review of patients and coordination where appropriate for additional input for critically unwell patients.

Implementation of a full 24/7 outreach service is recommended by key national guidance standards including Getting It Right First Time (GIRFT), and guidelines for the provision of intensive care surgery (GPICS) and is a recurrent theme in NCEPOD reports. It is also advocated in NICE guidance. Introduction of CCO was a recommendation in the 2022 Care Quality Commissions (CQC) inspection of OCC.

Aim: develop and pilot an outreach service for the Trust, coordinated and overseen by Oxford Critical Care / Critical Care, Anaesthetics, Preoperative Assessment and Resuscitation (CAPR). This will improve the follow-up of post-ICU patients, recognition of deteriorating patients, improve speed and quality of decision-making, improve bed length of stay, and provide a platform for improved nursing retention.

Table 5 Outreach Service from CCO QP 2025/26

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
Objective 1 (Q1)		
Project Board set-up	Project board initiated with agreed terms of reference	In progress

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
- Develop a CCO Project Board - To include Martha's Rule	- Minutes from meetings - Project plan progressing - Actions are occurring from the Project Board	- Project Board Terms of Reference (ToR) and Membership dependent on the option selected in the business case - Martha's Rule pilot progressed with support from Critical Care teams at JR and HGH. - Martha's Rule was rolled out to all areas of the Trust in March 2026.
Objective 2 (Q1) GAP analysis - GAP analysis for out of hours (OOH) medical and nursing escalation from wards - This will feed into the options appraisal / business case	Completion of the GAP analysis	Completed as part of business case
Objective 3 (Q2-3) Options appraisals		Completed Submitted as part of business case

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
Four hospital site analysis for CCO needs to create options appraisal which will include options for 'do nothing', 'minimum investment / restructuring of available resources through to the most ambitious options – this will feed into the business case	Completion of options appraisal	
Objective 4 (Q2-3) Communication - Agreed communication escalation methods for CCO – Martha's Rule / GAP analysis feedback – interim step overlaid to CCO - This may feed into the options and the business case	- Implementation and communication of the escalation process - Auditing will show if the escalation process is working effectively - The escalation will be working well, and staff will understand how to use it	In progress - Martha's Rule pilot (June – Dec 2025) provided additional route of escalation of concerns regarding rapidly deteriorating patient. Process for escalation has been agreed across JR and HGH adult wards. Rollout of patient and staff escalation of concerns has taken place in March 2026 across children and adults in all 4 sites. - Also see objective 7
Objective 5 (Q3) Business case		In Progress A draft outreach options appraisal and business case has been developed

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
Business case submission for CCO based on options appraisal	Successful submission of business case	
Objective 6 (Q3-4) Implementation CCO implementation based on outcome of options appraisal and business case	The OCC is in place as per the business case by end of Q4	Not yet commenced. Contingent on objective 5
Objective 7 (Q1-4) Martha's Law Agree alignment of Martha's Rule with CCO	- Process map with GA analysis for Martha's Law escalation - Communication strategy with resource allocation, potential alignment to the business case	In Progress - Martha's Rule pilot was launched in June-December 2025 in adult areas at the John Radcliffe Hospital and Horton General Hospital. - Roll out of escalation of patient and staff concerns across all areas of the Trust took place in March 2026 - Martha's Rule Implementation group working to reduce any impact on Critical Care teams by filtering out all non-critical calls from CCO.

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		A new QP on Martha's Rule has been approved for 2026/27 to implement all components of Martha's Rule across the Trust

Quality Priority 6: Discharges

Why is this a priority?

There is increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a 'Home first' approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person's home. Consequently, the volume and complexity of discharge planning has increased.

This Quality Priority will review discharge processes for all patients and seek to improve the quality and safety of discharge. This includes reducing delays and length of stay, as well as learning from incidents and feedback. There will also be an opportunity to explore the empowerment of nurses and other Allied Health Care Professionals to lead discharge-based decisions to improve quality and reduce length of stay.

This Quality Priority is being rolled over to 2026/27

Table 6 Discharges QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Objective 1 (Q1-3) Improve experience of continuity and quality of care for patients Establish a process for reviewing quality, safety and risk of discharge from hospital	- Availability and collation of internal and external information - Thematic analysis of internal themes as well as from system partners - Share internally to appropriate colleagues for awareness and action where needed	In Progress and rolled over to 2026/27 Complete (and ongoing) Complete

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
Low threshold for picking up 'to take home' (TTO) related incidents, including those that are couriered via City Sprint Contact Medicines Information team for data from patient contacts	- Close feedback loop to system partners. - Increase patient satisfaction scores related to discharge communication by 15% - Positive feedback from patients and families regarding discharge communication within six months (questionnaires and friends and family tests) - There will be a 15% reduction in discharge-related complaints - Reduction in incidents regarding discharges	Complete In Progress and rolled over to 2026/27 - Dashboard not yet available to track progress and objectives linked to this outcome still in progress. In Progress and rolled over to 2026/27 In Progress and rolled over to 2026/27 - Dashboard not yet available to track progress and objectives linked to this outcome still in progress. In Progress and rolled over to 2026/27 Workstream 1 Medication – detailed update <i>Current activity and achievements</i> <i>Stopping routine over the counter medicines dispensed at discharge approved and implementation underway; aim is to</i>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<i>reduce dispensary workload so pharmacy can focus on critical tasks.</i> ▪ <i>Limiting discharge supply to regular meds for >5 day stays is in place with ICB negotiations progressing.</i> ▪ <i>Electronic FP10 (CLEO) funding secured for outpatient prescribing; platform implementation planning under way.</i> ▪ <i>Discharge Medicines Service (DMS) rolled out to improve GP/community pharmacy comms; expected productivity gains.</i> ▪ <i>Live pharmacy dashboard created; risk assessment for medication couriers (CitySprint) in progress.</i> ▪ <i>Recent workstream call captured the operational focus: timeliness of TTOs, patient information on medicines, and courier use; alignment with dispensary KPIs (objective of 2 hr turnaround).</i> ▪ <i>Existing procedure draft for discharging patients with medicines has been shared to</i>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<i>unblock governance work; includes risk assessment flow considerations for leaving without meds and courier delivery.</i> <i>Data enablement: TTO monthly report exists analysis can identify the % prescribed ahead of day</i> <i>Monthly workstream meeting ongoing since programme commenced with Executive Oversight Meetings monthly to monitor progress of programme</i>
Objective 2 (Q1-4) Improve and provide assurance of the safety of discharge from hospital Standardise discharge processes on departure from hospital Implement a mandatory Discharge Safety Checklist within the 'depart' process in the electronic patient record (EPR); one specifically for adult	- The Discharge Safety Checklist is on EPR for both adults and children - Completion rates of the Discharge Safety Checklist for both adult and paediatric inpatients	In Progress and rolled over to 2026/27 In Progress and rolled over to 2026/27 Due to discovery of greater than expected level of work required following the review of the checklist. Additionally the intention is to pre-empt safety issues at an earlier point than on discharge and to implement robust and sustainable changes in

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
inpatients and one for paediatric inpatients	- Achieve a 90% compliance rate with the new Discharge Safety Checklist within six months - Monthly audits showing increased compliance rates - Increase by 15% in positive feedback from patients and families regarding the discharge process 15% reduction in discharge-related complaints and incidents	discharge safety planning at an earlier stage in the patient's journey. In Progress and rolled over to 2026/27 In Progress and rolled over to 2026/27 In Progress and rolled over to 2026/27 This has been amended on the QP 2026/27 to reflect the National Inpatient Survey question and response with appropriate target Workstream 2 Communication – detailed update <i>Current activity and achievements</i>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		▪ Nurse-led discharge process being modelled in EPR, generic discharge summary template in development for all inpatients. ▪ Mandatory Discharge Safety Checklist under development for EPR; coordination across workstreams to remove duplication this has been added to the standard work programme and will be delivered by the QI team. ▪ Improved GP discharge letter format deployed into EPR following extensive work alongside documentation updates. Workstream 4 Documentation – detailed update ▪ Unified electronic discharge summary (“PowerNote”) rolled out in EPR for inpatients (Oct 2025). ▪ Revisions to GP discharge letter and distribution process are in progress and merged with Communication work stream

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		▪ <i>Verification that summaries/letters are auto sent to community teams and specialty follow-ups is underway.</i> ▪ <i>Checklist build ownership transferred to Communication so Documentation can focus on content quality and AHP contribution. Oversight notes confirm AHP profile integration.</i>
Objective 3 (Q1-2) Provide clear communication to patients and unpaid carers to on discharge processes and follow up support • Review and improve the clarity and comprehensiveness of discharge instructions for patients and their families • Discharge information leaflet a. Produce a discharge information leaflet for patients	• Completion and adherence rates of the discharge communication protocol • The leaflet has been produced, is in circulation and staff know about it and use it • Reduced misunderstandings from staff/patients on discharge pathways and expectations	Objective amended for year 2 following review of actions Complete and on track In Progress <i>Workstream 3 Patient Experience – detailed update</i>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
b. Publish a discharge information leaflet for patients Brief ward staff on the contents and embed its use	Staff feel empowered and prepared to answer questions relating to complex discharge from patients/relatives	▪ <i>New patient discharge information leaflet created, and a plan for consultation with patients and Patient Safety Partners approved.</i> ▪ <i>Emphasis on early involvement of patients/carers and Home First approach.</i> ▪ <i>Regular FFT collection targeted specifically at discharge experience and analysis is ongoing conducted by the Patient Experience team and fed into the programme.</i> ▪ <i>Capacity constraints acknowledged; interviews and codesign sessions planned as staffing returns.</i>
Objective 4 (Q1-4) Nurse, Midwife, Therapies and Allied Health Care Professionals (AHPs) led discharge opportunities	• Integration of the guidelines into the electronic patient record (EPR) system • Training completion for all staff participating in criterion-led discharge criteria	In Progress and rolled over to 2026/27

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
- Q1-2: Set up a scoping session to identify what is required and who can discharge patients - Q3-4: Once established, produce a Standard Operating Procedure (SOP) for nurse-led discharges - Develop and implement a criterion-led discharge process for Nurses, Midwives and AHPs Q3-4: Train relevant nurses, midwives and AHP staff on the criterion-led discharge process	- Compliance reports showing adherence to the criterion-led discharge process - Achieve a 90% compliance rate with the criterion-led discharge process within 12 months - Reduction in length of stay once criterion-led discharges implemented - Positive feedback from patients and families regarding the discharge process Reduction in discharge-related complaints	Workstream 5 Safe Discharge (Criteria-/Nurse-led) Detailed update Current activity and achievements - Literature review completed to inform OUH approach; confirms safety/effectiveness of nurse/criteria led discharge. - Scoping meeting scheduled and stakeholders identified – defining criteria, scope, and pilot wards/patient groups. - Criteria led discharge workstream work continue into next year due to the size and complexity of the deliverables encompassing a systemic change in processes

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		Supporting winter operations: early data shows 20–22% uplift in before midday discharges Dec 2025 over Dec 2024 linked to escalation flow meetings and process tweaks.
Objective 5 (Q2-4) 25% of discharges are by midday on inpatient areas* - Develop and implement a process to prioritise and facilitate discharges before midday - Design, develop and implement a discharge prioritisation protocol/SOP - Explore the requirement for an electronic dashboard - Awareness of the new discharge prioritisation process through communications and	- All communications and media about the new discharge protocol have been disseminated - Data support adherence to 25% of ward discharge by midday - Positive feedback from patients and families regarding the discharge process, through PALS and Friends and Family Test	In Progress and rolled over to 2026/27 On Track. Most recent data indicates an increase in discharges before midday from 18% in December 2024 to 22% in December 2025 In Progress and rolled over to 2026/27 In progress

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
media to advertise and disseminate <i>* Note that this <u>excludes</u> Outpatients, Day Surgery Units, Short Stay areas (average <24 hours, e.g. Maternity, Orthopaedic Short Stay Unit), Assessment areas</i>	Reduction in discharge-related complaints and incidents	

Patient Experience

Quality Priority 7: Maternity Service User Experience

Why is this a priority?

The Trust is prioritising the improvement of 'Maternity Service User Experience' to enhance the quality of care and experience for expectant mothers and their families. This initiative aims to facilitate better communication and understanding between the healthcare professionals in our Maternity Service and service users, ensuring that the needs and preferences of women, birthing people and their families are effectively addressed.

By focusing on personalised care plans, we can support women, birthing people and their families throughout their maternity journey, from antenatal care to postnatal recovery. This Quality Priority emphasises the importance of a service user-centred approach, where healthcare professionals work closely with mothers and their families to understand their unique circumstances and expectations. The initiative will involve regular reviews and updates to care plans, ensuring they remain relevant and effective.

Improving the maternity experience will benefit patients by providing more tailored and compassionate care, reducing anxiety and enhancing overall satisfaction with Maternity Services. For the Trust, this focus on quality care will foster a positive reputation, increase patient trust, and promote a culture of continuous improvement in maternal and neonatal health.

This Quality Priority is being rolled over to 2026/27

Table 7 Maternity Service user experience QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 1 (Q1-2) Care planning	Evaluate and align the personalised care plans with the latest evidence-based practices and guidelines in maternity care	Complete Personalised care plans have been introduced- see objective 2 for more details

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
- Undertake personalised care planning questionnaire for sample of expectant mothers and birthing people - Undertake an audit for all feedback routes on satisfaction of care	Increase in service user satisfaction scores regarding maternity care via all feedback routes, reported monthly through the Triangulation and Learning Committee (TALC), Quality and Performance Dashboard Reports. Improved CQC Service User Feedback Survey	Complete and on going  Family and Friends Test Our feedback scores Department: Maternity Month: March 2026 518 Total number of responses 92.5% Very Good 4% Good 3.5% Poor Your feedback matters You said: Review indicators of labour pathway once ready for labour ward. We did: We have reviewed and updated the induction pathway. This will ensure timely transfer once ready for the next stage of the induction process. Positive responses - Staff have been supportive - Very quick helpful responses from midwives - Staff very friendly - A positive experience overall YOUR FEEDBACK MATTERS -163 Friends and Family Test (FFT) plus 355 Say On Day responses were received in March 2026. 96.5% rated the service as 'good' or 'very good' with an overall response rate of 82% when compared to the number of deliveries. - Feedback across maternity services was overwhelmingly positive, particularly for the screening and vaccination clinics, for efficiency, kindness, and ability to put patients at ease. The Banbury and Witney Community Midwife Teams were commended for their compassionate, knowledgeable care. The Spires Midwifery Unit and Delivery Suite teams were highlighted for their

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
		supportive, respectful, and professional approach. Postnatal care on Level 5 was generally well received. However, concerns were raised about long waits, discomfort, and communication issues at the Maternity Assessment Unit (MAU), indicating an area for improvement. Additional space has been identified to increase the physical capacity of MAU and work is ongoing to incorporate this space into the service. The expansion of 'Say on the Day' feedback devices into community and outpatient settings. This has included the 4 community birth centres and Florence park OX4. We have seen a consistent weekly response of 10-20. We are able to review these responses to ensure all voices including those from underrepresented or marginalised groups are heard and acted upon in real time. This is an example of the monthly published communications that are now consistently shared:

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
	Ensure that at least 50% of relevant healthcare professionals attend the training sessions within the first six months	Complete - Active Bystander training is now mandatory for all staff groups and measured as part of the PROMPT training. The training aims to empower staff to challenge poor behaviours that may have become normalised over time, and bring about change through the reinforcement of messages defining the boundaries of unacceptable behaviour. - This is a rolling mandatory session with projected 100% compliance.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
	- Positive feedback and evaluation from training modules and workshops - Reduce the number of red rated reported communication-related complaints by 50% with an improvement in communication ratings between healthcare professionals and service users	See objective 3 Complete - Complaints are reviewed monthly. We have seen an increase this financial year (45 compared with 25 in the previous financial year). None of these are red rated complaints. We continue to promote real time feedback with introduction of a new patient responder role. Other actions include proactively identifying reported incidents of moderate harm and above following which the family may benefit from a one to one debrief while still in hospital. - Several specific actions have been taken in direct response to the feedback received. Recruitment is underway for a maternity-specific Pharmacy Technician to start in May 2026. Additionally, infographics are currently in development for the Maternity Assessment Unit, which will provide clear information on average wait times to improve transparency and patient experience. These initiatives are in addition to the ongoing training programmes, including communication skills and active bystander sessions, which continue to be monitored as part of the mandatory training

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
	Positive trajectory of personalised care plan compliance measured through regular audit	requirements. The focus remains on addressing the recurring concerns and ensuring that improvements are both meaningful and sustainable, with progress regularly reported to relevant governance committees. Complete See objective 2
Objective 2 (Q2-4) Feedback from service users Incorporate feedback from service users into the regular review and update of care plans to ensure they meet the evolving needs and preferences of expectant mothers and birthing people	- Complete the development and initial implementation of personalised care plans by end of Q4 - Monthly audit of personalised care plans to measure compliance – they should be > 90% compliant	Complete - The introduction of personalised care plans audit from BadgerNet shows a consistent high performing trajectory of >90% compliance. This assures care is tailored to each individual's background, preferences, and needs. Complete Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP), - The quarterly survey shows a positive trajectory towards our communication pathways over the last 6 months. This continues.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
		- The co-production of patient information leaflets including multilingual menu options and sensitive language training (e.g. around BMI discussions), demonstrates a commitment to inclusive communication and respect for diverse experiences: HOW MATERNITY EDI (EQUITY DIVERSITY INCLUSION) SUPPORTS YOU Translated Antenatal Classes and Unit tour - Multi-lingual & at Florence Park - Refer via BadgerNet/EPR/Email - Second evaluation ongoing Ongoing Active Bystander Workshops: - New mandatory for all OUH staff, both clinical and non-clinical - Impact evaluation in progress with Health Innovation Oxford and Thames Valley – for maternity Maternity Audits: Screening - focus on access: - Look out for 'Book by 10' posters in GP waiting rooms, children centres, pharmacies, and churches near you. - If you have not seen any, please collect a printed copy from the EDI office (Level 4, JR) or request one to be posted to your hub. - Coming soon: 'SOP: Identification and Provision of Antenatal and Neonatal Screening Information in Accessible Formats' Neuro-inclusion, Disability & Accessibility conversations: - Continuing 1:1 and group support. - Trust Reasonable adjustments policy now live Digital inclusion funded by 'Good Things Foundation': - Provision of free pre-loaded SIMs and mobile phones for eligible women and birthing people (see SOP: Databank Sim Cards) - Refer via BadgerNet, EPR, or Email - In collaboration with Digital Mchives and Public Health Matron Engagement: - For support or questions, email: EDIinclusion@ouh.nhs.uk - Outreach visits: Rn's, A&IUN, East Oxford Stay and Play - Join your Maternity EDI working group - Connect with Trust Staff Networks for additional support Tackling bias & discrimination: - Continuing 1:1 and group support. - Ongoing QI project: 'Tackling Bias to improve staff Inclusivity and Cultural Safety in Maternity' Patient Information 'Animations' (PIAs) - Burdett Grant Project: - With Consultant Brenda Kelly, Maternity Clinical Governance, OMI and OUH communications - Production of resources voiced in Tatum with English Translation Staff EDI resources: - Find a wide range of EDI materials and useful links on the Maternity EDI Share/Join page. Friends and Family Test (FFT) - Oxford University Hospitals

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 3 (Q1-4) Training Conduct bi-monthly training sessions for healthcare professionals on effective communication and personalised care strategies. Pilot commencing April 25 (Q1) led by Maternity Psychologist	- Monthly reports on training sessions - Distribution records of educational materials - Workshop attendance and feedback records	Complete - The Practice Development team provide monthly maternity training sessions with educational materials Complete and on-going - Successful Schwartz rounds with bimonthly advertised Microsoft teams sessions

Quality Priority 8: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

Why is this a Priority?

ReSPECT is a national framework for discussing and documenting personalised recommendations for a person's clinical care and treatment in a future emergency in which they may be unable to make or express choices. These recommendations are created through conversations between a person, their families and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. The process respects both patient preferences and clinical judgement. This includes discussion and decision-making about resuscitation. The ReSPECT document is held by the patient / legal proxy / significant other and also available electronically to all health and social care professionals.

The Trust is required to implement the national ReSPECT framework as part of the Berkshire, Oxfordshire and Buckinghamshire (BOB) Integrated Care System-wide approach to align Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) policies and procedures. Current guidelines require cardiopulmonary decision-making to be contained within advance care planning for patients of all ages that includes consideration of all realistic life-sustaining treatments.

We will launch, evaluate, embed, and educate staff, on ReSPECT throughout the Trust.

Table 8 ReSPECT QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
Objective 1 (Q1) Launch ReSPECT Launch ReSPECT in OUH	Successful launch of ReSPECT in OUH following rollout and communication strategy	Complete Respect went live on the 11 March 2025 - ReSPECT document is working as designed. - There is one unanticipated effect. The GP/Pt DNACPR form is not automatically marked and

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
	- ReSPECT is live and used in OUH - EPR process is working as designed	this change has been requested through the EPR Clinical Advisory Group (CAG). - ReSPECT is now widely used in OUH. Examples include wards asking for order details for patient information leaflets as their original stock has run down. Numbers of ReSPECT plans each month approx. 900 - The GP/Pt ReSPECT PDF is now available in the patient summary page. Complete - The previous Treatment Escalation Plan (TEP) form was reviewed and found to contain the same information as in ReSPECT so is no longer used, preventing duplication of information and saving clinicians' time. Complete

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
		- BOB ICB have completed their ReSPECT digital form and ran a pilot with Headington GPs in Aug/September 2025. The BOB ReSPECT document is in the Thames valley Shared Care Record (GRAPHNET) which OUH clinicians can view but not edit. The BOB ReSPECT record does not interact with EPR nor open a related Mental Capacity Assessment (MCA). Options are being explored to fully integrate OUH and BOB ReSPECT forms. Complete - Options are being explored to fully integrate OUH and BOB ReSPECT forms so that the ReSPECT digital record is editable by all organisations in BOB
Objective 2 (Q 2-3) Evaluate Evaluate the ReSPECT process and its		Complete From March to June 2025 all ReSPECT plans were automatically delivered to Resuscitation inbox in EPR. These were read and acted upon during this time. This produced significant learning and has influenced the questions

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
documentation in EPR across the organisation	• Compliance with approved ReSPECT Policy • ReSPECT is used appropriately to document patients' wishes in the event of an emergency • Information from ReSPECT document is communicated via planned workflow to GPs and to South Central Ambulance Service (SCAS) • Review of documentation in line with patient admissions to the Trust and baseline data (numbers compared with current Resuscitation Status decisions) • ReSPECT plans increase and Do not Attempt CPR (DNACPR) forms go down (this can be seen as a summary on whiteboard)	within the audit plan currently being developed in Ulysess Assurance Hub. Complete Complete- A safety message was also sent out. Complete- Discern report created in EPR Complete • Turned off receiving all ReSPECT plans to resus message centre. Complete • No increase in ReSPECT complaints compared with DNACPR complaints since launch. Work with discharge lounge and discharge team ongoing. Complete

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
	- Monitor discharge information flow and review any issues highlighted by external partners - Audit of ReSPECT document completion – 90% of completed forms provide evidence of discussion with patients or those closest to them - The ReSPECT process is completed for 90% of patients with a pre-existing DNACPR as evident on EPR	- Monitoring practice through incident forms and PALS reports. In progress 90% of new admissions have ReSPECT plans. - A way in which figures can be obtained from EPR is being reviewed - No increase in ReSPECT incidents as opposed to DNACPR incidents since launch.
Objective 3 (Q1-4) Education and training Provide education to clinical staff in the ReSPECT process, ensuring the process is used to enhance patient experience of	By Q4 compliance with training appropriate to role is >80%	Complete - ReSPECT is contained in all clinical mandatory resuscitation courses. Compliance is 84.3% Complete - There are two advanced RePSECT courses in MyLearning Hub (MLH), one for medical staff and one for senior health care professionals with job roles that require advance care planning with their patients.

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
emergency care planning • This will be achieved through the provision of education via various formats to various staff groups • Education content will be completed and launched on My Learning Hub (MLH) in Q1 • We will monitor and report compliance on training in Q2 and provide an action plan to improve compliance if needed during Q3-4 • We will run face to face training for staff undertaking the ReSPECT conversation piloting the first course	• ReSPECT education content available in My Learning Hub (MLH) to provide robust reporting and compliance structure • Positive staff feedback on experience of and confidence in the ReSPECT process • Positive patient feedback of their experience of the ReSPECT process • Positive patient feedback can be achieved through Friends and Family Test, via questionnaires or captured within the auditing of the ReSPECT process (this is not exhaustive)	Complete • The Resuscitation Council UK have released their new national e-Learning course hosted on e-LFH and we have now linked our Trust ReSPECT course to this updated national resource. Complete • ReSPECT courses have been well attended and will continue. There has been positive staff feedback. Complete • There has been a reduction in complaints and incidents and the Trust audit includes a patient evaluation.

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
in Q2, refining and evaluating this course in Q3-4 • Design feedback form for face-to-face ReSPECT courses • Liaise with the Patient Advice and Liaison Service (PALS) to act on any feedback/complaints received in the organisation	• There will be a reduction in complaints and incidents regarding resuscitation and treatment decisions	
Objective 4 (Q1-4) Patient Information about ReSPECT • Make patient information available in a variety of formats-	Patients can access ReSPECT information with clinical staff also being able to demonstrate • Evidence of access to intranet site and use of ReSPECT patient information leaflets • Patients and those closest to them are aware of the ReSPECT process and how it is used within OUH	Complete • The Patient Safety Partner involved in audit and patient information leaflets has helped with this objective. • The information leaflets are on the Trusts internet

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
electronic/paper information leaflets • Liaise with Patient Safety Partners to review and refine messaging for patients • Review and action any complaints/feedback received associated with the ReSPECT process • Liaise with Patient Safety Partners for feedback	• Q4 audit within Discharge Lounge to establish that where a ReSPECT form exists patients and those closest to them are aware of the contents of the document and its purpose • A reduction in complaints received regarding resuscitation and treatment decisions when compared with previous years • Reduction in patient complaints associated with resuscitation decisions • Positive patient experiences with the ReSPECT process	In progress • The discharge lounge will be added to the ReSPECT audit. Complete (see above) Complete • Liaised with PALS manager and we have set up a quarterly auto report on DNACPR and ReSPECT complaints which will be sent to the ReSPECT lead to inform annual reporting to CIC.
Objective 4 (Q2-4)		Complete • A Specialist registrar from palliative medicine joined the ReSPECT lead in July 2025.

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
Audit - Build an audit tool to audit the ReSPECT documentation - Use the audit tool to audit completion/quality of the ReSPECT documentation	- Evidence of completion of the ReSPECT document in line with the Policy and ethos of ReSPECT - Evidence of quality conversations with the patient	- ReSPECT audit design and questions developed in Sept/Nov 2025. - Piloted questions Nov/Dec 2025 - Linked with Assurance Hub team to develop audit design. Further pilot of questions. Linked with OxSCA team for advice formulating questions to be used for patients and staff. - Developed educational video to provide ward managers with 'how to guide' to completing the audit. Complete - Trust communications introducing new audit, including educational video, to the organisation and key stakeholders, who are the adult inpatient ward managers, was completed in February 2026 - Liaised with Clinical Improvement Committee to ask for Divisional support to implement the new audit process which was agreed.

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
		The audit aims to interview patients and staff and examines the document to seek assurance against the ReSPECT policy.

Quality Priority 9: Supporting vulnerable patients including those with learning disability

Why is it a Priority?

Vulnerable patients including those with learning disabilities are at risk of poorer health outcomes and may require additional support through their healthcare journey. It is essential for staff to identify these patients and understand their needs.

This priority, supported by the Trust Learning Disability Liaison team, aims to improve staff confidence, enhance discharge processes, establish dedicated pathways, and implement the Reasonable Adjustment Flag (RADF) in the electronic patient record (EPR).

Table 9 Supporting vulnerable patients including those with learning disability QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 1: Deliver Oliver McGowan Training Trustwide	- By the end of Q4 2025/26, achieve at least 85% compliance with mandatory Oliver McGowan training (Part 1) for all staff, with quarterly increases of at least 2.5%. - Following delivery of Oliver McGowan training Part 2 use NHS Benchmarks staff questionnaire at the end of Q2 and Q4 to measure increased staff confidence in supporting people with learning disabilities.	Complete To end of March 2026: - Part 1 (e-Learning) for tier 1 and 2 compliance at 85.6% (Part 2 delivery commenced 28/10/2025) - Part 2 Tier 1&2 Currently on track to achieve target of 30% of the work force trained by September 2027. - Questionnaire developed and shared .

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 2: Improve Discharge Processes for Patients with Learning Disabilities (Integrate into the Discharge Assurance Group workstream Jan 2026)	• Benchmarking exercise (BOB) • Audit tool and completed audit • Comparative data on discharge delays (Integrate into the Discharge Assurance Group workstream Jan 2026) • Feedback reports from staff, patients, carers, and social care • Discharge process documentation and pathway (Integrate into the Discharge Assurance Group workstream Jan 2026) • Inclusion of discharge questions in Trust feedback process (Integrate into the Discharge Assurance Group workstream Jan 2026)	In Progress Audit tool developed and audit completed • Participation at the Trust QP Discharge working group. • Benchmarking within BOB ICB completed. • Positive feedback: 88% carers and 89% patients satisfied with discharge discussions

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
Objective 3: Develop Pathway for Diagnostic Procedures under General Anaesthetic	- By Q1 2025/26, benchmark best practice for diagnostic procedures under general anaesthetic. - By Q4 2026, establish a Trust wide pathway and review its impact.	In Progress - Thematic review of cases with unmet needs for sedation completed - Pathway in development (SBAR); discussed with clinicians and LD steering group.
Objective 4: Enhance Coordination Across Specialties Revised timeline: By the end of Q4 2027, review and update the Learning Disability policy to ensure effective care coordination for patients supported by multiple clinical	- Updated Learning Disability policy - Communication plan for policy changes - Benchmarking report on care coordination - Gap analysis report - Escalation plan for service/resource needs - Learning Disability Steering Group updates	Partially Complete Policy reviewed and updated. - This objective requires a detailed scoping project to confirm the range of needs for people with a LD. . - Monthly Learning Disability Steering Group monitoring coordination challenges / issues.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
teams, benchmark against best practice, and identify gaps.		
Objective 5: Implement Reasonable Adjustment Flag (RADF) in EPR Complete EPR functionality for RADF, define and test the pathway in six areas, and scale up Trustwide with training and reporting mechanisms. By December 2025, establish an operational group in the Outpatient Delivery Group to	- EPR RADF functionality (ready for national deadline) - Defined pathway for requesting reasonable adjustments - Pilot test results from six areas - Training materials and completion records - Dashboard/reporting mechanism for RADF usage - Rollout plan for Trustwide implementation - Operational group terms of reference and meeting notes	Partially Complete EPR project for RADF in place; rollout delayed pending Oracle Health system completion. Waiting for IT to build the defined pathway into EPR. There is currently a flagging process to indicate a healthcare passport is in place.

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
support the role out of the RADF.		
Objective 6: Launch External Media Campaign on Reasonable Adjustments By Q2 2025/26, develop an easy-read leaflet on reasonable adjustments, and reasonable adjustment flag. By Q3/Q4, publish and distribute the leaflet and update the Trust website, once the process for requesting adjustments is finalised.	• Draft and final easy-read leaflet on reasonable adjustments and how to obtain information in a flag • Social media content plan and posts • Website updates for patients and families • Distribution plan for leaflets	Not complete • Campaign on hold until the process for requesting/providing reasonable adjustments is in place. • Objective 5 is required to be completed before Objective 6 commences.

Choosing Quality Priorities

The ethos of the Trust and the NHS is a commitment to the delivery of compassionate and excellent patient care. Our quality of care has its foundation in the commitment of our staff to their patients and the focus on future excellence. Contained within this account are commitments to Quality Priorities within the domains of Patient Safety, Clinical Effectiveness and Patient Experience.

How we chose our Quality Priorities

We involve our patients, public, stakeholders and our staff in choosing our Quality Priorities through our annual public Quality Conversation event which was held in December 2025.

The Quality Conversation event provided an update on progress against the Quality Priorities for 2025/26 and focused on Quality Priorities for 2026/27 as part of the annual planning cycle and the Quality Account. Attendees discussed the proposed Quality Priorities for 2026/27 and made suggestions about how they could be shaped and what they should focus on.

Our Quality Priorities for 2026/27

Table 10 below gives a brief description of our Quality Priorities for 2026/27. The full detail for each Quality Priority, why we chose them, and a description of how success will be evaluated over the course of the year can be found in Annexe 1.

Table 10 Summary of Quality Priorities 2026/27

Quality Priority 2026/27	Summary
Patient Safety	
1. Improving escalation of the deteriorating patient	The prompt response to patient deterioration through escalation to an appropriate clinician is essential to patient safety. It is important in preventing cardiopulmonary arrest or the need for transfer to an intensive care unit, both of which impact on a patient's length of stay in hospital but most importantly may influence the outcome for that patient and those closest to them. This Quality Priority will focus on adult in-patient areas, where patient deterioration may occur requiring a senior clinical response
2. Venous Thrombo-embolism (VTE)	Venous thromboembolism (VTE) is the leading cause of preventable hospital deaths. The early identification of patients at risk of VTE and prescription of

Quality Priority 2026/27	Summary
	thromboprophylaxis are important measures in preventing the morbidity and mortality associated with hospital-associated thrombosis. In January 2025 NHS England stipulated that the VTE risk assessment must be completed on all patients age 16 and above within 14 hours of admission instead of 24 hours. The focus of this quality target will be to drive greater excellence in VTE prevention and to comply with, and exceed, the new NHS England target of 14 hours.
3. Martha's Rule	Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon. It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration. Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that a patient's condition is getting worse and their concerns are not being responded to. Following a successful pilot in 2025, a full rollout of Martha's Rule in adult and paediatric wards is planned in 2026
Clinical Effectiveness	
4. Excellence also in the basics: reducing variation, improving care through Standard Work (Rolled over from 2025/26)	We will build on the progress of our first year of Standard Work implementation as a successful vehicle for delivering high-quality care. Learning from year one has demonstrated measurable improvements in patient and staff safety, quality, and efficiency through the use of clear, evidence-based, step-by-step processes that create reliable and consistent care. The first year focused on key inpatient clinical teams, aligning Standard Work with existing structures to reduce duplication and improve areas such as equipment checks, board rounds, safe and secure storage of medicines, and safety huddles. In year two, the programme will shift towards wider organisational adoption as part of a longer-

Quality Priority 2026/27	Summary
	term strategy, supported by a clear, co-designed approach in partnership with key stakeholders, embedding Standard Work as a core element of our quality and operational management system
5. Strengthening Discharges (Rolled over from 2025/26)	We remain dedicated to progressing this Quality Priority into its second year and building on the objectives we have achieved so far. There is an increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a ‘Home first’ approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person’s home. Consequently, the volume and complexity of discharge planning has increased. This Quality Priority will review discharge processes for all patients and seek to improve the quality and safety of discharge. This includes reducing delays and length of stay, as well as learning from incidents and feedback. There will also be an opportunity to explore the empowerment of nurses and other Allied Health Care Professionals to lead discharge-based decisions to improve quality and reduce length of stay.
6. Ambient Voice Technology (AVT)	AVT is a smart system that listens to the conversation between a patient and their clinician and turns it into accurate notes and letters automatically. Instead of writing everything down by hand, the technology does the hard work in the background, so the healthcare professional can give patients their full attention. This technology relies on Artificial Intelligence (AI) to capture consultation notes and turn them into letters, referrals and other documents for the clinician to check. To evaluate its impact on workflow efficiency and patient experience, we launched an AVT pilot in July 2025 across multiple departments. Clinicians reported saving time on

Quality Priority 2026/27	Summary
	writing notes and some additional benefits such as a faster turnaround of clinic letters, and patients reported a positive experience during the consultations. These positive results have led to a decision to purchase the technology. Local pilots have shown a positive impact on staff, including • Reduced burnout and improved work-life balance. • Patients report getting more eye contact and attention from their clinicians. • Better quality documentation, • Less out-of-hours working for staff, • Reduced admin burden
Patient Experience	
7. Advance Care Planning (ACP) and End of Life Care (EoLC)	End of Life care (EOLC) focuses on recognising when a patient is approaching the last year, months, or days of life and ensuring care aligns with their goals, values and best interests. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a structured process and document that records personalised clinical recommendations. It summarises key information about a person's health and uses this to guide decisions about treatment escalation, resuscitation and priorities for comfort or intervention This Quality Priority will focus on education for staff to better recognise patients who are at risk of dying, and to support them with high quality advance care plans using ReSPECT. Education strategies will support better End of Life care and communication.
8. Public and Patient Participation Framework	A robust Patient and Public Participation Framework is essential to ensure that OUH consistently listens to, involves and works in partnership with the people it serves. It will provide a clear Trustwide approach for embedding lived experience into decision-making, improving the quality, safety and responsiveness of care.

Quality Priority 2026/27	Summary
	By setting out agreed principles, expectations and practical tools, the Framework will help OUH meet national requirements for working with people and communities and support efforts to reduce health inequalities. It will help to ensure that all voices are heard, engagement is meaningful rather than tokenistic, and services are shaped in ways that reflect the diverse needs of patients, families, carers and communities.
9. Maternity Patient Experience (Rolled over from 2025/26)	Recent national interest and scrutiny has rightly put an even greater emphasis on the importance of improving maternity service user experience, underscoring the need for transparent, responsive and inclusive approaches that truly reflect the voices of those users by actively engaging with feedback and learning from both local and national findings. This Quality Priority highlights the value of a service user centred approach with healthcare professionals dedicating time to listen to and understand the perspectives of mothers and families. By actively incorporating feedback and respecting personal choices, we aim to support staff consistently to deliver care that is both respectful and empowering. The initiative encourages ongoing dialogue, shared decision making and partnership, fostering trust and confidence throughout the maternity journey. In turn, this ensures that care remains safe, compassionate and tailored to individual needs while helping staff feel valued and empowered to deliver the highest standards.

Monitoring and reporting

Regular reports on all Quality Priorities go to the Trust level Clinical Governance Committee (CGC) and from there to the Integrated Assurance Committee (IAC) and the Trust Board.

Statements of Assurance from the Board

During 2026/27 OUH provided and sub-contracted 196 relevant health services. OUH has reviewed all the data available to it on the quality of care of these relevant health services. The income generated by the relevant health services reviewed in 2026/27 represents 100% of the total income generated from the provision of relevant health services by OUH for 2026/27.



Clinical Audits and National Confidential Enquiries

Clinical audit is a process for reviewing clinical performance by measuring clinical practice against agreed standards, and as a result should lead to the refining of quality of clinical care.

During 2025/26, 76 national mandatory clinical audits and 4 national confidential enquiries covered relevant health services provided by OUH.

During that period OUH participated in 96% (73/76) of all the eligible national clinical audits and 100% (4) of national confidential enquiries in which we were eligible to participate.

The national clinical audits and confidential enquiries that OUH participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in National Clinical Audit

Data are still being collected for the national clinical audits so some are listed as 'in progress' as they have not yet published participation figures.

Explanation of ascertainment below 100% is after Table 11

Table 11 National audits and whether the Trust participated in 2025/26

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
British Association of Urological Surgeons (BAUS) British audit Of the referral of women with rEcurrent uRinary tract infection using recent Guidance (BOOMERANG)	Yes	100
BAUS Evaluating Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	100
Breast and Cosmetic Implant Registry (BCIR)	Yes	In progress
British Spine Registry	No ¹	N/A
Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (ICNARC)	Yes	100
Cleft Registry and Audit Network (CRANE)	Yes	100
Emergency Medicine Quality Improvement Projects (QIPs): Adolescent Mental Health	Yes	17 ²
Emergency Medicine QIP: Care of Older People	Yes	80 ³
Emergency Medicine QIP: Time Critical Medications	Yes	100
Emergency Medicine QIP: Mental Health Self Harm	Yes	0 ⁴

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	100
FFFAP: National Hip Fracture Database (NHFD)	Yes	100
FFFAP: Fracture Liaison Service Database (FLS-DB)	Yes	Non-spine 80 ⁵ Spine - 100
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) - Learning Disabilities Mortality Review	Yes	100
Maternal, Newborn and Infant Clinical Outcome Review Programme (perinatal mortality surveillance)	Yes	100
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit (NDFA)	Yes	100
NDA: National Diabetes Inpatient Safety Audit (NDISA)	Yes	100
NDA: National Pregnancy in Diabetes Audit (NPID)	Yes	100
NDA: National Core Diabetes Audit	Yes	100
NDA Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	100
National Audit of Cardiac Rehabilitation (NACR)	Yes	100
National Audit of Care at the End-of-Life (NACEL)	Yes	100
National Audit of Dementia (NAD)	No ⁶	N/A

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NaoMe)	Yes	100
NATCAN: National Audit of Primary Breast Cancer (NAoPri)	Yes	100
NATCAN: National Bowel Cancer Audit (NBOCA)	Yes	100
NATCAN: National Kidney Cancer Audit (NKCA)	Yes	100
NATCAN: National Lung Cancer Audit (NLCA)	Yes	100
NATCAN: National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100
NATCAN: National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100
NATCAN: National Ovarian Cancer Audit (NOCA)	Yes	100
NATCAN: National Pancreatic Cancer Audit (NPaCA)	Yes	100
NATCAN: National Prostate Cancer Audit (NPCA)	Yes	100
National Cardiac Arrest Audit (NCAA)	Yes	100
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (NAPCI) (Coronary Angioplasty)	Yes	100
NCAP: National Adult Cardiac Surgery Audit (NACSA)	Yes	100
NCAP: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
NCAP: National Audit of Cardiac Rhythm Management Devices and Ablation (CRM)	Yes	100
NCAP: National Congenital Heart Disease Audit (NCHDA)	Yes	100
NCAP: National Heart Failure Audit (NHFA)	Yes	95% ⁷
NCAP: UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100
NCAP: Left Atrial Appendage Occlusion (LAAO) Registry	Yes	100
NCAP: Patent Foramen Ovale Closure (PFOC) Registry	Yes	100
NCAP: Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100
National Child Mortality Database (NCMD)	Yes	100
National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138	Yes	100
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	Yes	100
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100
National Emergency Laparotomy Audit (NELA)	Yes	83% ⁸
National Emergency Laparotomy Audit: No Laparotomy	No ⁹	N/A
National Joint Registry (NJR)	Yes	Horton – 45.1 ¹⁰ JR – 30.4 ¹⁰ NOC – 99.7 ¹⁰

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
National Major Trauma Registry (NMTR)	Yes	100
National Maternity and Perinatal Audit (NMPA)	Yes	100
National Neonatal Audit Programme (NNAP)	Yes	100
National Obesity Audit: NHSE ¹ (NOA)	Yes	100
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit (AMD)	Yes	100
NOD: Cataract Surgery	Yes	100
National Paediatric Diabetes Audit (NPDA)	Yes	100
National Perinatal Mortality Review Tool (PMRT)	Yes	100
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	JR - 14.1 ¹¹ HGH - 20 ¹¹
NRAP: Adult Asthma Secondary Care	Yes	29.3 ¹²
NRAP: Children and Young People's Asthma Secondary Care	Yes	100
National Vascular Registry: Royal College of Surgeons of England (breakdown as follows)	Yes	
• Abdominal Aortic Aneurysm (AAA)		54 ¹³

¹ NHS England

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
• Carotid Endarterectomy		88 ¹³
• Amputation		43 ¹³
• Infra-inguinal Bypasses		44 ¹³
• Lower Limb Angioplasty/Stent		21 ¹³
Paediatric Intensive Care Audit Network (PICANet)	Yes	100
Perioperative Quality Improvement Programme (PQIP)	Yes	14.3 ¹⁴
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100
UK Cystic Fibrosis Registry: Adults	Yes	87 ¹⁵
UK Cystic Fibrosis Registry: Children	Yes	97 ¹⁵
UK Interstitial Lung Disease	Yes	100
UK Parkinsons Audit	Yes	100
UK Renal Registry Chronic Kidney Disease Audit	Yes	100
UK Renal Registry National Acute Kidney Injury Audit (AKI)	Yes	100

Explanation of National Audit where case ascertainment is below 100%

¹ British Spine Registry:

This was a new addition to the 2025/26 national audit list and the service did not have sufficient infrastructure to participate.

^{2,3,4} Emergency Medicine Quality Improvement Projects (QIPs): Adolescent Mental Health/Care of Older People/Mental Health Self Harm:

A change in audit lead occurred this financial year which led to an interruption in participation, however this is resolved for forthcoming years. This is with the exception of Mental Health Self Harm audit which ceased running in December 2025.

⁵ Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database (FLS-DB):

Participation has increased from 61% (non-spine) / 76% (spine) in 2024/25 as the service has embedded new staff into established roles.

⁶ National Audit of Dementia:

The Trust was not required to participate as the audit was in developmental stage following a tender to a new provider.

⁷ NCAP: National Heart Failure Audit (NHFA):

The team achieved a 95% submission rate against a background of staffing and capacity challenges; scoping has identified the potential for more audit work to be transferred to suitably trained non-clinical staff.

⁸ National Emergency Laparotomy Audit (NELA):

Overall case ascertainment rates were brought down by non-participation of the Churchill Hospital due to relatively few NELA-eligible cases being undertaken there, meaning identification processes were not as embedded compared to the John Radcliffe Hospital. Since September 2025, a new consultant has been appointed with dedicated time specifically allocated to NELA data collection and submission for the Churchill site. As a result, the team have successfully established an up-to-date dataset for Year 12. Retrospective updates to Year 11 are not possible, as the dataset is now locked.

⁹ National Emergency Laparotomy Audit: No Laparotomy:

The service does not contribute to NoLap NELA at present. They are in discussions with the national team regarding the clinical rationale for the audit, recognising the significant amount of clinical time it would take to identify patients and participate in the audit.

¹⁰ National Joint Registry:

NOC procedures are conducted for elective patients, allowing for a straightforward consent process. In contrast, HGH and JR focus primarily on emergency surgical cases, where obtaining consent to participate in the NJR may be more challenging due to patient pain or impaired cognitive function. As a result, the submission figures in these units tend to be lower.

¹¹ National Respiratory Audit Programme (NRAP): COPD Secondary Care:

Data collection is performed by the Oxford Health Foundation Trust respiratory nursing team and data is collected separately for the John Radcliffe and Horton General Hospital sites. Not all patients are captured as the nursing service operates only in office hours on weekdays.

During this period, some factors contributed to the lower submission.

- Nursing staff levels were 50% of expected. This has since improved.
- Communication between OUH teams and the respiratory nursing team required improvement
- Elective admissions were included in HES and not NRAP

¹² National Respiratory Audit Programme: Adult Asthma Secondary Care:

A staffing shortage of administration and specialist asthma nurses has been identified and is currently on the Divisional risk register. Clinical work has been prioritised, reducing the ability to participate in the audit process.

¹³ National Vascular Registry:

In the previous year, case ascertainment varied from 2-81% of eligible cases, depending upon the intervention; current data show this has risen to 21-88% with work ongoing to improve this further. There is Divisional oversight of an action plan to support and to drive improvement.

¹⁴ Perioperative Quality Improvement Programme (PQIP):

Participation in PQIP continues; however, the most recently reported case ascertainment was 14.3% (30 of 210 eligible cases). This reflects limitations in recruitment capacity and specialty coverage within a multi-site organisation and restricts the level of assurance that can be drawn from PQIP outcome data. The national PQIP Co-ordinator has liaised with OUH Audit lead and advised that the number of required cases can be reduced to 20 per year. (The study is close to achieving its overall project recruit number)

¹⁵ UK Cystic Fibrosis Registry Adult: UK Cystic Fibrosis Registry Children:

Although the UK Cystic Fibrosis Registry demonstrates high population coverage, it does not routinely achieve 100% inclusion. This reflects the consent-based nature of the Registry and reliance on annual review data submission. A small proportion of patients under OUH care may not be captured in a specific reporting year due to patient choice, recent transfer into

or out of the service, death, or delayed annual review completion. This is recognised nationally and is not considered to undermine the overall robustness or representativeness of the data.

Participation in National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2025/26

Table 12 shows the list of OUH eligible NCEPOD studies in 2025/26, in which hospital sites participated, and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

Table 12 NCEPOD studies 2025/26

NCEPOD Studies 2025/26	Participating Sites	Clinical Questionnaire Returned	Case Notes Returned	Organisational Questionnaire Returned
Stabilisation of the critically ill child: Receiving unit critical care questionnaire	John Radcliffe	2/11 Submission still open	Not required for this element of the study	Not required for this element of the study
Stabilisation of the critically ill child: Stabilisation questionnaire	John Radcliffe Horton	1/8 Submission still open	8/8	JR - submitted HGH - submitted
Pleural Procedures	John Radcliffe Horton Churchill	8/15 Submission still open	15/15	Not yet due
Rib Fracture	John Radcliffe Horton	2/11 Submission still open	0/11	Not yet due
Managing acute illness in people with learning disability	John Radcliffe	1/4	4/4	Submitted

Actions taken and improvements made from National audits

The reports of 49 national clinical audits were reviewed in 2025/26. Agreed actions and progress to improve the quality of healthcare provided are summarised in Table 13 below.

The majority of audits presented in 2025/26 are audits from prior years, e.g. 2023/24 etc; this is due to the timing of the publications from the governing bodies.

Table 13 National audits with summary of actions and benefits for patient care following review (**Fully achieved; *Partially achieved)

Audit	Summary of Agreed Actions
Adult Asthma Secondary Care Audit	• Create and submit a business case for service comparison* • Audit of ambulatory management* • Statement of need for funding urgent nursing need* • Review of how this audit can run with no administrative support*
Age-related Macular Degeneration (AMD) Audit	• Develop a business plan for an off-site AMD north of the county hub and injection suite* • Recruit additional AMD co-ordinator** • Recruit a dedicated Specialty Doctor to the medical retina service* • Review and appraise administration team to support the service*
BAUS Nephrostomy Audit for infected Obstructed Kidneys	• To maintain the consultant led ward rounds to enable swift decision making**
BAUS Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT)	• Standard proforma for all transurethral resection of bladder tumour surgery to go live on EPR once finalised*
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care Audit	• Request to audit software platform to create a referral pool for patients in Ambulatory Assessment Unit (AAU), and EAU* • Work with coding to understand COPD coding and remove elective COPD admissions from the hospital episode statistics (HES) submission* • Review of current Oxford Health Respiratory Nurses service-level agreement** • Improve timely access to Non-Invasive Ventilation (NIV) treatment by reviewing the NIV pathway in the Emergency Assessment Unit and Emergency Department* • Increase in respiratory bed numbers where NIV treatment can be delivered at JR and HGH sites*
	• Review of current Oxford Health Respiratory Nurses service-level agreement**

Audit	Summary of Agreed Actions
Emergency Medicines Quality Improvement Programme (QIP): Care of Older People (Year 2)	• No actions were identified; performance was above the national benchmark
Emergency Medicines QIP: Mental Health Self Harm (Year 1 & 2)	• No actions were identified; performance was above the national benchmark
Epilepsy 12	• A standardised pathway of mental health support resources should be developed for all children and young people with epilepsy* • The completed resources leaflet will be shared at Paediatric Medicine and Paediatric Neurology governance meetings to ensure awareness and accessibility among clinicians* • Ongoing re-audit work will continue to monitor epilepsy nurse involvement and demonstrate improvement in nurse input* • Criteria for tertiary review will be promoted and discussed at Paediatric governance meetings to increase clinician awareness*
Fracture Liaison Service Database (FLS-DB)	• Completion of digital uploading of patient and GP demographics to updated FLS platform* • Complete homecare contracting* • Trust approval of funding of FLS business case* • NOTSSCaN to approve metabolic bone consultant statement of need*
Intensive Care National Audit and Research Centre (ICNARC)	• No actions were required: • There was considered, appropriate and safe discharge and stepdown to ward based care • Following a review, each readmission was deemed unavoidable as the patients had been assessed as being suitable to be stepped down to the ward. • Reasons for readmission included: cardiac arrest; cardiac arrhythmia and high oxygen requirement; hospital acquired pneumonia; relook laparotomy after ischaemic complications from recent surgery
Kidney Cancer	• To improve the recording of ethnicity by 5% over the next audit period* • To improve the recording of tumour size by 10% over the next audit period**
MBRRACE: State of the Nation 2023 National Maternity and Perinatal Audit (NMPA)	• No OUH Trust level actions were required as a result of this national audit as the recommendations were aimed at national bodies rather than at Trusts

Audit	Summary of Agreed Actions
MBRRACE: Maternity care – confidential enquiries 2021-23	• No OUH actions were required as a result of this national audit as the recommendations were aimed at national bodies rather than at Trusts
MBRRACE: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death	• No OUH actions were required as a result of this national audit as the recommendations were aimed at national bodies rather than at Trusts
Myocardial Ischemia National Audit Programme (MINAP)	• Collaborate with the ambulance service to review call-to-balloon (CTB) delays and implement pre-alert protocols* • Increase cardiac ward admissions for patients with Non-ST-segment Elevation Myocardial Infarction (NSTEMI)* • Improve CTB <120 mins performance* • Increase staffing of outreach team through a business case for 1.0 whole time equivalent* • Ensure all eligible patients are referred to Cardiac Rehabilitation* • Review catheter lab scheduling and prioritise NSTEMI slots to increase timeliness of angiograms*
National Audit of Cardiac Rehabilitation	• Increase number of clinic spaces for assessments* • Increase capacity of gym space* • Implement the use of Digital Cardiac Rehab App* • Run an audit to see why patients decline rehab* • Comprehensive review of heart failure service, and possible business case* • Improve data compliance by working with Cardiac Information team and the audit provider to check data entry and uploaded data**
National Audit of Cardiac Rhythm Management (RCM)	• Prepare for national requirement to collect and report follow-up outcome data*
National Audit of Cardiac Surgery (NCAS)	• Implement a bed ring-fencing plan for elective cardiac surgery by: Agreeing and documenting a minimum ring-fenced bed baseline for Cardiothoracic (CT) Ward and CT Critical Care Unit (including escalation/de-escalation triggers)* • Introducing a weekly elective capacity review (beds, staffing, theatre slots) with agreed actions logged* • Reporting monthly elective cancellations due to bed unavailability and implementing corrective actions when thresholds are breached*

Audit	Summary of Agreed Actions
	• Establish consistent capture of MDT discussion for all non-emergency cases by: Agreeing on a single MDT documentation standard (what constitutes 'discussed', minimum dataset, and where recorded)* • Update referral/booking workflow so every elective/urgent case has an MDT status recorded before listing (local MDT or referring MDT)* • Produce a monthly speciality dashboard* • Increase same-day admissions (SDA) for elective cardiac surgery to ≥50% and sustain this level for 3 consecutive months by March 2027, reducing avoidable pre-op bed days* • Agree and implement a named cardiac surgery data manager function (either recruitment or protected time) with clear responsibilities for data entry, validation, and submission* • Publish a data dictionary (mandatory vs non-mandatory fields, definitions, data sources) and provide brief training to all contributors* • Agree procedure-specific eligibility criteria and a prospective 'minimal access' case list reviewed weekly* • Confirm equipment requirements and procurement/maintenance plan (including instrument sets and imaging where needed)* • Allocate protected theatre capacity (e.g., minimum 1 list per month per relevant sub-specialty) and identify named operators for each list* • Establish a quarterly emergency aorta review (case volumes per surgeon, outcomes, learning points) via the regional MDT/governance meeting*
National Audit of Inpatient Falls (NAIF)	• Improve falls informatics to aid internal benchmarking for falls per 1000 occupied bed days (OBD) as a measure* • Creation of a monthly dashboard for OBD* • Improve lying and standing blood pressure compliance • Track monthly and present at Harm Free Assurance Forum and Falls delivery group** • Target teaching through the ward-based fall prevention training* • Develop ward compliance tracking with the digital team** • Educate and strengthen documentation for post-fall injury checks**

Audit	Summary of Agreed Actions
	• Create a hot debrief process** • Increase delirium screening for non-elective patients over the age of 65 years* • Create a cognition policy* • Develop the Power Bi dashboard to monitor delirium screening** • Reduce the length of time from injury to harm review meeting**
National Audit of Metastatic Breast Cancer (NAOME)	• A 2-year review (1 year retrospective and one year current) to be undertaken by the Breast MDT Chair into data collection*
National Bowel Cancer Audit (NBOCA)	• Improve recording of performance status from 2 week-wait referrals to Infoflex to allow capture in Rapid Cancer Dataset* • QI project to address timeliness of closure of ileostomy**
National Comparative Audit of Blood Transfusion- Audit of NICE Quality Standard QS138	• Complete OUH pre-op anaemia document guidance* • Refinement of transfusion PowerForm in EPR* • Develop business case for a patient blood management/peri-operative specialist nurse*
National Early Inflammatory Arthritis Audit (NEIAA)	• Locum consultant to be appointed** • Improve waiting times for new EIA appointments from ~3 months to 4-6 weeks**
National Emergency Laparotomy Audit (NELA) (2 years data)	• Improve poor case ascertainment** • Improve risk assessment documented before surgery* • Create a multidisciplinary pathway*
National Heart Failure Audit (2 years data)	• Run pilot intervention to improve rapid follow-up after hospital discharge** • Discussion at Oxfordshire Heart Failure Delivery Group to improve access to community heart-failure follow-up**
National Hip Fracture Database (NHFD)	• This audit topic is underpinned by the work of the Fragility Fractures Improvement Group, so no new actions were created as they are contained within Quality Priority 3: Fragility Fractures Pathway
National Joint Registry (NJR)	• Pathway improvements in theatres to ensure all patients undergoing eligible operations are consented to participate in the audit, improving data completeness and reliability**
National Oesophago-Gastric Cancer Audit (NOGCA)	• Work with Cancer Management team to explore data accuracy around the recording of disease stage and improve capture*
National Ovarian Cancer Audit	• Audit time frames for chemotherapy commencement after surgery in ovarian cancer*

Audit	Summary of Agreed Actions
	• Improve the recording of performance status using the MDT referral form*
National Paediatric Diabetes Audit (NPDA)	• Review NPDA quarterly reporting to identify missing and inconsistent data** • Aim for 90% of patients to have microalbuminuria recorded in next audit cycle, via doctors and nurses requesting a urine sample at every appointment* • Closed-loop group start sessions to commence* • Reduce missing ethnicity data in the next round of audit results by outpatient reception checking status and amending accordingly*
National Pregnancy in Diabetes Audit (NPID)	• Use of continuous glucose monitoring to increase by 20% in the next round of the audit by offering it at the first appointment*
National Prostate Cancer Audit (NPCA)	• Review of completeness of data entry to validate recording of MDT outcomes* • Accurate recording of true number of unplanned admissions within 90 days of robotic-assisted radical prostatectomy**
National Primary Breast Audit (NAoPri) 2 years data	• Year 1: Improve Performance Status- Data team to capture data from available information on EPR to flag improvement** • Recording of key-worker allocation* • Year 2: Create an audit of the reported recontraction rate* • Create an audit of the reoperation rate* • Do a root cause analysis of progesterone-receptor status*
NCEPOD: Juvenile Idiopathic Arthritis	• Business case development for replacement consultant* • Develop advice and guidance system for primary care, secondary care at OUH and secondary care outside of OUH*
NCEPOD: Testicular Torsion	• Re-audit the testicular pain pathway over a longer period to identify bottlenecks in pathway* • Analysis of 12-month audit data to quantify the extent of the delay in transfer to theatre and lack of post operative bed perceived problem* • Meeting with matrons and bed managers to find workable solutions that will not delay provision of NCEPOD 1 or 2 surgery* • Current paediatric testicular torsion patient information leaflet (PIL) to be updated and modified to include information on psychological support options* • Increase education on testicular torsion in primary and secondary care by running a training day for GPs and District General Hospitals*

Audit	Summary of Agreed Actions
	• Adult urology services to make use of the existing British Association of Urological Surgeons (BAUS) patient information leaflet*
NCEPOD: Endometriosis	• Update Trust website for both Endometriosis and Pelvic Pain services, including accurate information about the services and current contact details for administrative staff* • Organise and deliver a local training day focussed on endometriosis for any interested clinicians in primary or secondary care* • Replacement of pelvic pain consultant who retired* • Appoint to all pelvic pain physiotherapy posts that are currently not filled* • Business case for expanded pelvic pain service to have greater resources for patient support including nurse, doctor and psychology resource* • Deliver a training package to local NHS Talking Therapies clinicians on endometriosis* • Finalise standard operating procedure to include timing of medication reviews and ongoing shared care with primary care colleagues* • Finalise shared care protocol* • Develop further cooperation between clinical and pharmacological services to discuss possible drug interactions which might affect treatment efficacy and patient safety*
Non-Hodgkin Lymphoma Audit	• For radiology to remove 'refer to lymphoma MDT' from their reporting* • To replace with 'needs a biopsy' or other clinically appropriate comment* • Directorate/ Division to invest in day treatment unit infrastructure and space, nurses and pharmacists*
Obesity Audit	• Review body mass index data submission process to identify reason for invalid data**
Paediatric Intensive Care Audit Network (PICAnet)	• Reduce readmission rates by improving nursing recruitment, skill mix and decision making around discharging patients* • Continue to circulate lessons learnt and best practice about retrieval team mobilisation time* • Explore pathways that allow technology dependent patients to be looked after in non ICU settings*
Perinatal Mortality Tool (PMRT)	• Commence screening for early onset pre-eclampsia**

Audit	Summary of Agreed Actions
	• Update pre-booked scan pathways** • Additional high risk antenatal clinic**
Perioperative Quality Improvement Programme (PQIP) (2 years data)	• Discuss and agree new patient recruitment targets with national PQIP lead** • Ensure Direct Delivery team receives appropriate training and help with troubleshooting in the recruitment of patients** • DrEaMing (Drinking, Eating, and Mobilising within 24 hours of surgery) audit scores displayed on local Safety Boards**
Society of Acute Medicine Benchmarking Audit (SAMBA)	• Education about post-take ward rounds based on clinical priority and geographical considerations to be delivered to the Medical Registrar Group**
Sentinel Stroke National Audit Programme (SSNAP)	• Increase speech and language therapy provision to meet national standards for bed therapy ratios* • Review of stroke pathway (led by ICB)*
Serious Hazard of Transfusion (SHOT)	• Annual review of current e-Learning package to incorporate human factor influences** • Work collaboratively with Haemonetics through active development of a transfusion-associated circulatory overload risk assessment process to be available at the bedside** • To complete the Human factors study commissioned by Hospital Transfusion Committee*
Cleft Registry and Audit NETwork (CRANE)	• Explore options to be able to supply a Paediatric Dentist provision at service level looking to dental hospitals for potential input* • Run an audit on consent collection and identifying patients that need following up** • Ensure that all data is being collected at Clinical Review Clinics to fulfil CRANE requirements to aid a GIRFT approach**
Transcatheter Aortic Valve Implantation (TAVI)	• Increase data completion through monitoring of national data* • Evaluate if same-day discharge would be appropriate for the service* • Develop selection criteria for low risk patients* • Implement a discussion of readmissions in M&M Meetings** • Review of current data collection methods to identify areas for improvement in reducing readmissions rates*
UK Cystic Fibrosis (CF) Registry-Adult	• Review the significance of intravenous and inhaled antibiotics on CF patients while continuing to monitor and capture data*
UK Cystic Fibrosis Registry-Children	• Establish a regular core CF MDT half-day 'away day' to review latest evidence and local and national guidelines to ensure the

Audit	Summary of Agreed Actions
	service remains up-to-date and practicing in line with developments in CF management* • Develop a local patient information sheet on fertility issues in CF to help enable timely and open discussions with teenagers with CF*
UK Interstitial Lung Disease (ILD)	• Audit lead to meet with head of national registry and interrogate standards so they are fit for purpose** • Business case for additional radiology time at clinics* • Consider a proforma approach to ILD clinics**

Actions taken and improvements made from Trustwide audits

Trustwide audits are repeated annually and conducted across the organisation. The topics are derived from patient safety and quality standards and in 2025/26, there were ten Trustwide audits.

