

**Minutes of the Governing Body meeting held on
Tuesday 14 November 2017 3.00pm – 5.30pm
(Public)**

St Paul's Church, Hammersmith

Present

Name	Role	Organisation	Initials
James Cavanagh	Vice Chair/GP Member	H&F CCG	JCa
Vanessa Andreae	Vice Chair/Practice Nurse	H&F CCG	VA
Paul Skinner	GP Member	H&F CCG	PS
Trish Longdon	Lay Member	H&F CCG	TL
Jane Wilmot	Lay Member	H&F CCG	JW
Sena Shah	Practice Manager Member	H&F CCG	SS
Pritpal Ruprai	Co-opted GP Member	H&F CCG	PR
Clare Parker	Chief Officer	H&F CCG	CP
Keith Edmunds	Chief Financial Officer	H&F CCG	KE
Mary Mullix	Director of Quality and Safety	H&F CCG	MM
Ben Westmancott	Director of Compliance	H&F CCG	BW

In attendance

Name	Role	Organisation	Initials
Mark Jarvis	Head of Governance & Engagement	H&F CCG	MJ
Graham Terry	Interim Head of Partnerships & Development, Hammersmith & Fulham Council	London Borough of Hammersmith and Fulham	GT
Sue Pascoe	Deputy Director Quality and Safety	CWHHE	SP
Samira Ben Omar	Assistant Director of Patient Experience and Equalities	CWHHE	SBO

Apologies

Name	Role	Organisation
Tim Spicer	Chairman	H&F CCG
Tony Willis	GP Member	H&F CCG
Nick Martin	Lay Member	H&F CCG
Janet Cree	Managing Director	H&F CCG
Andy Petros	Secondary Care Clinician	H&F CCG

Minutes

Item	Agenda Item /Discussion	Actions
1.	Welcome, Introductions and Apologies	
1.1	JCa welcomed everyone to the meeting.	
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 meetings held on 12 September were approved as a correct record with the exception of the minute on page 5 relating to TL's comment in respect of changes being imposed on the CCG externally. She	

	<p>said that she was concerned that if the CCG did not demonstrate financial viability it was possible that others would do this on our behalf.</p> <p>The minutes of the meeting held on 26 September were approved as a correct record.</p>	
4.	Matters Arising	
4.1	There were no matters arising from either of the previous meetings.	
5.	Action Log	
5.1	<p>Action 0723 Financial Position. Action closed as reports provided to the Governing Body provide an over-view of the financial position and seminars were receiving finance and QIPP updates regularly.</p> <p>Action 0724 Business Plan. Action closed as initial update undertaken and proposals for reducing overall number of work streams to go to Governing Body seminar.</p> <p>Action 0722 Primary Care Strategy. It was agreed to delegate this to the Primary Care Commissioning Committee and for there to be a report back to the Governing Body in due course</p> <p>Action 0508 Last Phase of Life. Report was still pending.</p> <p>Action 0521 Tissue Viability. Report was still pending.</p>	
6.	Ratification of Chair's Action	
6.1	There were no items requiring ratification.	
7.	Report From the Chair	
7.1	JCa advised that as the Chair was not able to be present there would be no report.	
8.	Chief Officer's Report	
8.1	<p>CP introduced her report. She specifically highlighted the work that was being undertaken in respect of diabetes education through the development of on line applications and motivational video case studies. She said that the work was being led by Tony Willis. She highlighted the importance of using digital technology to support people to manage their conditions more effectively.</p> <p>SS sought confirmation that, in relation to the item on the General Data Protection Regulations, consent for sharing was covered in the local arrangements. BW confirmed that data sharing consent was covered.</p> <p>JaW advised the Governing Body that in relation to Information Governance there were four lay partners on the Information Governance Group. She sought clarification as to whether there was any lay involvement in the work being undertaken in respect of the Babylon on-line consultation programme. CP advised that the project concerned an assessment of a symptom checker in order to determine whether it would be a useful triage tool, with the aim of reducing workload. However, she said that testing had in fact identified that the number of people being advised to go to A&E increased and therefore the pilot had ceased. She also confirmed that this was different from the GP at Hand practice service although the technology developed by Babylon was the same but being used differently.</p>	

