NHS
Hammersmith and Fulham
Clinical Commissioning Group

Finance and Performance Committee Meeting

Tuesday 27th January 2015, 3.00 – 5.30 pm
St Paul's Church, Hammersmith

Governing Body members:		
Rohan Hewavisenti	Lay member, H&F Clinical Commissioning Group (chair)	RH
Susan McGoldrick	Vice Chair and GP, H&F Clinical Commissioning Group	SMG
Paul Skinner	H&F Clinical Commissioning Group – GP	PS
Zohreen Ashraff	H&F Clinical Commissioning Group – GP	ZA
Tony Willis	H&F Clinical Commissioning Group – GP	TW
James Cavanagh	H&F Clinical Commissioning Group – GP	JC
Helen Troalen	Deputy Chief Financial Officer, CWHHE	HT

Officers in attendance:		
Helen Poole	Deputy Managing Director, H&FCCG	HP
Shelley Martin	Head of Finance, H&FCCG	SM
Sophie Ruiz	Senior Network Co-ordinator, H&FCCG	SR
Rachel Stanfield	Head of OD and Governance, H&FCCG	RS
Gabrielle Darby	Head of Strategic Planning & QIPP, H&FCCG	GD
Julie Scrivens	OOH Clinical Pathway Lead for Planned Care, HFCCG	JS
Ed Cox	OOH Programme Manager, HFCCG	EC
Coral Alexander	Interim Out of Hospital Delivery Manager, HFCCG	CA
Steve Buckerfield	Head of Children's Joint Commissioning, Tri-Borough	SB
Dr Jai Shree Adhyara	MST Clinical Supervisor, Tri-Borough	JA
Janice Woodruff	Senior Commissioning Manager CNWL & NWL, Out of Hospital, Tri-Borough	JW
James Eaton	Head of Performance, CWHHE	JE
Margaret Kelly	Business Support Manager, HFCCG (minutes)	MK

Item	**Agenda Item /Discussion**	**Action Owner**
1.	**Apologies**	
1.1	Apologies were received from Sharon Robson, AD Acute Finance HFCCG.	
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 general conflicts of GPs as commissioners and providers were noted.	
4.	**Matters Arising**	
4.1	The outstanding actions were reviewed and discussed. Please refer to the actions table for updates.	
5.	**Expert Patient Programme – Delegated Decision for appointment of Preferred Bidder**	
5.1	RS presented the paper on the Expert Patient Programme on behalf of Helena Stokes as Central London CCG is leading on the procurement process. She informed members that the committee signed off the £111k in August 2014 and explained that the delegated decision is for the appointment of the preferred bidder. She reported that the reason for the request is due to the procurement timescales, in order to achieve a service start date of 1st April 2015. She informed members that due to technical errors with the incorrect template being issued by SBS that the dates were pushed back which put pressure on the available timescales. She explained that discussions have taken place with SBS to ensure this error does not reoccur. The committee **agreed** to delegate the decision on a preferred bidder to NHS Central London CCG, the host CCG, for Chairs' action to be taken.	

