NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING

26 January 2017, 09.00 – 12.45 Jubilee House, 5510 John Smith Drive, Oxford, OX4 2LH

	Dr Joe McManners, Clinical Chair
	David Smith, Chief Executive
	Dr Julie Anderson, South West Locality Clinical Director (voting)
	Dr Stephen Attwood, North East Locality Clinical Director (voting)
	Dr Andrew Burnett, South East Locality Clinical Director (voting)
	Dr Miles Carter, West Locality Clinical Director (voting) (from 12.00)
	Dr David Chapman, Oxford City Clinical Director (voting)
	Julie Dandridge, Deputy Director of Delivery and Localities, Head of Primary Care and Localities (non-voting) deputising for the Chief Operating Officer
	Roger Dickinson, Lay Vice Chair (voting)
	Gareth Kenworthy, Director of Finance (voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting)
	Catherine Mountford, Director of Governance and Business Process (non-voting)
	Dr Paul Park, North Locality Clinical Director (voting)
	Dr Guy Rooney, Medical Specialist Adviser (voting)
	Duncan Smith, Lay Member (voting)
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI) (voting)
	Sula Wiltshire, Director of Quality and Lead Nurse (voting)
In attendance:	Lesley Corfield, Business Manager - Minutes
	Clive Walsh, Oxfordshire Transformation Programme (OTP) Clinical Development Lead – Item 9
Apologies:	Mike Delaney, Lay Member (non-voting)
	Diane Hedges, Chief Operating Officer (non-voting)
	Stuart MacFarlane, Practice Manager Representative (non-voting)
	Kate Terroni, OCC Director of Adult Services (non-voting)

Item No	Item	Action
1	**Chair's Welcome and Announcements** The Chair welcomed everyone to the meeting and reminded those present the OCCG Board was a meeting in public and not a public meeting. He advised the public would have the opportunity to ask questions under Item 3 of the agenda. The Director of Quality read the Patient story and thanked the patient for their	

	consent.	
2	**Apologies for absence** Apologies were received from the Lay Member (non-voting), the Chief Operating Officer, the Practice Manager Representative and the OCC Director for Adult Services.	
3	**Public Questions** The Chair advised some questions had been received via the website relating to Deer Park Medical Practice and invited the Deputy Director of Delivery and Localities, Head of Primary Care and Localities to respond advising as these did not relate to OCCG Board papers responses would be posted on the website within 20 working days. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities reminded the OCCG Board there was a legal challenge against the decision to close Deer Park Medical Centre (DPMC) and this was currently going through the courts. The questions received covered two main themes: capacity of other practices to absorb patients from DPMC; and housing growth particularly in West Oxfordshire. OCCG was working closely with practices on plans to accept DPMC patients especially the three practices in the centre of Witney. OCCG was supporting the practices to ensure there would be capacity. There were additional GP and nurse appointments in the Witney hub to help as well as extra reception and administration staff to assist with patient registrations. The DPMC contract had been extended by five months to enable processes to be in place and for patients to have time to register at another practice. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities believed the other practices were now ready and able to absorb the patients. There was housing growth around west Witney and plans for additional housing in the Deer Park area. OCCG was working with the District Council to understand the rate of growth, when it was expected the houses would be occupied and when it was expected there would be patients wishing to register with GP practices. The tracking currently indicated this would be about 50 – 100 patients every year and there would be capacity within existing practices to absorb these patients. Making existing practices larger would make them more sustainable. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities stressed OCCG had been looking to a procurement to provide a service but the procurement had been unsuccessful and as there was no other provider OCCG had been left with no option except to close the practice and disperse the list. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities thanked Virgin Care and the other Witney practices for working in a manner to enable the dispersal of patients in a safe and managed way. The Chair invited questions from members of the public. Three members of the public addressed the Board. All questions would be answered where possible under the item to which they related and written responses would be uploaded to the website within 20 working days of the meeting. The questions relating to the consultation would be addressed under Item 9 and those concerning the Carers' Consultation under Item 12. With regard to those relating to Chipping Norton Hospital, the Chief Executive reported members of OCCG had met with representatives of the Chipping Norton & District Hospital Action Group (CNDHAG) and others on 6 January where the points in the questions had been raised. Robert Courts MP had attended the meeting and stated he was prepared to chair a meeting to discuss the facts as there had been disagreement around the numbers and analysis. The Chief Executive made it clear to members of the press present in the audience that OCCG did not agree the CNDHAG figures and stressed the importance of a meeting to discuss the facts. The Chief Executive advised it was with Robert Courts' office to set up the meeting.	
4	**Declarations of Interest Relating to Agenda Items**	

	The Chair and the Locality Clinical Directors (LCDs) for the North, North East, Oxford City, South East and West declared an interest in Item 11, Achieving a Sustainable Primary Care in Oxfordshire. The Medical Specialist Adviser advised he was the Medical Director at Great Western Hospitals NHS Foundation Trust which was mentioned in two of the Board papers but he did not believe they contained anything which would lead to a conflict of interest. If this were to change when the item was discussed he would advise the Board accordingly. There were no other declarations of interest over and above those already recorded.	
5	**Minutes of OCCG Board Meeting held on 29 November 2016** The minutes of the meeting held on 29 November 2016 were approved as an accurate record.	
6	**Matters arising from the Minutes of 29 November 2016** The actions from the 29 November 2016 minutes were reviewed and updates provided where these were not covered under items later on the agenda. *End of Life Coordination Centre* The South West LCD advised active discussions with Macmillan were continuing and the situation looked hopeful. *Operational Planning – Health Inequalities Commission (HIC) Recommendations* The Director of Governance confirmed the receipt of the HIC recommendations and outlined how we would consider them and the action was complete. *Deer Park Medical Centre (DPMC) Service Specification* The Deputy Director of Delivery and Localities, Head of Primary Care and Localities confirmed the DPMC service specification had been uploaded to the OCCG website and the action was complete. *Risk Registers* The Director of Governance reported work was underway for a new front sheet for the Board papers which would include a section to reflect the appropriate risk being addressed. *Oxfordshire Primary Care Commissioning Committee (OPCCC) Minutes* The Deputy Director of Delivery and Localities, Head of Primary Care and Localities advised the rise in A&E attendances between 2015/16 and 2016/17 for the Horton Hospital and the John Radcliffe had been reviewed and for the period beginning the financial year were 11 per cent for the John Radcliffe and four per cent for the Horton Hospital. *CCG Executive Terms of Reference (ToR)* The CCG ToR had been amended following the November Board meeting and the action was complete.	**JA**
Overview Reports		
7	**Chief Executive's Report** The Chief Executive introduced Paper 17/02 updating the OCCG Board on topical issues including performance against national targets, Quarter 3 Improvement and Assessment Framework meeting, and the Oxfordshire Transformation Phase 1. The Chief Executive highlighted: the Oxfordshire system referral to treatment (RTT) and cancer summit held on Monday 23 January advising a letter detailing formal actions was awaited and would be circulated; the Quarter 3 Improvement and Assessment Framework where the North Deputy Locality Clinical Director and cancer lead had given a presentation and a formal letter was again awaited; and the approval by NHS England (NHSE) for OCCG to proceed with the Phase 1 consultation. The letter confirming the scheme was fully assured against the Four Key tests of service change had been appended to the Chief Executive's report for information. The consultation would run for 12 weeks until 9 April 2017 and all the relevant documents were available on the OCCG website (here). The first consultation event would take place that evening, 26 January, in Banbury and there would be 12 events in total, 11 in Oxfordshire and one in Brackley, Northamptonshire. The events were due to take place at all times of the day including some in the evening.	

