NHS
Hammersmith and Fulham
Clinical Commissioning Group

JOINT QUALITY, PATIENT SAFETY AND RISK AND FINANCE AND PERFORMANCE COMMITTEE MEETING

Tuesday 23rd October 2018, 1.30 – 3.00 pm
St Paul's Church, Hammersmith, London W6 9PJ

Item AO (ii)

Present

Name	Role and Organisation	Initials
Governing Body Members:		
Vanessa Andreae	Vice Chair and Practice Nurse, Hammersmith and Fulham Governing Body (Chair)	VA
James Cavanagh	Vice Chair and GP, Hammersmith and Fulham Governing Body	JCa
Janet Cree	Managing Director, H&F Clinical Commissioning Group	JC
Amy Wilson	GP member, H&F Clinical Commissioning Group	AW
Vicki Cooney	GP member, H&F Clinical Commissioning Group	VC
Smitha Addala	GP member, H&F Clinical Commissioning Group	SA
Pritpal Ruprai	GP and Governing Body member	PR
Trish Longdon	Lay member	TL
Jane Wilmot	Lay member	JaW
Katie Embleton	Site Operations Manager and Elected Member	KE

Name	Role and Organisation	Initials
Officers in attendance:		
Sue Roostan	Deputy Managing Director, H&F Clinical Commissioning Group	SRo
Margie O'Connell	Assistant Director for Clinical Quality Improvement & Assurance	MOC
Nathan Whiting	Contracts Manager – Imperial, Hammersmith and Fulham CCG	NW
Owen White	Interim Head of Finance, H&F Clinical Commissioning Group	OW
Sue Hillyard	Interim Financial Recovery Director	SH
Margaret Kelly	Business Support Manager, H&F Clinical Commissioning Group (minutes)	MK

Apologies

Name	Role	Organisation
Paul Skinner	GP member	Hammersmith and Fulham CCG
Nick Martin	Lay member	Hammersmith and Fulham CCG
Andy Petros	Secondary Care Clinician	Hammersmith and Fulham CCG
David Hill	Senior Contracts Manager – Imperial	Hammersmith and Fulham CCG

1.	**Welcome**	
1.1	VA welcomed everyone to the meeting.	
2.	**Minutes of the previous meeting**	
2.1	The minutes of the previous meeting were approved as an accurate record of the meeting.	
3.	**Conflict of Interest**	
3.1	The previously acknowledged potential conflicts of GPs as commissioners and providers were noted.	
4.	**Matters Arising/Action Log**	
4.1	The action log and matters arising were discussed. Action ACT426 (ii) remain on-going, with updates to be provided following the meeting on actions, ACT428 and ACT429 with a further update to be provided on ACT425. All other actions were deemed as closed, with the exception of the following: **Action 425: To share the outcome of the Ambulatory Emergency Care (AEC) audit into the appropriateness of the numbers and to cross referencing AEC activity levels with Vocare:** The committee noted that a meeting was held between Dr Clare Jarman, GP Clinical Lead for Planned and Unplanned Care and Dr Sarah Elkin, Clinical Director for Integrated Care at Imperial Trust, to ensure that the coding issues identified through the clinical audit into AEC were resolved. The committee noted that Huw Wilson Jones, Director of Acute Contracting and Neil Ferrelly, Chief Financial Officer NWL CCGs, planned to discuss the AEC findings alongside the pathology pricing costs and 50 additional beds at Imperial Trust over the winter period, as part of an executive meeting with their counterparts at Imperial Trust. The committee were advised that a review was also being carried out into case mix and price mix of the urgent care contract with Imperial Trust, to be managed concurrently.	
5.	**M5 Integrated Quality and Performance Report (IPR) – 2018/19**	
5.1	NW introduced the M5 IPR report and provided a performance update on Imperial with a particular focus on the following: <u>Imperial College Healthcare Trust (ICHT)</u> **A&E:** The Trust did not achieve the performance trajectory in M5 (90.2%) achieving 89.0%. This was the first time Imperial did not meet the recovery trajectory in 5 months, however the upward trend seen over the past last 7 months has continued, with a 0.1% increase on the previous month. NW stated that the latest M6 figures show that M6 performance at the 21st October was on trajectory at 90.2% therefore should achieve the target.	