Six were reviewed by the Clinical Improvement Committee in 2025/26; the remaining four completed data collection in 2025/26 and will be presented in 2026/27.

Agreed actions and progress to improve the quality of healthcare provided are summarised in Table 14 below.

Table 14 Trustwide audits with actions taken and improvements made as a result (**Fully achieved; *Partially achieved)

Trustwide Audit	Summary of Actions
Safe and Secure Storage of Medicines	Business case for digital temperature monitoring to be approved**
Pressure Ulcer Prevention Audit NICE Clinical Guideline (CG) 179/Quality Standard (QS) 89	Revision of a HAPU Reduction Quality Improvement Programme (QIP)**
Nutrition Audit NICE Clinical Guideline (CG) 32	- Modify or introduce a nutrition screening tool suitable for Maternity inpatients and adapt OUH-MUST audit accordingly* - Develop a nutrition training programme / modules and deliver this through a train-the-trainer model , consider using My Learning Hub. ** - Update OUH Nutrition and Hydration Strategy* - Undertake MUST accuracy audits on sample group/wards**
Deteriorating Patient Audit	- Provision of information for consultant body by presentations at appropriate meetings. Ensuring SEND is easily accessible on computers in clinical areas* - Work with RAID Assessors in clinical areas to revise RAID education materials to meet current clinical needs* - Work with clinical colleagues and colleagues in IM&T to develop a document which can easily be incorporated into current workflows*
Health Records Audit	This audit was conducted from September-November 2025. The paper will be presented to CIC in the 2026/27 financial year.
Consent Audit	This audit was conducted from September-November 2025. The paper will be presented to CIC in the 2026/27 financial year

VTE Prevention Audit	• Introduction of the Thrombosis Risk Prediction Following Cast Immobilisation (TRIPCast) risk assessment tool for Lower limb Immobilisation, an electronic and validated tool* • Explore the use of Thromboprophylaxis column to be added to ward White Boards, following a recommendation at Safety, Learning and Improvement Committee (SLIC) meeting*
AutoReporting	• Divisions should be emailed to collect this data with plenty of notice (e.g. 3 months)* • Alert radiographers regarding the new policy* • Reconsider if pre-op templating type X-rays with measurement overlays require documentation in notes, given they are self-explanatory*
Mental Health Act	• The audit provided strong assurance that the Trust had applied the requirements of the Act correctly, and so no action plan was required •
ReSPECT - Recommended Summary Plan for Emergency Care and Treatment	• ReSPECT was newly implemented at OUH in 2025/26 so this is the first year of auditing following initial teaching, training and roll-out. It is anticipated the audit will be presented to CIC in June 2026, covering 2025/26 data



GIRFT Implementation Plans

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted

variations. A fundamental principle of this programme is to improve the quality of care and by doing so lead to a reduction in costs.

Peer review visits take place, resulting in observations and best practice recommendations which are then developed into an action plan for implementation and reported to the Clinical Improvement Committee.

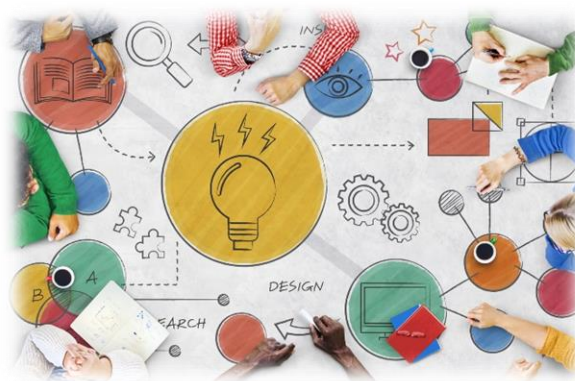
Table 15 below shows the specialties which have presented implementation plans to the clinical Improvement Committee in 2025/26.

Table 15 GIRFT implementation plans approved at Clinical Improvement Committee, observations and actions planned

Specialty and Date of Review	Observations and Actions Status
Diabetes in Children and Young People (CYP) (Dec 2024)	• Oxford is a pilot site for the NHSE Transition and Young Adult diabetes project and benefited from additional staffing resource from 2023-25 • The service has developed a standard operating procedure for managing CYP with high HbA1c levels • The use of hybrid closed-loop technology to monitor and manage bloods sugar levels was prioritised for the highest-risk patients and implementation is progressing well • Patient education is offered in the Young Adult Clinic, with follow-up provided by the Specialist Nurse and Dietician • Actions 4/8 delivered/total accepted
Paediatric Rheumatology (January 2025)	• There are examples of excellence including one-stop clinics with ophthalmology, highly respected chronic pain and skeletal dysplasia services, delivery of age-appropriate care from ages 0-25 years, and play specialist support • Challenges and opportunities include succession planning for the consultant workforce, expansion of the multi-disciplinary team to include a psychologist, and referral pathway review • There is a plan to deliver annual training across A&E, paediatrics, orthopaedics, musculoskeletal hubs, and schools • Actions 5/31 delivered/total accepted

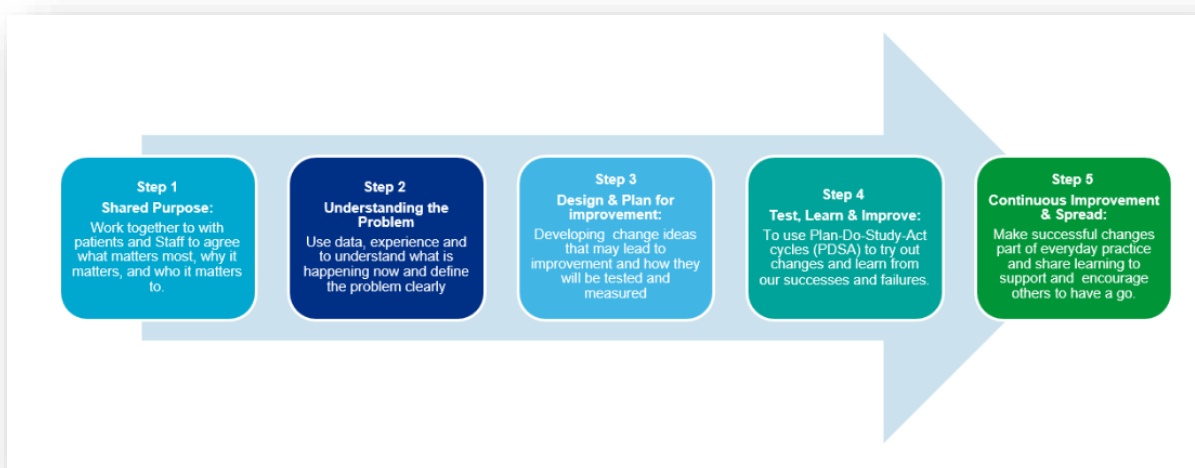
Quality Improvement 2025/26 Report

Oxford University Hospitals (OUH) remains committed to advancing our culture of continuous improvement, underpinned by the Trustwide adoption of Quality Improvement (QI). Building on a strong foundation, 2025/26 has been a year of consolidation, increased engagement and a continued focus on enhancing both patient care and the working environment for our staff through the defined Integrated QI Programme. This commitment reflects the Trust's resolve to align with the vision of NHS Impact and deliver healthcare that is continuously improving, patient-centred and efficient.



Building on the progress of the previous year, our Integrated Quality Improvement (IQI) Programme continues to drive meaningful change across these priority programmes, enabling improvements in both complex patient pathways and building our culture of continuous improvement and approach to meeting clinical and non-clinical standards. The OUH Improvement Framework, initiated in 2022 to guide teams and services through a five-step process of improvement was reviewed and updated in 2025/26 (see Figure 1 below). This update was informed by feedback of colleagues across the Trust.

Figure 1 OUH Improvement Framework (Version. Updated January 2026)



Integrated Quality Improvement Programme Overview

The Integrated Quality Improvement (IQI) Programme has made significant contribution to embedding quality improvement (QI) within the Trust, drawing a QI approach to support key organisational priorities. Our structured approach is underpinned by OUH Improvement Framework (see above).

The IQI programme maximises the impact of improvements by supporting engagement and testing of new ways of working at service and team level building, leveraging both intrinsic and extrinsic motivators while recognising the unique characteristics of each project and programme. This remains both an ongoing opportunity and a challenge as we collectively work towards developing the wider maturity of our organisational culture of continuous improvement.

In the past 12 months the IQI Programme has comprised four core programmes: QI Learning Hub, Urgent and Emergency Care, Standard Work, Cancer Improvement; and the initiation of a new programme from January 2026, Improvement Sprints. The following sections provide an update on the achievements and programme across these programmes.

Cancer Improvement Programme

The Cancer Improvement Programme supports multidisciplinary teams to address performance against the national cancer standards by using a QI approach. The Trust performs well for the 28-day faster diagnosis standard, so focus during 2025/26 has been on the 62-day standard (aim for 96% of patients receiving their first treatment within 62 days of diagnosis). The team have run a number of large collaborative multi-stakeholder workshops exploring constraints and identifying practical changes that can be put in place rapidly (e.g. within 100 days) to reduce waiting times for patients needing cancer treatment. Medium- and longer-term improvements have been discussed during the workshops which are helping to form a longer term Trust cancer strategy aligned to the National Cancer Plan (2026) published by NHS England <https://www.gov.uk/government/publications/national-cancer-plan-for-england>

Key improvements that have come out of the workshops in 2025/26

- Head and Neck (patients with thyroid cancers): waiting for treatment has improved by 30% and has exceeded the 96% aim of patients starting treatment within 31 days of a decision to treat. Also introducing remote clinics to give patients results where cancer has been excluded has helped the Head and Neck service exceed the 28-day faster diagnosis standard.
- Waiting times for patients with upper gastrointestinal and liver related cancers have improved by up to 30%, exceeding the national standards, by introducing a number of changes including earlier blood tests at appointments and identifying patients who need earlier multi-team reviews.
- A 'navigator role' was introduced to the renal service to closely scrutinise patients in the pathway and has contributed to nearly 30% reduction in waiting times for patients waiting treatment when a decision to treat is made by their doctor.
- The Breast cancer service has seen a 25% increase in performance for patients starting their cancer treatment within 62-days performance increased to 84.5% by

Dec 2026. This has been achieved by expediting patients for rapid review where breast cancer is likely, careful management of outpatient slots and other changes.

- The lower gastrointestinal service has set up a 'Pre-op Assessment Pool' by adding two clinic slots per week and enabling same day preop following surgical outpatient. This has reduced the time patients wait to for their fitness assessment before surgery. It is anticipated this will reduce delays for surgery associated with prehabilitation, the impact of this is being monitored by the service to inform ongoing adaptations and wider learning.

The QI team have used these workshops and follow up opportunities to support colleagues in cancer services develop and embed wider improvement knowledge expertise via coaching, mentoring and specific skill support.

The team has launched an Improvement Collaborative model within the lung cancer pathway as waiting times for patients to start their treatment have been challenging to meet. Lung cancer has particularly complex pathway involving multiple services that need to work seamlessly together including sharing important diagnostic information, communicating promptly with patients and experts from different services coming together in a coordinated way to propose the most effective and beneficial treatment options to patients. Robust administrative and communication systems and processes need to sit around this for all parts of the pathway to work efficiently. The Lung Improvement Collaborative is examining these processes referring to best practice in other Trusts and new technologies. We have started testing multimedia methods of running key multidisciplinary meetings where specialists come together to agree specific treatment options for patients, testing how this might expedite important follow up discussions with patients and arrangement of appointments so that treatment can be organised faster. In addition, we are testing new ways of tracking patients through their treatment pathway to ensure the most up to date and accurate information is visible for all members of the team providing care to both reduce unnecessary delays and support improved patient experience. Impact of testing will be tracked to adapt and adjust change ideas as the work continues, guided by the data and insights of staff.

Urgent and Emergency Care

The Urgent and Emergency Care (UEC) Quality Improvement Programme supports the delivery of safe, effective and timely care by working with frontline teams to improve patient flow, reduce delays and enhance the quality and reliability of care.

During 2025/26, the programme focused on priority areas with the greatest impact on patient safety and experience, particularly children's urgent care, discharge processes and reducing extended lengths of stay. Quality improvement methods were used to support teams to understand problems, test changes safely and measure their impact.

Significant improvements have been made in children's urgent and emergency care. Work to redesign pathways at the front door of Paediatric Emergency Departments has improved the timeliness of assessment and decision-making. As a result, performance against the four-hour standard improved from 58% to 71%. While further improvement is needed to reach national standards, this represents meaningful progress for children and families accessing emergency care.

The programme has also improved patient flow from Emergency Departments to inpatient wards. Improvements to "bed readiness" processes reduced the average time from a decision to admit a child to transfer onto a paediatric ward from approximately 136 minutes to 100 minutes. This has reduced waiting times in emergency departments and supported safer, more timely admission to inpatient care.

Discharge quality and reliability have been a major focus. By analysing the causes of on-the-day cancelled discharges and testing targeted improvements, teams achieved a 50% reduction in cancelled discharges, from an average of 20 per week to 10. This has improved patient experience, reduced wasted capacity and supported better use of hospital beds.

Further work to reduce extended lengths of stay has led to fewer patients occupying beds longer than clinically necessary, with an average reduction of six extended-stay patients per week. In addition, improvements to discharge planning increased the number of children discharged before midday from an average of 26 to 29 per week, supporting smoother patient flow and safer transitions of care.

Across all workstreams, the Quality Improvement Programme has strengthened multidisciplinary working and supported staff to develop improvement skills. Coaching and structured improvement approaches have enabled teams to take ownership of change and embed learning into routine practice.

Overall, the Urgent and Emergency Care Quality Improvement Programme has delivered measurable improvements in quality, safety and performance. By focusing on patient flow, timely care and reliable discharge processes, the programme is supporting OUH to provide more consistent, high-quality urgent and emergency care for patients and families.

Standard Work

At OUH, we are committed to delivering the highest quality of care, therefore we are prioritising the implementation of the Standard Work (SW) concept across our services. Drawing from the learning and evidence base from wider industries, this approach is designed to ensure that every patient receives consistent, safe and effective care while supporting our teams in their daily work.

The initial focus for the Standard Work programme has been supporting clinical inpatient teams, working to align with existing structures and reduce duplication and enhance care,

for example linking with and understanding the alignment with Care Assure. This provides a frequent opportunity to assess fundamentals of care.

Standard Work is a clear, step-by-step framework that outlines the best way to complete specific tasks based on evidence and expertise. It is about creating reliable processes that support excellence in care. Success will be evaluated through clear metrics, including audit results, staff engagement levels and outcome measures tied to organisational goals.

The overall aim of the Quality Priority is to enable the successful adoption of Standard Work in a structured, measurable and impactful manner on defined priority areas, building forward our culture of excellence and continuous improvement, benefiting patients, staff and the organisation.

The detail including key benefits from the first year of the programme is shown within the information within [Quality Priority 4, Standard Work](#)

QI Learning Hub (previously Building Quality Improvement Capability and Capacity)

The Trust continues to invest in building capability and understanding of quality improvement (QI) and continuous improvement across the organisation. This is delivered through a combination of formal training programmes and informal development opportunities, enabling staff at all levels to develop the knowledge, skills and confidence needed to improve services and patient care.

Impact and Benefits Realisation (Education Framework, April 2022–2025):

- At least 2,736 individuals have undertaken QI training, completing a total of 4,476 training courses.
- OUH staff have collectively dedicated over 568 hours to understanding the core concepts of QI, 6,126 hours to learning how to apply QI within their own services, and 7,908 hours to developing the skills needed to lead and support QI projects across the Trust.
- More than 1,000 new QI projects have been registered on Ulysses. The average time from project registration to approval has reduced significantly, from just under 40 days to just under 17 days.

QI Education Framework highlights from 2025/26

Below are some specific highlights from the QI Education Framework delivery over 25/26, this includes development of new training options and a focus on continuing to ensure our training directly supports tangible improvement across OUH.

In addition to our established 'Introduction to QI' e-learning program, over the past twelve months we have launched an in-person introduction to QI session as part of the reinstated in-person Trust staff induction programme. This session introduces new colleagues with our Trust approach to improvement from their first day at OUH, highlighting the importance of

continuous improvement, and encouraging them get involved and share ideas to enhance patient care and workplace practices.

QI Fundamentals

Our QI Fundamentals training is a 1-day introduction to focused improvement tools with a focus on application to a project or improvement initiative. Over 24/25 OUH partnered with NHS Elect to deliver these monthly one day QI Fundamentals session, testing a new redesigned format. The session aims to help staff move confidently from learning QI principles and tools to applying them in practice, supporting meaningful and measurable improvements within their teams and services.

Collaborative QI Practitioner (CQIP)

OUH have played an active role in the national leadership of codesigning the new Collaborative QI Practitioner (CQIP) programme with NHS Elect. Focused on addressing the need for a more balanced QI curriculum that strengthens adaptive, relational, and system level improvement skills alongside traditional technical tools.

CQIP has been shaped through extensive national engagement, and OUH has been part of the national pilot from August 2025 in advance of wider adoption from spring 2026.

The programme replaces the previous 'Quality, Service Improvement and Redesign' (QSIR) Practitioner course and provides free, evidence based training to develop skilled improvement practitioners who can lead and sustain change across the organisation. OUH continues to contribute to the national development of this programme.

Quality Coach Development Programme (QCDP)

The Quality Coach Development Programme continues to expand quality improvement (QI) expertise across OUH, focusing on establishing a core group of colleagues across the Trust who not only understand QI, but are also skilled and supported to help others embed this approach within projects and areas of practice. Since it's Trust launch in 2024/25 39 colleagues have been trained as a Quality Coaches, who are now actively supporting teams and individuals to deliver improvement work within Divisions and teams.

In early 2026 QCDP Cohort 3 started piloting a co-delivered approach in partnership with Oxford Health NHS Foundation Trust, aiming to strengthen collaboration and shared learning across organisations.

Masterclasses

We have introduced targeted QI Masterclasses to rapidly build skills in priority areas. Two masterclasses are currently available: *Standard Work* and *Maximising Value and Reducing Waste*. These sessions help teams working on improvement projects to align their work with Trust priorities and have a positive impact more quickly.

Further highlights from 2025/26

QI Sharing and Learning Events

To foster organisational learning and improvement, various methods have been evaluated and refined to facilitate colleague connections. In 2025/26, we piloted both 'QI Lunch and Learn' sessions and quarterly Community Engagement Events. Recognising the difficulties associated with releasing staff for extended sessions, and responding to ongoing requests for enhanced networking opportunities, these initiatives were merged in late 2025 to test regular, one-hour online 'QI Sharing and Learning Events.' These concise and practical sessions are co-delivered by clinical and corporate teams, recorded, and distributed via the Trust QI Zone intranet to support wider accessibility and broaden the dissemination of learning. Between 10 – 25 colleagues have attended these sessions, with session topics having included sharing of locally delivered QI projects, value stream mapping and publishing QI case reports. On going testing of different approaches to networking and linking colleagues to support shared learning and improvement are in discussion for 2026 – 2027.

BOB System Partnerships

Throughout 2025, OUH continued to collaborate with QI colleagues and share best practice and learning through the BOB QI Network. Following successful application for Q Community Grant from the Health Foundation the priorities over 2025/26 had been in four key areas that looked to enhance and mature the network support effective sharing and learning.

- **BOB QI Festival** – Building on the success of the past two years' virtual Improvement Festivals, we hosted an in-person conference attend by over 80 colleagues. Supported by all providers across BOB ICS this provided an opportunity to share best practice and link colleagues from different providers across the region to foster engagement and knowledge exchange.
- **Look, Go and See** – OUH Colleagues were supported to visit each of our organisations across the BOB ICS completing a QI 'show and tell' and discussion of key topics (PSIRF, RPIW, building QI Capability, QI Huddles).

In March 2026, we organised an industry visit to the Mini Factory in Oxford for 15 QI colleagues to explore Lean principles in manufacturing. Attendees reflected on applying these insights to the NHS with a virtual webinar is planned for 2026 to share learnings from the visits.

- **BOB QI and Co-Production Working Group** – OUH have been collaboratively working with Oxford Health to explore new opportunities for development of tools and

approaches to embed patient and community voices within all improvement. This work will continue into 2026/27.

- **BOB QI Practitioner Training** –OUH Took a leadership in running the pilot for the Collaborative QI Practitioner training, colleagues from across provider trust previously linking as faculty for QSIR practitioner delivery were invited to join the cohort.

Through these initiatives, the BOB QI Network will continue to grow as an inclusive and forward-thinking community, driving meaningful improvements in healthcare across the region.



Oxford Simulation, Teaching and Research (OxSTaR)

Human Factors and Patient Safety Education for OUH

OxSTaR has been providing award winning training using simulation and technology-enhanced learning for students and healthcare professionals in OUH for over 18

years. This collaboration has received national and international recognition for OxSTaR's teaching and research and benefits from an emphasis on robust educational governance (including accreditation by the UK's Association for Simulated Practice in Healthcare (ASPIH)). We have always focused on the importance of co-design in our educational interventions and have built strong relationships with educational teams across the Divisions in the Trust. This ensures we are responding to key quality and safety priorities in OUH and delivering learning outcomes that translate to safer, more effective care in the workplace.

Human Factors and safety training informs understanding of patient safety concerns in the workplace across the Trust and feeds directly into the design of quality improvement projects to mitigate risk and improve safety across the organisation. Feedback from participants is outstanding. We also collect data on safety culture using an internationally validated safety attitudes questionnaire designed for clinical staff.

There are three levels of training offered to OUH staff through OxSTaR.

Level 1 – introductory Human Factors / Ergonomics (HFE) training for all staff in OUH. This includes freely available online half-day introductory HFE courses, this course is supported by online learning materials, including a handbook and podcasts covering relevant safety issues such as recognition of the deteriorating patient and medicines safety. 452 OUH staff members attended level 1 training

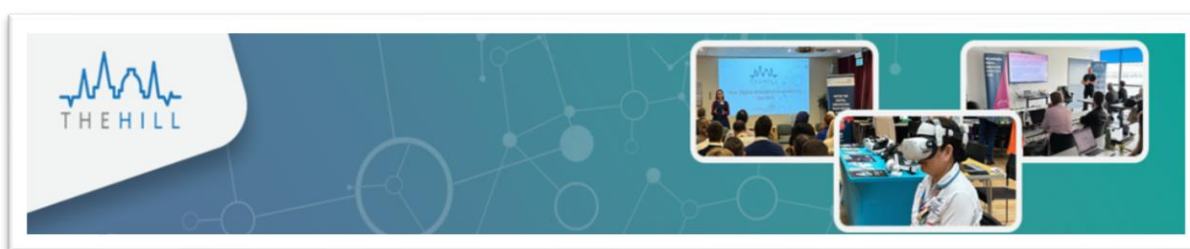
This year OxSTaR has created and delivered new courses on system-based incident analysis for Patient Safety Incident Investigations (PSII) using the London Protocol. This programme equips OUH incident analysts to deliver timely, system focused PSII's to maximise learning and improvement after safety incidents.

Level 2 – Simulation-Based Education (SBE) and HFE training to support key quality and safety priorities in OUH (e.g. SBE faculty development, care of the critically ill newborn, Advanced Critical Care Practitioner (ACCP) training) 451 OUH staff members attended level 2 training.

Level 3 – bespoke SBE and HFE training delivered according to need (e.g. in response to a specific safety incident or to support the development of a new patient pathway).

During 2025/26, OxSTaR collaborated with the psychological medicine team to deliver specialised training to OUH staff within their workplace environment. Certain hospital staff members require targeted instruction to manage behavioural disturbances in adults effectively, as such incidents may arise from various factors including mental illness, dementia, delirium, or substance use. Comprehensive training enables staff to identify early warning signs, de-escalate potentially aggressive situations, and respond in a manner that upholds patient safety, dignity, and minimally restrictive practices. Furthermore, it provides them with enhanced communication techniques, risk assessment capabilities, and a thorough understanding of legal and ethical obligations. Insufficient preparation can lead to diminished confidence among staff and reliance on reactive interventions, thereby increasing risks to both patients and personnel. This programme was attended by 31 OUH members, including security staff.

Digital Innovation



TheHill

TheHill plays an important role in supporting innovation across the Trust, enabling staff to engage with new technologies, build digital capabilities, and accelerate adoption of solutions that improve efficiency, effectiveness, and patient outcomes. Programmes supported by TheHill include:

Innovation Training

Innovation Training is delivered through a two-day, classroom-based programme featuring interactive sessions. It equips staff with the knowledge and skills to understand how innovation creates value, identify opportunities for improvement, and develop the practical capabilities required to lead and implement innovation projects successfully. The programme also promotes the adoption of new technologies and strengthens change leadership across departments.

Pre- and post-programme evaluation demonstrates a significant positive impact. The proportion of participants likely to explore innovative solutions increased from 0% to 100%, while those very likely to engage with new technologies or participate in trials rose from 60% to 100%. Confidence across key innovation competencies improved by an average of 60–80%.

Start-Up Labs

Start-Up Labs are designed for NHS staff with ideas for impactful innovations that can benefit colleagues and patients. It enables staff to turn their ideas into reality and provides opportunities to develop innovative technologies that address frontline challenges.

The 6 week programme offers a structured, fast-track pathway to support participants in developing their ideas into functioning prototypes. Participants have progressed their ideas in a variety of ways, including establishing companies, securing grant funding, submitting research proposals, and collaborating with SMEs and internal teams to co-develop and test solutions. Notable examples include a hand therapist at the Nuffield Orthopaedic Centre who secured grant funding for an AI-based solution developed during the programme and is now pursuing further research funding to support its development and validation. In a second example, a ward housekeeper is working with colleagues and voluntary services at the Churchill Hospital to develop a wayfinding solution to improve patient and visitor experience.

As well as offering a range of programmes for staff, TheHill enables collaboration between the Trust and the wider innovation ecosystem, bringing together NHS staff, SMEs, researchers, and industry partners to co-design and deliver digital solutions that address real-world healthcare challenges.

The Market Access Accelerator

The Market Access Accelerator (MAA) is a twelve-month programme which focuses on supporting digital health start-ups in gaining an in-depth understanding of how the NHS works while helping to scale innovative technologies which can improve patient care and reduce the pressure and burdens on NHS staff.

The Accelerator model allows us to work with companies that are at an earlier stage than a procurement would, and whose technologies require co-development and testing within an NHS environment. This approach creates products that are better aligned to NHS frontline needs and allows us to safely interact with technologies on the cutting edge of development.

In 2025, eight companies graduated from the programme, their details are below.

CEFREF

CEFREF is an advanced electronic migraine and headache diary app, designed by founder and consultant neurologist to simplify accurate monitoring of headache frequency/severity and painkiller usage and was created to improve management of migraines. Patients can also analyse their own data and share this information with their healthcare provider which can help determine the most appropriate treatment.

eAltra

eAltra is a conversational AI which aids cancer treatment delivery, reducing the time spent by clinicians in assessing patients by up to 50%. It allows patients to more freely exchange information with their clinical team, allowing for toxicity screening, holistic needs assessments, patient reported outcomes and patient concern logging, all while integrating with the patient's electronic health records (EHR).

Hatopy

Hatopy provides a novel approach to managing eczema by utilising wearable technology and AI to objectively track the condition and transform the daily experience of living with it into meaningful insights. Unlike traditional tracking apps, Hatopy offers real-time feedback and personalised interventions to help users recognise potential triggers, prevent flare-ups, and take more control of their condition.

Matriwell

Matriwell's innovation, MothersPA, is a healthcare companion for mothers which looks to tackle the systemic inequalities present in maternity care. The AI-powered software analyses the user's full medical history, symptoms, self-reported health data, and where possible, real-time electronic patient record (EPR) records to identify risks and provide a

summary. The summary empowers mothers to advocate for themselves and provides clinicians with data to enable them to make faster and more informed decisions, enabling mothers to receive the right care at the right time.

MedForce AI

MedforceAI is transforming healthcare with a deep medical reasoning system designed to close the global clinical expertise gap. Deep medical reasoning is the use of advanced artificial intelligence that mimics how expert clinicians think. It acts as a vital safety net for clinicians, helping to catch potential medical errors before they can happen, while proactively identifying patients impacted by evolving medical guidelines, automatically re-running their diagnostic and treatment plans, notifying clinicians if an updated course of action is recommended.

Sens-Vue

Sens-Vue have created an AI solution (GlauKomAI) to detect vision-threatening glaucoma for early prevention and precise treatment. Their artificial intelligence solutions operate on different devices, empowering care providers by enabling faster diagnosis, reducing referrals to ophthalmology clinics and wait times. GlauKomAI can diagnose glaucoma from eye images in seconds using an AI algorithm supported by bio-sensing technologies.

Skystrm (Senso24)

Skystrm have developed Senso24 which is a 24/7 AI-driven monitoring solution, designed to ensure safety and independence for individuals at home or in care settings. It uses non-invasive computer vision and machine learning to detect falls and health abnormalities in real-time and provides instant alerts to healthcare staff, carers and, if needed, the emergency services.

Vocavibe

VocaVibe's innovation is a conversational chatbot for people living with Parkinson's, which lets patients and clinicians catch the earliest signs of symptom progression. Through active interaction with patients throughout the day, the chatbot continuously monitors signs of motor symptom progression, cognitive decline, depression, swallowing difficulties and treatment effect. Real-time alerts are provided to the patient's clinicians, enabling earlier intervention and preventing common causes of hospitalisation, such as aspiration pneumonia and medication mismanagement.

Innovation Pipeline

The Innovation Pipeline connects the Trust to the wider innovation ecosystem, enabling TheHill to match external digital solutions to identified needs and facilitate approved pilots, research collaborations, and early-stage testing. By providing a structured, step-by-step framework, the pipeline ensures each innovation is assessed against real-world needs and Trust priorities, with oversight from OUH Innovation Panel, a committee of key stakeholders providing independent review and recommendations. Piloting technologies on a smaller scale ensures that only solutions demonstrating tangible benefits and alignment with Trust processes progress to full adoption, reducing risk and avoiding ineffective procurements. This guarantees that projects are clinically relevant, evidence-based, and deliverable within the Trust's operational and regulatory context. Currently, the pipeline is progressing 28 companies through its six stages to adoption.

Case study example: Ambient Voice Technology (AVT)

AVT is a tool that uses a microphone and secure artificial intelligence (AI) software to help clinicians document patient consultations in real time. It captures spoken words and converts them into clinical notes and letters, which clinicians then review to ensure accuracy and completeness before storing them in health records.

TheHill ran a 6-month AVT pilot which explored whether these tools could help ease the growing administrative pressures on clinicians and support more efficient, patient-centred care. The pilot ran across a variety of inpatient and outpatient settings, including Critical Care, Community Paediatrics and Outpatients, each with different levels of complexity and workflow needs, and tested four different AVT solutions.

Key outcomes from the AVT pilot included:

- **Time savings:** 88% of clinicians reported measurable reductions in documentation time, with nearly half saving 5–15 minutes per encounter and 22% saving an hour or more per day. Weekly time spent on documentation outside normal hours dropped from 3.02 to 1.55 hours.
- **Staff wellbeing:** Stress levels fell by 70.2%, fatigue at the end of shifts reduced from 82% to 57%, and staff reported improved work-life balance and reduced cognitive load.
- **Patient care:** Clinicians could focus more on consultations, producing more timely, thorough, and accurate documentation. Across the pilot, 199,651 minutes of transcription (138 days) produced 6,535 outputs.

Feedback from staff participating included:

- **Specialist Nurse:** “Not having the burden of extra paperwork has improved my wellbeing and job satisfaction. Losing AVT would feel like a step backwards”

- **Audiologist:** “After a back-to-back clinic, all admin would be done by the end of the day, which was previously unheard of. Reports went out on the day, families received them quicker, and referrals happen faster. It made a huge difference.”
- **Specialist Nurse:** “AVT let me focus on patients without taking notes, which enhanced the quality of interactions. Patients responded positively, appreciating the more open conversation.”

The AVT pilot demonstrated that AI-enabled voice tools can deliver significant benefits when implemented carefully, with strong engagement, training, and evaluation. Findings from the pilot have informed a Trustwide AVT procurement process and provide a practical model for the safe and effective adoption of AI technologies in healthcare.

Case study example: The Health Research Centre (HRC)

The HRC is funded by the National Institute for Health and Care Research (NIHR) and aims to address health inequalities by supporting applied health research that is place-based, inclusive, and community-driven. The HRC focuses on co-designed research that reflects local and regional health needs, builds research capacity in underserved and high-need areas, and promotes equity in health outcomes through strong partnerships across the NHS, academia, local authorities, and the voluntary sector. TheHill co-leads the Digital theme for the Thames Valley and Oxfordshire HRC.

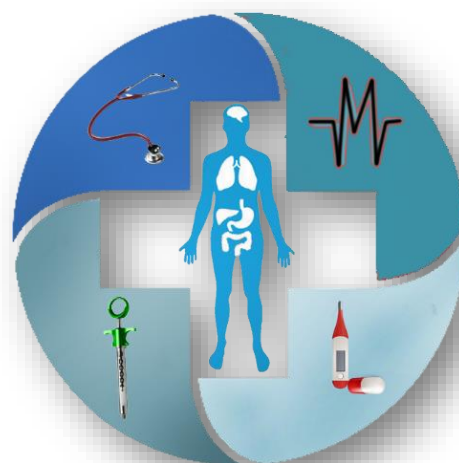
In collaboration with Adam Gordon, Professor of Care of Older People at the Academic Centre for Healthy Ageing, TheHill delivered a Falls Prevention workshop which:

- Identified key clinical challenges in falls prevention.
- Highlighted best practice approaches.
- Supported startups in refining their innovations with real-world clinical insights.
- Provided opportunities for collaboration between healthcare professionals, industry, and academia.

Over 100 participants registered, representing a wide range of health and care settings. The workshop facilitated cross-collaboration, sharing of best practice, and networking to improve falls prevention across the system.

Our participation in clinical research

As one of the United Kingdom's leading university hospital Trusts, OUH is committed to integrating clinical care and research. Together with its research partners, OUH aims to discover better ways to diagnose and treat patients locally, and to contribute to healthcare advances nationally and internationally. This is underpinned by bringing together academic research expertise with clinical teams throughout the Trusts clinical sites.



OUH's close partnership with Oxford University (OU) encompasses major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging, as well as interdisciplinary collaborations in digital health. Recent investment in the development of research led by nurses, midwives and allied health professionals (NMAHPs) at OUH, working closely with Oxford Brookes University (OBU's) Oxford Institute of Applied Health Research (OXInAHR), has helped to build a robust evidence base to drive improvements in broader aspects of patient care, as well as creating new career pathways for OUH staff.

Much of this activity benefits substantially from the NIHR Oxford Biomedical Research Centre (Oxford BRC), which has been based at OUH and run in partnership with OU since 2007. The Oxford BRC funds innovation across 15 research themes and a core team that supports researchers in areas such as patient and public involvement and engagement, business development, training and education and ethics. Plans are being made for a further bid in late 2026 for a further 5 years funding.

The NIHR Oxford Clinical Research Facility (CRF) is another partnership with OU, which is already delivering a wider range of early phase studies (many with Oxford BRC funding) for the benefit of patients, as well as to train and develop a new generation of doctors, nurses and allied health professionals in early phase experimental medicine trials.

During 2025/26, OUH hosted 1645 active clinical research studies. These include 314 new studies that have opened to recruitment at OUH during 2025/26.

The Joint research office (JRO) is a shared resource with OU, Oxford Brookes and Oxford Health. It continues to evolve and in 2026 plans have been developed to facilitate and accelerate the integration between the four partner organisations. This will reduce study set up times and reduce some of the bureaucratic processes that can be associated with research.

The number of patients receiving relevant health services provided or sub-contracted by OUH in 2025/26 who were recruited during that period to participate in research approved

by a Research Ethics Committee, was 9885, recruited to 488 studies registered on the NIHR portfolio.

In 2025/26, 103 OUH staff were directly supported by NIHR Oxford BRC funding. An additional 55 staff with honorary OUH contracts are also supported by PAs funded by the NIHR Oxford BRC. 148 staff were funded by the NIHR Regional Research Delivery Network (RRDN).

The following examples illustrate some of the diverse high-impact clinical research studies and facilities which OUH has been involved in during 2025/26, in many cases working in close partnership with OU.

- OUH is sponsoring the UK's first multicentre randomised controlled trial of **AI-assisted fracture detection in Emergency Departments**, working with Danish MedTech company Radiobotics. The [SAMURAI-Fracture study](#) will evaluate the real-world impact of the RBfracture™ AI tool across four NHS Trusts in the Thames Valley, under OUH [OxCAIR](#) programme. It aims to generate robust prospective evidence on accuracy, workflow impact, patient outcomes and system-level effects, addressing key gaps highlighted by NICE's Early Value Assessment for fracture-detection AI. The study also seeks to determine whether AI can reduce clinical errors, missed fractures and delays in care.
- The **outcomes for patients with multiple myeloma** could be significantly improved as a result of new studies opened to recruitment at OUH. The OUH-sponsored [MAGNETO trial](#) is testing a novel radiotracer developed with GSK to improve PET-CT imaging, which has the potential for earlier and more precise disease detection.
- OUH is recruiting patients to a clinical study testing whether deep brain stimulation (DBS) can **relieve severe chronic pain following stroke**. The [EPIONE study](#), led by Oxford neurosurgeons and engineers, is trialling an implanted DBS device in 30 patients whose pain has not responded to existing treatments. By comparing periods when the device is switched "on" and "off" in a randomised design, the research aims to produce robust evidence on whether DBS can provide meaningful pain relief. The findings of this study, which is sponsored by OU and supported by the NIHR Oxford BRC, will help determine whether this approach could be adopted more widely within the NHS.
- OUH also supports several OU vaccine studies recruiting healthy volunteers including in screening for eligibility and analysing safety bloods. This includes eligibility screening for a Phase 1 study of a new vaccine against Lassa fever in adults, which is also supported by the NIHR Oxford BRC.
- An OUH patient is the first person in Europe to be recruited to a heart inflammation treatment study. FORTIFY is an international clinical trial, sponsored by US biopharmaceutical company Abcentra, which is testing orticumab, a monoclonal antibody aimed at reducing coronary inflammation after a heart attack. It uses the

Fat Attenuation Index (FAI) biomarker, which was developed at the University of Oxford and commercialised by the OU spin-out Caristo Diagnostics, to identify patients with high coronary inflammation.

- OUH has recruited its first patient into a [clinical trial of CAR-T cell therapy for multiple myeloma](#), marking a significant milestone in advanced cancer research in Oxford. The study tests an innovative form of immunotherapy in which a patient's own T cells are genetically modified to target cancer cells and is one of the first trials of its kind at OUH. This international, randomised commercial trial, sponsored by Bristol Myers Squibb, is enrolling patients whose myeloma has returned despite previous treatment and compares CAR-T therapy with standard care. The results will help determine whether this approach could expand treatment options for myeloma patients in the future
- OUH has been awarded over £1 million in a national competition to **fund state-of-the-art [research facilities and equipment](#)**. This will help the Trust to meet the growing demand for commercially sponsored studies, in line with the expectations of the government. This capital funding will support and enhance studies across numerous disciplines, including respiratory and vaccine trials, ground-breaking imaging research using hyperpolarised xenon gas, and the vital work being done in pharmacy and pathology that underpins experimental medicine studies.

Reporting Excellence

The OUH Reporting Excellence (RE) Programme, established a decade ago, remains a key element of the Trust's Recognition framework, supported by a suite of instant recognition tools to express thanks and acknowledge effort. The focus continues on reporting excellence in practice, expressing gratitude and learning from Excellence. Actions and innovations undertaken by staff are celebrated with the nominee and also, when summarised, are shared directly with groups whose focus is on quality, efficiency and improvement. These rich data enable clinical and non-clinical areas to benefit from what goes well in daily work and to identify innovative or highly adaptive practice. This, in turn, contributes positively to learning, future quality improvement and constructive appraisal of existing practice.

In 2025/26 there were 2876 reports at the time of writing the report, with an average of 240 nominations per month (Graph 1).

Graph 1 Excellence reporting by Month October 2024 to March 2026

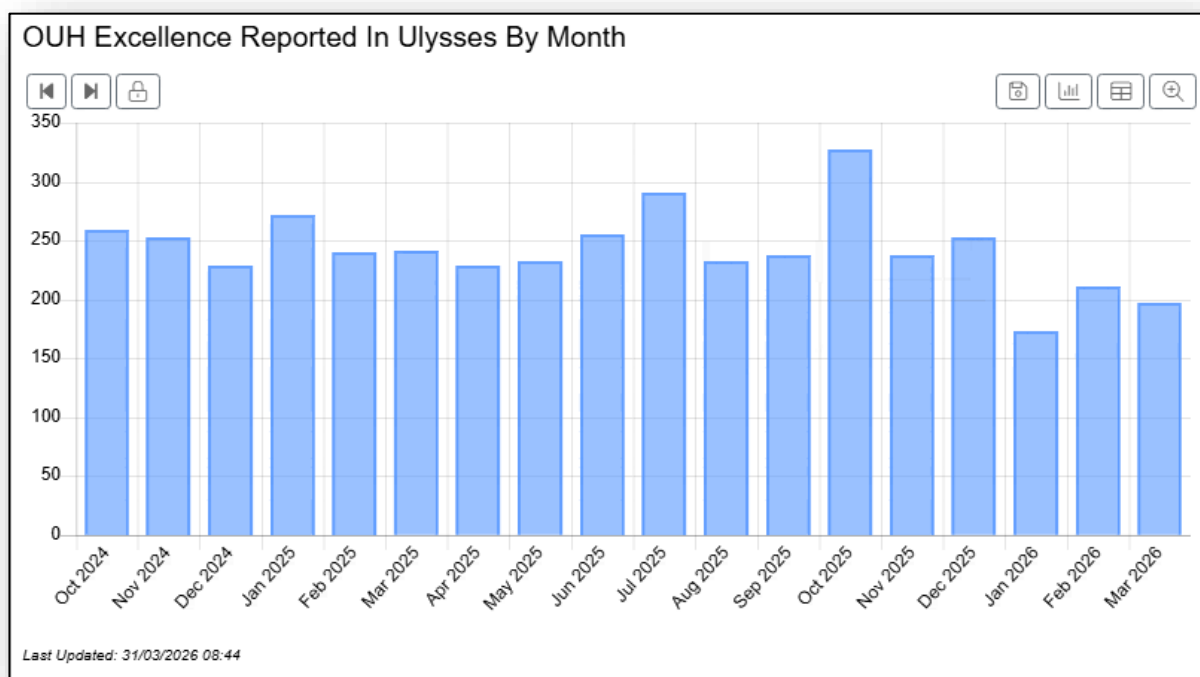


Table 16 OUH Excellence Reports in Ulysses by Theme August 2025 to February 2026

	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Total
Compassionate Care	47	27	69	55	47	24	31	300
Going Above And Beyond	104	109	141	99	114	81	115	763
Innovation	4	2	9	2	5	3	6	31
Teamworking	77	100	108	82	87	65	59	578
Total	232	238	327	238	253	173	211	1672

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Table 16 shows the breakdown of reports by theme. Alignment with Trust values remains a consistent strength of Reporting Excellence, providing assurance that these values underpin daily practice. ‘Going Above and Beyond’ is listed most commonly, followed by ‘Teamworking’. Innovation reports increased this year to 27 for the past six months, the highest since the scheme’s launch.

The Reporting Excellence Programme is far more than a simple way to thank individuals. While it preserves the essential cycle of recognition—from nominator to recipient—it goes further by reaching across professional groups to drive meaningful improvements in quality and safety. It uniquely supports the Trust in meeting national expectations for sharing innovation and positive healthcare outcomes. In doing so, RE fosters adaptability, strengthens professionalism and promotes healthy team dynamics. Ultimately Reporting Excellence doesn’t just recognise good work—it actively builds a safer, stronger organisation by investing in its greatest asset: it’s people.

Statements from the Care Quality Commission (CQC)



OUH is required to register with the Care Quality Commission (CQC) and its current registration status is without conditions.

The Trust is fully compliant with the registration requirements of the CQC. As of 31 March 2025, the Trust had an overall rating of 'Requires Improvement' (RI) from the CQC. This was consistent

with the rating disclosed in the previous Quality Account and reflected the activities undertaken by the CQC during the year 2025/26. The Trust continued engagement with the CQC; this is reported to the Clinical Governance Committee.

Activities involved, but were not limited to, the following.

- The management of 59 new enquiries from, or notifications to, the CQC.
- The notification of changes to the Executive team in accordance with regulatory requirements.
- Regular notifications covering: Deprivation of Liberty Standards (DoLS) applications, section 42 activities, allegations of abuse and IR(ME)R² related incidents in accordance with regulatory requirements.
- There was continued maintenance of quarterly engagement meetings with four held during the year. There were three new CQC inspections during 2025/26. These comprised maternity services at the Horton General Hospital, maternity services at the John Radcliffe Hospital and the neonatal services at the John Radcliffe Hospital.
- Commissioned a Trustwide Well-Led gap analysis against the CQC well led key questions by an external provider to support the development of a related action plan .
- Launch of phase 2 Perinatal Improvement Programme Continuing focus on staff wellbeing aligned to OUH People Plan 2025/28, with forums and initiatives to enable staff to discuss concerns and make recommendations for future focus.
- Engagement with national CQC surveys for Children and Young People (published May 25) Adult Inpatients (results published September 25), Maternity Services (results published December 25). Findings from surveys have resulted in action plans being produced by the services and will be monitored by the Evidence Review Group, Clinical Governance Committee and Maternity Safety Champions.

CQC ratings grids as published in the reports of April 2023 and March 2024 can be seen below, these did not change during 2025/26

² IR(ME)R - Ionising Radiation (Medical Exposure) Regulations

Figure 2 CQC ratings for John Radcliffe Hospital: last rated April 2023

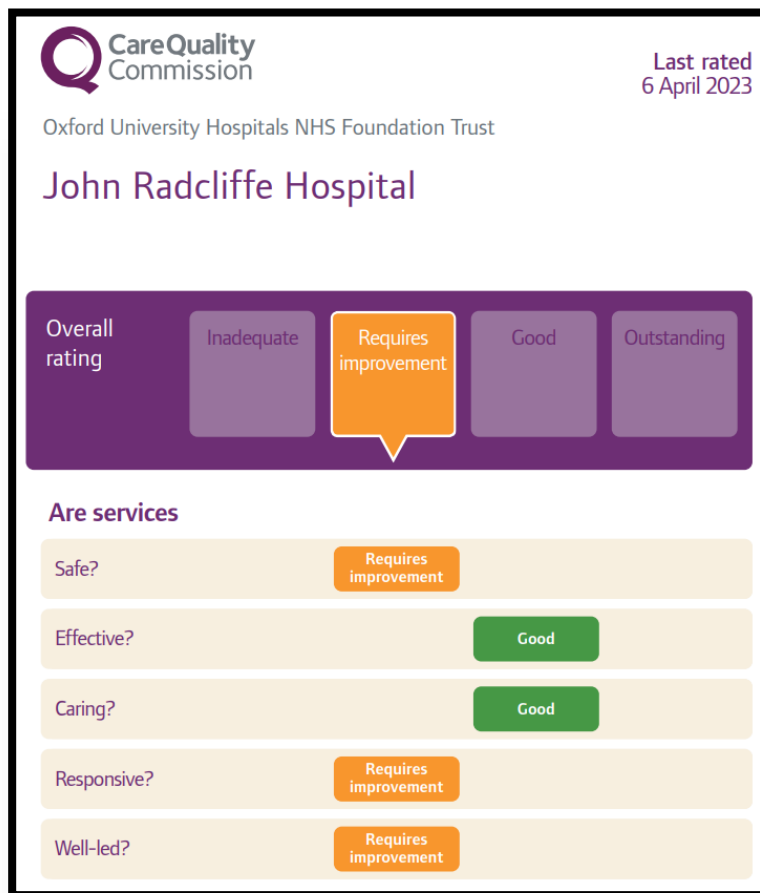


Figure 3 CQC ratings for Horton General Hospital: last rated March 2024 part 1

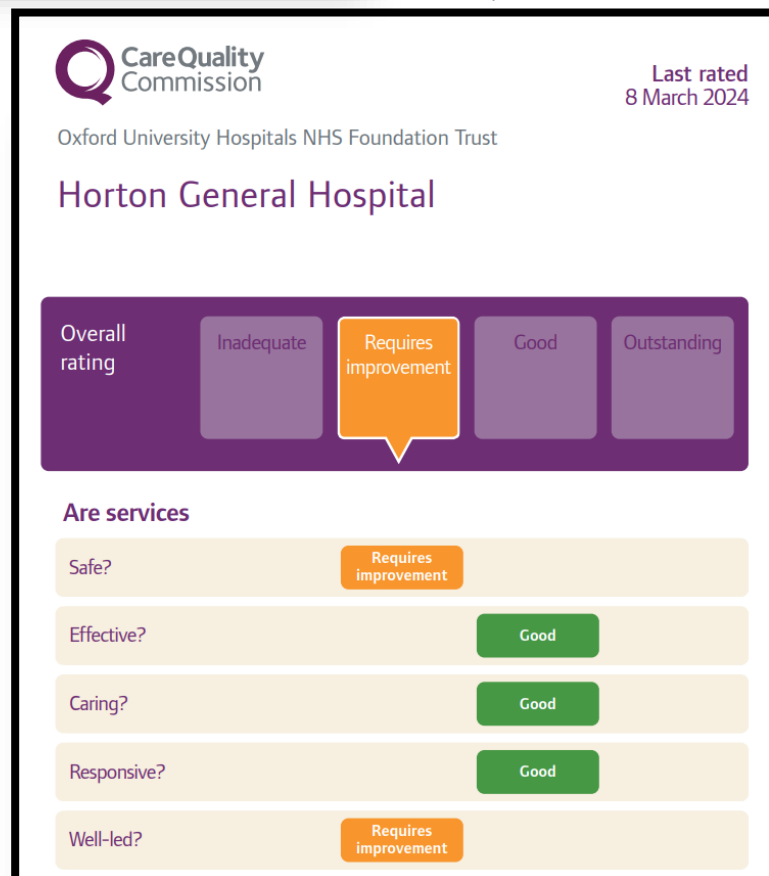


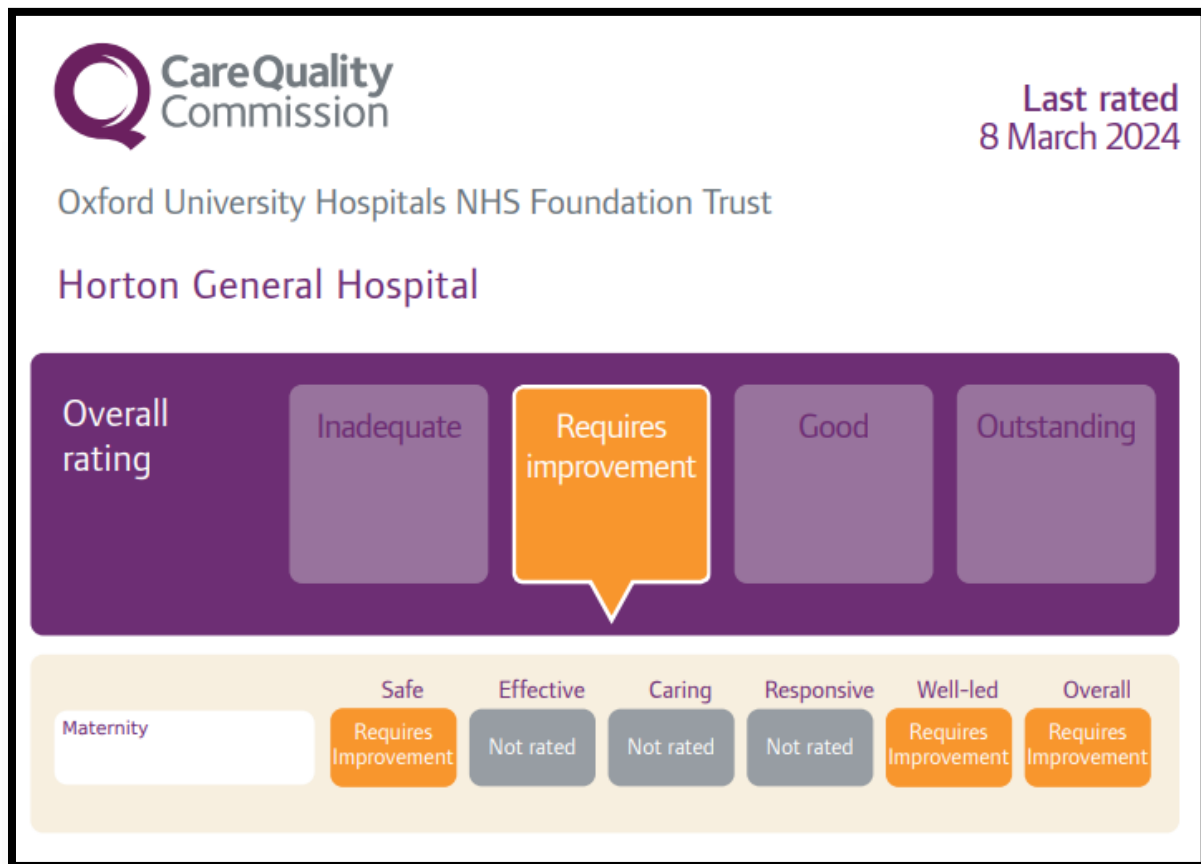


Figure 4 CQC ratings for the Churchill Hospital last rated June 2019



Figure 5 CQC ratings for Nuffield Orthopaedic Centre: last rated June 2019

Figure 6 CQC ratings for Horton General Hospital: last rated March 2024



Regulation and Reviews (External Reviews)

The accreditation, regulation, quality reviews and national peer review programme provide the Trust and the CQC with a measurable level of assurance regarding the delivery and quality of our services.

