NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP GOVERNING BODY

26 March 2015, 09.30 – 12.45, John Paul II Centre, Bicester, OX26 6AW

Present:	Dr Joe McManners, Clinical Chair
	David Smith, Chief Executive
	Dr Stephen Attwood, North East Locality Clinical Director
	Dr Julie Anderson, South West Locality Clinical Director
	Dr Andrew Burnett, South East Locality Clinical Director
	Fran Butler, Practice Manager Representative
	Dr Miles Carter, West Locality Clinical Director
	Dr David Chapman, Oxford City Clinical Director
	Mike Delaney, Lay Member
	Roger Dickinson, Lay Vice Chairman
	Diane Hedges, Director of Delivery and Localities
	John Jackson, OCCG Director of Strategy and Transformation/OCC Director of Adult Social Services
	Gareth Kenworthy, Chief Finance Officer
	Catherine Mountford, Director of Governance and Business Process
	Dr Paul Park, North Locality Clinical Director
	Duncan Smith, Lay Member Governance
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI)
In attendance:	Lesley Corfield - Minutes
	Helen Ward, Quality and Clinical Standards Manager (representing Sula Wiltshire, Director of Quality)
Apologies:	Dr Graz Luzzi, External Specialist Consultant
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire
	Sula Wiltshire, Director of Quality

Item No	Item	Action
1	**Chair's Welcome and Announcements** The Chair welcomed everyone to the meeting and expressed gratitude to Fran Butler the practice manager representative who was attending her last Governing Body meeting for all her hard work and efforts on behalf of Oxfordshire Clinical Commissioning Group (OCCG) and the Governing Body and wished her well for the future. The Chair also welcomed Helen Ward, the Quality and Clinical Standards Manager who was deputising for Sula Wiltshire, the Director of Quality, to the meeting.	

	The Quality and Clinical Standards Manager read the Patient story and thanked the patient for their consent. As this particular story started in 2012 it was stressed that many of the issues and concerns raised had been picked up by Oxford University Hospitals Trust (OUHT) and addressed.	
2	**Apologies for absence** Apologies were received from the External Specialist Consultant, the Director of Public Health Oxfordshire and the Director of Quality.	
3	**Public Questions** The Clinical Chair advised six questions had been received via the website and those pertaining to Governing Body papers would be covered where possible in the meeting with full responses to all the questions being placed on the website within 20 days of the meeting.	
4	**Declarations of Interest** There were no declarations of interest.	
5	**Minutes of Governing Body Meeting held on 29 January 2015** Paper 15/18, the minutes of the meeting held on 29 January 2015, was approved as an accurate record subject to the Director of Delivery and Localities checking the year to date A&E performance figure in paragraph four of Item 11, Quality and Performance Report.	
6	**Matters arising from the Minutes of 29 January 2015** The actions from the 29 January minutes were reviewed and updates provided where the item was not covered later on the agenda. *Proactive Medical Support to Care/Nursing* Homes It was reported the current figure was a third of the nursing homes were covered by 25 per cent of practices. *OCCG Constitution* A teleconference had been held with NHS England (NHSE) to work through the Constitution changes. External legal advice had been commissioned to enable the queries raised by NHSE to be addressed. The final version would be brought back to the Governing Body. It was reported a section on the joint commissioning requirement had been added, to the previous version of the Constitution and approved by NHSE. *Assurance Framework (AF) and Red Operational Risks* The new AF was in place and it was confirmed risk ID736 was followed up by the Primary Care Board. *Minutes* The timeliness around receipt of minutes would be picked up in the next tranche of the Constitution work.	
Overview Reports		
7	**Chief Executive's Report** The Chief Executive introduced Paper 15/19 updating the Governing Body on topical issues including the serious case review into child sexual exploitation in Oxfordshire, the NHS Constitution indicators and delayed transfers of care, most capable provider outcome for service for older people outcome based contract (OBC), system leadership development, 2015/16 contracts, quality concerns, the better care fund, new care models, the Prime Minister's challenge fund (PMCF) and Southern Health. The Chief Executive explained he had included delayed transfers of care in his report as he felt a more detailed discussion in addition to the coverage in the Performance Report was required. The target indicators were an NHS commitment written into the NHS Constitution and were not an option. Waiting times for referral to treatment and the 62 day cancer wait had improved but were still short of the target. The emergency care figures included in the Quality and Performance Report were for the whole of the Thames Valley and not just Oxfordshire. The Ambulance Trust was also struggling to meet its targets. Although DTOC was not in the NHS Constitution it was important as it contributed	

