Item 3

Minutes of the Governing Body meeting held on
Tuesday 13 September 2016, 3.00pm – 5.30pm
(Public)
St Paul's Church, Hammersmith

Present

Name	Role	Organisation	Initials
Tim Spicer	GP Member (Chair)	H&F CCG	TS
James Cavanagh	Vice Chair/GP Member	H&F CCG	JCa
Vanessa Andreae	Vice Chair/Practice Nurse Member	H&F CCG	VA
Tony Willis	GP Member	H&F CCG	TW
Paul Skinner	GP Member	H&F CCG	PS
Zohreen Ashraff	GP Member	H&F CCG	ZA
Peter Fermie	GP Member	H&F CCG	PF
Trish Longdon	Lay Member	H&F CCG	TL
Jane Wilmot	Lay Member	H&F CCG	JaW
Sena Shah	Practice Manager Member	H&F CCG	SS
Rohan Hewavisenti	Lay Member	H&F CCG	RH
Clare Parker	Chief Officer	H&F CCG	CP
Philip Young	Lay Member	H&F CCG	
Keith Edmund	Chief Finance Officer	H&F CCG	
Jonathan Webster	Director of Quality and Safety & Secondary Care Nurse Member	H&F CCG	JW
Stuart Lines	Assistant Director, Public Health	London Borough Hammersmith & Fulham	SL
Alan Hakim	Secondary Care Clinician	H&F CCG	AH
Ben Westmancott	Director of Compliance	H&F CCG	BW
Janet Cree	Managing Director	H&F CCG	JC

In attendance

Name	Role	Organisation	Initials
Helen Poole	Deputy Managing Director	H&F CCG	HP
Ed Cox	Assistant Director	S&T Team	EC
David Freeman	Programme Director	CWHHE CCGs	DF
Catherine Park	Paediatric Community Service Re-design Lead	S&T Team	CPA

Apologies

Name	Role	Organisation
Mark Jarvis	Head of Governance and Engagement	H&F CCG
Shelley Martin	Head of Finance	H&F CCG

Minutes

Item	Agenda Item /Discussion	Actions
1.	**Welcome, Introductions and Apologies**	
1.1	TS the Chair, welcomed everyone to the meeting. He noted apologies from Shelley Martin and Mark Jarvis.	
2.	**Declarations of Interest**	
2.1	There were no additional declarations other than those already declared and	

	published.	
3.	**Minutes of the Previous Meeting**	
3.1	The minutes of the meeting on 12 July were **approved**.	
4.	**Matters Arising**	
4.1	There were no matters arising from the last meeting.	
5.	**Action Log**	
5.1	There were no outstanding items on the action log.	
6.	**Ratification of Chair's Action**	
6.1	Members noted that there have been no actions taken since the last meeting that has required Chair's action.	
7.	**Chairman's Report**	
7.1	TS reported that the CCG had continued engagement with the Local Authority, in particular, through the Health and Wellbeing Board, and had contributed to refreshing the Health and Wellbeing Strategy, which will go out to consultation later this autumn. TS informed members that he provided clinical leadership to an initiative to improve the care of residents in the Last Phase of Life, and would share some early findings from the proposal at a future Governing Body meeting. TS acknowledged that it was Dr Zohreen Ashraff's last meeting as a governing body member, and thanked her, on behalf of the governing body and CCG members for her contribution to the CCG, especially for her clinical expertise and patient focused work. He informed members that Dr Amy Wilson had given birth to a baby boy and mother and baby were doing well. The Governing Body **noted** the Chair's report.	**TS**
8	**Chief Officer's Report**	
8.1	CP introduced the report. She highlighted, in particular, the work being undertaken on the forthcoming contracting round. She explained that NHS England (NHSE) released guidance in late July 2016 that requires CCGs to agree a two-year NHS contract with providers by the 23rd December 2016. CP emphasised that the contracts would need to be aligned with the deliverables in the North West London (NWL) Sustainability and Transformation Plan (STP), and will, therefore, need to be developed collaboratively between commissioners and providers, and cover the period 1st April 2017 to 31st March 2019. She noted that the planning guidance was due to be released on Monday 19 September 2016. She emphasised the challenges in delivering the contracting round during the three-month period, but advised that this should free up staff time during the busy winter period to focus on operational delivery and care. The Governing Body **noted** the report.	
9.	**Managing Director's Report**	
9.1	JC delivered a verbal update. She informed members that in August 2016, the CCG attended the H&F Older People Forum to discuss the 111 service, and hear any key issues to feed back into the design process. She explained that the next steps for the NWL programme include:- • Contract extension until April 2018 • Developing a directory of services to support the delivery of integrated urgent care • A gap analysis of current service against integrated urgent care standards and	