6.	**Tri-Borough Community Ophthalmology Service – Business Case**	
6.1	JS and EC presented the Tri-Borough Community Ophthalmology Service business case and explained that In July 2014, the F&P Committee approved in principle a business case for a community ophthalmology service, subject to the satisfactory answers to a number of questions posed during the meeting. Following this preliminary approval, the questions posed have been responded to and further engagement took place with clinicians, and the market through a market event, which led to an agreement to exclude paediatric care from the service. Subsequently since October 2014, an updated business case has been developed. Further analysis has taken place on activity to be commissioned through the community service, including engagement with Imperial College Healthcare Trust clinicians to understand what a realistic shift is and agreed to a 50% shift for first appointment activity and 60% for follow-up into the community. It also includes information presented through an internal audit of eye services. This has resulted in an update to the assumptions made in the previous version of the business case. The committee raised a number of questions, to be considered and addressed prior to the procurement. The questions raised were as follows: • How will we ensure that referrals from optometrists will include the medical history from the patient's GP? Will the service require referrers to complete a minimum data set? • How will we embed a culture of feedback and training to GPs on the quality of referrals that results in referral behaviour change in primary care? • How will we provide assurance that any procedure that requires a crash team, such as fluorescein angiography, is excluded? • How will we be able to differentiate which practice patients belong to if referred by optometrists (in relation to their referral rate monitoring)? • How will the service treat emergencies? Are red flags specified? • Will this service improve waiting times, in community and acute? • The minimum income guarantee seems low. How can we be assured this is high enough to ensure that risk is not costed into the tariff by bidders? • How will you ensure that rooms are suitably large for the required equipment? JS informed members that the business case would be taken to the 3rd February Governing Body for approval. The committee **recommended** for approval by the 3rd February Governing Body: ➢ The updated business case for a community ophthalmology service; and ➢ To proceed with a procurement for services, together with Tri-Borough CCGs, through a single procurement with two 'Lots'.	
7.	**Multi-Systemic Therapy Team - Business Case**	
7.1	SB introduced the Multi-Systemic Therapy (MST) team business case and explained that MST is an intensive home and community based intervention to target young people and their families with complex needs for whom usual treatment has traditionally been found not to work. He explained that it uses an evidence based model with therapists on-call 24/7 and works in partnership with 18 families to improve the functioning at all levels of life including health, wellbeing, relationships and education. He explained that there are good outcomes and the service is currently funded at £27-28k, which would rise to £56k a year. The following specific comments and questions were raised: • JE asked how the service demonstrates effectiveness. SB clarified that there are three indicators for each case, with local parameters set up to do local tracking. He explained that three out of four families have young people living at home. The service is a time-limited intervention, it has low-level monitors to ensure it diverts outcomes but the cost savings are weaker in relation to health benefits. SB informed the committee that he would ensure that indicators are included in relation to health and would focus on these outcomes, capturing data on depression, mental health etc. He explained that the service works with the family as a whole to understand what has gone wrong. • SMG commented that the service would only be a success if the three boroughs support it, noted that K&C usage is much lower and asked if the other boroughs had approved it. PB clarified that the proposal has not yet been to the other two CCGs, but if they were not supportive then the service would not go ahead. • SMG commented on the relationship to health outcomes and the national guidance for this service. • HT stated that a pilot has been in place for the past 2 years but the service is unable to show the cost benefit analysis split between health and social care. She noted that the wider economic benefits are national, but wanted to see the local impact of the investment over the past 2 years, and to pick out the health benefits. She asked for a commitment going forward to collect data on the health benefits. SB explained that what the service can capture is that the child remains at home, is now in education and has not reoffended, but public health data is hard to predict whether the an A & E attendance has been avoided. • TW asked if we have an indication of CAMHS usage historically that we can use going forward and asked whether the	

