Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD

Date of Meeting: 25 July 2019	**Paper No: 19/48b**

Title of Paper: CCG Executive Committee Minutes – 23 April and 28 May 2019

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**		**Information**	✓

Conflicts of Interest (please delete tick as appropriate)	
No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:
The CCG Executive Committee minutes are designed to provide assurance to the OCCG Board that there is focus and wider input on clinical issues and operational delivery including performance, finance and delivery of major work programmes.

Engagement: clinical, stakeholder and public/patient:
Not Applicable

Financial Implications of Paper:
None

Action Required:
The Board is asked to note the minutes of the CCG Executive Committee.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care

✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Not Applicable

Link to Risk:
Not applicable. Papers presented to the CCG Executive Committee identify the risk they are linked to.

Author: Louise Patten, Chief Executive

Clinical / Executive Lead: Dr Kiren Collison, Clinical Chair; k.collison@nhs.net

Date of Paper: 04 July 2019

MINUTES:

CCG Executive Committee

Tuesday 23 April 2019, 09.30 – 12.00

Conference Room B, Jubilee House

Present	Ed Capo-Bianco	David Chapman (until 11.50)	Catherine Mountford
	Miles Carter	Shelley Hayles	Will O'Gorman
	Kiren Collison	Diane Hedges	Louise Patten - Chair
	Jo Cogswell (JCo)	Gareth Kenworthy	Sula Wiltshire (from 09.55)
	Jonathan Crawshaw		
In Attendance	Lesley Corfield (Minutes)	Neil Fisher	Sam Hart (SHa)
	Julie Dandridge (from 10.10)		

Apologies	None		

		Action
1.	**Declarations of Interest Pertaining to Agenda Items** GP practicing in primary care and in partnership positions declared an interest in Items 5 and 6. MC declared a further interest under Item 5 as a Director of Qmasters Medical Informatics Ltd. It was agreed that all could participate in discussion of the items.	
2.	**Minutes of the Meeting Held on 26 March 2019 and Action Tracker** The minutes of the meeting held on 26 March 2019 were approved as an accurate record and the action tracker reviewed.	
Operational Delivery		
3.	**Continuing Healthcare Procurement** Rachel Pirie attended for this item to present Paper 2 and advised the Continuing Healthcare (CHC) assessment function was currently delivered by Oxford Health NHS Foundation Trust (OHFT). The CHC budget was under pressure and there was a plan of work over the year to address this. The proposal was to work jointly with Buckinghamshire to deliver one contract. Currently OHFT were the provider in both counties and it was believed there would be efficiencies and economies of scale through delivery by a single provider. A full procurement was advised and the work was being planned with the aim to start a new contract from 1 April 2020. A version of Paper 2 would be presented to the Buckinghamshire Executive in a couple of days' time.	

	The CCG Executive Committee was being asked to confirm agreement with the proposed approach. It was further proposed that once the procurement was complete and the new contract in place Buckinghamshire CCG would be the lead CCG and undertake the contract management going forward. It was pointed out that Oxfordshire had quite an efficient system for CHC and queried whether the efficiency in Oxfordshire would be retained with a single provider for both counties. The Committee was assured any joint arrangements would retain Oxfordshire's strengths and build on the Buckinghamshire position where improvements had already been made. It was noted CHC spend in Oxfordshire was increasing and was a significant risk for OCCG. RP reported the contract would be for a period up to a maximum of 10 years as this would allow investment and remodelling of service across the patch. She explained that 10 years was an increasingly common maximum contract length and it allowed more time to organise the service. RP confirmed during the procurement there would be an insistence on integration with the wider system. It was also suggested that Buckinghamshire CCG should be the lead to manage the procurement and the contract with Oxfordshire having strong involvement without duplicating management. **The CCG Executive Committee agreed:** • **To procure CHC services across both Buckinghamshire and Oxfordshire** • **The procurement approach proposed** • **To adopt a lead CCG to manage the procurement and on-going contract management on behalf of both CCGs.**	
4.	**Integrated Performance Report** DH introduced Paper 3. Points of discussion included: • It was believed SH would be formally invited to join the cancer meeting from May • Oxfordshire University Hospitals NHS Foundation Trust (OUHFT) had agreed with NHS Improvement to meet the trajectory by Quarter 3 2019/20 • An Urgent Care Delivery Group had been formed to address demand and performance around the 4 hour wait • Flow was the main issue and this was an engineering problem which required data and analytics support. There was a need to understand current demand and capacity on which interventions and triggers could be built • Contact would be made with, the Winter Director in Buckinghamshire • A more targeted look at waiting times to consider the impact on Oxfordshire residents was required • A piece of work needed to be undertaken around specialist versus generalist • Although February figures were concerning, there was only a tiny	