	how standards will be delivered from April 2017 JC highlighted that the CCG continues to develop its social media, with over 1000 followers on Twitter, which supports the CCG to engage effectively with the community and voluntary sector in addition to residents. She emphasised that further work would continue on broader engagement, to understand better the impact and scope of initiatives that we undertake as on organisation. JC highlighted recent personnel changes and noted that Kathleen Sadler, Deputy Managing Director, had left the CCG to take up a new role at Hillingdon GP Federation. In October, Hammersmith and Fulham CCG will welcome Sue Roostan as her successor, who will lead on a portfolio of work to include Mental Health, Planned Care, QIPP and Joint Commissioning. JC said that the CCG had welcomed Fozia Hamid, a new Darzi Fellow, who arrived with a wealth of experience as a GP as well as a background in Public Health. She said that her initial focus would be on supporting the CCG with Right Care and the Long-Term Condition (LTC) management programmes, working closely with Dr Tony Willis. She noted that the CCG had said farewell to Dr Chad Hockey, outgoing Darzi Fellow, and thanked him for his work on Urgent Care and Children's Commissioning. JC noted that the CCG also welcomed two new members to the team, Bethany Golding, Patient and Public Engagement and Communications Manager and Pete Ellis, Project Manager in the Planned Care Team. JC explained that the CCG had an increased emphasis on the completion of mandatory training and had seen a significant rise in completion rates over August but would need to see continued improvement as this is a statutory requirement for all CCG staff. The Governing Body **noted** the report.	
10.	**Local Service Transformation Programme**	
10.1	EC presented the report, which provided a detailed update on the transformation programme across NWL and specific information relevant to H&F CCG. . EC noted that the programme was recently discussed at a governing body seminar, and work in H&F CCG was well underway on some of the key areas to achieve the local services ambition. He highlighted the formation of the Tri-borough Self-Care Working Group, which is aligned to the Self-Care initiative and includes embedding the Patient Activation Measure (PAM) within social prescribing, Vitrucare and CIS. He stated that H&F CCG was the CWHHE lead site for diabetes in the Rightcare programme, alongside other Rightcare programmes to support reducing variations in care. EC reported that there were six initiatives: Right care, new models of local services care, self-care, wider determinants of health, rapid response and intermediate care, and expanding common discharge. EC explained that next steps were to continue setting up working groups for each initiative with leads from each CCG, refining the governance and completing the diagnostics phase of the programme, in collaboration with key stakeholders across	

	the sector. He said that a detailed financial analysis would then be produced. BW commented on the governance structures, and suggested simplifying them. He highlighted that the scheme of delegation lacked clarity, as did the Terms of Reference approval requirement. If CCGs wish to delegate decision making they need to do so in accordance with CCG instructions, and adhere to internal audit. PY stated that he supported the direction of travel, agreeing with the 5 CCGs working more collaboratively and having local CCG representatives on each of the groups. PY requested information on deliverables and anticipated costs. RH stated that in regard to the wider determinants of health, the NHS is not able to deliver on housing, employment and education. RH recommended that in terms of self-care CCGs could sign post people to the voluntary sector, who are keen to increase their influence and deliver more. TL reiterated the lack of clarity around deliverables and queried who was on the programme boards making these decisions. She also asked for a clear process to be developed to provide the CCG with assurance on deliverables. She emphasised her support on the direction of travel but stressed the importance of moving at a quicker pace. CP emphasised the importance of having representatives for H&F on the different groups, and not relying on the proposed newsletter approach of communication. CP said that each CCG representative would be accountable and take ownership and ensure that the group on which it is a representative delivers what the CCG needs it to. She said that each representative would be required to attend governing body meetings to provide the level of assurance required. JaC applauded the people who developed the workforce element of the report in recognising the unpaid carers in the local community. He raised some concern around the speed of development of primary care, and said it was behind some of the other areas. TW echoed the comments made about primary care development and said that work needs to happen to ensure capacity is increased. He said that the deliverables would need to include specific measurable outcomes for long-term conditions, quality of care, cardiovascular disease (CVD) and for people with diabetes, in order to reduce mortality rates. TS highlighted that the document focuses greatly on governance and delegation but makes little reference to evidence. He also noted that the report does not show a commitment to a transparent evaluation for some of the things it suggests and were asking the CCG to delegate work not clearly articulated in terms of scope and interdependencies, in particular, when one piece of work finishes and another starts. He said if greater clarity was provided around these areas the CCG would have greater assurance around delegating decisions. AH queried whether an external evaluation of our own processes was carried out. He asked whether we could stop the process at any point to re-evaluate. CP explained that guidance does not stipulate that the CCG could not stop.	