	service looked at personality disorders. SB clarified that of the 18 young people 15 are known to CAMHS but the service does not have a research team to focus on areas such as personality disorders. • It was noted that the proposed scheme scored highly in terms of investment prioritisation. SB informed the committee that local outcomes would be developed for the service and he would report to the committee over the next 2 years. The committee were informed that the investment prioritisation framework was used and showed that this service scored highly, with a score of 120.5. The committee **approved** the two-year funding, total cost per annum for 2015-16 and 2016-17 of £59,000, to continue H&F CCG's joint funding support for the local Multi-Systemic Therapy Team	
8.	**Mental Health Employment Support for common Mental Illness**	
8.1	JW presented her paper on the Mental Health Employment Support for common Mental Illness. She explained that the provision of employment support is key to promoting the whole system recovery of individuals, supporting them to retain their valued work related roles and independence or to find new work opportunities at a time when they may feel vulnerable. The proposed procurement timetable and process, led by the three borough shared services procurement team with support from mental health joint commissioning, is outlined for agreement to go forward into a tender process between February 2015 and July 2015 in partnership with Central and West London Clinical Commissioning Groups. It is proposed that the service will continue as a block contract continuing within the current annual investment of £109,200. It is further proposed that 10% of the contract value is will be aligned to employment stretch outcomes but this will be within the total budget. The specific comments and questions raised were: • ZA asked with regard to people with learning disability do LD teams know that there is an IAPT service with employment support and how can they refer into this service. JW clarified that there is a pilot in place for people with a LD but this does require a different approach due to the difficulties this client group experiences and the nature of the therapy. • ZA commented that LD people may not go via their GP but there would be better uptake if this was part of the LD service to allow greater access and suggested that the views of the LD carers is obtained. JW clarified that LD people could access the service and receive 6/8 sessions to support them to find and retain employment but people with LD may require greater support. • JC said that if we want to identify practices not using the service that we need to engage with them to do so, look at the monitoring report and the number of referrals by practice, target those practices with high employment and mental health issues and use public health data to target those practices with the highest need. JW stated that the funding is for 2.5 WTE members of staff but we need to have a strategic approach to commissioning across the Department of Work and Pensions and with the Local Authority if more people are coming through the service. The committee: ➢ **Approve**d the tendering of the employment support service for people with common mental illness within the current resource ➢ **Agreed** funding for the current provider for 6 months and an extension of the current NHS contract from (1st April 2015-30th September 2015) pending the conclusion of the procurement process, with a one month notice period (£54,600). ➢ **Agreed** to retain the current annual investment of £109,200 ➢ **Agreed** to adjust funding following the contract award in the S75 for 2015/16 and to vary the S75 in 2016/17 **Actions:** • **To provide a brief update on how the IAPT pilot is running and the numbers of people with a LD and CMI who are referred to employment support or referred on to specialist employment support agencies as appropriate** • **To develop a report by GP practice for the number of people who are referred to employment support with a CMI and how this could be reported** • **To obtain the views of LD carers whether there would be greater uptake if part of the LD service**	**JW** **JW** **JW**
9.	**0ut of Hospital Services Assurance Process**	
9.1	SR introduced the Out of Hospital Services paper and explained that the CWHHE Investment Committee agreed to the proposed investment in a suite of 18 Out of Hospital services. The purpose of the paper is to provide the committee with an overview of the process of assurance followed to date for the provision of Out of Hospital Services. She informed the committee that the Collaborative Out of Hospital Steering Group met last Tuesday and had recommended actions for the Federation to resolve prior to Governing Body approval in February. She noted that the first area that the Federation needed to resolve was the arrangements to manage financial affairs to calculate payments to practices. She explained that the Federation has an accountancy package in place with Ramsey Brown accountancy firm to pay practices. The specific comments and questions raised were: • TW asked how we would address the issue of practices not engaging in the programme. HP clarified that two practices have yet to engage on account of contractual considerations. The contract will be held by the Federation and they will be responsible for ensuring delivery.	