	<p>TL sought clarification on the progress being made with the reducing harmful drinking programme as she believed that progress had not been as good as set out in the report. CP said that training on prevention was being delivered and the business cases in relation to implement the NICE standards to have alcohol care teams in NW London hospitals were progressing with Ealing, Brent and Harrow being the early adopters. She said that role out into other areas would be taken forward as a second phase.</p> <p>The Governing Body noted the report.</p>	
9.	Managing Director's Report	
9.1	The Governing Body noted the report.	
10.	Review of the Transition of Children's Hospital Services in North West London	
10.1	<p>CP introduced the report. She said that the Governing Body was being asked to note the report. She reminded the Governing Body that the report had been commissioned following the changes to paediatric services at Ealing hospital and the establishment of a different model of care. She said that, overall, the report was positive and that there was evidence that the benefits originally envisaged were being realised. The report highlighted a number of recommendations for further work, for example, with regard to patient transfers and transport. CP advised the Governing Body that Ealing CCG had reviewed the report in detail and that it had been presented to the Ealing Overview and Scrutiny Committee.</p> <p>Members of the Governing Body welcomed the report. They wished for further clarification on outcomes of the Hillingdon modelling which appeared to put in more capacity than was actually needed. It was questioned as to whether this was sustainable given the overall financial position of the CCGs. CP confirmed that Hillingdon hospital had put in more capacity than was required. She said that this had been absorbed by the service and improvements in performance had been noted. She said that the modelling work on travel times and patient preference would be repeated and that it was acknowledged that a more flexible approach to capacity was needed. CP advised the Governing Body that there was an element of seasonality with paediatric activity. Consequently there were no plans to reduce the number of beds but that they would only be staffed as required.</p> <p>JW highlighted a concern that, within the STP, there was no agreement as to where discussions on patient transport should take place. She felt that this needed to be clearer, with a defined governance route and an emphasis on meeting the transport needs of patients following the shift of services from secondary to primary care. CP acknowledged that transport was not explicitly referenced in the STP. However, she suggested that if there was an appetite for this to be reviewed across North West London this could be taken forward. She said that at this time the transport advisory group that had been established as part of the SaHF programme had not been meeting as no major changes to the current arrangements were being taken forward.</p> <p>The Governing Body noted the report.</p>	
11.	Primary Care Update	