	VA said that in order for the CCG to have a clear governance process the document should include the tracked changes, so members were clear where it was discussed and when updated. She also said it was unclear when and where discussions had taken place on the wider determinants of health, and how the Health and Wellbeing Board fits into this process, and asked when discussions would take place with the Local Authority on the overlapping budgets. CP said that some of the deliverables and examples of evidence were presented in earlier papers, but may require more detail and need to be revisited. She suggested that the governing body could endorse the direction of travel and give the groups permission to get on with the work rather than wait a further two months before getting started. She said that the delegation still reserves all-important decisions to go through the Governing Body. She agreed that a proper comprehensive scheme of delegation was required, alongside strong deliverables. Further clarity on the governance arrangements and structures would be provided at a future governing body. Concluding the discussion TS said that a summary of the areas on which the CCG would require further feedback needed to be provided and that the CCG needed to receive a further report at a future meeting. He summarised that there was general agreement with the direction of travel and the need to work at pace across the collaborative. The Governing Body **endorsed** the direction of travel, but requested: • a suitable scheme of delegation for project and programme decision making, more detail of the deliverables, and a clear process to be devised to provide CCG assurance on what deliverables have been delivered, the costs, and a clear evaluation process • to have a greater discussion on the six priority areas to deliver the transformation to include the use of evidence, with some examples • further clarity on the governance arrangements and structures • a further report to come to a future meeting	
11.	**Accountable Care Partnership (ACP) and Project Initiation Document (PID)**	
11.1	DF introduced the ACP and Project Initiation Document (PID). He explained that the paper seeks to obtain Governing Body comments and approval for an Accountable Care Partnership programme PID. The governing body was also asked to approve the initial scheme or delegation for the interim governance arrangements to guide us in the current phase of the programme and to note that further governance proposals would come back to November's governing body for approval. DF explained to members that the ambition was to create and develop an ACP, as set out in the commissioning intentions, by 1st April 2018, and that the PID sets out the approach and work that needs to be undertaken to achieve this. DF highlighted that a number of areas would need to be looked at in detail and be discussed further with governing bodies to obtain their thoughts. The areas include the scope and size of the ACP footprint, the route to be taken to contract award, whether or not to pursue a competitive route, the priorities and outcomes for our ACPs, the population to be served and the contract mechanisms with our providers. He said that these pieces of work would come together later on.	

	DF indicated that the governance arrangements for the scoping stages were set out in the ACP summary document and includes the scheme of delegation and planned timescales. PY stated that he did not understand what ACPs were and asked for some working examples of how it works in a complex environment with many providers and many commissioners. He also questioned how achievable the March 18 deadline was, in particular, given that CCGs are moving to 2 year contracts with their providers from 1st April 17, with contracts to be signed off by the end of December 2016. He also queried how public engagement and public consultation fits into the process, and which parts require it. PY commented that the document mentions seeking agreement for the CCG to delegate to the programme board, by January 2017, the decision to proceed with the most capable provider, or proceed to competitive market procurement. He said that the CCG was not in a position to delegate this decision; therefore, as a lay member on the governing body he could not support this, but was supportive of all other elements of the scheme of delegation. He said it was effectively a single tender waiver and that there are significant legal issues, in particular, for primary care and community services. PS endorsed the concerns that were raised by PY, and said that the statement "it is widely recognised that health and care systems around the globe are facing unprecedented challenges and our experiences in North West London are no different" would need to be referenced, and include some example and academic evidence. PS supported the comments about public engagement but also asked for engagement with stakeholders, especially disparate groups of practices that need to be brought into the CCG's ambitions if ACPs are going to work. VA indicated that she understood the need for ACPs and was supportive of them in principle, especially the idea of shaping care around patient outcomes, but had anxieties about how it would work in such a complex multi-provider landscape, and required reassurance around this. VA commented that she had seen some examples where ACPs work in the Isle of Wight where geographically everybody is contained, but noted that ACPs have also failed in the UK where they have not been properly developed and the CCG needs to be aware of this and look at the lessons learnt. TS noted the concerns that were raised around how ACPs would work in a complex environment, because of the complexity of the landscape in North West London. PY reported an additional layer of complexity, about how to deal with providers not part of our ACPs, which is less significant for H&F than for some other boroughs. RH suggested changing some of the incentives driving up costs, which are mis-aligned and fail to deliver the desired patient outcomes. He noted that the level of spend on acute services is outside of CCG control and suggested altering how we commission services, but questioned whether having eight commissioners across NWL was the right approach. AH emphasised the importance of engagement in the transformation process and key role that all governing body members need to play and asked about the expectations for CCGs. He said that the governance structure includes an	

engagement process and the CCG would need to hold more local conversations about what the benefits and dis-benefits are and should set up further seminars dedicated to this, to debate the CCGs' collective concerns and how to deliver at pace and keep key stakeholders engaged.

TW commented on the number of overlapping processes such as STP, ACP and the Local Service Transformation Programme and said that we need to be clear how these areas interweave and should focus on fewer different initiatives. He asked for STP and ACP to be made more intelligible for clinical members to allow them to understand the relationships between each area and to focus examples on the disease entities, patients and on outcomes.

VA said that patients need to be the focus of everything we do and that the PID needs to include some patient examples of where ACPs have worked well, but we need to understand what it is going to look like for patients, especially the more complex patients.