	to the A&E figures. The Chief Executives of OCCG, the two main Trusts and Oxfordshire County Council had been called to a meeting with the Secretary of State for Health on three occasions. There were a number of plans to reduce the DTOC numbers but this had been a significant problem in Oxfordshire for quite some while. The Chief Executive commented the Oxfordshire system would lose credibility if the targets were not delivered. The measurement focussed on efforts by the two Trusts but the whole system needed to address the issue. It was commented attention was not always given to those services not covered by targets and initiatives such as the mental health access times target was welcomed as this would draw focus to other areas. It was observed that many people saw A&E as the front door to the NHS whereas it was primary care. The scope to learn lessons from the unsuccessful new care models programme application in order to achieve success in the future was queried. The Chief Executive reported there had been 269 expressions nationally for the new care models programme. Many of the bids had a long track record and were able to demonstrate where they came from as well as a good sense of vision. OCCG had come late to this particular programme and although disappointing to be unsuccessful it had enabled the testing and alignment of models with the Trusts' Alliance in a very short space of time. A cross system workshop had been organised for 21 April to consider how the work could be taken forward. Should the bid for the PMCF be successful it would provide another opportunity for funds particularly in primary care. This was acknowledged as an opportunity to link up areas of work across the system and for all organisations to work together. The Chief Executive noted one of the questions received concerned the involvement of the public and primary care in co-commissioning. He explained meetings were held with the chairs of the Locality patient forums every couple of months but some thought to other routes and the involvement of Healthwatch was required. The Chief Executive requested the Governing Body consider how this could best be achieved. The Director of Delivery and Localities advised the locality forum chairs had clear expectations on the role of patient participation groups (PPGs) but these were often distanced from the practice view and the guidance in this area was not very clear. The Locality Clinical Directors (LCDs) had been requested to assist in this debate. There was a need to engender real feedback and to encourage practices and patients to become involved. The speed with which the applications had to be produced meant the CCG could not always engage and this needed to be addressed as it was suspected this aspect would reoccur. **The Governing Body noted the Chief Executive's Report.**	
8	**Locality Clinical Director Reports** Paper 15/20 contained the Locality Clinical Director (LCD) reports. The South East LCD advised he attended all their locality forum meetings and the Chair of the forum attended the GP locality meetings. There was heavy involvement from members of the public in areas such as Townlands Community Hospital The North East LCD reported the Bicester Community Hospital was now open and felt people would be very impressed with the facilities available. The Chair felt the LCD reports had improved and a number had good content which gave a flavour of the discussions in the localities. **The Governing Body noted the Locality Clinical Director Reports.**	
Strategy and Development		

9	**2015/16 Operational Plan** The OCCG Director of Strategy and Transformation/OCC Director of Adult Social Services introduced Paper 15/21 explaining the requirement to refresh the existing CCG plan produced following a widespread consultation about a year ago. . The CCG was required to submit its plan by 7 April whereas the planning programme for the providers had been put back until the middle of May. This created issues as OCCG would possibly need to submit the plan prior to the conclusion of contract negotiations. Attention was drawn to Appendix 1 of the (tabled/circulated later) Executive Summary containing a significant list of transformation schemes and the challenge faced by OCCG in delivery. The Chief Finance Officer expected the Plan to be revised following the outcome of the contract negotiations. Contracts had not yet been agreed with the two main providers and the deadline was 31 March. If agreement was not reached by this date the national arbitration process would be entered into. There was a significant financial gap between OCCG and the providers. In total the gap exceeded the amount of reserves OCCG was trying to retain for transformation. The Governing Body would be kept informed of developments over the next week or two. Points of discussion included: • Some performance standards may not be turned around by 1 April 2015, particularly A&E, RTT admitted and 62 day cancer wait. It was understood the 95 per cent A&E target would be challenged until Quarter 3 • It was hoped 'the perfect week' event would provide some understanding and knowledge of changes required • National Constitution targets were agreed by Government and were not an option. Oxfordshire was not unique and should be able to meet the targets but the Governing Body needed to accept this would not be until the next financial year • The OCCG 2015/16 allocation had been increased by £41.0m as there was recognition at national level Oxfordshire had been funded under target. Discussions held with Trusts indicated more than £41.0m was requested by them to deliver current services. A low risk strategy would be to tie up monies with the main providers as OCCG would face very little financial risk but no money would be available for transformation. Should money be retained for alternatives the schemes would have to deliver otherwise OCCG would face a big risk in year and a financial challenge. The Governing Body was questioned as to which strategy OCCG should adopt • OCCG had capacity to run and manage a limited number of projects and should do what was best for the system. All locality schemes should be assessed as to whether they fitted with the OCCG strategy • A high risk strategy for OCCG would be not supporting primary care. Past experience showed money was used to support financial risk not transformation. If services were not provided in the community the hospitals would provide the care probably at a higher cost. OCCG needed to fund community schemes whilst finding a way for a stable financial environment • Oxfordshire was seen as a poor performing system but health outcomes were good and the population generally was healthy. The system was not operating at optimal level and in 2015/16 there should be zero tolerance around failure to deliver the national targets • Transformation would require funds at a commissioning level in order to be able to deliver. It would be necessary for the providers to be on board and for transformation to be included within existing contracts. All parties needed to ensure the financial system did not become unstable	