Perfusion Accreditation: College of Clinical Perfusion Scientists

An external accreditation visit of the Perfusion Service was undertaken by the College of Clinical Perfusion Scientists at the John Radcliffe Hospital in April 2025.

Following submission of the factual accuracy response, the final report was received in December 2025 and confirmed accreditation for one year. The report recognised strengths in training, procedural volume and team culture, and identified actions relating to workforce resilience, medicines management and development of a quality management framework.

Progress against actions will be monitored through service and Divisional governance, with a further progress report due to the College in May 2026.

GIRFT Surgical Hub Accreditation: Orthopaedics

An outpatient hub accreditation review of the Orthopaedic service was undertaken by NHS England through the Getting It Right First Time (GIRFT) programme in April 2025.

Positive feedback was received following the review, including improvements in day case performance and reductions in outpatient follow-up activity, although ongoing theatre staffing challenges were noted. Actions are being progressed through service and Divisional governance to support continued optimisation of the hub model.

Maternity Insight Visit and Rapid Quality Review

A rapid quality review and an insight visit both focussed on both the maternity and neonatal services was undertaken by NHS England and other key stakeholders in April 2025 as part of routine oversight and assurance arrangements. The visit reviewed service performance, safety and governance, with any feedback and actions progressed through service and Divisional governance processes.

ISO 45001: Health and Safety Management System

An external re-accreditation audit of the Occupational Health and Safety Management System at the Churchill Hospital, covering non-clinical activities, was undertaken in June 2025 by the Trust's UKAS-accredited certification body.

The service successfully achieved re-accreditation, with certification confirmed through to 2028.

Joint Advisory Group on GI Endoscopy (JAG)

An accreditation visit of the GI Endoscopy service was undertaken by the Joint Advisory Group on GI Endoscopy (JAG) in June 2025.

Positive feedback was received following the visit, and subsequent annual review submissions were completed in line with JAG requirements. Accreditation was renewed, subject to ongoing annual review, with progress and any required improvements monitored through service governance arrangements.

A further annual review took place in January 2026, with actions identified to be completed ahead of the next accreditation milestone. Progress is monitored through service governance arrangements in line with JAG standards.

Joint Area Inspection – Special Educational Needs and Disabilities (SEND)

A joint area inspection of Special Educational Needs and Disabilities (SEND) services was undertaken during June 2025 by Ofsted and the Care Quality Commission (CQC) to assess how local authority and health partners work together to deliver SEND provision.

The inspection focused on partnership working, governance and outcomes for children and young people, with Trust engagement coordinated through Children's Services and safeguarding governance arrangements.

Environment Agency, Anti-terrorism Inspection

An inspection was undertaken by the Environment Agency anti-terrorism team at the Churchill Hospital and the John Radcliffe Hospital in August 2025, to assess compliance with environmental protection, security and control requirements for regulated and hazardous substances. Both sites were found to be well managed, with no non-compliances identified.

A small number of observations and recommendations were noted, none of which required formal follow-up action.

National Maternity and Neonatal Investigation

Oxford University Hospitals was identified as one of 14 NHS Trusts included in the National Maternity and Neonatal Investigation, a nationally commissioned independent review announced by the Secretary of State for Health and Social Care in June 2025.

Baroness Valerie Amos was appointed to chair the investigation in August 2025, with the participating trusts, including OUH, publicly confirmed in September 2025. During 2025 the Trust supported site visits, staff focus groups, interviews and evidence submissions as part of the local review activity.

An overarching national 'Reflections and Initial Impressions' report was published in December 2025. Baroness Amos further published an interim report on 26th February 2026. The report highlighted critical issues of racism, inconsistent care, and lack of transparency

when baby loss occurred. The full report is expected in June 2026. No individual Trust findings have been published at this stage.

ISO 9001: Medical Physics and Clinical Engineering (MPCE)

A surveillance audit of the MPCE Quality Management System against the ISO 9001 standard was undertaken in September 2025 by SGS, the Trust's UKAS-accredited certification body.

The audit reported zero non-conformities and recommended continued certification, confirming that the quality management system remains effective.

ISO 13485: Surveillance Audit

A surveillance audit against the ISO 13485 Quality Management System standard was undertaken in October 2025 by the Trust's UKAS-accredited certification body. The audit confirmed that the quality management system remains effective and recommended continued certification. One minor observation was noted, with no corrective actions required.

ISO 15189:2022: UKAS Inspection of Microbiology

An external inspection of the Microbiology service against the ISO 15189:2022 Medical Laboratory standard was undertaken by the United Kingdom Accreditation Service (UKAS) in October 2025 as part of the routine annual accreditation cycle.

The inspection reviewed compliance with quality management, governance and technical laboratory standards. The outcome of the inspection is awaited from the Division and will be progressed through service and Divisional governance as required.

Maternity Services Unannounced CQC Inspection

An unannounced inspection of the Trust's maternity services was undertaken by the Care Quality Commission (CQC) commencing 7 October 2025, covering the John Radcliffe, Horton and community units. The inspection included site visits, staff interviews and detailed evidence submissions. The draft report has been received by the Trust and the final report is being prepared by the CQC following factual accuracy checks.

Microbiology Containment Level 3 HSE Inspection

A statutory regulatory inspection of the Containment Level 3 (CL3) Microbiology laboratories was undertaken by the Health and Safety Executive (HSE) in October 2025 to assess compliance with legal requirements for work involving hazardous biological agents.

A formal letter dated 30 October 2025 identified areas where minimum legal standards were not fully met and set out advisory, recommended and formal enforcement actions, including an improvement notice.

A formal response with supporting evidence was submitted within the required timeframe, and progress is being monitored through service and Divisional governance pending confirmation from the regulator.

OFSTED Regulatory Inspection: Apprenticeships (Education and Training)

A statutory inspection of the Trust's apprenticeship provision was undertaken by Ofsted in November 2025 under the current education inspection framework.

The review assessed the quality of training, supervision and compliance across apprenticeship programmes delivered across hospital sites. The final report, published on 22 January 2026, confirmed that the Trust met the Expected Standard.

Sarcoma National Data Review for NHSE Commissioning

A national compliance review of the Sarcoma service was undertaken by NHS England Specialised Commissioning during 2025 against the Sarcoma Service Specification.

The Trust submitted the required data returns and supporting evidence across two tranches, including documentation relating to pathways, standard operating procedures and audit activity.

Further information has been requested by NHS England, and additional evidence is being provided to address identified gaps.

Progress continues to be managed through service and Divisional governance pending feedback from the commissioner. The next meeting with NHSE is planned for March 2026.

Neonatal Unannounced CQC Inspection

An unannounced inspection of the Neonatal Service was undertaken by the Care Quality Commission (CQC) as part of its regulatory oversight of maternity and neonatal services. The inspection included on-site review activity and requests for further documentary evidence.

The Trust submitted the requested data and supporting documentation in February 2026 and remains within the inspection process pending receipt of the draft report, which will be subject to factual accuracy review prior to publication.

Environmental Agency (EA)

A planned visit by the Environmental Agency (EA) took place on 3rd March 2026 at the Specialist Service In-Patient (SSIP), Fracture Clinic and A&E Majors to review Gypsum disposal and Stoke Unit. Feedback was positive. The team await the final report.

Abdominal Aortic Aneurysm (AAA) Quality Review

A Thames Valley quality assurance visit took place on 5 March 2026. Feedback was positive and constructive, with no immediate concerns or enforcement action identified. Reviewers recognised improvements within the service and the engagement of staff. A small number

of development themes were identified, including documentation, audit arrangements and health inequalities. A draft report is awaited and an action plan will be progressed through service and Divisional governance.

Joint Targeted Area OFSTED Inspection (JTAI)

Led by OFSTED, the JTAI inspection took place in January 2026. JTAI is part of the multi-agency response to children who are victims of child sexual abuse in the family environment (CSAFE). The draft JTAI report has been received. Factual accuracy checks from an OUH Health perspective have been completed and returned via the ICB. The Trust now awaits publication of the final report.

Data Quality and Information Governance

Information Governance

A vital prerequisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. This underpins the effective delivery of patient care and is essential to both improvements in the quality of care and for patient safety. We are committed to pursuing a high standard of accuracy, timeliness, reliability and validity within all aspects of data collection in accordance with NHS data standards and expect that every staff member seeks to achieve these standards of data quality.



OUH have taken the following actions to improve data quality and information governance:

- Improved tools to assist in managing Freedom of Information (FOI) and Subject Access Requests are now embedded, giving the Trust the ability to manage requests on a Divisional and department basis. The Trust continues to receive more of both types of requests than in previous years.
- Digitisation of paper records has commenced; which enables access to historical records immediately in a searchable electronic format will significantly improve the availability of records previously stored off site.
- A new Digital Consent platform has been rolled out and provides the Trust with a much improved and easily accessible record of the consent patients have given for treatments and consent for potential use of their data for secondary purposes.
- A review of Trustwide working practices and policies around the adoption of systems that involve AI and Machine Learning has occurred and an AI policy has been adopted. Strong Information Governance and transparency around how the Trust uses these new technologies is vital to giving assurance to staff and patients that their use is appropriate and beneficial to all. Information Governance team work closely with TheHill and digital team to ensure that there is good governance around AI within the Trust.

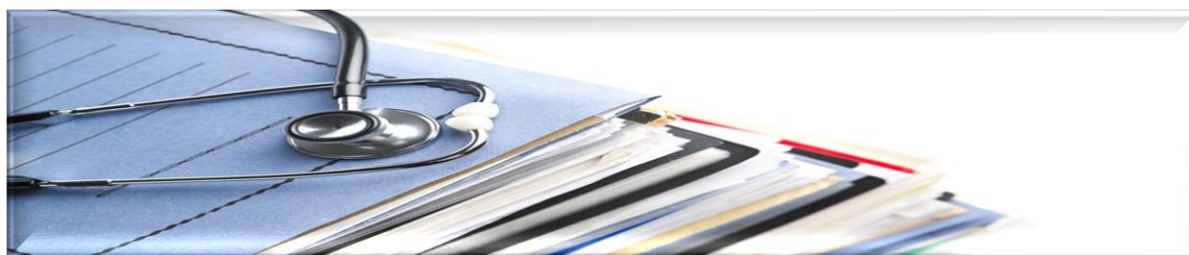
Data Security and Protection Toolkit (DSPT)

OUH's submission of the Data Security and Protection Toolkit for the most recent reporting period of 2024/25 reported an overall assessment of 'Standards Met', which was agreed by NHSE. This provides significant assurance to other parties who may wish to share data with us.

As part of the annual DSPT cycle the Trust undergoes an external audit; this was completed in February and March 2026. The Trust was given 'High assurance' for the quality of its

responses and was given an overall 'low' risk score. This is the best result that can be achieved under the assessment framework.

The final submission for the current toolkit will be on 30 June 2026 and the Trust is expecting to achieve 'standards met'.



Records submission

OUH submitted records during 2025/26 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SUS dashboards month 11 2025/26

Table 17 shows the information by inpatients, outpatients and ED demonstrating OUH compliance compared to the national average.

Table 17 [YTD as at month 11 (February 2026) results.]

Inpatients	OUH	National Average
Valid NHS number	99.5%	99.7%
General Medical Practice Code	100%	99.8%
Outpatients	OUH	National Average
Valid NHS number	99.9%	99.8%
General Medical Practice Code	100%	99.6%
ED (type 01 only)	OUH	National Average
Valid NHS number	98.8%	99.0%
General Medical Practice Code	100%	99.7%

Clinical Coding Data Quality

Clinical engagement is an important part of this process. Coding and Clinical staff are involved in but not limited to the following workstreams.

- Clinical Coding Audit Programme.
- Analysis of Coded data to support improvement and clinical collaboration.
- Data validation with clinical colleagues to improve data quality and patient care.
- Assurance of coded data affecting the NHS Payment Scheme (formerly Payment by Results).
- Participation in all aspects of clinical coding within the national GIRFT project.
- Improvements in clinical coding training.

- Participation in the Mortality Reporting process.

These workstreams demonstrate the Trust's commitment to the collection, analysis and reporting of high quality clinically coded data.

Learning from Deaths

During 2025/26, 2,661 people died in OUH. . Table 18 shows the number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care.

The National Quality Board (2017) state that 'Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die'.

All deaths are subject to a case record review to identify any care quality concerns or other learning. Approximately half of deaths are also subject to an even more detailed case record review, including Level 2 comprehensive mortality reviews (an OUH initiative) or structured judgement reviews (SJRs, a national requirement). Cases for more detailed review include those where a concern has been identified, deaths in certain clinical areas, and cases chosen at random to quality assure the process.

Table 18 Number of case record reviews by quarter and no. of deaths judged more likely than not to have been due to problems in care

	Quarter 4 2024/25	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Inpatient deaths	724	634	618	701	708
Number of case records reviewed (No./%)	287 (100%)	266 (100%)	278 (100%)	333 (100%)	<i>This Will be published in the 2026/27 Quality Account</i>
Number of deaths judged more likely than not to have been due to problems in care	0	1	1	0	

A total of 877 detailed case record reviews were carried out in relation to 1,953 deaths that occurred to the end of Q3 2025/26. Two avoidable deaths were identified in this period. (Further explanation of these are found in the summary of learning and impact of actions from mortality reviews section below)

In Quarter 4 2024/25, 287 case records were reviewed in relation to 724 inpatient deaths. No avoidable deaths were identified. These numbers have been compiled using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

The reviews of deaths which occurred during the fourth quarter of 2025/2026 are underway and the summary will be included in the Quality Account for 2026/27.

Summary of the learning and impact of actions from mortality reviews (from Q4 2024/25 and Q1-3 2025/26)

Avoidable death -venous thromboembolism (VTE)

A death in August 2025 was confirmed as avoidable by the Mortality Review Group (MRG), highlighting critical learning around the need to complete timely VTE risk assessment and administer VTE prophylaxis. The patient experienced missed opportunities for assessment and timely administration of preventative treatment during admission, ultimately resulting in a fatal pulmonary embolism following discharge.

The Coroner issued a narrative verdict noting that the delay in the risk assessment increased the risk of the development of the DVT and subsequent pulmonary embolus. While it was not possible to definitively determine whether earlier intervention would have prevented death, available evidence shows that appropriate VTE prevention significantly reduces risk. In response, actions have been implemented to strengthen the reliability of VTE assessment and prescribing processes, with a clear focus on ensuring consistent, timely risk assessment and delivery of prophylaxis as a core patient safety requirement across clinical teams. VTE risk assessment is also a Quality Priority for 2026/27. [Further information can be found in the VTE section below](#)

Avoidable death – suction rectal biopsy

An avoidable neonatal death was identified following review by MRG. The neonate underwent a suction rectal biopsy and was discharged home on the same day but deteriorated and died the following day from sepsis due to *E. coli* bacteraemia. Key learning highlighted the importance of robust governance for invasive procedures, including ensuring clear and documented parental consent, having established clinical guidelines, administration of appropriate pre-procedure antibiotic prophylaxis, and providing structured post-procedure monitoring and safety-netting. The case also identified the need for improved multidisciplinary communication and review of discharge decisions following procedures.

Actions have focused on standardising clinical pathways and consent processes, strengthening post-procedure care and communication across teams, and improving parental information and safety-netting to support earlier recognition of deterioration. This case was subject to a Coroner's inquest and a Patient Safety Incident Investigation.

Electrocardiograms (ECGs)

A small number of cases that were reviewed by the Mortality Review Group (MRG) highlighted critical learning relating to the recognition and escalation of abnormal ECG findings. Several factors contributed to a reduced awareness of an abnormal ECG. These included pathway design limitations (lack of real-time ECG review), atypical symptom presentation, and absence of timely escalation processes. In response, the Trust has

implemented a standardised ECG escalation algorithm, ensuring immediate review of abnormal results and prompt senior clinical input. This learning emphasises the need for robust diagnostic review systems and reliable escalation processes within elective and urgent care pathways to reduce the risk of similar events recurring.

There have been no reported incidents relating to ECGs since implementation of these standards.

Telemetry

At the Horton General Hospital telemetry failures meant that staff could not reliably detect/document arrhythmias; consequently, these episodes were not escalated. New telemetry devices have been procured, and this issue has been resolved.

Venous Thromboembolism (VTE)

Multiple mortality reviews in Neurosciences have highlighted the need for improved clarity and consistency in documentation of VTE risk assessment and prescribing practices for low molecular weight heparin. To address this, a mandatory field has been added to ward round proformas, which is completed daily. Regular audits are conducted to monitor compliance with an end of year compliance of 95.14 %. Outcomes are reported as part of Divisional quality reports to CGC meetings. VTE risk assessment is also a Quality Priority for 2026/27.

[Further information can be found in the VTE section below](#)

End of Life Care

Families may be unaware of the reasons behind repositioning of family members during End of Life care. To improve the understanding of this aspect of care and alleviate concerns, a patient information leaflet has been developed to address this topic.

Controlled Drugs (CD)

It was found that there were delays in administering pain relief medications on the Trauma Ward because some medications were not available on the ward. A ward pharmacist will work with staff to review controlled drug stock lists and ensure that these drugs are part of Ward CD stock which will reduce time to administration and improve availability of medicines. To further improve safety, a Medicines Safety representative will attend monthly Mortality Review Group meetings (starting in April 2026), to review cases where medication has affected patient care and ensure that the learning is translated into improvement on the ward.

Surgical Emergencies

MRG discussions identified learning across both oncology and surgical pathways. MRG reviews identified variation in escalation to senior clinical oversight, particularly in patients with multiple comorbidities and complex presentations.

Learning from these cases has focused on strengthening multidisciplinary decision-making, improving reliability of treatment pathways, and ensuring timely senior review and escalation, alongside reinforcing adherence to clinical protocols and documentation

standards. Overall, the discussions emphasise the need for robust, consistent processes across both oncology and surgical services to manage risk effectively in complex patient groups and support safe, high-quality care delivery. [A Quality Priority for 2026/27](#) will also address the deteriorating patient.

Further incidents of this nature have not been highlighted in MRG to date.

Coding of palliative care admissions

MRG discussions identified coding accuracy as a governance issue. Specific concerns were raised regarding the coding of palliative care admissions, including alignment of critical care data and classification standards, which had implications for mortality reporting and benchmarking. Work has been undertaken with clinical coding teams to clarify definitions and improve consistency in how palliative care activity is recorded, including in critical care settings. More broadly, MRG emphasised the importance of accurate clinical coding to ensure reliability of mortality indicators, appropriate case-mix adjustment, and meaningful interpretation of outcomes, alongside improving documentation quality to support coding accuracy.

This learning highlights the need for continued collaboration between clinical teams and coders, robust documentation, and strengthened governance oversight to ensure data accuracy and support effective mortality surveillance and improvement.

The quarterly and annual Learning from Deaths reports are presented to the Trust Board and are available online at ouh.nhs.uk/about/trust-board/meetings-and-papers

Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the preferred hospital mortality indicator adopted by NHS England. The SHMI is the ratio between the reported number of patient deaths during admission or within 30 days of their discharge, against the expected number of deaths based upon the characteristics of the patients treated.

The Trust considers these data are as described for the following reasons.

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived.
- Data are collected internally and then submitted monthly to NHSE via the Secondary Uses Service (SUS). The SHMI is then calculated by NHSE.
- Data are compared to the national benchmark, and the Trust's own previous performance, as set out in Table 19.
- The Trust reviews the SHMI in conjunction with other published mortality measures and the information from its internal review of deaths.

The SHMI, published on 12 March 2026, for the data period October 2024 to September 2025, is 0.89 (CL 0.85-1.17). This value is banded 'as expected'. The SHMI continues to compare favourably with national mortality benchmarks.

Care at the End of Life (EOL)

- During 2025/26 2405 adults over 18 years of age died in OUH. Providing care at the end of a person's life is an important part of the provision of healthcare. Work this year to improve care at the End of Life has included the following.
- An End of-Life Lead funded by Sobell House Hospice Charity leads the Trust's EOL improvement work. Sobell House Hospice Charity has also funded a Band 8 nurse for the EOL team, and an administrator post yet to be filled.
- The EOL group reports to the Mortality Review Group.
- The National Audit of Care at the End of Life (NACEL) 2025 identified that training is needed for OUH staff who provide care at the End of Life, with a particular focus on recognising dying and discussing the management of hydration and nutrition for dying patients.
- End of Life care e-Learning courses are now available for staff via My Learning Hub but await agreement for mandatory status.
- Tissue donations from OUH patients are now uniformly managed by the National Referral Centre (NHSBT) pathway. The hospice eye donation project in collaboration

with NHSBT is underway with the support of Sobell House and Katherine House charities.

The EOL team have supported implementation, training and audit of ReSPECT since March 2025. Benchmarking of palliative and End of Life care in the Trust against the recommendations of the NCEPOD report Planning for the End has identified the following areas for further improvement:

- Recording and sharing advanced care planning (ACP) discussions
- Opportunities to increase timely ACP conversations
- Opportunities to improve understanding of palliative and end-of-life care

Reporting against core indicators

Table 19 Reporting against core indicators

Indicator	Measure/ Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
Summary Hospital-level Mortality Indicator (SHMI)									
Ratio of observed mortality as a proportion of expected mortality	<1	Oct 2024- Sept 2025	0.89 (CL 0.85-1.17 as expected)	Jan 2024 - Dec 2024	0.91 CL ³ 0.88-1.14 (as expected,) ⁴	1.32	0.72	1.00	NHSE
Percentage of deaths which were coded as palliative deaths	NA	Oct 2024- Sept 2025	52.02%	Jan 2024 - Dec 2024	51.95%	-	-	42%	NHSE
Patient data of incidents, VTE and readmissions									
The number and percentage of patient safety incidents that resulted in severe harm or death	No. (% of all patient incidents)	FY 2025/26	86 (0.3%)	FY 2024/25	104 (0.34%)	-	-	-	OUH Ulysses
The percentage of patients who were admitted to hospital and who were risk	95%	FY 2025/26	95.14%	FY 2024/25	Q1-3 (24 hrs) 98% Q4 (14 hrs) 95%	-	-	-	ORBIT

³ CL - Confidence limit

⁴ SHMI data categorised as 'lower than expected', 'as expected', or 'higher than expected'

Indicator	Measure/ Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
assessed for Venous Thromboembolism during the reporting period									
Percentage of patients readmitted within 28 days of discharge Age 0-15 yrs	Readmissions data (%)	Oct 2024- Nov 2025	11.3%	Nov 2023- Oct 2024	11.8%	21.1%	4.1%	-	Dr Foster
Percentage of patients readmitted within 28 days of discharge Over 16 yrs	Readmissions data (%)	Oct 2024- Nov 2025	10.7%	Nov 2023- October 2024	10.7%	13.6%	3.8%	-	Dr Foster
CQC inpatient Survey Results									
<i>To what extent did staff looking after you involve you in decisions about your care and treatment?</i>	Score out of 10 Trustwide	2024	7.4	2023	7.2	8.5	6.3		CQC Inpatient Survey 2024
<i>Did you find someone on the hospital staff to talk to about your worries and fears?</i>	Score out of 10 Trustwide	2024	7.9	2023	7.9	9.2	6.6	7.7	CQC Inpatient Survey 20243
<i>Thinking about any medication you</i>	Score out of 10 Trustwide	2024	5.1	2023	5.0	6.0	3.5	4.5	CQC Inpatient

Indicator	Measure/ Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
<i>were to take home, were you given any of the following?</i>									Survey 20243
<i>Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?</i>	Score out of 10 Trustwide	2024	8.0	2023	8.4	9.6	5.	7.65	CQC Inpatient Survey 20243
<i>Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends</i>	% of staff	2024	74.35%	2023	74.84%	-	-	61.74%	NHS National Staff Survey 2024



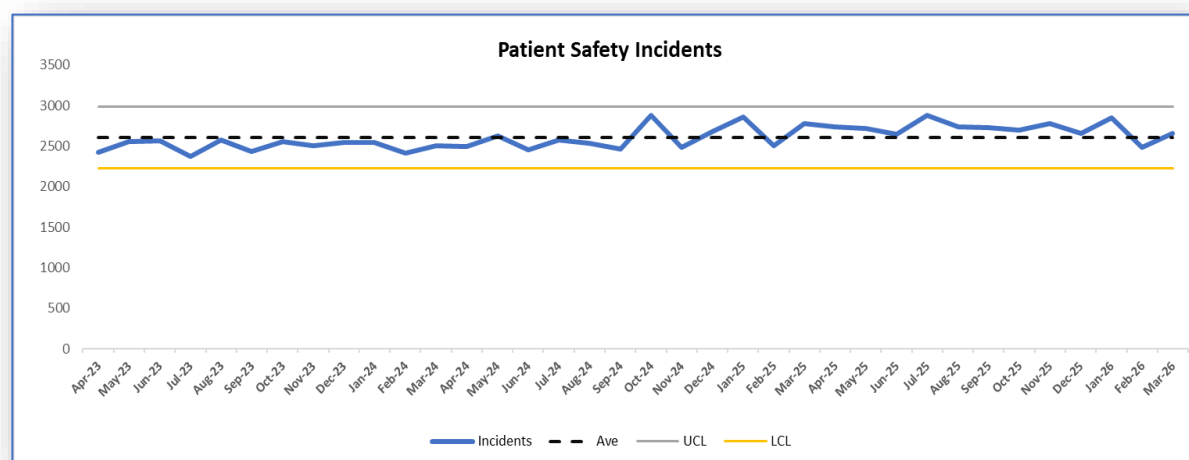
Safety Incidents and Learning Responses

OUH is now in its second complete year since the implementation of the Patient Safety Incident Framework (PSIRF).

It is crucial that we learn from every incident and near miss that happens, to

address concerns and continually learn. OUH actively encourages staff to report clinical incidents and near misses so that lessons can be learned in order to improve care. Measures used by NHS England and others to indicate a positive 'safety culture' within an organisation include the rate of incident reporting (the higher the better) and the proportion with significant patient harm (the lower the better). Graph 2 below shows the number of patient incidents reported per month by OUH since April 2023, demonstrating a sustained increase over that time. This has been driven by an increase in reporting of incidents of mild harm or no harm. Importantly, the number of incidents of moderate harm or above has not increased, suggesting the overall increase is driven by improved reporting rather than a true increase in incidents.

Graph 2 Number of patient safety incidents reported per month by OUH since April 2023 to March 2026



Trusts across England upload data relating to patient incidents reported locally to LFPSE (formerly NRLS) to allow NHS England to view incidents and to identify trends at a national level.

In addition to the review of all incidents by senior staff in each department, all incidents reported with moderate or above impact are reviewed each working day in a Patient Safety Response meeting, to confirm what immediate steps need to be taken or what information is required to be collected, as well as identifying whether any extra support is required for the staff involved.

In 2025/26 our staff reported

- 32,560 patient safety incidents,
- 31,063 (95.4%) resulting in no harm or minor harm,
- 1,411 (4.3%) resulting in moderate harm,
- 41 (0.1%) resulting in major harm,
- 45 (0.1%) with an impact of death (the management of deaths in the Trust is discussed above).

All impact gradings are confirmed through the Trust's incident management process and follow the LFPSE guidance.

The number of patient safety incidents has increased by 1437 since 2024/25. This demonstrates a positive reporting culture within the Trust. The percentage of incidents that were categorised as moderate harm, severe harm and death reduced from 5% to 4.5% indicating that fewer patient safety incidents resulted in higher levels of harm. All incidents are reviewed by the local manager to identify any potential learning. All moderate and above harm incidents are reviewed every working day by a team that includes senior Medical, Nursing and governance staff to identify immediate areas for investigation and support for staff.

The PSIRF framework provides for different learning responses to be undertaken including focused After Action Reviews, learning MDT meetings and Patient Safety Incident Investigations (PSII). Learning from these responses is shared by Divisions and subject matter experts at the Trust wide weekly Safety Learning and Improvement Conversation meeting. Key thematic patient safety initiatives are also presented, and the learning is shared in a summary slide across the Trust.

Patient Safety Incident Investigations (PSIIs)

Patient Safety Incident Response Framework (PSIRF) encourages organisations to learn more from incidents and event trends through smaller scale learning responses owned by local teams, inspired by the risk and opportunity for learning rather than the severity of the incident. Larger scale, formal Patient Safety Incident Investigations (PSII) may be undertaken when significant patient safety risks and/or the potential for new learning are identified. These PSIIs may be instigated on an ad-hoc basis, in response to recent incidents, or may be larger thematic PSIIs, identified at the start of the financial year in response to common themes identified in incident reporting, complaints and other external feedback, and legal cases.

During 2025/26 a set of 26 quantitative metrics were agreed to assess the effectiveness of PSIRF within the Trust. These metrics cover the 4 pillars of PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

These metrics will be reported, monitored and refined as necessary in 2026/27, overseen by the PSIRF Improvement Group.

In-house training continues for staff who wish to conduct an After Action Review (AAR). In addition, in 2025/26 Q4, training for Learning Multidisciplinary Review (LMDTR) conductors and those delivering the systems analyst role in PSIs was delivered through OxSTaR to 19 staff across all 5 Divisions.

All learning responses are reviewed to ensure high quality investigations and improvement plans:

- AARs and Rapid Reviews are reviewed by the Deputy CMO and Head of Clinical Governance, with discussion at the Trust Safety Learning and Improvement Conversation (SLIC) if required
- LMDTRs are reviewed at SLIC. Comments are incorporated into the review which is subsequently signed off by Deputy CMO
- PSIs are reviewed by a panel of experts and stakeholders, and ultimately signed off by CNO and/or CMO

On completion, selected actions from LMDTRs and PSIs are discussed at SLIC which demonstrate a closing-the-loop assessment of the actions' impact on safety, efficiency, or culture.

In 2025/26, 22 non-thematic PSIs were confirmed.

The three thematic PSI topics for 2025/26 were as follows.

1. Safety and timely discharges with medications.
2. Escalation of deteriorating patients.
3. Positive Patient Identification (PPID).

Each Thematic PSII working group has a lead and regular updates and shared learning are presented at the Safety Learning and Improvement Conversation (SLIC) meeting. These 3 workstreams continue into 2026/27.

Never Events

Graph 3 below shows that the Trust reported seven Never Events in 2025/26, compared to two last year. Details of these Never Events is summarised in Table 20. Never Events are defined by [criteria published by NHS England](#) and all Never Events were investigated as PSII. These PSII reports were presented to the CEO following sign off to summarise the investigation findings and recommendations and to update the progress against the improvement plan.

Graph 3 Never Events confirmed per year

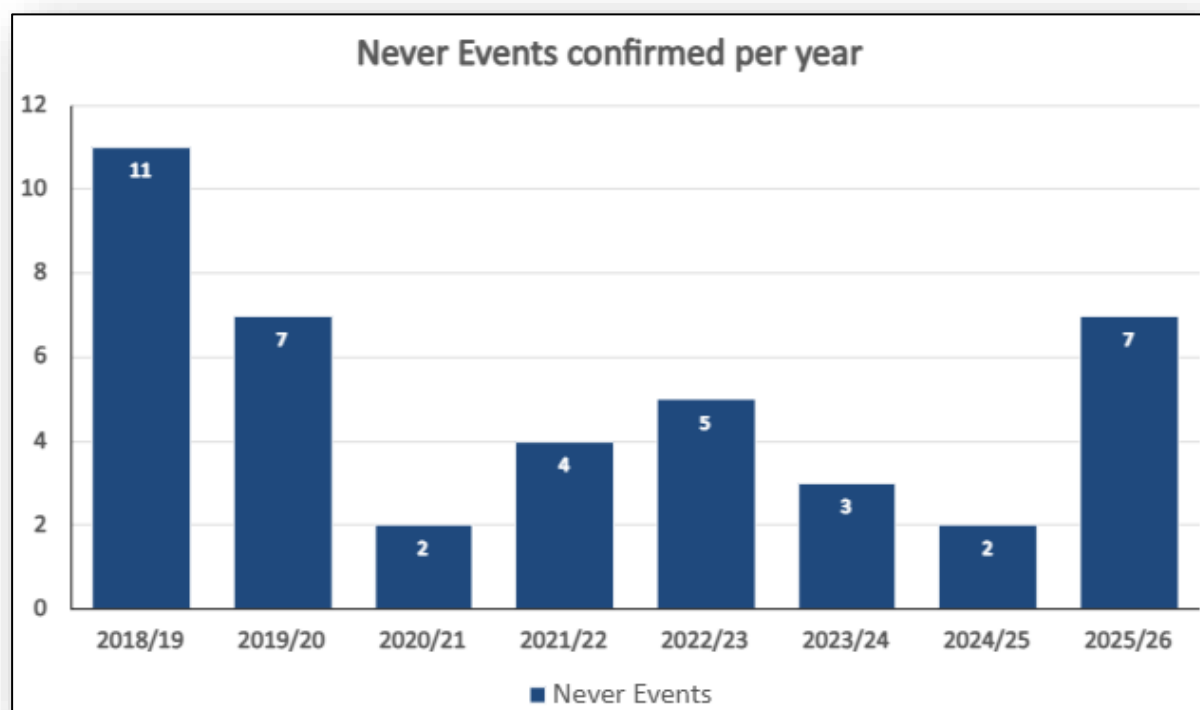


Table 20 Summary of Never Events 2025/26

STEIS number	Service	Type of event	Level of Harm	Response
2526-015	Ophthalmology	Wrong site injection	No harm	Ophthalmology Quality Group has been formed to address safety concerns. Actions include strengthening of departmental processes regarding WHO checklist and marking of sites.
2526-017	Ophthalmology	Wrong site laser	No harm	
2526-019	Ophthalmology	Retained corneal guard	No harm	
2526-021	Colposcopy	Retained swab	Moderate	Local Safety Standards for Invasive Procedures have been updated with clarity of roles and mirroring of processes used in theatres
2526-010	Maternity	Retained swab	Moderate	
2526-013	Anaesthetics	Wrong site anaesthetic block	Minor	The move to digital processes inadvertently impacted the 'Stop before you block process'. This has now been updated to better incorporate the digital processes. A standardised block tray has been developed with an embedded 'Stop before you block' process.
2526-009	Anaesthetics	Wrong site anaesthetic block	Minor	

Venous thromboembolism (VTE) Prevention and Anticoagulation Safety

VTE Prevention

Highlights of the new work the VTE Prevention and Anticoagulation teams have conducted in 2025/26 include the following.

VTE Risk Assessment (VTE-RA) and the new Performance Indicator

The venous thromboembolism risk assessment (VTE-RA) figures for OUH have been excellent and consistently above the national target of 95% for many years.

In January 2025, NHS England changed the parameters for the national target for VTE-RA, from completion of a VTE RA within 24 hours to 14 hours of hospital admission.

The VTE prevention team has been supporting clinical teams to ensure compliance with the new indicator. Performance against the new metric has been above the national target of 95% since November 2025. Ongoing improvement work is overseen by the Medicines Safety Group and supported by the Trust's VTE Quality Priority for 2026/27.

Lower Limb Immobilisation VTE Risk Assessment (VTE-RA)

Work is ongoing to introduce the TRiP⁵ (cast) Tool for patients with Lower Limb Immobilisation. The TRiP (cast) Tool is a validated tool for lower limb immobilisation and trauma.

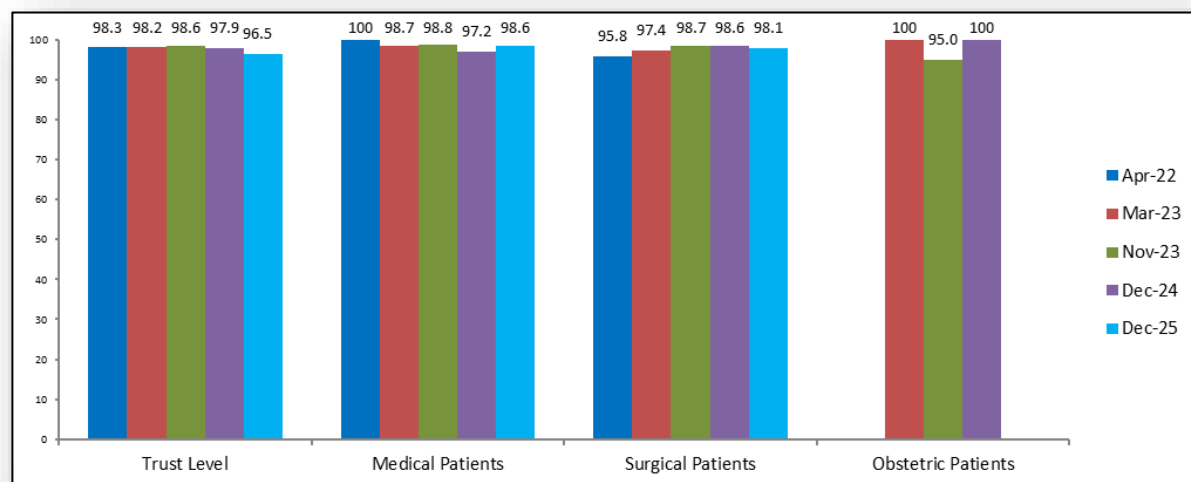
The research team for urgent and emergency care are currently using the TRiP (cast) Tool as part of the TILLi Trial evaluating the effectiveness and cost effectiveness of different methods of prophylaxis for patients with temporary lower limb immobilisation.

Trustwide Audit of Appropriate Thromboprophylaxis (TP)

The audit was performed across all Divisions and evaluated whether a patient was prescribed and receiving appropriate TP. The audit demonstrated sustained high performance with 98.4% of patients receiving appropriate TP.

⁵ [\[1\]](#) TRiP (cast) stands for 'Thrombosis Risk Prediction for Patients with Cast Immobilisation' and is a score used to predict the risk of venous thromboembolism (VTE) in patients with lower limb trauma requiring immobilisation.

Graph 4 Comparison between, April 2022, March 2023, November 2023, December 2024 and December 2025 (No Obstetric patients included in Apr-22 and Dec-25) Trust wide audit of appropriate thromboprophylaxis



Trustwide transition from dalteparin (Fragmin) to enoxaparin (Inhixa)

The VTE team successfully led the Trustwide transition from dalteparin (Fragmin) to enoxaparin (Inhixa) for VTE prevention in January 2026. This change brings the Trust in line with national practice, enhancing supply resilience and generating a significant cost saving to the Trust, allowing the savings to be reinvested to support high-quality patient care.

Training and Education

Staff training modules have been updated to support the Trustwide switch from dalteparin to inhixa and training compliance continues to be monitored.

The VTE prevention team continue to provide education and training for the preceptorship training programme, health care support workers course, post graduate advanced perioperative care course, drs induction training, specific clinical areas as requested and training on mechanical TP. The VTE prevention and anticoagulation teams have also worked in collaboration with Thrombosis UK to develop and launch a national UK patient information VTE application(app) offering information to those at risk of VTE and those diagnosed with a VTE event. The app was launched in the Houses of Parliament at the VTE Awards in November 2023. The OUH VTE team was “Winner” of the Outstanding Patient Resource category at the 2025 VTE Awards for their work in sharing information about VTE prevention for patients.

Research

The thrombosis research team has been collaborating with the NIHR trial examining the benefit of graduated compression stockings in the prevention of VTE in low-risk surgical patients. The Trust was the second highest recruiter to the large multicentre national PETS Trial.

Deep Vein Thrombosis (DVT) Clinic and Outpatient Anticoagulation Service

New DVT diagnostic pathway:

In April 2025, Oxfordshire DVT service introduced a new DVT diagnostic pathway based on recent published research from Canada. The new pathway has helped ensure timelier DVT investigations and improved compliance with national guidelines.

Oxfordshire Warfarin POC service:

The Oxfordshire Warfarin Point Of Care (POC) service has three elements:

- i. **Home visit service:** The anticoagulation service continues to provide a point-of-care (POC) home visit service for patients who are housebound, difficult to bleed, or unsuitable for anticoagulants other than vitamin K antagonists. This service, which began during the COVID pandemic, has been highly successful in supporting a growing number of complex patients and has therefore been maintained.
As a recent development, we have now trained the community phlebotomy team based in central Oxford. This enables them to see and support patients as part of the home visit service, further expanding our capacity to deliver safe and effective anticoagulation care to patients in the community.
- ii. **District nurse liaison project:** The District Nurse Liaison Project remains ongoing and continues to make progress in supporting patients to self-test their INR at home. To date, 17 patients have been successfully signed off and are now self-testing their INR. In addition, another 17 patients are currently in the process of being set up for self-testing. However, progress with this group has been slower than anticipated due to capacity constraints within the district nursing team.
We will continue to monitor progress and explore opportunities to improve onboarding of patients.
- iii. **Charitable funds project:** The anticoagulation service was successful in obtaining funding from the charitable funds team for 50 coaguchek POC devices which can be given to patients who are otherwise unable to fund their own machines. The service is allocating these machines based on need and eligibility, are providing training and ongoing device support and calibration, and are following up the patients to measure and collect impact data.

Time in therapeutic range

Improving Time in therapeutic range (TTR) for patients on dialysis project:

The anticoagulation team manages warfarin dosing for patients across Oxfordshire, with most testing done in the community. A small group of patients, however, have their INR tests performed during dialysis at three county units. This process required daily manual checks for results and frequent communication with dialysis staff about testing schedules, often leading to missed or delayed testing. Additionally, it was difficult to obtain timely updates on patient health or medication changes, impacting INR control for this complex group.

To address these challenges, we began a project at the Horton unit at the Horton General Hospital in collaboration with the lead nurse. We introduced a system where patients brought their therapy records for each blood test and dose instructions, which they complete and the dialysis team to submit with their blood sample. Dialysis staff now also been supplied with blank therapy record forms available if needed. This change streamlines communication supports safe and efficient dosing, and helps improve patient's compliance thus improving their TTR.

Improving Time in therapeutic range (TTR) for dialysis patients:

The anticoagulation team faced challenges managing warfarin dosing for patients having their INR tested during dialysis, due to manual result checks and communication issues. To resolve this, a new process at Horton General Hospital was introduced, requiring patients to bring therapy records for each test, which are completed and submitted with their blood sample. This has streamlined communication, improved safety and dosing efficiency, and enhanced patient compliance and TTR.

Infection Prevention and Control

The Trust considers these data are as described for the following reasons:

- OUH has a process in place for collating data on organisms subject to mandatory reporting (*Clostridioides difficile* (C. difficile) infections and *Methicillin resistant Staphylococcus aureus* (MRSA), *Methicillin sensitive Staphylococcus aureus* (MSSA), *Escherichia coli* (E. coli), *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia cases).
- Data is collated internally and submitted daily to the UK Health Security Agency (UKHSA).

Each year NHS England assigns the Trust a threshold for healthcare-associated C. difficile infection cases, and for E. coli, *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia cases. There is no threshold for MSSA, and there remains zero tolerance for MRSA.

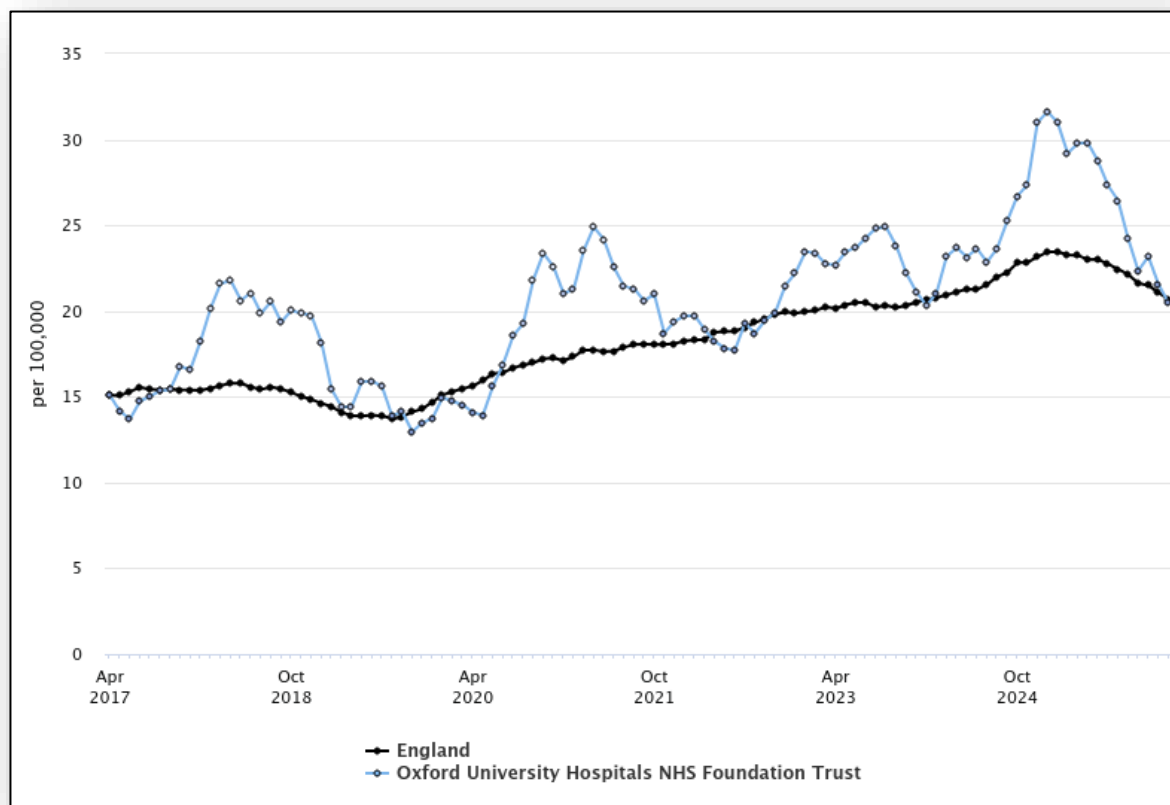
Table 21 Number of IPC cases in 2025/26 compared with 2024/25

Indicator	Target	2025/26	2024/25	2025/26 compared to 2024/25
<i>Methicillin-resistant Staphylococcus Aureus</i> (MRSA) bacteraemia cases	0	6	9	Decrease of 3 cases (improvement)
<i>Clostridioides difficile</i> infection (C. difficile) cases	123	109	164	Decrease of 55 cases (improvement) Target met
<i>Escherichia coli</i> (E. coli) bacteraemia cases	165	220	220	No change
<i>Pseudomonas aeruginosa</i> bacteraemia cases	59	46	63	Decrease of 17 cases (improvement) Target met
<i>Klebsiella</i> species bacteraemia cases	89	86	102	Decrease of 16 cases (improvement) Target met
<i>Methicillin-sensitive Staphylococcus Aureus</i> (MSSA) bacteraemia cases	n/a	75	66	Increase of 9 cases (deterioration)

Clostridioides difficile (*C. difficile*)

The threshold for OUH-apportioned cases of *C. difficile* for 2025/26 was set by NHSE at 123 cases. At the end of March 2025/26 the Trust is reporting 109 cases, an improvement of 55 cases, and 14 cases below NHS trajectory

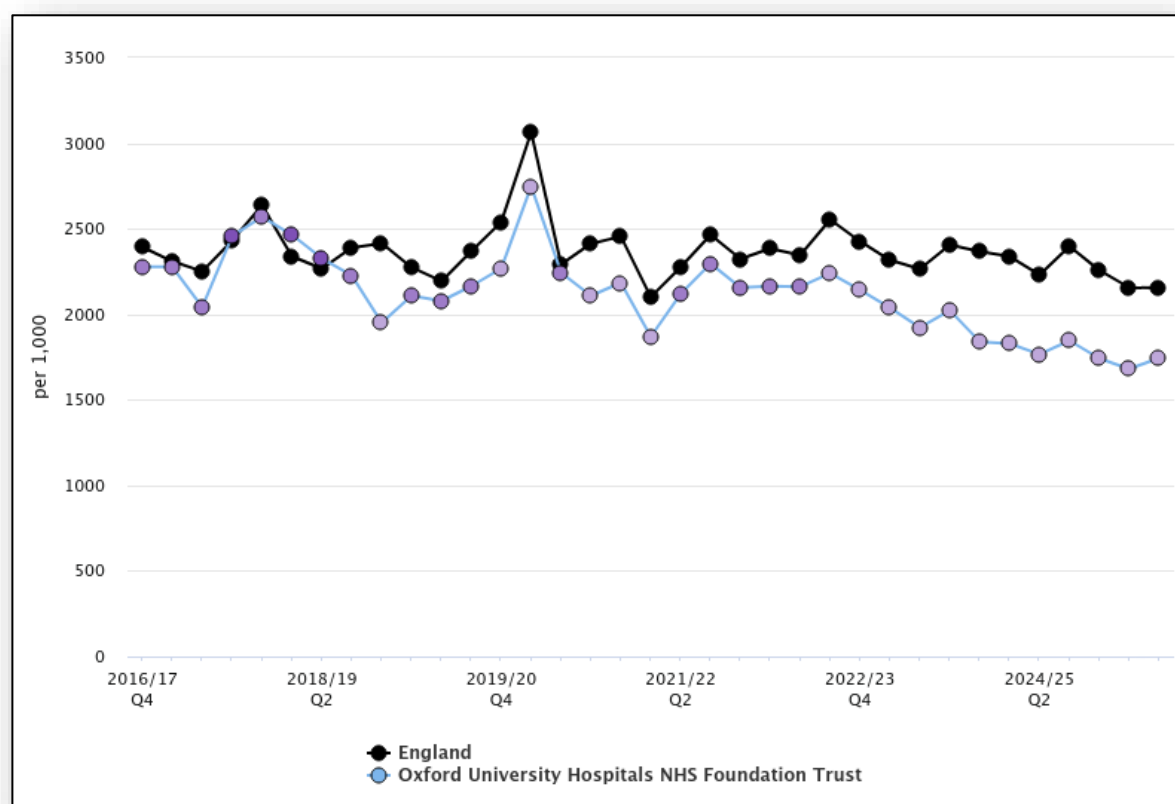
Graph 5 *C. difficile* infection 12-month rolling case counts and rates of hospital onset April 2017 to December 2024



The reduction in *C. difficile* follows the successful work of the antimicrobial stewardship team and the Trust in reducing antibiotic use in general, and certain antibiotics in particular as one of the major modifiable risk factors for *C. difficile*, in line with the National Standard Contract.

OUH 2025/26 prescribing data shows a continued reduction in overall antibiotic use, and in the use of particular antibiotics predisposing to *C. difficile*, including a reduction in 'watch and reserve' antibiotics as per the National Standard Contract and in comparison, with other English Trusts.

Graph 6 Antibiotic prescribing from the 'Watch' and 'Reserve' categories of the nationally adapted WHO AWaRe index; DDDs per 1000 *



Gram negative bloodstream infections

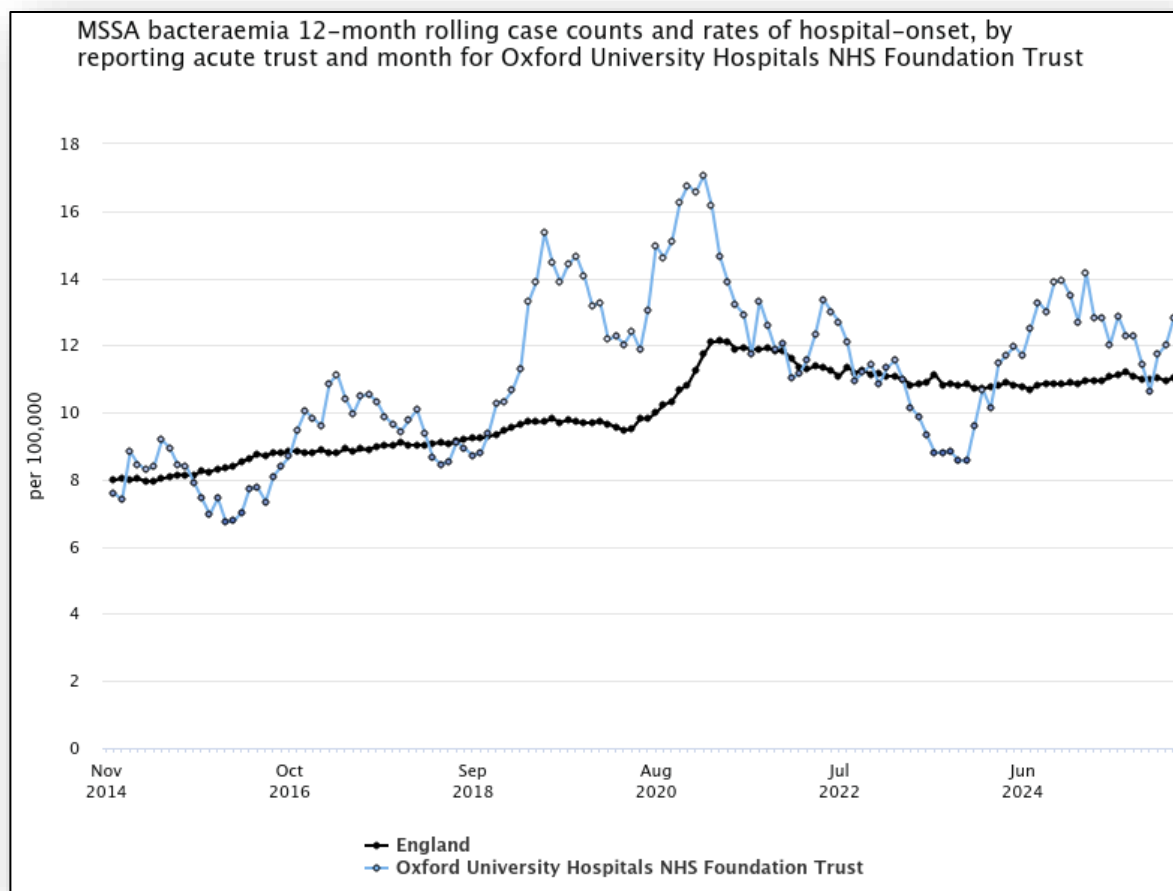
There has been a reduction in healthcare-associated *Klebsiella sp.*, and *Pseudomonas aeruginosa* cases this year with all numbers below the NHSE target value. The number of *E. coli* cases has remained static against the national trend.

There are no clear themes or interventions to reduce the rate of Gram-negative bloodstream infections in secondary care. The changes in patient demographics with an ageing population (18.6% of the total population was aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011), and more people at risk because of comorbidity or treatment such as immunosuppression make these targets especially challenging.

Methicillin-sensitive Staphylococcus Aureus (MSSA) Bacteraemia

For 2025/26, at the end of March there were 75 healthcare associated MSSA cases in OUH, an increase of 9 cases from 2024/25. All cases undergo a root cause analysis. Peripheral cannula associated cases have been a theme this year, and work has been completed through the PSIRF and patient safety forum to highlight appropriate management of peripheral lines.

Graph 7 MSSA bacteraemia 12-month rolling case counts and rates of hospital onset* November 2014 to December 2025



Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteraemia

For the financial year 2025/26, at the end of March there were three Hospital-Onset, Healthcare-Associated (HOHA) and three Community-Onset, Healthcare-Associated (COHA) cases in OUH making a total of six health care associated infections; in 2024/25 there were nine cases.

All cases undergo a root cause analysis where learning and preventable actions, if any, are identified.