CP highlighted that in order for ACP to work we need multi-disciplinary teams, a clear evidence base and good business intelligence and said that the document was co-produced with a group of lay partners. She said that we need to revisit this work and said that there are many examples that could be looked at across the country and wider which could be referenced. She suggested allocating sufficient time at a future governing body seminar to enable a greater understanding of ACPs. She also suggested bringing together groups of CCG for wider discussions and a shared understanding, as one of the possibilities was for the final ACP to cover more than one borough.

TL stated that answers are known for many of the issues raised. She indicated that it would be useful to obtain support from our local providers who are coming together, and in particular the GP Federation who are already involved in ACP discussions and have signed up to a memorandum of understanding, to comprehend what it might mean for them and why they think ACPs are a good idea.

SS suggested that the lessons learnt from the recent CIS could be absorbed into the discussions and processes.

The governing body:

- **Approved** the Accountable Care Partnership (ACP) Programme PID and confirmed the CCG's commitment to support ACP delivery against the timelines described.
- **Approved the direction of travel** for governance as set out in the PID, in particular, to provide a mandate for the Initial ACP Programme Board to proceed
- **Approved the Initial Scheme of Delegation** (Authority to Act) for the initial ACP Programme Board and associated assurance mechanisms outlined in the governance section, with a caveat, that PY's reservations are taken into account, in particular in relation to the scheme of delegation and most capable providers and for these areas to be reviewed further
- **Noted** the intention to bring back proposals for full governance arrangements and associated full scheme of delegation, for approval in November 2016, and for something more concrete to be discussed around STP, ACP and local

	services and to articulate the relationship between each for practices, patients and the local community	
12.	**Sustainability and Transformation Plan (STP)**	
12.1	CP presented the detail of the Sustainability and Transformation Plan (STP). She informed the Governing Body that discussions were on-going with the Local Authorities with regard to shared governance and delivery arrangements. It was noted that Hammersmith and Fulham and Ealing councils had not signed up to the STP, in view of the position on Shaping a Healthy Future. CP said that a number of engagement events were being held, ahead of the submission of the final STP in October 16. CP explained that Hammersmith and Fulham CCG would ensure that residents of Hammersmith and Fulham are not disadvantaged in relation to the he Local Authority not having signed up to the STP. She explained that there are a number of areas where Hammersmith and Fulham CCG and the council have joint agreements, and that the CCG would continue to work collaboratively with them on areas such as out of hospital services, wider determinants of health and on some of the prevention work. She highlighted that some of the delivery areas of STP are dependent on the integration of health and social care, and that there was a commitment from both sides that residents should not be disadvantaged. CP noted that the STP document was still in draft form, but would expect the document to be formally signed off in October, once it had gone through the governance processes. The Governing Body **noted** the STP update.	
13.	**In-Patient Paediatric update**	
13.1	CPa introduced the report and provided a brief summation of the elements in the paper. She informed members of the clinical benefits and improved quality of care for children in Hammersmith and Fulham and broader North West London (NWL), the level of assurance provided and that the new models of care have been implemented safely. CPa highlighted that, in terms of next steps, the CCG will continue to monitor performance with the on-going monitoring data from the paediatric dashboard to be built into the Integrated Performance Report (IPR) to be monitored through the CCG Quality and Safety Committee. She also said that the CCG would be working closely with St Mary's to further develop paediatrics over the winter period. TL acknowledged the benefits documented and improved quality of care that children were receiving but asked whether there were any real outcome targets and wider benefits and whether we had achieved them. CPa explained that it is too early following the transition period to assess demand levels, but that a detailed review and analysis of the changes to short stay admissions and A&E would be carried out in April/May 2017. She agreed to share the findings from the review with governing body members. TW commented on the difference between expected and actual numbers and maximising capacity and asked how assured we were that the service was being utilised and people were not going elsewhere to be seen. CPa explained that the modelling was developed over the course of a year and takes into account the winter period, which is busier. She said it modelled up to 20% of the total system and did one set of modelling geographically and one set on transport and added in	