	The Lay Member (voting) commented that the performance issues around the national targets had been of concern to the Board for some time. The performance in 2016/17 had been particularly challenging and resulted in OCCG losing around £4.0m in funding (from the quality premium). He was also unclear of the roles of the organisations sitting round the table at the summit agreeing the actions to be taken specifically in terms of who would hold Oxford University Hospitals NHS Foundation Trust (OUHFT) to account and which organisation took the lead. The Lay Member (voting) queried whether the executive from NHSE and NHS Improvement (NHSI) should be invited to attend a meeting to explain their responsibilities, how OUHFT would be held to account and actions monitored. The Chief Executive explained NHSI were the regulator. OUHFT as a Foundation Trust operated under a licence and only NHSI could enforce issues around the licence. The Chief Executive felt it had been unclear at the meeting on Monday 23 January what would happen if the series of actions agreed were not delivered. The Chief Executive was prepared to reflect back the comments from the Lay Member (voting) to the two regulators. An action plan would be formed from the meeting but the Chief Executive observed there had already been a number of action plans some of which had been delivered but there were areas where the trust had not been able to resolve the issues – this had not been from a lack of will but because it was a complex issue to resolve particularly in relation to the cancer targets but OCCG would continue to press the trust. The Chair had previously written formally to the OUHFT Chair and it might be necessary to consider this again. The Chair advised an earlier issue concerning differences between trajectories requested by NHSI, NHSE and OCCG had been resolved. The Chief Executive advised in terms of other neighbouring acute trusts OUHFT did not compare very favourably on performance but this was partly due to being a tertiary centre and the referral process. In terms of how the service was delivered, there was more the trust could do and this was part of the action plan that was being worked through. RTT was a national issue. Further monies from NHSE and OCCG had been provided to the trust to address the RTT waiting list backlog but there was also rising demand and a finite amount of money in the system to meet that rising demand. The South West LCD observed by not achieving the national targets OCCG stood to lose £4.0m and although the capacity issues were understood, a new contract for 2017/18 which was £15.0m more than last year had been agreed. The contract included a risk sharing agreement but within the contract there would be financial penalties that could be raised if OUHFT did not meet the national targets. The South West LCD queried whether these penalties would be sufficient to cover the £4.0m or if it could be taken out of the risk share arrangement. She asked if it was possible to be sure these would not be negotiated away and OCCG lose out in terms of patient care and financially. The Director of Finance explained the £4.0m was the quality premium which was linked to performance delivery. What OCCG would lose was the opportunity to earn the money. Historically the most OCCG had received was £2.0m, and that had been in 2015/16. For 2016/17 OCCG had received £700k. The non-achievement of the quality premium did not impact financially in terms of the financial plans but did limit what was possible in primary care investment. A change had been made for 2017/18 and the penalties for not delivering NHS constitution standards had been waived in the face of the sustainability and transformation fund (STF) for which the trusts were eligible. The trust would agree an improvement trajectory and if this was delivered it would earn STF funding. It the trajectory was not delivered the STF funding would not be	**DS**

	received. The penalties in the contracts had been waived for 2017/18 to ensure the trust was not penalised twice. This would continue whilst the STF stayed in place. **The OCCG Board noted the Chief Executive's Report.**	
8	**Locality Clinical Director Reports** Paper 17/03 contained the Locality Clinical Director (LCD) Reports. The South East LCD reported the rapid access care unit (RACU) at Townlands Hospital had opened on Monday 23 January and the first patients had been seen. He felt sure the RACU would help to treat people in a way which would avoid hospital admission. The Lay Vice Chair advised the Townlands Stakeholder Group had been very positive around what was happening at Townlands Hospital and how all the steps had been worked through. As it had been a public meeting on Monday the Lay Vice Chair had asked those present how they thought the arrangements at the Hospital were working and a very positive response had been received. The North East LCD observed a practice had closed in Bicester and the patient list dispersed. He wished to acknowledge the support given to the Bicester practices. The dispersal had not been easy but had been well managed and supported particularly for vulnerable patients. The South West LCD reported two practices had closed in the south west during the last two years, in Faringdon and Grove. Both practices had merged with larger practices without any formal support. It had been difficult but was achieved with very little upset in the local communities. The Oxford City LCD advised the partners at Kennington Health Centre had handed in their notice and arrangements were in hand and moving fairly rapidly. He highlighted that primary care was facing significant pressures commenting the capital investment settlement had been derisory and the estate was a problem which need to be taken seriously. The Chair commented the merger of practices involved a huge amount of work and could be destabilising stating OCCG would need to be supportive as the issue would not go away and was likely to become a direction of travel due to the pressures faced by smaller practices. The Chair observed the GMS contract was not favourable and there was a reluctance to take on this type of contract which OCCG should be addressing as the issue was not being picked up nationally. The South West LCD remarked that the expected housing growth in the south west seemed to increase every time a meeting was held with Planners. It appeared there would be insufficient provision for health in Wantage and Grove particularly which would cause pressure on primary care in that area. The Chief Executive advised a meeting had been arranged for 14 February with the South Oxfordshire and Vale District Councils. He commented that there had been discussion with Planners but felt it was important to engage with the Leaders of the Councils. The Chief Executive stated there was a need to look for different solutions following receipt of only £2.0m for primary care infrastructure from a bid of £50.0m. He suggested by working with the District Councils OCCG might be able to attract additional funding. The Chair noted the District and County Councils met as the Growth Board and suggested he and the Chief Executive should attend as a discussion around health was due to take place soon and there was a need for organisations to become more joined up. The Chief Executive advised he had been in touch with all the MPs around the issues and stressed the importance of linking with the MPs through all networks. The Lay Vice Chair observed planned care, an item which was included in the consultation, had not been included in the North Oxfordshire Locality Group list of	