	• Many key transformation elements were not new ideas and OCCG should gain knowledge from other organisations/CCGs who had successfully implemented changes • Consideration should be given to the contribution each initiative made as there would become a point where a decision on which schemes to take forward would have to be taken. Thinking in advance rather than in response to a crisis was important. As the work continued to finalise the plan a triangulation between transformation schemes, QIPP and contracts should be undertaken • Savings (formerly known as QIPP) had not been as successful as it should have been in 2014/15 and there was a necessity for OCCG to deliver around 1.5 per cent of savings. There was a need to drive efficiency in the system • OCCG needed to do better at balancing external expectations messages • Savings clinical models had merit but there was a lack of confidence in the figures. The organisation should commence a parallel scheme to produce savings in case the new innovations did not deliver. Primary care and community services should be expanded but it was not possible to prop up the hospital and put money into community and primary care services as there was insufficient money available. The Chair advised one of his responsibilities was to push transformation but with the caveat of maintaining a stable financial system. The vanguard bids would effectively result in paying twice for services as until a new service was up and running there would be a need to continue to fund the existing service. This would be a challenge to achieve without the vanguard monies. The Governing Body was being asked to delegate authority, with appropriate input from directors, to the Chief Executive to sign off the Plan and submit by 7 April. The Chief Executive observed the Plan would need to be in draft because contracts had not yet been agreed. He suggested the Governing Body might need to meet in next four weeks in order to discuss and sign off the final plan. **The Governing Body agreed delegated authority to the Chief Executive to sign off and submit the refreshed Operational Plan and that there might be a need to convene a Governing Body meeting. The submission to be brought to the next Governing Body meeting.**	
10	**Outcomes Based Contracting (OBC) – Mental Health** The Chief Finance Officer advised considerable time had been spent in negotiations around the contract and the issues had been largely resolved. Some due diligence on social care aspects was outstanding and it was expected when this information had been received it would be possible to move swiftly to a signed contract. **The Governing Body noted the latest position with regard to the negotiations of the Outcomes Based Contract – Mental Health.**	
Business and Quality of Patient Care		
11	**Safeguarding Activity Report** On behalf of the Director of Quality, the Quality and Clinical Standards Manager presented Paper 15/23 providing an update on developments in safeguarding for OCCG. Work was on-going to address the findings of the serious case review (SCR) into child sexual exploitation (CSE). There had been too much reliance on self-reporting and work to raise awareness and skilled questioning of patients was being implemented. In addition the lack of follow up after disengagement with services was highlighted and would be addressed. CSE read codes for GPs would be introduced and there would be more information sharing. The multi agency safeguarding hub (MASH) was now receiving all child safeguarding	