	extra capacity and would be reviewed this in April and would readjust accordingly. CPa explained that other areas are also being monitored in line with what is being modelled and said that the sites are coping well with the transition. ZA commented on table 1 and suggested that for ease of reading an extra column is added to reflect the changes post transition and whether it is a minus or plus figure. The Governing Body **noted** that the transition has taken place safely and that the new models of care have been implemented safely. They acknowledged that the next steps for the CCG would be to continue to monitor performance via the Quality and Safety committee.	
14.	**Finance update**	
14.1	<u>Month 4 Report</u> KE introduced the month 4 finance report. He advised the Governing Body that at month 4, the CCG was reporting a year to date surplus of £0.91m, which was on plan and forecast to deliver the planned surplus of £2.72m. He said that the focus for 17/18 would be to get acute spend under greater control and achieve delivery of the QIPP plans. KE highlighted some significant cost pressures, with the acute contracts over performing by £1.74m year to date. He also reported that continuing healthcare and physical disability placement budgets are facing pressures, overspending by £0.41m at month 4 and primary care is now showing an YTD overspend of £0.21m; with a forecast overspend of £0.40m. KE explained that the underlying position forecast shows a surplus of £1.03m, a worsening of £5.27m from the position we forecast in the operating plan and 5-year model. He explained that as no firm plans are in place to address the QIPP gap, this target will carry forward into 2017/18, and along with overspends in acute and continuing care, would lead to a reduction in the recurrent surplus. KE said it was important to note that the risks are recurrent but the mitigations, which will provide cover in 2016/17, are mainly non-recurrent in nature, and should these risks materialize it would have a significant impact on the underlying position. CP stated that the report did not explain the worsening of £5.27m. She stated that even if the CCG balances the accounts, it would have £5m less funding available to spend on new services. She sought clarification of the mitigating actions put forward to recover performance and to strengthen the underlying position. She asked for an explanation of what caused this worsening position and the discussions that had taken place at the Finance and Performance Committee. KE explained that he was aware that the CCG was focusing on maximising the delivery for its planned QIPP schemes and was looking at alternative and additional savings in year. He said that the level of overspend on the Imperial contract had been escalated as this is not financially sustainable for NWL as a whole. JC explained that additionally, H&F was reviewing the work going on in other CCGs, and in particular were focusing on Central London (CL) CCG, as they are further ahead in terms of recovery work. She indicated that H&F were reviewing the CL action plan, and as part of our own formal review process, were looking to integrate this into the H&F action plan.	

JC reiterated that H&F had a particular focus on maximising the benefits and expected returns on its existing QIPP programme of work. She indicated that some of the schemes interface with Imperial Trust, as they are also the provider of some community services and QIPP schemes in Hammersmith and Fulham. She highlighted the monthly QIPP review processes and that the CCG are working closely with Imperial Trust to ensure a system wide response, and are supporting the work that Imperial are doing internally around their efficiencies and cost improvement programme.

VA raised concern with the two-year contracting round, with all contract holders, and in particular, the difficulties in extracting money out of these contracts, as the CCG was going to need further efficiencies given its financial position. She queried the level of CCG assurance that could be taken if contracts need to be finalised by the end of December 2016.

KE explained that the new contracting round is a significant change for the NHS, but said that the CCG had requested the planning process start sooner to allow budgets to be available in Q4, and to issue the operating guidance sooner. He said that the other key change is how the contracts link into the STP process and the key assumptions within it.

TL concurred with the comments made concerning the CCG financial position, and lack of reserves available in 17/18, but emphasised the importance of the CCG being clear and transparent with its residents about the actions the CCG can realistically take to address performance issues and to bridge the QIPP gap.

HP explained that the H&F action plan was building on the work from the other CCGs across the three, five and eight boroughs to get real transformation under way. She explained that the plan would be presented at September's Finance and Performance (F&P) Committee with monthly updates to come to F&P. She noted that an update would feature in Rohan's F&P update report at a future governing body meeting.

HP highlighted that some elements of the plan were presented at a recent governing body seminar, to understand from members which areas are more likely to be successful and which areas to prioritise in terms of delivery. She said that next week's additional seminar was dedicated to looking at the plan in detail, to understand which of the CCG actions are likely to have the greatest and quickest impact.

RH welcomed the comments from KE that the Q4 budget be brought forward and said that ideally the governing body should be signing off budgets before the end of March. RH said that a lot of QIPP delivery was outside of CCG control, and acute spend was increasing, but emphasised the importance of the CCG in getting to grips with its expenditure, particularly, with STP and ACP in the horizon.

TS commented on the lack of sustainability in the CCG's current model of delivery and said that it needs to look at other ways of delivering services.

JaW queried whether the CCG knew what money other commissioners were spending on its behalf. JC explained that the CCG has visibility and detail of all