	• HP explained that those practices that are to deliver services have to complete a competency checklist. • As off today, there are two practices outstanding because of contractual matters and three others who would be contacted by the Federation to get them formally signed up and to pay the subscription. She noted that the Federation is in a state of readiness to go live on the 9th February, on the proviso that the 3 (non-contract related) outstanding practices are signed up before next week's Governing Body. . • JE commented that we would need to see the commitment from the Federation to move from where we are to extended services in 3/6 months' time. HP stated that a six-month review would be carried out and that an iterative contractual process would be in place to ensure services are delivered to the standards. • SR reported that Hammersmith and Fulham want to go with an APMS Contract, which is also the consensus across the collaborative. SMG asked how the performance management of the APMS contract would occur and whether it would be more difficult to manage compared with a standard NHS contract. HP clarified that the APMS contract would be like for like with additional clauses inserted, but would differ in terms of pensionable arrangements. HP informed the committee that the Federation are meeting the assurances with the exception of all practices being signed up. The committee: ➢ **Noted** the process of Assurance followed to date. ➢ **Noted** the outstanding actions to be undertaken by the Federation in advance of February's Governing Body and requested confirmation in writing by Friday 30th January that all outstanding subscriptions have been received. ➢ **Agreed to recommend** to the Governing Body that they approve the assurance process and contract award, subject to completion of all outstanding actions	
10.	**PMCF Update**	
10.1	SR provided a verbal update from the PMCF Programme Executive and explained that a meeting was held today to review progress against the schedule approved on the 2nd December and to ensure that the Federation were clear about the additional information required for progress. SR explained that the PMCF Executive Committee was asked to approve funding for the following three projects:- - *On-line access* – The PMCF Executive Committee were not in a position to approve the additional £8k. Further information was required and would be e-mailed out to the group for a decision to be made virtually. - *The Care Information Exchange Project* – the funding was approved. - *Patient Engagement* **–** The PMCF Executive Committee has already agreed £15k. The Federation asked for an additional £40k for project scope work to support patient engagement. The additional funding was approved. SR informed the committee that the Local Improvement Scheme (LIS) was approved by NHSE, which would allow the PMCF Programme Executive to proceed and arrange for the funding to be released. SR asked the committee to approve the recommended approval by the PMCF Programme Executive and to note progress made since the last meeting. The committee **approved** the decision taken at the PMCF Programme Executive and **noted** progress.	
11.	**QIPP Update month 9 – 14/15** **QIPP Plans - 15/16**	
11.1	GD presented the month 9 QIPP report and stated that year to date at M08 we are reporting an achievement of 83% delivering savings of £4.4m against the plan of £5.3m, with a shortfall of £908k. She explained that the largest shortfall to date of £639k is on the Community Independence Service (CIS) plus (Virtual Ward) scheme, which is the largest of our admission avoidance scheme this year. She noted that in December, we saw the highest level of referrals (105) because of increased staffing funded through winter resilience monies. She explained that SUS data to-date includes the coding issue at Imperial post CERNER implementation. However, we have noticed a material reduction in NEL activity and cost at Imperial since August-14. This may indicate some corrections to the coding errors but this is to be confirmed. She informed the committee that the CCG are 2% off target, and if we remove the block we would have achieved the target and do not expect the QIPP position to change much between now and the end of the year. She presented a table, which lists the 26 QIPP schemes planned for 15/16, which included a brief description of each scheme, the key aims, the implementation plans, key risks, responsibilities of the providers, investments and gross and net savings associated with each scheme. GD explained that a stocktake has been carried out of all the planned care schemes and said that the CCG would be more selective about the size of the projects to be taken into 15/16. She explained that a rolling deep dive is being carried out into particular QIPP programme areas and that today Coral would be doing this for the CIS NEL scheme. She also said that for next month the aim would be to focus on planned care. CA presented information on the CIS plus (Virtual Ward) scheme, which included activity data for December 14, activity month to date and the dashboard for November 14, also a breakdown of total referrals by month since April 2014. CA informed the committee that the biggest sources of referrals are from GP practices. She noted that for rapid response that the reason for referral will change each month and said that a large proportion of the referrals are for bloods but agreed to let the committee know where they are extracted from and provide the revised categories for the reason for referral. She	

