Healthy Future

NHS Hammersmith and Fulham Clinical Commissioning Group

Minutes of the Governing Body meeting held on Tuesday 12 January 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
Vanessa Andreae	Interim Vice Chair/ Practice Nurse Member	H&F CCG	VA
James Cavanagh	Interim Vice Chair/GP Member	H&F CCG	JCa
Tony Willis	GP Member	H&F CCG	TW
Paul Skinner	GP Member	H&F CCG	PS
Zohreen Ashraff	GP Member	H&F CCG	ZA
Michele Davison	GP Member	H&F CCG	MD
Christine Elliot	Co-opted GP Member	H&F CCG	CE
Samia Hasan	Co-opted GP Member	H&F CCG	SH
Trish Longdon	Lay Member	H&F CCG	TL
Jane Wilmot	Lay Member	H&F CCG	JaW
Philip Young	Lay Member	H&F CCG	PY
Paul Ferguson	Practice Manager Member	H&F CCG	PF
Alan Hakim	Secondary Care Consultant	H&F CCG	AH
Rohan Hewavisenti	Lay Member	H&F CCG	RH
Clare Parker	Chief Officer	H&F CCG	CP
Jonathan Webster	Director of Quality and Safety & Secondary Care Nurse Member	H&F CCG	JW
Janet Cree	Interim Managing Director	H&F CCG	JC

In attendance

Name	Role	Organisation	Initials
Ben Westmancott	Director of Compliance	H&F CCG	BW
Mark Jarvis	Interim Company Secretary	H&F CCG	MJ
Kathleen Sadler	Deputy Managing Director	H&F CCG	KS
Eva Hogan	Deputy Chief Finance Officer	H&F CCG	EH
Rachel Tustin	7 Day Service Programme Lead	CWHHE	RT

Apologies

Name	Role	Organisation
Susan McGoldrick	Vice Chair/GP Member	H&F CCG
Keith Edmonds	Chief Finance Officer	H&F CCG
Paul Skinner	GP Member	H&F CCG
Peter Fermie	GP Member	H&F CCG
Samia Hasan	Co-opted GP Member	H&F CCG

Minutes

Item	Agenda Item /Discussion	Actions
1.	**Welcome, Introductions and Apologies**	
1.1	The Chair welcomed everyone to the meeting.	
2.	**Declarations of Interest**	
2.1	MD wished her interest in North End Medical Centre be formally noted in relation to item 12. No other interests were declared other than those already recorded.	
3.	**Minutes of the Previous Meeting**	
3.1	It was noted that AH and RH had been present at the previous meeting. The minutes were **approved**.	

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4.	**Matters Arising**	
4.1	There were no matters arising from the minutes.	
5.	**Action Log**	
5.1	The Governing Body noted that all actions had been taken forward and agreed that they should be closed.	
6.	**Ratification of Chair's Action**	
6.1	TS reported that he had signed off the collaboration agreement document in respect of London devolution. He confirmed that no decision makingresponsibilities were devolved as part of the agreement. TS advised the Governing Body that he had taken Chair's action for the award of contract in respect of financial support to the work required on the implementation business case. The Governing Body **ratified** the action taken by the Chair. TS sought Governing Body approval to take Chair's action in respect of the decision to go out to procurement for the community independence service subject to agreement from the finance and performance committee. The Governing Body **agreed** that Chair's action should be taken in required because of timing.	
7.	**Chairman's Report**	
7.1	TS advised the Governing Body that the CCG had now received its allocation for 2016/17 and indications for the years up to 2020/21. He said that the allocation reflected the changes in capitation equalisation that was being moved forward across CCGs. For Hammersmith and Fulham 2016/17 would effectively be a less than stand still budget. TS highlighted the increasing emphasis that was being placed on managing the local workforce. He indicated that at the members event later in the day there would be a presentation on the role of pharmacists in primary care. He said that there would also be a significant change in how medicine is practiced in the future with the focus on genomic medicine. TS said that Health Education North West London was offering bursaries for people interested in working in this area. TS reported on the working together event that took place on 14 December. He said that it have been a very positive joint engagement event with the London Borough of Hammersmith and Fulham and that it was a key part of the CCG's strategy for working more closely with local people. TS highlighted the work that had been done on the joint needs assessment of end of life care. He said that it coincided with work that the CCG was taking forward on the last phase of life. He said that the CCG had made a bid for social enterprise finance in respect of this area of work and were awaiting the outcome of this. TS reported that the CCG had been shortlisted for a national initiative with public health on working with people at high risk of developing diabetes. TS reported that following the nomination process that took place before Christmas for Governing Body membership five nominations had been received for five vacancies. He said that the advice received from the Electoral Referral Service, who undertook the process, was that it would not be necessary to proceed to an election subject to confirming that all nominees met the eligibility criteria. He confirmed that this had been checked and all were eligible. He said that three current members would be continuing on the Governing Body – Paul Skinner, Tony Willis and himself. There would be two new members – Dr Amy Wilson, a salaried GP at 82 Lillie Road practice and Sena Shah, practice manager at North End Medical Centre. These appointments would take effect from 1 February	