	percentage increase in Ambulance service response times. These would be reviewed to see if there was any cause for concern; whether there appeared to be a trend or it was a one off. GK advised there was no Finance Report as the team were dealing with the year-end. OCCG had closed the year-end accounts and achieved the financial targets. Some headroom had become available at the year-end which, subject to the audit work, would be carried forward into the 2019/20 financial year.	
5.	**GP Workload in the Community** SH presented and explained the current position where some practices were not monitoring some patient conditions. LP observed no commissioner wanted to set a precedent that monitoring was or was not 'core GMS'. JD commented the main issue was patient safety and discussions had been held with the Local Medical Committee (LMC) around provision of a safe call and recall system. Whether six one month audits of practices could be funded was being considered. SH stated the need for agreement on the clinical pathway. If the pathway was agreed it would then be possible to decide where the monitoring occurred. In some cases it might be more appropriate in secondary care whereas others would need to be in primary care. Whatever the proposed pathway it was important that this could be accessed by all patients. The OUHFT OneView monitoring system worked and OUHFT was able to review results and decide on the best course of treatment or intervention for a patient. OneView could be used for a call and recall system for any service and was currently being piloted in urology. Whilst declaring an interest as a director of the company, MC advised the QMasters Medical Informatics system was robust, searches were already in place and a practice level recall system was written which was being used in practices in other areas. LP remarked if there was a robust system it might reassure GPs of the feasibility. GK stated an options appraisal was required. It was agreed SH would bring a clinical options appraisal to the next CCG Executive Committee. The tight turnaround was noted as well as the need for some management support from both planned and primary care.	**SH**
6.	**Primary Care Network (PCN) Workshop Feedback / Discussion in Relation to Support of PCNs / Neighbourhood Incentive Approach** LP stated the need to consider a vision for PCNs, what they should look like currently and in three to five years' time from a provider and commissioner point of view. NF advised PCNs arose from the Vanguards around the country. He presented Paper 4c advising the idea was to learn from other areas what it could be possible to do in Oxfordshire.	

There was a far reaching discussion which included:

- A query around where the finance and pump priming monies would come from. Oxfordshire was considered healthy in terms of primary care investment in the Thames Valley and it would be difficult to make a case that more money was needed
- In 2019/20 there was the highest ever financial risk and no more funding was available to commit. Questioned whether the proposal was gainshare and undertaking work in 2019/20 or setting up for the next year which would allow planning time for the necessary monies
- Some areas were looking to give PCNs tangible pieces of work many of which concerned integrated teams. Some transformation funds had been used to look at what was required for integrated teams, how they benefitted patients, where they would be housed and what was the vision.
- Low hanging fruit for each PCN should be considered and support provided to address
- North East Hants and Farnham were good examples of where integrated teams had worked
- The first workshop on transactional requirements of PCNs had been held. The next would consider the Long Term Plan and integration with secondary care. The third phase around a multi-disciplinary team approach had already been trialled
- Queried whether the current spend, the delegated budget and the Sustainability and Transformation Fund (STF) should be reviewed and consideration given to spending the monies differently
- If monies were moved there was a risk of impact on the current ways of working. Removing hubs could affect the sustainability of primary care
- A road map over the next five years with manageable steps was required. There was a need to accept the problems would not be solved in this or the next financial year. Services and teams needed to sign up to a five year vision and needed confidence there was a realistic way to achieve the vision
- Queried what would incentivise PCNs to join together and undertake work, the building blocks required and how to prepare people; should PCNs be commissioner led or organisations working alongside each other; what should commissioners be doing
- NHS England (NHSE) believed 50,000 was the ideal population size for delivering services
- PCNs would be perfectly placed to provide many of the services but clarity around financial support and the mechanisms of support was required
- Frailty had been discussed as an integrated care system and it was felt would be a good start
- A list of requirements of PCNs, planned offers of support and

