APPROVED 231117

Minutes of Investment Committee meeting held on

Thursday 26 October 2017, 11.30 – 12.00,
Room 5.4, 15 Marylebone Road

Members in attendance

Philip Young (PY)	Lay member for Audit & Governance, CWHHE CCGs (Chair) [i]
Trevor Woolley (TW)	Lay member, Hounslow CCG [i]
Michael Morton (MM)	Lay member, Central London CCG [i]
Nick Martin (NM)	Lay member, Hammersmith & Fulham CCG [i]

Non-members in attendance

Dr Andrew Steeden (AS)	Chair of finance & performance committee, West London CCG
Dr James Cavanagh (JC)	GP member, Hammersmith & Fulham CCG
Mary Clegg (MC)	Managing Director, Hounslow CCG
Sue Jeffers (SJ)	Director of primary care development
Simon Carney (SC)	Head of Corporate Governance, CWHHE CCGs (Secretary)
Cathy Bowyer (CB)	Corporate Governance Officer (minutes)

[i] = Independent Member

	Business items	Action
1.	**Welcome / apologies**	
	Apologies were received from: • Dr Tim Spicer - Chair, Hammersmith & Fulham CCG • Simon Tucker - Lay member, West London CCG • Keith Edmunds – Chief Finance Officer, CWHHE CCG's	
2.	**Declaration of interests**	
	There were no further declarations other than those already given. The inherent interests of GPs present as providers were noted. It was confirmed that clinicians with an interest in a particular item would not be part of the decision on that item; however, would be permitted to contribute to the discussion.	
3.	**Minutes of meeting on 28 September 2017**	
	The above minutes were agreed as an accurate record of the meeting.	
4.	**Matters arising and Action Log**	

	The committee agreed the items could not be closed until confirmation had been received from the Chief Finance Officer of the process followed.	
5.	**CA prostate services**	
5.1	The paper was introduced and the Committee was asked to endorse the approach and pricing structure across CWHHE once funding released from national cancer transformation fund; noting that the Collaboration board had agreed a start date in principle of January 2018. The Committee requested that the Business Case go to each CCG finance committee for sign off prior to this being set in place.	**SJ**
5.2	Funding for the first year would be through Cancer Transformation Funding; any ongoing costs would be funded by CCG, through reduction in Outpatient Follow Up. Each subsequent year would be included in the CCG baseline figures. In respect of the initial transformation funding, Dr Afsana Safa would confirm the process required and timeline of receipt of the monies.	**AS**
5.3	The specification was one agreed to be rolled out across London, by the vanguard NWL/SWL Prostate clinical board including all NWL Trusts as well as by London Clinical Board and London Cancer Commissioning Board; subject to local government processes. The service was for stable patients to be followed up in the community by primary care rather than in an acute setting. Currently, there was a backlog of 3000 patients, with 260 being referred each year.	
5.4	The Committee heard that Hillingdon CCG had commissioned the service separately, and had added a welcome appointment, as well as a wider assessment of co-morbidities into the specification.	**SJ**
5.5	The clinical consensus was that it was the correct thing to do, but the challenge was reaching the targets. The aim was to increase the discharge rates from acute services, providing assurance to consultants that there was a contractual framework to ensure a consistency of care once discharged into the primary care system.	
5.6	Moreover, as some practices were already providing this service, there was a query as to why this was now being picked up as new and payment being offered. It was requested that work be carried out to understand how common this position was across the CWHHE primary care providers. Also, the question was raised of whether the vanguard had previously encountered the matter of the service already being provided through primary care practices as above, with any problems or challenges being addressed at that point. Sue Jeffers would lead on producing this information.	**SJ / AS**
5.7	A discussion regarding providing reassurance to consultants of pathway and care outside of the acute service ensued. Clinical risk within primary care was raised, stating that standardising the system around GP practice call and recall processes would provide a safety mechanism for confident delivery, as well as holding a capitated budget with list of services with expected outcomes.	
5.8	**Subject to** confirmation/explanation of; 1. of the timeline for receipt of year one funding; 2. that CCG finance committees have approved the business case; 3. of the number of practices already providing this service; 4. of any lessons learnt by the vanguard; and 5. why Hillingdon CCG differed to NWL CCG's with their commissioning of the	**SJ / AS** **113 - 117**

	service provision. the Committee was content to **endorse the approach** and pricing structure across CWHHE. Nb. It was requested that the answers to the above be circulated to the committee once received.	
6.	**Out of Hospital Services Core principles (to endorse) and update on future commissioning (to note)**	
	The Committee was asked to endorse agreement of core principles for out of hospital commissioning from general practice across CWHHE once the CCGs move to individual wrap around contracts for 18/19; and agree the on-going support for delivering out of hospital specifications and services across the NWL STP rather than at CCG level. Sue Jeffers gave a background into the wraparound contracts which were being created, incorporating the out of hospital services, PMS commissioning and LIS plans; with population coverage being of the core principles. Contracting had been done differently across the CCG's, with the core principles running through each, following Chair and MD oversight. CCG's would have the contracts in place and ready for implementation from April 2018. It was requested of the Committee that it continue to confirm and endorse the above mentioned CCG pathways in regard to wraparound contracts through to 2018/19. The principles to underline future primary care provision and contracting were yet to be agreed, but appeared in the document presented in draft as the following: Equity of provision - aim to deliver whole population coverage of services across all GP practices with clear outcomes; Contract management - To deliver high quality service provision through consistent and well-developed principles to contract management and sub-contracting (where applicable); Workforce development - Consistent approach to development of the OOHS workforce, the inclusion of robust guidance on training and competency requirements within service specifications and commissioning of training through the Community Education provider Networks (CEPNs); Primary care commissioning framework - A wraparound primary care contract flexible to incorporate other strategic primary care priorities and that the services meet the deliverables in the STP; Contracting mechanism - Single contracting mechanism- consistent framework across the 5 CCGs;	

	Patient engagement - Continuous patient engagement in the development and monitoring of services; Value for money - Each CCG will have a rationale for current and future investments into general practice which considers value for money; Costing Model - Each CCG will apply the same price for the same work using the agreed costing model; Specifications - Consistent approach to the development of service specification and associated performance indicators; Outcome framework - Adopt consistent outcome based commissioning approach to contracting for services; and Strategic vision - NWL alignment with primary care strategic objectives. Updates were available in relation to the CCG's achievement of each of the principles. It was recognised that each CCG should follow its own path, as a component part of the single control total, and working with the NWL capped expenditure process. It is essential for future commissioning to be based on needs and evidence in order to justify expenditure. Any contract modification would be undertaken according to prevalence. Healthcare commissioning was moving towards the landscape of an ACP holding a capitated budget and a suite of services; this was part of the transition. The idea of CCG's holding each other to account was mentioned; with the suggestion that there be an out of area entity or person to act as monitor for transparency. The Committee; • **endorsed** the core principles; and • **agreed** the on-going support of OOH services at STP level.	
7.	**Any Other Business**	
	There were no items raised for discussion.	