11.1	<p>TH introduced the report. He reminded the Governing Body that the primary care strategy had been approved in September and that since then the first phase of implementation had been taking place. These included revised primary care network configurations, the development of investment proposals and preparation of a business case to support these and the bid evaluation process. He asked the Governing Body to consider and approve the business case for investment.</p> <p>AW welcomed the additional investment for primary care. She sought clarification on how the impact of the projects would be monitored and how lessons learnt would be shared. TH said that in light of the priorities set out in the business case in relation to releasing capacity, increasing quality, improving collaboration between practices and improved clinical pathways it was expected that there would be a reduction in hospital activity in certain areas which would be monitored and evaluated closely. He said that all projects would have to demonstrate clear outcomes and that there would be shared learning within and across networks. KE confirmed that the Finance and Performance Committee had reviewed the business case and had recommended approval subject to the outcome of discussion at the CWHHE joint finance group.</p> <p>TH provided a briefing on the recent development with services provided by the GP at Hand practice. He acknowledged that there had been significant media and stakeholder interest in the services launched by the GP at Hand practice. He said that the service being offered provided comprehensive digital access to those patients who registered with the practice. He confirmed that, in line with the GP Choices policy, patients from outside of the practice catchment would be able to register. He said that the situation was being monitored closely and that the CCG was working closely with NHS England. He advised that the Primary Care Commissioning Committee was receiving detailed updates and seeking appropriate assurances in relation to patient safety, impacts on local practices and the local financial consequences of this development. TH confirmed that a clinical review of the service had been undertaken in advance of the service being launched and that this would be published as part of the Primary Care Commissioning Committee papers. The report had made a number of recommendations that were being pursued. TH also confirmed that the Care Quality Commission would inspect the provider in the usual way. He also reminded the Governing Body that the GP at Hand practice was a NHS practice, subject to the same regulations as all practices in contract with the NHS.</p> <p>TL assured the Governing Body that the Primary Care Commissioning Committee was particularly concerned about the patient safety aspects of the service and the impacts on other local practices and would be seeking assurances on these aspects in particular. She said that the Committee was mindful of the potential impact on the CCG's finance as more patients registered with the GP at Hand practice and that this needed to be flagged as a risk. TL wished to assure the public that the Committee would be seeking robust assurances about how the services was being delivered.</p> <p>AW sought clarification on where the new registrations were coming from.</p>	
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	<p>TH confirmed that the majority were from other CCG areas.</p> <p>PR asked how patient safety would be measured. TH said that the clinical review had been undertaken which had been satisfied on patient safety issues. However, in addition to the usual monitoring an evaluation of the service would be undertaken.</p> <p>The Governing Body approved the business case and noted the update on the GP at Hand service.</p>	
12.	Prescribing Wisely	
12.1	<p>MJ introduced the report. He reminded the Governing Body that at the July meeting of the Governing Body a request had been made for additional work to be undertaken on the equalities impact of the proposals in the prescribing wisely recommendations; that subject to the outcomes of the additional work providing assurance that appropriate mitigations were already in place or that additional mitigations had been agreed, the original proposal should be implemented. He advised the Governing Body that a period of five weeks additional public dialogue had taken place which had resulted in 88 responses and 481 comments. As a result of the comments made additional mitigation had been recommended. These were</p> <ul style="list-style-type: none"> • A widening of the groups that would be exempt from being asked whether they would consider purchasing medicines/products on the CCG list over the counter • Ensuring that communications were clear and unambiguous for patients that no one will be denied a prescription if the GP considers that a patient requires one or more of the medicines or products on the proposed list • Communication to and with GPs needs to ensure that there is no suggestion of a blanket ban on products on the list of over the counter medicines and that if they are in any doubt about a person's ability to pay then they should prescribe in the usual way • A strengthening of the communication to GPs, pharmacists and patients to make it clear and explicit that where a patient will not be able to put alternative arrangements in place that are safe and workable for the patient, their existing arrangements should be maintained <p>MJ advised the Governing Body that a report had been prepared for the Accountable Officers detailing the outcome of the additional public dialogue and putting forward the additional mitigations. The report had been reviewed externally by lawyers. MJ advised that the Accountable Officers were content to sign off the report and recommended additional mitigations as they were assured that the additional work undertaken had been satisfactory. MJ advised the Governing Body that they were being asked to note the additional work undertaken and the decision on the Accountable Officers.</p> <p>VA said that she was anxious that the changes in the repeat prescribing arrangements could have an impact on primary care workloads. PR said that many GPs had been talking to patients for many years about purchasing certain medicines and products over the counter. JW</p>	