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	TS advised that Governing Body that this would be the last Governing Body meeting for Michele Davison and Paul Ferguson. He said that in addition to being on the Governing Body both had contributed to work on various committees. Michele had also provided a significant contribution in respect of child health. TS thanked them both for their contributions. TS reminded the Governing Body that both Philippa Jones and Abigail Hull, the permanent Managing Directors were currently on maternity leave and had taken the decision not to return to the role of Managing Director. He said that an advert for the role would be issued later in the week. The Governing Body **noted** the report.	
8	**Chief Officer's Report**	
8.1	CP introduced her report. She highlighted that the clinical board of the CCGs was currently reviewing the report prepared my Michael Mansfield QC. She also said that the CCG would receive a paper on the report commissioned from Professor Welbourne at a future meeting. CP noted that the junior doctors were on strike as the meeting was taking place. She said that local Trusts and GP practices were managing the situation and maintaining safe services for the public. CP advised the Governing Body that James Riley, Central London Health Care Trust, had taken retirement on ill health grounds and that Carolyn Regan had taken up her post as Chief Executive at West London Mental Health Trust. The Governing Body **noted** the report.	
9.	**MSK Contract Award**	
9.1	KS provided an overview of the contract awards being presented to the Governing Body. She advised the Governing Body that all contracts had been subject to a transparent and non-discriminatory procurement process that determined which bid provided the optimal combination of service quality and bid price within the affordability envelope set by the CCG. She confirmed that the outcome of the three processes had been scrutinised in detail at the Finance and Performance Committee which had made its recommendation regarding contract award at a confidential Governing Body meeting. The recommendation was made at a private Governing Body due to the commercial nature of the information provided by bidders as part of the process. KS said that the Governing Body had therefore undertaken a comprehensive review of the information in private and would now be taking the decision in public. In respect of musculoskeletal service KS advised that: • Procurement of a new service took place following a service re-design process across NWL that resulted in a new service specification and clinical pathway. • Currently, the commissioned service provided community physiotherapy, assessment and treatment of more complex MSK conditions and some pain management in the community. The newly procured service had a wider scope in conditions it would see, including more pain management and rheumatology • The procurement process secured Connect Physical Health Centres as the provider of the new service. • The contract value wass £6.7M over the three year contract period KS confirmed that mobilisation of the new service would start in May and that patients in the existing service would be picked up by the new service as part of the mobilisation plan.	

