OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 16 September 2010 commencing at 10.00 am and finishing at 2.40 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	Councillor Tim Hallchurch MBE Councillor Jenny Hannaby Councillor Neil Owen Councillor John Sanders Councillor Don Seale Councillor Lawrie Stratford Councillor Susanna Pressel (Deputy Chairman) District Councillor Dr Christopher Hood District Councillor Rose Stratford District Councillor Hilary Fenton Ann Tomline Dr Harry Dickinson Mrs A. Wilkinson
Co-opted Members:	Ann Tomline Dr Harry Dickinson Mrs A. Wilkinson
Other Members in Attendance:	Councillor Larry Sanders (for Agenda Item 5)

Officers:

Whole of meeting	Julie Dean and Roger Edwards (Corporate Core)
Part of meeting	Dr Jonathan McWilliam and Shakiba Habibula.

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

49/10 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

An apology was received from Councillor Jane Hanna OBE.

50/10 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

51/10 MINUTES

(Agenda No. 3)

The Minutes of the meeting held on 8 July 2010 were approved and signed, subject to the word 'two' being amended to 'ten'; in Minute 44/10, page 6, line 1 and Councillor Pressel being added to those who attended the meeting with Sir Jonathan Michael, Chief Executive, ORH, as noted in Minute 47/10, page 12.

With regard to Minute 44/10, first bullet point, page 6, Dr McWilliam reaffirmed his hope that spending on family support would be an ongoing topic of interest for the Committee. He added that he had requested data from Linda Watson, Chief Executive, Oxfordshire Rural Community Council, in a bid too tease out types of deprivation, whether that be of a poverty nature, or housing, rural access to services etc.

52/10 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to a request from Councillor Larry Sanders to address the Committee at Agenda Item 5.

53/10 LIBERATING THE NHS - THE WHITE PAPER ON HEALTH

(Agenda No. 5)

The recent White Paper and other related consultation papers set out a whole series of radical proposals for change to the NHS. The White Paper was now out for consultation with responses required by 11 October 2010.

For the purposes of this Committee, consideration of the White Paper was addressed in relation to three major areas:

Adult Social Care - A paper by the Director of Social & Community Services entitled 'Health White Paper' was circulated (**JHO5(a)**);

Public Health – A paper by the Director of Public Health was circulated (**JHO5(b)**);

Implications for Oxfordshire County Council and the Implementation of the Proposals – to include the implications for this Committee and for the Health & Well Being Partnership Board – current and future. A paper by the Health Scrutiny Adviser was circulated at **JHO5(b).**

A wide range of speakers from Health, Oxfordshire County Council and other interested organisations had been invited to address the Committee on the issues raised by the proposals. The speakers are listed as follows:

- Councillor Arash Fatemian (Cabinet Member for Adult Services – Oxfordshire County Council (OCC));
- John Jackson (Director of Social & Community Services - OCC);
- Joanna Simons (Chief Executive – OCC);
- Fred Hucker (Chair, Oxfordshire Primary Care Trust (PCT) Board);
- Sonia Mills (Chief Executive – Oxfordshire PCT);
- Dr John Galuszka (Acting Medical Director – Oxfordshire PCT);
- Dr Jonathan McWilliam (Director of Public Health);
- Dr Peter Von Eichstorff (Practice Based Commissioning consortia representative);
- Dr Paul Roblin (Local Medical Council (LMC) representative);
- Mark Ladbrooke (Secretary – Oxfordshire Unison – health branch);
- Dermot Roaf (Oxfordshire Link); and
- Olga Senior (SHA Director of Communications & Corporate Affairs).

Prior to the above business, Councillor Larry Sanders addressed the meeting prior to the above as follows:

- His view that the overarching themes of the White Paper would create risks and his hope that these would be minimised in Oxfordshire;
- The ongoing 'Keep our NHS Public' campaign had aired their concerns about the 'privatisation and fragmentation' of the NHS;
- He advocated that there should be one sole commissioning consortia for Oxfordshire, adding that it had only been a short while ago that 5 PCTs had been reduced to one and the ensuing costs had been substantial;
- In the past, similar PBC consortia had proved very expensive to run. He asked what would be the consequences if they should run into financial difficulties;
- He warned of the alleged 'power and unscrupulous working practices' of the private sector;
- He asked what would happen if a Foundation Trust should run into financial problems. The Government had indicated that any organisation could bid for services and expressed a hope that a cautious stance be taken with regard to outsourcing any commissioning responsibilities.