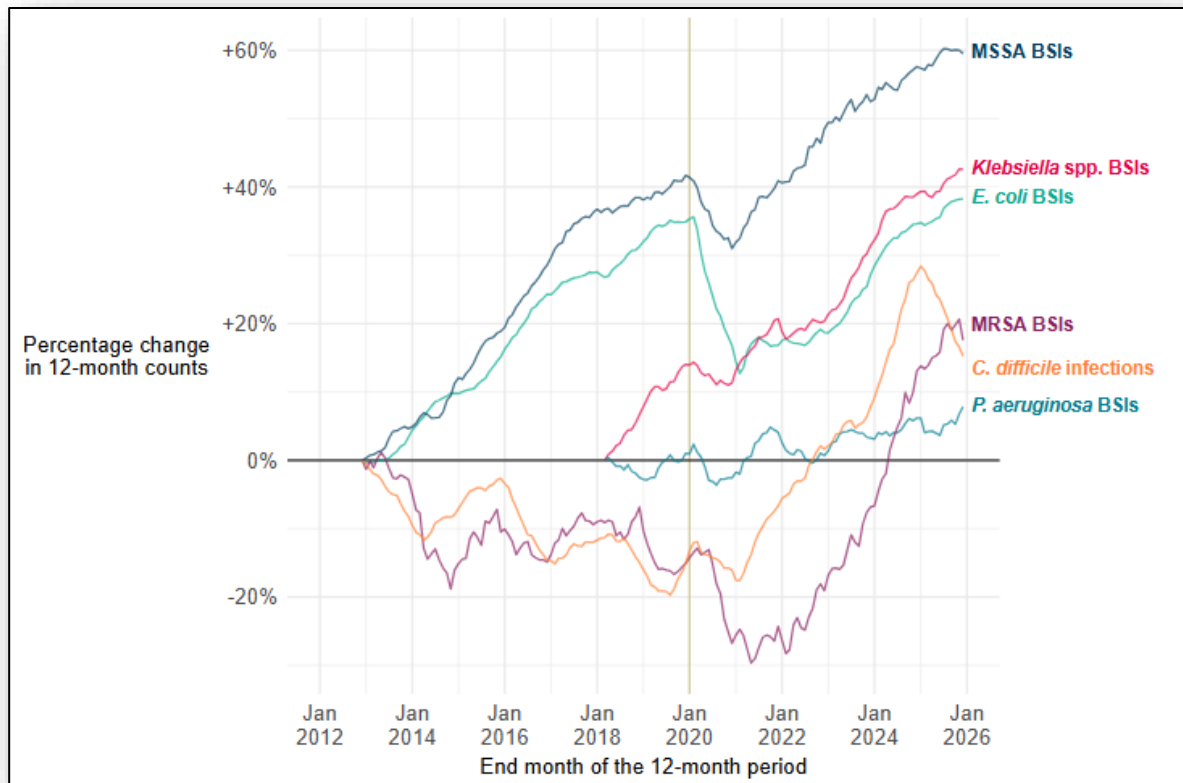
Graph 8: MRSA bacteraemia 12-month rolling case counts and rates of hospital onset* April 2017 to December 2025



National incidence of organisms subject to mandatory surveillance

These figures are in the context of a national increase in *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella sp.* bacteraemia. The national data show a recent small decrease in hospital onset cases of both *C. difficile* infection and MRSA bacteraemia in the last year.

Graph 9: 12-month rolling percentage change since calendar year 2012 for MRSA, MSSA and *E. coli* bacteraemia and CDI, and from calendar year 2017 for *Klebsiella* spp. and *P. aeruginosa* bacteraemia, December 2012 to December 2025*



Data source [Quarterly epidemiological commentary: mandatory Gram-negative bacteraemia, MRSA, MSSA and *C. difficile* infections \(data up to October to December 2025\) - GOV.UK](#)

*Data up to date to January 2026

Antimicrobial Stewardship

Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans (NAP) and national surveillance of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics.

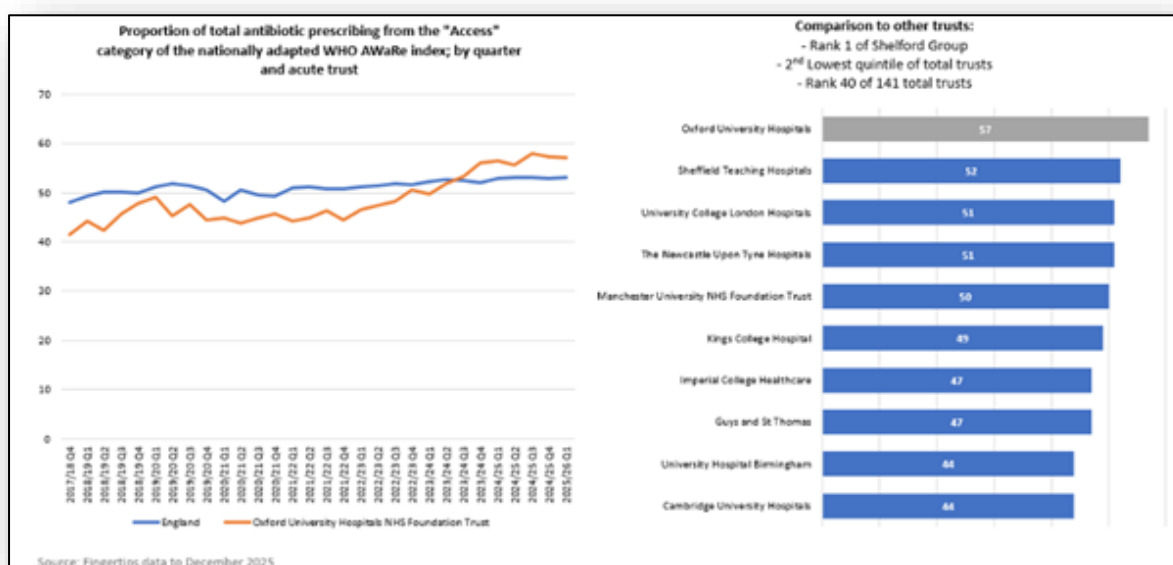
The World Health Organisation (WHO) categorised antibiotics into three broad groups ('AWaRe') based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare-associated infection such as *Clostridioides difficile* Infection (CDI). The UK uses a modified version of the WHO list.

One of the targets within the UK NAP, 'Confronting antimicrobial resistance 2024 to 2029' is to achieve 70% of total use of antibiotics from the 'Access' category across the human healthcare system by 2029. To support this, as well as the broader stewardship agenda, the Antimicrobial Stewardship (AMS) team identifies and implements initiatives to increase the use of 'Access' antibiotics and reduce 'non-access' antibiotic use (i.e. 'Watch' and 'Reserve' antibiotics).

The AMS team monitor consumption of all antibiotics and consumption in the individual antibiotic categories using both local and national data. Graphs 10 and 11 below show data presented on a national platform (extracted from the Fingertips platform).

The AMS team have undertaken many activities to increase the proportion of 'Access' antibiotics. This has been successful with the proportion of 'Access' antibiotics gradually improving in OUH, and the consumption of this category is now better than the national average. Additionally, when comparing our results with peer-group (Shelford) UK Trusts, OUH is ranked first within the Shelford group as shown in Graph 10

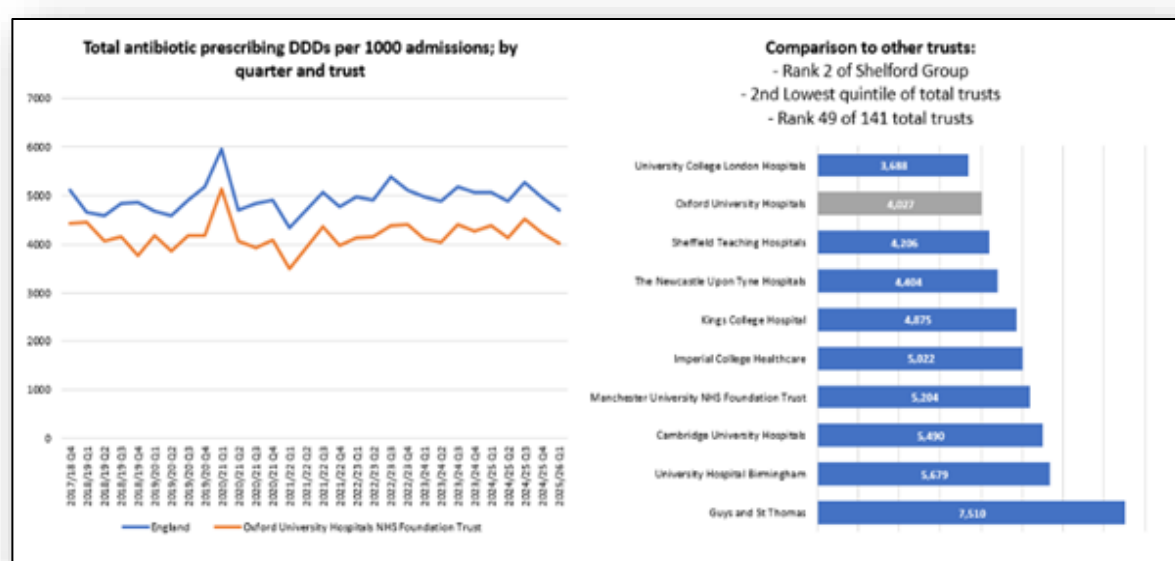
Graph 10 Proportion of total antibiotic consumption from the 'Access' category



To support reduction in total antibiotic consumption as well as increasing the proportion of antibiotic use in the 'Access' group, a coordinated multidisciplinary programme is required that promotes the appropriate use of antimicrobials. The AMS programme involves many activities which aim to achieve optimal antimicrobial use.

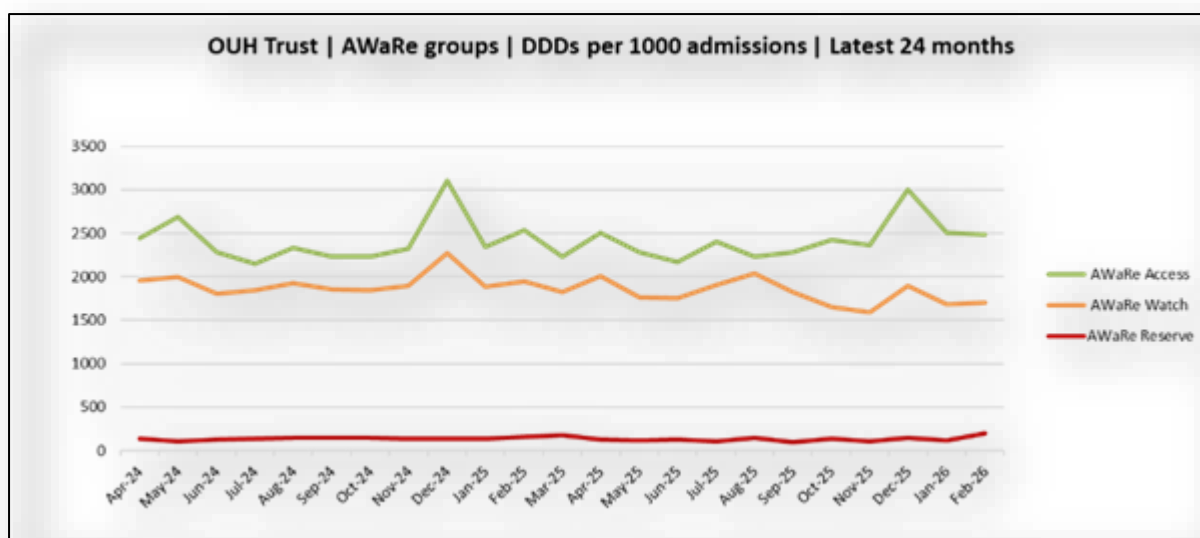
Another target in the NAP is to reduce total antibiotic use in human populations by 5% from a 2019 baseline. Graph 11 shows that OUH consumption of antibiotics is consistently less than the average for England. The Trust is second lowest user in the Shelford Group and 49th in all the Trusts on Fingertips platform. There are areas for improvement, and the AMS team continues to work with clinical teams to review antibiotic use.

Graph 11. Antibiotic consumption expressed as Defined Daily Doses (DDDs) per 1,000 admissions



The AMS team monitor consumption internally as well as reviewing national data and Graph 12 shows the change in antibiotic groups over time.

Graph 12: Antibiotic consumption for each AWARe category expressed as Defined Daily Doses (DDDs) per 1,000 admissions



A key initiative in the AMS program is AMS multidisciplinary team (MDT) ward rounds. These are conducted on all sites for adults, paediatrics and neonates on a weekly basis and consist of AMS pharmacists, an AMS Advanced Clinical Practitioner (ACP) and infectious diseases clinicians to review patients on broad spectrum antibiotics. During each AMS MDT ward round interventions are made. The nature of the intervention is recorded, and the AMS ACP follows up to assess if the recommended intervention has been actioned.

The AMS ward rounds were started in 2021, and the number of rounds has increased over time. In a previous Quality Account, the AMS team shared that a paper was published in the Journal of Infection showing that OUH multidisciplinary AMS ward rounds (between September 2021 to December 2022) reduced antibiotic use and likely reduced length of hospital stay. Senior clinician input and more AMS experience increased advice uptake. Following advice to de-escalate / stop antimicrobials was associated with a 0.58 day [95% CI 0.22-0.94] reduction in hospital stay. In 2025 the AMS team won the research category at the national Antibiotic Guardian Awards for the AMS ward round work within OUH.

During January to December 2025 there were 347 AMS ward rounds, adults and paediatrics, reviewing 4,543 patients with 3,257 interventions. Ward rounds have provided opportunities for education of colleagues about AMS and have supported guideline reviews, local audits related to antimicrobials, and engagement from clinical teams with the AMS vision for OUH.

Antibiotic prescribing feedback is available at Division, speciality and consultant level via a dashboard. The data allows departments and consultants to evaluate their performance with their peer group for reflection and learning.

Emergency readmissions within 28 days of discharge from hospital

The Trust routinely monitors emergency readmissions as one of the indicators of the efficacy of its provision of care and treatment. In some cases, readmissions may be inevitable and appropriate. A complete avoidance of unrelated emergency readmissions is therefore not realistic, and too low a readmission rate might reflect excessive lengths of stay due to an inappropriate degree of risk aversion and the associated harm of prolonged hospitalisation.

As part of the Trust's discharge support, advice is provided to patients regarding how to seek support if they are experiencing symptoms of ill health following a treatment or procedure (contacting the patient's GP, 111, 999 or contacting the treatment unit directly). Emergency Departments are situated at the John Radcliffe Hospital and Horton General Hospital, but patients known to the Trust's services may also be admitted directly to the Churchill Hospital or Nuffield Orthopaedic Centre, or unit that they were discharged from.

The most up-to-date data on readmissions within 28 days of discharge are provided by Dr Foster. For November 2024 to October 2025, the rate was 10.8% for children and adults. The Trust considers these data are as described for the following reasons.

The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.

Data are collected internally and then submitted monthly to NHSE via the SUS. The data are then used to calculate readmission rates.

NHSE develops the SUS data into Hospital Episode Statistics (HES).

Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.

Data are compared to peers, highest and lowest performers, and our own previous performance.

The Trust takes the following actions to improve this indicator and so the quality of its services.

Negative (higher than expected) readmission rates are investigated by the respective Division.

If the investigation identifies any care quality concerns, actions are implemented and monitored by the Divisional Clinical Governance team and reported to the Trust's Clinical Governance Committee.

Patient Experience

The Trust is dedicated to prioritising patients, carers, and families in everything we do. Our goal is to ensure timely, compassionate, and inclusive access to services, care, and treatment. We strive to listen to our patients' feedback about their care and treatment. To capture this, we gather patient experience data through various formal and informal channels, including the Friends and Family Test, Healthwatch Oxfordshire, the National CQC Patient Survey Programme, Patient Stories, Patient Participation Groups (PPGs), ad-hoc surveys, and a dedicated patient feedback email. All feedback is shared with the relevant clinical service areas and plays a vital role in driving continuous quality improvement as well as sharing positive experiences of care.



Our commitment to ongoing service enhancement for patients and their families is grounded in the Trust's core values of Learning, Respect, Delivery, Excellence, Compassion, and Improvement.

Our Divisions and corporate teams utilise the feedback from the national patient surveys and the Friends and Family Test (FFT) to assess and enhance the quality of care and services provided, including monitoring aspects like patient satisfaction with food, as well as overall experience.

The Trust undertook Patient Led Assessment of the Care Environment (PLACE) visits in October 2025. Over 70 assessments took place across the Trust sites over the course of a week, and included communal and external areas, meal services, wards and outpatient departments. Overall, the patient assessors found the Trust to be clean and tidy, the environment well cared for, and they were confident in the environment providing a good experience.

The Trust has established a Patient Experience and Engagement Committee (PEEC). PEEC is responsible for the development and oversight of the Trust's strategic objectives relating to patient experience and engagement and reflects the Trust's recognition of the value of listening to the voice of lived experience to enhance continuous learning and improvement. The committee meets monthly with an alternating strategic and assurance focus to facilitate implementation of the new Patient Experience and Engagement Strategy, and to provide oversight of patient experience data and improvement initiatives.

Patient Involvement

The Trust continues to present patient stories to the Trust Board meetings in public to share lived experience of receiving or delivering services. These stories have included a patient who overcame substance misuse and encouraged others to get tested for Hepatitis C, a long-term paediatric patient and family discussing multidisciplinary communication and financial challenges, and a family's experience with the RIPEL team as they supported them during a terminal diagnosis while ensuring their priorities were respected. A patient safety partner also shared an insightful account of their experience in the role. These unscripted stories, shared by patients, relatives, or healthcare professionals, allow the Trust Board to hear healthcare experiences directly from our patients and families.

Patient Safety Partners (PSPs) are being recruited in alignment with the NHS Patient Safety Strategy, and the Trust has recruited and onboarded nine PSPs to date. These volunteers contribute at all levels of the organisation and are invited to participate in Trust committee meetings including the Patient Safety and Effectiveness Committee, Clinical Governance Committee, Safety Learning and Improvement Conversation (SLIC) meeting, Clinical Improvement Committee, as well as the recently established Patient Experience and Engagement Committee. PSPs also engage in short-term project workstreams, such as the Martha's Rule implementation project. Their insights play a crucial role in ensuring that the patient perspective remains integral to organisational decision-making.

Friends and Family Test (FFT)

The Trust is delighted that, overall, across the year, 172,483 responses were received.

93% patients told us that they rated their experience as good or very good. The FFT also asks patients to provide any further comment on their care, and this feedback is shared with the respective wards and departments. The comments are themed which helps the Trust to understand a balanced view of patient experience alongside complaints, claims and compliments.

Table 22 Results from OUH Friends and Family Test (FFT) survey April 2025 to Feb 2026

Service	Results
Inpatients and Day Cases	Based on 35,862 responses, 94% of patients rated their experience on their ward as very good or good (*national average: 95%).
Emergency Departments	Based on 15,121 responses, 83% of patients rated their experience within the Emergency Department as very good or good (*national average 79%).

Outpatients	Based on 119,456 responses, 94% of outpatients rated their outpatient experience as very good or good (*national average: 94%).
Maternity	Based on 2044 FFT responses, 88.8% of women rated their experience of the Trust's Maternity Services as very good or good (*national average 92%). This is a significant improvement compared to 2024/25 data where there were 106 responses and 63% rated the Maternity Services as very good or good **

* National average sourced from NHS England, February 2026 data.

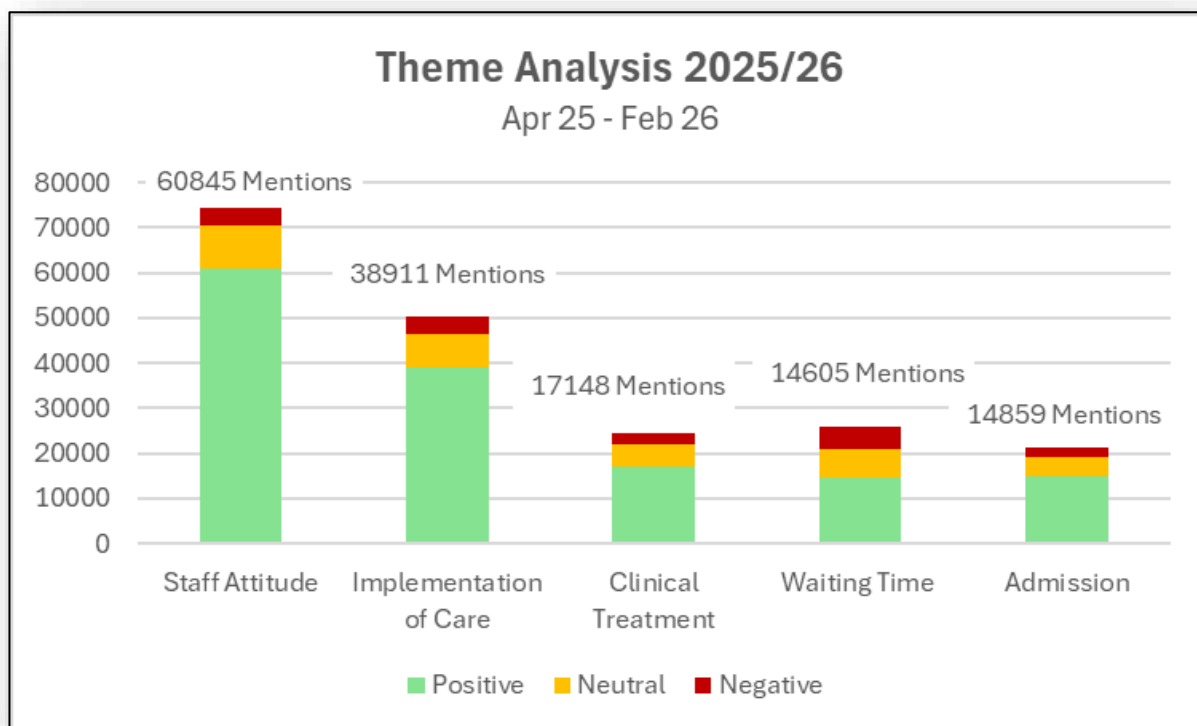
** This data is for FFT only. Additional feedback is also received via 'Say on the Day', with >95% service users now rating the service as 'good' or 'very good'.

Table 23 Trust's overall results from the FFT survey for 2025/26, April 2025 to Feb 2026

April 2025 to February 2026	Very good	Good	Neither good nor bad	Poor	Very poor	Don't know
No. of responses overall	139,325	21,045	5,108	2993	3215	797
Percentage	81%	12%	3%	2%	2%	0%

There have been 318,078 comments via the FFT throughout the year. Graph 13 below shows the mix of positive and negative sentiment among comments relating to the five most mentioned themes: Staff Attitude, Implementation of Care, Clinical Treatment, Waiting Time and Admission.

Graph 13 Mix of positive and negative sentiment among comments relating to the five most mentioned themes



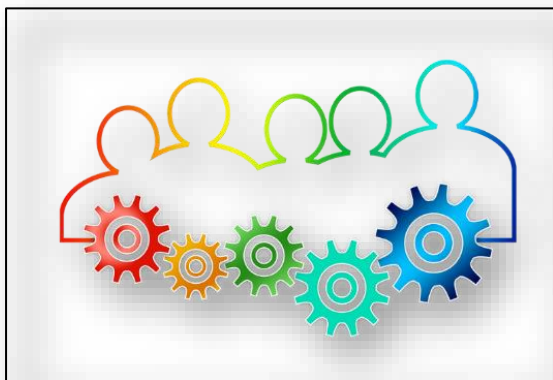
NHS England Learning Disability Improvement Standards

The Learning Disability Improvement Standards have been developed to help NHS Trusts measure the quality of care provided to people with learning disabilities, autism or both. The outcomes have been developed by individuals and their families, keeping their experiences the focus for the standards. There are four standards (the first three apply to all NHS Trusts and the fourth to specialist NHS Trusts).

- Respecting and protecting rights.
- Inclusion and engagement.
- Workforce.
- Learning disability services standard (aimed solely at specialist mental health Trusts providing care to people with learning disabilities, autism or both).

Further information about the standards can be found on the [NHS England website](#). OUH submits an annual self-assessment alongside accessible patient questionnaires and staff questionnaires. The Trust's systems and process's support compliance across the majority of the standards, with a focus for further improvement on staff confidence in their ability to provide person centred care. Significant developments have taken place in identifying people with learning disabilities on waiting lists and involving people with learning disabilities and carers in service development.

Improvement work is co-ordinated by the learning disability steering group through the delivery of OUH Learning Disability Plan.



Staff Experience

Staff recommendation of our hospitals to friends and family

Our 2025 Annual Staff Survey results relating to staff recommending our hospital to friends and family are as follows.

- 70.6% staff would be happy with the standard of care provided at OUH if a friend or relative needed treatment – the national average is 60.8%.
- 72.8% staff agree that care of patients is OUH's top priority – the national average is 71.6%.
- 58.2% staff would recommend OUH as a place to work – the national average is 57.7%.

Our People Plan

The [People Plan 2025-2028](#) sets out a vision that *'together we make OUH a great place to work where we feel we belong'*. In 2025/26 the People and Communications Directorate has continued to deliver on the key elements of the People Plan including the following:

- The launch of a new Wellbeing and Occupational Health Programme of Support intranet site at the beginning of February 2026. This provides a 'one stop shop' where all our staff can find the health and wellbeing support that they require, quickly and easily. Since the launch, there have been more than 3400 staff visit the site.
- A series of six lunchtime financial wellbeing webinars showcasing all the financial organisations we have partnered with to support our staff. Approximately 150 staff attended these. Over 130 staff attended wellbeing check-in training and self-care strategies workshops online with a further 150 doing sessions in person.
- The creation of new changing rooms on our Horton site which will also encourage staff to use more sustainable forms of transport to work such as cycling.
- Creation of bespoke support programmes for our Emergency Department and Maternity and Neonatal Departments.
- Our Wellbeing Service Leads (Occupational Health, Staff Support Service, Here for Health, Wellbeing team, Oxford Hospitals Charity and Freedom to Speak Up) met quarterly to ensure a connected, holistic wellbeing offer is available to our people.

- Our team of 350+ Wellbeing Champions at OUH continued to promote and identify ways to support our colleagues. They share wellbeing information at local level and organise team meetings to share all the support available and monthly forums to share excellent practices. Wellbeing Champions are connected to Divisional Programme Leads of our Eradication of Bullying and Harassment Programme to help support their work.
- Approximately 4,200 staff had a Wellbeing Check-in with their manager to discuss their wellbeing and explore practical ways to support it in the workplace
- Our 'Creating a Suitable Estates and Environments Enabling Group' met quarterly to provide a forum for staff feedback on our estates and to escalate any issues directly impacting staff wellbeing to the Trust's senior management.

Active Bystander Training

In November 2025 we launched the Active Bystander Training, which was offered across the Trust. This includes e-Learning for all staff and an optional workshop for staff to further explore the skills required to become an active bystander. At the end of 2025/26, 1553 people have completed the Active Bystander Training e-Learning and 151 have attended a workshop. This work has been integrated into the Leadership Development Programme and is a workstream in the eradication of bullying and harassment programme as a key part of our strategy to develop skills in calling out behaviours and helping people develop the confidence to become an active bystander. The workshops were initially delivered by a supplier as we developed our internal training team to take on the delivery from June 2026 onwards. This work will ensure a sustainable model to deliver the workshops ongoing.

OUH Leadership Development Programme

In October 2025, OUH Leadership Development Programme for Matrons, Clinical Directors, Clinical Leads, Directorate Managers and Corporate Directors commenced. This content has been adapted from the LDP delivered in 2023/24 to include content from the Better People Leaders Programme and links to the updated people plan objectives. This programme has also been updated to align with the soon to be launched NHS Managers and Leaders framework to ensure that we are modelling best practice and aligning our leadership development to the demands of the future. The first cohort started in March 2026 with two further cohorts planned for the summer offering a total of 75 places.

Onboarding programme for new managers

We continue to develop our onboarding programme for new managers. Revised and updated resources include new pages around career conversations, additional resources and 'how to' guides, training opportunities for managers and links to opportunities for personal development including skills development pathways.

Equity Diversity and Inclusion

There have been conference vents for Black History Month, International Day for Persons with Disabilities, and International Women's Day.

We have worked with our Staff Networks to implement initiatives that advance equality, such as launching site accessibility maps with AccessAble, and increasing provision of breastfeeding and expressing spaces.

We launched our new Reasonable Adjustments Policy that will facilitate managers to better support their disabled staff in the workplace. The launch included various materials to support implementation such as training and a reasonable adjustments passport tool.

We implemented an accountability intervention for recruitment of consultants to mitigate against bias and enable equality of opportunity for candidates. This involves panels having to provide clear justifications for their recruitment decisions, with those justifications being regularly reviewed by the Chief People Officer (CPO).

Staff Recognition

During the reporting period, 5788 colleagues sent Instant notes of appreciation, enabling staff to recognise a colleague who has gone above and beyond by sending a short personalised instant message aligned to the Trust Values.

Our Annual Staff Recognition Awards this year received 1,928 nominations, and we saw 157 colleagues being recognised in our monthly recognition programme in the last year. From these monthly recognitions, 52 colleagues have been recognised in the last year Quarterly Recognition Events, as well other colleagues who have celebrated long-service awards and reporting excellence. These initiatives. All of these programmes support the Trust's continuous commitment to recognising staff for their outstanding contributions.

To help people have more focused training and development, a new section within the Values Based Appraisal (VBA) was created in the *My Personal Development Plan (PDP)* section focussing on staff development and career aspirations. To support this a new career development site was also launched in May 2025; this offers resources, training and guidance to help staff with career planning and development.

The national appraisal compliance rate for 2025 was 85.1% and our Trust compliance rate was 91.7%.. This was the highest score nationally.

Bullying, Harassment and Discrimination-

From the 2024 and 2025 Staff Survey results, there are several areas showing improvement in staff experience relating to bullying, harassment and discrimination. At organisation level, the proportion of staff saying they never experienced harassment, bullying or abuse improved across all three sources: from patients/service users/public, increasing from 77.8% in 2024 to 79.2% in 2025 (+1.4 percentage points); from managers, increasing from 90.3% to 90.7% (+0.4 percentage points); and from other colleagues, increasing from 81.7% to 82.6%

(+0.9 percentage points). There were also improvements in discrimination-related measures, with staff reporting no discrimination from patients/service users/public increasing from 91.0% to 91.9% (+0.9 percentage points) and staff reporting no discrimination from managers/team leaders/colleagues increasing from 89.8% to 91.1% (+1.3 percentage points). Reporting of the last incident of harassment, bullying or abuse remained unchanged at 50.1% in both years.

We have continued to deliver the Trustwide Eradication of Bullying and Harassment Programme, the purpose of which is to tackle all forms of negative behaviours ranging from incivility to violence and aggression.

We have delivered two parts of a 'No Excuses' campaign, that promotes behaviours in line with our Trust Values and advises staff how to raise complaints of discrimination and harassment.

We have rolled out a WorkinConfidence platform that enables all staff to raise Freedom to Speak Up concerns anonymously.

OUH performance with NHS Oversight Framework indicators

OUH Performance Management and Accountability Framework governs the oversight and the delivery of the Trust's strategic and performance goals. The Framework provides a focus from Board to ward on Corporate Governance, Risk Management, Accountability and Performance Management, which is integrated across Trust Divisions (Clinical and Corporate).

Table 24 Performance against relevant indicators and national average

Indicator	Target	Trust Performance 2025/26	Trust Performance 2024/25	Trust Performance 2023/24
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	≥92%	63.0%	57.1%	57%
Patients waiting for consultant-led treatment (RTT ¹)	N/A	88,213	89,833	82,990
Patients waiting over 52 weeks (RTT ¹)	<950	1,590	2,711	3,586
Patients waiting over 78 weeks (RTT ¹)	0	1	15	80
Patients waiting over 104 weeks (RTT ¹)	0	0	0	1
ED performance within 4 hours (all types)	≥78%	78.5%	72.2%	65.1%
62-day general standard	≥85%	56.5%	60.6%	63%
Diagnostic activity levels (elective) *New system introduced in 2025/26	N/A	321,849*	254,800	240,545
Percentage of people waiting within 6 weeks for a diagnostic procedure or test	95.1%	79.1%	76.3%	83.6%
Local priorities				
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 per 10,000 bed days	<2.0	2.7	2.2	2.8

Indicator	Target	Trust Performance 2025/26	Trust Performance 2024/25	Trust Performance 2023/24
Hospital Acquired Pressure Ulcers (HAPUs) Category 4 per 10,000 bed days	0	0	0.1	2
Reported incidents of violence and aggression against staff ³	0	2,210	2,192	1,708
Incidence of violence and aggression (rate per 10,000 bed days)	N/A	62.6	56.8	51.5
Results endorsed within 7 days	>85%	80.9%	81.2%	82.5%

¹ Referral to Treatment (RTT) pathway; ² Emergency Department (ED); ³ Reported rate on Trust's incident management system.

Elective care

We are committed to seeing more patients more quickly, and to reducing the time patients are waiting. We are grateful to our staff from across the Trust who have continued to focus on improvements to patient pathways, and to our system partners for the collaborative approach to delivering services to our patients.

For a second consecutive year, we successfully maintained a zero position for the number of patients waiting more than two years at the end of March 2026. Focused work has continued on reducing the number of patients waiting more than 65 weeks and 78 weeks; at the end of March 2026, there were 46 patients waiting over 65 weeks compared to 63 in March 2025, and 1 patient waiting over 78 weeks at the end of March 2026 compared to 15 in March 2025. We remain committed to further reducing the waiting times for patients requiring elective care.

Patients on a Referral to Treatment (RTT) incomplete (i.e. still waiting) waiting list at OUH decreased by 2% from March 2025 to March 2026. In February 2026, OUH held the 13th largest incomplete waiting list nationally.

Contributing to the challenge of fully recovering the long waiting patients in 2025/26, was a group of specialty capacity constraints either due to recovering from a pathway redesign, staff vacancies, inability to secure mutual aid at another qualified provider across region or a greater volume of patients in the cohort, resulting in the reliance of delivery fund schemes.

Harm reviews continue to be performed digitally for patients waiting in excess of 52 weeks, to identify any psychological clinical harm arising from delays in line with the national e-prioritisation policy. The harm reviews have allowed services to expedite treatment of patients as necessary.

In line with an agreed protocol, any cancer patient waiting more than 104 days for treatment also has a review conducted of potential for clinical harm from the delay.

Emergency care

Performance within the ED, measured across the full year using the national standard for the percentage of patients attending the ED for less than four hours from arrival to admission, transfer or discharge, was 78.5% for 'all types', and 70.7% for 'type 1' attendances. 'Type 1' activity accounts for approximately 72% of patients at OUH and covers the Emergency Departments at the John Radcliffe and Horton General hospitals. 'All types' includes activity outside these settings that incorporate 'type 2' single specialty departments and 'type 3' Minor Injury Units.

ED performance improved compared to the previous year by 6.3% for 'all types' and by 6.8% for 'type 1'. ED performance was better than the national average for 'all types', which was 74.9% nationally, and also better than the national average for 'type 1' attendances, which was 60.9% in 2025/26.

Cancer treatment within 62 days

OUH cancer demand continues to grow year-on-year, with an increase in demand of 6.7% compared to 2024/25. OUH delivered 82.9% for 28-day Faster Diagnosis Standard (FDS) at the end 2025/26 compared to 77.9% in 2024/25. This is above the national target of 75%.

The proportion of patients waiting more than 62-days on 31st March 2026 was 7.3% of the total waiting list size which is 2% improvement compared to 2024/25.

OUH achieved one out of the three national standards at the end of March 2026 (28-day FDS). The 62-day and 31-day combined standards were not achieved and are the focus of specific initiatives within the Trust's Cancer Improvement Programme. The achievement of the 28-day FDS has been supported by the Trust's investment in increasing diagnostic capacity as well as capacity from the Community Diagnostic Centre.

Diagnostic test within six weeks

Diagnostic waiting time performance is a fundamental aspect of delivering elective treatment for patients within timeframes set in the Trust's Operating Plan, as well as the national standards.

The March 2026 diagnostic performance, against the standard measuring patients waiting within six weeks, was 79.1% (an improvement on last year's 76.3%). OUH was ranked below the national average. The Trust holds one of the largest waiting list volumes in the region and the Shelford Group. The main reason for not achieving a higher performance was a 2024/25 change in the national referral process to allow direct audiology referrals and for audiology to refer directly to ENT rather than via the GP. A recovery plan was developed and implemented, with steadily continued improving waiting times for patients into 2026/27. Additionally, challenges related to demand and capacity for endoscopy modalities contributed to the outcome.

Freedom to Speak Up (FtSU)

The Trust takes very seriously its responsibility for ensuring all members of staff feel confident and supported in being able to speak up when they believe the highest standards of care and service are being compromised or could be compromised. Processes are in place to ensure that our staff feel able and safe to raise concerns and have confidence they will be listened to, and their concerns acted upon.



Most issues raised are addressed quickly and effectively through our established procedures, as set out in the Trust's *Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy*, which was refreshed in 2025/26 to strengthen guidance, protections and accessibility for staff. Under this Policy, the Freedom to Speak Up (FtSU) Lead Guardian and the wider Guardian team provide support and guidance to anyone wishing to raise a concern. Speaking up is something that everyone is encouraged to do, and our current Policy aligns with the National Model Policy and the recommendations of the National Guardian's Office to ensure it fully supports this aim. The FtSU Lead Guardian presents an Annual Report to both the Trust Management Executive (TME) and the Trust Board. We also have a nominated Non-Executive Director and a nominated Executive Director with responsibility for FtSU, ensuring independent representation and leadership at Board level.

The Trust launched a new anonymous reporting platform as an extension of our existing Freedom to Speak Up service in November 2024. This provides a confidential, two-way anonymous speaking up platform operated independently by Work in Confidence, offering an additional route for staff to raise concerns in writing or anonymously. Overseen by the Freedom to Speak Up Guardian team, the platform helps reduce barriers to speaking up, particularly for those concerned about confidentiality or potential detriment, supports earlier reporting of issues, and enables ongoing dialogue while protecting staff identity, contributing to a culture of psychological safety and continuous improvement

The purpose of the FtSU function is to support all staff and help foster an open, transparent and supportive culture where speaking up is normalised and staff feel safe to raise issues without fear.

Ensuring staff do not suffer detriment

Speaking up about concerns at work is essential to helping the Trust continuously improve services for patients and the working environment for staff. We recognise that some staff may feel anxious about raising a concern, but this should never deter them. In line with our duty of candour, our senior leaders and the Trust Board remain committed to maintaining an open and honest culture.

Staff who raise concerns will always be treated with respect and supported throughout the process. The Trust will apply the new guidance on detriment issued by the National Guardian's Office in February 2025, ensuring that no-one who raises a concern under the Policy is at risk of losing their job or experiencing any form of reprisal. Harassment or victimisation of anyone raising a concern will not be tolerated and, if upheld following investigation, may lead to disciplinary action as it represents a breach of Trust Values.

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<https://www.workinconfidence.com/about-workinconfidence/https://www.workinconfidence.com/measuring-the-success-of-employee-engagement/>

Rota Gaps and the Plan for Improvement

Resident Doctors: Safe working hours

Background and contractual framework

Resident doctors represent approximately 40% of the medical workforce nationally. The Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (2016) include governance arrangements requiring partnership working between resident doctors and their employing Trusts to ensure safe working hours and appropriate executive oversight.

Oxford University Hospitals NHS Foundation Trust (OUH) employs approximately 1,500 resident doctors, including around 1000 on national training programmes, alongside locally employed, university-employed, and military doctors. Although contractual arrangements differ across these groups, OUH applies the principles of the 2016 TCS to all resident doctors in order to support consistent oversight of safe working hours and promote safe and sustainable service delivery.

Governance and oversight arrangements

To support compliance with the 2016 TCS during 2025–2026, OUH ensured that all resident doctors were provided with compliant work schedules and access to an electronic exception reporting process to report variance from rostered hours. The Trust Board continued to receive quarterly and annual reports from the Guardian of Safe Working Hours, informed by workforce data, exception reporting intelligence, and feedback from the Resident Doctors' Forum.

National and local context

The reporting year took place against a challenging national context, including ongoing industrial action involving resident doctors and continued financial pressures across the NHS. During this period, national contractual reforms were introduced, including the NHS England 10-Point Plan to Improve Resident Doctors' Working Lives and a revised national Framework Agreement for exception reporting. These developments required Trusts to review and strengthen local arrangements for working hours oversight, rota transparency, rest facilities, and resident doctor engagement.

Exception reporting

In previous years, limitations within the legacy exception reporting system reduced the reliability of aggregate exception reporting data for assurance purposes. These limitations included inaccurate attribution of supervisors and specialties and were formally recorded on the Trust risk register. As a result, exception reporting data were excluded from the 2024/25 annual report.

During 2025/26, OUH transitioned from the legacy system to DRS5, a supported and reform-compliant exception reporting platform aligned with national requirements. While exception reporting continues to support individual contractual outcomes, including payment or time off in lieu, aggregate assurance remains limited for part of the year due to the timing of the system transition. The implementation of DRS5 establishes stronger foundations for exception reporting governance in future reporting periods.

Improving working lives

Implementation of the NHS England 10-Point Plan to improve Doctor's working lives progressed during the year through the Improving Working Lives Group, supported by multidisciplinary engagement and executive oversight. Our performance against the 10 point plan showed 95% compliance.

Activity during 2025/26 included improvements in resident doctor engagement, strengthened governance arrangements, continued operation of the Resident Doctors' Forum, and the appointment of a resident doctor peer lead. OUH also progressed the appropriate use of fatigue and facilities funding and funding accrued from Guardian-levied fines, in line with national guidance and local agreement.

Rota gaps and locum usage

Trust-wide vacancy data for resident doctor posts were not available in a single consolidated dataset due to variation in local data collection arrangements across services. This continues to limit Trust-level assurance and remains an area for further development. Locum shift activity is therefore presented as an indirect indicator of rota pressure. During 2025/26, locum shifts continued to be used primarily to mitigate vacancies and maintain service delivery, with the majority of shifts filled through OUH bank and a smaller proportion through agency cover.

Table 25 Number of locum shifts undertaken by bank and agency staff, broken down by quarter, and the reason for the locum shift

Locum Shifts	2025			2026	Total
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Total	2660	3043	2775	2845	11323
Agency	330	211	84	133	758
OUP Bank	2330	2832	2691	2712	10565

Summary

In summary, OUP remains committed to supporting safe working hours for resident doctors. This year's report reflects progress in system reform, governance arrangements, and implementation of national initiatives, while acknowledging ongoing data limitations. Further improvement and assurance will be reflected in future reporting as these developments continue to embed.

Annexes

Annexe 1: [Quality Priorities 2026/27](#)

Annexe 2: [Statements from the Integrated Care Board, Local Health watch organisations, NHSE, Council of Governors Health, Overview and Scrutiny Committee \(HOSC\)](#)

Annexe 3: [Statement of Directors' responsibilities in respect of the Quality Account](#)

Annexe 4: [Glossary Medical, Clinical and Technical Terms](#)

Annexe 1: Quality Priorities 2026/27

Patient Safety

Quality Priority 1: Improving escalation of the deteriorating patient

Why is this a priority?

The prompt response to patient deterioration through escalation to an appropriate clinician is essential to patient safety. It is important in preventing cardiopulmonary arrest or the need for transfer to an intensive care unit, both of which impact on a patient's length of stay in hospital but most importantly may influence the outcome for that patient and those closest to them. This Quality Priority will focus on adult in-patient areas, where patient deterioration may occur requiring a senior clinical response.

Table 26 Improving escalation of the deteriorating patient QP 2026/27

What we will do.	How will you know the objective is completed and that it is working?
Objective 1 (Q1-4) Empower staff providing patient care with the tools to appropriately escalate a patient for whom they have concerns. This will be achieved by: - establishing a stakeholder group. - supporting the education and development of staff in communicating information surrounding escalation.	(Q1-4) - Reduction in the number of Ulysses incident reports pertaining to a delay in escalation of a deteriorating patient (target 25% reduction). - Pre and post implementation questionnaire to clinical staff who may be required to escalate deterioration to determine whether communication and confidence in escalation has improved.
Objective 2 (Q1-4)	(Q1-4)

What we will do.	How will you know the objective is completed and that it is working?
Understand the current enablers and barriers in escalating patient deterioration to develop a systems-based approach to escalation which is applicable across the Trust • Distribute a questionnaire to 100 nurses and resident doctors, collating a summary of enablers and barriers to escalation from the responses received. Complete process mapping exercise using QI methodology and implement QI programme cycles. • Identify key clinical areas for intervention following QI exercises. Conduct a focus group in the pilot areas to assess the effectiveness of measures and guide future planning. • Continue implementation of RAID Huddles.	• To have defined and commenced 2 focused PDSAs cycles informed by robust, frontline-informed evidence on escalation barriers and enablers, shaping clear quality improvement interventions next steps. • An observed decrease in Ulysses reporting relating to escalation (aiming for a 25% decrease). • RAID Huddles will be embedded in 25% of adult in-patient ward areas as part of daily ward routine. This measure will support a 10% reduction in the instance of 2222 calls to these areas.
Objective 3 (Q1-4) • Ensure the concerns raised by patients and those closest to them are heard and appropriately escalated, including incorporation of escalation through Martha's rule. • Support education of staff in documenting concerns raised as per Martha's rule as part of routine documentation on EPR. • Explore the use of EPR to capture patient concerns	(Q1-4) • PDSA cycles on 4 different wards will take place to understand how best to capture the concerns raised by patients and relatives. The workflow will be subsequently defined and embedded. • This will be added to through a regular review of Martha's Rule calls and through a review of EPR documentation • Data will be cross referenced with Ulysses reporting (bi-monthly) to ensure compliance with the objective.

What we will do.	How will you know the objective is completed and that it is working?
Objective 4 (Q1-4) Observations are recorded and documented in line with the Trust Recognising Acute Illness and Deterioration (RAID) Policy and the Early Warning Score with supporting documentation provided if the observation interval deviates from that laid out by the National body.	(Q1-4) Monitor compliance with the documentation of patient observations monthly and work with areas where compliance is not at the expected standard, aiming for a 20% increase in baseline recorded compliance. Share learning across clinical areas.

Quality Priority 2: Venous Thrombo-embolism (VTE)

Why is this a priority?

Venous thromboembolism (VTE) is the leading cause of preventable hospital deaths. One in every four preventable hospital deaths across the UK is related to a blood clot. The early identification of patients at risk of VTE and prescription of thromboprophylaxis are important measures in preventing the morbidity and mortality associated with hospital-associated thrombosis. Evidence from clinical trials has shown that thromboprophylaxis can reduce rates of VTE by 60% in the highest risk patients.

At OUH, we use a VTE risk assessment tool that is available electronically in the patient record which is based on the national tool and complies with NICE guidance. A key feature of our VTE risk assessment is the automatic generation of an appropriate prescription for thromboprophylaxis, on completion of the form. Since 2012, OUH has met and exceeded the 95% national target for VTE risk assessment within 24 hrs of admission.

In January 2025 NHS England stipulated that the VTE risk assessment must be completed on all patients age 16 and above within *14 hours* of admission, this is supported by NICE guideline NG-89. This is an appropriately challenging target, and one that will improve the safety of all adult (16 years +) in-patients, both during their hospital stay and will protect them from hospital-associated morbidity (and mortality) during their immediate discharge period.

The focus of this quality target will be to drive greater excellence in VTE prevention and to comply with, and exceed, the new NHS England target of 14 hours.

Table 27 VTE QP 2026/27

What we will do.	How will you know the objective is completed and that it is working?
Objective 1 (Q1-4) To reduce the number of missed doses of Thromboprophylaxis	(Q1-4)

What we will do.	How will you know the objective is completed and that it is working?
a) Thromboprophylaxis Column to be added to the electronic White Board in collaboration with the Digital team – with a coloured traffic light system, which will be mandated on every in-patient ward. b) After the traffic light system has been introduced – we will audit the number of missed doses of low molecular weight heparin (LMWH) across all wards, using digital support. c) We will add the ‘missed LMWH figures’ to clinical governance meetings for Divisions and Directorates – for their review. d) We will work with the digital team to streamline the link between the VTE-RA and VTE prescribing. e) We will, with the support of the medical photography/video team develop five 60 second teaching videos aimed at different front line staff groups, to increase their awareness, knowledge and confidence around VTE e.g. VTE Prevention and Mobility, VTE Prevention and Lower Limb Immobilisation.	Our preliminary data show that there are 20% in-patient days where LMWH is not given. We will collect data on missed doses and continue to collect data on Hospital Acquired Thrombosis (HATs). • Our aim is to reduce missed doses by a challenging 50% (e.g. down to 10% in-patient days). Q4 • We expect, over time to see a meaningful reduction in the number of Potentially Preventable HATs. At present we have 30 - 35 potentially preventable HATs per year. We will aim to reduce this by 30%, i.e. down to 20 per year.
Objective 2 (Q1-4) Increase compliance of the VTE Risk Assessment (RA) for In-patients (e.g., specifically excluding VTE cohorts) In addition to the interventions above we will do the following to increase VTE-RA to >95% for all directly reviewed in-patients:	Q3-4 • Achieve 95% of <u>directly assessed</u> VTE Risk Assessment completed within 14 hrs.

What we will do.	How will you know the objective is completed and that it is working?
a) Visit other VTE Exemplar centres to learn directly from them, how to improve direct VTE-RA figures. b) Focus our work with junior clinical staff to understand barriers to timely VTE-RA, and how to develop innovative measures to overcome these barriers. c) Using data from the last 15 years, develop the evidence base to support earlier LMWH delivery.	
Objective 3 Introduction of the electronic validated Risk Assessment tool for Lower Limb Immobilisation. a) Agreement with Key Stakeholders to implement the TriPCast Tool for Lower Limb Immobilisation (LLI). b) Development and roll out of the LLI tool on EPR and assistance with development of the tool to be suitable for patients to start to complete prior to their – mostly fracture clinic – appointments, to assist with the limited time available for clinicians to complete these risk assessments in their clinics which commonly see 50+ patients.	Objective 3 Q1 • Work with stakeholders to understand workflows and get agreement from all stakeholders to implement a digital risk assessment tool for LLI. Q2 • Determine baseline assessment of LLI VTE risk assessment through roll out of the digital tool across the relevant teams. • Aim to increase risk assessment by 50% from baseline Q3-4

What we will do.	How will you know the objective is completed and that it is working?
	Monitoring assessments-compliance/reporting system demonstrating sustained increase in compliance.

Quality Priority 3: Martha's Rule

Why is this a priority?

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration.

Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that a patient's condition is getting worse and their concerns are not being responded to.

Following a successful pilot in 2025, a full rollout of Martha's Rule in adult and paediatric wards is planned in 2026.

Table 28 Martha's Rule QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
Objective 1 - Roll out of escalation pathways for patients, relatives, carers and staff of Martha's Rule (MR) in Q1-2 • Full roll out of across all four OUH sites of the ability of patients, relatives, carers and staff to escalate concerns. • Launch Martha's Rule in all patient groups i.e. adults, maternity and paediatrics. • Deliver a communications plan to raise awareness internally and externally to our local population that MR will be available for everyone to use across all sites.	(Q1-2) • Achieving roll out of to all 4 sites by the end of Q2. • Completion of communications plan. • Delivering consistent Trustwide access to MR and access to an escalation pathway across all services.

What we will do	How will you know the objective is completed and that it is working?
Objective 2 - Pilot Patient Wellness Questionnaire (PWQ), component of Martha's Rule (Q2-4) Q2 - Pilot the Patient Wellness Questionnaire (PWQ) in adult wards, starting with 2 adult wards in Q2 and a further 2 wards in Q3. Q3-4 - Roll out of PWQ for Paediatrics.	(Q2) - Completion of 2 Plan, Do, Study, Act (PDSA) cycles in 2 adult wards of PWQ. - Clear plan for digital capture of PWQ. - Clear plan for how to incorporate PWQ into usual escalation triggers. (Q3-4) - Completion of 2 Plan, Do, Study, Act (PDSA) cycles in another 2 adult wards of PWQ. - Paediatrics PWQ will be embedded into introduction of National Paediatric Early Warning Score (PEWS). - Data from Paediatrics PWQ regularly captured and used to improve care.
Objective 3 - Evaluation of Martha's Rule Q2-4 - Collect feedback from callers regarding the service. - Measure awareness of Martha's Rule in staff and patients. - Ensure robust escalation pathway. - Implement monitoring questions surrounding Martha's rule into Care Assure framework.	(Q2-4) - Consent to gather feedback will be incorporated into the Martha's Rule call proforma. - Project manager will work in partnership with the Patient Experience team to gather feedback from every patient and family that gives consent. - Feedback will be analysed and reported appropriately.

What we will do	How will you know the objective is completed and that it is working?
	• Service will be improved according to feedback. • Embed staff and patient awareness in regular audits carried out of staff and patients across all 4 sites. • Review escalation pathway at 6 months of rollout and adjust as necessary. Review and amend question bank embedded within Care Assure framework and audit responses to assess effectiveness during evaluation stage.

Clinical Effectiveness

Quality Priority 4: Excellence in the basics: reducing variation, improving care through Standard Work

Why is this a priority?

We will build on the progress of our first year of Standard Work implementation as a successful vehicle for delivering high-quality care. Learning from year one has demonstrated measurable improvements in patient and staff safety, quality, and efficiency through the use of clear, evidence-based, step-by-step processes that create reliable and consistent care.

The first year focused on key inpatient clinical teams, aligning Standard Work with existing structures to reduce duplication and improve areas such as equipment checks, board rounds, safe and secure storage of medicines, and safety huddles. In year two, the programme will shift towards wider organisational adoption as part of a longer-term strategy, supported by a clear, co-designed approach in partnership with key stakeholders, embedding Standard Work as a core element of our quality and operational management system

Table 29 Excellence in the basics: reducing variation, improving care through Standard Work QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
Objective 1a (Q1-4) Continue to build on the work initiated during QP year 1 – applying standard work principles of practice in defined core clinical domain of Safe and Secure Storage of Medicines to complete adoption - ensuring metrics agreed within task and finish groups.	(Q1-4) Standard Work documents to be completed and rolled out across defined clinical areas as prioritised by Trust wide Safe and Secure Storage Medicines Audit and Care Assure Audit. Improvement in agreed metrics will be linked to the Safe and Secure Storage of Medicines – e.g.

What we will do	How will you know the objective is completed and that it is working?
	○ 100% of prioritised clinical areas with safe and secure storage and stock management using standard work documentation. ○ By March 2027, achieve incremental improvement from baseline in Care Assure audit scores for the safe and secure storage of medicines, through Divisional implementation of 5S using the SW template, with ongoing monitoring via Care Assure audits to ensure sustained compliance. The scale of improvement will be defined in alignment with local baseline/root cause to support sustainable and meaningful improvement). ● Staff report increased confidence and ease in applying Standard Work practices, as represented through: ○ Improvement in Care Assure audit compliance against Standard Work criteria. ○ Attendance and completion rates for Divisional level Standard Work training across key defined staff groups ○ Qualitative feedback from key staff groups evidencing improved understanding and usability (i.e. pharmacy and ward-based nursing staff)
Objective 1b (Q1-4)	(Q1-4)

What we will do	How will you know the objective is completed and that it is working?
Continue to build on the work for initiated during QP year 1 – applying standard work principles of practice in defined core clinical domain of Safety Huddles to complete adoption - ensuring metrics agreed within task and finish groups and including review of safety huddles principles.	- Agreed Trust Safety Huddle Principles and core standard incorporated into Trust policy by October 2026 - embedded within Divisional assurance as part of Care Assure. - By March 2027, Divisions will have embedded agreed Safety Huddle Principles across 50% of inpatient clinical teams will achieve increased compliance, as measured through Care Assure. The increase in compliance will be defined in alignment with local baseline/root cause to support sustainable and meaningful improvement. - Staff report increased confidence and ease in applying Standard Work practices, as represented through: - Improvement in Care Assure audit compliance against Standard Work criteria. - Attendance and completion rates for Divisional level Standard Work training across key defined staff groups - Qualitative feedback from key staff groups evidencing improved understanding and usability (i.e. Inpatient ward Matrons)
Objective 2 (Q1-4) Building forward on the work already in progress with Ophthalmology, the team will collaborate with two or three chosen Directorates/services to trial, adapt, and introduce	(Q1-4) By May 2026, have identified 2–3 Directorates/services with the CMO and CNO to trial and implement Standard Work, building on the Ophthalmology pilot and aligned to Trust priorities.

What we will do	How will you know the objective is completed and that it is working?
standard work, refining proposed changes that could facilitate ongoing broader Divisional led implementation. • Services will be determined in consultation with the CMO and CNO, ensuring alignment with Trust priorities. This approach will include: • Development of Standard Work documentation collaboratively with frontline staff, support adoption of continuous improvement approach and digitisation of results from ward/department to board level. • Capture lessons learnt to share best practice, scale and spread	• Co-develop and approve Standard Work documentation with frontline staff in each participating service, with 100% of agreed processes documented and made accessible at ward/department level by the end of working with each service. All final versions for the services will be complete by March 2027. • Improvement in agreed priority metrics agreed with CMO and CNO aligned to identified priorities services, including consideration of safety, quality, efficiency and patient/staff experience metrics. The size of improvement will be defined in alignment with local baseline/root cause to support sustainable and meaningful improvement. • By March 2027, complete a lesson learnt review for each participating service, with identified best practice and improvement themes shared Divisional-wide to support scale and spread. Including, internal and external shareable case studies. • Services to share learning through QI Stand Up sessions where Standard work has been embedded.

What we will do	How will you know the objective is completed and that it is working?
Objective 3 Q1-4 Develop the Standard Work Toolkit – bringing together tools available to support wider adoption and implement within services taking an approach aligned with OUH Improvement Framework. • Review and align all Trust adopted Standard Work documents to present clear materials for wider scale and spread, utilising the Standard Work branding. • Roll out of Standard Work masterclasses to key Divisional teams to help adoption, engagement and further spread of concept. • Collation of videos sharing impact and learning from adoption of Standard Work principles from QP year 1 achievements • Support videos to support team and service level leaders / managers engaging local staff to understand purpose and value of adoption of standard work principles	(Q1-4) • Suite of Standard work documents as examples on QI Zone SharePoint for staff to download, use and understand the concept further. • Inclusion of videos on QI Zone. • Pages on the Standard Work section within QI Zone on SharePoint for any key priorities – e.g. in Year 1 the Board Rounds page was developed and assisted all staff involved and provided a level of sustainability. • Increased uptake of Standard Work masterclasses across all Divisional teams, with initial focus on colleagues linked to priority areas and ongoing assurance processes. Captured through: ○ Increased numbers of Ward Managers or equivalent completed Standard work Masterclass across all Divisional inpatient wards ○ Increased numbers of Inpatient Matrons completed Standard work Masterclass across all Divisional inpatient wards ○ Increased numbers of Care Assure assessor colleagues completed masterclass, including corporate support staff.