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	The Governing Body **approved** the award of contract.	
10.	**Community Cardio-respiratory Contract Award**	
10.1	In respect of the Community Cardio-Respiratory service contract award KS advised the Governing Body that: • a community respiratory service was currently commissioned, however this did not include community based cardiology services • neighbouring CCGs (West London & Central London) had started a community cardio-respiratory service in April 2015 and feedback received from local GPs and patients had indicated that community based cardiology provision was also required in Hammersmith and Fulham. • The procurement process secured Imperial College Health Care Trust as the provider of the new service • The contract value was £6.1M over the three year contract period. The Governing Body **approved** the award of the contract.	
11.	**Neuro-rehabilitation Contract Award**	
11.1	KS advised the Governing Body that the contract for neuro-rehabilitation service was for a new level 2 specialist neuro-rehabilitation service. She said that this was being commissioned across 3 CCGs (West London, Central London & H&F CCGs). She highlighted that: • This was a new service for the CCGs which built on the current interim level 2 service provided by Imperial College Healthcare Trust since November following the transfer of the service from University College London Hospitals Foundation NHS Trust. • The business case for the new level 2 service was based on recognition of a gap in provision of neuro-rehabilitation services locally within the 3 boroughs. • The new level 2 service was based on a national specification for this type of provision but would develop this model to combine bedded provision with a community based outreach service. • The procurement process secured Imperial College Health Care Trust as the Lead Provider for provision of the service, working in partnership with Hillingdon Hospitals NHS Foundation Trust and Central London Health Care • The contract value was £3.59m per year across the 3 CCGs of which Hammersmith and Fulham's funding was £1.1M per year. • The contract duration was for three years. The Governing Body **approved** the award. TL wished to highlight that for all three procurements there had been good levels of user and patient involvement, which had added significant value to the process. JaW sought clarification on how the contracts would be monitored. KS said that the arrangements were currently being confirmed. Where contracts have been awarded to existing providers she said that monitoring would be added to current arrangements whilst specific arrangements would be put in place with the new provider for MSK services. TS thanked those involved in the three procurements and said that the MSK and cardio-respiratory services would provide an increase in locally available services and that the neuro-rehabilitation service provided dedicated beds for local people with a community element. He felt that this would provide improved outcomes for local people and that the development had sound clinical and economic benefits.	
12.	**PMS Review**	
12.1	JC introduced the paper. She reminded the Governing Body that Personal Medical Services (PMS) contracts had been used as a vehicle to provide additional services for local people within practices who had opted to become PMS practices. She said that following guidance that PMS practices should be reviewed, NHS England had begun a process of review that needed to be completed by the end of June 2016.	

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	She said that the purpose of the review was to determine whether current arrangements within PMS practices were providing the best value for patients. JC advised the Governing Body that there was only one PMS practice in Hammersmith and Fulham and that the review would be undertaken jointly with NHS England. Going forward she said that it was intended to ensure that all practices should be offered the opportunity to provide a range of additional services in order that provision was more equitable for patients. She said that because the resources available for this would come from existing PMS expenditure it would impact on North End Medical Centre, the single PMS practice within the CCG area. However, transitional relief would be available. She also advised the Governing Body that, in order to offer the mandatory elements to all practices, additional investment would be required. JC advised the Governing Body that in order to address the conflict of interest issue associated with taking a decision as to whether to invest additional resources, it was proposed to establish a committee of the Governing Body that was made up of non-conflicted members. TL welcomed the approach to ensure that all patients had equal access to services, recognising that even if not all practices delivered the services themselves patients would be able to access them from other practices. She welcomed the fact that this would also provide consistency across North West London. She said that it was important to do this in a way that was consistent with the financial position. PY agreed and sought clarification on the timing of the proposed non-conflicted committee. JC advised that the detail was being worked through with NHS England in order to ensure all discussions that needed to take place had happened in advance of the committee meeting. HP said that it was hoped to have a meeting in early February. RH supported the approach. However, he raised concern about whether core services would be affected as a result of practices concentrating on the additional services for which they would be getting additional resources. HP said that this would be closely monitored by NHS England and the CCG through a range of key performance indicators. The Governing Body: **Noted** the background to and rationale for the PMS review; **Endorsed** the NWL principles for the PMS review; **Endorsed** the progress to date made on CCG commissioning intentions and **Approved** the delegation of the ability to approve additional CCG investment into the premium specification to a CCG non-conflicted committee .	
13.	**Seven Day Services**	
13.1	RT introduced the paper. She reminded the Governing Body that, as a sector, North West London accepted the opportunity to be a national first wave delivery site for the new acute seven day services programme. As part of the programme local acute Trusts had agreed to achieve delivery of the four prioritised clinical standards by April 2017. She said that progress with the standards was being made and that the latest position was summarised in the paper. AH suggested that the gap analysis in respect of the time to first consultant review standard of being met by 30% of sites was likely to be an under-representation at some sites. TL sought clarification on the assessment of the diagnostics standard in view of the concerns that had recently been raised within the quality committee about these services. RT said that from the self assessment data provided Trusts were meeting the requirement for urgent/critical patients to receive diagnostics within 24 hours. Trust had acknowledged that this was not necessarily the case for other patient	