John Jackson – introduced his paper (**JHO5(a)**) informing the Committee that the Cabinet deadline for responding was 5 October and for its supplementary papers was 12 October. He added that the OCC response would focus on a package which was intended to be part of a continuing debate within OCC with regard to future services. The Chairman added that this Committee had the task of making two responses, one appropriate for health related OCC services and a separate response was to be made to the Department of Health.

Dr Jonathan McWilliam introduced his paper (**JHO5(a)**) making the following comments:

- Within the White Paper it clearly stated that local authorities would have the lead role to play in joining up the three leading pillars of public health ie, that of the local authority, the local Health function and the national Public Health

service. Strong emphasis had been placed on the Health & Well-Being Board as the organisation which would effect this unity;

- At the local level, there were advantages to be gained in local government joining the pillars as long as it is managed efficiently. A safe transition was required in order to maintain the gains which had been made in Oxfordshire over the last four years in public health;
- The role of the Health & Well-Being Board performs a facilitative role in the creative working together of the Health/Local Government and Public Health. It was his view, and the Director of Social & Community Services view, that the Health Scrutiny function was invaluable to this Council and therefore should not be merged with the Health & Well-Being Board.

Joanna Simons put forward the following views:

- There was a long history of good joint working with the Oxfordshire NHS , with good outcomes. This placed it in a good position in the future;
- Oxfordshire's Joint Needs Assessment had been commended;
- Oxfordshire had seen some very positive outcomes from the decision to employ a Joint Director of Public Health. The priorities of OCC's Communications Strategy was now very different to those of its predecessors. There were inequality 'hot spots' which were being addressed. This would have taken place without the Director of Public Health;
- Health Scrutiny within Oxfordshire had worked well. There was a need to revise the current arrangement, but care must be taken not to 'throw the baby out with the bath water'. It was her view, therefore, that a recommendation should be made to Government to implement an arms length arrangement on a local basis, to enable the Committee to continue into the future;
- There was a need for OCC and the GPs to adopt a more formal way of working. The PCT would play a key role in this over the next year or so;
- There was a potential to come closer with regard to joint commissioning, though this may not be easy, as funding was squeezed with national targets. When the scale of public spending reductions was known, then systems would be looked at in a more integrated way. There was a need to find ways of looking holistically to make more effective, locally, the role of GPs , social service authorities and children's services;
- The primary risk regarded capacity. Colleagues in the PCT had a less secure future and it was important to hold on to key people in order to mitigate this risk;
- It was important to find the means of making sure that OCC and Health worked together with a clear end goal; and
- In conclusion, Oxfordshire was better placed than other colleagues, but the work that was required to implement the above should not be under-estimated.

Councillor Arash Fatemian concurred with Joanna Simons that OCC and Health were well placed in Oxfordshire to deal with some of the recommendations coming out of the White Paper. OCC and Health already held a genuine, advanced pooled budget. He echoed his colleagues in stating that this Committee had undertaken some important and valuable work within the County and welcomed the possibility that its functions could continue in some form, in a separate capacity from the Health & Well-Being Board. He added that all the changes to Adult Services needed to be joined

up. There were challenges ahead but real opportunities as long as it was approached in a constructive manner.

In response to a question from the Committee if OCC was adequately resourced to undertake the above, Councillor Fatemian responded that undertaking it was a necessity, but that there was a need to look at it in a different way, to look at how best placed resources were to meet the challenge. Dr McWilliam also commented that the Public Health Transition Group would have six channels of work, one of which would be to look at how well placed the information was at the centre.

Olga Senior stressed the following:

- The White Paper was an opportunity to influence the Government on change;
- The SHA had run six sessions on the White Paper across the Thames Valley region, linking with partners ie. the District and County Councils, Thames Valley Police, NHS organisations, GPs etc;
- The framework all were waiting for was still to be developed nationally. It was hoped that national frameworks were not hugely prescriptive; and that there would be sufficient flexibility to suit local need;
- At the sessions, the SHA were given a strong message that there should be a consistency across the county;
- As the budget reductions hit, the tariff dictates that it is important to shape the future on outcomes rather than inputs so that the patient is at the centre;
- With regard to Dr McWilliam's 'three pillars', there is a need for careful relations between the three so as not to cause a mismatch.