	enquiries. A health team within the MASH liaised with all health providers and collated health information. This then informed the multiagency assessment. There had been a significant increase in work following increased awareness and concerns were being raised. The Care Act would come into force on 1 April which would put Adult Safeguarding on a statutory footing for the first time. **The Governing Body noted the contents of the report and agreed actions within the CCG in response to the SCR would be reviewed at the Governing Body meetings.**	
12	**Finance Report Month 11** The Chief Finance Officer (CFO) introduced Paper 15/24 briefing the Governing Body on the financial performance of the CCG to 28 February 2015, the risks identified to the financial objectives, the current mitigations and a most likely, best and worst case forecast outturn against plan. The CFO advised: • Year to date OCCG was reporting a much improved position and was on target to achieve its forecast surplus of £1.5m • Two key cost pressures were high cost drugs and devices which was forecast to be overspent by £2.0m; and primary care prescribing which was forecast to be overspent by £2.2m • A number of risks had either not materialised and their value had been reduced or were not material and had been removed from the Month 11 reporting • A 10 per cent reduction in running costs was expected from April and as a result this reserve would no longer be available for 2015/16 • Although the position had improved and a surplus forecast, the underlying position was still a deficit and, therefore, the CCG still faced a serious challenge • Key elements of red schemes in savings plans were being taken forward and would be reflected in future plans. There had been changes in the middle of the year which had led to an unexpected increase in prescribing costs. These had been managed by practices in year and plans for managing these increased costs were being worked up for future years. The planning assumptions had been set with the expectation of meeting costs and a provision for growth had been made. The Governing Body could take assurance from the continuing work of the Medicines Management Team and the evidence presented to the Finance and Investment Committee of the identification of further efficiencies. It had been noted that high prescribing practices had a tendency to lower admissions. This aspect was being investigated but insufficient profiling was currently available to reach a conclusion. The Medicines Management Team also undertook a vigorous review of high cost drugs and devices and checked patient treatment was appropriate under NICE guidance. Challenges on prices and tariffs were issued and this had been flagged as part of the contract negotiations. Management of the audiology over performance was queried and it was advised the budget had been set without really knowing the demand and need, which were not necessarily the same thing. Contracts were up for renewal towards the end of the year and OCCG would be looking to see if it would be possible to have some sort of filter whereby those who were in need, and wanted and would wear a hearing aid, would be provided with one but those who might not use it would not necessarily receive one.	

	The Governing Body considered there was sufficient assurance that the CCG was managing its financial performance and risks effectively, that it could mitigate any risks identified and was on track to deliver its financial objectives.	
13	**Quality and Performance Report (including Datix update)** The Quality and Clinical Standards Manager introduced Paper 15/25 providing an update on quality and performance issues and advised: • One of the recommendations in the Francis report was for GPs to undertake a monitoring role on behalf of their patients. In OCCG this is undertaken using the Datix system for GP feedback had been in place since 2012. This had provided a good understanding of systemic issues • Outpatient clinical communication still required some improvement and the performance notice remained open. An electronic system had increased performance but more was required • A plan for the management of test results had now been received for addressing issues but this would remain on the agenda • There continued to be very high performance in the Friends and Family Test. The Director of Delivery and Localities apologised that an annex providing details of the work being undertaken around the A&E target had not been included with the paper. This would be circulated. Extensive efforts were underway including a daily telephone conference call; Alamac data tracking; Emergency Care Intensive Support Team analysis/action plan; breach analysis; and delayed transfers of care (DTOC) where three areas (reablement, choice and assessment) were receiving focus. Work around a common agreement on counting DTOC numbers was underway although further work was required. All organisations had agreed to undertake a 'perfect week' or 'breaking the cycle'. All services would galvanise around the hospital for an intense period and a gold command would be in place. The aim was to see what 'good' would look like if everyone was delivering the right services at the right time. Examples of where this had been tried were available on the NHS England website (http://www.england.nhs.uk/resources/resources-for-ccgs/breaking-the-cycle/). The Lay Member PPI raised concerns she felt around quality and safety. She queried how information was used to obtain evidence of the safety of services across the system and raised the need to be assured service issues were being addressed; contract queries were known by the Governing Body; and there was knowledge of the type of questions asked at Trust board meetings and that these questions were answered. She felt organisations should be concerned about the rise in serious incidents and never events in the Oxfordshire system. The Lay Member PPI also felt there should be awareness of staffing levels and whether staff were following basic safety protocols. She queried how the Governing Body could be assured intelligence available in the system as a whole was being used to ensure safe, high quality services and issues such as those experienced by Morecombe Bay could be avoided. The Chair agreed there was a need to be assured OCCG was not only finding out information about quality issues but that there were good processes in place to deal with the issues. He suggested the Governing Body could work more closely with the OUHT board to raise visibility and to highlight and resolve issues. The Chief Executive reminded the Governing Body that the Quality and Performance Report was an exception report. He stressed the need to not lose sight of the fact the Report did not cover all areas and services commissioned from all providers where quality was absolutely excellent and Oxfordshire was of world class standard. In terms of actions, the Chair and Chief Executive would	**DH**