	discussions. The North LCD advised it was not a controversial issue in the north as GPs were quite happy that more procedures would be undertaken at the Horton. The Lay Vice Chair felt it was important for it to be known that around 90,000 trips by patients from the north to Oxford would be saved. **The OCCG Board noted the Locality Clinical Director Reports.**	
Strategy and Development		
9	**Oxfordshire Transformation Programme: Transition to Phase Two and Outline Timeline** The Chair welcomed the OTP Clinical Development Lead to the meeting for this item. The Chief Executive presented Paper 17/04 providing an update on the Oxfordshire Transformation Programme with a particular focus on transition to Phase Two building on the work and proposals in Phase One and including an outline timeline for work in the second phase. The Chief Executive highlighted the length of time required for the work and assurance process to be undertaken stating it was not expected the consultation for Phase 2 would start until November 2017 at the earliest. This was partly due to the technical work required around the Phase 2 options but also the engagement piece. Unless NHSE could be assured around engagement with stakeholders they would not be prepared to sign off the assurance process without which OCCG could not go out to consultation. A pre-consultation business case (PCBC) would be required. This process needed to start in parallel with the formal consultation on Phase 1 which could cause some confusion but if it did not, the work would not commence until after June. This had been highlighted to the Transformation Board. There was also a question around whether Phase 2 could be signed off locally or if it needed to be via the national team which would extend the time period. It was not possible to go out to consultation until the Secretary of State Four Key Tests had been passed. Referring to the question raised by a member of the public, the Chief Executive indicated the proposed governance structure included on page 5 of the paper. He advised the Programme Executive would be the 'engine room' for the work to be undertaken; recommendations would be made through the Transformation Board whilst statutory decisions would be made by the OCCG Board. The paper contained a fair amount on the governance structure as unless this was approved it would not be possible to pass the NHSE assurance process. The scope for Phase 2 was shown on page 2 although the Chief Executive advised the first bullet point should more properly be urgent and emergency care pathways not just the provision of Emergency Departments. Children's services were also included but a significant part of the work would be primary care particularly if services closer to home were to be considered. This would pose challenges as a level of engagement with GP practices around the model of primary care would be required. The Lay Vice Chair considered it was a two part paper: transition to Phase 2 and governance. Around the transition to Phase 2 he felt OCCG was falling back from taking an Oxfordshire system wide view as primary care was not included as a particular category. Nor was prevention and education in health which was a major factor in reducing pressure. From a governance perspective the relationship with the Transformation Board was not clear and in his view the diagram indicated the flow of data but not, control and where items would be considered. The Terms of Reference (ToR) for the Transformation Board included Oxfordshire County Council (OCC) in the membership but there was nothing in the purpose in the remit other than NHS services. This should be health services and social care. The ToR should also include reporting back to the OCCG Board if there were any changes to the ToR.	

Other points of discussion included:

- The assurance from the Chief Executive around primary care was welcomed as the importance of primary care did not come through the paper. There would be a need for significant consultation with the public around primary care as patients would see someone in the primary care team but not necessarily a GP. This change in direction of travel had not been fully communicated with the public and there was a need for wider engagement and possibly consultation on this aspect
- More around the financial challenge needed to be added as there was still £134.0m to deliver which would require financial modelling and affordability work to be undertaken
- Clarity was required around whether integrated community services including primary care were to be discussed and in terms of locality meeting reports there would be a need to see discussion around that future model of primary care
- The wording of item 3g of the Programme Executive ToR was clumsy and should be amended to reflect the Programme Executive was held to account in terms of project delivery whilst the accountability for the overall transformation programme was the responsibility of the Boards of the statutory organisations
- Engagement with the public, patients and carers was unclear and something more detailed should be included. There were many fora with whom OCCG could engage but not a public forum
- Some disquiet around the length of time the process had taken to achieve Phase 1 of the consultation was expressed as well as the need to balance the work required and the engagement and consultation requirements for meeting the assurance process. If primary care was not included in Phase 2 it would be difficult to make sense of the whole as primary care was an important part of how the whole system worked. Some comments around inequalities would be welcome
- The essence of transformation could be lost if the process was driven by the consultation rather than structural changes. Transformation required properly integrated social, primary and community care
- The comments around governance would be picked up but the OCCG Board had requested the review as there had been confusion around the previous governance and the lack of clarity around where decisions were made and the role of the Transformation Board. The paper clearly stated the OCCG Board, which were meetings held in public, would make decisions
- There might be some cross over between the primary care and community services worksteams.

The OTP Clinical Development Lead emphasised the paper was clear where final responsibility for decisions lay. Options would be generated and refined through workstreams led by clinicians in OCCG with partner clinicians and additional information. There were fundamental elements to how health and social care should be organised in Oxfordshire and the paper was trying to emphasise those areas where it was believed engagement in a formal consultation would be required. It was expected proposals around prevention could be enacted and organised rather than requiring a consultation. This was the distinction the paper was trying to draw.