What we will do	How will you know the objective is completed and that it is working?
	(Above numbers to be agreed with Divisional representatives within programme board to ensure sustainable approach with clear Divisional ownership and oversight).
Objective 4 Q2-4	(Q2-4)

What we will do	How will you know the objective is completed and that it is working?
- Supporting adoption of OUH approach to the concept and principles of “Leader Standard Work” (SWL), underpinning our ongoing Trust approach to developing our culture of excellence and continuous improvement. This will be delivered through: - Embedding these principles at the centre of Divisional development and delivery of the SW programme, supported by the QI team, incorporating key enablers such as: “Go See” Leadership Walkabouts: Leaders observe work directly to identify opportunities for improvement. - Coaching: encourage developing staff through ongoing coaching, building team capability. Leaders being problem Framers not always problem solvers. - Visual Management: Performance is made visible with boards and charts to track key indicators, model through SW priority metrics. - Strategic Alignment: Align routine tasks direct link to the organisation’s long-term goals throughout the programme. - By the end of Q1, we will have integrated Leader Standard Work principles into OUH QI Managers and Leaders offer, building on learning to date to better equip leaders for their role in setting	- By the end of Q4, to achieve a 25% increase in the uptake of Band 7+ leaders/managers attending QI for Leaders and Managers training at the Trust - By the end of Q4, we will deliver a Standard Work Symposium to showcase Standard Work implementation and impact, share learning, and celebrate achievements, with participation from identified Divisional teams and key stakeholders. - By the end of Q3, work in collaboration with the Culture and Leadership team to identify 2 PDSA cycles focused on priority areas supporting ongoing integration of Leader Standard Work principles at OUH - Within the Standard Work Programme we will have: - By the end of Q2, each defined SW priority will have had leaders conduct at least two structured workplace observations, documenting a minimum of one improvement opportunity per visit, with actions reviewed in monthly team meetings. - Over duration of the programme 100% of OUH QI Coaches will access Standard Work Masterclass and be supported to consider impact and learning within their Divisions.

What we will do	How will you know the objective is completed and that it is working?
both the context and culture for others to driver forward local continuous improvement. Working in collaboration with the Culture and Leadership team, identify areas of organisational strength and map opportunities for joint approach to incorporating principles into leader and management training and development at OUH	- By the end of Q3, all priorities in the programme will have a visual performance board displaying agreed SW priority metrics, for local adoption aligned to support performance discussions with at least one Task and Finish priority review meeting per month. - Divisional Leadership will be supported to review and draft clear well led CQC preparation question or briefing for clinical staff aligned to sharing standard work impact through priority areas at OUH.

Quality Priority 5: Strengthening Discharges

Why is this a priority?

We remain dedicated to progressing this Quality Priority into its second year and building on the objectives we have achieved so far. There is an increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a 'Home first' approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person's home. Consequently, the volume and complexity of discharge planning has increased.

This Quality Priority will review discharge processes for all patients and seek to improve the quality and safety of discharge. This includes reducing delays and length of stay, as well as learning from incidents and feedback. There will also be an opportunity to explore the empowerment of nurses and other Allied Health Care Professionals to lead discharge-based decisions to improve quality and reduce length of stay.

Table 30 Strengthening Discharges QP 2026/27

What we will do.	How will you know the objective is completed and that it is working?
Foundation (overall) objective Improve experience of continuity and quality of care for patients being discharged from hospital. • Write a Trust Discharge Policy. • Establish a process for reviewing quality, safety and risk of discharge from hospital.	(Q1-4) • There will be Trust wide engagement and awareness in agreed discharge processes. • There will be standardisation in discharge safety checks across the Trust. • There will be an approved Trust Policy on Hospital Discharge.

What we will do.	How will you know the objective is completed and that it is working?
	• Sustain a discharge assurance group. • There will be a dashboard to collate and display internal and external information. • Thematic analysis of internal themes as well as from system partners. • Share internally to appropriate colleagues for awareness and action where needed. • Close feedback loop to system partners.
Objective 1 Medication (Q1-3) Improve timeliness of TTO prescription and readiness • Improve TTO ('to take out') medication turnaround times • Increase visibility and reporting of TTO medication related issues, including instances when TTOs couriered to the patient because not ready at time of discharge.	(Q1-3) • Target reduction of 20% reduction in the use of courier to deliver TTO's. • Risk assessment in place for the safe use of courier when it is required for TTO's. • 10% improvement in percentage of TTO's turnaround within 120 minutes. 15% reduction in reported incidents related to TTO's timeliness.
Objective 2 Communication (Q1-4) Improve and provide assurance of the safety of discharge from hospital	(Q1-2) • The Discharge Safety Checklist has been reviewed and validated for each patient group and includes key discharge safety

What we will do.	How will you know the objective is completed and that it is working?
- Standardise the discharge processes on departure from hospital. - Implement a mandatory Discharge Safety Checklist within the 'depart' process in the electronic patient record (EPR) with specific check lists for adults, maternity, neonates and children's.	concerns as identified in Overarching objective thematic review of incidents, complaints and feedback. (Q2-3) - The Discharge Safety Checklist is on EPR and is mandatory for all patient groups. (Q3-4) - Phased implementation will show increasing compliance rates to 100% of discharges for areas included. - Increase positive feedback from patients and families regarding the discharge process (target 20% increase in positive feedback). 20% reduction in discharge-related complaints and incidents.
Objective 3 Patient Experience (Q1-2) Provide clear communication to patients and unpaid carers on discharge processes and follow up support - Increase awareness of the new Discharge Information Leaflet - Brief ward staff on the contents and embed its use.	(Q1-2) - The leaflet has been produced, is in circulation and staff know about it and use it. - Reduced misunderstandings from staff/patients on discharge pathways and expectations. - Staff feel empowered and prepared to answer questions relating to complex discharge from patients/relatives. - Increase patient satisfaction scores related to discharge communication by 20%.

What we will do.	How will you know the objective is completed and that it is working?
	• Positive feedback from patients and families regarding discharge communication by end of Q4 (measured through questionnaires and friends and family tests – 6 months to implement changes and 6 months to see improvement in feedback). • All Inpatient Directorates will achieve the national average score of 7.9 with 75% exceeding the Trust average for the previous year (8.6) for <i>“Before you left hospital, were you given any information about what you should or should not do after leaving hospital? This includes any verbal, written, or online information”</i> in the National inpatient survey. • There will be a 20% reduction in discharge-related complaints.
Objective 4 Documentation(Q1-4) Improve the quality of discharge documentation • Revisions made to the GP discharge letter template that encompass community partner feedback on content. • Enable a system and approach that allows for regular review and update of the template based on feedback and incident trends. • Enable Allied Health Professionals (AHP) colleagues and other clinical colleagues to contribute to the discharge summary as required.	(Q1-2) • The new discharge summary template will include feedback and requests from key community partners. • OUH discharge summaries will be from the Multi-disciplinary Team, not just the medical team. (Q3-4) • There will be a decrease by 25% in negative feedback from community partners regarding discharge information. • All Inpatient Directorates will achieve the national average score of 7.9 with 75% exceeding the Trust average for the previous

What we will do.	How will you know the objective is completed and that it is working?
	year (8.6) for “Before you left hospital, were you given any information about what you should or should not do after leaving hospital? This includes any verbal, written, or online information” in the National Inpatient survey.
Objective 5 Timeliness of Discharge (Q2-4) Nurse, Midwife, Therapies and Allied Health Care Professionals (AHPs) led discharge opportunities • Q1-2: Set up a scoping session to identify what is required and who can discharge patients. • Q3-4: Once established, produce a Standard Operating Procedure (SOP) for nurse-led discharges. • Develop and implement a criterion-led discharge process for Nurses, Midwives and AHPs. • Train relevant nurses, midwives and AHP staff on the criterion-led discharge process. Reduce average length of stay and improve patient flow in the morning*. • Develop and implement a process to prioritise and facilitate discharges before midday. • Embed discharge prioritisation guidance. • Explore the requirement for an electronic dashboard.	(Q3-4) • Training completion for all staff participating in criterion-led discharge criteria. • Compliance reports showing adherence to the criterion-led discharge process. • Reduction in average length of stay by at least 6 hours once criterion-led discharges implemented for areas where this is embedded. • 25% of discharges are by midday on inpatient areas on the JR site. • Positive feedback from patients and families regarding the discharge process. • 20% Reduction in discharge-related complaints. • All communications and media about the new discharge protocol have been disseminated.

What we will do.	How will you know the objective is completed and that it is working?
<i>* Note that this <u>excludes</u> Outpatients, Day Surgery Units, Short Stay areas (average <24 hours, e.g. Maternity, Orthopaedic Short Stay Unit), Assessment areas</i>	• Data support adherence to 25% of ward discharge by midday. • Positive feedback from patients and families regarding the discharge process, through PALS and Friends and Family Test. • Adapt discharge documentation process in EPR to support criteria led discharge. Integration of the guidelines into the electronic patient record (EPR) system.

Quality Priority 6: Ambient Voice Technology (AVT)

Why is this a priority?

AVT is a smart system that listens to the conversation between a patient and their clinician and turns it into accurate notes and letters automatically. Instead of writing everything down by hand, the technology does the hard work in the background, so the healthcare professional can give patients their full attention. This technology relies on Artificial Intelligence (AI) to capture consultation notes and turn them into letters, referrals and other documents for the clinician to check.

To evaluate its impact on workflow efficiency and patient experience, we launched an AVT pilot in July 2025 across multiple departments. Clinicians reported saving time on writing notes and some additional benefits such as a faster turnaround of clinic letters, and patients reported a positive experience during the consultations. These positive results have led to a decision to purchase the technology.

Local pilots have shown a positive impact on staff, including

- Reduced burnout and improved work-life balance.
- Patients report getting more eye contact and attention from their clinicians.
- Better quality documentation,
- Less out-of-hours working for staff,
- Reduced admin burden

Table 31 AVT QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
Objective 1 (Q1-3): Complete procurement, governance, and mobilisation	(Q1-3) • Procurement completed and contract signed. • DPIA, safety case and DTAC documentation approved.

What we will do	How will you know the objective is completed and that it is working?
- Finalise AVT procurement and award contract. - Complete Data Protection Impact Assessments (DPIA), Clinical Safety Case, Digital Technology Assessment Criteria (DTAC) and cybersecurity assurance. - Confirm Divisional Points of Contact and establish Implementation Group. - Develop standardised templates, workflows, and training materials.	- Divisional POCs in place; Implementation Group active. - Training materials and templates ratified by governance.
Objective 2 (Q1-2) Phased rollout Onboarding of priority areas - Identify, train and onboard priority areas. - Implement AVT in standardised “stand-alone” mode. - Activate Trustwide comms and engagement plan. - Monitor early safety, user experience and accuracy metrics.	(Q1-2) ≥5 priority services onboarded. ≥80% of trained clinicians routinely using AVT within one month. - Monthly early phase benefits reports produced. - No unresolved high severity safety/IG issues.
Objective 3 (Q 1-4) Evaluate benefits and embed AVT into business as usual (BAU) - Produce Trustwide evaluation across clinical, operational and staff experience domains. - Confirm long-term ownership and BAU support model. - Agree ongoing training and optimisation plan.	(Q 1-4) - Evaluation completed and submitted to CGC. - Demonstrated improvements in documentation, turnaround time, administrative time, staff wellbeing and patient experience. - AVT embedded as BAU with clear governance and reporting structure.

What we will do	How will you know the objective is completed and that it is working?
Develop recommendations for integration and licence scaling.	

Patient Experience

Quality Priority 7: Advance Care Planning (ACP) and End of Life Care (EoLC)

Why is this a priority?

End of Life care (EOLC) focuses on recognising when a patient is approaching the last year, months, or days of life and ensuring care aligns with their goals, values and best interests. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a structured process and document that records personalised clinical recommendations. It summarises key information about a person's health and uses this to guide decisions about treatment escalation, resuscitation and priorities for comfort or intervention

This Quality Priority will focus on education for staff to better recognise patients who are at risk of dying, and to support them with high quality advance care plans using ReSPECT. Education strategies will support better End of Life care and communication.

Table 32 Advance Care Planning (ACP) and End of Life Care (EoLC) QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
Objective 1 e.g. (Q1-4) Improve recognition of inpatients who are at risk of deterioration and dying. - Enlist End of Life care link nurses in all inpatient areas. Q1-4: - Introduce tiered and role-specific EoLC training.	(Q1-4) - Recruitment and engagement of EoLC link nurses. - There are mandated role-specific e-Learning modules.

What we will do	How will you know the objective is completed and that it is working?
• Offer educational resources and teaching sessions (that focus on recognition of dying, conversations about hydration, recording ethnicity, using translating services and discharging a dying patient from hospital) to all inpatient areas. • Use complaints and feedback on discharges and translation services to identify and address further opportunities for improvement. Present quarterly data at Mortality Review Group meeting. Q1-2: • Encourage and increase use of the <i>Care of the Dying Patient Prompt</i> in EPR, which highlights the key parameters: recognise dying, communicate about dying, manage discussions about hydration, chaplaincy and use a translator; manage symptoms at EoLC and stop all unnecessary tests, treatment and medications.	• At least 50% of patient-facing staff working in inpatient areas will have completed training by the end of Q4. • Aim for all inpatient areas to be offered palliative and End of Life care education, aiming for 50% uptake by end of Q4. • Reduce the number of complaints related to discharges and translation services at the End of Life (by 10%). • Audit recognition of dying before and after establishing use of the prompt in specialities where number of deaths are high – i.e. Adult General Medicine (AGM). Target: 50% of AGM ward doctors are confident in recognising and managing dying patients following training on this and using the prompt.
Objective 2 (Q1-4):	

What we will do	How will you know the objective is completed and that it is working?
All patients should have personalised care and support planning (PCSP) conversations that are documented in ReSPECT and advance care planning (ACP) PowerNotes. • Undertake audit to assess how well all sections of ReSPECT document are completed. • Undertake audit to assess the patient's and/or their significant other's experience of a ReSPECT conversation • Undertake audit to evaluate the clinician's perspective in undertaking ReSPECT conversations and recommendations. Review incidents in Ulysess relating to identified search terms and identify trends and produce safety messages to summarise key learning from clinical events.	(Q1 - 4) • ReSPECT mandatory audit is created in Assurance Hub, adult inpatient ward managers or appointed deputy will complete 2 ReSPECT audits monthly. Each audit has three elements. In the first element of the audit, wards will provide evidence on how well the ReSPECT form is completed • The second element, wards will provide evidence of the patient's experience. • The third element, wards will provide evidence of the clinician's experience of the ReSPECT process. All three elements will be collated and presented as an annual report presented at clinical improvement committee. • Incidents and complaints regarding conversations will be collated to establish a baseline of numbers of incidents and patient complaints associated with ReSPECT. • Safety messages sent periodically to OUH clinicians

What we will do	How will you know the objective is completed and that it is working?
Produce learning materials based on learning from practice and locate on Resuscitation/ACP-ReSPECT Sharepoint page.	Education materials located on Resuscitation/ACP-ReSPECT Sharepoint page.
Objective 3: (Q1-4) Make ReSPECT and related ACP documents easier to understand and access, for clinicians, patients and those close to them. - Develop resources for patients and families explaining the importance of these conversations. Work with the patient experience group to develop an OUH information leaflet on ReSPECT and ACP. - Work with informatics to rationalise place of documenting ACP on EPR, aiming to collate all related documentation in one place on EPR. - Work with informatics to rationalise place of documenting LPA on EPR, aiming to collate all related documentation in one place on EPR.	(Q1-4) - Results of patient and family feedback on ReSPECT and related conversations. - A OUH patient information leaflet. - Develop a 'help' guide to locate ACP documents on EPR. - Evidence that the EPR have created a shared folder on EPR. - Develop a 'help' guide to locate LPA documents on EPR. - Evidence that the EPR have created a shared folder on EPR.
Objective 4 Q1-4	

What we will do	How will you know the objective is completed and that it is working?
Work in partnership with Integrated Care Board and other local providers to improve sharing of ReSPECT across organisations and with patients. • Develop an options appraisal for integration of OUH and ICB digital ReSPECT forms. • Work with partners towards implementation of a single shared digital ReSPECT document (that is readable and editable and can be accessed across partner organisations including out of hours and emergency services).	• OUH options appraisal developed and presented to Clinical Governance Committee and Digital Clinical Advisory Group. • Formation of OUH ReSPECT Graphnet scoping group. • Regular engagement with ICB ReSPECT stakeholder group to move the project forward.

Quality Priority 8: Public and Patient Participation Framework

Why is this a Priority?

A robust Patient and Public Participation Framework is essential to ensure that OUH consistently listens to, involves and works in partnership with the people it serves. It will provide a clear Trustwide approach for embedding lived experience into decision-making, improving the quality, safety and responsiveness of care. By setting out agreed principles, expectations and practical tools, the Framework will help OUH meet national requirements for working with people and communities and support efforts to reduce health inequalities. It will help to ensure that all voices are heard, engagement is meaningful rather than tokenistic, and services are shaped in ways that reflect the diverse needs of patients, families, carers and communities.

Table 33 Public and Patient Participation Framework QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
Objective 1 (Q1-4) Collaboratively develop and publish a set of clearly defined roles, responsibilities and expectations for Patient Safety Partners (PSPs) and Patient Participation Groups (PPGs), including their contribution to governance, quality improvement, policy development and service redesign. Q1: Establish a small group of PSPs, PPG members and staff to determine principles and collaborate on development of policy and toolkit. These should cover recruitment, onboarding,	(Q1-4) - Policy, tools and resources are developed and published. - Increased evidence of governance, quality improvement, policy development and service redesign involving PSPs and PPGs: - At least one PSP member on key governance committees, including CGC, CIC, PSEC, Policy Committee, Patient Experience and Engagement Committee (PEEC) and Divisional CGCs. - A pathway for PPGs to escalate issues to governance committees.

What we will do	How will you know the objective is completed and that it is working?
induction, mentorship, supervision, remuneration and impact evaluation. • Q1-3: Develop a policy and toolkit. • Q3-4: Implement the policy and toolkit.	• Stakeholder evaluation (PSP, PPG, staff) demonstrates positive experience and impact on outcomes.
Objective 2 (Q1-2) Develop and deliver an annual Patient Census to capture demographic, cultural, linguistic, accessibility, social and spiritual characteristics of OUH patients and service users. • Q1: Develop and pilot the Census instrument. • Q2: Administer the Census and present findings to PEEC and consider engagement of community partners to optimise reach.	(Q1-2) • Instrument developed and piloted. • Demographic, cultural, linguistic, accessibility, social and spiritual characteristics of OUH patients and service users captured and presented. • Community partners reflect diversity of patient population.
Objective 3 (Q1-3) Establish a comprehensive and regularly updated network of community groups, charities and Voluntary Community and Social Enterprise organisations (Trusted Partners) that reflect the diversity of OUH's patient populations. • Q1-3: Establish database and accessible, culturally safe methods of sharing information with at least 10 priority organisations. • Q3: Capture learnings and insights in central repository to inform equality, diversion and inclusion improvement initiatives.	(Q1-3) • Database and communication methods available • Evidence of improvements using lived experience voices from diverse populations available.

What we will do	How will you know the objective is completed and that it is working?
Objective 4 (Q3-4) Introduce a structured approach for evaluating the impact of PSP, PPG and Trusted Partner involvement on quality improvement, governance, policy development and service redesign to improve patient experience. • Q3: Develop and implement an evaluation tool for measuring the impact of patient and public participation. • Q4: Implement reporting of patient and public participation including impact evaluation through the PEEC.	(Q3-4) • Evaluation tool available. • Reporting implemented and continuous learning evident.

Quality Priority 9: Maternity Patient Experience

Why is it a Priority?

Recent national interest and scrutiny has rightly put an even greater emphasis on the importance of improving maternity service user experience, underscoring the need for transparent, responsive and inclusive approaches that truly reflect the voices of those users by actively engaging with feedback and learning from both local and national findings.

This Quality Priority highlights the value of a service user centred approach with healthcare professionals dedicating time to listen to and understand the perspectives of mothers and families. By actively incorporating feedback and respecting personal choices, we aim to support staff consistently to deliver care that is both respectful and empowering. The initiative encourages ongoing dialogue, shared decision making and partnership, fostering trust and confidence throughout the maternity journey. In turn, this ensures that care remains safe, compassionate and tailored to individual needs while helping staff feel valued and empowered to deliver the highest standards.

Table 34 Maternity Patient Experience QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
Objective 1 (Q1-4) Strengthen mechanisms for listening to service users • Increase promotion and accessibility of feedback routes (FFT, surveys, digital platforms, focus groups). • Introduce targeted postnatal listening events and listening clinics, particularly for women with complex or adverse experiences.	(Q1-4) • Increase volume and diversity of feedback received across all maternity pathways by 10%. • Evidence of an increase of feedback (by at least 5%) from underrepresented groups • Increase service user satisfaction scores (e.g. FFT, CQC survey) by 10% including among service users with protected characteristics.

What we will do	How will you know the objective is completed and that it is working?
• Work closely with the community partners including the Oxfordshire Maternity Neonatal Voices Partnership (OMNVP) to co-design engagement activity. • Reinforce personalised care planning and shared decision-making across antenatal, intrapartum and postnatal care.	• Increase by 10% the proportion of service users (compared to the number of deliveries/month) reporting feeling involved in decision-making, with increases among all demographic groups. • Reduce number and themes of complaints related to communication, discrimination, or cultural insensitivity by 10%. • We should see an increase in the proportion of appointments with interpreter support provided when requested. This will be monitored through existing systems.
Objective 2 (Q1-4) Ensure feedback leads to visible action (“You said, we did”) • Implement a clear feedback-to-action process with defined timescales. • Share learning and improvements with service users via newsletters, posters, social media and the Trust website. • Align local learning with national findings from CQC survey.	(Q1-4) • “You said, we did” communications published monthly. • Audit of the rapid responder role-service demonstrates that users report increased confidence that their feedback is heard and acted upon. • Evidence of changes made directly in response to feedback. • Comments from social media and Trust web sites are reviewed and appropriately responded to. • OMNVP will highlight any feedback from other media sources. • Completed CQC survey action plan.

What we will do	How will you know the objective is completed and that it is working?
Objective 3(Q1-4) Support and develop staff to deliver excellent patient experience • Provide training and reflective learning sessions focused on communication, compassion, cultural humility and trauma-informed care. • Use learning from complaints, incidents and national reviews to support improvement rather than blame. • Celebrate good practice and staff contributions to positive experiences.	(Q1-4) • >95% of all staff completing Active Bystander and Equality Diversity Inclusion (EDI) training. • Staff Survey results demonstrate improvement in inclusion, respect, and confidence in addressing bias. • Improved diversity of maternity workforce compared to local population demographics. • Reduced number of staff-reported incidents related to discrimination or bias, and resolution rates. • Increased examples of positive feedback naming staff and teams (through FFT). • Increase in Daisy awards- staff recognition rewards including nominations.
Objective 4 (Q1-4) Strengthen openness, transparency and learning culture • Share outcomes of CQC inspection findings and national investigations openly with staff and service users. • Regularly review patient experience data at local and Directorate governance meetings.	(Q1-4) • Clear evidence of patient experience discussed at maternity governance forums and Triangulation and learning committee (TALC). • Completed CQC inspection action plans.

What we will do	How will you know the objective is completed and that it is working?
• Ensure learning is embedded into practice and monitored.	• Number of improvement actions arising from TALC including specific themes around triage and induction of labour. • Dashboard demonstrates sustained improvement trends over the year. • Feedback forms from staff to confirm they have been made aware of learning and improvements.

Annexe 2: Statements from the Integrated Care Board, Local Health watch organisations, NHSE, Council of Governors Health, Overview and Scrutiny Committee (HOSC)

Council of Governors Statement

Statement from NHS England Specialised Commissioning

Statement from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)

Statement from Health and Wellbeing Board

Statement from Healthwatch Oxfordshire

Response to Healthwatch Oxfordshire

Statement from Health, Overview and Scrutiny Committee (HOSC)

Annexe 3: Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves of the following.

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance provided on. www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements
- The content of the Quality Account is consistent with internal and external sources of information.
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account are robust and reliable, conform to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

NB: sign and date in any colour ink except black



Simon Crowther
Acting Chief Executive Officer



Sarah Hordern,
Acting Chair

Annexe 4: Glossary Medical, Clinical and Technical Terms

This glossary provides explanations of medical, clinical, and technical terms used within this Quality Account. It is intended to support accessibility for all readers, including governors, patients, and members of the public.

Table 35 Glossary of medical, clinical and technical terms

Term	Definition
A	
Advance Care Planning (ACP)	A structured process in which patients, often together with healthcare professionals and family members, discuss and record their wishes, values, and preferences for future care and treatment. This is particularly important for patients with long-term conditions or those approaching the End of Life
Adverse Drug Event (ADE)	An injury or harm resulting from the use of medication.
After Action Review (AAR)	A structured reflective process undertaken after an incident or event. It helps teams understand what happened, why it happened, and what can be learned to improve future care and safety
Allied Health Professional (AHP)	A healthcare professional who is not a doctor, nurse, or dentist but plays a key role in patient care. Examples include physiotherapists, occupational therapists, radiographers, and speech and language therapists
Ambulatory Care	Medical care provided on a same-day basis without hospital admission
Antimicrobial Resistance	The ability of microorganisms to resist treatment with antibiotics, making infections harder to treat.
Antimicrobial Stewardship (AMS)	A coordinated approach to promoting the appropriate use of antibiotics and other antimicrobial medicines. Its aim is to improve patient outcomes while reducing the risk of antimicrobial resistance.

Artificial Intelligence (AI)	Technology that enables systems to perform tasks that typically require human intelligence, such as analysing data or generating clinical documentation.
B	
Bacteraemia	The presence of bacteria in the bloodstream. This can lead to serious infections such as sepsis and requires prompt treatment.
Best Practice Tariff (BPT)	A national NHS financial incentive used to encourage high-quality care by rewarding healthcare providers for meeting evidence-based clinical standards.
C	
Care Quality Commission (CQC)	The independent regulator of health and social care services in England. The CQC assesses and rates organisations to ensure services are safe, effective, caring, responsive, and well-led
Case Ascertainment	The proportion of eligible patients included in an audit or dataset.
Clinical Informatics	The use of data, information systems, and digital tools to improve patient care, safety, and service delivery.
Clinical Pathway	A structured, multidisciplinary plan of care designed to support the diagnosis and treatment of specific conditions.
Clinical Trial	A research study involving patients to evaluate new treatments or interventions.
Cohorting (Patients)	Grouping patients with similar conditions together in a specific clinical area to improve care and efficiency.
Critical Care Outreach (CCO)	A specialist clinical service that supports patients who are deteriorating on wards and provides follow-up care for patients discharged from intensive care units
D	
Dashboard (Clinical/Operational Dashboard)	A visual display of key metrics and performance indicators used to support decision-making.

Deep Brain Stimulation (DBS)	A neurosurgical treatment that involves implanting a device to deliver electrical signals to specific areas of the brain to treat certain neurological conditions.
Deep Vein Thrombosis (DVT)	A condition where a blood clot forms in a deep vein, usually in the leg. It can be serious if the clot travels to the lungs (pulmonary embolism).
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	A clinical decision indicating that cardiopulmonary resuscitation (CPR) should not be attempted if a patient's heart or breathing stops.
E	
Electronic Patient Record (EPR)	A digital record containing a patient's medical history, treatment, and care information. It enables healthcare professionals to access and share information more efficiently.
Electrocardiogram (ECG)	A diagnostic test that records the electrical activity of the heart to help detect abnormalities.
End of Life Care (EoLC)	Care provided to patients in the final phase of life, focusing on comfort, dignity, and quality of life, rather than cure.
F	
Friends and Family Test (FFT)	A national feedback tool used across the NHS, asking patients whether they would recommend the services they received to others.
G	
Getting It Right First Time (GIRFT)	A national NHS improvement programme focused on reducing variation in care, improving outcomes, and sharing best practice across organisations.
H	
High Intensity Focused Ultrasound (HIFU)	A non-invasive treatment that uses focused ultrasound waves to heat and destroy targeted tissue, such as tumours, without surgery.

Hospital-Acquired Infection (HAI)	An infection developed as a result of care in a hospital or healthcare setting
Hospital Episode Statistics (HES).	Hospital Episode Statistics (HES): NHS data on hospital activity (admissions, outpatient and A&E), used to monitor services and support improvement
I	
Integrated Care Board (ICB)	An NHS organisation responsible for planning, funding, and overseeing healthcare services within a defined geographical area.
Intensive Care Unit (ICU)	A highly specialised hospital unit that provides intensive monitoring and treatment for critically ill patients.
K	
Key Performance Indicator (KPI)	A measurable value used to assess how effectively a service, team, or organisation is achieving its objectives.
L	
Learn from Patient Safety Events (LFPSE)	A national NHS system used to record, analyse, and learn from patient safety incidents.
Learning Multidisciplinary Team Review (LMDTR)	A structured review process involving multiple clinical disciplines to assess patient safety incidents and identify system-wide learning.
Length of Stay (LOS)	The duration of a patient's hospital admission.
M	
Magnetic Resonance Imaging (MRI)	A scanning technique that uses magnetic fields and radio waves to produce detailed images of the body.
Medication Discrepancy	A difference between a patient's prescribed medications and what they are actually taking or should be taking
Mental Capacity Assessment (MCA)	An assessment used to determine whether a patient has the ability to make a specific decision about their care or treatment.

Multidisciplinary Team (MDT)	A group of healthcare professionals from different disciplines who work together to plan and deliver patient care.
Malnutrition Universal Screening Tool (MUST)	A validated screening tool used to identify patients who are malnourished or at risk of malnutrition.
N	
National Early Warning Score 2 (NEWS2)	A standardised scoring system used across the NHS to identify early signs of a patient deteriorating, based on observations such as heart rate, oxygen levels, and blood pressure.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	A national programme that reviews patient care to identify areas for improvement and enhance clinical outcomes.
O	
Options Appraisal	A structured process used to evaluate different solutions or approaches before making a decision, often for digital or service changes
P	
Palliative Care	Specialist care focused on relieving symptoms and improving quality of life for patients with serious illness.
Patient Safety Incident Investigation (PSII)	A structured investigation carried out under the Patient Safety Incident Response Framework to understand incidents and identify improvements.
Patient Safety Incident Response Framework (PSIRF)	A national NHS framework guiding how organisations respond to and learn from patient safety incidents. It focuses on systems-based learning rather than individual blame.
Patient Safety Partner (PSP)	A patient, carer, or member of the public who works with healthcare organisations to improve patient safety by contributing to governance and learning processes
Plan–Do–Study–Act (PDSA)	A quality improvement method used to test changes in practice, evaluate their impact, and refine improvements.

Q	
Quality Improvement (QI)	A systematic and continuous approach to improving healthcare services, patient outcomes, and experiences.
R	
Radiotherapy	A treatment that uses high-energy radiation to kill cancer cells.
Rapid Review	A short, initial review of a patient safety incident to determine whether further investigation is required.
Readmission	When a patient is admitted to hospital again within a defined period after discharge.
Recognising the Acutely Ill and Deteriorating Patient (RAID)	A clinical approach and policy framework focused on identifying and responding promptly to patients whose condition is worsening.
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)	A personalised care plan that records a patient's wishes and clinical recommendations for emergency care when they may not be able to communicate their preferences.
Rota (Clinical Rota)	A schedule showing staff shifts and working patterns.
S	
Safety Learning and Improvement Committee (SLIC)	The Trust's governance forum where patient safety issues, investigations, and learning are reviewed at organisational level which included patient safety partners and Trust staff.
Serious Incident Framework (Superseded)	The previous national NHS framework for investigating serious patient safety incidents, now replaced by the Patient Safety Incident Response Framework (PSIRF).
Standard Operating Procedure (SOP)	A formal written document providing step-by-step instructions on how to carry out a specific clinical or operational task.
Summary Hospital-level Mortality Indicator (SHMI)	A national measure that compares the number of deaths in a hospital with the number expected, based on patient characteristics.

System for Electronic Notification and Documentation (SEND)	An electronic system used to record patient observations and support early identification of deterioration.
T	
Thematic Patient Safety Incident Investigation (Thematic PSII)	A type of investigation that examines patterns or recurring themes across multiple incidents to identify system-wide improvements.
Thromboprophylaxis	Medication or treatment used to prevent blood clots.
To Take Out (TTO) Medicines	Medications provided to patients when they are discharged from hospital to take home.
Transcatheter Aortic Valve Implantation (TAVI)	A minimally invasive procedure used to replace a narrowed or damaged heart valve.
Treatment Escalation Plan (TEP)	A clinical plan outlining the level of treatment appropriate for a patient if their condition deteriorates.
V	
Venous Thromboembolism (VTE)	A condition involving blood clots, including deep vein thrombosis (DVT) and pulmonary embolism.
W	
Whole Time Equivalent (WTE)	A measure of staffing levels that represents the number of full-time staff required.
Work in Confidence (WiC)	A secure, anonymous platform that allows staff to raise concerns safely as part of the Trust's Freedom to Speak Up arrangements

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Oxfordshire Health Overview and Scrutiny Committee

Date of Meeting: 11 June 2026	Agenda item:

Title of Paper: NHS Dental services in Oxfordshire

Paper is for: (Please ✓)	Discussion	✕	Decision		Information	

Executive Summary

This paper provides an update of dentistry services across Buckinghamshire, Oxfordshire and Berkshire West following the item previously presented to Oxfordshire HOSC in April 2024.

It provides

- 1) an update on recommendations from HOSC April 2024 – Appendix 2
- 2) an update on dental access including delivery across Oxfordshire (p7)
- 3) data on an improvement in urgent dental access (p 11), and increase in the population seen by a dentist (p5)
- 4) an update on the ICBs commissioning initiatives and how these have reached groups of greatest need (p9)
- 5) information about our children's oral health programme (p13)
- 6) the Golden hello campaign to incentivise recruitment (p14)
- 7) our plans to implement the new dental contract during 26/27

Action Required

Oxfordshire HOSC is asked to note the update and progress made to improve access to dental services

Author: Julie Dandridge, Associate Director – Primary Care

Date of Paper: 27 May 2026

NHS Dental services in Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB

Report to:

Oxfordshire Health Overview and Scrutiny Committee

Hugh O’Keeffe, Head of Pharmacy, Optometry and Dental Services

Julie Dandridge, Associate Director – Primary Care

May 2026

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1. Introduction

1.1 Commissioning arrangements

In 2022, the 6 ICBs in NHS England South-East took on delegated responsibility for Dentistry, alongside Pharmacy and Optometry. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board Integrated Care Board (ICB) was one of these ICBs. The ICBs have an explicit purpose to improve health outcomes for their whole population, and the delegation allows the ICB to integrate services to enable decisions to be taken as close as possible to their residents. The ICB is working to ensure their residents can experience joined up care, with an increased focus on prevention, addressing inequalities and achieve better access to dental care and advice.

As part of its 10-year plan for the NHS ('Fit for the Future'), published in July 2025 the government advised of a new operating model for the NHS. This includes making the ICBs strategic commissioners of local healthcare services. The number of ICBs in the South-East was reduced to 4 on 1st April 2026. The Buckinghamshire, Oxfordshire, Berkshire West ICBs joined with the East Berkshire area of Frimley ICB to create the Thames Valley ICB.

Clinical engagement is currently achieved via a Local Dental Network (LDN) covering the Thames Valley area (Buckinghamshire, Oxfordshire, Berkshire West and East Berkshire). This is a clinically led group involving Dentists, Dental Public Consultants, representatives from NHS England, the Local Dental Committees and commissioners. Reporting to the LDN are specialist led Managed Clinical Networks for Oral Surgery, Orthodontics, Restorative Dentistry and Special Care and Paediatrics. At the end of 2025, the ICB established a new MCN; the Children's Oral Health Improvement MCN to oversee the Children's Oral Health Improvement pilot project running until 31st March 2027.

This report will focus on the delivery of NHS services in BOB ICB over the last year, also taking account of the impact of organisational change on commissioning dental services in the Thames Valley area.

1.2 NHS Dental services

Patients are not registered with a dentist in the same way as they are with a GP. A dental practice is only responsible for a patient's care while in treatment, although many will maintain a list of regular patients so may only have the capacity to take on new patients when patients do not return for scheduled check-ups or advise they are moving away from the area.

Dental practices deliver services via cash limited contracts with the NHS through which they are required to deliver agreed levels of activity each year ('Units of Dental Activity' – UDAs).

The challenges facing NHS Dental services have been similar across the country with changes made to the national contract in 2022 and 2024 to try to address these challenges. This has included actions, such as:

- Incentivising practices to take on new patients through the new patient premium (2024-25).
- Increasing the amount the NHS could pay practices for contract delivery, allowing for payment for up to 110% performance rather than 102%.
- Improving information for patients.
- Increasing the minimum Unit of Dental Activity (UDA) price from £23 (in 2022) and then £28 (2024).
- Increased payments for more complex Band 2 treatments.
- Personalised patient recall intervals.
- 'Golden Hellos' to support recruitment in areas facing greater challenges.
- A 'Smile for Life' programme to promote oral health.
- Deployment of mobile vans in identified underserved areas to support access.
- Consultation on expanding water fluoridation, initially in the north-east.
- Workforce changes, such as Dental Care Professionals to work to their full scope of practice.
- Increase training places for new Dentists and Dental Care Professionals.
- Making it easier for practices to recruit overseas Dentists who meet the UK's regularity standards.
- ICBs were given powers to recurrently rebase financial allocations to practices if they persistently underperformed in delivering their contracted levels of activity. Previously, monies could only be recovered on a non-recurrent basis. This is due to take effect from 2026-27.

The most significant changes to the NHS contract since 2006 are being implemented from April 2026. The key features of the changes under the 'NHS dentistry: quality and payment reforms contractual guidance' are described in Appendix 1 .

The increased payments for urgent and non-urgent dental care have replaced the national and local schemes designed to support delivery of the national goal to increase urgent appointments by 700,000 in 2025-26. The additional 700,000 urgent appointments goal has been broadened to all appointments. The guidance that underpins access to urgent and non-urgent appointments is unchanged from 2025-26

<https://www.england.nhs.uk/long-read/clinical-guidance-unscheduled-urgent-and-non-urgent-dental-care/>

Practices have received information about the minimum number of appointments they are required to deliver in 2026-27. If practices fall short of their minimum number of urgent appointments, financial recoveries will be made.

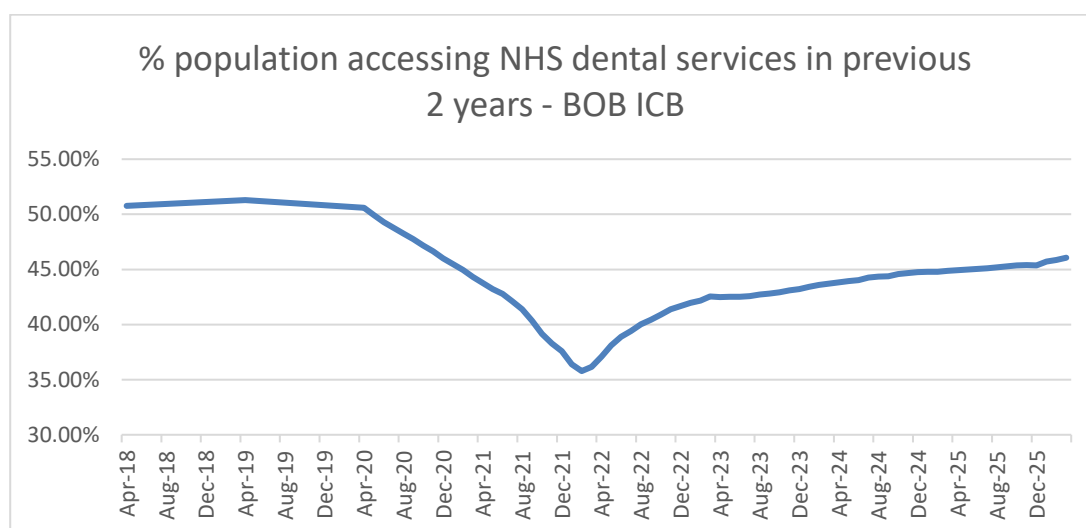
The expectation nationally is that these changes will increase the level of activity delivered by about 10% per annum. This means that some practices are likely to overperform on their commissioned levels of activity. The ICB has therefore written to practices to advise that performance reviews will be carried at the end of quarters 1 and 2 to assess whether increase need to be made to contract values. The ICB has also advised that it will enact its powers to recurrently rebase financial allocations during 2026-27 if practices have persistently underperformed in delivering their contracted levels of activity.

2. Access to NHS dental services

Access to primary care dental services is measured based on the number of unique patients attending over a 2 year period. The introduction of the current dental contract in 2006 was accompanied by a programme of ringfenced financial investment under the Dental Access Programme designed to recover NHS dental access which had fallen significantly following the introduction of the 1992 contract. Access to NHS Dentistry in the Thames Valley (BOB plus East Berkshire) increased from about 43% of the population in 2008 to just over 51% in 2019 (an increase of about 250,000 people; 25%).

The impact of the pandemic was such that by early 2022, the number of patients attending BOB ICB dental practices in the previous 2 years fell to below 36%. Since then, there has been a recovery in access. In March 2026, 46.05% of the BOB ICB resident population had attended an NHS dental practice in the previous 2 years (793,565 people, an increase of 176,957 compared to February 2022).

Chart 1 Access to NHS Dental services in BOB 2018 – 2026

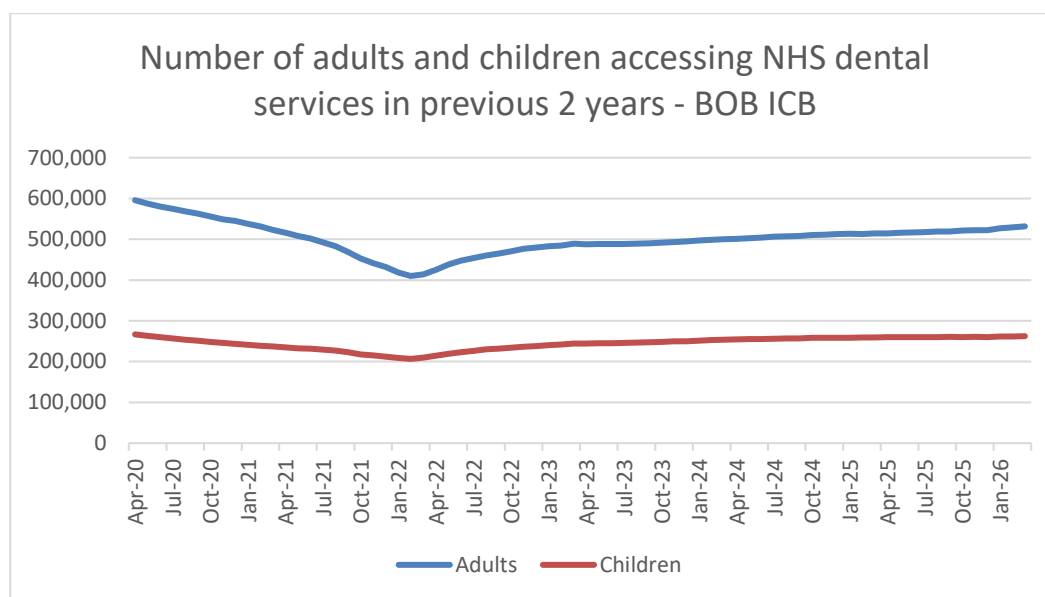


The rate of increased access has been similar for adults and children. The table and chart below detail the numbers of adults and children in BOB accessing NHS dental services in this period:

Table 1 Number of people accessing NHS Dental services in BOB February 2022 and August 2025

Patient group	Number attending Feb '22	Number attending Aug '25	Increase	% increase
Adults	409,943	531,293	121,350	29.60%
Children	206,665	262,272	55,607	26.91%
Total	616,608	793,565	176,957	28.70%

Chart 2 Number of adults and children accessing NHS Dental services 2020 - 2026



However, the number of unique patients attending is still some way below the pre-pandemic figure of 51.29%.

As capacity has been increased practices have been able to deliver more of their contracted activity. Practices are required to deliver an agreed number of Units of Dental Activity (UDAs) each year. The UDA payment bands relate to the patient treatment bands under the NHS Patient Charges Regulations 2005.

<https://www.nhs.uk/nhs-services/dentists/dental-costs/how-much-will-i-pay-for-nhs-dental-treatment/>

3. Contract Delivery

NHS Dental practices are independent contractors and are paid to deliver an agreed level of activity each year. These levels are based on levels of activity commissioned at the point the current dental contract took effect in 2006 and any additional activity commissioned since then.

Practices are contractually required to deliver a minimum of 96% of contracted activity each year to avoid financial recoveries. If they fall below this threshold financial recoveries will be made. Prior to the pandemic the average annual delivery in the BOB area was about 94%. This fell to 28% in 2020-21 and has been increasing since then, recovering to 85.8% in 2023-24. The table below details contract delivery in 2024-25 and 2025-26.

Table 2 BOB ICB contract delivery 2024-25 and 2025-26*

Area	Number of practices 24-25	UDAs commissioned 24-25	UDAs delivered 24-25	% delivery 24-25	Number of practices 25-26	UDAs commissioned 25-26	UDAs delivered 25-26	% delivery 25-26
Bucks Central	10	144,154	129,974.60	90.16%	11	141,063	131,048.20	92.46%
Bucks East	14	80,810	77,233	95.57%	14	85,780	76,779.20	89.51%
Bucks North	4	48,246	36,753.8	76.18%	4	47,986	43,165.00	89.95%
Bucks South	16	119,172	110,237	92.50%	16	119,172	103,961.00	85.82%
Bucks West	22	199,295	189,664.60	95.17%	22	197,695	185,081.80	92.98%
Buckinghamshire	66	591,677	543,863	91.92%	67	591,696	540,035.20	90.66%
Cherwell	14	215,668	155,943.60	72.31%	15	215,256	170,951.20	79.57%
Oxford	19	256,790	246,608.20	96.03%	19	256,216	251,041.80	97.95%
South Oxon	19	149,380	141,853.20	94.96%	19	147,859	133,681.80	89.55%
Vale of the White Horse	11	95,930	80,026.80	83.42%	12	103,918	85,856.00	82.52%
West Oxon	15	114,285	100,588.20	88.02%	15	109,102	97,374.40	89.03%
Oxfordshire	78	832,053	725,020	87.14%	80	831,351	738,905.20	88.62%
Reading	16	202,846	200,366.80	98.78%	16	237,245	214,764.40	90.25%
West Berkshire	19	199,519	169,928.20	85.17%	19	179,165	153,611.20	85.41%
Wokingham	12	163,272	159,940.20	97.96%	12	178,070	171,958.20	95.53%
Berkshire West	47	565,637	530,235.20	93.74%	47	594,480	540,333.80	90.67%
Total	191	1,989,367	1,799,118.20	90.44%	194	2,017,707	1,829,274.20	90.17%

*Final figures for 2025-26 due in June 2026

During 2025-26 there was a slight increase in the number of UDAs commissioned and when final figures arrive for the year, they will indicate a slight increase in the number of UDAs delivered both as a total and as a % of activity commissioned. By year-end delivery should be about 91%. Prior to the pandemic annual delivery was about 94%.

The localities with the highest percentage delivery in 2025-26 were:

- Oxford 97.95%
- Wokingham 95.53%
- Bucks West 92.98%

4. Actions to address the access challenges

4.1 Replacing lost activity

To address the impact of contract handbacks and reductions, the ICB commissioned temporary UDAs for the period to 31st March 2024. The ICB has also been working to replace UDAs that have been lost due to contract handbacks and reductions. This is being pursued as a two-stage process. The first was to approach local practices to apply to provide additional activity to replace what has been lost in their area. If this fell short of the activity sought, the ICB would go out to procurement to seek new provision into the area.

The first stage of the process was completed, with increases implemented from 1st April 2024. During 2025-26, the ICB commissioned additional activity through the procurement of new practices.

Table 3 Number and locations of approved applications for additional activity

Local Authority	Number of contract handbacks and reductions	Number UDAs handed back since 2021	Additional UDAs commissioned from April 2024 – phase 1	Location(s)
Bucks Central	2	5,527	7,356	Haddenham and Aylesbury
Bucks East	2	3,606	0	
Bucks North	2	611	0	
Bucks South	1	760	117	Chalfont St Peter
Bucks West	1	446	12,082	High Wycombe, Wooburn Green and Loudwater
Buckinghamshire	8	10,930	19,555	
Cherwell	3	22,764	3,995	Bloxham and Banbury
Oxford	3	3,962	7,800	Cowley and Headington
South Oxfordshire	4	4,819	5,608	Thame, Henley and Didcot
Vale of the White Horse	3	31,310	35,993	Abingdon, Milton and Faringdon
West Oxfordshire	7	45,353	41,601	Chipping Norton and Witney
Oxfordshire	20	108,208	94,997	
Reading	3	9,888	13,250	Reading
West Berkshire	0	0	4,800	Newbury and Thatcham

Wokingham	2	13,690	14,047	Woodley, Wokingham and Twyford
Berkshire West	5	23,578	32,097	
BOB	33	142,716	146,649	

Since the pandemic 33 practices have handed back their contracts or reduced their NHS commitment resulting in a reduction of capacity of 142,716 UDAs (6.41%). The commissioning of 146,649 UDAs since April 2024 means that the lost capacity has been fully recovered. In Oxfordshire 4 new practices have opened in:

- Chipping Norton – West Oxfordshire (Bloxdent Smiles) – September 2025
- Milton – Vale of the White Horse (Damira Dental Studios Ltd) – November 2025
- Witney – West Oxfordshire (Haddenham DC Ltd) – February 2026
- Faringdon – Vale of the White Horse (Smile Care Oxford) – April 2026

Further to bidder representations in respect of the ICB contract award decision in Cherwell East, this procurement has not been pursued at this stage. It will be subject to review by the ICB at mid-year 2026-27 as part of the ICB review of the impact of the changes being made to the dental contract.

4.2 Support for patients who have faced challenges accessing services

Between June 2023 and March 2026 the ICB commissioned a Flexible Commissioning service for patients who have faced challenges accessing dental care. If practices wished to take part, they could convert up to an agreed percentage of their contract value from delivery of activity targets to providing access sessions for patients who have struggled to access dental care. The scheme reduces overall capacity, but it allows more time for practices to treat patients with more complex needs.

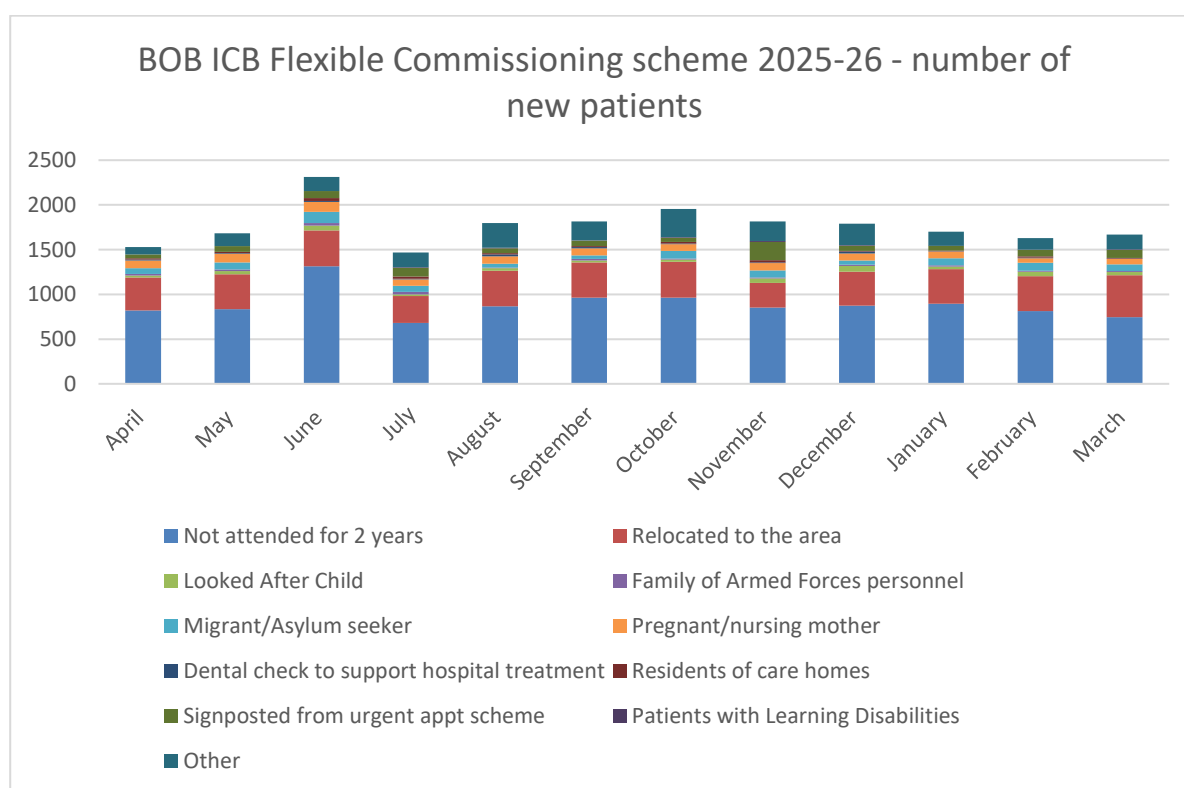
The following patient groups were identified in priority groups for the scheme:

- Those who have not attended the practice in the previous 2 years
- People relocating to the area who cannot access NHS services
- Looked After Children, who are very vulnerable and the responsibility of the local authorities
- Families of armed forces personnel especially due to large influxes of personnel into the area
- Asylum seekers, evacuees and refugees, who have never had dental services in this country and often do not know the language or knowledge of how they access NHS services
- Patients who need dental check ups in support of hospital treatment
- Pregnant and nursing mothers
- Residents of care homes with identified treatment need who are able to attend the dental practice for treatment

- Patients seen under Urgent and Non-Urgent Unscheduled Dental Access Appointments scheme who need and wish to attend for further non-urgent treatment and the practices don't have the capacity to treat the patients via their core contracts (introduced April 2025)
- Patients with Learning Disabilities (introduced July 2025)
- Other groups as identified by the practice

In 2025-26, 40 practices took part in the scheme with 25 from Oxfordshire, 9 from Buckinghamshire and 6 from Berkshire West with over 21,000 patients seen and more than 30,000 attendances.

Chart 3 Patients seen under the Flexible Commissioning scheme 2023 – 25



In 2026-27, the Flexible Commissioning scheme is being replaced by the Dental Access Service for Vulnerable patients. The service will focus on the following patient cohorts:

- Looked After Children, who are very vulnerable and the responsibility of the local authorities
- Families of armed forces personnel especially due to large influxes of personnel into the area
- Asylum seekers, evacuees and refugees, who have never had dental services in this country and often do not know the language or knowledge of how they access NHS services
- Patients who need dental check ups in support of hospital treatment
- Pregnant and nursing mothers

- Residents of care homes with identified treatment need who are able to attend the dental practice for treatment
- Patients with Learning Disabilities (introduced July 2025)
- Homeless patients (introduced April 2026)
- Other groups as identified by the practice

The changes are made due to the impact of the actions taken locally to restore the levels of activity commissioned to pre-pandemic levels and the impact of dental contract reform which requires practices to deliver a minimum number of urgent appointments, introduces complex care pathways for high needs patients and is likely to result in higher levels of contract delivery which means the ICB will need to optimise commissioning capacity.

4.3 Urgent Access

During 2025-26, there was a significant focus on access to urgent dental care with a national target to increase the number of urgent appointments by 700,000 (20%).

In 2024-25 there were 1.034m patient attendances in the BOB area, of which about 95,000 (9.1%) related to urgent treatment. There are services provided on evenings, weekends and bank holidays to treat patients who have an urgent treatment need (usually defined as pain, swelling or bleeding), but this only accounts for about 6% of urgent activity.

The vast majority is provided in dental practices. In its election manifesto in 2024 the government made a commitment to commission an additional 700,000 urgent appointments across the country. This equated to a target of 15,454 additional appointments in BOB, increasing the total number of urgent attendances to 110,457 per annum.

The ICB piloted a scheme for practices to deliver additional urgent appointments, which went live in the BOB in January 2025 with 34 practices taking part. The practices involved have submitted details of the days on which they provide the sessions which has been forwarded to NHS 111 who can direct patients as appropriate.

This continued into 2025-26 with 36 practices providing an additional 2,576 sessions. The table below details where the additional sessions are being provided:

Table 4 Number and locations of Additional Urgent Appointment sessions

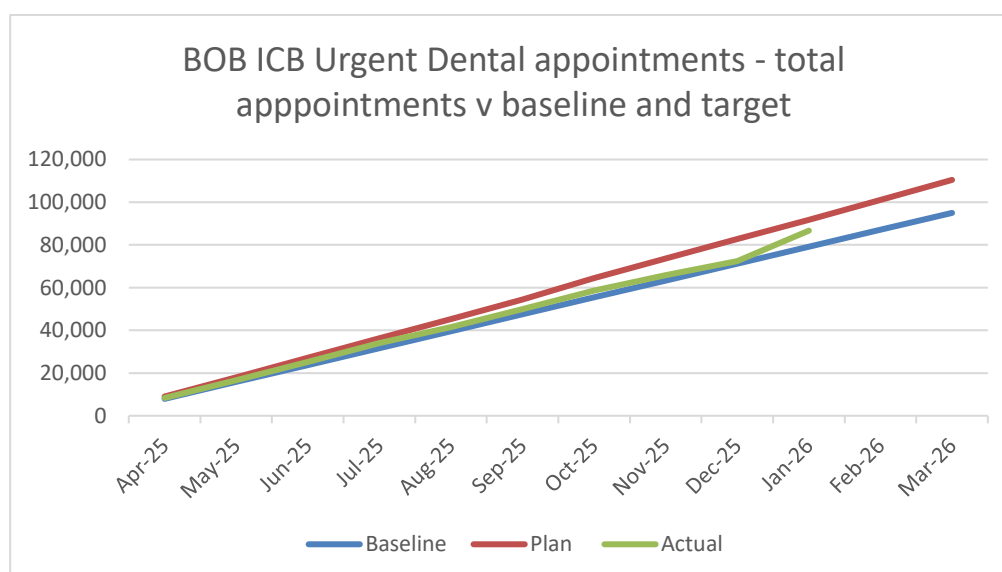
Health system	Number of practices	Number of sessions	Planned number of attendances
Buckinghamshire			
Bucks East	1	10	60
Bucks Central/North	2	321	1,926

Bucks West	5	515	3,090
Total	8	846	5,076
Oxfordshire			
Cherwell	5	239	1,434
Oxford	6	412	2,472
South Oxfordshire	6	221	1,326
Vale of the White Horse/ West Oxfordshire	2	164	984
Total	19	1,036	6,216
Berkshire West			
Reading	4	310	1,860
West Berkshire	3	229	1,374
Wokingham	2	156	936
Total	9	695	4,170
BOB	36	2,576	15,462

In September 2025, the government introduced the Urgent Dental Care Incentive Scheme to incentivise all dental practices to increase the number of urgent appointments they delivered.