5.	M5 Integrated Quality and Performance Report (IPR) – 2018/19	
5.1	NW said that the main focus was on the patient flow programme, with the Trust obtaining support from 20/20 to use live bed state technology, which allows patients to move more rapidly through the hospitals. NW noted that 3B HomeFirst capacity was being increased, with an extra 60 'bed' assessment capacity in their homes, split across Imperial and ChelWest. NW reported on the additional 50 additional beds opening up at Imperial using £5m capital funding, but noted that the funding does not cover staffing and operational costs. NW said that the commissioners supported the operational aspect; but the financial impact would need to be worked through, with on-going discussions held also in managing the risk. NW added that a new ward would be established at Hammersmith Hospital, by moving the sleep lab elsewhere to an area currently underutilised, with a total of 26 beds provided, split into 16 therapy led discharge beds, 6 new cardiology beds and 4 renal beds. NW stated that the acute medical ward at St Mary's Hospital would be allocated 13 beds, with 11 beds located at the acute medical ward at Charing Cross. JC stated that H&F CCG were supportive of the necessity for more beds, but were not willing to accept the increased risk in terms of expenditure. JC said the Trust requires the beds but noted the different perspectives, with the commissioners and provider to reach agreement on the proposed figures and plan. JC suggested utilising the Joint Committee as leverage to move this forward with Imperial, London and West. JC said from a quality perspective, some of the issues relate to bed usage and how these beds are managed. JC emphasised the importance of establishing a clear mechanism for support and discharge. JCa reported that the Trust were transparent from a clinical perspective and was confident that standards would be maintained and clinically acceptable to the CCGs. JC mentioned that an additional four beds would be available at the St Mary's site, with a lot of work underway to ensure these are operational by the end of December. JC noted the on-going discussions had around the requisite for these beds, whether they are at a manageable level and if the go live date of the end of December was achievable. JC noted that the Trust was working at 92% capacity but need to enable patients to flow through the system. NW said the aim was for the beds to go live by x-mas eve, but all beds may not be available by this date. **18 Weeks RTT:** Performance had dropped below the recovery trajectory of 85.2%, with the Trust achieving 83.4%, with performance impacted by system errors. The Trust anticipates that the majority of system errors would be removed for the September M6 data.	

TL made reference to the number of system errors with RTT which the Trust were dealing with for some time and asked why the situation had not improved. JCa highlighted less frequent and fewer system errors with the Trust confident of achieving an acceptable trajectory. JaW acknowledged the Trust's openness and transparency in reporting these errors; also recognised the work happening at Imperial to get to grips with this, but felt that better information should be made available to detail what was happening to address this issue.

52 week breaches: The number of 52-week breaches reported in M5 was 40, a small increase compared with M4 due to patient choice and capacity issues over August. NW said that September was forecast to show a similar performance prior to further reductions achieved in October with an aim of reducing the backlog to 4. NW stated that the number of tip-overs from below to beyond 52 weeks remains relative low, and remained at its second lowest since pre October 2017, when monitoring began.

NW reported that when Imperial uncovered its long waiter backlog, the Trust made up a significant proportion of the national 52- week backlog; peaking at more than 30% in October 2016. However, as of June 2018, the Trust made up less than 3% of the national position.

TL queries if the Trust had a specific way of managing 52-week waits in order to maintain performance. JC clarified that this was a key part of the Trusts overall programme and workstream and getting it right first time was one of the key drivers. JC said it was important to note that the Trust had improved its process and were identifying and resolving issues quicker.

Cancer: The Trust had achieved the standard and performance of 85.4% in M5, after a three month dip, due to biopsy delays. NW noted that M6 performance was anticipated to be within standard, but sustainability of the 62-day performance remains dependent on improvements to the inter-trust performance. JCa said that patient delays into Imperial were significant and this was being looked at in conjunction with a couple of SI's, but the Trust was not responsible for patient delays.

6-week Diagnostics: M5 performance was 99.1%, meeting the 99% standard for the 7th consecutive month. A modality breakdown of breaches was not yet available, but the data issues should be resolved over the coming months. However, this remained a risk.

MOC provided a quality update, and noted in particular the following:

<u>Imperial College Healthcare NHS Trust (ICHT)</u>

Quality of Care and Patient Experience

MOC presented the second report of the Trust's new reporting structure. MOC said the report was discussed at the CQG, with the importance of making sure that concerns and performance issues were reported on time was highlighted, with members' content with the level of assurance provided. MOC said the report was also used by the Trust to report internally to their Board.

Safety culture programme
MOC said that the safety culture programme had been designed to continuously improve Imperial's safety culture objectives, with the Trust focusing on 9 workstreams, and would share the detail to ensure the committee remained sighted on the work and what was being picked up through the Serious Incident (SI) process.