	groups. She said that there was a clinical improvement group for radiology which was looking at ways to ensure improvements in treatment times. VA raised concern that there was nothing in the standards that addressed the issue of safe discharge and improving the overall patient journey. RT said that this was being addressed as part of the delivery of all of the standards, of which there were10 in total. Standard nine was looking at the safe movement of patients between acute and community settings. She said that a lay partners working group was being established to look at discharge issues and that work was being undertaken to design a common needs assessment referral form. The Governing Body welcomed the progress being made and wished to see future updates that put progress being made into the wider context of work being undertaken across the local health care system. The Governing Body **noted** the report	
14	**Patient and Public Engagement Update**	
14.1	TL introduced the report. She highlighted the work being done on the stay well this winter campaign, the progress being made with the community grant initiative and the work being done on reviewing and setting new equalities objectives. The Governing Body **noted** the report.	
15.	**Finance**	
15.1	15(i) CCG Month 8 Report EH presented the report. She advised the Governing Body that at month 8 the CCG was reporting a surplus of £6.10m and was on target to deliver the planned £9.5m surplus at year end. She highlighted that acute Trusts were over performing by £5.43m in the year to date and were forecast to be £7.34m overspent at the year end. This represented a worsening of £0.85 on the previous month. EH advised that acute reserves had been released and mitigated the overspend in part. EH reported that the underlying overall position had worsened by £0.41m in the month reflecting the slippage in mental health investments . The CCG was £1.07m away from the planned position for 2015/16. In relation to risk EH advised that the CCG had identified risks of £5.24m. Mitigation totalling £5.18m had been identified, leaving a small risk of £0.6m which could be managed through the CWHHE risk share. VA sought clarification as to whether there were any plans to move away from the payment by results contract as this mechanism was more costly than a block arrangement. EH said that options were currently being considered as part of the contracting discussions. The Governing Body **noted** the report. 15(ii) Escalation Report ZA advised the Governing Body that there were no items for escalation. 15(iii) Shaping ad Health Future Month 7 Report EH introduced the report. She said that there was now a strong indication that Harrow CCG would now only require £2.5 of the support previously agreed. However, she indicated that it was likely that £2.5m would be required to support the Trust modelling for the Implementation Business Case.	

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	The Governing Body **noted** the report. 15(iv) Financial Planning 2016/17 – 2020/21 EH provided a briefing on the planning guidance. She said that a key elements of the guidance was the requirement to produce an operational plan and a five year sustainability and transformation plan. She advised the Governing Body that the CCG had received its allocation for 16/17 and details of allocations up to 2020/21. These would be lower than had historically been the case as the CCG was moved closer towards its capitation position. PY sought clarification as to what was happening to running costs and the target for primary medical services. EH said that the running costs would be the same as before. However, because it was based on a head of population calculation and there had been population growth there was in effect less money overall. The sustainability and transformation plan would be used to help deliver financial balance. In terms of primary medical services she said that work was only just starting in relation to identifying the full extent of spending on local people. TL said it was very positive to have financial planning in place. She wanted to ensure that there would be opportunities for local people to be involved as things progressed. EH said that various workstreams would be included as the year progressed. CP also confirmed that there would be work across North West London that would contribute e.g. Like Minded and that these programmes would include public engagement. The Governing Body **noted** the report.	
16.	**Performance**	
16.1	VA introduced the report. She said that the Quality and Finance & Performance Committees were now meeting jointly to review the integrated performance report. She advised the Governing Body that the report highlighted the areas that had been discussed and that there had been no items identified as requiring escalation to the Governing Body. PY asked for and update on the A&E position over the Christmas period. CP said that generally performance had been good across North West London. Activity had been broadly the same as last year. Admissions were up year on year. Over the New Year period she advised that Imperial College Healthcare Trust and Chelsea and Westminster had coped whilst Hillingdon hospital had face a number of challenges. TL wanted to understand whether the underperformance against the maternity metrics were linked to the Ealing maternity closure, whether there was anything stopping progress being made on the community independence service and some assurance on actions being taken in respect of ambulance hand over delays. In relation to maternity ZA commented that she did not feel that there was a direct link to the Ealing closure. She said that the indicators were positive and that there was a plan in place to achieve consultant hours. CP reminded the Governing Body that the intention was to move towards 260 hours of cover. She said that work was on going with all Trusts to determine time lines for achieving this. She said that midwifery ratios had improved as had overall data completeness. In relation to the community independent service it was noted that the planned re-procurement had been delayed and that final decisions on this would be taken by the Chair under delegation approved earlier in the meeting. JC said that in respect of ambulance handover delays there was work being done to	