The areas people felt should be included in the paper had been noted, together with the comments around showing the flow of data and control and a different diagram might perhaps be required. The public engagement plan was intended as a demonstration and had not yet been finalised. It was felt it would be

	beneficial to engage the Lay Member PPI on the specific engagement plan. With regard to the NHSE process, OCCG was working within the statutory framework and there were some actions that could be taken in Phase 2 to ease the situation. The information NHSE would need for assurance was being collected to enable clinicians to use the packages of information when delivering their proposals. Another advantage of the assurance process was providing OCCG and partners with a level of confidence around decision making and any possible challenge to the process. The Director of Finance advised the financial gap had changed during the transformation work. Originally it had been £200.0m but there was a need to update the information following the current financial year. It was believed the gap was in the region of £130.0m but this would be clarified as the process was progressed. Referring to a comment by a member of the public, the Director of Finance advised as an NHS body OCCG had very limited ability to publicly lobby government. OCCG also had a statutory responsibility to remain within its financial allocation. The submissions and assurance with NHSE were articulated through the Operational Plan. OCCG faced a series of choices or trade-offs which were being looked at through the contracts, the system work and through the transformation programme. In response to a query around OCCG still being four per cent away from its fair share of funding, the Director of Finance advised historically OCCG was ten per cent away but this had now moved to within five per cent. Notification of the allocation for the next two years had been received and there was no indication of a move to get OCCG closer to the target. The Chair commented that the CCG had been asked to increase its surplus in 2016/17 by 0.5 per cent which OCCG would like to be returned in order to use for the patients in Oxfordshire and there was a need to continue the internal lobbying for its return. The Chair believed people would want to talk about prevention and primary care and it would be important to have a cohesive story even if some areas did not require consultation otherwise focus could be lost. The Director of Public Health observed there was a lot of heightened concern around NHSE slowing OCCG down but there was a need for openness and transparency and although there might be areas on which there was no need to consult, the public should be informed. **The OCCG Board:** • **Subject to the comments above confirmed the scope for Phase Two** • **Considered and approved the outline timeline for Phase Two** • **Considered and approved the revised governance structure for the Transformation Programme subject to the discussion above** • **Noted the activity planned for Phase Two and the potential risks currently faced by the Oxfordshire Transformation programme.**	
10	**Planning for 2017/18 – 2018/19** **Final OCCG Operational Plan 2017/18 – 201718/19 and OCCG Priorities** The Director of Governance presented Paper 17/05a advising in line with national planning guidance an Operational Plan covering a two year period, 2017/18 – 2018/19, had been developed and successfully submitted on 23 December 2016. The first draft of the document had been approved by the OCCG Board at its November meeting and Paper 17/05a was the final version. The Operational Plan reflected the commitments outlined in the BOB STP, the commissioning intentions agreed for 2017/18 – 2018/19 and the Oxfordshire Transformation programme. The Plan had been considered by NHSE and feedback received. There had been	

no substantial changes to the narrative but there was a need to consider the activity, finance and savings. The proposed overall priorities included as an appendix had been slightly updated. Within the covering paper attention was drawn to a discussion held by the Executive on the key areas for the next six months and these were highlighted in the report.

The Lay Member PPI felt it would be helpful if the diagram on page 16 in the Maternity section could reflect maternity was about having babies and include issues around the Special Care Baby Unit (SCBU) and the Neonatal Intensive Care Unit (NICU). She also commented MLU stood for Midwife Led Unit, not Maternity. The Lay Member PPI was pleased to see some positive items about digital care and technology together with the mention of chronic obstructive pulmonary disease (COPD) for which she understood there were some online services OCCG was sighted on and which would be fully reimbursed by NHSE. She welcomed the move as it should result in some positive outcomes.

The Deputy Director of Delivery and Localities, Head of Primary Care and Localities drew attention to page 9 and the hope to meet the 62 day target for cancer throughout the year and not just in Quarter 2. The backlog in RTT needed to be resolved but the ambition was to meet the target before the end of Quarter 2 and to get ahead of the trajectory. The 4 hour A&E was a very challenging target and OCCG was looking to build in trigger points and reach agreement with OUHFT around how the 90 per cent target would be met. This was below the NHSE target but something realistic and achievable was required. The 90 per cent would be the minimum delivery OUHFT needed to achieve whilst working towards the 95 per cent target. The Director of Governance advised the section on the 62 day cancer target needed to be re-written as this should be met from the beginning of April. The current RTT trajectory was by the end of Quarter 2 but it was planned OUHFT would reach and maintain the target much earlier.

The OCCG Board:

- **Approved the CCG's 2017/18 – 2018/19 Operational Plan narrative**
- **Approved the OCCG priorities for 2017/18 – 1018/19**
- **Noted the operational priorities outlined for the next six months.**

2017-19 Contract Update

The Director of Finance presented Paper 17/05b which provided an update and overview on progress in agreeing the 2017 -19 contracts. Contracts had been agreed for 2017/18 – 2018/19 with the two main providers, Oxford University Hospitals NHS Foundation Trust (OUHFT) and Oxford Health NHS Foundation Trust (OHFT). This was achieved by the deadline set for the NHS of 23 December 2016.

The contract values were affordable within the 2017-18 CCG Financial Plan at OUHFT £331.0m and OHFT £89.5m (excluding the Mental Health Outcomes Based Contract). Negotiations had identified a combined contract gap of £18.0m, £16.0m of which related to demand risk on the acute contract with OUHFT and the balance linked to pressures on the OHFT contract. The gap was considered to be the system 'risk pool'. A list of risk mitigations consisting of demand/activity management savings initiatives had been developed. An in-year risk sharing agreement had been agreed in the proportion of 40 per cent CCG, 40 per cent OUHFT and 20 per cent OHFT reflecting the nature of the risk and the ability of each organisation to bear the risk. Although not capped the OUHFT activity assumptions had been based on a continuation of 2016/17 trend plus RTT backlog clearance. On that basis the OCCG risk could be considered to be in the region of £7.2m. As part of the risk share agreement a strategic review of mental health investment and primary care capacity in Oxfordshire would be undertaken to inform investment plans and contracts moving forward.

The transfer of learning disability services from Southern Health NHS Foundation Trust (SHFT) to OHFT would be subject to separate negotiation to be undertaken in February 2017 and it had been recognised that additional investment might be required.

As part of the risk sharing agreement it had been agreed:

- 95 per cent A&E 4hr wait standard would be delivered for the month of March 2018
- 18wk RTT incomplete standard would be met throughout 2017-19 at system agreed trajectories
- All cancer standards would be met throughout 2017-19
- Data challenges would be raised as per the terms and conditions of a contract operating national tariff rules and broadly consistent with the level of challenges raised in previous years
- Contract management clauses would be exercised as necessary
- Any monies resulting from the application of penalties or non-delivery of CQUINs would be used to offset any risks within the risk pool.

The OCCG Board needed to note with the end of the block contract arrangements with OUHFT that the CCG would carry more financial risk going into 2017/18 than over the past two to three years. The governance structure and programme management approach to oversee the development, delivery and on-going monitoring of the mitigations identified was under development although it was anticipated each organisation would need to identify a senior leader to oversee delivery of organisation specific tasks. A senior responsible office for the system programme and a dedicated programme director to oversee and manage the programme in its entirety was also proposed.