	noted that the next dashboard would include 4 categories for reason for referral. It was reported that a large proportion of people are on red beds but the service plan to look at this intervention in a different way going forward. CA reported that in regards to reason for discharge for a hospital admission over 7 days that the current figure shows 11%. ZA commented that 26% of these patients end up being admitted. SMG suggested that the reason people are to be admitted needs to be split into 2 areas. It was noted that in regards to 14 days post discharge that there is a large proportion of data omitted, but the CCG should have this data for December. SMG raised a concern around the ongoing issues with Dermatology over the past 10 months and said that the contract is not performing and there are recruitment issues. ZA noted that people have stopped referring into the service. GD agreed to take this issue back and have a discussion at the next QIPP meeting around Dermatology and to consider the options for the future of this service and ask Julie to focus her deep dive in particular on this service. GD reported that a detailed database would be in place for each 15/16 QIPP scheme, which will reflect what goes into the discussions with each provider. The committee **noted** the month 9 QIPP Report and the QIPP Plans for 15/16. **Actions:** ➢ **To reflect on the dashboard MDT input into one patient, to demonstrate the level of integrated working** — **GD** ➢ **To update the committee on revised categories of "Reason for referral"** ➢ **To update F&P in respect of the outcomes of the planned actions to reduce the gaps in the category of "14 days post discharge" Acknowledging that this considerably large percentage of missing data requires improvement** — **CA** ➢ **To confirm in regard to sources of referral which "Charing Cross Hospital Ward" is referred to within the referral sources** — **CA** ➢ **To review LoS on Amber ward against originally profiled to consider the impact of an increased LoS and understand evidenced explanation for this** — **CA** ➢ **To consider how to use the data to demonstrate more of a patient journey picture through the service – i.e. what's happening with GP referral vs charring cross referrals etc** — **CA** ➢ **To consider how to demonstrate multi-disciplinary input to one patient to show impact of the integrated service over what these services could deliver alone** — **CA**	
12.	**Finance - Cost Pressure on Commissioning Support Service Budget for 2014/15**	
12.1	HT introduced the cost pressure paper on the Commissioning Support Service Budget for 2014/15 and explained that the eight CCGs have pooled the budget that was set to pay for the CSU in the second half of this financial year. She noted that this was raised at the Governing Body and that the total fund for this period is £15.2m. In addition to the recurrent cost of delivering the commissioning support service, this budget also needs to cover some one-off transitional costs. Some of these were recognised at the time of budget setting and the total budget issued for the remainder of 2014/15 was £16.2m. It shows a £1.5m overspend across NWL when compared to the original pot of funding. This has arisen because of planned additional spend on transition activities and due to the sheer number of posts covered by interim staff that were inherited from the CSU. RH asked if some of the £3.1m of non-recurrent costs are associated with the Hitachi project and asked what is driving the overspend. HR clarified that overspends resulted due to organisational changes and vacant roles being covered by interim staff and that work is underway with HR to get these posts filled. SGM said she was not assured and suggested that a tracking process is put in place to identify all interim staff by CCG. HT stated that she has received communication from HR that they were developing a new process of tracking and that all organisations would need to provide a status update of all interim staff in place. She reported that a Governance Team Policy is being pushed through about interim staff and recruitment. She also said that a discussion took place last week at the collaborative board across the 8 CCGs to discuss HR, comms, headline vacancies, interim staff and the plans in place to reduce the number of interims. HT stated that the number of interim staff in place in H&F would not put them beyond the management budget. For next year, the structure around CIS comes with 10% running costs and as long as we recruit into the vacancies, we should stay within the allowance. SMG raised a concern that H&F were paying McKinsey for work on A & E at Imperial. HT explained that the costs were coming out of the programme budget and not from running costs. **Action: To ensure HR are tracking interim staff numbers and vacancies** — **HP** The committee **noted** the financial position and the proposal to fund the cost pressure using non-recurrent reserves.	
