Kingston Clinical Commissioning Group

GOVERNING BODY

LEAD: Tonia Michaelides – Head of Commissioning and Delivery	**ATTACHMENT:** K
REPORT AUTHOR: Charles Alessi – GP Clinical Lead	**AGENDA ITEM:** 10
RECOMMENDATION: The Governing Body is asked to note the report.	**MEETING DATE:** 12th June 2012

SYSTEM SUSTAINABILITY BOARD (SSB)

EXECUTIVE SUMMARY:

The System sustainability Board was set up to by the Clinical Commissioners and Kingston Hospital Trust to try to improve relations between Clinicians from all segments of the health system and try to achieve a common understanding as to how to promote sustainable development of the differing parts of the health and social care continuum.

It has been meeting over the past few months and this paper is an update of progress to ensure the Kingston CCG is kept appraised of developments and to seek views as to how the systems that are being put in place can be improved for the benefit of our population.

KEY SECTIONS FOR PARTICULAR NOTE:

The following areas have been identified as worthy of focus to try to see if it is possible to promote a more cost efficient solution to a particular problem maintaining at all times the quality of the service delivered. These areas have been identified through some joint working between the Clinical Commissioners and Kingston Hospital mediated via Public Health in Kingston.

These areas comprise:

- High Cost Drugs
- Urgent Care
- Cardiology
- Care of the frail older people with long term conditions
- Future models of care around the intact including outpatients

RECOMMENDATIONS:

The Governing Body is asked to note the progress made to date.

RISKS IDENTIFIED:

No risks have been indentified to date but these will be tracked as the recommendations are implemented

FINANCIAL IMPLICATIONS:

NATIONAL DOMAINS - TOWARDS AUTHORISATION:

All papers to the CCG are assumed to be evidence towards authorisation.

Please indicate below all the domains which the paper provides evidence for

☒ Clinical focus adding value
☐ Patient, carer, community engagement
☐ Planning and QIPP delivery
☐ Corporate and clinical governance incl. non financial risk management
☒ Finance incl. financial risk management
☒ Collaborative or joint commissioning, commissioning support
☒ Leadership

If not, please explain below:

EQUALITY IMPACT ASSESSMENT:

None.

PRIVACY IMPACT ASSESSMENT:

No PIA issues were identified as no personal data was used whilst compiling this report.

Position Paper to Kingston CCG

SYSTEM SUSTAINABILITY BOARD (SSB)

Charles Alessi

6 June 2012

1. Scene setting

The System sustainability Board was set up to by the Clinical Commissioners and Kingston Hospital Trust to try to improve relations between Clinicians from all segments of the health system and try to achieve a common understanding as to how to promote sustainable development of the differing parts of the health and social care continuum.

It has been meeting over the past few months and this paper is an update of progress to ensure the Kingston CCG is kept appraised of developments and to seek views as to how the systems that are being put in place can be improved for the benefit of our population.

2. Areas of interest and focus

The following areas have been identified as worthy of focus to try to see if it is possible to promote a more cost efficient solution to a particular problem maintaining at all times the quality of the service delivered. These areas have been identified through some joint working between the Clinical Commissioners and Kingston Hospital mediated via Public Health in Kingston.

These areas comprise:

High Cost Drugs

Urgent Care

Cardiology

Care of the frail older people with long term conditions

Future models of care around the intact including outpatients

3. High cost drugs

- Diabetes: on track in South West London, South London and Surrey with a Business case currently being compiled for the diabetes training programme and work is being undertaken on the finances
- Lucentis: decision deferred to allow assessment of new treatments and judicial reviews.
- Anti TNFs: Operational agreement from 1st July 2012

This work stream is being the first tangible outcome of what primary and secondary care can deliver when working together. In terms of the financial benefits, what is anticipated is a unitary reduction in cost achieved, with an expected 10% reduction in price for anti TNFs, though activity is to be modelled to determine full impact and savings dependent on referral thresholds.

4 Urgent care

This is an area which has been subject to considerable debate over the past few years and a lack of consensus as to the best model to follow to unify streams of care which work best for individual patients and populations. The real challenge is agreeing to an optimal pathway of care as well as managing what comes into urgent care and that the next steps are critical over the next months to get to where the service needs to be.

5. Cardiology

The now appears to be agreement around the Kingston Cath Lab subject to cost effectiveness. The next task is going to be looking at how pathways are going to work to avoid duplication with the complex work going to St George's and simpler work to Kingston. Much work had already been done to repatriate patients locally and that the torrent of patients to Guys and Brompton had slowed to a trickle however there was still room to improve local flows subject to patient choice and very complex surgery needs.

6. Care of frail old people with Long term conditions

It was acknowledged this was a particularly complex service and there were many differing views on how to manage the LTC process. Progress has been made and we seem to be moving to agreement on a common path.

The next steps would be to explore this in far greater detail through a compromise agreement reached with the participant CCGs and Kingston Hospital Trust, through the intensional of the Kings Fund. It was anticipated this group would have completed many aspects of it's work by the next SSB where there would be clarity on whether this process would ultimately yield tangible results.

7 Future of outpatients, what does secondary care in the community look like?

The outpatient shift to community work was challenging and there was some uncertainty what the end state would look like. There are many different models muted, eg email consultations, joint clinics, etc but that the real key to delivering the new model had to be around doing things differently and not just doing what consultants are doing in the hospital in a different setting.

It was suggested that clinicians should be asked how they would do things differently and that there had to be an awareness that the new care model would need to rely on a different skill set with different clinical and financial risk management processes.

There are different dimensions and themes which are emerging and these are as follows:

- Educating the healthcare professionals to consider changing the models of care around patients
- Ensuring diagnostic pathways are accessed directly
- Long term conditions – educating patients to look after themselves so less demands on primary and secondary care are made
- Exploring Virtual clinics / different ways of accessing advice

This is an area of work which is likely to develop over the next months within the SSB.

8. Conclusions

The SSB has already delivered some tangible outcomes in its short lifespan. However it is clear that we face some very considerable challenges and the behavioural changes we have seen in the SSB need to be replicated in the day to day transactional processes that take place between the commissioners and providers. This is a considerable challenge.

Whether the SSB delivers real change remains to be proven. It has the potential to do this with good will and firm but inclusive leadership. The key to its success will be determined by how successful it will be in ensuring it has buy in to it's decisions and how it manages the most difficult areas of difference which is what it is attempting to explore at present.

I am very grateful for the continuing support of colleagues. Without their support, we would not have achieved what we have managed to achieve to date.

Charles Alessi

GP Clinical Lead