Other contracts agreed were:

- South Central Ambulance Service (999) contract agreed - £21.9m
- Great Western Hospitals - £3.5m
- Frimley Park North & South - £0.4m.

Contracts still under negotiation were:

- Royal Berkshire Hospitals NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- Gloucester Hospitals NHS Foundation Trust
- Independent sector providers
- Buckinghamshire Healthcare NHS Trust
- London NHS providers (through the collaborative Thames Valley and Hampshire agreement managed by Optum).

The Director of Finance felt it was important to stress around £9.0m of the increased OUHFT contract value was due to changes to identification rules for specialised commissioning, the transfer of commissioning from Wessex to OCCG. The underlining increase in the contract value was £4.0m. All the financial risk was around demand activity and growth. It was believed there were the right incentives across the three parties to enable them to work together to manage the demand but OCCG would enter 2017/18 carrying a higher level of financial risk. For the schemes identified there would be a need to agree an overarching contract agreement which firmed up plans and moved to delivery.

In response to the South West LCD who again queried why there would be no claw back if the targets agreed in the contracts were not delivered, the Director of Finance reported the agreement had been signed before Christmas at the point contracts were agreed. There would be detailed documentation which would

	contain trajectories, expand on the statement, show delivery by month and when this was expected to be achieved. DS observed it was a series of trade-offs but the trust did not control all of the activity and it could be argued no one did, which made it difficult to penalise the trust. However it was necessary to ensure the trust had all the right processes in place to ensure flow through was as good as it could be and it was in this area OCCG needed to ensure action was taken. The RTT situation was different. In order to help address the backlog patients were offered an appointment at the Royal Berkshire Hospital but many chose to wait for an appointment at the John Radcliffe even though the waiting time would be longer. It would be easy to put in more money to enable patients to attend private sector hospitals but the system could not afford it. This was the trade-off when making decisions around where to invest monies. OCCG could not have a series of perverse incentives which encouraged treatment in the private sector rather than at the John Radcliffe. The Chair emphasised the need to be clear that patients waiting a long time for treatment and appointments was not acceptable and the impact of longer waiting times which affected a lot of individual people needed to be considered. The Chief Executive concurred but reiterated it was a question of patient choice and if a patient wished to wait for an appointment which resulted in a breach of the target there was little anyone could do. The Chair observed it was quite an aggressive contract and congratulated the team on their achievement. The Chief Executive advised oversight of the various workstreams within the system programmes would be via the Finance Report to the OCCG Board. There was a need for collective governance and these would also be reported in the Chief Executives' Group from which he would update the Board and the Finance Committees of the various organisations. The Lay Member (voting) would work with the Finance Committee Chairs from the other trusts although the exact mechanism had not yet been worked through. The Lay Member PPI noted the South Warwickshire NHS Foundation Trust contact was still under negotiation and queried whether there might be an increase in the numbers using the hospital and thus cost implications. The Director of Finance advised the starting position was always a forecast outturn which was built into the baseline. Following on would be consideration of movement in activity and whether it was recurrent. It was anticipated the contract would be signed soon and although there was a challenge around forecasting reduced deliveries in OUHFT activity against increases elsewhere, an overall cost pressure was not expected though at this stage the activity might not be matched exactly. The Lay Member (voting) congratulated the management team as this was the first time since he had been involved in Oxfordshire that the system had been aligned to financial risk sharing and incentives to work together around transformation. As a system there was still a need to delivery £18.0m savings otherwise all organisations would be exposed to a significant financial hit. It was noted the providers still would need to deliver cash releasing savings on top of the £18.0m. The Director of Finance advised this covered just over half of OCCG commissioning spend which also meant the CCG had a savings plan in addition ot the £18m **The OCCG Board noted the content of Paper 17/05b.**	
11	**Achieving a Sustainable Primary Care in Oxfordshire** The Deputy Director of Delivery and Localities, Head of Primary Care and	

Localities presented Paper 17/06 describing the steps taken during 2016 and those planned for 2017/18 by OCCG to achieve a sustainable Primary Care.

Many issues had already been discussed and LCDs noted changes to general practice in their localities. The paper did not contain all the answers but tried to pull ideas together. It was also worth the Board noting those actions already taken to help support general practice many of which would not have been possible if OCCG had not received delegated authority for primary medical services. OCCG had already undertaken direct input to vulnerable practices; commissioned additional primary care services; looked at addressing GP workforce issues; and ways to reduce patient demand on practices. Funding for general practice was via a national formula but further monies were available from the GP Forward View (GPFV) and there was a need to ensure this funding was spent appropriately and innovatively.

Going forward the Primary Care Framework was intended to provide a strategic direction for a sustainable primary care in Oxfordshire. The document was being circulated in the localities and had been presented to OPCCC and an early draft would be presented to the Health Overview and Scrutiny Committee (HOSC). The Framework would allow localities to decide which areas would work for them. Consideration would also be given to supporting practices by using staff in different ways as well as up-skilling staff. There would also be a need to educate patients that they might not always need to see a GP and other staff could be better equipped to help them.

Primary care estates had already been discussed under other items and many practices were on a fine line of vulnerability continuum where a small thing could push them over the edge. OCCG was putting together a support package whereby a small team could be parachuted into a practice to provide assistance.

The aim was to work up programmes of work to provide key milestones with objectives which would be reported into OPCCC. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities hoped the paper provided the Board with some assurance OCCG was working hard to get a sustainable primary care.

The North LCD reiterated the point the paper did not contain detail of all the work being undertaken but that it was a recognition of the problems and demonstrated how they were being addressed. He reported two practices in the North had employed clinical pharmacists and this was working well and had improved sustainability. There had also been good feedback from patients. Some bids had been made for national pharmacist funding around the county which it was hoped would be successful. There was a need to improve detection of vulnerable practices to ensure more support was provided before the situation became critical. The North LCD commented that it was a complex piece of work but OCCG was doing its best.