	<p>commented that the patient leaflets were clear and concise and she commended the work of those involved in preparing them.</p> <p>The Governing Body noted the report.</p>	
13.	Finance	
13.1	<p>CCG Month 6 Report</p> <p>KE introduced the report. He advised the Governing Body that the CCG continued to report on plan both year to date and forecast outturn. He said that in relation to risks and opportunities there was currently a £1.24m net risk, which was a reduction on the £3.6m reported in the previous month and that the improvement was largely due to the additional work undertaken to give a more robust assessment of the balance sheet position, coupled with the requirements to reduce the level of gains to be released to balance the position in month. KE also advised the Governing Body that the underlying position was based on the forecast to deliver on plan, assuming delivery of the backended QIPP.</p> <p>GT sought clarification on when the planning would start for 2018/19. KE confirmed that a first cut plan should be presented to the Finance and Performance Committee later in the month.</p> <p>TL sought clarification as to whether the reference in the cover sheet to the annual budget updating placed any additional requirements on the CCG. KE confirmed that this was an expected costs and CP confirmed that this had been budgeted for at the start of the year and was 25% less than last year.</p> <p>The Governing Body noted the report.</p>	
13.2	<p>Report from the Finance and Performance Committee</p> <p>KE reported that the committee had met twice since the last Governing Body meeting and summarised the key items discussed as set out in the paper.</p> <p>TL raised concerns that the overall levels of QIPP assurance were quite low and was concerned that the required savings would not be achieved. She sought comment on what more could be done to achieve the level of QIPP required.</p> <p>CP said that it was important for the Finance and Performance Committee to focus its attention on getting all the assurance it needed in relation to QIPP delivery. She said that certain additional measures had been taken, noting that there was now a vacancy freeze and that all discretionary expenditure had been stopped. She said that further collaborative projects were being explored and that planning for 2018/19 had already started, with an emphasis on ensuring that systems and process were better aligned across North West London. She also said that there was a strong emphasis on making sure there was robust contract management and challenge where appropriate.</p> <p>VA commented that the Governing Body received regular updates on the</p>	

	<p>QIPP position through Governing Body seminars, the quarterly joint committee sessions and that there was an operational QIPP Delivery Group in place within the CCG which met fortnightly.</p> <p>The Governing Body noted the report.</p>	
14.	Integrated Performance Report	
14.1	<p>Month 5 Integrated Performance Report</p> <p>The Governing Body noted the report.</p>	
14.2	<p>Report from the Quality, Patient Safety and Risk Committee</p> <p>VA provided a summary of the items of business discussed by the committee in the previous two months. She highlighted two areas of escalation that the committee wished the Governing Body to be aware of – the increase in the number of long waiters being identified as part of the referral to treatment review process and the closure of the St Mary’s birthing unit. In relation to the latter point JaC said that the unit had now re-opened and that during the time it was closed people were given the opportunity to go elsewhere. He said that a lot of work had been undertaken to ensure that no one had been put at risk during the closure. TL welcomed the re-opening of the unit however she wished the Governing Body to be aware that during discussion at the Quality Patient Safety and Risk committee no assurance could be provided as to how long the unit would be closed and for this reason it was felt appropriate to escalate it to the Governing Body.</p> <p>The Governing Body noted the report.</p>	
14.3	<p>Report from the Joint Quality and Finance & Performance Committees</p> <p>The Governing Body noted the report.</p>	
15.	Board Assurance Framework	
15.1	<p>BW introduced the report. He advised the Governing Body that the local entries had been updated and provided a more comprehensive systemwide/CCG perspective. He highlighted that the risk appetite for risk 2.3 - evidence based quality improvement for small contracts – had been reduced. He asked Governing Body members to consider whether the risk score for 4.2 – mental health of children and young people – was correct in light of the differing approaches in each CCG. He also asked the Governing Body to consider whether, in light of the fact that there had been no changes in the risk scores of 5 risks, the further planned actions were adequate.</p> <p>TL raised concern about the progress with the development of the GP dashboard (referred to in risk 2.1). She said that this was important to have the dashboard in place but that although primary care had been delegated since April no quality reporting had been presented to the Primary Care Commissioning Committee. CP advised that there were in fact two dashboards. The one referenced in the BAF related to the practice facing dashboard and how the CCGs work with practices which was different to the quality dashboard that was being developed for delegated commissioning. MM advised that work was continuing on the quality dashboard, using exiting measures, and that it was to be piloted in Hammersmith and Fulham.</p>	