	spend, but needed to review whether it could spend the money differently. She explained that the detail of all spend is included in the finance pack, and JaW could be assured that the figures are reviewed monthly by members of the Finance and Performance Committee, on behalf of the governing body. RH explained that the budget for 16/17 and forecast was £11m more than in 15/16, which showed 4% growth, but that the budget was insufficient to meet the level of demand. He explained that a number of small investment and business case proposals had been presented to the F&P committee, which were often approvals for additional spend, but that these amounts add up over time. He said that the CCG would need to priorities and look at the whole investment portfolio upfront in the planning and budgeting phase. JC explained that planning and budgeting is one element of the process undertaken for next year's budget. She explained that some difficult decisions were required to decide which services to invest in, in order to reach a good balance. The Governing Body **discussed** and **noted** the month 4 finance update. It emphasized the importance of ensuring that all appropriate actions would need to be undertaken to achieve the year-end position. It was mindful of the lack of reserves post the 16/17 financial year and the importance of investment prioritization, and budgeting and planning earlier in the year, and to consider new ways of delivering services	
14.2	<u>Report from the Finance and Performance Committee</u> RH summarised the report, which was prepared following the July and August F&P Committee. He informed members that the committee had approved Transforming Care Plan (TCP) funding of £40.6k for 2016/17, based on a population basis. RH explained that the report also included investment proposals approved at the Operational Group, by the Managing Director and Chair, which were as follows: • CAHMS Transformation 2016-17 - £30k for 2016/17 from the transformation funds • Cognitive Impairment and Dementia Service (CIDS) £54,079, non-recurrent funds in 2016/17 • Tissue Viability - £46,776, non-recurrent funds in 2016/17 The Governing Body **noted** the report from the Finance and Performance Committee	
14.3	<u>CCG Budget – 2016/17</u> KE presented the final CCG Budget for 2016/17. He explained that the budget went to the July F&P committee for recommendation to the governing body, for final approval. He said that the paper set out the small number of changes that had gone through since the draft budget went to governing bodies in March 16. VA commented on the reduction to programme spend of £1.36 million and sought clarification on what this actually means. KE stated that this relates to health care costs and is distinct from running costs. CP explained that the CCG has made less of a contribution to the NWL Financial Strategy, which consisted of a reduction in non-recurrent funding under Part C of £2.27m, and the removal of the recurrent £1.0m Part A contribution. She emphasised that the CCG are not spending less on healthcare and that services have not stopped to increase our surplus.	

	TL commented that governing body members are required to approve the final 2016/17 budget and queried whether this meant that the CCG would not consider any new funding requests this financial year. KE explained that it would only consider investment proposals with good financial and clinical cases. HP stated that the NHS is a dynamic environment and there would inevitably be funding requests in-year, for example on occasions NHS England (NHSE) offered CCGs match funding to invest. She said that any legitimate cases for funding would need to go through a due diligence process of governance, and it was not due to lack of planning that these requests materialize, but rather in part due to the dynamic environment in which we operate. TS said that the issue would be whether the match funding was available on a recurrent or non-recurrent basis. KE explained that if match funding were available in year, then the CCG would need to consider whether it could afford its share of the funding, also whether the service offered value for money, and the implications for guaranteeing future years. CP explained that there are cost pressures that come up in year that are unavoidable such as high cost patients that can cost in the region of £500k, but there are areas where the CCG has control. She stated that the CCG has always had a contingency budget, which it used to offset additional in year cost pressures and acute over performance. VA said that she was mindful of funding requests in the pipeline, not accounted for, and said that the option of not investing in some services would mean that the forecast spend is worse. She said that as a governing body member, it requires clear guidelines when investment proposals go to the F&P committee, and how it decides whether to invest in the business case/investment proposals or not. TS explained that the F&P committee and chair had a clear understanding of the financial climate in which the organization is trying to operate. He said that when investment proposals are presented at the F&P committee that they have already been discussed at the Operational Group, and there is a clear case of merit, with financial affordability and clinical robustness in order for the case to be considered. TS indicated that the guidance that the governing body receives from the F&P committee has to be guidance, and may need to discuss the cases further at the governing body, given that the organization is trying to operate within its current level of allocation. TS said that it did not want the F&P committee to hold full responsibility, as ultimately it is Governing Body responsibility to make these major decisions. The Governing Body **approved** the 2016/17 budget	
14.4	<u>Shaping a Healthier Future month 4 report</u> KE introduced the Shaping a Healthier Future month 4 report. He explained that the report flags some pressures on budget but was working to ensure the management of these pressures within the overall budget, and would report on them in the month 5 report. TL highlighted that at the last governing body meeting it only approved the Shaping a Healthier Future budget for 6 months, therefore expected to receive a revised budget at November's meeting, which takes into account the needs of Hammersmith and Fulham residents, for final approval.	**KE**