Points of discussion included:

- There was the potential to increase inequality and difficulty of access and primary care and its workforce should be viewed through an inequalities ‘lens’
- A potential direction of travel was towards large practices but in future planning smaller practices should be considered as with plans for extra homes smaller practices could become more viable as patient numbers could increase to the region of 7,000 rather than the current 5,000
- A lot of general practice was working well and many patients were very happy. Moving care into the community would usually mean general practice picking up the work and care should be taken as a sudden

transformation to the whole system could destabilise those practices

- Some understanding of the role of Federations in supporting sustainability in primary care was required and whether that role could be broader and include workforce and back office functions
- Many models of care were predicated on more care in the community but a number of practices would need funding to enable this particularly in premises terms. In some areas, particularly market towns, there was a move to larger units of practices and there was a need to look at a way of supporting practices that were left with a lease on premises. Morally this was very unfair. Many young doctors were not taking on partnerships as they did not wish to have the responsibility of a lease. There was a need to avoid a 'last man standing' situation where if a couple of partners left the rest would not wish to remain as they would not want to have responsibility for the lease. In order for people to come into primary care safeguards should be put in place
- The contracts were not designed to support a cottage industry and there was a push towards larger practices and practices working together. There was a need to start to mobilise the Primary Care Framework and move more quickly to start transformational change. More monitoring of the take up of the national resilience programmes and the high impact changes was also required. Concern was expressed as to how headroom to engage in programmes could be found when practices were under pressure
- Congratulations were given on the management of vulnerable practices but it was not a one size fits all solution and every situation was different. The fundamental problem was workforce and funding. What was not addressed was the level and intensity of work. GPs did not have the time or space to undertake mergers or getting into communities. The pharmacist funding tailed off after three years and practices were then expected to pick up the cost. This needed to be addressed and safeguards put in place. The GP Access Fund had strings attached which in some areas did not allow the service required to be implemented, although this did work in other parts of the county. It was necessary to have funding that was not central so it could be used sensibly to help primary care. The finance section of the paper needed to be developed
- The award of £2.0m from a bid of £50.0m from the Estates Technology and Transformation Fund (ETTF) showed how much central government was supporting OCCG in this area
- The paper was missing linkage to the transformation plan which was necessary to be coherent with the story and message. As the future of primary care would be very different there should be a link to enable people to better understand
- The best way to build primary care teams was to integrate with the community care teams and this was a good and exciting model into which the multispecialty community provider contract should be brought. Funding was a big issue which needed to be resolved and inequality considered properly. The question of the role of Federations also needed to be answered in order to understand how they could help with the solution
- The point around inequalities was accepted but there were also demographic inequalities such as the south west population had 22 per cent over the age of 65 which led to higher morbidity whereas the percentage over 65 in Oxford City was 11 per cent.
- A lot of evidence existed to show a funding formula did not even out inequalities. The hospital activity gap was identified but not the primary care and funding gap. There was also a need to quantify the inequalities gap.

The Chief Executive commented the work needed to be packaged up and circulated to practices and members of public. The issues faced and how it was proposed to deal with them would form part of the Phase 2 work. A more user friendly document was required particularly for the public. It was not possible to quantify the shift of spend it would be necessary to make but this was really important. Although it was not all about money there were a number of areas where there was a need to invest in primary care and some analysis to establish the need would be required. There was also a need to be stronger on inequalities. Currently there was a life expectancy gap across Oxford City of eight years. It was known that the most deprived area was Blackbird Leys. If there was an intent to address this decisions would be required on how and what. There had been a lot of discussion but the Board had not made a decision that this was what was required.

The Deputy Director of Delivery and Localities, Head of Primary Care and Localities commented there was a lot of good practice such as the clinical pharmacy scheme and this good practice needed to be shared. It was clear there was not a one solution fits all which was why a framework to guide and understand how work fitted into transformation had been developed rather than a strategy. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities expected to bring the Primary Care Framework back to the next Board meeting.

The OCCG Board noted the steps being taken to achieve a sustainable Primary Care.

Business and Quality of Patient Care

12 Services for Carers – Outcome of Joint OCCG-OCC Consultation

The Deputy Director of Delivery and Localities, Head of Primary Care and Localities presented Paper 17/07 explaining at the CCG Executive meeting on 20 December 2016 option 27a had been approved regarding the future provision of services for Carers in Oxfordshire. The paper set out the conclusions from the consultation and the plans to invest in new services for Carers.

The Deputy Director of Delivery and Localities, Head of Primary Care and Localities advised an impact assessment had been undertaken by OCC and was available on the OCC website. A joint consultation on the carers' strategy and personal health budgets had been undertaken. There had been a limited response of 51 replies but those responses had indicated support for personal health budgets and their continuation. Currently there was an underspend on the budget and it was proposed to continue to fund at the current level of spend and increase year on year as the numbers of carers increased. Secondly there would be an investment of some of the remaining funds in a new service to help carers' access health and advice services.

The paper had been considered by the OCC Cabinet at its meeting on 24 January where the direction of travel and recommendation of option 27a was agreed.

A plan to reinvest £200,000 per annum in a new service to help carers access help, advice and information to support them in their caring role had been agreed. OCCG was exploring a model of primary care based carers' prescription service through which a GP would be able to refer directly to dedicated carers support in each locality from the GP case management system. This would encourage practices to maintain and update their record of carers, enable the GP to specify the type of support required by a carer to address his or her needs and produce direct contact between the carer and the service enabling it to be tailored to support the specific need of the individual.

	There were a number of ways in which the carers' prescription service could be set up and these had been explored at a meeting on 18 January with representatives from the Surrey service, which was already in place, and carers' representatives. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities referred to the question asked earlier in the meeting and advised a fuller response would be supplied through the website but OCCG would look to ensure the new service did support the seven outcomes of the previous carers' strategy. The aim was to improve the health and wellbeing of carers. A review was also being undertaken around how the mental well-being of older people could be met which would also meet some of the needs of carers. The Oxford City LCD and mental health clinical lead stated the important element was continued support and dementia support funding. The Lay Member (voting) felt it was not possible to understand the impact on individuals from a significant disinvestment in the budget, albeit some monies were being reinvested, and iterated the need for an Equality Impact Assessment (EIA). He was of the opinion that although there might be an impact assessment on the OCC website, it should have been seen by the Board and an EIA or Quality Impact Assessment (QIA) should have been undertaken. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities believed this had been carried out by OCC but undertook to check. The Director of Finance would check the finances in the paper as he advised the current spend would be maintained and OCCG would look to increase the funding as the numbers increased whilst the Lay Member (voting) felt the figures in the report indicated £1.0m would come out. The Lay Member (voting) was not prepared to support ratification of the CCG Executive decision without clarity on the budget. The Board was prepared to ratify the decision of the CCG Executive subject to the two issues of clarity around the finances and whether an EIA/QIA had been undertaken. It was agreed these would be investigated and advised to the Lay Member (voting) in the first place. If he was content with the information supplied the information would be circulate to the Board and the CCG Executive decision ratified. The Chief Operating Officer was delegated responsibility for sign off as the lead director. **The OCCG Board:** • **Noted the outcome of the consultation** • **Ratified the decision of the CCG Executive subject to confirmation from the Lay Member (voting) as detailed above.**	**JD** **GK** **DH**
13	**Transforming Care for People with Learning Disabilities** The Director of Quality presented Paper 17/08 and reminded the OCCG Board it had approved proposals in March 2016 to manage the transfer of specialist learning disability health services from SHFT to OHFT, the CCG's preferred provider. In January 2017 OHFT submitted a bid for the learning disability service which had been supplemented by a presentation and clarification questions to an invited audience. The evaluation panel comprising OCCG, OCC and expert by experience representatives unanimously agreed the bid met the requirements of OCCG's Most Capable Provider process. The OHFT bid was formally endorsed by the Transforming Care Partnership Board on 13 January 2017 and it was recommended that OCCG entered into contract negotiations with OHFT with a view to signing a contract by 1 March 2017.	