13.	**CWHHE Risks and Opportunities – Planning for Year End**	
13.1	HT presented the paper on CWHHE risks and opportunities planning for year-end. She explained that the risk share is in place to ensure that risks and opportunities are managed at the most appropriate level, and to ensure that all CCGs deliver against the planned surplus, which is held as a control total. She explained that the paper covers the nature of the risks that are emerging across the 5 CCGs this year, and the best estimate of the CCG net opportunity position as forecast for the year at this point. She explained that the CCG does not have to accept all of the recommendations. She stated that it covers costs for McKinsey, LAS, paediatric cost pressures,	

	emergency pathway review (2 sites), C&W/ WMUH merger costs etc. HT discussed the 4 recommendations and stated that WLCCG have not approved recommendation 4, as they have a high net opportunity therefore would end up picking up the largest share of the risks. She said it should be noted at this point if these risks are not shared on this basis then individual CCGs run the risk of breaching the surplus control total. In the event that this happens, it is highly unlikely that the funds will be returned to the CCG at any point. The committee **approved**: *Recommendation 1* - that the risk share agreement be expanded to incorporate the types of risks that are emerging this year and are best handled across all five CCGs. *Recommendation 2* - to hold £1.42m to cover off any other emerging pressures and to review this at month ten *Recommendation 3* - this leaves a balance of a net £5m opportunity. It is proposed that the CCG looks at the potential for using this funding in this financial year in order to strengthen the financial position next year. This includes seeking to increase the surplus control total by £1m per CCG. *Recommendation 4* - the risks that have been identified as suitable for risk sharing should be split between CCGs in relation to the overall net opportunity that the individual CCG is carrying. This means that those with the largest net opportunity pick up the largest share of the risks.	
14.	**Finance and Activity month 9 report – 2014/15**	
14.1	SM introduced the Finance and Activity report and explained that at month 9 the CCG is reporting a year to date surplus of £9.3m, which is £0.8m above plan and is now forecasting a surplus for the year of £12.4m, which is £0.6m above plan. This is a change from previous months where the CCG has forecast on plan. She informed the committee that NHS England have returned a proportion of the CHC risk share fund to CCGs nationally this month and the H&F share is £0.6m. The decision has been taken across CWHHE to increase each CCGs surplus by this value and the expectation is that this will be returned to the CCG in 2015/16. She explained that the acute contract position is overspending by £1.4m in the year to date position with a forecast outturn of £2.3m variance from plan. This is an improvement of £0.5m from the previous month, which is driven by a further improvement in the C&W position. Acute reserves are released in full to offset the over performance and have reduced the forecast to £0.8m. SMG asked why the CCG are paying 67% costs towards the McKinsey review. HT clarified that £700k is per site but work has only been carried out on two of the sites. SMG asked how the figure is calculated. HT explained that £420k is included, this is across the 5 CCGs to cover the costs of three sites, and stated that it is shown as 67% as it does not cover the three sites. SMG asked whether it was advisable for the CCG to consider additional investments before year-end, if money not spent could disappear. SM said if the money is non-recurrent, there is flexibility to do this. SM said that we could look at each investment and identify any slippage, which will form part of the apportionment and overall collaborative assessment of the upside and downside. SMG suggested the IRIS project, as an area to consider investing in, on a non-recurrent basis and that the service would cost approximately £70k; and meets the public health national standard and has NICE backing. The committee suggested that given the governing body had not supported this proposal previously that we should not re-visit it. SM reported that at month 9 the underlying position of the CCG is calculated to be a £13.9m surplus, which is a £3m improvement from the Q2 position and a strengthening of the position reported to NHS England (NHSE) in June of £2.3m. The main driver is a significant improvement in the assessment of the Imperial contract position following removal of the income guarantee, which has been worked through for the 15/16 contracting round. This now fully reflects the reductions in activity that has been incentivised in 14/15. The C&W contract position is still worsening but less than previously reported as RTT activity has now been removed from the calculation. TW asked how much data have we received from Imperial as the Trust agreed to submit accurate data by the end of January 15. JE explained that accurate RTT data was due to be submitted at the end of December 14, but have not received it. HP stated that some information has been submitted, which shows an increase against our projections. RH queried the corporate costs and asked what the real costs are. SM explained that we are expecting to spend the full amount, therefore this is the expected actual budget but there should be a small balancing figure. **Action: To confirm the actual corporate costs (as they are stated to be exactly on budget each month)** The committee **discussed and noted** the Finance and Activity performance of the CCG at month 9.	**SM**
15.	**2015/16 Draft Operating Plan**	
15.1	SM presented the 2015/16 draft Operating Plan and explained that the draft was submitted to NHSE on the 13th January and that the next iteration of the detailed plan is due on the 28th February. She informed the committee that whilst the overall change in growth is an increase of £0.6m, this is following the addition of £1.3m to be ring-fenced for system resilience, which is effectively a reduction in growth for the CCG from the 1.7% previously modelled to 1.4%, as the CCG moves closer to target, therefore shows a worsening underline position. SM said we would need to consider how we balance the level of QIPP with the level of investment etc.	