	meet with the OUHT Chief Executive and Medical Director, and Board to Board meetings with both main providers to discuss a range of issues would be organised. The Director of Delivery and Localities pointed out the Performance Report also highlighted areas of deterioration in performance at the Royal Berkshire NHS Foundation Trust. The Chair cautioned against being black and white and the tendency to focus on areas of poor performance. **The Governing Body noted the Quality and Performance Report.**	
14	**Oxfordshire County Council and Oxfordshire Clinical Commissioning Group Big Plan – Learning Disability Strategy 2015 – 2016** The Oxford City Locality Director presented Paper 15/26 proposing a number of significant changes to the delivery of healthcare for people with learning disabilities. The drivers for change were listed in the document and the proposals provided an opportunity to change the way learning disability was delivered in Oxfordshire. The outcomes were the result of extensive consultation and in particular an active patient forum who had fed into the strategy. The strategy allied with the national strategy for health care to be within mainstream services. The timetable was very tight as the contract with Southern Health expired in December 2015. A great deal had to be accomplished before then and the risks were outlined in the document. The OCCG Director of Strategy and Transformation/OCC Director of Adult Social Services advised in this instance he was commenting in his role as OCC Director of Adult Social Services. He explained this had been a joint piece of work and that historically there had been close working between the CCG and the former primary care trust (PCT) in approach. The review of services had been prompted by issues over the last couple of years. Health would see the biggest impact whereas there would only be a small change in the social care provision. The importance of supporting these services was stressed as they were critically important in helping people to live their lives normally. It was advised the Governing Body was being asked to agree the proposed implementation approach for provision of services for people with learning disability and the start of the process for negotiations with mainstream providers. The timetable was for the new system to be up and running by the end of December 2015. The proposals were deemed to be sensible in terms of the direction of travel and it was felt the case for change was well made. Anxiety was expressed on behalf of the service users particularly during the implementation due to the complexity of the level of change. It was suggested more thought should be given to the timeline and the amount of time allocated to planning the implementation as opposed to the actual implementation. This would need training, support and infrastructure. The CFO queried the financial aspects as the CCG Plan did not include specific funding or an allocation to meet the associated costs. It was advised monies to fund some of the start-up would come from the Southern Health contract. It was suggested the Project Board proposed in the paper should be set up and that it should report directly to the Governing Body. It was agreed that the Project Board would be chaired by the Chief Executive. The Project Board would also need to work closely with other organisations including Oxfordshire County Council (OCC) and should provide proper oversight for the Governing Body. Between Governing Body meetings the Project Board would report to the OCCG Quality and Performance Committee. **The Governing Body noted the report and supported the proposal. It agreed**	

	that the proposed implementation approach and timelines as set out in the paper should be reviewed by the Project Board.	
15	**Process for Approval of Annual Accounts and Annual Report 2014 – 15** The Chief Finance Officer presented Paper 15/27 requesting the Governing Body to agree to delegate authority to the Chair of the Audit Committee, the Chief Finance Officer and one other of either the Accountable Officer or a qualified accountant Lay member of the Integrated Governance and Audit Committee (IGAC) to approve any changes to the final accounts following submission to the IGAC and/or the Governing Body in May. It was anticipated the Governing Body would receive a near final version but due to the timescale for submission some last minute changes might be required. It was confirmed this was the same process as in the previous year. The Lay Vice Chair confirmed the arrangement had been supported by the IGAC. The Director of Governance advised as this would be an on-going issue it would form part of the Scheme of Delegation to negate the need to bring back each year to the Governing Body. **The Governing Body agreed to delegate authority as set out above.**	
16	**Public Involvement and Engagement** The Director of Delivery and Localities presented Paper 15/28 outlining proposals for reporting public involvement activity and outcomes to the Governing Body and a summary on the development of a partnership with the Public Locality Forums in Oxfordshire. A letter of intent between OCCG and the Locality Forums around the working relationship was available on the website: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/03/Final-Letter-of-Intent-2015.03.06.pdf. A specific pilot had been agreed with the West Locality Forum whereby the CCG would fund Healthwatch to provide administrative support to the meetings and three public events per year. The West Forum would also work with the District Council to encourage people to take responsibility for their own and their family's/community's health and wellbeing. The Director of Delivery and Localities explained the proposal to bring a twice yearly redesigned comprehensive public involvement and communication activity report to the Governing Body and a summary to the intervening meetings. The Lay Member PPI reported a refreshed communications strategy was in hand and would be circulated and presented to the May Governing Body. The need for a complete closed loop process was stressed from pulling information together and informing the Governing Body right through to feeding in to operational planning, contacts and how the results of the patient engagement were used. **The Governing Body approved the process for reporting public involvement activities and noted either an update or the Communications Strategy would be brought to the May meeting.**	
Governance and Assurance		
17	**Corporate Governance report** The Director of Governance introduced Paper 15/29 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest. **The Governing Body noted the Corporate Governance Report.**	
18	**Assurance Framework and Red Operational Risks** The Director of Governance presented Paper 15/30 which included the Assurance Framework (AF) Executive Summary and the Red Operational Risks Executive Summary. There were currently six risks on the AF rated as 'red'. The Director of Governance stressed the need to ensure actions and controls detailed work being undertaken to manage risks.	