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	look at the current pathway as Imperial College Healthcare Trust believed that the number of breaches had been over stated. JW advised the meeting that the Collaborative Quality and Performance Committee would be having a deep dive on London Ambulance Service Trust in late January. The Governing Body **noted** the report.	
17.	**Board Assurance Framework**	
17.1	BW introduced the report. It was noted that once further work had been done, and risks reviewed based on a full understanding of the actions taken to mitigate the risks, there could be some adjustment to the scores. The Governing Body **noted** the report and **agreed** that all current risks should be reviewed.	
18.	**London Devolution Update**	
18.1	CP summarised the key elements in the report. She advised the Governing Body that the pilot areas would now be working on the detail of devolution options. She said that if the pilots were considered successful it would enable others to adopt the same principles in order to move forward with wider devolution. The Governing Body **noted** the policy.	
19.	**Patient Outcome Committee Terms of Reference**	
19.1	BW introduced the proposed terms of reference for the new Collaborative Quality and Performance Committee. He said that these would be further refined as the committee began to meet and undertake its business. He sought approval from the Governing Body of the establishment of the new committee and the dissolution of the previous committees once they had completed their remaining pieces of work. He said that there would be stronger lay representation on the committee and that discussions were continuing in relation to whether the committee would have input in respect of financial review. PY supported the increase in lay representation on the committee. He advised that the Hounslow CCG Governing Body meeting had suggested that there should also be public representation on the committee. He felt that the changes would leave a gap in relation to the scrutiny of financial and procurement issues which would need to be addressed. JaW sought clarification on the relationship between the new committee and the local quality committee. BW said that local committees would be asked to identify what issues might benefit from a wider, collaborative discussions which could be referred to the new committee. VA asked whether the local quality committees would still have the opportunity to escalate issues to the new committee. JW said that across the CCGs local committees have used the escalation arrangements to the current CWHHE quality committee differently. There was still a line of escalation within the terms of reference however, CP felt that the new committee should be the place where key strategic discussions that affect all CCGs take place collectively. She hoped that local committees would either be able to resolve issues themselves or seek support from relevant teams/colleagues to support resolution. VA expressed concern that there is often a time lag with things being discussed at the current collaborative quality committee once things have been highlighted by local committees and hoped that this would improve with the new arrangements. It was agreed to **approve** the terms of reference not withstanding the points highlighted with regard to escalation and time delay concerns which would need to be addressed as the new committee began its work.	
20.	**Changes to Governance of Health and Safety Across CWHHE**	