2018 General Medical Council National Training Survey for trainees and trainers
MOC reported that the results from the 2018 General Medical Council National Training Survey for trainees and trainers; specifically with regards to the quality of medical education and training had shown a deterioration in the trainee feedback with a 56% increase in red flags and a 33% decrease in green flags measured across all programmes by site. MOC said a different matric was used this time and the results highlighting issues regarding supervision and access to training, with the Trust focusing on areas of poor performance. MOC added that a report including the actions for improvement was presented to September's CQG, with commissioners asking for a progress report to be brought back to the CQG in six months. MOC said one of the actions taken forward would involve conducting a series of interviews with clinical directors.

JCa said how the CQG operates had altered and receiving this presentation was one of the ways to improve the way information was shared with the CQG and to retain trust.

Never Event
MOC stated that one never event was reported in real time. The patient did not come to harm and the swab and balloon were intentionally retained following treatment. The Trust were now at a position to request de-escalation following the immediate actions taken to correctly document the presence of the swab on their clinical system, therefore this was no longer deemed a never event.

TL supported the inclusion of a summary for each area reported on, what had transpired and the actions taken forward to be incorporated into the IP&QR cover sheet, as an alternative to appending the reports. TL said the report on the Quality of Care and Patient Experience and the update provided was helpful and shows the positive change in culture at Imperial Trust.

Service spec issues relating to the NW London pathology Laboratory Information Management System (LIMS)
MOC advised the committee on the service spec issues relating to the NW London pathology Laboratory Information Management System (LIMS) discussed at the CQG. MOC said a number of incidents had occurred due to defects in the new system. MOC highlighted that each incident was investigated and clinical impact on patient care assessed, and assured the committee that no patient harm had occurred. MOC added that work was underway at the Trust to ensure the governance process was robust and were working through the SI process making sure that plans were implemented and improvements made.

Cancelled operations
MOC stated that the reportable on the day non-clinical cancelled operations remained high during the first half of 2018. In the quarter ending June 2018, the cancelled operations equated to 1.3% of total elective admissions which was above the national

	figure for NHS cancelled elective operations in England of 1.0% for the same period. TL raised concern about the high number of on the day non-clinical cancelled operation and felt it was a real issue for patients. JCa said this related to the St Mary's trauma site, and the movement of teams of the site impacting their ability to do the work. JCa said the Trust was asked to review the figures; but were not an outlier for cancelled operations in comparison with other Trusts, and this did not impact any particular speciality. TL stated that the 28 day rebooking breach also remained high with 20.7% of patients not treated within 28 days of their operation being cancelled, compared with a national figure of 10.8%, therefore requested an update be provided in next month's IP&QR cover sheet, following October's meeting. JCa agreed that a review of the original paper presented by Imperial at PCE on 27th September would be undertaken. <u>West London Mental Health Trust</u> MOC mentioned that a great deal of work was happening at the Trust in regards to the Serious Incident (SI) and incident reporting, on the CQC Action Plan with four of the seven areas of concern completed, also on the risk profiling tool and deep dive into planned and primary care. MOC highlighted plans in place for a CQC re-inspection, but noted that the CCG were still awaiting the revised report. VA commented on the Friends and Family Test (FFT) response rate of 1.2% against a target of 6% and queried what the Trust was doing to address this. SRo agreed to ask Wendy Lofthouse for an update on the Trust's plans to improve performance. TL said that the Delayed Transfer of Care (DToC) target (M4, M5 and YTD) was shown as red, with M5 performance of 10.2% against a threshold of less than 7.5%. TL raised particular concern as the CCG was approaching winter. SRo agreed to raise this at the next social care meeting with the Local Authority and to arrange for the numbers to be reviewed to identify which patients were impacted. <u>Central London Community Healthcare NHS Trust</u> MOC said that conversations were being had to review the CQG arrangements and the main area of concern remains the bedded element of the Palliative Care service at Pembridge. VA emphasised the importance of having accurate data to allow constructive dialogue between the commissioners and provider. VA reported that a paper on the Podiatry service would be taken to the overview and scrutiny committee for discussion and agreed to share a copy with JC for information, once produced. The committee noted that in month DNA rates at CLCH for first appointments was 3.6% against a target of 2.8%, with underperformance impacted by high DNA rates into the podiatry service. TL highlighted that the percentage of podiatry non-urgent first appointments and patients seen within 28 days from referral was 30% in August against a target of 98% and requested an update on what the Trust were doing to improve performance. VA	**MOC/ JCa** **SRo** **SRo** **VA** **VA**