	The Oxford City LCD remarked that the experience showed how effective it was when service users were involved as they brought enormously powerful points and influence for transformation. He advised this was the first stage and there was now a need to discuss the financials. The Chair concurred, congratulating the team on having reached this stage stating it was very positive to have reached this position. He observed the engagement of users was a good model to follow. The Director of Quality confirmed it was a proposal to use the usual services and not long term care in an institution adding the overall model was for people with learning difficulties to have the same access to services as everyone else. The Oxford City LCD advised most services would sit in the community and would be managed by primary care not OHFT. The Lay Member (voting) advised the Finance Committee had discussed the outcome of negotiations in terms of the budget set aside and this would come back to the Committee for sign off. **The OCCG Board:** • **Noted the successful bid by OHFT for the provision of specialist learning disability health services** • **Approved the proposal to enter into a contract negotiation with OHFT with the intention of agreeing a contract for future provision of the services and that OHFT would assume responsibility for delivery of the services by 1 July 2017.**	
14	**Finance Report Month 9** The Director of Finance presented Paper 17/09 providing the financial performance of OCCG to 31 December 2016; the risks identified to the financial objectives and the current mitigations; and a most likely, best case and worst case forecast outturn against plan. The Director of Finance reported OCCG remained on plan and there were no significant changes between Month 8 and 9 although there was some over performance on the OHFT contract at Month 9 which would add to the risk and pressure for the next financial year. The forecast was a £3.9m over performance on that contract which would be managed through the next year's contract. The Director of Finance referred to the table on page 3 of the report which set out the financial management. There was a £5.2m overspend on funded nursing costs which was mainly being managed through in year contingency but was a recurrent pressure which would need to be addressed in the next year. Under the national business rules a non-recurrent reserve of £8.2m was still held and OCCG would be advised in the latter part of 2016/17 whether this could be used locally but this was contingent on the NHS position as a whole. The latest information was the monies would be used to address the national figure. The money was held in OCCG accounts but NHSE could remove it. The only option for release by OCCG would be to show as an underspend which would increase the surplus to in excess of £20.0m but the money was held under national business rules over which OCCG had no discretion on how it was spent. The Chair remarked if the monies were returned to OCCG it would be difficult to explain a surplus of £20.0m. The Chief Executive suggested finding the relevant clause in the NHS Act which made clear the power of the Secretary of State over NHS money and circulating this as a reminder to the Board. The Director of Finance stressed the need to recognise the resources were being used to support the NHS as a whole and that 'whole' would impact on OCCG. Unless issues were addressed as a whole there could be a reflection in the	**CM**

	allocation received in the future. The North East LCD understood the position but felt in terms of the public and their understanding of a surplus in excess of £20.0m there was a need to be explicit and be clear it was not a choice made by OCCG but one that was required of the organisation. The South West LCD questioned whether it would happen again in the next financial year and thereafter with the result if OCCG was half as successful with plans at it hoped to be but the money had to be returned, OCCG would be left with nothing with which to sustain services. The Director of Finance expected the same rules to apply and advised there was a need to hold the reserve until told otherwise. The North LCD felt the numbers should be a matter of record. The Chair observed it was clear the politicians' saying the NHS had received an increase was not the case. The Chief Executive suggested splitting the amount to make it clear. **The OCCG Board noted the Finance Report for Month 9 and considered sufficient assurance existed that OCCG was managing its financial performance and risks effectively, that it could mitigate any risks identified and that it was on track to deliver its financial objectives.**	
15	**Integrated Performance Report** The Deputy Director of Delivery and Localities, Head of Primary Care and Localities introduced Paper 17/10 updating the OCCG Board on quality and performance issues to date. The Integrated Performance Report was designed to give assurance of the processes and controls around quality and performance. It contained analysis of how OCCG and associated organisations were performing. The report was comprehensive but sought to direct members to instances of exception. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities advised in the majority of cases the data was from Month 7. She drew attention to the Quality and Performance dashboard which showed Oxfordshire had not fared as badly as elsewhere for the 4 hour wait and were one of the top performers over the Christmas and New Year period even though the target was not met. Escalation calls were being held daily. On page 8 of the paper was an OUHFT Provider Summary providing information by departments. This provided another way to identify areas of focus. The Director of Quality advised the infection control data was to the end of December; clostridium difficile (Cdif) rates were reducing; there were no further never events; the lack of target achievement had impacted on the Quality Premium; OCCG was in the process of agreeing trajectories with OUHFT for out and in patient test results and this sat with the two Chief Operating Officers to agree. There was still further work to be done in this area as the current position was 82 per cent for out-patients, 72 per cent for discharge and 75 per cent for test results. Test results were one of the clinical operational risks. The Specialist Medical Adviser suggested obtaining some feedback from the Local Delivery Board around measures to meet the 4 hour target and to provide some assurance on approach as this was a measure of the system and how the system was working. The Lay Member (voting) noted the figures were shown for the 52 week waits but nothing was included for the over 18 weeks breaches and requested this to be monitored at Board level. He also felt it would be useful to see OHFT and access	