Fred Hucker commented as follows:

- The PCT was created four years ago. The Board is totally committed to whatever takes place in the future. It will be legally responsible until 2013 for public expenditure and will retain its accountability until then. The PCT would continue with the 'day job' focussing on its usual business and on issues of major concern such as finance, the practicalities of bed blocking , mergence of the CHO and the OBMHT, savings required by the ORH etc. The Board was intent on ensuring the success of these projects and that they would be handed over to the consortia in a right and proper manner;
- Although the legislation had not yet been finalised, there would be time to deliver what the PCT thinks best in the interests of Oxfordshire. For example, on ensuring that there was sufficient staff for the Paediatric/Maternity services at the Horton Hospital, Banbury;
- He was unsure if there would be one consortia for PBC in Oxfordshire, or a number of them. He did however assure the Committee that Public Health funding would be ring-fenced, which was right and appropriate for Oxfordshire.

Sonia Mills commented as follows:

- During the transition to any new structure there was a need to capture and protect skills and experience. The PCT would ensure that this would take place. GP colleagues recognise the need for this;

- Work would also be ongoing in relation to the transfer of functions to the local authority, the transfer to more local structures for the NHS Commissioning Board and also to providers who would be in a more 'stand alone' role;
- The number of consortia would be put where they would be best placed, following discussion, and then their legality, accountability and support functions would be slotted in afterwards. The PCT is listening to what people want and will then marry suitable expertise for the future;
- There would be £200m cash to effect the change, The cash element would not grow and therefore it was important to find the best way of releasing it to the best effect. There is a need to set out the direction which will be a very different configuration. There will be no choice about what is spent.

Dr Galuska gave feedback on plans for the implementation of the White Paper proposals commenting that:

- GPs wanted to ensure a maximum quality of services as possible within the available budget;
- GPs were keen to work collaboratively and feel the need to be a little more radical, more relaxed and even a little 'more parochial' in respect of some services;
- The endeavours to maintain their current workload was very much an issue;
- GPs were trying to be as efficient as possible and were constantly evaluating what they should be doing;
- There were benefits to the smaller PCTs;
- The localities work well, though there were partnership issues;
- GPs wanted to ensure that vital services were retained. There was a wish not to spoil aspects of services which were working well, but they needed to know what they were;
- GPs had the impression that the PCT would prefer to use the NHS providers if at all possible;
- Maximum input was required – at present, many GPs invested in services on a much smaller scale.

Peter von Eichstorff put forward his personal views as follows:

- He felt confident the new arrangements would work effectively provided GPs, OCC, the voluntary sector, Public Health and the PCT all worked together;
- The PBC had been working together for three years and was already responsible for £290m of the budget. It had already seen success in the development of new services and changes in the management of some services. They had, however, kept some of the same, which was difficult given the 'push to the private sector';
- The consortia had already begun efforts to engage the public regarding future structures via Oxfordshire LINk;
- There were many practices still not engaged or aligned with the consortia;
- A small number of consortia were overspending and thus some were 'bailing out' others. Therefore an overarching management structure was an effective ay forward;
- The messages for the consultation were that (1) the GPs were keen and ready to help and keen not to commission services which were not fit for the future:

(2) CHO and Out of Hours would be reviewed to see how they were operating:
(3) the functions of Payment by Results systems needed to be teased out and renumerated;

- There was a need to look at information systems in light of the abolishing of NHS Direct;
- In conclusion, he was optimistic that the new systems could improve equity and excellence in Health using simple and pragmatic solutions, avoiding duplication.

Paul Roblin expressed the following views:

- He was pleased with what he had heard to date with regards to the direction of travel;
- The White Paper did not contain much detail and was subject to local determination – thus it was possible to tailor services to suit Oxfordshire;
- The White Paper stood for vast change, as significant as in previous decades;
- There had been variable support for the changes;
- There would be vast change at the time of financial constraint – it would be important therefore to maintain services in times of constriction;
- Consultation must take place on all aspects;
- There would be a dramatic change in the workload portfolio for some GPs;
- There had been variable enthusiasm from GPs - in the face of this it was hoped that change would be delivered;
- The Consortia was driven by 'bottom up' developments;
- The best of the present system would be taken and the 'not so good' would be circumvented;
- The PCT would continue to exist acting as an agency for the development of the GP consortium development. It was important to map PCT functions and tasks to decide on their destination;
- There must be local determination to ensure that a system is developed that works, GP need considerable local management. It cannot be done at a distance;
- The consortia should be of a size to ensure a balance to cope with risk management; and
- The opportune and transaction costs in making the changes must not be so vast that the 'day job' does not get done.