	<p>In relation to 4.2 TL said that when the risk had been reviewed locally there was no assurance on the appetite for change. She felt that there needed to be more action taken. CP agreed that consideration needed to be given to determine whether the right mitigations were in place to address the risk. She said that good work had been undertaken within Child and Adolescent Mental Health Services but that better assurances needed to be provided. In respect of adult mental health services CP said that work was on-going to look at how the CCG could be assured that value for money was being achieved the investments being made. She did not feel that the risk was sufficiently well enough defined for the risk that was trying to be mitigated.</p> <p>The Governing Body noted the report and agreed that risk 4.2 needed to be revised.</p>	BW
16.	Collaboration Board Report	
16.1	The Governing Body noted the report.	
17.	Subject Access Request Policy	
17.1	<p>BW advised the Governing Body that as a result of a gap in the Subject Access Request Policy in relation to information governance reporting a revised policy had been prepared.</p> <p>The Governing Body approved the policy.</p>	
18.	Safeguarding report combined adults and children 2016-17	
18.1	<p>SP introduced the report. She highlighted the report covered a range of areas including information on Looked After Children, Nursing Homes and Deprivation of Liberty Safeguards (DoLS). She highlighted that the Quality, Patient Safety and Risk Committee received regular reports throughout the year on all the information in the report.</p> <p>SP highlighted specific pieces of research that had been undertaken with nursing homes in relation to hydration and on the Mental Capacity Act in conjunction with the New Buckinghamshire University. In relation to DoLS she said that work was being done jointly with the Local Authorities and providers to help prioritise the assessments that needed to be undertaken and to ensure that they were completed comprehensively. She said that in 2018 there would be an audit within Imperial College Healthcare NHS Trust of DoLS referrals received to look at whether improvements can be made in order to deliver a more effective and timely service.</p> <p>The Governing Body noted the report.</p>	
19.	Annual Combined Patient Experience and complaints report 16/17	
19.1	<p>MM introduced the report. She reminded the Governing Body that it was a statutory requirement for the complaints report to be formally approved. She said that as in previous years a combined complaints and patient experience report was being presented. She said that the report highlighted that the main areas of complaint related to continuing health care and independent funding reviews.</p> <p>SBO said that the patient experience report summarised the themes and trends across providers which showed similar outcomes to previous years.</p> <p>GT sought clarification as to whether information should be included on the</p>	

	<p>number of complaints upheld, as was required within Local Authorities. MM stressed that it was important to look at the learning from complaints and the CCGs looked for evidence that this was in fact the case.</p> <p>In response to a question from JaC MM advised that it was difficult to identify themes in complaints received by the CCGs as they were few in number.</p> <p>The Governing Body approved the report.</p>	
20.	Any Other Business	
20.1	There were no items of any other business	
21.	Questions From the Public	
21.1	<p>Question 1</p> <p>We are concerned about the Fulham based Babylon smart App GP consultation service.</p> <ul style="list-style-type: none"> • Do you not think that such a service were it to become established could “cherry pick” relatively simple, discrete consultations leaving GPs with more complex and chronic care conditions? • Do you not think that this service could drain patient numbers from GP practice registers thus undermining the viability of already financially hard pressed services? • Are you not worried about the lack of published evidence that such a service could operate safely in the interests of patients? • What are the published CQC protocols showing how the safe running of such a service can be monitored? • How will a patient who is unsatisfied with the quality of the smart App service re-register with a GP surgery? • Is this not just another example of a private company being subsidised by the NHS for private profit while taking money from GPs? <p>Jim Grearly</p> <p>CP said that some of the points had been picked up during the discussion of GP at Hand earlier in the meeting. She emphasised that the GP at Hand service was not something that the CCG had commissioned and that the practice notified the CCG that they intended to put the service in place. She said that the contractual obligations had been reviewed to ensure that they were consistent with NHS contracting requirements and obligations of general practice. She stated that a clinical review had been undertaken to look at the model of service and that papers would be published with the Primary Care Commissioning Committee papers. She said that the service would appeal to a section of the public but not all. She confirmed that the review of the service that was to be undertaken would look at issue of “cherry picking”, the impact on other practices locally and the overall financial outcomes. She said that ultimately this was about patient choice.</p> <p>Mr Grearly questioned how it was that the service was allowed to start before the clinical review had been completed and before there was a better</p>	