	areas for consideration were included in Paper 4a. Views on whether these were the right areas were sought • The PCN Clinical Directors were keen to progress and should be given project management support and priorities to get off the ground • OHFT was mapping all out of hospital services to PCNs. These would be a resource for the PCNs • An NHSE BMA Clinical Support Workshop would be taking place for clinical leaders to attend. A local support group was required • NHSE would provide coaching to Clinical Directors. The Clinical Directors would need access to resources rather than being experts in every field • Clinical Directors would be part of a provider collaborative and OCCG would need to provide support to all the provider collaborative • The role of the Locality Clinical Directors going forward would be picked up at the Clinical and Management Forum (CMF) meeting. Locality meetings may become PCN meetings • A letter, which would be shared, would be issued to the LMC explaining the OCCG core allocation, delegated funds and that as part of the annual budget process review of all monies and those local investment schemes it had been agreed not to fund, the source of the £1.50. Consideration would then be required on how to use the remaining STF funding. It was agreed areas from the discussion would be picked up and formed into a straw man for discussion at the CMF. KC would Chair the CMF as SH would not be present.	**JCo/JD**
STP Update		
7.	**Sustainability and Transformation Partnership (STP) Update** LP advised in order to address the referral to treatment (RTT) issues planned care work was being undertaken at STP levels to enable hospitals to understand capacity in areas, theatres and consultants to enable patients to be treated at other locations if the patient wished to do so. The work was being led by provider organisations with DH leading the management support on behalf of the STP. Clinical variation was also being undertaken at scale and the Primary Care workstream was gaining momentum to achieve consistency. At the Integrated System Delivery Board (ISDB) the organisation and Federation Chief Executives were agreeing the workstreams. At the last meeting the need to actively encourage providers with some commissioners to come together and review contracts had been agreed. A particular area for consideration was the role of the Federations and PCNs across the system to ensure they were properly enabled in the future. Each STP had to appoint an Independent Chair and the BOB STP Independent Chair was currently being advertised. The process was being managed by the Berkshire Healthcare Trust Workforce Lead with	

	the NHSE/NHSI Regional Director (South East). A non-executive from each system would also be on the appointment panel. Once the Independent Chair was in place the STP Lead would be appointed. The current Executive Lead for the BOB STP was on a temporary contract. Discussions had been held around the STP Lead going forward as the STP would have more of a strategic commissioning role. The message was around undertaking more at scale where possible. Primary Care in the STP context included the wider range of services including items such as dentistry, optometry, etc.	
For Information		
8.	**Papers Circulated / Approved Between Meetings** No papers were circulated or approved between meetings.	
9.	**Confirmation of meeting quorum and note of any decisions requiring ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
10	**Any Other Business** There being no other business the meeting was closed.	
11	**Date of Next Meeting** 28 May 2019	

MINUTES:

CCG Executive Committee

Tuesday 28 May 2019, 09.30 – 12.00

Conference Room B, Jubilee House

Present	Jo Cogswell (JCo)	Sam Hart (SHa)	Catherine Mountford
	David Chapman	Diane Hedges	Louise Patten - Chair
	Shelley Hayles	Gareth Kenworthy	Sula Wiltshire
In Attendance	Lesley Corfield (Minutes)		

Apologies	Ed Capo-Bianco	Kiren Collison	Will O'Gorman
	Miles Carter	Jonathan Crawshaw	

		Action
12	**Declarations of Interest Pertaining to Agenda Items** DC and SHa as GPs in partnership positions declared a direct financial interest and SH as a GP practicing in primary care declared a direct professional interest in Items 6, 9 and 10. It was agreed all the GPs could participate in discussions as no decisions were being made on these items.	
13	**Minutes of the Meeting Held on 23 April 2019 and Action Tracker** The minutes of the meeting held on 23 April 2019 were approved as an accurate record and the action tracker reviewed. *Approval of Sub-committee Minutes* The assessment and discussion with the Lay Vice Chair to be completed prior to the next meeting. *Finance Performance Report* CM reported this piece of work had been superseded by the Health and Wellbeing Board (HWB) workshop which would focus on the Oxfordshire £. The action was closed. *OCC Plans for Public Health and Adult Social Care* A paper on the planning cycle had been circulated to the Committee. The action was closed. *GP Workload in the Community* Agenda item. *Primary Care Networks (PCNs) Discussion*	**CM** **LC** **LC**