	Governing Body members **noted** the Shaping a Healthier Future month 4 report.	
15	**Performance**	
15.1	VA introduced the report prepared following the discussion at the Quality, Patient Safety and Risk Committee on the 26th July and the 23rd August. She explained that the Quality Report provides a brief summary of the issues discussed and reviewed the reports in detail with wide-ranging and detailed discussions. VA noted the overall level of assurance provided in respect of patient safety reporting, and the actions being taken, to ensure they were appropriate. She said that concerning Never Events reported by Imperial, the Trust was implementing processes to strengthen the mitigations, to reduce future risks. She highlighted the positive outcome following a recent visit to St Vincent's Nursing Home and the work done across agencies in relation to adult safeguarding. VA explained that the Joint F&P and Quality, Patient Safety and Risk Committee discuss the integrated quality and performance report, with details included in the minutes and had either received assurance on the items discussed, or identified specific actions to be undertaken, in order to provide the level of assurance required. The Governing Body **noted** the performance report and the committee summary report.	
16.	**Board Assurance Framework (BAF)**	
16.1	BW presented the latest iteration of the BAF. He said that the BAF had been revised and the CWHHE governance team has worked with risk owners to ensure that the narrative included for each risk provided a more robust reflection of the current position and plans for the management of the risks going forward. BW highlighted that the BAF summary page now outlines any variation in risk score in line with the agreed risk appetite and brings this to attention using the RAG system. He said that further work is planned to develop not only the BAF entry but also the lines of assurance that underpin it and that the CWHHE Senior Team and Governing Body Committees would be integral to that process. BW drew members' attention to the presentation of the report and the new coding for risk summaries in red, amber and green. He explained that green is the risk code that has reduced since the last iteration; amber is where the risk score has not altered, and red is where the risk score has increased. He said this reflects the degree of changes since the last report and the scores show how significant the risks are. BW indicated that risk 9 had increased and that this related to the procurement of the new business informatics tool. He said that to provide governing body members with assurance that there is a project risk register, which sits behind this report, to ensure that the risks are being managed appropriately. BW explained that 3 risk entries had reduced following discussions with individuals and other governing bodies, but there has been some debate about whether some of these risks should have reduced. He explained that the risks were, risk 3: Long Term Condition Prevention and Management, risk 5: Strengthen the organisation's infrastructure to help us deliver high quality commissioning. He said that concerning risk 5 that the general consensus was that even though infrastructure had been	

	implemented in terms of the management of systems and processes, that this risk still remains as high as it was previously, and whether we should wait until we see the change within primary care before altering. He said that the final risk was risk12, around the overall system of regulation and assurance, and has been reduced down to a 9, which suggests that we have done everything that we need to do or have the appetite to do but there remain reservations over this. BW explained that the risk appetite is the score that we want to reduce the risk to by the second half of the year if not before, and said that in using the new coding we are trying to show at a glance what has been altered as a quick eye catching indicator. He noted that the document would continue to be reviewed through the directors and the committees, especially, the risks that have increased. RH stated that as a Governing Body that we would need to ensure we allocate time and attention to discuss the key risk areas. TL queried why the finances were not flagged and shown as red. BW explained that it was not shown as red as the rating had stayed the same, and said that these ratings are about whether the risks have changed and not those that are an absolute priority or concern. TL suggested also including the top three risk areas that the CCG should be concerned about and any changes from the last report, as without this, governing body members might not focus enough on these key priorities. RH stated that given the pace of change and prioritisation, and to ensure we understand all the different programmes of work, that the level of information that governing body members receive, and the length of some papers, is excessive, which makes it too complicated for members to comprehend. RH asked whether a page limit could be applied to documents. CP said that she and BW had debated this and agreed somewhere in the region of between four and twenty pages. TS said that all members would welcome shorter papers, in particular on board pad, which the majority of members use. The Governing Body **noted** version 4.1 of the BAF report.	
17.	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report**	
17.1	JW introduced the EPRR annual report. He explained that there is a statutory requirement for an EPRR Annual Report to be presented to the CCG Governing Bodies. He stated that the report outlines the activity through 2015/16 relating to EPRR, and provides information regarding the NHS England assurance process, which deems the CCG complaint with the NHS England Emergency Preparedness Framework for 2015. JW outlined the following key areas of development during the year: • On-call Directors must meet identified competencies and key knowledge and skills for staff as outlined in the NHS England (London) assurance process. • CCGs to have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR • CCGs have an overarching framework or policy, which sets out expectations of emergency preparedness, resilience and response • Embed joint working and alignment across the 8 CCGs in NWL including confirmation of one SRO for all 8 CCGs. • To have a table top review of on call arrangements across NWL CCGs on the	

	7th September 2016 led by NHS England – NWL EPRR Lead • To reconvene the NWL CCGs' Resilience Forum The Governing Body **approved** the EPRR) Annual Report.	
18.	**Revised Statutory Guidance on Conflicts of Interest**	
18.1	BW presented the revised statutory guidance on Conflicts of Interest. He explained that the guidance supersedes Managing Conflicts of Interest: Statutory Guidance for CCGs, which was published in December 2014. BW highlighted the key requirements: • to have a minimum of three lay members on the Governing Body, in order to support conflicts of interest management • the introduction of a conflicts of interest guardian in CCGs. It is expected that CCG audit chairs will assume this role • Registers of Interest to include declarations from all staff (whether permanent, interim, consultants etc.) nil returns will be required. Inclusion of all of Practice partners / directors and managers where one such has a formal decision-making role in the CCG • strengthened provisions around decision-making when a member of the governing body, or a committee or sub-committee is conflicted • strengthened provisions around the management of gifts and hospitality, including the need for a publicly accessible register of gifts and hospitality covering all staff • strengthened provisions around the management of gifts and hospitality, including the need for a publicly accessible register of gifts and hospitality covering all staff • a requirement for all CCG employees, governing body and committee members and practice staff with involvement in CCG business to complete mandatory online conflicts of interest training • Quarterly reporting to NHSE on compliance and breeches, from beginning of Quarter 4 BW explained that the Audit Committees would oversee the development of a revised policy that combines CWHHE and BHH's current policies and creates a unified one for NWL CCGs; but subject to the Audit Committees' approval, a small reference group will be created to support the policy development. BW explained that the CWHHE Audit Committees would be considering the proposals in the briefing at their meeting on 15 September 16; and the final version of the policy, along with a detailed update and implementation plan, will be tabled at a future Governing Body meeting for approval. TL commented on the importance of having officers who are alert to these issues, and can identify conflicts, and asked if there was any evidence that people had inadvertently crossed an inappropriate boundary, and who should members contact for this type of advice, and whether that was something that the audit committee might consider as part of the review. JC said that the officer(s) present would need to take on board the responsibility; but would need to ensure this was made explicit and clear to other members that this was part of their role, and in doing this in a more formal way would be helpful for everybody, and to remind all of us of our responsibilities.	