	<p>understanding of the potential impacts. He was also surprised at the level and extent of marketing being undertaken. CP said that the service did not start before the conclusion of the clinical review and that the release of the review document was more a matter of timing. She said that the type of artificial intelligence that supported the service was safe and that it had been trialled in a number of areas nationally and in other health systems. She also acknowledged that there had been a very effect marketing campaign.</p> <p>Question 2</p> <p>2. This question relates to a personal issue, raised by one of our supporters, which seems to have wider ramifications. A patient with mental health difficulties, which led to him being off work and on half-pay i.e. he was not looking for a job, completed his prescription form inaccurately because he did not understand just which box was applicable. This confusion led to the issuing of a series of incremental fines as it remained unclear as to what he had done incorrectly. In the end, a total of £90 was paid. Surely there should be a more supportive system for checking eligibility for free prescriptions, not least for people with mental health problems and those without 'secure' English in this borough.</p> <p>Merril Hammer</p> <p>VA said that it would be inappropriate to comment on the specific case highlighted. However, she said that in general pharmacy staff have a responsibility to ask the patient to provide satisfactory evidence of entitlement to free prescriptions. If a patient is unclear as to which part of the prescription form to tick they should seek advice from the pharmacy staff at the time of presenting their prescription.</p> <p>Question 3</p> <p>3. SOC 1 for the implementation of the NW London STP has been 'referred back' to NW London CCGs. We understand that the core reason for not receiving £513 capital funding is that the evidence for such monies being spent in a way that would reduce the need for acute beds was poorly evidenced. SOH has been querying the status of the evidence for SaHF and the STP for many years now.</p> <ul style="list-style-type: none"> • What evidence do the CCGs have that might be acceptable to NHSI? When will it be made available to NHSI and to the public? • What are the implications of this rejection for future planning – not least for SOC 2? <p>Merril Hammer</p> <p>CP said that for the last 10 months we have been progressing a SOC 1 assurance process with regulators (NHSE and NHSI). This process had been an on-going iteration of questions and answers. She said that she had not seen or heard any reference from regulators suggesting that the reduction in the need for acute beds was 'poorly evidenced'. She said that a SOC by definition is a strategic case, with a limit to the detail that is</p>	
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normally provided at this stage. The usual process is that increasing detail is added at Outline Business case and Full Business case stages. CP commented that given the scale of investment being sought regulators were reasonably seeking an additional level of detail at the SOC stage.

CP confirmed that the SOC 1 had been approved by NHSE and the NHSI Resource Committee and that NHSI had recently made the following statement:

“‘Doing nothing’ is not a viable option in North West London. In Shaping a Healthier Future (SaHF), the NW London health and care system sets out a joined-up plan to deliver first-class health care for its population, and we support their commitment to do the right thing for their communities. A significant capital investment is needed in order to make the plans a reality, and SaHF remains a top priority for strategic capital investment in the London region.

“In our role as a system leader and regulator, it is right that we take time to properly scrutinise plans at every appropriate stage for a programme of this scale. As part of this scrutiny we have asked partners in the NWL health and care system to set out more clearly how they will work together to achieve some of the changes which Shaping a Healthier Future includes. There is no reason to think that this will have any impact on the timetable for delivering this important and much-needed change in North West London, or the capital funding for it, both of which will be subject to ongoing checks and assurances as this extensive programme moves forward.”