	PCNs were part of the ongoing transformation work and the action was closed. DH advised the Director of Strategy at the Royal Berkshire Hospital had been identified as the Senior Responsible Officer (SRO) for planned care in the Sustainability and Transformation Partnership (STP). DH would provide support and be the commissioner lead for Oxfordshire and Buckinghamshire.	**LC**
Operational Delivery		
14	**Annual Report** CM presented Paper 2 explaining due to the timing of meetings the report had been presented to the Board on 23 May 2019 prior to being brought to the CCG Executive Committee. DC observed OCCG should be holding the Trust to account on the over performance of acute out-patient activity. SH advised there were ongoing discussions about reducing follow ups in various specialities and consideration was being given to pathways. Part of the work was overseeing who gave permission for follow up appointments and consultant clinicians were looking at this in out-patients. More information was contained in the Planned Care Strategic Plan. SH believed the Trust was being held to account and reported there had been good progress in some areas and referral to treatment (RTT) across the board had been a major focus. LP advised out-patient transformation was an in-year priority and there had been a successful bid at STP level. She felt this could be a first topic for the Clinical and Care Forum to consider as the Forum would be the clinical voice across the system for all organisations in the future. It would provide the opportunity for wider clinical discussion. DH felt there was a need to be better at explicit plans and discussions had taken place with Oxford Health NHS Foundation Trust (OHFT) around a consistent plan. JCo advised a number of the Oxfordshire University Hospitals NHS Foundation Trust (OUHFT) senior team had attend the OUHFT strategy day where this had been a significant discussion item. She commented if this was not cascading down in the divisions it should be taken back but there was also a need for an agreed strategic direction and plan for the system. GK raised the question of oversight of the key priorities and projects pointing out highlight and exception reports should be presented to the CCG Executive Committee and added that there should be an agreed plan that was tracked on a regular basis. **Action:** SH to provide DC with information on local work. DH to circulate the appendix to the Planned Care Plan which would provide further assurance. Reports would soon be brought to the CCG Executive Committee.	**SH** **DH**

15	**Finance Performance Report** GK presented Paper 3 which was the same Finance Performance Report as presented to the Board on 23 May 2019. LP remarked that most areas were looking at a level of transparency around what was funded for PCNs and for community services to then be able to discuss what these should look like in the future. JCo advised discussions had been held with OHFT around mapping against community services. DC was concerned about the references to PCN delivery as this remained theoretical whilst PCNs did not exist as an entity. GK perceived DC was alluding to the inherent risk and stated there would be a need to manage the situation as a risk. It would be necessary to see the mapping from OHFT as this would provide a sense of the real risk. JCo commented this was part of the workstream led by the OHFT Chief Executive on integration of community and primary care services. It also linked to the finance group in terms of how money was distributed. JCo would pick up with KC in the next week to identify a clinical lead and feedback to the CCG Executive. A decision around whether a commissioner and provider clinical lead was required would be dependent on the person selected. GK felt the risk management approach should be taken and that it could be within the review of the strategic risks for OCCG although it was a system risk. He suggested it could be identified and managed within the workstream. JCo agreed it could be considered and if the risk was articulated could be discussed with the OHFT Chief Executive. The risk would be reported back to the Finance Committee.	**JCo** **JCo**
16	**Integrated Performance Report** DH introduced Paper 4 which was the same report as presented to the OCCG Board on 23 May 2019. SH commented on the drop in performance at the OUHFT during March and felt the work to address the long outliers had affected RTT performance. The workforce and theatre issues had also had an impact. SH advised the cancer meeting had been quite positive although there was still some reticence to share information. SH would send the dates of the cancer meetings to LP. DC expressed disquiet at the worsening of the Mental Health performance indicators. OHFT was already working to eight weeks rather than 28 days for routine referrals. The 28 days would become a national target and there was concern the further drop in performance should not be more than a temporary slippage. CM stated the 56 days for routine referrals should be being monitored in the IPR. DC also felt the 'tail' should be monitored as these patients were not within the 56 days.	**SH**