	The Governing Body **noted** the revised statutory guidance on Conflicts of Interest	
19.	**Collaboration Board Report**	
19.1	CP introduced the summary update report. She explained that other areas of collaboration continue to be developed in a consultative manner before being taken to governing bodies for local decisions and /or adjustments. VA commented that in the Collaboration Board minutes, and said that under AOB it was reported that children's services in Hillingdon A&E needed to be expanded to accommodate the increase in demand, following the closure of the children's at Ealing hospital. VA said that additional funding was required, however having said that we were assured about the transformation of children's services, asked whether additional funding was now needed. CP explained that this comment was misleading and that there have been on-going conversations with Hillingdon for a long time and it has always been an intention to increase capacity in their A&E and the capital required to enable that to happen was available and the building work is complete. She said that conversations around additional staffing issues have been on-going for months and there was one element of funding where we had not given the final confirmation to the trust that the funding would flow. VA said that the minutes need to be amended when the collaboration board at the next meeting to reflect this explanation. BW agreed to have the minutes reviewed. The Governing Body **noted** the report.	**BW**
20.	**Any Other Business**	
12.1	There were no items of any other business.	
21.	**Questions from the public**	
21.1	JaC noted that no formal questions were submitted by members of the public to the governing body in advance of the meeting. The following questions were raised at the meeting. **Question 1 (Q1)** There have been some suggestions that Hammersmith and Fulham Council would be penalised due to lack of funding and lack of access to community health and asked for assurance that this was not the case. **Answer (Q1)** CP responded to the question posed and explained that it was not the responsibility of Hammersmith and Fulham Clinical Commissioning Group (CCG) to provide funding to Hammersmith and Fulham Council. It was, however, the CCG's responsibility to ensure that residents of Hammersmith and Fulham receive the best care and services needed. CP explained that through the STP there is an opportunity to access national funds which are not sitting at CCG level to enable us to deliver change. She said the CCG were keen for the council to work with them, but if they are not prepared to do so, that the CCG would do everything in its power to ensure it delivers services and improves the quality of care for its residents, but would prefer that the council worked with the CCG to deliver these services. **Question 2 (Q2)**	

	Article from the guardian was circulated by a member of the public on the "gap between funds and delivery is a chasm in the NHS: something has to give". A question was raised that acute services are vastly underfunded right now and have requested additional funding for extra local services to be delivered. **Answer (Q2)** CP responded to the question raised and clarified that Hammersmith and Fulham CCG do not have the power to set its own allocation. She explained that the CCG allocation is set by the government. It is then passed to NHS England who then decides how much is allocated towards specialist commissioning, primary care and how much goes to public health and the level of funding to be allocated to CCGs to commission local services. CP noted that once CCGs receive their allocation, they need to ensure that they obtain the best health outcomes within that financial envelope. CP said that the Financial Strategy clearly sets out what the CCG are trying to do, such as investing in out of hospital services, and will try to alleviate pressure away from acute services and treat people closer to their home in a more effective way. She explained that many people do not want to go into hospital unless they need to do so, and when they have to go to hospital, they want to be able to get home as quickly as possible. CP stated that in some parts of the country, CCGs have taken decisions to stop surgery for people who are overweight and to limit access to cataract surgery, hip and knee operations. She emphasised that Hammersmith and Fulham CCG have not done this, but this does not mean that the CCG cannot make its local strategy work. CP explained that Hammersmith and Fulham CCG are trying to deliver the best patient outcomes by treating people in a different way and support them to understand how they can influence their own health, and work with the voluntary sector to make this happen. She said that the CCG understands the out of hospital pressures, and are trying to reduce these pressures, but are mindful that there was not enough money in the health system to carry on with the current model of care. She said that the CCG would welcome more money but must do the best it can within the current budget allocation. James Cavanagh closed the meeting and thanked everyone for attending. He reminded everyone that the next meeting is scheduled for: Tuesday 8 November, between 3.00 – 5.30 pm, St Paul's Church, Hammersmith.	