The chart below reports on the ICB's performance to January 2026:

Chart 4: ICB delivery against Urgent Appointment target 2025-26



Whilst falling short of its target to deliver the number of urgent appointments planned (in line with every ICB in the country), the ICB exceeded its baseline and in the period to the end of March 100,311 urgent appointments were delivered. This target was altered in guidance issued in February 2026 ('Broadening the 700,000 urgent care commitment') with the focus to be on increasing the overall number of appointments and practices to deliver a minimum number of urgent appointments each year.

4.4 Children's Oral Health Improvement

Prior to the coronavirus pandemic, the ICB was part of the national 'Starting Well' programme designed to encourage children to attend the Dentist at an early age as possible (as part of the national 'Dental Check By One' campaign). The scheme involved practice engagement with a range of stakeholders to encourage attendance. The scheme was put on hold due to the pandemic. In December 2025, the ICB started to test the provision of a Children's Oral Health Improvement service along the lines of Starting Well. The service is being tested in the 4 new practices in Oxfordshire and 12 others across the ICB have joined the scheme.

The following practices are taking part in the pilot:

Practice name	Practice address	Local area
Haddenham Dental Ltd	Banks Cottage, Banks Road Haddenham, HP17 8EE	Bucks Central
Cambridge Street Dental Practice	27 Cambridge Street, Aylesbury, HP20 1RP	Bucks Central
The Chesham Dentist	Chess Medical Centre, 260 – 290 Berkhamstead Road, Chesham, HP 5 3EZ	Bucks East
Brocklehurst Dental Practice	202 White Lion Road, Little Chalfont, Amersham, HP7 9NU	Bucks East
Scandic Dental Practice	The Clockhouse, Frogmoor, High Wycombe, HP13 5DL	Bucks West
Valley Dental Care	205 Desborough Road, High Wycombe, HP11 2QL	Bucks West
Westbridge Dental Practice	127 Pound Way, Templars Square, Oxford, OX4 3XH	Oxford
Busby House Dental Practice	13 Hagbourne Road, Didcot, OX11 8DP	South Oxfordshire
Wootton Dental Care	Besselsleigh Road, Abingdon, OX13 6DN	Vale of the White Horse
Damira Dental Studios	Unit 10, Park Square, Milton Park Milton, OX14 4RR	Vale of the White Horse
Smile Dental Care	18 and 18A Market Place Faringdon, SN7 7HP	Vale of the White Horse
Haddenham Dental Ltd	2 Corn Street, Witney, OX28 6BL	West Oxfordshire
Bloxdent Smiles	Unit 14, Rounday House, Cromwell Business Park, Chipping Norton, OX17 6BL	West Oxfordshire
Bespoke Dental	6 Chapel Hill, Tilehurst, RG31 5DG	Reading
Newbury Dental Practice	4 The Courtyard, London Road, Newbury, RG14 1JX	West Berkshire
Loddon Bridge Rd Dental Practice	281 Loddon Bridge Road, Woodley, RG5 4BE	Wokingham

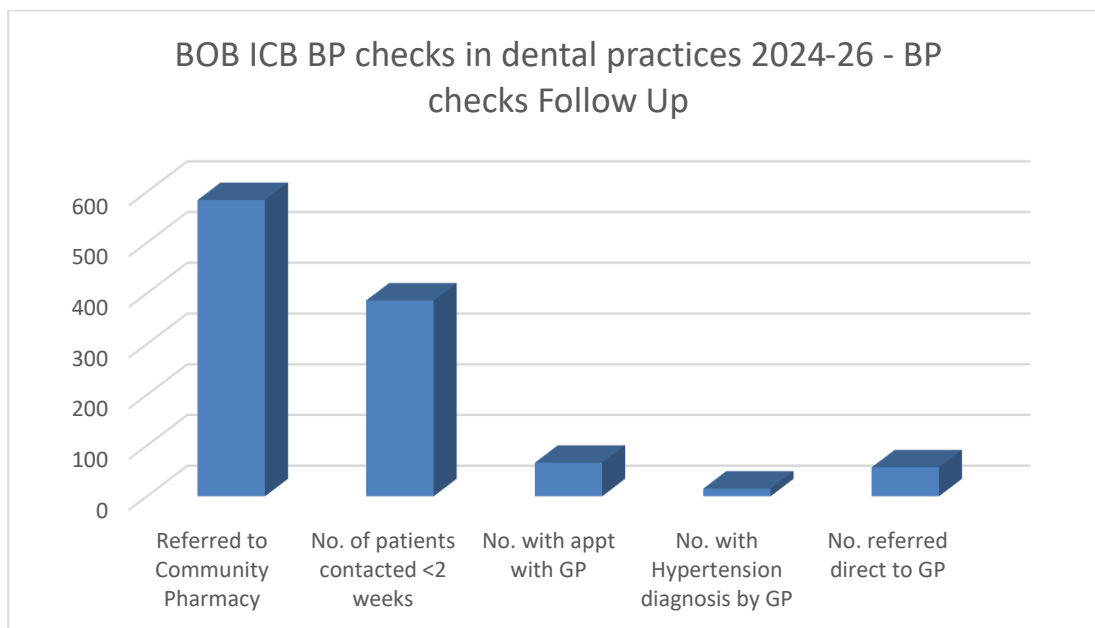
The ICB is in the process of recruiting more practices from East Berkshire to take part in the pilot which will run to 31st March 2027. A Children's Oral Health Improvement Managed Clinical Network has been established to review progress with the pilot, enable practices to share ideas and engage with other stakeholders. The Network will receive quarterly reports on progress with the scheme with first reports to be provided for the period to 31st March 2026.

In 2025, the government announced the launch of the local authority Supervised Toothbrushing with resources allocated to the local authorities to underpin delivery. The ICB scheme aims to link with the Supervised Toothbrushing schemes providing expert support as required and encouraging dental attendance amongst children from an early age.

4.5 Blood Pressure Monitoring

As part of the drive to increase the number of patients with recorded blood pressures, NHS England established several pilot sites across the country to test the delivery of a Blood Pressure monitoring services in Dental and Optometry practices. BOB was one of 11 dental pilot sites. There were referral pathways to Pharmacy and GPs if patients have a high reading in a dental practice. The pilot schemes, which received national funding ran until 31st March 2026. In BOB, more than 2,400 patients have had checks in dental practices in BOB since the scheme began. The chart below reports on the outcomes of those checks, also noting they resulted in a Hypertension diagnosis for 15 patients.

Chart 5: Outcome of Blood Pressure monitoring checks in dental practices



Results have been fed back within the ICB and nationally. An evaluation of the scheme nationally has been completed. This links closely to the ICB's intention to ensure residents can experience joined up care, with an increased focus on prevention, addressing inequalities. As Neighbourhoods develop, with a focus on prevention and primary care integration this pilot demonstrates that an effective service can be provided by dental practices as part of a prevention agenda that is wider than just oral health.

4.6 Golden Hellos

In 2024-25 3 practices recruited Dentists under the Golden Hello scheme in support of recruitment in areas where this has been more challenging. The scheme has been pursued in line with national guidance:

<https://www.england.nhs.uk/long-read/dental-recruitment-incentive-scheme-2024-25/>

In 2025-26, it was agreed the ICB would re-run the scheme with an increase in payment, increasing it from £20k to £30k phased over 3 years in line with the national guidance with £10k paid per Dentist in each of the 3 years.

The 2025-26 scheme has focussed on recruitment in the more rural parts of the ICB with practices with an annual UDA target of more than 10,000 UDAs in the following local areas eligible to take part in the scheme:

- Bucks North
- Cherwell
- South Oxfordshire
- Vale of the White Horse
- West Oxfordshire
- West Berkshire

The ICB approached practices in early November to seek Expressions of Interest. In December the ICB wrote to the following practices to confirm approval of their applications (17 practices):

The practices have been advised that they have until 31st March 2027 to recruit Dentists under this scheme. To date a total of 3 Dentists have been recruited under the scheme running until 31st March 2027.

5. Other Dental Services

In addition to primary care dental services, the ICB commissions specialist services in community and hospital services. The services commissioned are detailed below:

Table 5 Other Dental services commissioned in Thames Valley ICB

Service	Name of provider	Contractual status	Key challenges
Orthodontics	21 practices	Time limited PDS contracts. ICB has agreed to extend to 31 st March 2029	Waiting times for treatment. Working with MCN to review.
Community Dental Service (for adults with additional needs and children)	Central and North-West London NHS Foundation Trust (Bucks) Oxford Health NHS Foundation Trust	Time limited PDS contracts. NHS standard contracts for treatments provided in hospital setting.	Waiting times for treatment, particularly treatment under General Anaesthetic where there are challenges accessing hospital theatres with all hospital specialties

	Berkshire Healthcare NHS Foundation Trust	ICB has agreed to directly award under Provider Selection Regime regulations (2023) to 31 st March 2028.	to address backlogs. The ICB is working with a range of stakeholders on short term and longer term solutions.
Unscheduled Dental Care (evenings, weekends and bank holidays)	Central and North-West London NHS Foundation Trust Oxford Health NHS Foundation Trust Berkshire Healthcare NHS Foundation Trust Drs Tariq and Kaur (Reading) DA Clinics (Thatcham)	Time limited PDS contracts. ICB has agreed to directly award under Provider Selection Regime regulations (2023) to 31 st March 2028.	Impact of proposed of changes to dental contract from April 2026.
Oral and Maxillofacial, Restorative and Orthodontic Services	Buckinghamshire Healthcare NHS Foundation Trust (spoke) Oxford University Hospitals NHS Foundation Trust (hub) Royal Berkshire Hospital NHS Foundation Trust (spoke)	Annually renewable NHS standard contracts.	Waiting times for treatment. Commissioning of community-based tier 2 services with required capacity to reduce pressure on hospital services.
Tier 2 Oral Surgery	Locations in Buckinghamshire, Oxfordshire, Berkshire East and Berkshire West	Time limited PDS contracts. ICB re-commissioning services with new contracts to take effect from 1 st September 2026. New service commissioned in Berkshire East from April 2026. New services to commence across the Thames Valley during 2026-27.	Waiting times for treatment. Plans to increase in tier 2 capacity following procurement of new services during 2026-27.
Tier 2 Restorative	Locations in Buckinghamshire, Oxfordshire, Berkshire East and Berkshire West	Time limited PDS contracts. ICB re-commissioning services (Endodontic and Prosthodontic) with new contracts to take effect during 2026-27. Bidders to be advised of the outcome of ICB decisions in May 2026.	Impact of Dental Contract Reform on periodontal pathway. New contract proposing significant increase in periodontal provision in primary care.

6. Summary

There have been significant improvements in access to and delivery of dental services since the peak of the coronavirus pandemic. Contract delivery and access to services has been increasing over the last few years.

Local actions such as allowing practices to deliver more activity; additional urgent capacity; the Flexible Commissioning scheme and replacing activity lost due to contract handbacks/reductions has helped to ease the pressures.

Significant challenges remain. The ICB has now restored the levels of activity to pre-pandemic levels. The changes to the national contract from April 2026 are the most significant since the 2006 contract was introduced. There has been recognition at national level that many of the schemes developed locally by the ICBs have been established to address gaps in the national contract. The changes are designed to provide more support for practices to take on new patients and provide on-going care achieving improved oral health for those with greater oral health needs.

The ICB has also been seeking to increase the emphasis on prevention, supporting patients who have struggled to access dental care through the Flexible Commissioning scheme (now Dental Access Service for vulnerable patients); the Children's Oral Health Improvement pilot and supporting the wider prevention agenda through participation in the national pilot on Blood Pressure checks in dental practices. The national contract changes through the increased payments and use of skill mix for children's oral health prevention should also strengthen prevention.

The financial support for practices to carry out Quality Improvement audits and appraisals recognises the importance of dental care teams being able to reflect on services provided at practice and professional levels.

There are on-going challenges with access to specialist referral services. The ICB is carrying out re-commissioning programmes to meet those challenges, particularly around waiting times for treatment. The ICB is planning to increase investment into these services.

At this stage it is difficult to assess the likely impact of the quality and payment reforms. These reforms aim to increase investment, improve access, strengthen prevention and improve the quality of services. The ICB is focussed on working with stakeholders to ensure these aims are realised.

Appendix 1 – Dental Contract reform 2026

Implementation from April 2026

Urgent/unscheduled care

Increased payments for urgent care/unscheduled care

Current arrangements	Arrangements from 1 st April 2026
Urgent care courses of treatment remunerated at 1.2 UDAs (£42.60 for the average practice).	Payment increased to £75. The equivalent of £15 per patient to be paid upfront to support management of flexible capacity and to recognise the risk. This portion will be paid irrespective of actual levels delivered.
	£60 to be paid/credited to the practice once the FP17 has been submitted
	This new payment applies to all urgent/unscheduled care patients seen under a practice's general dentistry contract, whether patients have been to that practice before or not, and irrespective of whether the patient has been referred (eg from 111) or presents as a walk-in.
	Practices will be required to undertake a minimum level of urgent/unscheduled care (as above, for any patient including those known to the practice already) – 8.2% of Total Annual Contract Value (or 11 courses per treatment per £10,000 of contract value).
	The minimum level of urgent activity will act as a target for the practice to achieve with monies to be recovered for underperformance. For any delivery over the minimum level of 8.2% practices will be paid at £75 per course of treatment.
	Where there is evidence that demand for unscheduled care is insufficient to fill the available capacity, commissioners will be given limited powers to reduce these requirements. Further guidance to follow.
	Excluded contracts: Historic (pre-2006) Child Only contracts Separate contracts for additional unscheduled care capacity, for example contracts for out of hours unscheduled care services Community Dental Service contracts

	Contracts for services delivered in secure/detained estates
	The new arrangements do not affect commissioned urgent care sessions or appointments which some practices may have been offered by ICBs under separate contracts, which will continue to be locally agreed by commissioners.

Oral Health Prevention

A suitably skilled and educated Dental Nurses to apply fluoride varnish without the patient needing a full dental examination.

Current arrangements	Arrangements from 1 st April 2026
No payment.	A new course of treatment will be introduced at 0.5 UDAs.

Quality Improvement

Opportunity to access a new Quality Improvement (QI) domain in the contract

Current arrangements	Arrangements from 1 st April 2026
No payment	Practices will be able to opt into in funded quality improvement activities with a focus on participation in audit and peer review on a defined national topic or area of concern which will be determined annually. This will be supported by local clinical leadership and will lead to improved data on care quality in dentistry and evidence of change. This is not mandatory but for those taking part it will be funded at an average of £3,400 per participating practice per year, which will count towards the practice's contractual UDA requirement. The exact remuneration arrangements will be confirmed in due course.
	The initial topic is likely to focus on applying NICE guidance on recall intervals, with the goal of reducing unnecessary check-ups in those who are orally fit.

Recall intervals will still be set by individual dentists

- Recall decisions will continue to be based on clinical judgement of oral health risk at individual patient level.
- Practices are asked regardless of whether they take part in the funded QI scheme to apply the NICE guidance rigorously, in order to ensure NHS capacity is used appropriately and access is maximised.

Annual appraisals will be funded for associate dentists, dental therapists and dental hygienists providing clinical services to NHS patients

Current arrangements	Arrangements from 1 st April 2026
No payment	This will be funded at £213 per eligible clinician and will be claimed by the clinician receiving the appraisal. As with the new QI domain, this appraisal activity will count towards the practice's contractual UDA requirement. The clinician will be able to claim this payment once a year, once an appraisal is completed. The proposal excludes members of staff normally employed by practices, for whom performance reviews and appraisals will already be provided as part of their employment

Expected implementation from June 2026

Complex care pathways

The ability to treat patients under three new complex care pathways, remunerated at higher levels to support practices to prioritise higher needs groups

Pathway 1 - at least 5 teeth with caries into dentine with no unstable periodontal disease (6 months duration). Set fee £284.

Pathway 2 - at least 5 teeth with caries into dentine with currently unstable periodontal disease (12 months duration). Set fee £709.

Pathway 3 - a new diagnosis of grade C periodontal disease (6 months duration). Set fee £248.

Current arrangements	Arrangements from 1 st April 2026
Payment of Band 1,2 or 3 based on treatment provided.	These pathways are only available for adults (over 16s)
	Where a patient also needs laboratory work that would otherwise require a Band 3 Course of

	Treatment, a single Band 3 will be able to be claimed in addition to the pathway.
	Once a practice has confirmed that a patient has been accepted onto a pathway, activity will be credited throughout the duration of the pathway, to ensure practices are aware of progress towards their contracts
	For avoidance of doubt, these new pathways do not replace existing banded courses of treatment, and decisions about whether to use an existing course of treatment or a new complex care pathway where applicable will be taken based on the dentist's professional judgement. Separate guidance on complex care pathways is in development and will be published in due course

Denture modification or relining alongside other Band 2 care

Current arrangements	Arrangements from 1 st April 2026
No payment.	Eligible for an additional payment of 2 UDAs. These additional two UDAs will also be available when doing a modification or relining of a denture in addition to one of the new complex care pathways set out above. Denture repairs will also be remunerated at 2 UDAs, an increase on the current remuneration of 1 UDA. Like a Band 3 course of treatment, denture modifications will be able to be claimed in addition to a complex care pathway.

Appendix 2

Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

HOSC Recommendation April 24	Accepted, rejected or partially accepted	Proposed action (including if different to that recommended) and indicative timescale. (June 24)	Update May 2026
1. It is reiterated that underspends should be spent in Oxfordshire, and that priority is given to areas within Oxfordshire that have experienced the worst shortfall in capacity. It is recommended that the ICB prioritises areas within Oxfordshire in light of the increased need within the County relative to other areas under the BOB footprint.	Rejected	BOB ICB is the delegated commissioner for dental services across the footprint. With this comes a BOB level budget for provision of services The ICB does not receive separate budgets for each county. However, the first principle being pursued is that the levels of activity should be re-commissioned, at the very least to the levels that have been lost as a result of contract handbacks and reductions. There has been a loss of 91,049 UDAs in Oxfordshire since April 2021 and BOB ICB is actively looking to replace these.	Final position for dental ring fence budget for 2025/26 is an underspend of approx. £71k

		The ICB will prioritise areas of greatest need across the whole footprint.	
2. To support the creation of new practices within Oxfordshire with urgency, and to explore avenues of funding to support the ICB in developing solutions in this regard.	Accepted	The ICB has agreed to commission 5 new NHS practices (in Abingdon, Bicester, Carterton, Faringdon and Witney). The re-commissioning of services in these areas is being carried out as part of an NHS South-East programme. Significant levels of activity have been handed back in all SE ICBs. The Commissioning Hub for Dental services (hosted by the Frimley ICB) is working with each of the ICBs to understand proposed levels of activity to be commissioned with the aim of commencing the process in late 2024. The BOB ICB is investigating how it may move the programme forward more quickly if necessary.	Addressed in the report
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	Accepted	The ICB has carried out a review of practices' reporting new patient acceptance on https://www.nhs.uk/service-search/find-a-dentist in June 2024. This information is available to all patients.	https://www.nhs.uk/service-search/find-a-dentist has been updated to reflect the requirements of the new dental contract 2026. All practices now offer urgent dental appointments

for help, they can benefit from an effective outreach.		In Oxfordshire: • 25 practices are advising they open to all new patients (when availability allows). • 4 practices are open children only • 28 practices are not open to new practices. The ICB has written to these practices who have not recently updated their profile to seek confirmation of their plans to update their information.	
4. For the Oxfordshire system to seek to influence a timely consultation in Oxfordshire on the fluoridation of the County's water supply.	Partially accepted	The ICB would not have a role as the responsibility for consultation on water fluoridation lies with the Secretary of State and central government. The ICB has not considered water fluoridation, but officers are aware of the benefits for the oral health of the local population and the potential to reduce oral health inequalities.	The ICB would not have a role as the responsibility for consultation on water fluoridation lies with the Secretary of State and central government.

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Report to the Oxfordshire Joint Health Overview and Scrutiny Committee

11th June 2026

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1. Healthwatch Oxfordshire reports to external bodies

For all external bodies we attend our reports can be found online at:

www.healthwatchoxfordshire.co.uk/reports-to-committees

We attend and report to Health and Wellbeing Board (2026) and Health Improvement Board (2026). We attend Primary and Community Board, Neighbourhood Health working groups, and Oxfordshire Health Inequalities Forum and Oxfordshire Marmot Place meetings.

We published our priorities and focus for the coming year 2026–27 here:

<https://healthwatchoxfordshire.co.uk/our-priorities>

We have published Healthwatch Oxfordshire responses to Oxford Health draft strategic framework, and to government consultation on proposals for Local Government Reorganisation here:

<https://healthwatchoxfordshire.co.uk/correspondence>



We are holding a public event to showcase our work over the last year! This will be held online, **via Zoom, on Wednesday 8th July, from 1–2pm**. Members of the Healthwatch Oxfordshire team will talk about some of our achievements in 2025–26 and how our work has helped to improve local health and social care services. We will also take questions about our work.

All are welcome – just follow this [Zoom link](#) on the day to join.

If you are unable to attend but would like to submit a question to be asked at the event, please [contact us](#).

2. Update since the last Health Overview Scrutiny Committee (HOSC) Meeting April 2026

Healthwatch Oxfordshire reports

We make sure we hear from people via a mix of methods, including survey online and in paper form, and through ongoing face to face outreach, on the streets, at events and community settings. All this years' reports, along with summaries, and responses from providers and commissioners to date can be seen here:

www.healthwatchoxfordshire.co.uk/reports-hub

All reports are available in **easy read**, and word format. We follow up responses to recommendations again after six months.

- **What we heard about GP services in Oxfordshire** (April 2025 – March 2026 summary of themes from feedback from 786 people). We presented to Health Overview Scrutiny Committee (HOSC) working group on GP services in April.
- **Hearing from older Chinese people in Oxfordshire.**

We supported community researcher Derek Ng to interview 20 older Cantonese-speaking people from Oxfordshire about their experiences of health and care services.

We heard about language barriers and a lack of interpreting and communication support, including when booking and attending GP appointments. People told us that health and care services could use text messages and outreach to community centres to share information and hear their voices.

"Interpreter! I need help from an interpreter. It is quite troublesome if there was no help from interpreter. My daughter could not do the job right as both her Chinese and English languages were not fluent."

"Well, if it is just a simple conversation in the GP surgery then I do not have a problem. However, if I attend a hospital appointment, the medical terms that the specialty consultants use would be too much for me. I do not think I could manage."

"I think I did manage to understand up to like 70% of the whole conversation. It was because he sometimes used medical terms which I did not understand. So I guess I covered about 70% only."

"It gets a bit more complicated as well in case you want a face-to-face appointment. They rather offer telephone appointment which is not ideal for me. I do have a problem in using phone as I find it difficult to express myself over the phone."

- **"If we were treated the same as any other race" – Black Women in Maternity (BWIM)** is a community project developed by Black female community workers in Oxford. The project is funded by Well Together and supported by Healthwatch Oxfordshire, bringing together community leadership, lived experience, and local insight to improve maternity experiences for Black women in Oxfordshire.

Together, BWIM and Healthwatch Oxfordshire worked to create a safe and trusted space where Black women could access peer support, share their experiences of maternity care, and contribute to community-led learning aimed at informing and influencing maternity services. The project focused particularly on supporting Black mothers living in priority neighbourhoods.

BWIM provides a maternity peer support and mentoring group rooted in advocacy, trust-building, and continuing to bridge the gap between Black women in the community and local maternity services.

Community research and engagement

Healthwatch Oxfordshire supported BWIM to incorporate a community research approach into the project. With the consent of the women attending the sessions, BWIM captured what women shared through post it notes and written summaries of their conversations. BWIM also heard from a wider section of the community through a short survey. In total, BWIM heard from 52 women.

What women told us

Women told us they valued being listened to, receiving clear and useful information, being offered pain relief when needed, and feeling supported by those providing their care, such as midwives and doctors.

Some women told us their care was poor, particularly after giving birth.

Women also told us they had ideas for improving maternity care and support, including the need for better education and postnatal support for new mothers. They

valued the opportunity to share their experiences in a supportive environment with Black women of different generations.

Outcomes

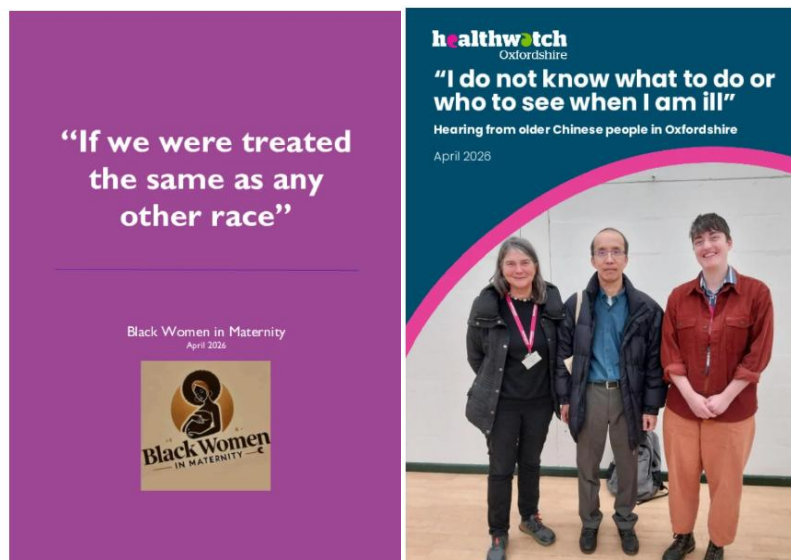
BWIM reduced isolation, built confidence and mutual support among participants, and helped women feel more able to engage positively with maternity services.

Sharing learning and next steps

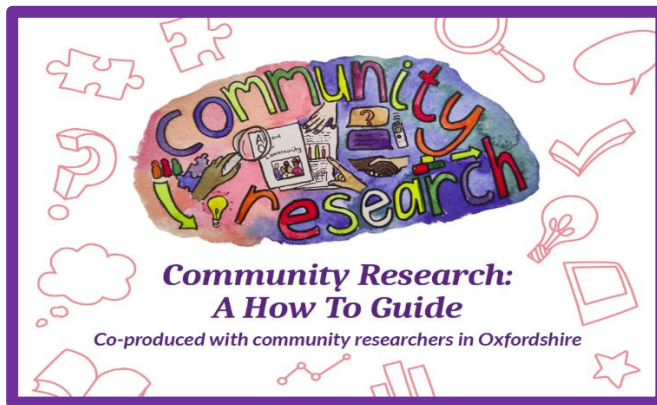
This report enhances and builds on past community research bringing the voice of lived experience into maternity (see for example film Black Women in Maternity by community researcher Omotunde Coker here [Women's views on maternity care | Healthwatch Oxfordshire](#) and subsequent development of Early Lives, Equal Start project and collaborative work with maternity services and grassroots communities [Equal Start – Flo's – The Place in the Park](#))

BWIM has shared its report with the National Maternity and Neonatal Investigation (Amos Review). The findings have also been shared with local maternity services and decision-makers.

BWIM is now working on next steps, including hosting an event and producing a leaflet to support ongoing dialogue with service providers and decision-makers, and to ensure women's experiences continue to inform improvements in care.



- **We launched a 'How to Guide – co-produced with community researchers in Oxfordshire'**



See here for online version <https://healthwatchoxfordshire.co.uk/community-research-how-to-guide> which can be used by anyone in Oxfordshire and is free for others to promote and use.

This is the culmination of work in Sept-Dec 2025 when we held a series of participatory workshops with local grassroots groups, including Oxford Community Action, AFIUK, Transition Lighthouse, Sudanese and Nepali community among others, building on the insights and learning from community members skills and knowledge. (Funding for us to convene and run workshops by Oxford University, via Oxfordshire County Council).

Healthwatch Oxfordshire then resourced it to fruition, editing and designing the guide with local designer, getting it printed, and developing it in an online format. We are developing next steps for supporting groups to use the guide, continue skills development and working with members of Oxfordshire Community Research Network.

The development of this resource took has relevance and potential to wider community development, resident voice and asset-based capacity building approaches, including Neighbourhood Health and Marmot Place, and wider health inequalities work in Oxfordshire and Thames Valley ICB.

To read more about the impact of all our work and reports, and how we make a difference along with commissioner and provider responses and agreed actions, see

here: www.healthwatchoxfordshire.co.uk/our-impact See also snapshot summaries of our month-by-month work.

Enter and View Visits

We have statutory powers under the Health and Social Care Act 2012 to make **Enter and View** visits to publicly funded local health and social care services. The aim of these visits is to identify what works well and what could be improved to make people's experiences better.

We published **Enter and View reports** based on our observations from visits to the following services:

- Katharine House Hospice
- Ashurst Ward at Littlemore Mental health Centre

All published Enter and View reports with recommendations to, and responses and actions from providers are available here:

www.healthwatchoxfordshire.co.uk/enter-and-view-reports

Healthwatch Oxfordshire Webinars

Since the last meeting we held one public webinar: To see our webinar programme, zoom links and **recordings of all past webinars**:

www.healthwatchoxfordshire.co.uk/our-webinars

- Tuesday April 14th 1-2 p.m. giving people a chance to feed into Oxford Health strategy 2026-31.

Community Marmot Event Monday 8 June at Rose Hill Community Centre.

We supported a community led event to hear from grassroots communities about the activity they are doing to support Marmot objectives, and to hear from decision makers about the collaborative efforts' county wide. This was led in conjunction with Oxford Community Action, Melissa Latchman, and Oxfordshire Community and Voluntary Action (OCVA) and Community First Oxfordshire (CFO). A report and details of the day will be on our website shortly.

Forthcoming reports include:

- A focus on hearing from people about views on **end of life care**, www.healthwatchoxfordshire.co.uk/have-your-say/complete-a-survey with

an online survey supplemented by focused outreach. Working alongside Oxfordshire Palliative Care network and others

- Rural insights from 14 **rural areas** (Deddington, Cropredy, Heyford, Yarnton, Chipping Norton, Charlbury, Long Hanborough, Freeland, Chalgrove, Sonning Common, Faringdon, Stanford in the Vale, Shrivenham and Watchfield) for Oxfordshire County Council as part of the Marmot focus on health inequalities. We worked in partnership with Community First Oxfordshire and ran a survey outreach and focus groups. A final draft report will be presented to public health in June.



3. What we are hearing from the public

Along with our themed research above, we hear from members of the public via phone, email, our advice and signposting, and online feedback on services (for reviews and to leave a review. see www.healthwatchoxfordshire.co.uk/services).

We also hold conversations when out and about on the street, in community settings, at hospital stands, with patient and VCS groups and services, and community events. This enables us to raise what we are hearing, including emerging themes, with health and care providers and commissioners.

Ongoing themes

We continue to pick up on more general themes including GP access and waiting times, communication and admin challenges. We continue to support people in understanding the changing landscape of the Integrated Care Board and health service planning <https://healthwatchoxfordshire.co.uk/understanding-health-and-care>

We hear from people who are **navigating complaints and feedback** to ICB and other health providers – often facing delayed responses, and with all the changes taking place, remain concerned that issues and complaints are being managed in a timely way, and lessons learned.

"in pain and treated in a dismissive manner, other women deal with this you need to, made a formal complaint and met with a senior member of the [hospital team] and still felt dismissed. I am now worried about my ongoing treatment"

"made a complaint early in the year; and no timelines followed. Resolution meetings cancelled at a days' notice spoke repeatedly to PALS and their manger "we have no staff" I'm told. That's not good enough".

"Please see below a complaint that has been raised with the [hospital name]. We have raised this complaint twice and we have raised another two incidents following the same issues today. I have raised this with the manager of the ward, main complaints department of the hospital and PALS. I have only had correspondence from the ward manager and none from PALS or complaints".

Future of Healthwatch

Healthwatch Oxfordshire continues an independent charity to be here to listen to people using health and care services and ensuring their voices are heard by decision makers.

The recent publication of the Health Bill <https://bills.parliament.uk/bills/4124> includes removal of statutory function of Healthwatch as an independent voice. We are working closely with health and social care system to explore future iterations for our charity.



Oxfordshire County Council

Joint Health Overview Scrutiny Committee

Commissioning Paper on SCAS CQC Improvement Journey

Introduction

In February 2024 South Central Ambulance Service (SCAS) attended the Joint Health Overview Scrutiny Committee to provide information around our performance, staffing and resourcing within Oxfordshire, wellbeing for our staff, management of Infection, prevention and Control measures, health and safety measures, but also to update the committee on our Care Quality Commission (CQC) visits in 2022 where the Trust was moved from Good to Requires Improvement.

SCAS has been invited to provide an update and to share an update on the progress made during our journey back from requiring improvement.

1.0 Clear Baseline and Context for the Improvement Journey

The CQC review 5 elements when they look at a provider organisation. Those are, Safe, Effective, Caring, Responsive and Well-Led.

The chart below shows the current status of SCAS by service when they last inspected us in 2025.

There was a review undertaken by the CQC in January 2026, we are still awaiting their latest rating following that visit.

It must be noted that Oxfordshire Patient Transport Service (PTS) is no longer provided by SCAS

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Good ▲ May 2025	Good May 2025	Good May 2025	Good ▲ May 2025	RI ▼ May 2025	Good ▲ May 2025
Patient transport services	RI ▼ Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Emergency and urgent care	RI ▲ May 2025	Good May 2025	Good May 2025	Good May 2025	RI ▲ May 2025	RI ▲ May 2025
Resilience	Good Nov 2018	Good Nov 2018	Insufficient evidence to rate	Good Nov 2018	Good Nov 2018	Good Nov 2018

There were 3 main areas of concern when we previously inspected:



- Regulation 1 – Continued concern regarding the storage, and oversight of medicine management.
- Regulation 17 – Lack of understanding regarding governance and risk management, with roles and responsibilities unclear.
- Regulation 18 – Lack of clinical oversight to ensure staff were supported and had effective development, to consistently deliver safe care and treatment.

Following the visit a Trust wide action plan was written and shared with the CQC to ensure they addressed the regulatory breaches.

Work was started and continues to ensure the breaches of the regulations are met but also maintained for the future.

2.0 Structure and Governance of the Improvement Programme

- The overall structure of the CQC improvement programme, including key workstreams and priorities.
- How the programme is governed at board and executive level, including frequency of oversight and challenge.
- The role of external support or assurance (e.g. NHS recovery or improvement support) and how this is being used; and
- How learning from inspections and assurance visits is translated into operational change rather than standalone action plans.

2.1 Trust Improvement Programme

Trust improvement programmes have continued during 2025/26. Following a recommendation made to the NHSE Executive Performance, Quality and Delivery Group by the NHS England South East regional team, the Trust has received formal confirmation of its exit from the Recovery Support Programme (RSP) in January 2026.

NHS England wrote to the Trust in March 2026 to confirm a full review of the existing 2024 undertakings and determine progress. The South East Regional Support Group (RSG) approved the recommendation on 15 April 2026 to issue a compliance certificate and therefore removal of the SCAS 2024 undertakings. The existing September 2023 Finance undertakings will remain as is and will be reviewed during Quarter One 2026/27. The removal of the 2024 Undertakings is a positive step in the improvement journey of SCAS.

Whilst these are positive milestones the board are clear that further improvement is required. The improvement work that is required already forms part of our Fit for the Future programme and we will continue to use the framework as our mechanism for reporting our progress to the Board and to the NHSE regional team.



3.0 Progress Against Issues Previously Raised by the CQC and by JHOSC

- The key themes raised by the CQC as still requiring improvement (for example, elements of safe or well led domains).
- What tangible changes have been made since the last inspection, with examples of impact rather than process alone; and
- Where challenges remain, an honest account of why improvement is harder in those areas and what mitigations are in place.

Work has been undertaken across SCAS and continues to be developed. Areas of focus have been:

Areas of focus for further improvement include

- Patient safety (PSIRF) has been introduced to the Trust, as part of the national role out, e-learning and physical learning has been provided to staff with practices developed to comply with the PSIRF process, this continues across the Trust with good compliance of the e-learning aspect, achieving further focus on embedding this learning continues to be rolled out.
- Medicines management, whilst a lot of progress has been made in this area, including relocating the pharmacy team to a new site in Southampton, this continues to develop as we upgrade our management process and change the management of controlled medicines within the Trust.
- Culture – sexual safety. As with many public organisations changing the culture of the organisation takes time, effort and consistency. SCAS is on that journey to recognise, challenge, manage and form behaviours, ensuring that the Trust remains a safe place to work, developing a psychologically safe working environment.

The CQC recognised Improvements demonstrated and recognised in the 2025 CQC visit including:

- Safeguarding – The work started in this area continues, the safeguarding team was increased in size, which enabled improvements in management of workload. Work continues to monitor and improve the feedback process of any safeguarding concerns.
- Infection prevention and control – work is constant in this area, aiming to ensure compliance with regulations and ensuring that SCAS manages to maintain a safe environment for patients and staff. One recent activity is the work being undertaken to introduce pouches on new ambulances coming onto the fleet which will reduce the impact time of deep cleaning of ambulances but also ensuring that consumables items are kept clean and able to be replaced quickly when the need arises.



- Patient Safety – Work continues to embed PSIRF within the organisation, including the setting up of review panels to regularly look at potential and actual incidents of harm, with learning and action wherever required.

4.0 Measurable Improvement and Outcomes

- Performance indicators that demonstrate whether changes are actually improving patient experience and safety (for example response performance, call handling, handover delays, and medicines management where highlighted by CQC)
- How SCAS assures itself that improvements are sustained, not just short term compliance responses; and
- How performance in Oxfordshire specifically compares with system wide performance, where data is available.
- Details of the demand trend for Oxfordshire.
- What is the current strategy for meeting demand without the need for private providers and what is progress.

Performance

During 2025/26 SCAS was set a target by NHSE of achieving a category two response time of 29 minutes and 49 seconds. Considerable work was undertaken throughout the year to ensure the target was met, including looking at the time taken to complete an incident (task time), operational hours, fleet availability, maximising alternatives to conveyance. SCAS ended the year at thirty minutes and two seconds, so just short of the target.

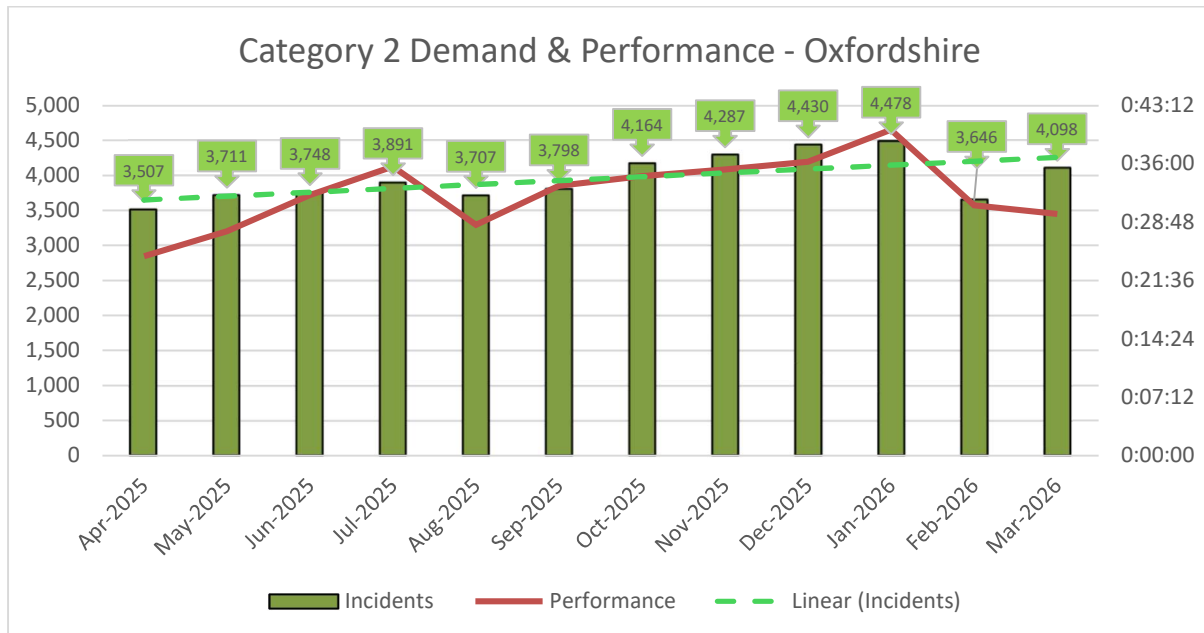
Whilst SCAS did not meet the response target, the management of patients, namely Hear and Treat (speaking with the patient in the clinical co-ordination centre CCC to manage them without dispatching an ambulance) exceeded the 15% target and achieved 17.3% for SCAS. Oxfordshire achieving 18.3%.

See and Treat targets, where a crew attend a patient and manage them within the community, without transporting to the Emergency Department exceeded the 30% target with SCAS achieving 30.6% and Oxfordshire achieving 32.9%

Category 2 demand increased by 2.36% compared to the 2024/25 year, with 47,465 incidents responded to in Oxfordshire.

Category 1 demand, however, saw a reduction of 2.62% across the year, with 6,544 incidents responded to in Oxfordshire.

Our Resource Escalation Plan (REAP) level was reduced to 2, which is the lowest it has been for some time. Reflecting modest pressure across the Trust. With the heatwave and spike in demand, this has just been increased back to 3. During the previous year the Trust was at both REAP levels 3 and 4 for points of the year, reflecting the sustained pressure on the service. However, pressure started to ease towards the end of the last financial year.



5.0 Workforce, Culture and Staff Wellbeing

- progress on staff recruitment, retention, training and appraisal, including whether staff feel supported to deliver high-quality care.
- actions taken to strengthen speaking-up culture, leadership visibility and staff engagement; and
- how staff wellbeing is being protected in the context of operational pressures.

Since the last visit to the JHOSC, SCAS has undergone a review of rota's operated across the Trust to better align resourcing to the demand. This is an ongoing process and the Trust is regularly reviewing to identify where change may be necessary. It must be understood that this change needs to be carefully managed, as it is important to try and balance the delivery of service with family friendly rotas as much as possible.

The financial pressures experienced by the whole of the NHS has meant that SCAS has had to review and manage our resources and finances extremely carefully. The new rotas and the financial pressure have resulted in a realignment of establishment for Oxfordshire and other parts of SCAS.

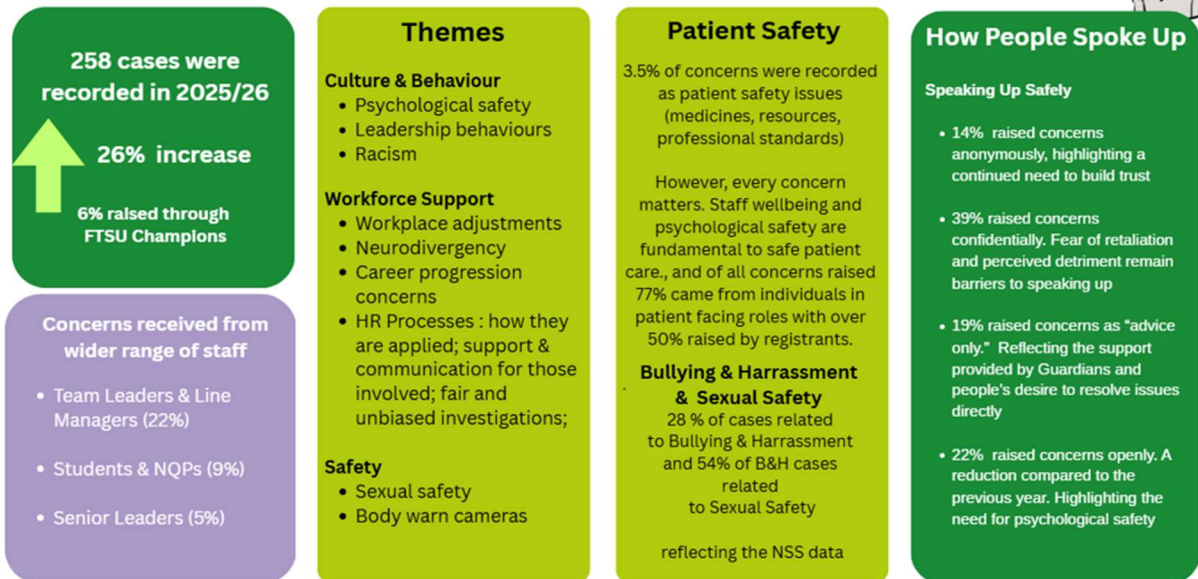
As a result of this, Oxfordshire is currently over-establishment for clinical colleagues, but under establishment for clinical support colleagues.

As part of the culture work being undertaken in SCAS, Freedom to Speak up (FTSU) has played an essential role in working towards a psychologically safe place for colleagues to work in. We have developed a network of 'Champions' across all parts of the organisation, this has helped enable over 800 conversations with staff, enabling them to speak up, improving our ability to listen up and enabling better follow up.

As part of our education programme for staff, we have achieved a 99% compliance in 2025 for the FTSU e-learning. There was a 26% increase in concerns being recorded.



The year at a glance



The data shows:

- There are a greater awareness and use of the speaking up process.
- An increase in anonymous concerns being raised, suggesting there is still some concern around fearing retaliation, judgement, or negative consequences.
- Concerns being raised are from a wider range of staff than previously, including students and leaders.
- The significant themes are still ones of bullying and harassment, behaviours, psychological and sexual safety.
- It is recognised that staff welfare and psychological safety are closely linked to safe patient care.

This demonstrates and reinforces the goals of the organisation in building a culture where:

- People feel safe to speak up
- Concerns are listened to early
- Colleagues treat each other with civility and respect
- Everyone feels valued, included and supported
- Creating that culture is not one person's responsibility, it belongs to everyone

Over the last year SCAS has worked to embed speaking up within the wider leadership and cultural framework, rather than treating it as a standalone process. This has included aligning the FTSU work with the supporting our people leadership framework, particularly its emphasis on accountability, integrity, curiosity, inclusion, collaboration and compassion.



This is now explicitly linked to the expectations of leaders to encourage open dialogue, listen effectively and ensure staff feel safe to raise concerns and challenge appropriately.

SCAS has developed a Building Trust Together Culture Improvement programme, with a focus on building foundations to delivering a visible, measurable impact.

We have a goal to ensure:

- People feel valued
- People feel well-led
- People feel safe

The background to this requirement is the latest NHS staff survey. Whilst we scored higher than the national average for, We are a Team which reflects positive local team relationships and peer support, staff health and wellbeing, morale and burnout scored below the national average. Both organisational trust and engagement have also both declined. The key challenge is in reducing the gap between local and organisational trust levels.

2025/26 was the foundational year for this programme, focussing on listening, designing the programme and building the governance structures. There is now a clear leadership ownership, defined workstreams and delivery structures. The active measurable delivery has now started as the 2026/25 workstream.

People Feel Valued

- Monthly Building Trust Together sessions established to strengthen openness and staff voice
- Digital PDR rolled out Trust-wide with positive staff feedback
- People Voice Hub refreshed and relaunched
- Culture Champions network established to support local engagement and communication
- Self-rostering pilot launched with positive feedback
- Staff Recognition Awards relaunch underway

People Feel Well Led

- Monthly Leadership Forum now fully embedded
- First Leadership Symposium delivered for operational leaders in April
- NHS Elect leadership modules delivered across multiple cohorts
- Sub-Executive leadership development launched (32 leaders), including 360 feedback and self-assessment
- Art of Showing Up programme launched to strengthen compassionate and visible leadership
- Every Conversation Counts toolkit and handbook developed to support quality conversations in 1-1s and appraisals



People Feel Safe

- Sexual Safety Prevention Lead appointed
- 80 managers trained as sexual safety investigators
- Sexual Safety Programme Oversight Assurance Group established with weekly check in
- ER and FTSU sexual safety cases now formally classified for improved oversight and reporting (support by triage group)
- 95% All staff trained in sexual safety and 93% all managers
- See Me First campaign relaunched with pledges increased from 51 to over 120 in 2 months
- Values & Behaviours Framework confirmed Caring, Professional and Honest

People Management Improvement

SCAS as part of improving support services for staff and leaders have, working with partner suppliers, introduced, Manager self-service to improve payroll accuracy and reduce delays.

SCAS has also provided additional interview skills training delivered to support staff through organisational change, introduction of a recruitment and retention taskforce within the Clinical Co-ordination Centres (CCC).

Health and Wellbeing

As part of our commitment to improving staff health and wellbeing, we have provided Wellbeing conversations e-learning and been actively promoting it across the organisation, SCAS has also actively supported:

- Mental Health First Aid network and Trauma Risk Management (TRiM) practitioner support being strengthened to support staff immediately (60)
- Occupational Health moved to a hybrid model to improve on-site access for staff
- £250k Wellbeing grant secured to strengthen wellbeing support and interventions for learners/ new recruits
- Management development modules support wellbeing, recognising early concerns and to create safe, supportive teams.
- Prioritise burnout and mental health support via Mental Health Toolkit
- Develop one Occupational Health service with SECamb
- Mental Health Suicide Prevention Steering Group as a priority area of focus to drive coordinated action to improve mental health safety.

Culture

As part of SCAS' commitment to improving and developing a healthy culture within the organisation we are actively encouraging staff to feedback via the monthly Pulse Survey response rates.

With the aim to have 2- 3 check-ins with staff annually we are aiming to embed quality conversations into those meetings and also the personal development reviews (PDR) which are held annually.

- Developing Culture Champions to cascade messages and support local engagement
- Improve PDR completion toward 95% target



- Continue with monthly Building Trust Together all staff sessions
- Continue Sexual Safety Programme, with full Charter compliance by October 2026
- Work closely with SECAMB to share learning and strengthen sexual safety practice
- Publish trauma-informed Sexual Misconduct Policy in June, supported by dedicated campaign
- Publish quarterly anonymised sexual safety data to improve transparency and learning
- Launch Values & Behaviours Framework on 22 June 2026
- Deliver roadshows, clinics and local conversations on appropriate and inappropriate behaviours
- Continue See Me First pledge campaign including site visits, with conversations on allyship, race equity and not being a bystander

To date, we have achieved training 80 managers as sexual safety investigators and exploring collaborative working with SECAMB to strengthen relationships and a capability that did not exist 12 months ago.

ER and FTSU cases are formally classified for the first time, giving us real data to track and a dedicated prevention lead to drive it.

SCAS has established Executive and Sub-Executive Visible Values Walkabouts across sites.

Delivering of local leadership sessions to reinforce visibility, role-modelling and behavioural expectations, continuing to support and deliver NHS Elect leadership modules, including first-line manager development.

Working with our group partner we are exploring the opportunities to develop a joint leadership programme for SCAS and SECAMB leaders and close partnership e.g. Mates to Managers

Continue Art of Showing Up training, focused on compassion, presence and role-modelling (available every quarter). New managers are being provided an induction programme (3 days) following a successful launch. Monthly Leadership Forums and Symposiums with guest speakers from other organisations. In June SCAS are launching the Every conversation counts toolkit and weekly lunch and learn sessions to improve the quality of every day conversations.



Designed Intentionally for Sustainable Change

Every workstream was designed with intent and shaped by what our people told us.

This is what coordinated, purposeful culture change looks like to win hearts and minds.

01

We listened first

Staff Survey, Pulse Survey, FTSU disclosures, ER themes and local engagement all of it read, triangulated and acted on.

02

Leadership at the centre

We put visible, compassionate and accountable leadership at the heart of this because leadership is the engine for change

03

Built to connect

Valued, Safe. Well Led. Three pillars, one programme. Each workstream reinforces the others intentionally to build trust and confidence

04

Sprint and Marathon

We fixed the basics fast payroll, ER grip, JD governance to build confidence. And we are running the long race on culture and conditions simultaneously for positive change.

Recruitment

The financial pressures experienced by SCAS resulted in the requirement to redefine the establishment numbers, based on funding as well as performance pressure.

Nationally there were pressures experienced and resulted in most Trusts reducing their recruitment of clinical staff. This had the beneficial consequence of reducing our attrition numbers. Due to the improved retention and budgeted establishment constraints, a recruitment freeze was put in place last year and a renewed pause was continued for this financial year. Onboarding has been limited and driven primarily by station availability rather than targeted workforce planning. As a result, only one Emergency Care Assistant (ECA) was appointed in Oxford in February 2025, with no further hires at this location. However, we are onboarding 6 ECAs to Buckinghamshire and 2 to Berkshire next month to support. Oxfordshire has always been a popular location to work, so we have been fortunate to experience good staffing levels. The recruitment freeze does create challenges, but not as significant as other areas within Thames Valley, we are over-established on our clinical workforce, but under-established on our clinical support workforce.

Looking ahead, we are acutely aware of the impact of not recruiting new graduates this year, particularly in relation to our engagement with students and our partnership with Oxford Brookes University. We work closely with the University, but this is impacted by not being able to offer employment opportunities to newly qualified Paramedics who we have supported through their 3 year degree. Internal students undergoing the same process are guaranteed employment as a Paramedic, but we may not be able to facilitate their employment within Oxfordshire but may have to move them to other parts of the Thames Valley. There is also a risk that future recruitment efforts may be more challenging, as the current pause means we will need to rebuild our candidate pipeline.

Additionally, the removal of Patient Transport Services in the Thames Valley has reduced a valuable internal feeder route into ECA roles, which had previously supported workforce development and progression.



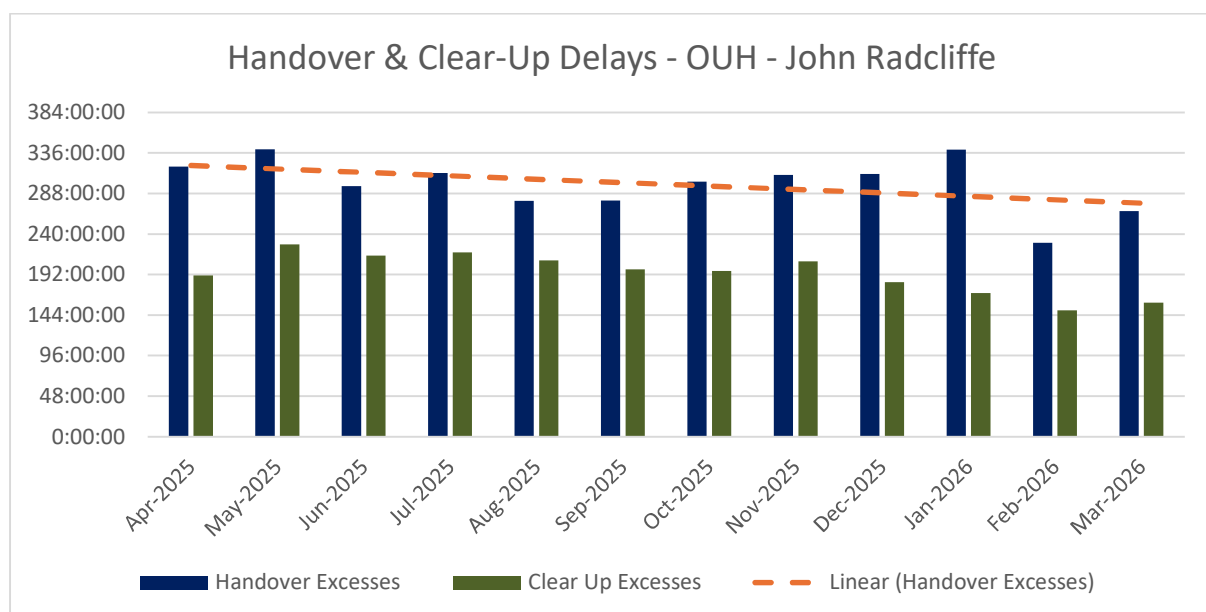
6.0 Interaction with the wider Oxfordshire health system

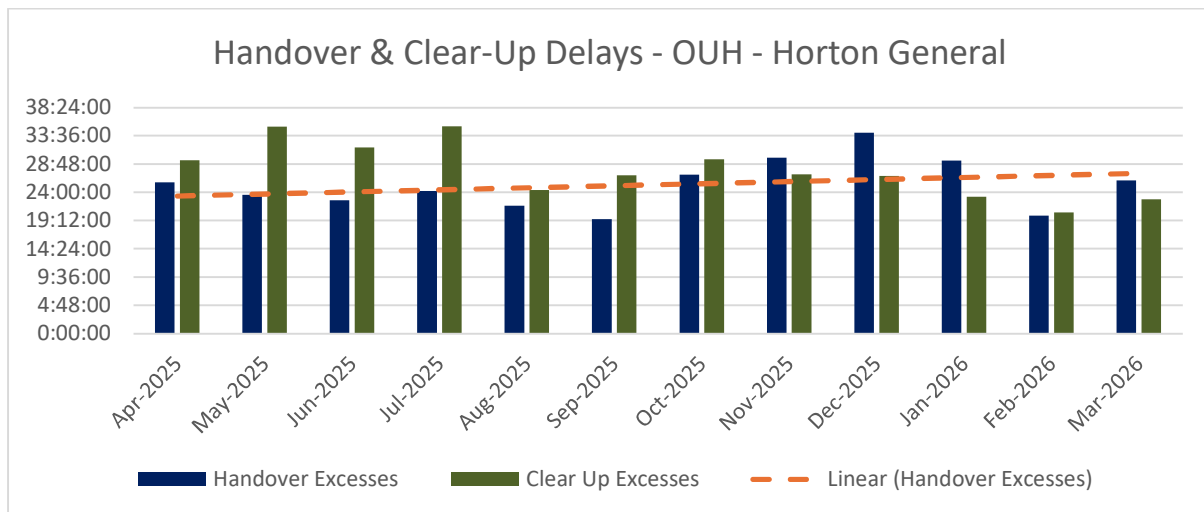
- How improvement depends on, or is constrained by, system-wide factors such as hospital handover delays
- What joint work is taking place with ICBs and acute trusts in Oxfordshire to address these issues; and
- How SCAS escalates risks that sit beyond its direct control.