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20.1	BW introduced the draft terms of reference. The Governing Body **approved** the terms of reference.	
21.	**Revalidation of Nurses**	
21.1	JW introduced the paper. He advised the Governing Body that all nurses would be required to revalidate their registration from April 2016. He said that the CCG needed to provide support to nurses in primary care and their employees in order to ensure that they can achieve revalidation. The Governing Body **noted** the paper	
22.	**AOB**	
22.1	HP reminded the meeting that the CCG had established a new primary care co commissioning meeting which would meet in public. The dates were published on the CCG website.	
23.	**Questions from the public**	
23.1	Q1. Jim Grealy submitted the following question. A recent Freedom of Information request, publicised in national media, has revealed that Hammersmith and Fulham CCG has paid £107,600 to GP surgeries to NOT refer patients for specialist assessment/treatment. He wanted to know: • How many surgeries in H&F are receiving payments for non-referrals? • What kinds of conditions/treatments might be included in the non-referral? • Are cancer diagnoses/treatments part of this payment for non-referrals, specifically given that the UK has the worst survival rates for cancer in Western Europe, largely due to late diagnosis? • Do non-referrals have a later impact on the number of patients later admitted to A&E? • Do these payments not amount to an inducement to GPs to behave unethically (as suggested by the GMC)? • How can patients know whether their non-referral is a result of these payments? • How is the CCG monitoring the use of such payments, ensuring that patients are not victims of these payments, and how are the public to be informed about the operation of such payments? TS said that this had been discussed at the Patient Reference Grouped. He said that the CCG was not trying to hide anything and that the arrangements in place were about encouraging practices to refer effectively. Q2. Anne Drinkell submitted the following question. The data presented in the Integrated Quality and Performance Report with Patient Safety (16(I) indicates a serious lack of capacity within the local accident and emergency systems. With below target performance at Imperial for month 7 and anticipated poor performance in month 8. Could you clarify the results on the most recent data for Imperial in particular for type 1 patients - the most unwell? Could you also clarify the outcome of the meeting on 21st December between CCG and Imperial NHS Trust on this issue? In particular the status of the Remedial Action plan and the 2% withdrawal of trust monthly income. I note that there were there were 214 breaches of the 30 minute handover standard in month 7 by LAS at Imperial NHS Trust Hospitals. Could you provide the latest data on LAS breaches please? SAHF is predicated on a speedy, effective patient transfers - 3 years on why has	

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there been a deterioration in service? Will the CCG reconsider plans to close A&Es as proposed by the Mansfield Commission given these problems?

CP said that it was important to understand that the national measure is for all types of attendance. The national standard is 95% of people having need seen and a decision taken on their care within four hours. She said that there were sub sets of data for types 2 and 3 and that Trusts measured these in different ways. She acknowledged that there had been some deterioration in the Imperial position although it was not possible to compare this performance on a like for like basis across the country. The only consistently reported measure was for all types of attendance. CP said that the validated month 7 data was not currently available. She said that in general North West London had been performing better than the London average.

In respect of the meeting on 21 December CP said that this was an opportunity to go through the detailed challenges being faced by the Trust. Performance improvements had been agreed in relation to Charing Cross which included an increase in the number of majors cubicles and joint work on discharges and improvements in the systems and processes. She said that the trajectory for getting back to delivering the 95% standard had not yet been agreed. She confirmed that the remedial action plan was outstanding and therefore the 2% was being withheld until this was in place.

CP reminded the meeting why A&E services had been closed. The action had been taken on safety grounds. However, this was before the full range of out of hospital services could be made available. She also reminded the meeting that the Governing Body had previously received a report that did not support the position that the changes had led to a reduction in overall A&E performance and that there were a number of contributory factors. She confirmed that there were no plans for any other A&E closures. She said that the Secretary of State had given a clear message that access needed to be maintained however this did not need to be in the same configuration.

CP confirmed that the clinical board was reviewing the Mansfield Report.

In response to a further question about the impact of the changes on ambulance performance CP said that the report that the Governing Body had previously considered had indicated some issues at Northwick Park because of bed issues but that this was now being addressed with additional beds becoming available.

Q3. Merril Hammer submitted the following question. How does the CCG monitor referrals from GPs and other NHS bodies to hospital services to ensure that referrals are followed through in a timely fashion?