Questions 4 and 5

4. We have noted that the UCC in St Mary's but run by Vocare (or its purchaser!) rather than Imperial has been put into special measures. While we are aware that the commissioning of this was from the Central London CCG, it is also the case that NW London is looking to develop plans for greater collaborative commissioning in the STP.

- How is it that a private company can win a commissioning bid and be allowed to go into special measures?
- What oversight is there for checking the compliance of commissioned services?
- Given the concerns repeatedly raised by Imperial, how is it that these were not picked up and acted on by the CCG which commissioned the service?
- How can we have any confidence that, when commissioning is delegated to a joint committee, we will not face more such failures?

Merril Hammer

5. I want to ask about the poor performance of Vocare, the company which is running the UCC at St Mary's hospital, part of the Imperial College Healthcare NHS Trust.

H&F CCG is not responsible for the award of the contract for the UCC at St Mary's to Vocare. The "Central West London" CCG (as Kensington and Chelsea is called) was responsible for that decision and the contract with

<p>Vocare started in April 2016, I believe. But it is obviously extremely material to Imperial that the UCC has been performing badly and pulling down the figures for all types of A&E attendances at Imperial (Type 1,2 and 3) by making Type 3 so bad.</p> <p>Can I please ask H&F CCG as follows:</p> <p>(1) to "take note" of Vocare's poor performance in your discussion today and in the minutes?</p> <p>(2) to exercise any influence that you can to insist (by financial or other means) with CW London CCG that Vocare does reach the agreed performance targets or faces penalties for non-compliance?</p> <p>Una-Jane Winfield</p> <p>In relation to question 4 CP said that the original decision to put the service to procurement had been based on problems within the service and following a request by the Trust to put the service out to tender. Vocare had been appointed and had a positive track record in delivering this type of service. She recognised that there were issues with the service in relation to the physical environment which Central London CCG, as lead commissioner, was working with the provider to resolve. She said that quality concerns had been highlighted and that no new concerns had been highlighted by the Care Quality Commission. She confirmed that action was being taken to address these concerns. CP advised that Vocare had taken action and increased management capacity within the service which had seen a positive impact.</p> <p>Cllr Coleman asked how confident the CCG was in ensuring that the service was able to improve to an acceptable level. MM said that there were regular visits to the service, that the Care Quality Commission did not highlight any additional concerns and that work had been done to address the concerns that had been raised. MM reinforced the point that the provider had increased resources on site and were looking to make sustained improvements in line with an agreed plan.</p> <p>CP emphasised that there was on-going work with the provider to ensure that the service was able to deliver to a high standard. If a point was reached where improvements were not happening a decision would be taken on the future of the contract. In response to a question from Cllr Coleman about the timescale for withdrawing the contract CP said that a standard NHS contract was in place which set out the steps required to address poor performance, including the issuing of contract notices which had, in fact, been sent to the provider. She said that ultimately if there is no improvement the contract can be withdrawn.</p> <p>In relation to question 5 SR said that the 4 hour type 3 performance at the St Mary's UCC for the past 3 months was:</p> <p>Aug 2017 97.03% Sep 2017 96.91%</p>	
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	<p>Oct 2017 98.06%</p> <p>She said that it was worth noting that a new senior team had been in place since July 2017 and that there had been improvements in performance and improvement in the service delivery over the past 3 months.</p> <p>SR said that there were monthly governance meetings between St Mary's and Vocare and that these focused on specific areas to improve the UCC patient pathway. There had already been considerable improvements implemented on the streaming process and further work was underway to reduce and improve the process of referrals and redirects back to A&E.</p> <p>SR said that both Imperial and Vocare had recently agreed a joint improvement plan to deliver a high quality of urgent and emergency care. The progress of this was being monitored on a weekly basis. Additionally, monthly contract meetings take place between Vocare and Commissioners, where Key Performance Indicators were monitored and the contract process followed as required.</p>	
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