SCAS is an integral part of the health and social care system within Oxfordshire. We are represented at many levels across the system including daily calls where we can provide an update on our daily position, understand the other partners situations and offer support where we can.

Hospital Handover

A key part of our improvement to task time is the ability to offload patients when we arrive at the Hospital. Nationally this has been a key challenge, SCAS has built an excellent working relationship with the Oxfordshire University Hospital and supported by the Integrated Care Board (ICB, Berkshire, Oxfordshire, and Buckinghamshire, which has just amalgamated to become the Thames Valley ICB), we have seen improvements in the excess handover times. We continually work together to see how we can improve processes and reduce the amount of time taken to transfer care of the patient to the receiving hospital.





Whilst the trend line is going up for the Horton, it must be stressed that their handover times are normally within the national guidance and, whilst we have seen an increase in handover times, it is as a result of spikes during winter.

At the daily calls, we review handover delays that exceed 45-minutes and have honest and open conversations around the causes for those delays. Not all delays are classed as true delays, as they may be a process issue, rather than a capacity issue. SCAS within Oxfordshire are extremely fortunate to have ability to access many pathways and the system fully supports opportunities to avoid admission to hospital wherever possible.

SCAS has regular meetings with colleagues from the OUH where handover is the main discussion point, looking at how we support each other, what steps we need to put in place jointly to improve the handover situation, this is a collaborative opportunity where we review process to identify any blocks to improving handover. This has resulted in a reduction in 45-minute delays being reported and ensuring that the majority of delays are due to a physical delay, rather than a process error. These delays are then reviewed to identify if any learning can be identified from both the OUH and from SCAS.

The OUH is extremely cognisant of the impact created by handover delays and works hard to reduce that impact wherever it is possible. SCAS will send out messaging to staff on a daily basis, especially if there are pressures being experienced. Colleagues from other services will aim to surge their availability to support operational crews in managing patients as effectively within the community, rather than defaulting to conveyance, thereby actively reducing the pressure on the OUH, but also improving our availability to respond to the next call, without being delayed at a pressured unit.

Oxfordshire maintains the highest non-conveyance rate within SCAS, this is because of the support and willingness to explore as many alternatives provided by partner providers within the wider system.

SCAS is represented at ICB and system led meetings, where we review areas and concerns, plus reporting around work being undertaken by us and other partners to improve the non-conveyance options.



When SCAS faces challenges, we are able to discuss directly with the OUH, but also able to raise to the Thames Valley ICB to gain their support in enabling progress. One recent example has been staff reporting delays whilst trying to refer to one of our partners, which has increased our times on scene, reducing availability for the next incident. We invited the partner provider and the ICB to an Oxfordshire leadership meeting, where we were able to discuss the challenges faced by staff, recognition of how our partner agency may be able to adapt to improve that was discussed and solutions offered by the partner agency. This has enabled some work to be commenced in ensuring a faster acceptance of our referrals, which will hopefully start to show improvements.

7.0 Forward look and readiness for future inspection

- Any next milestones in the improvement journey
- how SCAS is preparing for any future CQC inspections or re-assessments; and what risks could derail progress, and how these are being actively managed.

We look forward to the realisation of the regulatory breach action plans and report progress against these. However, some of these are integral to existing workstreams, with timelines drafted and some that will be subject to the submission of business cases.

SCAS has introduced an accreditation regime across the Trust, a team made up of members from the Clinical Team (who lead on our CQC inspections), a member of the executive team, or a non-exec Director, plus the local senior leadership team undertake an inspection of a site.

Preparation for CQC inspections is business as usual. The accreditation programme provides assurance against internally agreed standards. All stations have been through the first round of the programme, and the second round of visits has commenced.

SCAS is working in close collaboration with South East Coast Ambulance Service (SECAMB) as we are the first two ambulance trusts in the country to form a Group model. Both Trusts work independently but have an alignment with one Chief Executive and Chairperson who both lead the joint organisations. Both organisations are focussed on partnership wherever possible to improve and level up any differences between the two Trusts. We have always been collaboratively minded as partners and are already part of the South Ambulance Service Collaboration, which is made up of SCAS, SECAMB, London (LAS), Great Western (GWAS), and East of England (EEAS) to enable improvements in processes and alignment with cost benefits of scale.

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Oxford Health NHS Foundation Trust

Quality Account 2025/26

Agenda Item 15

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Oxford Health
NHS Foundation Trust

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Be valued
Be proud
Be part of our team



Part 1: Statement on Quality

Caring, safe and excellent

Part 1: Statement from our Chief Executive

Welcome to the Oxford Health NHS Foundation Trust 2025/26 Quality Account.

I am delighted to introduce the Oxford Health NHS Foundation Trust Quality Account for 2025/26. This report reflects a year defined by dedication, resilience, and meaningful progress across our organisation. Despite continued operational pressures and increasing demand, colleagues across the Trust have remained steadfast in their commitment to delivering high-quality, compassionate care to the communities we serve.

Over the past year, Oxford Health has taken significant steps forward in strengthening the safety, experience, and effectiveness of our services. I am particularly proud that Oxford Health was placed in Segment 1 of the NHS Oversight Framework for the first half of the year—evidence of the professionalism, diligence and consistency shown by our teams every day.

Tackling health inequalities remains central to our purpose, and through our neighbourhood-based approach we are working with system partners and communities to ensure people can access high quality, compassionate care that meets local needs and improves outcomes.

Creating the right culture for our workforce to thrive remains central to our mission. We have continued to embed an organisational culture rooted in kindness, civility, and continuous learning, alongside expanding our wellbeing offer and celebrating excellence through our Staff Awards. These achievements reflect the talent, compassion, and innovation of our people, who are the foundation of everything we do.

This has also been a year of important progress in equality, diversity, and inclusion. Our strengthened governance, improvements in ethnicity data, enhanced staff network activity and commitment to anti-racist practice demonstrate our determination to deliver equitable care and foster a workplace where every colleague feels valued and able to contribute fully.

We are equally proud of the advances we have made in improving patient safety, enhancing learning from incidents, and strengthening multi-disciplinary collaboration across our mental health, forensic, learning disability and community, primary care, and dental services. The creation of our new Mental Health Acute Pathway Forum aims to support integrated decision-making and helping us to reduce variation, share best practice and improve patient outcomes.

continued on next slide

Part 1: Statement from our Chief Executive cont.



Oxford Health
NHS Foundation Trust

Our commitment to future generations is reflected in the launch of our Green Plan 2025–2028. This sets a bold pathway towards environmental sustainability and climate resilience, including decarbonisation of our estate, digital transformation, and support for sustainable travel.

We have also invested significantly in professional development, training, and research, enabling our nurses, midwives, AHPs, psychologists, medical staff, and wider workforce to continue developing their skills and shaping the future of care.

While we celebrate these achievements, we remain acutely aware of the challenges ahead. Demand continues to outstrip capacity across several services, and our ability to meet needs in a timely way remains an area of focus and concern. We are working closely with our system partners to strengthen pathways, redesign services, and ensure that people receive the right care, in the right place, at the right time.

I am deeply grateful to all our colleagues, partners, volunteers, service users, families, and carers who have contributed to our progress this year. Your commitment, innovation and compassion embody the values of Oxford Health and make a profound difference to the lives of the people we serve.

As we look ahead, we do so with a renewed focus on quality, equity, sustainability, and continuous improvement. I am confident that together we will continue to strengthen our services and deliver the highest standards of care—locally, compassionately, and safely.

To the best of my knowledge the information contained in this report is an accurate representation of the year's events.



Grant Macdonald - Chief Executive

Part 1: Introduction to our Quality Account 2025/26



Oxford Health
NHS Foundation Trust

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS.

This definition sets out three dimensions of quality, which must be present to be able to provide high quality services:

- ✓ **clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- ✓ **safety** – quality care is care which is delivered to avoid all avoidable harm and risks to the individual's safety
- ✓ **patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

Our 2025/26 Quality Account looks back on the progress we have made over the past year to achieve our goals. The report also looks forward to the year ahead (2026/27) and identifies our priority areas for improvement and how we hope to achieve these.

Throughout the document we have used the terms patients, families, and carers to mean any person who has used or been involved with our services now or may be in the future.

The Quality Account should be read alongside the trust 2025/26 Annual Report that gives an overview of trust activity, summarises performance during the year and provides background information about its performance, business model and governance arrangements. When published the 2025/26 Annual Report can be found here: [Publications | Oxford Health NHS Foundation Trust](#)

If you require any further information about the Quality Account, please contact our Patient Advice and Liaison Service: pals@oxfordhealth.nhs.uk

Part 1: Our vision and values



Oxford Health
NHS Foundation Trust

Our vision is that no matter who you are or where you are, you will tell us that you receive:

“Outstanding care delivered by an outstanding team”.

The Trust works towards its vision through its values – **Caring, Safe, and Excellent:**

Caring

- ✓ Privacy and dignity is at the heart of our care.
- ✓ We treat people with respect and compassion.
- ✓ We listen to what people tell us and act upon what they say.

Safe

- ✓ Our services will be delivered to the highest standards of safety.
- ✓ All services will be provided within a safe environment for patients and staff.
- ✓ We will support our patients and staff with effective systems and processes.

Excellent

- ✓ We aspire to be excellent and innovative in all we do.
- ✓ We aim to provide the best services and continually improve.
- ✓ We will recognise and reward those who deliver excellence.

Caring, safe and excellent

Part 1: Our Trust Strategy

The Trust five year strategy 2021 – 2026 set out Oxford Health's four strategic objectives grouped into four themes:



Quality

Read our 2021-2026 strategy

- [Accessible Summary](#) (pdf)
- [One page summary](#) (pdf)
- [Full version](#) (pdf)



People



Sustainability



Research & Education

Oxford Health's current strategy comes to end in 2026, giving us an important opportunity to shape our new strategy for the next five years.

[Find out more and give us your thoughts.](#)

Our strategy: At a glance
2021-2026

Our **four** strategic objectives:

- 1. Quality**
Deliver the best possible care and health outcomes
To maintain and continually improve the quality of our mental health and community services to provide the best possible care and health outcomes. To promote healthier lifestyles, identify and intervene in ill-health earlier, address health inequalities, and support people's independence, and to collaborate with partner services in this work.
- 2. People**
Be a great place to work
To maintain, support and develop a high-quality workforce and compassionate culture where the health, safety and wellbeing of our workforce is paramount. To actively promote and enhance our culture of equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment.
- 3. Sustainability**
Make the best use of our resources and protect the environment
To make the best use of our resources and data to maximise efficiency and financial stability and inform decision-making, focusing these on the health needs of the populations we serve, and reduce our environmental impact.
- 4. Research**
Be a leader in healthcare research and education
To be a recognised leader in healthcare research and education by developing a strong research culture across all services and increase opportunities for staff to become involved in research, skills and professional qualifications.

Mission
To be the **best Trust of our kind** in the country

Vision
Outstanding care delivered by an **outstanding** team

Values
Caring • Safe • Excellent

Part 1: Our services

Who are We?

Oxford Health NHS Foundation Trust is a community-focused organisation that provides physical and mental health services and social care with the aim of improving the health and wellbeing of all our patients and their families. The trust is one of the largest NHS trusts in the country providing services for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset.

Primary, community and dental care services across Oxfordshire (including planned, preventative and urgent care) along with vaccination services for Buckinghamshire and Oxfordshire

Mental health, autism and learning disability services in Buckinghamshire, Oxfordshire along with Swindon Wiltshire, Bath and North East Somerset

Specialist health services include forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire and Wales.

Our services are delivered at community bases, hospitals, clinics and in people's homes.

We focus on delivering care as close to home as possible. In everything we do, we strive to be caring, safe and excellent.



Overall, our services are rated as “**good**” by the Care Quality Commission (CQC)

To find out more about our trust and the services we provide visit our website: www.oxfordhealth.nhs.uk

Part 1: Our services



Oxford Health
NHS Foundation Trust



We lead three NHS Provider Collaboratives, these are regional partnerships that provide specialised mental health services for patients, forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire and from Wales.

To find out more about NHS-led Provider Collaboratives visit:

<https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/>

https://youtu.be/V4J0FX_lfk4

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The collaboratives we lead on are:

- The Thames Valley & Wessex Adult Secure Provider Collaborative, known as the [For Me Provider Collaborative](#)
- Thames Valley Specialised Children and Young People (CYP) Mental Health Services Provider Collaborative, [Tier 4 Provider Collaborative](#)
- HOPE (Healthy Outcomes for People with Eating disorders) [Adult Eating Disorder Provider Collaborative](#)

We are leading partners in:

- [Buckinghamshire, Oxfordshire, Berkshire West \(BOB\) Mental Health Provider Collaborative](#) with Berkshire Healthcare NHS Foundation Trust in partnership with BOB Integrated Care Board to improve the quality and efficiency of patient care across the neighbouring localities.
- [Thames Valley Community Dental Services Partnership](#), a collaboration between Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Central and Northwest London NHS Foundation Trust. We provide specialist dental care for children, young people and adults with additional and complex needs who require specialised care that cannot be provided by the general dental service.

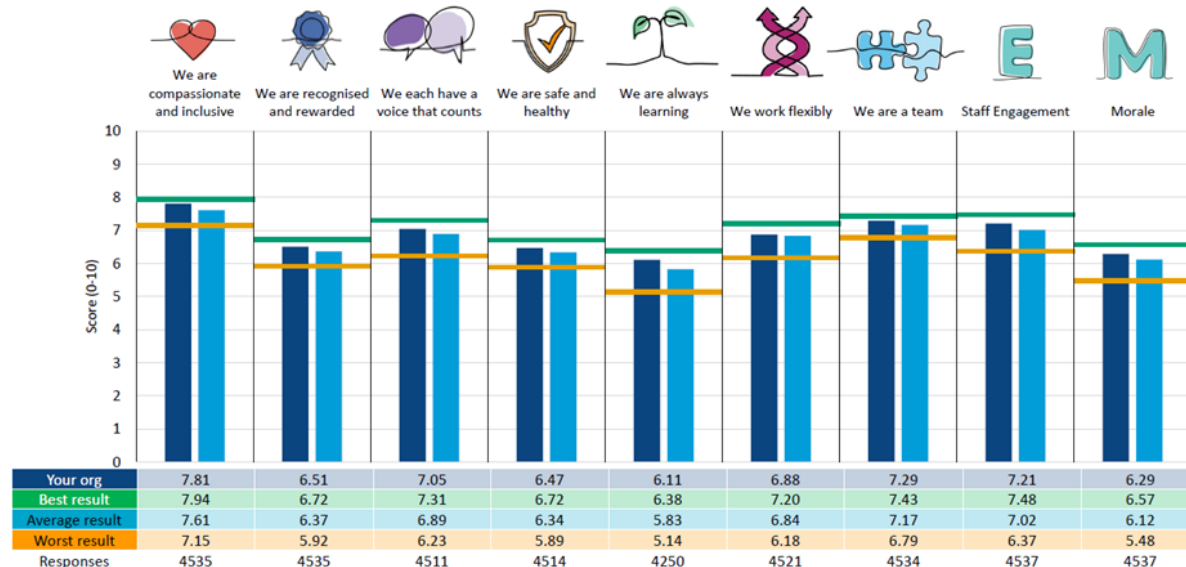
Part 1: Our people

We employ around **7,507 (6,920) people** or **6,672.33 (5,386.82)** whole time equivalent staff (2024/25 data).

The launch of the National People Promise in 2021 has given NHS Trusts a renewed drive to create a wellness culture for all. Providing the tools to help shift from a reactive response to staff wellbeing, to one that is proactive and preventative, truly embedded within our culture.

We are active participants in the National Staff Survey, 4,541 colleagues responded to the most recent 2025 survey. We achieved our highest response rate since 2009 of 61.3% which was also above the national average response rate (52% for our sector of Mental Health & Learning Disability and Mental Health, Learning Disability and Community Trusts). We are pleased to see that we are above the national average for all nine of the elements / themes for our sector compared with the national benchmark as shown in the graph below.

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



Part 1: Staff support and Wellbeing

Last year we launched two new programmes of work aimed to support staff in the workplace by reducing harm to staff and increasing our offer of post incident support.

Reducing staff experience of violence and aggression in the workplace

During 2025/26, Oxford Health made substantive progress in strengthening its approach to Violence Prevention and Reduction (VPR), moving from a narrow zero tolerance model to a trauma informed, system wide framework focused on prevention, staff support and organisational learning.

A new VPR Policy was developed and launched, replacing the previous Zero Tolerance Policy and providing clearer expectations on risk assessment, incident reporting, lone working and post incident support. It explicitly distinguishes clinically related challenging behaviour from intentional violence, while strengthening protections for staff.

Operationally, Operation Cavell was implemented in Oxfordshire (although not fully embedded), formalising joint working with Thames Valley Police and improving support for staff who experience criminal assaults. Staff engagement, training and communication activity increased, including policy launch webinars and continued rollout of TRiM and Post Incident Psychological Support.

Staff Sexual Safety

Our organisation signed the NHS England first ever sexual safety charter demonstrating our commitment to reducing and eliminating any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, since 2024 we have developed a programme of work to support the ten core principles and actions to help achieve this.

During the last year we have:

- Undertaken self-assessment against Sexual Safety Assurance Framework and developed actions in response
- Utilising the Sexual Misconduct National Policy Framework, statements have been placed in all relevant policies with work underway to adopt the overarching national policy into OHFT.
- Introduced an e-Learning for health module: Understanding Sexual Misconduct in the Workplace
- Established Domestic Abuse (DA) Champions across the trust.
- Committed to raising awareness by displaying posters across sites, holding trust wide webinars and holding Health and Wellbeing Champions training days



Part 1: Staff support and Wellbeing



Our Health & Wellbeing promise

As an organisation we want to embed and enable a culture of support where staff feel valued, can perform to the best of their abilities, and view OHFT as an enjoyable and fulfilling place to work.

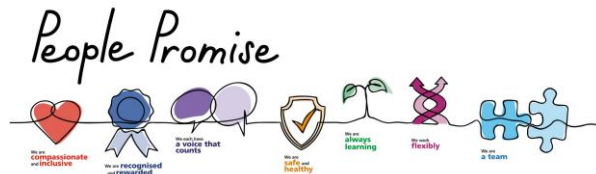
We want to build health and wellbeing into everyday of our working lives, acknowledging our values of caring, safe and excellent to help all staff achieve a sustainable balance between work, life and family.

The Trust's Strategic Framework sets out our vision for outstanding care delivered by outstanding teams.

It is of great importance that we have a happy and healthy workforce, not only because staff are our most valued asset but because there is also a need to bring existing and supportive elements together and develop these further into an integrated and coherent strategy which improves wellbeing.

We also continued to prioritise staff wellbeing, maintaining our commitment to providing an annual Wellbeing Day for all substantive staff for the fifth consecutive year— having listened to feedback from staff, we know that it helps to give a little more time and space for self-care and wellbeing.

In addition, we have supported teams to undertake a team-based activity to support 'We are a team' NHS People Promise.



Part 1: Staff support and Wellbeing

We recognise staff achievements through our trust awards processes, some of these are detailed below:



We also support staff to share their achievements more widely and have had some fantastic national achievements this year!

Sustainability and National Recognition

“Leave the paper behind” project, led by Comfort Nkum, Health Visitor, made it through to the finals of The Nursing Times award, under the heading of Sustainability in Nursing and Midwifery.

National Nurse of the Year!

Gabbie Parham, Senior Matron Community Nursing won the *British Nursing Journal* – Sustainability Nurse of the Year award. A significant achievement showcasing leadership in environmentally responsible practice.

Excellence in Tissue Viability – Winner.

Martha Williams, Tissue Viability Clinical Lead, has won the Society of Tissue Viability – Going Green in Wound Healing Award 2026. This highlights innovative, sustainable approaches to wound care within our services.



Part 1: Staff support and Wellbeing



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We have a range of offers for staff support and wellbeing, that includes our Employee Assistance Programme (EAP) Wisdom Wellbeing.

Oxford Health's 24/7 staff helpline is fully operational offering compassionate support for our people whatever challenges they face.



Part 1: CQC

The CQC's approach to assessment

The CQC are moving forwards with plans for sector-based regulation based upon consultation at the end of 2025 that sought views on CQC proposals to evolve and improve the approach to assessing and rating health and social care providers

Whilst this develops CQC continue to assess health and social care providers using a developed assessment framework as part of their regulatory approach. The assessment framework is based upon the 5 key questions, are services:

- ✓ **safe**
- ✓ **effective**
- ✓ **caring**
- ✓ **responsive to people's needs**
- ✓ **well-led**

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The CQC assess services against quality statements that replaced the previous key lines of enquiry (KLOEs). Assessments may be responsive relating to information and data CQC receive and monitor or planned inspections.

The CQC last assessed Trust services as **Good** at 13th December 2019.

During November 2025 the CQC assessed trust Child and Adolescent Mental Health Inpatient Services applying the current CQC assessment framework.

As of 31st March 2026, the Trust is awaiting the formal report of findings and the outcome of the assessment that will inform the re-rating of the services assessed.



Part 1: Summary of successes!

The opening of Murray House!

Murray House, which is in the Jordan Hill Business Park in the north of Oxford, is the new base for a range of community health care -based services

Whilst many of the teams at Murray House, such as district nurses and health visitors, travel out every day to see their patients, often in their own homes, others provide clinics at the newly refurbished building itself. This includes podiatry, dentistry and specialist therapy services for children, young people and adults

Working with staff, patients and people from local communities, Murray House was designed and refurbished to be as welcoming as possible for patients and their carers, as well as great place for staff to work in. Previously teams were located in several, often poor-quality buildings in and around Oxford, which also meant that some patients had to travel to different locations for aspects of their care.



Banbury's Fiennes Centre refurbished

The project at The Fiennes included the complete refurbishment of the urgent care centre, GP out-of-hours and podiatry spaces, as well as additional staff offices and related facilities

Work got underway during the Autumn 2025 and continued at pace, with all phased works on track to conclude by mid-April 2026

This has all been made possible through the coming together of a project groups with representation from the clinical services based at The Fiennes, as well as representatives from Oxford Health's estates, facilities, IT, operations and transformation teams.

Working together, on-going patient care was prioritised whilst managing the refurbishment of a 'live' clinical building.



Part 1: Summary of successes!

Buckinghamshire Neurodevelopmental Pathway Transformation

This inspiring project showcases a bold redesign of the neurodevelopmental assessment pathway, improving both efficiency and experience for children, young people (CYP) and families while ensuring our resources are used sustainably and wisely.

Key achievements include:

- A dedicated Pre-assessment Team now manages information gathering and pathway decisions, reducing clinician admin and streamlining workflow.
- A one-day assessment model replaces multiple appointments, reducing travel, saving time and ensuring CYP receive a more focused and holistic diagnostic experience.
- Diagnostic meetings twice daily improve pace and clarity of decision-making.
- Diagnostic letters and reports sent within two weeks, offering a timely, reliable experience for families.
- A robust quality assurance framework, including reviews by Assistant Psychologists/trainees, ensures consistent use of neuro-affirming language and high-quality reporting.
- A strengthened staff induction and competency framework supports workforce development and confidence.
- Strong commitment to co-production, with parents and CYP shaping resource packs, letters, and forms.
- Ongoing process improvement, including exploring AI support for admin tasks, reviewing roles and refining pathways for those with previous private diagnoses.

This transformation is a powerful example of how smart redesign, teamwork and co-production can improve outcomes *and* ensure we use our resources responsibly.

It highlights the Trust's commitment to sustainable practice, high-quality care and meaningful involvement of families.

The project was a Trust wide winner at our 2025 Quality Improvement conference!



Part 1: Summary of successes!

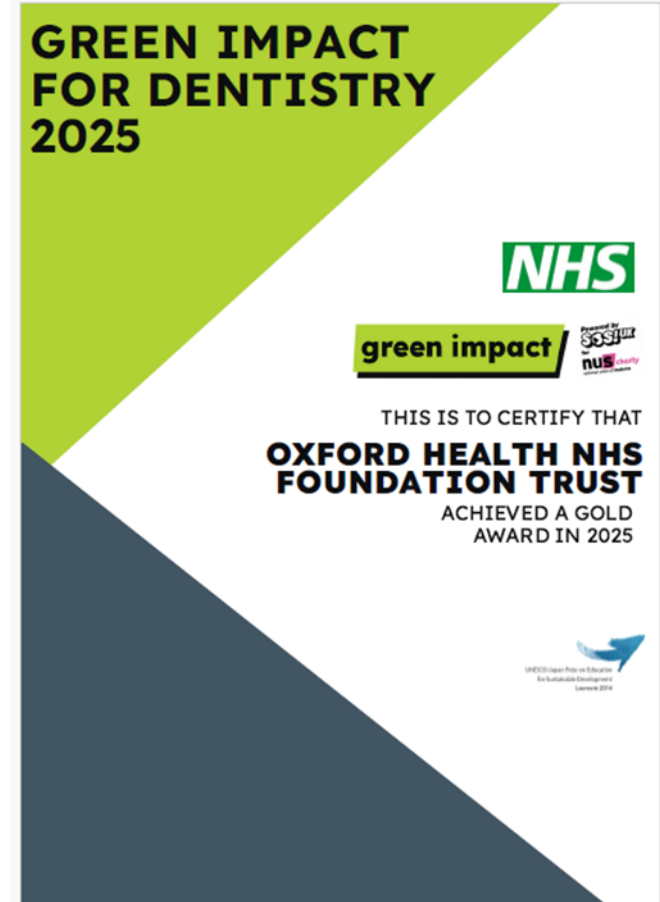
Dentistry – Green Award

Community dental team wins gold award

The community dental service recently achieved the gold award for Green Impact for Dentistry as part of the NHS Green Impact Scheme. This is an upgrade on the silver award the team was awarded in 2023. These national awards are a sustainability accreditation scheme that supports NHS services in making meaningful improvements to the environment and sustainability.

Building on its successful previous silver submission, the team worked through the wide range of indicators within the Green Impact environmental toolkit to identify where it could make meaningful and realistic improvements within community dental services. The toolkit covers multiple areas, including waste, energy, procurement and sustainable practice.

The team considered carefully those actions that were most relevant to its clinical setting, before then focusing on implementing and evidencing change in those areas. Key developments included launching a paper-free QI project to support the move towards digital working and reviewing the use of single-use items to reduce disposables where clinically appropriate. By strengthening and expanding on previous work, the team was able to demonstrate sustained progress and achieve gold accreditation.



Part 1: Summary of successes!

BSW CAMHS Complex Trauma Pathway

During 2025/26, Bath and North East Somerset, Swindon and Wiltshire (BSW) CAMHS implemented a Complex Trauma Pathway to improve access, experience, and outcomes for children and young people affected by complex trauma.

Positive experience and quality indicators The pathway has demonstrated strong quality indicators, with no complaints received to date and very low DNA and CNA rates, suggesting high levels of engagement and acceptability. Feedback from children and young people highlights feeling safe, listened to, and actively involved in decisions about their care. Carers and partner professionals report improved trauma-informed formulation, increased confidence, and greater stability within placements and professional networks.

Improved access and responsiveness Between April and September 2025, the pathway supported 265 children and young people, either through direct clinical input or consultation and wider network input. This included children and young people who had previously experienced long waits or who would not have met traditional CAMHS access criteria. Retrospective audit evidence indicates that the pathway has successfully widened access and addressed previously unmet need.

Workforce capability and system impact In addition to direct clinical impact, the pathway has strengthened workforce capability and system working. CAMHS practitioners describe the consultation model as essential in supporting trauma-informed practice, formulation, and care planning. At system level, the pathway has supported wider culture change through multi-agency collaboration, including delivery of a trauma conference attended by over 200 professionals.

External recognition and leadership The pathway has also received external recognition, with Trauma Pathway leads invited to present at the Institute for Recovery from Childhood Trauma at the House of Lords in September 2025. There was particular interest in the pathway's system-change approach, focusing on strengthening networks and partnerships rather than operating as a standalone specialist service.



Part 1: Summary of successes!

Oxford Health Renews Veteran Aware Accreditation

We are proud to share that Oxford Health NHS Foundation Trust has successfully renewed its Veteran Aware accreditation, delivered by the Veterans Covenant Healthcare Alliance (VCHA).

This recognition confirms that the Trust continues to meet the national standards required to support the Armed Forces community, following a comprehensive submission demonstrating our ongoing commitment and progress across key areas.

This achievement reflects the continued dedication of colleagues across the Trust in supporting the Armed Forces community, including serving personnel, reservists, veterans, service families and cadet force adult volunteers, ensuring they are treated with fairness, understanding and respect in both employment and access to our services.

The Trust remains committed to working in a forces-friendly way, and we will continue to develop and review our approach to ensure that members of the Armed Forces community are not disadvantaged and receive the understanding and support they deserve.



Part 1: Summary of successes!

Oxfordshire Talking Therapies (OTT)

During 2025/26, Oxfordshire Talking Therapies (OTT) continued to strengthen access, quality and workforce wellbeing through innovation, research and collaboration. The service implemented LIMBIC AI to streamline pre-assessment processes, reduce administrative burden and support early risk identification, with high patient satisfaction and ongoing staff feedback informing improvement.

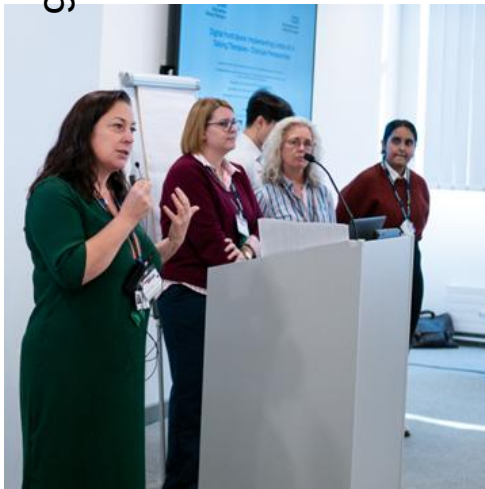
Through active participation in the Buckinghamshire, Oxfordshire and Berkshire West (BOB) clinical network, OTT contributed to collaborative quality improvement, sharing learning on recovery, productivity and leadership. OTT maintains a strong research portfolio, supporting national studies in CBT and equity-focused service improvement. Workforce wellbeing and inclusivity remain priorities, underpinned by a co-produced Local Wellbeing Strategy and completion of anti-racism training across the service.



Psychological Therapies (PT)

During 2025/26, Psychological Therapies (PT) improved access and engagement through implementation of a Mentalisation-Based Therapy (MBT) group programme. Patients are booked directly from assessment, with flexible start dates and session times, resulting in reduced waiting times, improved engagement and higher therapy completion rates.

PT is planning to introduce expert-by-experience involvement within MBT groups to improve understanding, build confidence and reduce drop-out. This work reflects PT's continued focus on improving patient experience, accessibility and outcomes through service innovation and co-production.



Part 1: Summary of successes!

Forensic Recovery College



The Forensic Recovery College was privileged to present at the EPA 2026 European Congress of Psychiatry in Prague. The presentation, Pathways to Empowerment: Integrating Psychoeducation, Peer Support, and Co-production for Lasting Recovery, explored the particular challenges of recovery in forensic mental health services, where long stays in secure care can affect hope, identity, and personal agency.

The team demonstrated how peer support and recovery college approaches can work together in practical ways — for example, Peer Support Workers contributing as Student Support Officers within the College, supporting students during courses, enrolling as students themselves, and in some cases progressing into co-tutoring and wider co-production roles.

The presentation also highlighted how these approaches can complement one another through educational opportunities, improved relational security and shared recovery values, helping to strengthen a more recovery-focused culture within secure care.

The conference was also a valuable opportunity to network with international colleagues, share learning, and raise the profile of Oxford Health's recovery-focused work in forensic services, including opening up potential future links with Koç University School of Nursing in Istanbul, Türkiye.

Peer Support Worker Evaluation

Over the last 12 months the service completed an evaluation of the impact of peer support workers in a forensic mental health setting.

Thematic findings of the impact of the role of peer support worker:

- Created a ripple effect by offering a new perspective brought to MDTs by PSWs
- Enhanced opportunities for collaborative working with patients
- Brought a renewed embodiment of hope and promoted the human experience of services
- Challenged the fear of the unknown and enabled better scrutiny around role clarity.

The evaluation will be submitted for publication and is one of the presentations being delivered as part of the International Association of Forensic Mental Health Services 2026 Conference in Helsinki (in June of this year).



Part 1: Summary of successes!

Safeguarding people with mental health needs

The Trust led a cross-sector event to improve how well we support people with mental illness experiencing self-neglect, in November 2025.

Over 100 mental health professionals, social workers, VCSE practitioners and local authority leads attended a safeguarding session on adult colleagues attended the workshop.

This learning session was held in response to thematic findings from practice and review work and involved people with experience of mental health services as well as presentations by the trust service manager for social work and the chair of the Oxfordshire safeguarding adult's board.

Cross sector tenancy support event

The trust also led a Housing Needs system event, with cross-sector partners, in March 2026 to support 'tenancy sustainment and move on to independent living' for people recovering from mental illness.

Over 40 colleagues from different organisations attended the workshop, including a trust Peer Support Worker, who provided personal insight.

This workshop session was held to improve people's recovery outcomes with respect to the OHFT-commissioned supported accommodation pathway. Attendees developed ideas and further work is being done with housing providers and local authorities on next steps.





The Nursing Summit 2025

Part 2: Priorities for improvement and statements of assurance

Part 2: Quality Management System

Quality Management System

By utilising a Quality Management System (QMS) a range of factors are included to ensure a continual cycle of improvement is in place that is supported using a QI approach, the Trust continues to work towards the implementation of a full QMS that places learning at the centre of all its efforts.



Oxford Health Quality Improvement Team continue to be the corporate support for teams and services across the trust to embed a Quality Improvement approach to improve safety, experience, effectiveness and outcomes for patients, carers and trust colleagues. The team provide training and support for quality improvement projects, enable collaboration, sharing of outcomes and horizon scanning for future projects, with the aim that improvements to patient care are always co-produced with patients and their families.



Part 2: Quality Priorities 2025/26

During 2025/26 we chose to focus our priority areas on five specific areas that are key indicators of quality across the trust. Other areas of quality and safety not included in priority areas are continually monitored by our Integrated Performance report, Quality Dashboard and local governance groups. A copy of our Board papers that include these reports can be found [here](#)

Priority Area	Detail	Aim	Trust area involved
Reducing restrictive practice	To continue to reduce the use of restrictive practice and care for patients using the least restrictive way possible.	To build upon previous years progress to reduce the use of prone restraint and seclusion.	MH & Forensic inpatient wards
Implementing PSIRF and creating a learning culture	To continue to develop the embedding of PSIRF across the trust with a focus to support continuous improvement of safety cultures, systems and behaviours.	To embed patient safety incident response within a wider system of improvement that supports cultural shift towards systematic patient safety management	Whole trust services
Involving patients and their families	Patients, carers and families are at the core of all we do. We aim to progress and develop ways to work together to learn from experience and improve trust services.	To have a framework for co-production developed and in place.	Whole trust services
Embedding continuous quality improvement.	To continue to develop the Quality Improvement (QI) culture across the trust to enhance patient care, safety and satisfaction.	To improve progression of QI project activity demonstrating a culture of improvement. To embed coproduction as an improvement fundamental.	Whole trust services
Address inequalities in the delivery of healthcare	To better achieve health equality, reliable data is required that supports the identification of potential areas of inequality across the trust to drive improvement.	Reliable and meaningful data is recorded and provides the trust with meaningful insights to focus antiracism interventions..	Whole trust services

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: To reduce the use of seclusion and prone restraint



Oxford Health
NHS Foundation Trust

Progress rating: Partially Achieved

Reducing Restrictive Practice

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The aim of the 2025/26 quality priorities were to build upon previous years progress to reduce the use of prone restraint and seclusion.

Reduction in the use of Seclusion

The year 1 target to support seclusion reduction was to achieve a baseline measurement for seclusion usage with duration and episodes. Combined reporting from Ulysiss and RiO with retrospective data entry dating back to Sept 2025, when the RiO seclusion form went live. Data quality cleansing is being completed by teams. Manual reporting is currently available to provide duration along with episodes with development ongoing to feed into the Trust BI system.

Seclusion reduction achievements

We have achieved what we set out to do during 2025/26 for this area of the quality priority. Seclusion usage data is now generated from both RiO and Ulysiss achieving improved data quality. Duration data is available via a manual report and in the final stages of data quality checking of historical duration and episode data. Weekly data quality monitoring is in place to ensure the data is reliable going forward. Updates to the seclusion form have been made to improve data quality.

Reduction in the use of Prone Restraint

We did not achieve a sustained reduction in prone restraint this year. Over the previous two years we achieved year on year reduction in the use of prone restraint, for 2025/26 we set an ambitious increased reduction target based upon previous achievements which we have not been able to achieve.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: To reduce the use of seclusion and prone restraint



Oxford Health
NHS Foundation Trust

Progress rating: Partially Achieved

Reducing Restrictive Practice

Page 523

Prone restraint data review

We have reviewed trust data that captures the use of prone restraint from 01/04/2025 – 31/03/2026. Prone restraint was applied most frequently across 2 CAMHS inpatient services, 1 adult male acute ward and 1 adult female acute ward.

We found that CAMHS inpatient and CAMHS Psychiatric Intensive Care Unit (PICU) data combined accounted for just under 50% of the total amount of prone restraint that occurred during the year.

Over two thirds of prone restraint were applied to prevent Young People from harming themselves, with the remaining third largely attributable to prevention of violence and aggression to others.

Combined CAMHS inpatient data review shows that 89% of prone restraints that occurred, involved three Young People across the two units.

One adult male acute ward accounted for 11% of total prone restraints applied, involving 14 different patients, almost half of prone restraints were to prevent violent and aggression to others.

One adult female acute ward accounted for 11% of total prone restraints applied, involving 12 different patients, over half of prone restraints were in relation to health causes often relating to self harm.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: To reduce the use of seclusion and prone restraint



Oxford Health
NHS Foundation Trust

Progress rating: Partially Achieved

Reducing Restrictive Practice

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Prone restraint progress

During the year we have continued to focus our efforts to reduce the use of restrictive practice. We have made continued to equip our staff with skills and knowledge to support development of strong therapeutic relationships to deliver care that is individually planned and with patients and their carers/families using the least restrictive options.

Some of the ways we have approached this are highlighted below:

- Alternative injection site (non gluteal) training to reduce the need for prone restraint has been rolled out across inpatient and community teams.
- Positive Engagement And Caring Environments (PEACE), training is aligned to alternative injection site administration incorporating the use of the safety pod for administering alternative injection sites.
- Patient information leaflets created (also in an accessible format) for alternative injection sites.
- Staff guidance on alternative injection sites.
- Safety pods are available in each team. All PEACE trained staff are trained in their use. The safety pod is the highest reported restraint position, used in 54% of all restraints during 2025/26.
- Oversight and governance for all prone restraints is now through the trust Weekly Review Meeting where all prone restraints are reviewed, and the service is undertaking reviews of each prone restraint to identify learning. It is acknowledged that this needs to be strengthened to allow for week-on-week identification of themes and trends.

Next steps

Whilst we acknowledge we have not made as much progress in the use of prone restraint as hoped this year, we continue to work collectively to drive down the use of restrictive practice across the trust. We will continue to focus on the use of prone restraint and seclusion as Quality Priorities for 2026/27.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: To reduce the use of seclusion and prone restraint



Oxford Health
NHS Foundation Trust

Progress rating: Partially Achieved

Reducing Restrictive Practice

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Next Steps continued

A task force commissioned by the Chief Nurse is being launched dedicated to reducing the use of restrictive practice across the trust. Work will focus on areas identified with high use of restrictive practice whilst also setting up real time robust monitoring systems to alert to the use of prone for timely review and deployment of resource to support staff and patients to be cared for in the least restrictive way.

We have appointed a Clinical Lead for Reducing Restrictive Practice as of 1st April 2026 who will provide specialist resource to support the task force objectives. Efforts will continue to embed a culture that does not view prone restraint as acceptable while maintaining an open culture of transparency and one of learning. We will establish a formalised monitoring process for all prone restraints to capture learning and to prompt real time review and intervention.

We will monitor the use of seclusion via duration secluded as well as by number of episodes to inform of the reason for, how often as well as the length of time restrictions are applied, this will allow us to understand usage, inform improvement actions and capture and share learning and best practice.

Impact on Health Inequalities

Work to achieve accurate ethnicity data has taken place and errors in how the data reports are compiled has been adjusted. A full data set is now available on TOBI in relation to restrictive practice. This has begun reporting in quarterly reports since quarter 3 2025/26. Ongoing analysis of the data is required to inform this work and identify health inequalities that require focus in line with the Use of Force act, this work has been achieved in conjunction with PCREF work.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: Address inequalities in the delivery of healthcare



Oxford Health
NHS Foundation Trust

Progress rating: Partially Achieved

Address
inequalities
in the
delivery of
healthcare

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The aim for the year was that 90% of patients had reliable and meaningful ethnicity data recorded to provide insight of patient populations and ensure the delivery of services is in line with an antiracism approach. The end of year trust position is 82.4% of all records include ethnicity data, the target has not been fully achieved but demonstrates a continuously improving position.

Achievements this year include:

- Mental Health services: Over the course of the year, there has been a steady increase in data quality at an average rate of approximately 0.3% per month. This trend has continued throughout the year with 82.4% of records including ethnicity data.

Primary Community and Dentistry services:

- Total open end of year caseload data evidences that 58.56% of all records have evidence of ethnicity data, although low this is an improving picture with Community Hospital data demonstrating 90.52% of patients have ethnicity recorded

Next steps

- Aligned with PCREF Mental Health services are engaging in a QI project modelled on the successful Gateway QI improvement project approach.
- Specific test sites in Primary, Community & Dentistry services have been identified to adopt a place-based improvement approach with learning to inform rollout across wider services.

Impact on Health Inequalities

Alongside a range of aligned equalities work within the Trust, directorate have been focusing on improving data quality. There have been additional (non-tangible) benefits when discussing the importance of asking, recording and acknowledging protected characteristics in the interest of patient centred care.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: Involving Patients, Carers and their Families



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NHS Foundation Trust

Progress rating: Partially Achieved

Listening and Responding to the Voices of Patients, Carers and their Families

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We have made significant progress over the last year with increasing practical resources and regular training for staff as well as the beginning of lived experience infrastructure taking place. We still have a lot of progress to make against the targets within this quality priority, however this year we have focused on the foundations to strengthen and support this shift in culture.

Achievements this year include:

- Development and roll out of co-production training for all staff - 2 levels of co-production training, co-delivered by the Experience & Involvement (E&I) team and people with lived experience of our services aimed at staff across all directorates
- Regular session for engagement and involvement at trust induction
- Development and publication of 2 co-production handbooks, one for Experts by Experience (EbE) and one for staff to promote, guide and support involvement.
- Established induction session for all EbE's who join the trust to undertake involvement work.
- Established project groups for workforce development and Quality Improvement.
- Lived experience project plan approved by Executive Team in Feb 26.

Next steps

- Integrate lived experience into board governance, including rotating Voice Group members and pairing board members with Experts by Experience (EbE) mentors – commencing in May 2026.
- Pilot a Lived Experience Reference Group with governance and decision-making responsibilities, evaluating its impact for future Trust-wide adoption – commencing April 2026.

Impact on Health Inequalities

Representation: Voices from marginalised communities shape service design and governance.

Accessibility: Digital tools and proactive communication reduce barriers to participation.

Responsiveness: Data-driven action enables targeted improvements for disadvantaged groups.

Cultural Change: Coproduction and lived experience become embedded in organisational practice, aligning with the NHS Long Term Plan's vision for inclusive, equitable care.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: Implementing PSIRF and creating a learning culture



Oxford Health
NHS Foundation Trust

Progress rating: Fully Achieved

To continue to develop the embedding of the PSIRF (Patient Safety Incident Response Framework) across the Trust with a focus to support continuous improvement of safety cultures, systems and behaviours

Progress has been made around each of the programme deliverables set out for 2025/26, although some pieces of work have not yet been fully completed.

The position against all the PSIRF measures identified for 2025/26 is monitored via the Trust Quality and Clinical Governance Sub Group and shows an improving picture over the last 12 months with specific areas of focus identified to take forward.

Achievements this year include:

- The Trust's Patient Safety Incident Response Plan was last reviewed/approved by the ICS in May 2025. In 2025/26 the Trust identified **37 PSIRF cases** across the organisation using a range of different review types including ILH, PSII, system reviews and thematic reviews.
- Incident learning huddles continue to be well used as a learning response to identify changes, with **203 ILH** were completed in 2025/26.
- WE recruited the second cohort of **Patient Safety Partners** in July 2025. The partners are involved in a number of QI projects, as well as the Trust's PSIRF oversight processes and they led on a mechanism to collect feedback from patient/family members on their experiences of safety review processes.
- In November 2025 we self-assessed our position against the Health Services Safety Investigations Body (HSSIB) report on future learning from investigating under the PSIRF ([Investigating under the Patient Safety Incident Response Framework \(PSIRF\): sharing HSSIB learning for future development — HSSIB](#)). The self-assessment demonstrates the benefits of investing in dedicated reviewers/investigators whereby staff are trained, have ring fenced time and experience in applying safety science analysis and methods, engaging with those affected and writing high quality reports.

Part 2: Review of Quality Priority progress 2025/26



Oxford Health
NHS Foundation Trust

Quality Priority area: Implementing PSIRF and creating a learning culture continued

Progress rating: Fully Achieved

To continue to develop the embedding of the PSIRF (Patient Safety Incident Response Framework) across the Trust with a focus to support continuous improvement of safety cultures, systems and behaviours

Achievements this year include:

The NHS Trusts across the BOB system completed a second annual peer review of completed safety reviews. This most recent peer review was completed in the BOB system Patient Safety and Improvement Forum held in November 2025 including our Patient Safety Partners, commissioners (ICB), NHS England and Health Innovation Oxford and Thames Valley. The feedback we received about our reviews was very positive. We have used the exercise to reflect on our report templates.

The Trust has introduced a new mechanism called Safety Action Review Visits, to enhance the current process to monitor not only the completion of actions after a safety review but also the effectiveness and whether the change has been sustained

We have seen an improvement in safety culture and staff engagement within safety reviews. This is demonstrated in a number of ways one being the annual staff survey results. All 4 patient safety measures in the national staff survey improved from 2024 and are above the national average levels.

- 19a treat those involved in an incident fairly 71%,
- 19b encouraged to report incidents 92.3%,
- 19c take action from incidents 77.4%,
- 19d feedback about changes from incidents 71.3%.

The 6-weekly patient safety webinars have been a success alongside sharing the learning from all PSIRF cases at team/ward level meetings and on the intranet.

The Trust has regular reviews of progress against PSIRF held with BOB ICB and NHSE. We have had positive feedback throughout about continued progress and level of maturity.

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: Implementing PSIRF and creating a learning culture continued



Oxford Health
NHS Foundation Trust

Progress rating: Fully Achieved

To continue to develop the embedding of the PSIRF (Patient Safety Incident Response Framework) across the Trust with a focus to support continuous improvement of safety cultures, systems and behaviours

Next steps

The programme board will re-set the PSIRF programme deliverables and measures for 2026/27.

Focus areas are likely to include;

- Continue with QI project on improving the patient/family voice in ILH
- Introduce new medicine incident safety reviews with the clinical pharmacists and MSOs
- Work on strengthening ILH and IRR actions, pilot started in Oxon and BSW
- Build on initial Duty of Candour/professional transparency contact by clinical team with patient/family
- Roll out the agreed new patient safety educational programme

Impact on Health Inequalities

The ethnicity, age and gender are identified for the patient(s) involved in every PSIRP case and ILH. We also capture this information for all incidents. We have completed thematic reviews around neurodiversity, CAMHS to adult transitions and more.

In 2025/26 we have been piloting some work on cultural sensitivities within safety reviews.

The Patient Safety Partners with lived experiences of services are involved in the safety review oversight and sign off processes as they provide an important different perspective to look at inequalities

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: Embedding Continuous Quality Improvement



Oxford Health
NHS Foundation Trust

Progress rating: Fully Achieved

To continue to develop the Quality Improvement (QI) culture across the trust to enhance patient care, safety and satisfaction

We have made strong progress in advancing our priority to develop a sustainable Quality Improvement (QI) culture across the Trust. This is evidenced by a consistently high level of engagement in QI activity including clinical audit, improvement work, webinars and work being submitted for awards and publication. This is alongside a significant investment in capability building within improvement with 751 staff members completing a form of QI training across the year.

Importantly, our approach has evolved from focusing on volume to emphasising quality and impact as part of a robust quality management system. The introduction of vigorous approval processes across all hubs ensures that QI projects are not duplicated, well-designed, with clearly defined aims, measurable outcomes, and alignment to organisational priorities. This has strengthened the overall standard and effectiveness of improvement work across the Trust. We are now seeing the Trust adopt the improvement process for larger scale pieces of work, looking at patient flow, patient safety incidents and culture building.

In addition, we have seen a meaningful increase in the involvement of patients and carers in QI initiatives with 45% of relevant projects now involving lived experience, up from 36% last year. This reinforced our commitment to co-production and ensures that improvements are informed by the patient voice and experience. Collectively, these demonstrate a maturing QI culture that is embedded, collaborative, and increasingly focused on delivering measurable benefits for patients.

Achievements this year include:

- Primary, Community & Dental Services have delivered a year of exceptional progress and innovation which has received national recognition. Teams across services have demonstrated a strong commitment to improvement, sustainability, and high-quality care, contributing to a growing culture of excellence with 76 active QI projects

Part 2: Review of Quality Priority progress 2025/26

Quality Priority area: Embedding Continuous Quality Improvement continued



Oxford Health
NHS Foundation Trust

Progress rating: Fully Achieved

To continue to develop the Quality Improvement (QI) culture across the trust to enhance patient care, safety and satisfaction

Achievements this year continued:

- OxBSW adult and older adult services have maintained stability with over 20 active QI projects at any one time. There has been an increase in the number of projects having patient and/ or carer involvement with currently 86% of projects evidencing this.
- CAMHS services number of active projects has remained around 20 with an increased engagement across a range of CAMHS services as well being active participants and champions of research.
- Forensic services have experienced a consistent level of projects over the year with a core, engaged group of staff utilising QI to make improvements across the directorate. There has been extensive work across the Culture of Care programme as part of the national transformation programme for inpatient care.
- Buckinghamshire have made significant progress embedding a culture of Quality Improvement, contributing to broader and more sustained QI activity. This is evidenced by an increase in the number of active QI projects underway, alongside stronger alignment with Trust Quality and Patient Safety priorities
- Corporate Services welcomed Senior Leaders to a series of Q&A sessions on 'What QI Means to Me', supported by Executives. These candid interviews provided excellent insights and real validation for improvement approaches that reach from 'the Board to the ward' staff have feedback that they have felt inspired to take on more improvement work as a result.

Impact on Health Inequalities

Quality Improvement has contributed to reducing health inequalities across the trust through targeted projects. One prominent example of this is the Bucks Gateway ethnicity information project, which has significantly improved ethnicity data capture, increasing from 26.32% to 77.41%, enabling better understanding of population and outcomes. A further example is a recently initiated project focusing on reducing dropout rates for underrepresented communities in Bucks Talking Therapies.

Caring, safe and excellent

Part 2: Quality Priorities 2026/27

During 2026/27 we have chosen to focus our priority areas on six specific areas that are key indicators of quality across the trust and align with strategic objectives. Other areas of quality and safety not included in priority areas are continually monitored by our Integrated Performance report, Quality Dashboard and local governance groups.

Priority Area	Strategic priority	Quality Priority Aim	Trust area involved
Reducing restrictive practice	To continue to reduce the use of restrictive practice and care for patients using the least restrictive way possible.	Reduction of the use of prone restraint and duration of seclusion.	MH & Forensic inpatient wards.
Violence Prevention and Reduction	Establishing Mental Health Acute Care Board overseeing improvements in inpatient and crisis services including restrictive practice and patient experience.	Reduction of staff harm associated with restrictive practice in inpatient services	MH & Forensic inpatient wards.
Patient & Carer Experience	Progress methods of collecting feedback on patient experience and consistently demonstrate patient involvement and choice in the delivery of care everywhere	Meaningful focus on patient/ family experience feedback and actions taken in response.	MH, PC&D, LD and Forensic services.
Physical Health	Establishing an oversight group for integrating physical health care and specialisms across Trust services	Embed and progress the trust Integrated Health Strategy across directorates.	MH, PC&D, LD and Forensic services
Quality Management System	Strengthening the Quality Management System driven by Quality Improvement methodology.	Embed a consistent approach to quality across the trust, using real-time data and strengthened governance to deliver consistent and measurable improvements in care.	MH, PC&D, LD and Forensic services
Core Clinical Standards	Assurance around core clinical standards such as care plans, risk assessments, and physical health assessment and observation.	Develop mechanisms to support the monitoring, review and improvement of the quality-of-fundamental standards of care that includes care plans, safety assessments and develop .	MH & Forensic inpatient wards.

Each quality priority area has identified key deliverables and measures of success and progress which are monitored throughout the year via the trust Quality priority Programme Board and reported by trust internal governance structures.

Part 2: Monitoring our performance

Performance Reports

The Integrated Performance Report (IPR) provides the Board of Directors with an integrated view of the strategic domains of Operational Performance, Quality and People. It has been re-designed for an improved alignment with Trust strategic ambitions, national and local reporting performance requirements. The report continues to be developed further to provide a comprehensive and reassuring oversight of Trust performance measures. The report continues to be developed further to provide a comprehensive and reassuring oversight of Trust performance measures.

The IPR is fed by directorate data that is monitored and reviewed robustly at a local level to understanding performance metrics and inform improvement and appropriate early escalation where necessary.

In summer 2025, NHS England published an updated version of the NHS National Oversight Framework (NOF). Under the new framework, NHS England assesses provider performance against a defined set of metrics to determine segment scores. These scores will inform where targeted improvement is required. The resulting improvement interventions will be tailored based not only on performance but also on an assessment of each organisation's leadership, governance, and overall capability, ensuring a balanced and proportionate approach to oversight and support.

The Integrated Performance Report has been reviewed to ensure alignment with the updated National Oversight Framework. Detailed performance data and the annual strategic measures reporting can be found within the trust public board papers [here](#)

Further information about performance can be found 2025/26 Annual Report when published : [Publications | Oxford Health NHS Foundation Trust](#)



Part 3: Key Dimensions of Quality

Part 3: Clinical Audit

Clinical Audit - a tool for improvement

Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust takes actions to improve the care provided.

Clinical Audit activity forms part of the trusts wider Quality Management System aimed to support inform learning, improvement and to ensure the trust can demonstrate that it is meeting regulatory, commissioning, contractual and legal requirements in relation to the quality and safety of the services provided.

In 2025-26 we participated fully in 13 national audits. Alongside these we carried out 41 locally identified clinical audits. Updates for the national audits we participate in can be found in appendix 1 of this report.

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13 national audits



126 locally managed clinical audits.

The clinical audit plan 2026/27 has been developed by the corporate audit team in coordination and collaboration with the directorate governance leads and clinical teams. The plan has been developed to balance directorate/service level audits with national and trust wide priorities.

Summary of the National Audit Results appendix 1 of this report.

Part 3: Implementing the Patient Safety Incident Response Framework



Oxford Health
NHS Foundation Trust

Background The PSIRF was introduced as part of the National Patient Safety Strategy to fundamentally shift how the NHS responds to patient safety incidents and makes changes to improve care. With NHS Trusts being empowered to determine their incident responses locally, and a shift to a system-based approach to learning.

OHFT transitioned to working under PSIRF from 3rd Dec 2023. This programme remains in place to oversee the next phase of changes, which will continue to embed the PSIRF's principles and approach.

We have had regular reviews of our progress with embedding the PSIRF principles with our commissioners and NHS England throughout 2025/26.

Vision and Outcomes The vision for the next phase of the programme is to achieve a patient safety culture where staff report all incidents, there is openness to identify learning and make changes, and we can demonstrate the impact of this. We expect to see;

- Increase in patient incidents reported with a decrease in moderate and severe harm incidents.
- Improved feedback from staff and patients/families affected by incidents about their experience.
- Increase in use of alternative learning response approaches, to enable tailored and richer learning.
- More reviews occurring with other organisations/external agencies participating to maximise learning
- A reduction in reoccurring learning themes, demonstrating safer systems of care

Further details More details about the Trust's approach and patient safety incident response plan can be found at Patient Safety Incident Response Framework (PSIRF) - Oxford Health NHS Foundation Trust.