She went on to say that she was asking this question based on personal experience. She had been referred, by the GPs with Special Interest service, to Chelsea & Westminster dermatology department for skin cancer treatment, after the GP treatment had not worked. The GPSI follow-up appointment was on 2nd Sept 2015. The referral was made on 7th Sept and the Parsons Green Centre had confirmation that the fax had been received on 14th Sept by Chelsea & Westminster Hospital (C&W). The referral asked for an appointment soon after 14th Dec, as she was unavoidably abroad.

On her return, there was no information from C&W. She contacted the Parsons Green Centre and was given the above information about the referral and asked to phone C&W. She did this, only to be told that there was No record of a referral. Merrili again contacted Parsons Green who confirmed that they had a record of the above referral but would re-refer, with the suggestion that she call C&W again in the

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week following Christmas.

Merril did this and was initially then offered an appointment in April 2016 – 7 months after the initial referral. This is an unacceptable timetable for any condition but seems an extraordinary response to a facial skin cancer.

Merril did, in fact, after protesting, get an appointment for this week – but if she had not phoned and had not protested, she would have been left waiting for the 7 months – or, had she not myself followed up the referral, might have waited indefinitely.

Merril said that normally, she might well have referred this to C&W PALS as an individual complaint. However, when she spoke to the very helpful receptionist at Parsons Green, she was told that there have been a significant number of referrals, confirmed as received by C&W, which have, in fact, not been actioned. Hence her.

TS suggested that, in view of the individual nature of the issue raised that this be looked into further and direct contact made with Merril.

Q4. Suzanna Harris raised the following question. I had an MRI scan a few months back and was then referred to the Musculo-skeletal section at Richford Gate. The appointment letter asked me to bring my scan results. I asked at my GP practice for these to be faxed to Richford Gate and was told that this was not possible; I should visit the practice and I would be given a paper copy to take to my appointment.

Recently I asked at the GP practice why scan results could not be faxed directly to the clinic. I was told that in fact they could be, but only at the direct request from the clinic, not from the patient. Why was I not told this at the outset ?

It seems to me that appointment letters should state this clearly. It is as quick for results to be faxed direct as to print out a copy for the patient to take. This vital information will then arrive safely at the clinic; and it is obvious that without it the clinic appointment is a waste of the practitioner's and the patient's time.

Patients can lose papers and forget them; if they are faxed this removes the worry of finding and remembering to take them at a time when they may be stressed anyway.

Why can results not be faxed routinely to a clinic where a patient has been referred?

By way of contrast, at Richford Gate I was asked to request a disk of the MRI scan images from the scanning clinic, to take to my appointment with Neuro-Surgery at Charing Cross. I was told the images would be emailed directly, and I received a confirmation email. This is how it should be done. The scanning clinic was a private one (to which my GP referred me). I am totally opposed to privatisation; but the NHS should emulate this standard of effective communication.

Please do all you can to update and streamline communication methods between patients and the different professionals involved. It is essential for getting the best diagnoses and treatment, and would reduce costs.

TS acknowledged that this had not been a good experience and said that best practice was to move away from fax communication. He agreed that the experience at Richford Gate should become the norm for the future.

Q5. A question was raised in relation to the decision making process in respect of

	having a payment by results contract and whether there were opportunities for commissioners to negotiate that internal referrals were not charged for. CP said that paying for activity as it happens was working relatively well for planned care. However, she said that it did not work so well for emergency/unplanned care. In these services costs were driven more by the staff needed to deliver the services rather than activity. She said that the decision to use the payment by results approach was the result of negotiation between commissioners and providers. In respect of internal referrals CP said that the CCG was looking at different models in respect of this element. Q6. A question was asked in relation to the London devolution agreement, in particular when it had been decided and what the anticipated outcomes would be. CP said that discussions had been going on across London since April/May last year. She reminded the meeting that this had been brought to a previous Governing Body meeting. She said that there had been expressions of interest and that some pilot sites were being put forward. She confirmed that none of the pilots would be in North West London. Merril commented that there was a significant democratic deficit in the proposals as local people had not been involved. TS said that nothing in the NHS constitution had changed as a result of the devolution discussions. The CCG still had responsibility for commissioning for local residents.	

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