Mark Ladbrooke raised the following concerns expressed by the Branch:

- The common concern across NHS unions was that of the development process, the changes happening and public engagement issues;
- The abolition of the PCT was a 'bolt from the blue' and this had 'shaken the public to its roots'. The Government was doing the public a disfavour in 'de-stabilising the PCT';
- The national Union thought it important that there was strong engagement with the public and staff. There was a concern that this was ' not just another weakening of the NHS' but had a real potential for changing the NHS 'into a mere logo';
- Oxfordshire MPs should be well informed of change/developments in Oxfordshire;

- There should be no underestimation of how difficult the mechanics of change will be;
- The Union would be delighted to work with local councillors in order to effect the best possible solution. The Union was well aware of the importance of accountability and of the changes in the future to the powers of this Committee. There were many big issues, such as how the consortia would access the general population for their views; on financial stability; staff insecurities and potential loss of skills for staff; and
- He concluded by urging councillors to facilitate public discussion with the NHS.

Dermot Roaf commented as follows:

- The pooled budgets had proved to be a great success in Oxfordshire; and
- The Oxfordshire LINk had valued enormously the opportunity to work closely with this Committee. He hoped that this Committee retained its powers. Even without its powers, he hoped it would still exist.

Issues and questions raised by Committee members during the question and answer session, and responses received, where appropriate, are as follows:

- Cross border GP consortiums? – (response) It is important to address more pressing issues first;
- GP training? - (response) The SHA is addressing this;
- GP training in Public Health? – (response) It is an integral practice;
- Will services be free at the point of use? What can the patients expect? (response) We are taking ten patient journeys and 'road testing' them. We will try to bring patients closer together with the clinicians, led by GPs;
- How will patients gain access to GPs to ask questions and voice their concerns? (response) The new arrangement will be very patient focussed as services may have to be changed in light of developments such as the joint working of CHO and the OBMHT services;
- What has happened to localism? (response) It was hoped that this would happen within the framework, there were challenges to be faced;
- The Committee would like to see an audit of all current areas of PCT work – (response) The transition organisation planned for this will be carried out as a core strategy obligation: to ensure that it is entered into the new legislation and the old is either repealed or has somewhere to go. She added that it would be a challenge for all to take out £1.3b of cost over the next three years. Assurances would have to be given that some services were to be maintained. GPs would be commissioning services, some of which might not look the same. The Committee were assured that there would be consultation on each major change;
- Who would pick up the commissioning for primary care in relation to rural dispensing? (response) It was clear in the White Paper that a National Commissioning Board would undertake pharmacy, patient care and maternity services. The Committee were advised that there should not be a narrowing of its focus solely in relation to the implementation of the services, the Government were also interested in hearing the comments of HOSCs on the content of the White Paper also.

The Committee thanked all those who took part in the discussion for being frank and open. It was **AGREED** to support the recommendations contained within the papers submitted by the Directors of Social & Community Services and Public Health. The Committee's response to the proposals, for consideration by the Cabinet, is set out below:

Response to the White Paper – Equity and Excellence: Liberating the NHS

The Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) has considered the White Paper. The HOSC understood from the White Paper that the consultation is on "how best to implement the changes" and not on the overall strategy. Having said that members expressed their concerns that the proposals to scrap PCTs and pass most commissioning to GP consortia could create significant dangers for the provision of health services.

In particular they were worried about whether GPs would have the capacity and knowledge to undertake the level of commissioning involved. Issues of financial stability, democratic accountability, loss of existing knowledge and expertise by the dissolution of PCTs and the adequacy of resourcing also caused concern.

Furthermore the White Paper left a number of major questions unanswered.

These concerns are reflected in the comments below. The first section sets out general responses to the White Paper that will be communicated to the Secretary of State. The second section contains specific recommendations for the Oxfordshire Cabinet.