	agreed to pick this up with the provider. VA said the number of podiatry referrals into the service by GPs had reduced, and plans were in place to reduce the backlog now that the previous staffing issues were resolved. TL asked if the number of patients on the podiatry backlog were new appointments. VA agreed to clarify. VA stated that the service had not picked up the number of patients on the backlog as quickly as expected and the KPI's only monitor two areas of the service. The committee noted that VA and Carol Lambe had reviewed the service specification, with the proposed changes now implemented by the provider. MOC reported that the CLCH quality strategy received an award from the HSJ Patient Safety Awards 2018, with the key focus of the strategy in reducing unwarranted variation in care and in moving the Trust from a good to an outstanding rating, building on their previous quality strategy. The Trust wanted to establish a model of shared quality governance throughout the organisation, with staff and patients further involved in trust decisions, with significantly improved engagement alongside shared responsibility. MOC noted the many facets to the overall CLCH service. VA said that James Benson; the Trust's new Chief Operating Officer was keen to implement these changes. VA mentioned the CLCH NHS leadership academy; funded by Health Education England (HEE) to undertake joined up work with allied professionals. VA said the leadership academy was also opened up to Primary Care Nurses and Pharmacists and she had been approached to sit on this board, which was positive news. <u>CNWL – Community Independence Service</u> MOC reported that the tri-borough CCGs have recently concluded negotiations with CNWL on a new CIS contract, which is due to be signed off next week. <u>Vocare (St Mary's UCC)</u> MOC advised that the concerns that previously triggered escalation was at a national, NHSE and London level and could be closed to the Quality Surveillance Group. MOC said that contractual monitoring and quality of patient experience would continue on a monthly basis by Central London CCG. MOC noted that a meeting scheduled last week focused on the providers SI process and that any further concerns would be picked up locally. MOC reported that the impact on performance was the highest in the sector. The following questions arise during discussion: • TL commented on IAPT performance for 17/18 and the number of referrals shown as red for the four quarters; relating to the proportion of people accessing IAPT services aged 65+ and the overall indicator of success, with two out of the four quarters rated red for recovery rate of people accessing IAPT services identified as BAME. TL queried the lack of referrals into the service. • JC said there was a seasonal element impacting performance. AW indicated that part of the issue was the self-referral element and patients failing to self-refer, but highlighted the work underway with GP practices to resolve this issue. VA was uncertain that patients were aware that they could self-refer, other than being told by their GP, and asked for clinicians present to inform her of any specific issues at their own practice.	**VA**

	• AW reported that all GP practice websites include a link to the IAPT service. VC reported that her practice only refer more complex patients with all other patients are asked to self-refer. AW said it was important to identify those patients that would not use the self-referral option. VA asked AW to liaise with Paul Skinner to ensure he was aware of this issue. VA requested an update on IAPT psycho local support and long term conditions. AW responded that a clinic was being set up at Lillie Road using 18 months of available funding, therefore should see a change in behaviour at the end of the six month period, with GPs being asked to focus more on this. SRo noted that no additional funding was available to support the service. • TL commented on children's occupational therapy (OT) and an initial assessment within 12 weeks of referral, with 16 out of a total of 73 children on the CYPOT waiting list (21.9%) waiting over 18 weeks to be admitted for assessment at the end of August, and requested an update on what was happening at CLCH to address this issue. VA said that CLCH were picking this up with an action plan being produced. VA asked MOC to liaise with Molly Larkin, in Central London CCG, to request an update on progress for next month's IP&QR cover sheet. The committee **noted and discussed** the M5 IPR performance report	**AW** **MOC**
6.	**QIPP – 2018/19 M6 report plus Financial Recovery Plan update**	
6.1	SRo introduced the report. She reported that the forecast outturn position was maintained and remained to plan with no significant material changes in month or in the forecast. SRo stated that the QIPP expectation was for the delivery of £12.6m in year and at that level the forecast remains £4.7m off the £17.3m plan (27%). The committee noted that the pressures were mostly offset by the release of full reserves totalling £4.6m, but the forecast also includes £1.6m of in-year support from across NW London to offset a range of other pressures. SRo reported that H&F CCG was unlikely to achieve 80% QIPP delivery in 2018/19 and this was the threshold from a financial perspective. SRo said the aim was to deliver as much as possible in 2018/19 to allow 2019/20 to stabilise. SRo said that SH was working with individual teams to identify areas where greater savings could be achieved. SH indicated that the Financial Recovery Programme Group (FRPG) was focusing on primary care and were considering the options under the actions, with a proposal to be worked up and brought back to the F&P committee and replicated across other areas. SH said that the outcome of the GP seminar was that £2.3/2.4m of QIPP was identified for next year, and the focus was in looking at other ways of identifying further QIPP schemes to achieve the QIPP ask to deliver circa £27m QIPP savings in 2019/20. SH indicated that the investment decision paper provides greater clarity. SH stated that previous investment decisions taken by the committee and governing body, including contract extensions, would need to be revisited owing to the H&F CCG	