17	**GP Workload in the Community – Summary of Progress** SH reported a meeting had been held during the previous week attended by some OUHFT managers. A short term solution had been agreed for a six month period so GPs would to monitor existing and subsequent patients. There had also been a meeting with the OUHFT and the Local Medical Committee (LMC) where clinical pathways had been agreed. OUHFT was producing an IT solution business case whilst OCCG was looking at solutions in primary care. The two proposals would then be brought together. It had been indicated clearly that the funding for supporting the short term solution was a one-off. LP stated the need for congruence across the areas for payments to GPs and the need for the local work to be included in the primary care work across the STP. She stressed that precedence should not be set. SH pointed out Buckinghamshire already had a solution which did set a precedence. JCo would check the Buckinghamshire solution did not set precedence in terms of payment and was in alignment with work in other areas. SH advised future proofing was a major part of the work and finding the long term solution which was the reason it was taking longer to get in place. DC concurred future proofing was a big piece of the work adding this would need agreement with LMC. SH reported minutes of the meeting and a Gantt chart were being produced and these would be circulated. Options to be brought to the next meeting.	**JCo** **SH** **SH**
18	**Barton Healthy New Town (BHNT) – Programme Evaluation** DH presented Paper 6 explaining Oxfordshire had two out of the 10 healthy new towns. The programme had produced a large amount of learning particularly around population health management (PHM) and the way practices and GPs in Barton had worked closely with the community and had facilities and a space that was able to be used free of charge. The CCG would need to draw on this work. JCo concurred remarking there were pieces that needed to be extracted and applied to PCNs as there were many aspects of genuine integrated care. It was felt the work should be presented to the HWB and be one of the areas to talk through with PCN clinical leads. DH advised the Barton Group was still meeting and had agreed to continue after the end of the funding. The practices were also keen to retain many services but it was unknown how this could be funded. DC observed that every PCN would be able to use the work to put forward proposals but funding would be an issue. He stated the CCG should be thinking ahead and consider how funding would be provided. JCo advised the incentive scheme would be paid directly to PCNs and PCNs should determine their service specification. JCo and the Deputy Director Head of Primary Care and Localities had volunteered to help in	

	developing and designing service specifications. The CCG Executive Committee felt all involved in the Barton Healthy New Town project should be congratulated on the work that had been achieved. LP would draft a communication.	**LP**
19	**Executive Committee Risk Register** CM presented Paper 7 and advised a full review of the Risk Register would be undertaken. **The CCG Executive Committee noted the Executive Committee Risk Register.**	
Place Programme Delivery		
20	**Primary Care Networks (PCNs)** JCo advised Paper 8 had been prepared for the Oxfordshire Primary Care Commissioning Committee (OPCCC) following a special Oxfordshire Primary Care Commissioning Operational Group (OPCCOG) meeting. OCCG would have 19 PCNs as Abingdon had decided to split into two: Faringdon and Botley would form a PCN. All the PCNs would have a population greater than 30,000. Banbury Town PCN was the largest covering a population of 66,000. There had been good input from both the LMC and OHFT. There were three issues: the new provider for South Oxford Health Centre was unlikely to take the contract until August. This would be resolved either by the practice signing up to a PCN for a month or by the patients being allocated to a PCN during the period; the North Oxfordshire Rural Alliance (NORA) would take on the patients from the Sibford practice for the purposes of the DES; the recommendation at OPCCOG was that the Luther Street practice should sign up as a peripheral member which would allow a service to be provided from the City practices as it was possible to be a peripheral member of more than one PCN. The LMC had also recommended Luther Street be a peripheral member of more than one PCN. The situation remained unresolved and OCCG had agreed to investigate this further. DC was concerned the practice would not engage with most of the services and felt OCCG should guarantee the City PCN would not be put at a disadvantage if the Direct Enhanced Service (DES) was not achieved due to that small population. LP advised OCCG could give an underwriting it would undertake its best efforts but technically the decision was not with the CCG. She added that as services would be through the PCN there was a need for practices to sign up to ensure patients were not disadvantaged. LP queried whether a memorandum of understanding could resolve the issue. JCo advised the workshop to be held on 13 June would cover how PCNs worked together and that integrated teams were more than district nurses. JCo had also attended a number of budget meetings and had requested a payment schedule in order to advise PCNs of the income they would be receiving each month. Most would be paid monthly in arrears.	