	The Governing Body noted the contents of the Assurance Framework and the Red Operational Risk Register and the actions in place to address gaps in controls and assurance.	
Papers For Ratification		
19	**Joint Primary Care Commissioning Group Terms of Reference** The Director of Governance presented Paper 15/31, the draft Terms of Reference (ToR) for the Commissioning Board/Joint Committee and advised a significant amount of guidance had been issued by NHSE on the content. The ToR were compliant with guidance and all guidance had been taken into account. The two sections of the meeting were required to function slightly differently and the ToR had been split to reflect this need. An added complication had been the need to overlay the document on current OCCG organisational governance requirements. The guidance strongly suggested there should be two lay members to help manage conflict of interests. One lay member was required to be the chair but this could not be the chair of the audit committee although the chair of the audit committee could be the second lay member. The guidance stated there should be an equal number of votes between commissioners and NHSE. The current member from NHSE was the most senior person from NHSE (South Central) and it was, therefore, anticipated this person would hold authority to vote all the NHSE votes. It was suggested the ToR should include the opportunity for the clinical member to be absent during discussion in order to manage the conflict of interest issue. The Commissioning Board would report directly to the Governing Body either through the Chief Executive or separately. The intention was for the Commissioning Board to have oversight of commissioning activities and plans and its main function would be the alignment of plans to ensure these were coherent and overlapped before considering how to extract better value from the totality. The Commissioning Board had agreed the ToR would be reviewed in six months' time (September). The OCC Director of Adult Social Services reported on discussions nationally around health and social care aspects coming together after the General Election which might result in the Health and Wellbeing Board being reorganised. **The Governing Body ratified the Oxfordshire Commissioning Board, incorporating the Joint Committee for the commissioning of Primary Care, Terms of Reference.**	
20	**Annual Equality Publication** The Director of Governance presented Paper 15/32, the Annual Equality Publication detailing how OCCG had addressed its duties under the Quality Act and advised in future the report would be presented at the January Governing Body meeting. **The Governing Body ratified the OCCG Annual Equality Publication.**	
21	**Review of the Oxfordshire Patient Choice Equity and Fair Access Policy** The Director of Delivery and Localities presented Paper 15/33 informing the Governing Body that a review of the Oxfordshire Patient Choice Equity and Fair Access Policy was being undertaken. **The Governing Body noted a review of the Choice Policy was being undertaken and the revision would be presented to the May Governing Body.**	
For Information		

22	**Oxfordshire Clinical Commissioning Group Sub Committee Minutes** The Governing Body noted Paper 15/34 which shared the minutes from the December 2014 and January 2015 Finance and Investment Committee meetings, the November 2014 Integrated Governance and Audit Committee meeting and the December 2014 Quality and Performance Committee meeting.	
23	**Oxford University Hospitals NHS Trust Board minutes** The Governing Body noted Paper 15/35 sharing the minutes of the Oxford University Hospitals NHS Trust Board meeting held in January 2015.	
24	**Oxford Health NHS Foundation Trust Board minutes** The Governing Body noted Paper 15/36a and 15/36b sharing the minutes of the Oxford Health NHS FT Board meetings held in November 2014 and January 2015.	
25	**Older People's Joint Management Group minutes** The Governing Body noted Paper 15/37 sharing the minutes of the Older People's Joint Management Group meeting held in December 2014.	
26	**Health Overview and Scrutiny Committee minutes** The Governing Body noted Paper15/38 sharing the minutes of the Health Overview and Scrutiny Committee held in December 2014.	
27	**Health and Wellbeing Board minutes** The Governing Body noted Paper 15/39 sharing the minutes of the meeting of the Health and Wellbeing Board held in January 2015.	
28	**Any Other Business** There being no other business the meeting was closed.	
29	**Date of Next Meeting: Thursday 28 May 2015, 9.30 – 12.45, Henley Town Hall, RG9 2AQ**	