current financial position.

TL queried why H&F CCG had not achieved the 80% QIPP savings this year, given the use of reserves totalling £4.6m, and questioned whether the gap in outturn was likely to be less and whether as an organisation it could make up the 20% run rate given the lack of additional reserves.

JC responded that H&F CCG was likely to report an unbalanced position in 2018/19 and this would have an impact. TL asked if H&F CCG would have a bigger gap than forecast. JC responded that the gap would be £27m or greater. OW said that £27m QIPP savings for 2019/20 may be too small, and will relate to cost savings, efficiencies and change in guidance. JC reiterated that only £2.5m of the £27m target had been identified to date.

OW reiterated that previous decisions taken by H&F CCG were being reviewed but discussions would also be required around the restructuring and decommissioning of services. SRo said that teams that had undertaken the work had responded to the national requirements to allow needs to be identified and targets achieved. JC mentioned the need for change and assured the committee that teams were responding to what was now required of them.

SH restated the necessity to review the decisions made by H&F CCG for some of the community services where a reduction in acute data was not visible, and to prevent doubling of data and payments for areas such as phlebotomy and tissue viability and also to review palliative care where the cost of the community service was greater. SH said that H&F CCG may need to go out to procurement for some services currently commissioned.

TL suggested focusing on the Integrated Care Partnership (ICP) changes and ways of working in partnership with providers to support the £27m QIPP ask for 2019/20. SH said as acute were in a similar financial position that a joint recovery plan and risk share must be produced.

AW acknowledged that ICP was the way forward, but for this year that the focus should be on reviewing existing schemes and to consider restructuring and decommissioning of services not required locally.

VA asked if other NHS organisations had taken decisions around the restructuring and decommissioning of services. SRo mentioned that a PCT she previously worked for had a £20m deficit, consequently it decided to decommission IVF services and imposed blocks on expenditure, but noted the complexities and level of dissatisfaction of these decisions and emphasised the importance of being prepared locally for similar consequences.

VA asked where H&F CCG stood in terms of the NWL STP footprint given the work happening at a larger scale, but financially remained detached. VA said a similar set of risks would need to be in place if services are decommissioned at a NWL level, and any work happening locally for example the restructuring or decommissioning of IVF would need to be escalated at a NWL level.

	SH mentioned circa £5m in community contracts for duplicate payments also in acute and said as an organisation it was better to focus on this than decommissioning IVF as the CCG would end up with no service. AW asked what the next steps are. SH stated that a discussion was required on cardio respiratory with the clinical leads involved, to decide whether to commission the service, and to capture the risks and issues associated with the proposed options. SH said that contact would be made with the governing body clinical leads for this service to collectively work through the options in partnership. AW suggested commissioning parts of the service. SH said that a pricing reduction and consolidation exercise of sites was required. SRo highlighted that some of this work was captured in the rationale for the extension. JaW emphasised the importance of early public consultation and devising plans to consult with the public on any decisions taken to decommission services, which would reduce the financial impact of implementing such decisions. SH said the intention was to evaluate this for the 2019/20 QIPP plan and to decide on the areas that required public consultation. VA said at this stage H&F CCG would need to make the decisions. JC said as an organisation we must be clear on the elements of risk we are willing to accept, associated with such decisions, for example the accessibility of services elsewhere for instance in acute. JC added that greater clarify was required on the financial decisions and must go through the process we are required to follow. The committee **noted and deliberated** the M6 QIPP report plus the Financial Recovery Plan update and FRPG action log and next steps and decision to be taken to support H&F CCG to achieve the QIPP ask of circa £27m in 2019/20	
7.	**Any other Business**	
7.1	<u>Investment Cases : Decision Making Policy</u> SH introduced the paper. She said it was proposed at the Governing Body Seminar of the 16th October to formalise the H&F CCG rules regarding the principles against the way future investment decisions would be made. The following comments arose during discussion. • AW sought further clarity on the wording used for the second part of point 3, “with the required actions to ensure activity reduces where needed to support the investment case”. SH said this related to invest to save and the requirement for a clear evidence base to be provided, with a drop in activity in acute evident elsewhere in the country, and that the CCG would no longer accept referrals from elsewhere. • SRo mentioned point 1, and reference to invest to save requests for 2018/19 which must deliver a positive return on investment (ROI) and the ratio of 1-2 and if the scheme requires £100,000 of investment, it must deliver a required level of savings in 2018/19 of £200,000 or more, so the net benefit of £100,000 is as large as the initial investment. SRo queries how this would be achieved as the service would require a year to achieve the return on investment. SH responded that this form of	