	RH noted that the allocation level has increased and asked what is the planned spend. HT explained that it includes the £4.2m for the better care fund, which will go to the Local Authority. SMG commented on and queried the NWL strategy spends. HT explained that £7.4m is an element of what we contributed to this year plus £6m, which is our contributions, with the £6m non-recurrent. RH commented that the acute figure on page 6 of the report shows a drop of approximately £5m from £129m to £124m. SM stated that the £129m shows the forecast outturn for this year and the transformation funding which is non-recurrent, a £3.4million QIPP reduction and £4.5m reduction for efficiency based on our tariff deflator. SMG queried the reduction in spend on primary care. SM explained that there are elements of this year's spend that are non-recurrent and agreed to provide a breakdown with some additional narrative. SM informed the committee that there is £1.9m in reserves for acute, which allows flexibility to settle the contracts. SM explained that in next month's finance report that the figures would be more explicit. HT informed the committee that the interim budget would be agreed at the Governing Body in March. The committee **noted** the 2015/16 draft Operating Plan. **Action: To provide a breakdown of the primary care spend to include some additional narrative**	**SM**
16.	**Integrated Performance and Quality Report month 8 – 14/15**	
16.1	JE introduced the month 8 integrated performance and quality report. He explained that the key areas to note are: • That RTT, cancer, A&E and LAS have all shown slight improvements in month 8. • **RTT:** - Imperial have send in their data and have reported that they are hitting the admitted target, but not for non-admitted, which shows a deterioration for month 8. Imperial are not meeting the incomplete pathway standard in all specialties except for Neurology and Neurosurgery and there has been an overall increase in backlog. However, Urology has improved over the last 3 months. JE noted that McKinsey hold weekly meetings with the Trust to review performance. • **LAS arrival to handover waits:** - There were a total of 318 patient breaches > 30 minutes (Imperial – 233 and C&W – 78) and 6 patient breaches > 60 minutes in M8. • **A&E:** - Imperial and C&W did not meet the all types A&E standard in M8 achieving 91.86% and 94.7% respectively. Processes are in place to utilise capacity across Trust sites. • **HCAI:** Imperial had one case of MRSA and three cases of C-diff in-month at M8. • **IAPT:** WLMHT narrowly failed to achieve targets for IAPT access and recovery across Hammersmith & Fulham CCG in M8. The committee **noted** the month 8 integrated performance report.	
17.	**Board Assurance Framework (BAF)**	
17.1	RH presented the BAF report, which sets out the key risks to achieving our strategic goals. The committee discussed the key risks allocated to it and noted that in regard to risk 5 that the risk of Imperial failing to provide revised data in month 9 was not added to the latest iteration of the BAF. The committee **reviewed the BAF and provided feedback** to Ben Westmancott via the proforma. **Action: To feedback via the BAF proforma to Ben Westmancott the risk around the failure of Imperial to submit their month 9 data**	**MK**
18.	**CWHHE Performance Committee Report**	
18.1	JE presented the CWHHE Performance Committee Report The committee **noted** the Report.	
19.	**Any Other Business**	
19.1	No other business was discussed.	
The next meeting is scheduled for: Tuesday 24th February, 3.00 – 5.30 pm, St Paul's Church, Hammersmith		