Response to the consultation:

1. The focus on reducing inequalities and the plan for targets to be based on outcomes are welcomed.
2. The proposal for Public Health and health improvement to once again be a local authority responsibility is also welcomed. However, it will be vital that, the service be fully resourced to ensure that local authorities are funded adequately to undertake those responsibilities.
3. Scrutiny should not be included in the responsibilities of the Health and Wellbeing Board. The Board members, being responsible for overseeing the commissioning agenda and the provision of health improvement and social care, should not be placed in a position whereby they would, in effect, be scrutinising themselves.
4. Health Overview and Scrutiny Committees should be retained with all of their existing statutory powers being extended to cover all organisations involved in the provision of health services whether in the NHS, local government or the private sector.
5. The White Paper contains little reference to children. It is the HOSC's view that the Health and Wellbeing Boards should include representation from services for children as well as adults and older people.
6. If GPs are to undertake the role of being the main commissioners of health services they must be made statutorily accountable to local communities through elected representatives. This should also apply to Foundation Trusts

and Monitor. The NHS Commissioning Board will be unelected and too remote to undertake this role effectively and the HOSC should have the power to refer concerns to the Commissioning Board as well as to the Secretary of State.

7. It is important that GP commissioners should be adequately trained and resourced, in the widest possible meaning of this term, specifically to include time and administrative and clinical support.
8. There is a need for greater clarity around what would happen if the GP commissioning groups were to fail to carry out their clinical, managerial and/or financial responsibilities properly.
9. Legislation should be introduced to ensure that joint commissioning and pooled budgets are used effectively and appropriately wherever possible.
10. The role of HealthWatch, both national and local, and how it will work, must be clarified as should the issue of their funding. It is questionable whether the CQC will have the necessary expertise to oversee such a complex national organisation.
11. The costs of restructuring should not be detrimental to front-line services.
12. It has taken a number of years for co-terminosity to be established between local authorities and the NHS and the development of GP consortia threatens to undermine that. Steps should be taken to ensure that co-terminosity should be re-established as soon as possible.

Specific recommendations for bodies in Oxfordshire:

The HOSC:

I. Supports fully the recommendations of the Adult Services Scrutiny Committee (ASSC) and those of the Director of Public Health (DPH)
II. Requests that the Cabinet should endorse the comments above directed to the Secretary of State
III. Advises the Cabinet that the HOSC considers that:

- The high-level steering committee proposed by both the ASSC and the DPH should be led by the County Council and include major public sector stakeholders, in particular GP representatives, and elected members. It should be set up as soon as practicable and liaise with national and regional bodies as necessary. The committee's role would be to ensure that public sector organisations in Oxfordshire work closely together to further the development of a reconfigured NHS that will ensure the continuation and sustainability of high quality health services.
- The above committee could be developed subsequently into the Health and Wellbeing Board. The Board Chairman should be a Cabinet Member level appointment.
- The levels of joint working that already exist within Oxfordshire should be developed and improved further.
- The commissioning expertise that has been built up over many years by the County Council, much of it in joint commissioning with NHS colleagues, should be drawn upon in developing and providing support for the new GP consortia.

54/10 LESSONS FROM THE IRP REVIEW: THE IMPORTANCE OF COMMUNITY ENGAGEMENT

(Agenda No. 6)

The Better Healthcare Programme for Banbury and the surrounding area has been a major community engagement project. With the advent of the NHS White Paper, and talk of a 'Big Society', the Committee has wondered how can lessons learnt locally help to ensure that health services are designed and delivered with, and for, patients and the public? Julia Cartwright, Chair of the Community Partnership Forum, will share insights into the benefits of, and barriers to, collaborative working.

The Committee had before them a copy of Julia Cartwright's presentation entitled 'Lessons from an IRP Review: The importance of Community Engagement' is attached at **JHO6**.

The Committee thanked Julia Cartwright, Chairman of the Community Partnership Forum, for attending the meeting and for her insights to their questions on lessons which could be drawn from the IRP review in relation to community engagement, in light of the White Paper and talk of a Big Society. They congratulated her once again for her excellent leadership skills and the exemplary role she and members of the Forum played in co-ordinating the community response to the Horton proposals.

55/10 NUFFIELD ORTHOPAEDIC CENTRE (NOC) - UPDATE

(Agenda No. 7)

Jan Fowler, Chief Executive, Nuffield Orthopaedic Centre (NOC), together with Sarah Randall, Director of Operations & Performance, had been invited to speak to the Committee on the Centre's current position and its possible future.