	words would prevent people from bringing investment proposals to H&F CCG for investment. SRo said if someone had done the work and were able to deliver the ROI in 12 months' time they could bring the proposal in April. SRo asked for this section to be reworded to stipulate, do not bring any investment proposals in 2018/19 unless there was clear evidence of ROI in 2019/20. VA said this also related to any money being spent and included discretionary spend where the CCG may have agreed to spend money where it felt there was no alternative, but if the quality impact shows there was a case to not spend the money then the CCG should not authorise this extra expenditure. • The committee discussed additional money required for estates costs and agreed that funding requests should be considered on a case by case basis. • SH said as an organisation it would need to be clear that the 2019/20 QIPP schemes could deliver ROI but was necessary to be sighted on the schemes now. • MOC said where the use of the policy and associated processes leads to a decision to decommission/disinvest due to a lack of ROI that the obligatory Equalities / Health Inequalities Impact Assessment (E.H.I.A.) and Quality Impact Assessment (Q.I.A.) would need to be carried out and related engagement activities taken forward as required. JC said that the document should stipulate that an E.H.I.A and Q.I.A would need to be undertaken. • VA said any decisions made by H&F CCG should be referred up to the NWL committee and be implemented more widely at a NWL level. • SH said under point 8 it includes contract extensions and the process it needs to go through. AW said it would also need to include that the decisions taken were done in a logical and clear way. • SRo commented on point 5 and queried the new benefit for H&F CCG, in particular with reference to the re-procurement of District Nursing which will not deliver the same return. VA asked for this point to be amended to say in line with point 3 around scrutiny and national benchmarking and turning off the tap elsewhere in the system. • VA proposed that the name of the document be reviewed as it was not an investment policy. VA also asked for the document to be split into the following three areas: o New Investment o Review of Existing Contracts o Decommissioning • VA said for points 2 and 3 that an E.H.I.A and Q.I.A were required. • JAW said if a service ends in March 2019 when would a paper be required to come to the F&P committee for consideration. SH responded that the contract end date would be noted and the contract would include a six month notice period, with a paper to come to the F&P committee prior to this. JC said that clear direction would be provided to the team on this. • TL questioned the significance of point 7 (Where specific sums have been invested in contracts to fund specific posts, all such investments will cease where the investment sits within a tariff based contract. All other such investments will be treated as per 4 above). SH said this relates to formal posts paid on tariff based contracts and as a CCG would need to discontinue doing this. • TL said the review post implementation referenced in the paper would need to form part of the policy. JC said that all elements referenced in the paper would form part of the policy and asked for this section to be moved up.	**SH** **SH** **SH** **SH** **SH**

	• VC mentioned that she received an e-mail from Imperial about a frailty pilot and business case to fund a new post at a cost of £68k to prevent admissions and deliver a ROI circa £500k over a one year period. The committee suggested that Imperial should fund the post and deliver the work as part of business as usual. JC said if you applied this to the policy, it would not fit under point 7 as the CCGs are paying the tariff. JC suggested this forms part of an ICP discussion and the Trust should take it to the ICP Board or consideration or fund it themselves. VC said this differed to CIS and was a good model. • AW asked if H&F CCG had obtained the views of NWL CCGs on this policy. SH agreed to share the document and obtain the views of the NWL Finance and Quality Teams. • JC emphasised the importance of making sure the patient element was precise. The committee: • Deliberated the policy and requested that the document be revised to include the proposed changes and recirculated to the committee for any final comments. • To obtain formal approval from the Deputy Chair of the F&P Committee • To present the document at November's governing body for ratification once formal approval was obtained	**SH**
Date of next meeting: Tuesday 27th November, 1.30 – 3.00 pm, St Paul's Church, Hammersmith		