21	**Primary Care Services for 2019/20** JCo presented Paper 8, an update for information capturing some of the main apportionment of funding from primary care resources. A full financial report would be brought to the CCG Executive Committee. DC commented monies from the distribution of the Sustainability and Transformation Fund (STF) mainly funded services delivered by the Federations. He queried what would happen to these services from 2020/21 when the monies went to the PCNs. JCo advised where there were contractual commitments across future years these would be honoured by the CCG but, in line with national policy, it was likely future funding allocations would be made at PCN level. The Federations were aware that this would be the case. There would be a need to consider how to use any future discretionary spend received by OCCG for primary care. A piece of work would be undertaken to produce an approach to address the issue around deprivation and this would be in line with the LTP. LP advised the expectation was the CCG would not devise a formula but consider how deprivation was addressed. It was felt full transparency could be obtained if the work was undertaken as part of the Health Inequalities Commission Implementation group. JCo added the work should be about the system and where the system was putting its resources. The benefit would be a shared understanding of population health enabling the collective use of resources. Some concern was expressed around sustainability of practices that planned on a year to year basis and were expecting the budget to meet costs. With the move to PCNs practices might receive less funding which could lead to issues. The Committee agreed that communication was important as there appeared to be some anxiety. Further anxiety was raised around the prescriptive nature of the PCNs and funding with the comment that the Vanguards, which were the basis for most of the proposals, had been pump primed. This would not be the case for PCNs. JCo advised people were looking at these issues and had been concentrating on how to provide practical support to practices as the work moved forward. There was a need to help providers work together to deliver care in a more integrated way in line with the LTP. The LTP was a 10 year plan. GK remarked that it was a CCG role to implement national policies. A lot of concerns had been raised and discussion of risk management approaches. It would not be possible to do anything in time for the June/July deadline and practices would need to have some faith that attempts were being made to put the right processes in place. It would be necessary to look at the needs of the population, prioritisation and development of PCNs. SW commented that it would be a huge cultural shift and the pace expected would be difficult. In order to achieve some	**JCo**

	of the ambitions there would be a need to ensure people were brought along with the process.	
22	**Draft BOB STP Primary Care Strategy** JCo presented Paper 9 advising it was a national requirement to produce an STP Primary Care Strategy. The Strategy mirrored the content of the Long Term Plan (LTP). The overall work would be led by the Berkshire West Chief Executive and would focus on the transformation of primary care. The paper would be presented to the OPCCC. Any constructive comments or feedback on the content to be provided to JCo, KC or the Deputy Director Head of Primary Care and Localities. SH commented the description might be based on the LTP but as a strategy it was lacking in detail. She queried how other groups linked in. CM explained it would be in the governance going forward which would be picked up at the next Board Workshop.	**All**
STP Update		
23	**STP Update** LP advised a piece of work by Price Waterhouse Cooper (PwC) around STP governance had been signed off. The proposed governance framework which stated the STP would become a BOB Integrated Care System (ICS) from April 2020 would be circulated. Each place would need to become an Integrated Care Partnerships (ICP). JCo explained due to the size and scale of places there would be some items undertaken at place which smaller STPs would do at STP level. The interviews for the STP Independent Chair were held on Friday 24 May 2019. The STP Chair would select the STP Executive Lead. It was agreed the Integrated System Delivery Board (ISDB) workstreams updates would be placed in a separate folder for easier access (O:\Public\Meetings\Integrated System Delivery Board\Workstream Reports\2019). The CCG Executive Committee noted the STP Update.	**LC** **LC**
For Information		
24	**Papers Circulated / Approved Between Meetings** The Annual Leave, Health and Wellbeing and Appeals Policies had been circulated for approval and members needed to respond by close of play on Thursday 30 May 2019.	
25	**Confirmation of meeting quorum and note of any decisions requiring ratification** It was confirmed the meeting was not quorate but no decisions were taken that would require ratification.	
26	**Any Other Business** *Vision Practice* Extra work was being undertaken to support a practice in Oxfordshire with 2,500 patients that used Vision rather than EMIS. The Deputy Director Head of Primary Care and Localities would be asked to be as	

	proactive as possible with the practice in suggesting and helping a move to EMIS and to update the Committee on progress. *Vasectomy Service* SH reported a tender process was required but the service needed criteria applied to enable the service to stay within the commissioning budget envelope. CM explained the draft paper had not been accepted for the meeting as it did not answer the questions on system impact posed by the Committee. DH added further work had been requested. Concern was raised about potential challenge if the service had not had a full review at the Thames Valley Priorities Committee. DH commented a piece of work on priorities and where there was a difference between the CCGs was required. To be picked up outside of the meeting. There being no other business the meeting was closed.	**JCo** **DH**
27	**Date of Next Meeting** 25 June 2019	