Jan Fowler made the following points:

- She had been in discussion recently with the Chairman of this Committee and Roger Edwards;
- The last time she had attended the Committee it had been to discuss the underlying issues relating to a shortfall of £8.5m. Since then and significant amount of work had been undertaken and high levels of performance had been delivered;
- The Board had considered what would constitute the best clinical and financially sustainable service in the future which was most unique to the NOC, but also wide reaching;
- The decision to merge with the ORH to form a new acute organisation for Oxfordshire had been taken within the context of the NHS White Paper and its inherent financial pressures;
- There would be a new name, which was symbolic of the new organisation, but individual sites would retain the same name;
- The change was not about changing services – they would continue to be delivered from the present site – but there would be better resilience for the service;

- A new business case was now being developed which would be signed off by the Trust Boards at the beginning of next year. It would then need further approval by the SHA and finally by the DoH;
- A new Foundation Trust application would hopefully be submitted in 2012/13;
- The merger would be likely to happen in mid 2011;
- The NOC Trust Board had decided to run a public consultation from September to the end of November, even though the SHA had advised that this was not required. The NOC had very strong stakeholder support. The Chairman commented that whilst this Committee did not require the NOC to hold a public consultation, it required continuous informal consultation.

Questions asked, and issues raised by the Committee and responses received were as follows:

- What savings would be made by the merger? (response) There would be one Board. The NOC were already cross working with the ORH looking at opportunities to deliver improvements within a larger organisation – the merger would enable them to be provided more cost effectively. The NOC's contribution in the face of huge financial pressures have been made very clear to staff;
- What would you be consulting on? (response) Plans to create a clinical division within a bigger organisation which would work in a semi-autonomous way. An exploration of what it would look like and what is important to the clinicians;
- By merging, will the patients be seen quicker? (response) We will be working with the JR to support more complex cases. There will be a requirement to be confident that there is a strong clinical infrastructure in place. We will be streamlining trauma cases with the JR, giving better access for patients;
- Do you envisage sharing staff with the ORH? (response) Specialist staff will continue to provide services on site. We already share staff and give specialist support. There will be opportunities to look at pathways of patient experience with the ORH and identify where we can provide the expertise. We will be sharing skills across both organisations;
- Will the GP consortiums have an impact on the NOC? (response) This will be an opportunity to look at the patient pathways. Staff were coming up with ideas about how we can deliver services in a different way and how they can be better managed;
- Could the transport facilities be better organised? (response) This is a very valid point – we need to take that forward;
- What are the major threats and weaknesses to the new plans? (response) The major concern would be of staff recognising the ORH itself and impact on the current quality of services the NOC provides. The new Chief Executive of the ORH has a good track record of bringing organisations together. There will be much tension for staff, particularly for those working in corporate services as there will be some rationalisation;
- What is the total PFI repayments? (response) For the NOC it is £6m per annum, the ORH £34m in total. Approximately £40m per annum will be top sliced off the budgets. The NOC and the JR offer excellent facilities, but the

ability to generate savings will be limited. It is an issue and part of the challenges we face.

The Committee thanked the Chief Executive and the Director of Operations & Performance for attending and explaining the situation with regard to the merger with the ORH to form a new, acute organisation for Oxfordshire.

56/10 THE DISCHARGE OF PATIENTS FROM ACUTE HOSPITALS
(Agenda No. 8)

Representatives from Patient Voice (a group of members of the former Oxfordshire presented their report, which had been commissioned by the Oxfordshire LINk, on Discharge Procedures. Copies of the papers submitted by Patient Voice were attached at **JHO8**.

The Committee thanked the representatives from Patient Voice and from the Oxfordshire LINk for attending to present their report on discharge procedures from acute hospitals. They also thanked Susan Brown, Communications Manager for the ORH for her input to the discussion.

It was noted that the LINk were keen to revisit the recommendation in Spring, 2011 to ascertain whether the plans, systems and implementation had taken place. The LINk had also requested Patient Voice to carry out some research with regard to the quality of food, the appropriateness and presentation of food, and the enablement to eat accorded to patients, in an acute setting.

57/10 OXFORDSHIRE LINK GROUP – INFORMATION SHARE
(Agenda No. 9)

Adrian Chant presented an update of the latest Oxfordshire LINk activity (**JHO9**).

The Committee thanked Adrian Chant for his report.

58/10 CHAIRMAN'S REPORT
(Agenda No. 10)

The Chairman reported on a number of meetings which he, the Deputy Chairman and Mr Edwards had attended. These included meetings with the Chief Executives of the Nuffield Orthopaedic Centre, the Oxford Radcliffe Hospitals Trust and the Oxfordshire Primary Care Trust.

..... in the Chair

Date of signing .....