	to mental health services performance for older adults and adults of working age in addition to the Child and Adult Mental Health Service (CAMHS). The Lay Member (voting) commented on the over performance on activity and stated if activity and waiting lists were increasing there would be a need to understand and correlate the information. **The OCCG Board noted the Integrated Performance Report.**	
16	**Safeguarding Update** The Director of Quality presented Paper 17/11 updating the OCCG Board on safeguarding issues and advised the Refugee Health Initiative was a pilot to link students and refugees to help them understand how to use health services. The scheme had not yet started but feedback would be provided once the data was available. The Director of Quality confirmed that every death of a person in Oxfordshire with learning disabilities or other vulnerable adults would be reviewed through the Vulnerable Adults Mortality Group. The Director of Finance would follow up on the query concerning the Child Death Review Processes and the on-line system for which there was only one supplier around whether there were any particular rules to ensure value for money or if the service was being commissioned with other organisations which would provide value at scale. **The OCCG Board noted the Safeguarding Activity Update Report.**	**GK**
	Carers' Consultation At this point in the meeting the Director of Public Health reported he had been advised a Quality and Diversity Impact Assessment had been undertaken for the Carers' Consultation and this would be sent to the Business Manager for circulation to the Board (see Item 12).	**LC**
Governance and Assurance		
17	**Annual Equality Publication** The Director of Governance presented Paper 17/12 advising Section 149 of the Equality Action (2010) required organisations to demonstrate compliance with the Public Sector Equality Duty (PSED) which placed a statutory duty on organisations to address unlawful discrimination, advance equality of opportunity and foster good relations between people when carrying out their activities. The paper was the OCCG Annual Equality publication detailing equality and diversity work in 2016. OCCG had continued to work with the Equality Reference Group and the Staff Partnership Forum to undertake and publish the Equality Delivery System (EDS2) and Workforce Race Equality System (WRES) reports. The Director of Governance advised feedback from the previous year had been to include more patient stories to identify where an action had been taken. The Director of Governance expressed her gratitude to the Equality Reference Group who had been closely involved and the Staff Partnership Forum who had assisted on staff issues. OCCG had improved over the year against the equality delivery system scoring although further work was required. The meeting front sheets would be changed and rather than a tick box there would be a need for a written piece. There had been a change in the way the needs of patients with protected characteristics were addressed and the Director of Governance thanked patients for their feedback and advised OCCG would learn from the experience. The Chair thanked the Director of Governance and pointed out when the Health Inequalities Commission report had been reviewed at the OCCG Board Workshop it had been agreed inequalities would be more than a tick box exercise. The Oxford City LCD advised a bid had been made for funding from the Home Office for asylum seekers and migrants adding there had been some dramatic changes in ethnicity in areas of the county. The North LCD concurred advising	

	the locality supported and funded patients through the vulnerable person Syrian refugee scheme. The Lay Member PPI remarked there was a need to be clear health inequality was an issue but observed the report was specifically around diversity. She felt there was a need to look at the workforce and be mindful of the nine protected characteristics and should support the workforce to be as diverse as it was possible to be. **The OCCG Board approved the Annual Equality Publication.**	
18	**Corporate Governance report** The Director of Governance introduced Paper 17/13 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest. **The OCCG Board noted the Corporate Governance Report.**	
19	**Strategic Risk Register and Red Operational Risks** The Director of Governance presented Paper 17/14 advising there were no new strategic risks and no risks were recommended for closure or merger, the risk rating of AF21 had reduced from 20 to 16, AF26 had been assessed as an extreme risk to reflect the current pressures within primary care, AF21 remained an extreme risk and Operational Risks 735 and 769 remained extreme risks. The Director of Governance highlighted the areas on the Board paper front sheet and advised risk would be picked up in a more strategic way in the Board papers. The Lay Member (voting) advised the Finance Committed had not accepted the rating reduction in AF21 as it was felt the actions needed to be further along in Phase 2 of the consultation and particularly with the financial modelling and implementation plan. **The OCCG Board:** • **Noted the content of the Strategic risk register and the Red Operational risk register** • **Noted that AF19 – Demand and Performance Challenges – remained an extreme risk** • **Noted that AF26 – Delivery of Primary Care Services – had been assessed as an extreme risk with a risk rating of 20** • **Agreed that AF21 – Transformational Change – rating had reduced from 20 to 16 making it a high risk but given the views of the Finance Committee this would be referred back to the Directors' Risk Review meeting** • **Noted that two Operational Risks – 735 OUH Test Results and 769 Primary Care Capacity, remained Extreme risks.**	**CM**
20	**Oxfordshire Clinical Commissioning Group Sub-Committee Minutes** *Finance Committee* The Lay Member (voting) as Chair of the Finance Committee presented Papers 17/15a and 17/15b, the minutes of the Finance Committee held on 22 November and 13 December 2016. *Oxfordshire Primary Care Commissioning Committee (OPCCC)* The Lay Member (voting) as Chair of the OPCCC presented Paper 17/15c, the minutes of the OPCCC held on 3 January 2017. The Lay Member (voting) and the Vice Chair highlighted the ETTF bid and the small amount awarded to Oxfordshire which was a quite significant risk in terms of sustainability and a potential block in the transformation of services. The Lay member (voting) also highlighted the Primary Care Framework and that this would be presented to the OCCG Board before the end of March.	

	The Chair advised a review of the successful ETTF bids across the country indicated they were focussed on large scale developments rather than general practice as OCCG would know it. *Quality Committee* The Lay Member PPI as Chair of the Quality Committee presented Paper 17/15d, the minutes of the Quality Committee held on 22 December 2016. The Lay Member PPI advised the Quality Committee had wished to be assured around the health and safety issue regarding the transfer of patients between the Horton Hospital, the John Radcliffe and the Midwife Led Unit (MLU) as there was an apparent discrepancy between the report to the Quality Committee and the LCD report but having received the actual data it could be confirmed there was no discrepancy. The Quality Committee received quality indicators that had been put in place around the temporary closure of obstetrics and data on the number of births, transfers and out of county births was now available. The Director of Quality reported she had visited both the Horton and Chipping Norton MLUs with Lead Commissioner (Children and Maternity) and the patients at the Horton MLU had been very positive about their experience. The numbers of patients were quite small and as a result some work had been undertaken around breast feeding and helping families with obesity. The North LCD commented only a few patients attended but generally they had a good experience but they found it difficult to speak about this good experience due to the general feeling in Banbury. **The OCCG Board noted the Sub-committee minutes.**	
For Information		
21	**Any Other Business** There being no other business the meeting was closed.	
22	**Date of Next Meeting: Thursday 30 March 2017, 09.00 – 12.45, John Paul II Centre, Bicester, OX26 6AW**	