A report on embedding PSIRF and learning from safety reviews is published at each Board of Directors meeting, papers are available here [Board Papers](#) | Oxford Health NHS Foundation Trust

Key deliverables 2025/26

- Implement next iteration for Incident Learning Huddles (also commonly known as After Action Reviews) including developing how patients/families are more involved.
- Develop the Patient Safety Partner role, involving people with lived experience working with us.
- Continue improvement work on duty of candour/professional transparency
- Focus on demonstrating impact of changes/actions from PSIRP cases which overall improve the safety of systems
- Continue to support a positive staff safety culture
- Continue to develop how we share learning and feedback to teams about changes being made, in different formats and through different routes

Part 3: Patient Safety

Learning from patient incidents We review the immediate learning and trends from all patient incidents.

We use incident learning huddles (ILH) (sometimes known as After Action Reviews) as an initial learning response where there has been significant harm to a patient, or we believe there is a potential for great learning. An ILH is a facilitated group discussion with professionals involved in the care provided to a patient to help us to understand more about what's happened and why. The huddles will check support is in place for those affected and focus on what can be learnt. The approach has proven to be an effective way to improve engagement in identifying and acting on learning. In last 12 months we have completed 203 incident learning huddles (this compares to 183 in 2024/25).

Some incidents are identified for further in-depth review, these are categorised through the Trust's Patient Safety Incident Response Plan. The plan was last reviewed in May 2025 and available here [Patient Safety Incident Response Framework \(PSIRF\) - Oxford Health NHS Foundation Trust](#). Every review is focused on learning to inform improvement.

In 2025/26 the Trust identified 37 cases under our Patient Safety Incident Response Plan, there is a break down by clinical directorate and safety area in the table below. We have used a range of learning responses including Incident Learning Huddles, Patient Safety Incident Investigations, System Reviews and Thematic Reviews. Most cases have been in the local safety area of 'access to care and treatment'. All safety reviews have used a human factors methodology (SEIPS = Systems Engineering Initiative for Patient Safety) to better understand what happened ('work done') and why, against what we think or expect should happen ('work imagined') so that the learning and the safety actions we identify address the real issue(s).

Directorate/ Type of learning Response	Safety Area						Grand Total
	Assess care/treatment	Detained patient death	Emergent theme	Homicide	Joint working with other organisations	Physical Deterioration	
Buckinghamshire Mental Health	4	1	2 [1-perinatal death 1- self neglect]	1	2		10
Forensics Mental Health	0	0	0	0	0	1	1
Oxfordshire Community, Primary and Dental	5	0	2 [1-Wrong tooth extraction 1 -missed diagnosis of fracture]	0	2	3	12
Oxfordshire & BSW Mental Health	9	0	2 [1- capacity assessments/decisions 1 – Adult ADHD deaths while waiting]	0	1	2	14
Grand Total	18	1	6	1	5	6	37

Part 3: Patient Safety



Oxford Health
NHS Foundation Trust

Learning from Patient Incidents continued

There has been a measurable improvement in safety culture and staff engagement within safety reviews. This is demonstrated in a number of ways one being the recent annual staff survey results for 2025. All 4 patient safety measures in the survey improved from 2024 and are above the national average levels compared to other NHS Trusts.

We have recruited the second cohort of Patient Safety Partners from July 2025, they are in 18-month fixed term contracts and are a really valuable addition to the patient safety team and organisation. The partners are involved in a number of quality improvement projects, as well as the Trust's PSIRF oversight processes and they led on a mechanism to collect feedback from patient/family members on their experiences of safety review processes.

Current performance with the national patient safety syllabus level 1 is at 96% (end of March 2026) for all staff in the Trust. We have rolled out additional patient safety training for all reviewers/investigators, key staff in oversight roles and those engaging with patients/families.

In the last year the key areas for learning are:

- ❖ Sharing information and engaging with family members
- ❖ Joint working and communication with external agencies (GPs, care homes, police, private providers)
- ❖ Coordination of care between OHFT services
- ❖ Quality of clinical documentation – risk assessments/formulations, capacity assessments, care plans, NEWS2

Coroner Preventing Future Death Notices

In 2025/26 the Trust received 3 Preventing Future Death Notices (June 2025, September 2025 and February 2026), and a letter from an Oxfordshire Coroner in December 2025. The learning identified in the four cases is described below for each we have reflected and identified actions.

- ❖ Develop inpatient discharge processes and medication supervision in the community.
- ❖ Strengthen communication of important clinical information and decisions to GPs.
- ❖ Transfer of care between OHFT teams and oversight by the multidisciplinary team.
- ❖ Communication between OHFT teams and communication of risks with patient/family.

Part 3: Learning from Deaths

Oversight and Reviews

The Trust takes our role and responsibilities very seriously around reviewing, learning and taking appropriate actions after a death. The Trust's learning from deaths process reviews all patients against a national database to ensure we identify all deaths, including patients under our care at the time of their death and those who die within 12 months of their last contact to help identify any themes or trends.

The Trust's internal mortality review process involves the deaths of all patients under the Trust's care at the time they die, screened by at least two senior clinicians to decide whether a formal review of care is required, the outcome of the screening feeds into our weekly patient safety forums and is aligned with our approach under the Patient Safety Incident Response Framework (PSIRF). Most deaths are expected however where there is either; a concern about the care provided, the death relates to self-harm, or a patient comes from a particularly vulnerable group, there is a formal review. The level of review required depends on various criteria such as our level of involvement in care provided, the persons age, the setting they die in, the circumstances surrounding their death and whether the family have concerns about the care provided.

The Trust is an active member of various external multi-agency review processes for, all child deaths, for people who are homeless or in temporarily accommodation at the time they die and for those people with autism or a learning disability. We attend the Buckinghamshire and Oxfordshire suicide prevention multiagency groups and the BOB integrated care system Learning from Deaths Network. The Coronial and Medical Examiner processes run independently and are parallel to the Trust's internal mortality review process.

We also submit information to the following national confidential enquiries to support national learning:

Learning disabilities and autistic people mortality review programme

National child mortality database

National confidential inquiry into suicide and homicide

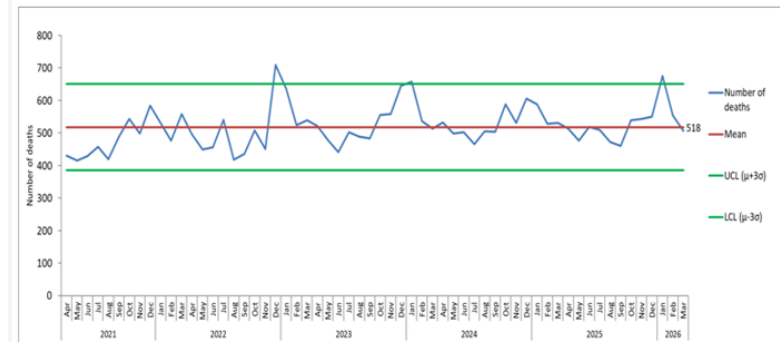
The following slide gives an overview of our review of mortality data and trends.

Part 3: Learning from Deaths

Mortality data and trends up to 31st March 2026

- No significant change in number of deaths over the last 5 years including patients open to services at the time they have died and those discharged from services within 12 months. Average 518 deaths per month. Figures generally within normal levels of variation but spike seen in January 2026 during period of excess winter deaths.
- An even split between male (49%) and female (51%) deaths.
- Compared to total deaths in England and Wales (ONS) – similar pattern over time, the spike in January was also seen in national figures.
- Majority of deaths are for patients last seen by physical health services such as District Nursing. With most deaths are for patients aged 75 plus from natural causes.
- There have been 3 inpatient mental health deaths in the last 12 months,. All patients died unexpectedly of natural causes on the ward. There were also 2 patient deaths on a Community Treatment Order in the previous 12 months; 1 death is a suspected suicide and 1 death was an unexpected natural death.
- There have been 57 confirmed/suspected suicides for open and discharged patients in the last 12 months, of which 21 were open at the time to mental health services, 4 open to physical health services and 4 to both types of services. 6 were seen by urgent care services in the 7 days prior to death. Higher number of male suspected suicides although not as big a gap as seen previously (31 males/26 females).

Total number of deaths
current patients and patients discharged from our care



Pattern: Trust deaths vs National rate
current patients and patients discharged from our care



Part 3: Learning from deaths

Summary of the key areas for improvement in progress:

- ❖ Mental health services;
 - Updating risk formulation, safety planning and care plans.
 - Clarity of roles within MDT.
 - Family involvement/consideration of their needs.
 - Cross agency working and sharing information.
- ❖ Physical health services;
 - Involving families.
 - Cross agency working and sharing information, with a particular focus on end-of-life care
 - Continued work around early recognition and responding to soft signs of sepsis and physical deterioration (inpatient and community teams).
- ❖ Care for patients with a Learning disability;
 - Strengthen proactive end-of-life planning. Workstream underway on RESPECT processes and accessible information.

Part 3: Learning from Deaths



Oxford Health
NHS Foundation Trust

Suicide Prevention

The Trust is committed to supporting the national suicide prevention strategy as well as the local authority action plans and we actively contribute to the multi-agency suicide prevention groups to strengthen collaboration and joint working. The Oxfordshire plan [Oxfordshire Suicide and Self-Harm Prevention Strategy 2025-2030](#) and the Buckinghamshire plan [Buckinghamshire-Suicide-Prevention-Action-Plan-2024-2028.pdf](#).

We are part of two real time surveillance systems one in the Thames Valley and one national.

The suicide rate for OHFT is 4.36 per 100,000 people which is similar to the national median of 4.39 for NHS Trusts (data source latest NCISH annual safety scorecard).

5-year national strategy to 2028 focuses on ([Suicide prevention strategy for England: 2023 to 2028 - GOV.UK](#)):

- ❖ Making suicide prevention everyone's business, maximise the collective impact to prevent suicides.
- ❖ Data and evidence
- ❖ Priority groups and risk factors such as middle-aged men and autistic people, and financial difficulties
- ❖ Stigma and language
- ❖ Improve support for people bereaved by suicide

The Trust's Suicide Prevention Steering Group oversees the Trust's partnership work to help prevent and reduce suicides in populations we serve.

The Trust continues to embed the *Staying Safe from Suicide Best Practice Guidance for Safety Assessment, Formulation and Management*, published in 2025 <https://www.england.nhs.uk/long-read/staying-safe-from-suicide/>. The guidance promotes a person-centred collaborative approach to safety assessments to understand a patient's situation, changeable risk factors and to co-produce a safety plan, rather than relying on risk prediction tools, scales and static stratification which is unreliable as suicidal thoughts are dynamic and can change quickly.

The Chief Medical Officer is the Board lead for suicide prevention and for implementing this guidance. The latest update on the actions we have taken was presented to the Board of Directors in March 2026 available here [25 March 2026 | Oxford Health](#)

Part 3: Patient Experience

Complaints, Concerns and Compliments

The Trust continues to embed the new NHS Complaints Standards introduced 1st April 2024.

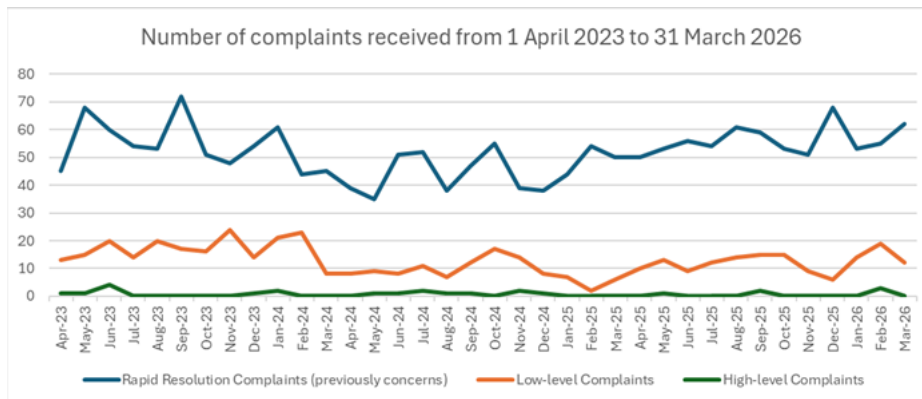
The Complaint Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service. The new standards encourage organisations to focus on the early resolution of complaints and as such have changed the language used and the way we approach and categorise complaints to promote early resolution. Pre-1 April 2024 categories: *Formal Complaints and Concerns*. post 1 April 2024 categories: *Rapid Resolution, Low-Level Complaints, High-Level complaints*.

In 2025-26, Oxford Health NHS Foundation Trust (OHFT) received a total of 825 complaints which is an increase from the previous year of 629

2025 -26 breakdown by type:

- 670 rapid resolution complaints (2025 = 513)
- 149 low-level complaints (2025 = 108)
- 6 high-level complaints (2025 = 8)

The Trust also received and responded to 187 early resolution cases, 48 CQC cases and 112 MP cases during the year.



- ✓ 100% of low/high level complaints were acknowledged within three working days.
- ✓ 100% of low/high level complaints were responded to within a timescale agreed and communicated with the complainant. This includes complaints with an extension to the timescale.

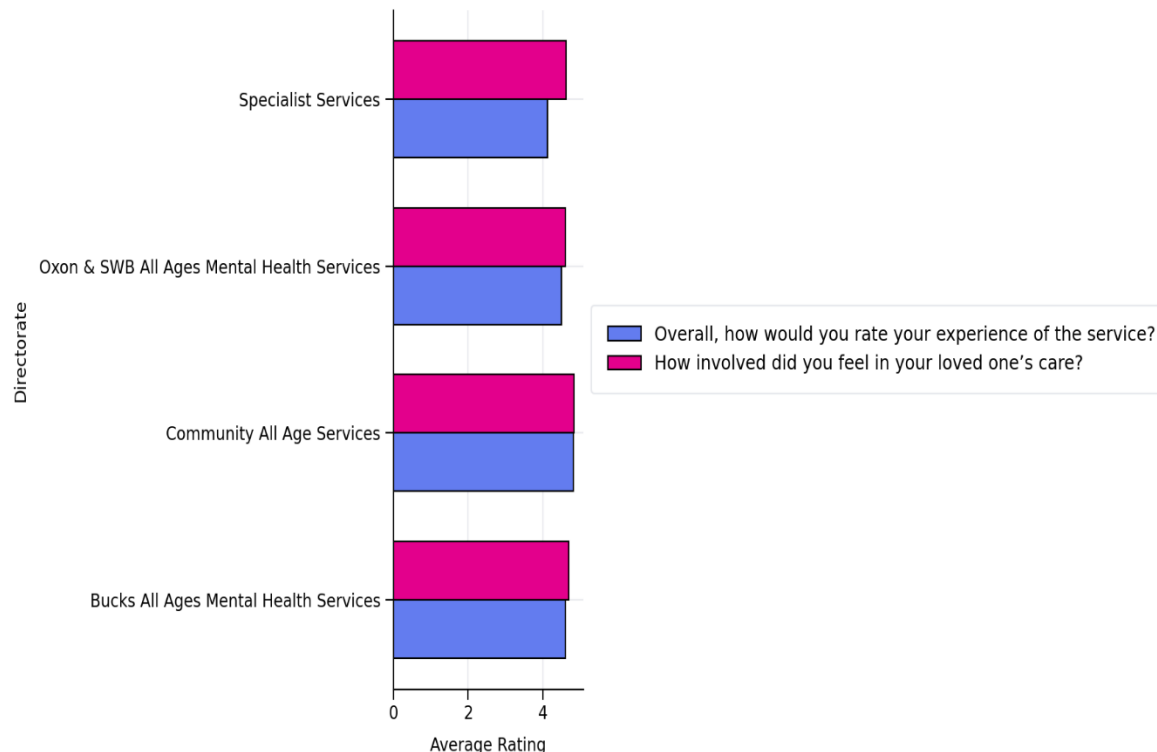
Part 3: Patient Experience

Feedback from patients and carers

We have a mechanism for collecting feedback. 19,121 reviews were received on I Want Great Care (IWGC) over a 12-month period with 4,702 of those coming from self-identified friends, family members and carers.

The graph shows the responses across the organisation from parents, carers and friends who answered the questions, “overall, how would you rate your experience of the service?” and “were you involved as much as you wanted to be in your loved ones care?” between March 2025 –Feb 2026

Friends, Family members and Carers: Involvement and Experience Ratings by Directorate

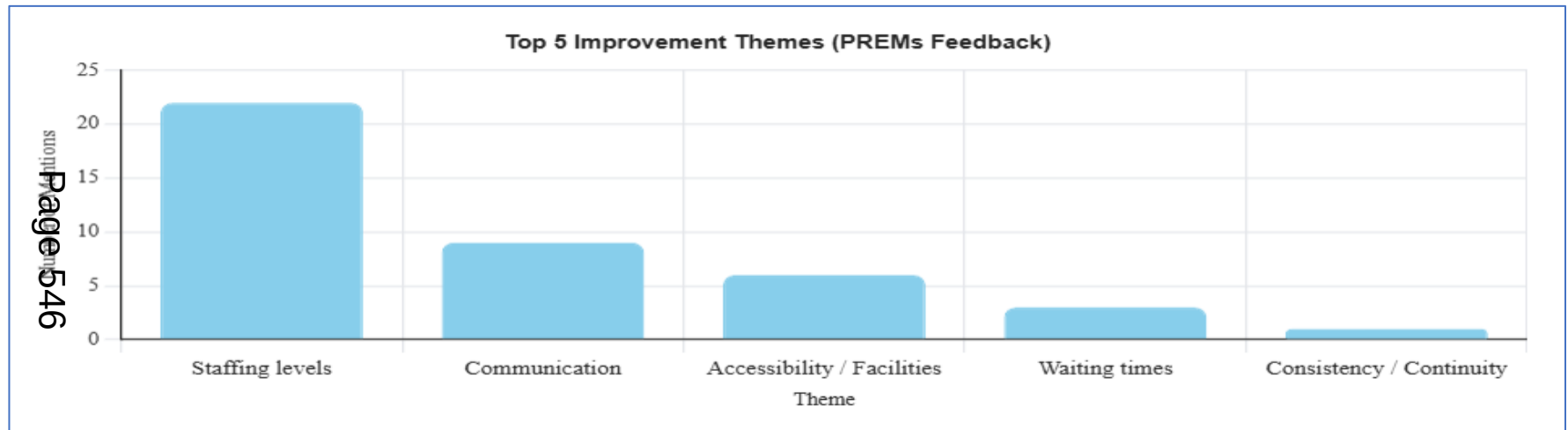


Part 3: Patient Experience

Feedback from patients and carers

Themes from IWGC qualitative data

Themes emerging from the “what could be improved?” qualitative feedback from self identified friends, family members and carers:



Staffing levels – 22 mentions

Includes comments about needing more staff, stretched teams, or limited clinician availability.

Communication – 9 mentions

Includes requests for better updates, clearer information, being kept informed, or easier ways to contact staff/services.

Accessibility / Facilities – 6 mentions

Covers issues such as wheelchair access, building layout, signage, parking, or room suitability.

Waiting times – 3 mentions

Refers to long waits for appointments, delays between contacts, or long gaps between therapy/clinical sessions.

Consistency / Continuity – 1 mention

Touches on regularity of sessions, staffing continuity, or consistent scheduling.

Part 3: National Survey Outcomes

National Survey Adult and Older Adult Community Mental Health Patient Survey 2025

The Care Quality Commission (CQC) undertakes an annual community mental health survey, which asks people who use NHS community mental health services in England about their experiences of care. OHFT response rate was 21.06% with 254 respondents

The trust's results were about the same as most trusts for 29 questions. 2 questions scored worse or somewhat worse than most. 3 questions scored better or somewhat better than most. 0 questions scored much better or much worse than other trusts. The trust is reviewing the results of the survey in further detail to understand where improvement efforts may be directed and share the good practice identified.

Lowest scoring questions (red) and highest scoring questions (green) below:

Question number	Question	Respondents 2025	Score 2025	Band 2025
Q32_2	In the last 12 months, did your NHS mental health team give you any help or advice with finding support for... Finding or keeping work	141	2	About the same
Q40	Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	206	2.1	Somewhat worse
Q32_3	In the last 12 months, did your NHS mental health team give you any help or advice with finding support for... Help with money or benefits	151	2.2	About the same
Q32_1	In the last 12 months, did your NHS mental health team give you any help or advice with finding support for... Joining a group (e.g. art, sport etc)	200	3.7	About the same
Q37	Do you feel the support provided meets your needs?	72	4.4	About the same
Q39	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	244	8.1	About the same
Q21_2	Have any of the following been discussed with you about your medication? Benefits of medication	121	8.3	Better
Q25	Thinking about the last time you received therapy, did you have enough privacy to talk comfortably?	118	8.3	About the same
Q21_1	Have any of the following been discussed with you about your medication? Purpose of medication	124	8.6	Better
Q22	In the last 12 months, has your NHS mental health team asked you how you are getting on with your medication?	113	8.9	About the same

Part 3: Statement of Directors responsibilities in respect of the Quality Account



Oxford Health
NHS Foundation Trust

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out by NHS England, available here [NHS England » Quality Accounts requirements](#)
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2025 to March 2026
 - papers relating to quality reported to the Board over the period April 2025 to March 2026
 - feedback from commissioners 02/06/2026
 - feedback from governors: 18/05/2026
 - feedback from local Healthwatch organisations: 26/05/2026
 - feedback from Overview and Scrutiny Committees: **to be received post HOSC meeting**

The Trust's annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009

Part 3: Statement of Directors responsibilities in respect of the Quality Account

- The 2025 national patient survey
- The 2025 national staff survey
- The Head of Internal Audit's annual opinion of the Trust's control environment
- Any CQC inspection reports
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

DATE- Trust Chair DATE–Chief Executive to be completed post HOSC feedback

Appendices

- Appendix 1: National Clinical Audit summary
- Appendix 2: Commissioners feedback
- Appendix 3: Council of Governors feedback
- Appendix 4: Health watch feedback
- Appendix 5: Oxfordshire Joint Health Overview & Scrutiny Committee feedback

Appendix 1: National Clinical Audit updates

Clinical Audit	Summary
Core National Diabetes Audit (NDA) – Education Element	National deadline for 2025/26 data is 07/05/2026. Audit team will liaise with relevant service to receive the information for upload by the deadline. The audit collects data on diabetic patients. There are multiple audits which track a patients diabetes management to form a wider registry of diabetic care in England and Wales. Oxford Health provides structured education to Type 2 diabetic patients and enters this data into the audit. For the 2024/25 year, 1873 patients were offered structured education, of which 415 attended. This gives an attendance rate of 22% (down from 61% in 2023/24). Data is currently being collated ready for upload to the national audit.
Page 551 National Audit of Diabetes Footcare (NDFA)	Audit data is collected and submitted on a quarterly basis. Collections are ongoing, with a final submission deadline for 2025-26 data in June. Outcomes below are based on quarter 1 and quarter 2 reporting. Deadlines: Q3: 25/03/26 Q4: 13/06/26 Key Successes • NHS digital access has been updated to include new/ relevant staff. • Clinic manager working alongside staff to support data collection. • Monthly review meetings for NDFA champions now in place. Key Concerns • Completed audit form numbers are below target at end of Q2. • Staffing levels continue to be cause of concern. Actions • The NHS digital access to be updated at regular intervals to include new/ relevant staff. • Investigate options for including NDFA form accessible via a template on the EMIS system. • Regular, monthly NDFA review meeting within podiatry team.

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
Page 552 National Audit of Eating Disorders	The National Audit of Eating Disorders (NAED) is a new audit commissioned by the HQIP and is part of the NCAPOP Programme on behalf of NHS England. The audit will run from August 2024 to July 2027. All services were invited to register for the audit – 16 teams from OHFT have registered and leads for each team have been identified. Between 2024-25, NAED undertook a mapping exercise for eating disorder services to understand provision and the pathway of care. This included two organisational surveys for completion by as many registered teams as possible. The trust submitted 15 responses for survey 1, and 12 responses for survey 2, based on the 16 registered teams participating in the audit. The service mapping report was made available in December' 2025 which was shared with the teams for information only purposes. In December 2025, NAED released a survey, to gather views of children and young people under the age of 16 with lived experience of an eating disorder. Teams were encouraged to actively participate with the aim that the voices of the Trusts service users and carers could be used to influence the build of the audit to support areas that matter to them. A staff survey was issued in February 2026, gathering data regarding workforce, referrals, caseloads, inpatient beds, contacts and budget. The deadline for submission is March 2026. Dates for main data collection is yet to be confirmed but the Trust have met all deadlines pertaining to all elements in the preparatory phase.
National Audit of Care at the End of Life (NACEL) Mental Health	Oxford Health NHS Foundation Trust registered to participate in the NACEL Mental Health Spotlight Audit. The audit ran from 20/01/2025 – 16/01/2026 and included; Case Note Reviews, Staff Reported Measure, Trust/Health Board overview and Annual death data collection. Oxford health took part in all elements however, there were no eligible cases for case note review submission. The national report is due August 2026.

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary		
National Audit of Care at the End of Life (NACEL) Page 553	Data collections took place from Jan – Dec 2025. Key Indicator Summary:		
	Key Indicator	Submission (n)	Submission (%)
	The number of deaths where it was expected that the person would die during the final admission as a proportion of the sample ‘all deaths’ included in the audit	61	78.7%
	The proportion of people who died with documented evidence in their clinical records of communication about hydration with those important to the dying person, or a reason recorded why not	61	88.5%
	The proportion of people who died with documented evidence in their clinical records that anticipatory medication was prescribed for symptoms likely to occur in the last days of life	59	100.0%
	The proportion of people who died with documented evidence in their clinical records of an assessment of the emotional/psychological needs of the person, or a reason recorded why not	61	98.4%
	The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good	0	-
	The proportion of hospital/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week	1	0.0%
	The proportion of bereaved people that strongly agree or agree that they were communicated to by staff in a sensitive way	0	-
	The proportion of people who died who had an individualised plan of care addressing their needs at the end of life, where it was recognised that the person may die during the final admission (Cat 1 only)	48	89.6%
	The proportion of people who died with ethnicity documented in their clinical records	61	96.7%
AMaT Compliance per month:			
Jan 96.2% (5 deaths) May 93% (6 deaths) Sep 100% (3 deaths)			
Feb 97.6% (4 deaths) Jun 95.7% (6 deaths) Oct 94.8% (5 deaths)			
Mar 95.9% (7 deaths) Jul 97.5% (8 deaths) Nov 93.9% (6 deaths)			
Apr 95.4 (7 deaths) Aug 90.9% (4 deaths) Dec 91% (6 deaths)			
		The corporate audit team are currently working with clinical leads to review data to inform key successes and areas of improvement to support the creation of improvement actions.	

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
Prescribing Observatory for Mental Health (POMH-UK) – Improving the quality of Valproate prescribing in adult mental health services Page 554	This audit was included on the 2024/25 Quality accounts list. It commenced on 16th June’2025 with data collection ending on 8th August’2025. The final report was published in January’2026 The eligibility criteria specified – all patients currently prescribed Valproate and under the care of adult Mental Health services (including forensic services), irrespective of age. CAMHS, LD and Older Adult were not required nationally to participate in this audit. A total of 65 patients were audited, covering 23 teams/wards across the Trust. Areas for improvement - Documentation of information including: - Valproate prescribing, including recording the indication and target symptoms, age-related prescribing requirements and specialist justification. - Discussion of maternity and paternity risks prior to initiation. 3-month treatment review (response and common side effects.) - Annual risk–benefit review including therapeutic benefit - Adverse effects and adherence. Actions - To address the identified gaps, the teams will explore using our existing digital clinical systems to embed mandatory prompts, templates, and review triggers for valproate prescribing and monitoring. These system-based checks will support clinicians to complete and document all required criteria at the appropriate stages of treatment.

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
Prescribing Observatory for Mental Health (POMH-UK) - The use of Clozapine Page 555	The audit was conducted in the Q4 of 2024-2025 between 3rd March' 2025 to 30th April' 2025. The national report was released in September' 2025. The audit included any person under the care of adult mental health services at the time of audit, irrespective of age, and currently prescribed Clozapine treatment. The trust data collections included a sample of 139 patients, covering 23 teams/wards across the Trust. Key successes • Pre-treatment screening which included physical examination with cardiovascular assessment. • During the first two weeks of treatment, patients had daily monitoring of temperature, blood pressure, and pulse, and in the first month there was weekly assessment for common side effects such as cardiac symptoms, hypotension, constipation, and weight gain. • Patients established on clozapine for more than a year were reviewed annually by a senior clinician. • Initiation of clozapine for treatment-resistant schizophrenia was preceded by documented discussion with patients and/or carers about potential benefits and side effects. Areas for improvement • Off-label Clozapine prescription should have the discussion with the patient and registration with the relevant monitoring service documented. • Patients on Clozapine for more than a year should have an annual medication review, addressing therapeutic response and recognised side effects. Actions Clinical teams are currently in discussion to create action plans to effectively address the improvement areas.

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
Prescribing Observatory for Mental Health (POMH-UK) – The use of medicines with anticholinergic (antimuscarinic) properties in older people’s mental health services	This audit was included in the 2025/26 Quality accounts list. The audit took place between 1st Oct’2025 and 28th November’2025 and the national report is due to be published in April’ 2026. All patients under the care of Older Adults Mental Health services were eligible for inclusion, without age restriction. Patients under care of any other services irrespective of age were not included. The sample included patients across Inpatient wards, Memory Clinics and Community MH teams for Older Adults. A total of 351 patients were audited covering 12 teams/wards across the Trust. While we are awaiting the National report, a preliminary analysis was carried out by the Corporate Audit team and shared with the relevant stakeholders. This preliminary report highlighted key success and areas that require close monitoring. Key Successes • Prescribing practices in older adults generally favoured medications with low or no anticholinergic burden. • Antidepressants and antipsychotics were largely selected to minimize anticholinergic effects, including in patients with dementia. • Similarly, medications for urinary incontinence were predominantly chosen for their low anticholinergic activity, reflecting attention to reducing potential cognitive and systemic side effects in this population. Areas for Improvement • Assessment of cumulative anticholinergic burden: When medications with anticholinergic properties are prescribed, the patient’s total burden should be assessed, ideally using a formal screening tool. • Screening and monitoring of anticholinergic side effects. • Screening and monitoring of urinary incontinence/bladder instability medications. Actions To provide a targeted training for prescribers on the evidence and gaps regarding anticholinergic burden This will be achieved by developing a brief, recorded presentation of current evidence, which can be shared with prescribers for ongoing education and encouraging the use of formal screening tools to assess cumulative anticholinergic burden and document monitoring of side effects, particularly in patients prescribed urinary incontinence medications or those at higher risk (e.g., dementia.)

Appendix 1: National Clinical Audit Updates



Oxford Health
NHS Foundation Trust

Clinical Audit	Summary
National Respiratory Audit Programme (NRAP): Pulmonary rehabilitation Page 557	This audit is ongoing and has an annual deadline of 07/08/2026 for the data collection period 2025-26. Currently, 100% of eligible patients submitted. Key Successes Wait times are reducing even with numbers continuing to increase. Staff actively engaged in service improvement plan. Results remain stable despite some disruption in team. Key Concerns Equity of provision still isn't where the team would like it to be, but the number of venues being used is starting to increase to provide a service closer to patient's homes where possible. Enhancing the engagement of ethnic minorities continues to be a concern and something that requires attention. Staff are now permanent and need a robust development plan in place. Accreditation process is ongoing. The results in terms of % achieving MCID in 6MWT and CAT are lower than national average and lower than historic local targets. The team need to find a way to monitor this and determine what the cause is, if any, and create plan to improve. Actions Reduce waiting time from referral to being offered a first appointment to under 1 year, a working group has been set up to lead on initiatives to achieve this. Submit accreditation self-assessment paperwork. Utilisation of all suitable venues around the county (gym plus separate confidential area for education) to allow equitable access for all patients suitable for PR within Oxfordshire. Implementing regular data review process within monthly PR team meeting to review assessment data input each month. To include a quarterly review of audit result data. Review assessment process and data collected to ensure all data is accurate and complete (to include ensuring MRC score is collected at post-assessment routinely.)

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary																					
National Clinical Audit of Psychosis (NCAP) (EIP) Page 558	The national audit of Psychosis has now transitioned to using routinely collected data through standard reporting structures i.e., the Mental Health Services Data Set (MHSDS) using team codes. With the aim to help EIP teams to improve the quality of data submitted and to understand the impact of changing data source, NCAP ran a pilot in early 2025 not only to check the completeness/coherence of the data but also allow NCAP to test proxy measures which were introduced (where data for historic NCAP standards is not available in MHSDS). NCAP shared a comprehensive list of SNOMED codes associated with each audit standard to support more accurate data submissions. Following the pilot, refinement of proxy measures and sharing of SNOMED codes, a national roll-out of the routine audit was commenced.																					
	Eligibility for audit are; people with first episode psychosis (FEP) or an at-risk-mental-state (ARMS) diagnosis, who are: Aged 65 and below and; Have been on the team’s caseload for 1 year or more at the date of data extraction and still on the caseload of: NHS-funded EIP teams in England or; NHS-funded Children and Young People’s Mental Health/Child and Adolescent mental health services in England (where EIP teams do not extend their offer to children and young people under 18yrs).																					
	Exclusions are all the patients who are experiencing psychotic symptoms due to an organic cause (for example, brain diseases such as Huntington’s and Parkinson’s disease, HIV or syphilis, dementia, or brain tumours or cysts). NCAP will be performing quarterly extractions throughout 2026, with the goal of moving to monthly extractions at the end of the year																					
	The NCAP routine dashboard has been made available from December’ 2025 onwards to view the reports with organisational access:																					
	Due to the nature of data collection and infancy of the process, there may be some data quality issues. The data pull at each extraction is being monitored to address possible issues. Collaborative working with information teams will ensure the appropriate changes are implemented and correct data is pulled in extraction. Therefore, it may take a few data extractions before data is fully reflective of practise.																					
<table><tr><th>MHSDS data extraction date</th><th>Reporting period</th><th>NCAP dashboard publication</th></tr><tr><td>July 2025</td><td>1 April 2022 - 31 March 2025</td><td>December 2025</td></tr><tr><td>September 2025</td><td>1 September 2022 - 31 August 2025</td><td>February 2026</td></tr><tr><td>December 2025</td><td>1 December 2022 - 31 November 2025</td><td>February 2026</td></tr><tr><td>March 2026</td><td>1 March 2023 - 28 February 2026</td><td>TBC</td></tr><tr><td>June 2026</td><td>1 June 2023 - 31 May 2026</td><td>TBC</td></tr><tr><td>September 2026</td><td>1 September 2023 - 31 August 2026</td><td>TBC</td></tr></table>		MHSDS data extraction date	Reporting period	NCAP dashboard publication	July 2025	1 April 2022 - 31 March 2025	December 2025	September 2025	1 September 2022 - 31 August 2025	February 2026	December 2025	1 December 2022 - 31 November 2025	February 2026	March 2026	1 March 2023 - 28 February 2026	TBC	June 2026	1 June 2023 - 31 May 2026	TBC	September 2026	1 September 2023 - 31 August 2026	TBC
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Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary					
Sentinel Stroke National Audit programme (SSNAP) Page 559	This audit is ongoing and includes quarterly data collections by extraction. The information below is informed by Quarters 1&2 of data collections 2025-26. SSNAP reports on the processes of care and patient outcomes in two ways: • Patient-centred’ results are attributed to every team which treated the patient at any point in their inpatient care. • A team’s patient-centred results demonstrate the quality of care that their patients received across the whole inpatient care pathway, regardless of how many teams cared for the patient, or which of the teams provided each aspect of care. ‘Team-centred’ results attribute to the team considered to be the most appropriate to be responsible for a given measure. SSNAP scores hospitals based on the care they provide against these key indicators and domains. Both patient-centred domain scores and team-centred domain scores are calculated. An overall SSNAP score is calculated as follows: • Domain levels are combined into separate patient-centred and team-centred total key indicator scores. • A combined total key indicator score is derived from the average of these two scores. • This combined score is adjusted for case ascertainment and audit compliance. • Further guidance and how key indicators are calculated is available on the SSNAP website. For simplicity, the following key can be used as a guide for compliance A to E: <table><tr><td>Band A 90-100</td><td>Band B: 80-89.9</td><td>Band C: 70-79.9</td><td>Band D: 50-69.9</td><td>Band E: 0-49.9</td></tr></table> Overall SSNAP level for 2025/26 was rated D for patient centred and E for team centred measures for Quarter 2. (Quarter 3 / 4 were not yet passed). Key points from specific domains are: • Standards by Discharge rated B for patient and team centred in quarter 2 • Specialist pathway rated E for both patient and team centred in quarter 2 • Therapy intensity rated C for patient centred and D for team centred in quarter 2. • Therapy frequency rated D for patient and team centred in quarter 2	Band A 90-100	Band B: 80-89.9	Band C: 70-79.9	Band D: 50-69.9	Band E: 0-49.9
Band A 90-100	Band B: 80-89.9	Band C: 70-79.9	Band D: 50-69.9	Band E: 0-49.9		

Clinical Audit	Summary
UK Parkinson's Audit	Physiotherapy (PDPS) submitted 30 cases and Speech and language therapy (SALT) submitted 12 cases. The national report is due in March 2026. Preliminary analysis was completed by the audit team and shared with the services for action planning. These will be reviewed and updated once the National report is published. Key successes SALT: Holistic communication assessment including language impairments and intelligibility as well as voice and speech. SALT: The need for Augmentative and Alternative Communication (AAC) was addressed. SALT: The impact of Parkinson's on communication and friends/family was documented. SALT: Therapists supported patients to make informed decisions about their care. SALT: Reports were made back to the referrer. PDPS: Improving the use of and recording of outcome measures and exercise provision - now being nearly 100% on both scores. This is due in part to assessment forms being updated a couple of years ago with emphasis on these 2 areas. In addition to that, forms are now also set as a 'template' on EMIS so inputting a record of outcomes and exercise interventions has been made even easier for the team. Key concerns SALT: On/off phase and assessment of drooling not documented - the Parkinson's Disease (PD) case history form is not being used consistently. SALT: Swallowing was not always screened if the person was referred for communication alone. However, it would be expected for swallowing to be screened at the MDT clinic/by Parkinson's Nurse Specialists and a referral made if needed. SALT: It is currently not possible to store audio recordings of patients' speech on EMIS. SALT: Reports not always sent to the acute trusts' Parkinson's Specialist nurses (who are unable to view them on EMIS). PDPS: A key ongoing concern, which is not really reflected in the audit, is the growing wait time for patients to be seen - often over 20 weeks now (was 14 weeks a year ago).

Continued on next slide.....

Appendix 1: National Clinical Audit Updates

Clinical Audit	Summary
UK Parkinson's Audit continued Page 561	Recommendations/Actions PDPS: Reduce waiting times: Offering more clinic slots in outpatient settings. PDPS: Promote participation in research with patients: Sign posting to local projects and the NIHR https://bepartofresearch.nihr.ac.uk/ PDPS: To maintain excellent work of recording outcomes/exercises taught and ensure new members are encouraged with this too: All to complete relevant outcome measures and exercises on EMIS templates following patient assessments/To promote teaching regarding outcome measures in team meetings/Induct new team members re- relevant measures to be used. SALT: PD case history to be reviewed and relaunched; and reports should be copied to PD nurse/referrer: The PD case history form is being revised and developed as a template on EMIS in consultation with the whole team and could include prompt to send report to referrer. SALT: Explore recording devices & decibel meters: Re-visit whether audio recordings of patients' speech can be stored. SALT: Training for the team about On/off phases: Team to watch Parkinson's UK bitesize training which includes on/off phases.
National Audit of Inpatient Falls (NAIF)	From January 2025, NAIF expanded to collect information from patients who sustain any fracture, spinal or head injury as a result of an inpatient fall and allowed participating organisations to identify patients who are eligible for audit data collection. Monthly falls reports are being reviewed and eligible cases audited. 11 falls were identified as eligible for the NAIF audit and uploaded within the deadline. The audit team is awaiting feedback from the clinical leads regarding this data while the national report is being generated. The report analysing the 2024 falls was published in October 2025.

Statement from NHS Thames Valley Integrated Care Board Oxford Health NHS Foundation Trust Quality Account 2025/26

Dear Grant Macdonald,

NHS Thames Valley Integrated Care Board (TV ICB) has reviewed the Oxford Health NHS Foundation Trust Quality Account and believes that it is accurate and meets the requirements of a Quality Account as published in the [NHS England Quality Account List for 2025-26](#).

The National Quality Board now includes the additional dimensions of sustainability, leadership, and equitable care to its definition of quality in addition to the established areas of safety, effectiveness, and experience. We would encourage the consideration of these additional dimensions for discussion in the organisational clinical quality priorities. The quality of the services provided at Oxford Health is therefore measured by looking at:

1. Patient Safety:

Key developments across the patient safety space are still driven by the ongoing implementation of the NHS [Patient Safety Strategy](#), with a focus on system-wide digital, cultural, and operational reforms. A key part of this is the introduction of Martha's Rule – giving patients, families, and staff a way to request a rapid review if they are worried about patient deterioration.

Oxford Health NHS FT is demonstrating this further by developing this through strengthening patient and family escalation routes, improving consistency of awareness across the services, and embedding patient safety principles into routine practice through the PSIRF approach.

The Patient Safety Incident Response Framework (PSIRF) is a system-based learning and continuous improvement approach to incidents. It is now implemented in most Thames Valley provider organisations delivering NHS-funded care and is transforming how we learn and respond to patient safety events. Oxford Health has embraced and demonstrated this very well through the implementation of its PSIRF plan for 2025/26, completion of 37 PSIRF reviews, delivery of 203 incident learning huddles, and introduction of system-wide thematic reviews.

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The ICB would like to see further development in embedding the patient voice more consistently into safety governance arrangements and demonstrating that learning from incidents results in measurable and sustained reductions in harm.

Planned improvement workstreams for 2025/26 are highlighted within the Quality Account as a continued reduction in restrictive practices, further embedding of PSIRF across the services, increased involvement of patients and families in safety processes, strengthening continuous quality improvement approaches, and enhancing equality data to support improved monitoring and assurance.

2. Delivering clinically effective patient interventions:

One of the aims of the [10-Year Health Plan](#) (published in July 2025) is to improve clinical effectiveness. This is proposed through shifting care from hospitals to the community, moving from analogue to digital, and pivoting from illness to prevention. Oxford Health has demonstrated this through:

- Electronic Prescribing and Medication Administration (ePMA) rollout has improved medication safety and efficiency by reducing prescribing errors.
- Adoption of the trauma-informed care approach is improving patient outcomes and stability.
- The implementation of the PSIRF framework is strengthening system-wide learning and continuous improvement.

It is clear from this Quality Account that Oxford Health has a comprehensive process in place for the implementation and auditing of NICE Guidelines, Quality Standards, Baseline Assessments, and Technology Appraisals.

Improvement opportunities highlighted through national audit results linking to improvement workstreams within Oxford Health and the wider TV ICS – including assurances around sustainability.

Annual evaluation of clinical effectiveness priorities as set in the previous year's Quality Account to celebrate successes and identify next steps to address any gaps or deviation from the original vision.

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3. Patient feedback about care provided:

The primary purpose of gathering patient feedback is to listen to, reflect on and act on the feedback to improve patients' experiences, interactions, and health outcomes. Within OHFT, this has led to the following improvements over the past year:

- Enhanced feedback from staff and from patients, families, and carers affected by incidents, particularly in relation to their experience of care and incident management.
- A total of 19,121 reviews were received on I Want Great Care (WGC) over 12 months, of which 4,702 were submitted by self-identified friends, family members, and carers.
- Feedback from children and young people indicates that they feel safe, listened to, and actively involved in decisions about their care.

4. Sustainability:

The NHS remains on track to achieve its interim target of an 80% reduction in direct emissions by 2032. ([NHS England » Five years of a greener NHS: progress and forward look](#)). Between 2020 and 2024 in England, the UK Health Security Agency (UKHSA) estimated there were a total of [10,781 heat-associated deaths](#) as a direct consequence of heatwaves. It is encouraging to see that sustainability is increasingly embedded within the improvement activity, with some services already exceeding sustainability standards and achieving recognised sustainable service accreditation in dentistry. OH NHS FT contribution to the NHS commitment to combat climate change in line with The [Health and Care Act 2022](#).

5. Leadership:

The [draft Management & Leadership Framework](#) was published by NHS England in September 2025. ([NHS England » Management and leadership development](#)). The ICB is excited to work with Oxford Health Foundation Trust over the coming months to see how this will translate into practice.

continued on next slide

6. Equitable care:

Reducing health inequalities is a national priority and a key focus for the TV system. The ICB would like to see this and a clear alignment between the organisation's quality priorities and the overall Integrated Care System goals as set out in the Buckinghamshire, Oxfordshire and Berkshire West Joint Forward Plan (Thames Valley Joint forward plan still in development).

TV ICB is delighted that OHFT has improved on key quality metrics such as embedding PSIRF implementation and continuous quality improvement. The ICB would like to see improvement in Prone restraint reduction, health inequalities data completeness, and embedding lived experience into governance fully.

TVICB is noting that OHFT has maintained an overall CQC rating of good on 13th December 2019. In November 2025, the CQC assessed the Trust's Child and Adolescent Mental Health Inpatient Services, and as of 31st March 2026, the Trust is awaiting the formal report of these findings and the outcome of the assessment that will inform the re-rating of the services assessed.

2025/26 has been yet another challenging year for health and social care, with significant challenges across our geography in both the Health, Social Care, and VCSE landscapes. TV ICB is looking forward to collaborating with its system partners to develop the national direction of travel for healthcare to future-proof the NHS for future generations by continuing to work on the following [3 key shifts at the core of the government's health mission](#):

- From hospital to community – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- From treatment to prevention – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- From analogue to digital – greater use of digital infrastructure and solutions to improve care

Your Sincerely



Sarah Bellars
Chief Nursing Officer
NHS Thames Valley ICB

Appendix 3: Council of Governor feedback 1 of 1



Oxford Health
NHS Foundation Trust

As Lead Governor, I welcome the opportunity to reflect on the Trust's Quality Account for 2025/26. This report demonstrates the continued commitment of colleagues across the organisation to delivering safe, compassionate and high-quality care, despite ongoing pressures. I am particularly encouraged by the strengthening of a learning culture, through the embedding of PSIRF and the growing maturity of quality improvement approaches across the Trust (pp. 34–36, 37–38).

I want to highlight the importance of lived experience and co-production as a central theme within this report. The progress made in developing co-production training, strengthening lived experience infrastructure, and planning to embed these voices within governance arrangements is positive (p. 33). It is essential that this continues, ensuring that people who use our services, alongside their families and carers, are not only heard but actively shape how services are designed, improved and evaluated.

I also want to emphasise the critical importance of listening to and learning from our staff. The report reflects strong investment in staff wellbeing, safety and development, alongside high levels of engagement in improvement activity (pp. 12–13, 37). From my perspective, creating a culture where staff feel safe to speak up, share learning and influence change is fundamental to improving quality and patient experience.

Whilst there has been good progress, I recognise that further work is needed in key areas, including reducing restrictive practice, addressing inequalities and embedding learning consistently across the organisation (pp. 27–31, 32). As Governors, we remain committed to working with the Board to ensure that learning—particularly from lived experience and frontline teams—continues to translate into meaningful and measurable improvements for the communities we serve.

Vicki Power, Lead Governor 18th May 2026

Thank you for letting Healthwatch Oxfordshire and Healthwatch Bucks have sight of the Oxford Health NHS Foundation Trust Quality Account for 2025/26 prior to publication and giving us the opportunity to comment. We are the independent local health and social care champions for Oxfordshire and Buckinghamshire residents.

We would like to thank all staff for their commitment to patient care, service delivery and improvement during the year, and in what is still a fast-changing landscape.

We also thank staff for supporting Healthwatch Oxfordshire and Healthwatch Bucks visits to Oxford Health services during the year, as part of our programme of **Enter and View** visits, (part of our statutory responsibilities), and outreach to community hospital settings, enabling us to speak to both patients, carers and staff about their experiences. These visits included to the Phoenix Ward at Littlemore Mental Health Centre, Wintle Ward at Warneford, Ashurst Ward at Littlemore in Oxfordshire and Bucks Safe Haven service in Aylesbury You can see the reports on the Oxfordshire and Bucks Enter and View visits, which reflect findings on experiences of support and care here: <https://healthwatchoxfordshire.co.uk/enter-and-view-reports> [Enter and view visit to Bucks Safe Haven, Aylesbury – Healthwatch Bucks](#).

We also thank you for asking for support of Healthwatch Bucks and Healthwatch Oxfordshire in joint engagement on the Oxford Health Strategy 2026-31. We were able to pull on our extensive community, Patient Participation Group and resident contacts, to bring in patient view on this, and to convene a Webinar in April to enable people to speak directly with Oxford Health. <https://healthwatchoxfordshire.co.uk/our-webinars#Oxford-Health-strategy-webinar>

Healthwatch Oxfordshire and Healthwatch Bucks have also been actively involved in supporting patient engagement into the development of Neighbourhood Health models, in which Oxford Health plays a strong role.



Quality Priority area: To reduce the use of seclusion and prone restraint

We look forward to seeing the implementation in the coming year of improvements as outlined in the Care Quality Commission (CQC) Report published in April 2026 on the Child and Adolescent Mental Health (CAMHS) inpatient wards. This service was identified as 'requiring improvement' and recommended that young people need to be supported to be more involved in decisions about their own care, so critical in supporting improved experience and outcomes.

The progress on the 2025-6 Quality Priorities shows some positive areas of improvement, along with areas that remain unchanged – for example use of restrictive practice and prone restraint in mental health services including the above mentioned CAMHS inpatient services. What does the data tell you about ethnicity and the use of restraint? How are patients and families themselves involved in supporting this target and insight into factors to support reduction of restraint?

Quality Priority area: Address inequalities in the delivery of healthcare

We see that you have made improvements in collecting meaningful and reliable data on ethnicity – although the target has not been fully achieved. This data is essential for better understanding of how Oxford Health is meeting the needs of all its populations, and in providing a baseline understanding of where health inequalities in access and experience may exist. How will you be working to achieve the target of 90% data capture, and what are the actions needed to implement this?

Data collection is the first step in understanding inequalities in delivery of healthcare. Addressing the persistent barriers – including to access and experience of care- involves development of patient led and culturally appropriate services, working with patients and families to understand and create progress. Understanding what you are hearing from communities and people who may be experiencing inequalities in healthcare also is key and making sure that they too have a voice. It will be critical to see how this was also to be achieved.

Quality Priority area: Involving Patients, Carers and their Families

We are pleased to see some progress on development of a co-production approach across the Trust. You committed to produce a co-production framework in Quality Accounts for 2025-6, and this indicates an early development. It is positive that staff now have co-production training, and that you have developed co-production handbooks with Experts by Experience.

We would like to see more indication of how members from marginalised communities might be supported to be meaningfully engaged, including important relationship building key to a shift to community care. The mention of accessibility being improved by digital communication, also needs to be supplemented with opportunities for relationship building and genuine listening.

Learning from deaths

Upnote, Healthwatch Oxfordshire raised the issue of LeDeR reviews at Oxfordshire Health Overview Scrutiny Committee in January 2026 meeting. Healthwatch Oxfordshire raised the question about the local Integrated Care Board (ICB) backlog in LeDeR reviews and sought reassurance that this would not impact on local intelligence, tracking and response planning in Oxfordshire.

Patient Experience

In the section on 'Feedback from patients and carers' with the summary of I Want Great Care – can you provide an explanation of the rating (1-4) used?

You also provide a summary of themes, with relatively low levels of responses of qualitative feedback (for example 1 mention of consistency) - if derived from the overall 19, 121 responses. It would be good to understand what the other themes from the wider reviews told you.

We would also like to see emphasis on how what you hear from patients and families drives improvement and change, how this is tracked, and how it is reflected back to demonstrate how you have acted on feedback.

We would like to see reference to your adherence and commitment to ensuring Accessible Information Standards in all your communications, including provision of interpreting and translation, and additional formats, as well as enabling people who may not use digital means to provide feedback, through listening in a range of ways. How are you ensuring you address inequalities in health through linking data and action?

Finally, we thank Oxford Health for your support in our insight and engagement, and in responses to recommendations in our reports, based on what we have identified.

Healthwatch Oxfordshire and Buckinghamshire reports of relevance

Our reports published in the last year on what we have heard from residents, patients and carers include:

Reports Healthwatch Oxfordshire: <https://healthwatchoxfordshire.co.uk/research-reports>

- Women's health
- Navigation or urgent and emergency care
- Digital health
- Trans and Non-binary people's experiences of healthcare

[Reports Archive – Healthwatch Bucks.](#)

- Men's Health
- Healthcare Travel Costs Scheme
- Finding information on Adult Social Care in Buckinghamshire

We ask you to pass on to all staff and volunteers at the Trust our thanks for their ongoing commitment to serving the people of Oxfordshire and Buckinghamshire and congratulate you and your team on awards you have received, in particular the award for community dentistry.



Dr. Veronica Barry, Executive Director, Healthwatch Oxfordshire



Zoe McIntosh, Chief Executive, Healthwatch Bucks

Appendix 5: Oxfordshire Joint Health Overview & Scrutiny Committee feedback

1 of



Oxford Health
NHS Foundation Trust

To be received post HSOC meeting

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**OXFORDSHIRE
COUNTY COUNCIL**

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Work Programme 2026/27

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 June 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	David Eltringham (SCAS CEO)
Dentistry Services in Oxfordshire	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a report from the NHS Integrated Care Board on developments around improving NHS dentistry access and contracts.	Overview and Scrutiny	Hugh O Keefe (BOB ICB)
Oxford Health NHSFT Quality Account	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive the draft of the Trust's Quality Account for this year, with a view to provide feedback to the Trust that will be published in the final version of its Quality Account at the end of June 2026.	Overview and Scrutiny	Sam Shepherd (Oxford Health NHSFT)
Oxford University Hospitals NHSFT Quality Account	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive the draft of the Trust's Quality Account for this year, with a view to provide feedback to the Trust that will be published in the final version of its Quality Account at the end of June 2026.	Overview and Scrutiny	Olivia Clymer (Oxford University Hospitals NHSFT)
10 September 2026				

Topic	Relevant Strategic Priorities	Purpose	Type	Lead Presenters
Independent Patient Voice Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive a detailed update on the steps being taken by the Health and Wellbeing Board and system partners to explore what a future local independent patient voice could look like subsequent to government's planned abolition of Healthwatch.	Overview and Scrutiny	Ansaf Azhar (Director of Public Health) Carole Stowe (Healthwatch contract manager)
Horton General Hospital Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update from Oxford University Hospitals NHSFT on the current services delivered at the Horton Hospital, as well as what the local demand patterns are for such services.	Overview and Scrutiny	Olivia Clymer (Director of strategy and partnerships, OUH)
System Pressures Update	Tackle Inequalities in Oxfordshire; Prioritise the Health and Wellbeing of Residents.	To receive an update from Oxfordshire system partners on the steps being taken to address Urgent and Emergency Care pressures.	Overview and Scrutiny	Lily OConnor (Urgent Emergency Care Director for Oxfordshire, Thames Valley ICB+ OCC joint post)

New Committee will agree its work programme beyond this meeting.

Recommendation Tracker

Oxfordshire Joint Health Overview & Scrutiny Committee

Chair Cllr Jane Hanna OBE | Dr 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
Page 575 29 January 2026	Maternity Services	1. To implement a Trust wide maternity communication standard covering: listening, timing, clarity, and translation of information, as well as expectations during induction, labour, and postnatal care.	Olivia Clymer, Yvonne Christley	Accepted See agenda item 5
		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.		Accepted See agenda item 5
		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.		Partially Accepted See agenda item 5

Agenda Item 17

KEY	Report Due	With Cabinet / NHS	Complete

Meeting date	Item	Recommendation	Lead	Update/response
		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.		Accepted See agenda item 5
		5. For the Trust to provide a written update on progress on the accepted JHOSC recommendation on epilepsy within 28 days, and how it plans to align with the NHS England maternity bundle section on epilepsy.		Accepted See agenda item 5
Page 576 29 January 2026	Oxfordshire Learning Disability Plan	1. That partners at place consider an anniversary event to share progress and good practice.	Karen Fuller, Ian Bottomley	Accepted See agenda item 5
		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.		Accepted See agenda item 5
		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.		Accepted See agenda item 5
		4. For there to be further engagement with people with a Learning Disability/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.		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

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	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@oxfordshire.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	Item	Lead	Update
06-Jul-24	GP Provision	Julie Dandridge; Dan Leveson	Progress updates to be provided
12-Sep-24	Dentistry Provision	Hugh O'Keefe; Dan Leveson	Progress update to be provided
04-Oct-24	Palliative/ End of Life Care in Oxfordshire	Dr Victoria Bradley; Kerri Packwood; Karen Fuller; Dan Leveson	Progress update to be provided
26-Nov-24	Medicine Shortages	Julie Dandridge; Claire Critchley; David Dean; Nhulesh Vadher	Progress update to be provided
16-Dec-24	Epilepsy Services Update	Sarah Fishburn; Dan Leveson; Olivia Clymer	Progress update to be provided
06-Mar-25	OUHFT Maternity Services in Oxfordshire	Olivia Clymer, Yvonne Christley; Andrew Brent	Progress update to be provided

KEY	Update Pending	Update in Item	Updated

Response Date	Item	Lead	Update
05-Jun-25	Oxfordshire Healthy Weight	Derys Pragnell	Progress update to be provided
05-Jun-25	Health and Wellbeing Strategy Outcomes Framework	Ansaf Azhar; Kate Holburn; Karen Fuller; Dan Leveson; Matthew Tait	Progress update to be provided
05-Jun-25	Support for People Leaving Hospital	Ansaf Azhar; Claire Gray; Angela Jessop; Alicia Siraj	Progress update to be provided
11-Sept-25	Musculoskeletal Services in Oxfordshire	Matthew Tait; Neil Flint; Tony Collett; Mike Carpenter; Suraj Bafna	Progress update to be provided
11-Sept-25	Cancer Services in Oxfordshire	Matthew Tait; Felicity Taylor; Andy Peniket	Progress update to be provided
11-Sept-25	Audiology Services in Oxfordshire	Matthew Tait; Neil Flint; Phil Gomersall	Progress update to be provided

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