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To: Shadow Health & Wellbeing Board – 23 November 2011

Subject: Developing provider relationships - what does the Health and Well-Being Board need?

Summary: At the first meeting of the Health and Wellbeing Board (HWB) members identified the need for means to support the Board in engaging with Healthcare Providers. This paper considers the potential to utilise Clinical Leadership Groups as such a mechanism.

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1. Background:

1.1 During the development of the terms of reference (ToR) for the shadow HWB, consideration had been given to explicitly provide for Pathway Advisory Groups (PAG) as a mechanism to support Clinical Commissioning Group (CCG) and HWB engagement with healthcare providers in order to facilitate pathway redesign, improve the patient journey and healthcare outcomes. This would also have enabled the formal commissioner/provider split inherent in the Health and Social Care Bill to be maintained.

1.2 Reference to PAG (but not the role to support pathway redesign) was removed from the HWB ToR on the basis that the Clinical Senates, announced as part of the NHS Futures Forum, might take on that function instead. However, given the spatial scale that Clinical Senates will seemingly operate at (national and regional tier) they will likely focus on supporting pre-existing clinical Pathway Development Groups for nationally and specialised services, and may not cover the range of services currently commissioned by PCTs or those services which will be commissioned by CCGs post April 2013.

1.3 This paper explores the current configuration of clinical leadership for pathway development within Kent and the issues the Board might wish to consider in developing a PAG or other mechanism.

2. Clinical Care Pathway Development Groups

2.1 Clinical services are planned and commissioned based on different population sizes. Some diseases or conditions are rare and therefore affect small number of patients. These services are provided in a small number of Trusts by highly specialised teams, and are commissioned by the National Specialised Commissioning Group. Some of the services that fall in this category are: heart transplantation, high secure mental

health services and certain children's cancers. The Clinical Care Pathways for these diseases are developed at the national level.

2.2 Regional Specialist Services are commissioned by regional Specialised Commissioning Groups on behalf of the Primary Care Trusts. Locally, there is a South East Coast Specialist Commissioning Team which supports the three PCT Clusters and CCGs in Kent & Medway, Surrey and Sussex. There are 38 services that are defined as regional specialised services. The planning and commissioning of these services requires populations in excess of 1 million. Some of the examples of these services are: haemophilia services, bone marrow transplantation services, paediatric cardiac services and paediatric neurosurgery services. The developments of Clinical Care Pathways for these services usually involve Specialised Commissioning Groups, local commissioners and providers of these services.

2.3 The majority of the NHS services are currently commissioned by the PCTs. Clinical Networks and other clinical groups support the commissioning of services by the PCT. The most prominent examples of Clinical Networks are: Cancer Network, Cardiac and Stroke and Vascular Services Network. These networks in Kent and Medway have supported the development of Clinical Care Pathways relevant to their services. In the future, this type of clinical network is likely to be hosted by the National Commissioning Board but will continue to operate at local level.

2.4 The leadership arrangements for pathway redesign for other services have evolved differently in different PCTs. NHS West Kent and NHS Eastern & Coastal Kent each had structures in place which involved clinical leaders from providers and commissioners together in reviewing pathways, and a range of groups have been established, generally feeding into local whole system planning arrangements – for example the Whole System Delivery Boards in West Kent and the Integrated Care Board in Eastern & Coastal Kent – as well as into the governance structures of individual organisations. Even if one was to hold a census of these groups, this would only provide a snapshot. It is worth noting that the number of groups reviewing pathways at any one time reflect the number of clinical care pathways that need developing or revising and that will change over time.

3. Issues:

3.1 Clearly provider engagement is important. However, in developing a mechanism for engaging with providers there are a number of issues/questions that the shadow HWB must consider:

a) Presuming that the NHS Commissioning Board and Clinical Senates become the locus for supporting Clinical Care Pathway Development Groups for specialist and nationally commissioned services, how will the HWB and local commissioners receive clinical advice on pathway development for locally commissioned services?

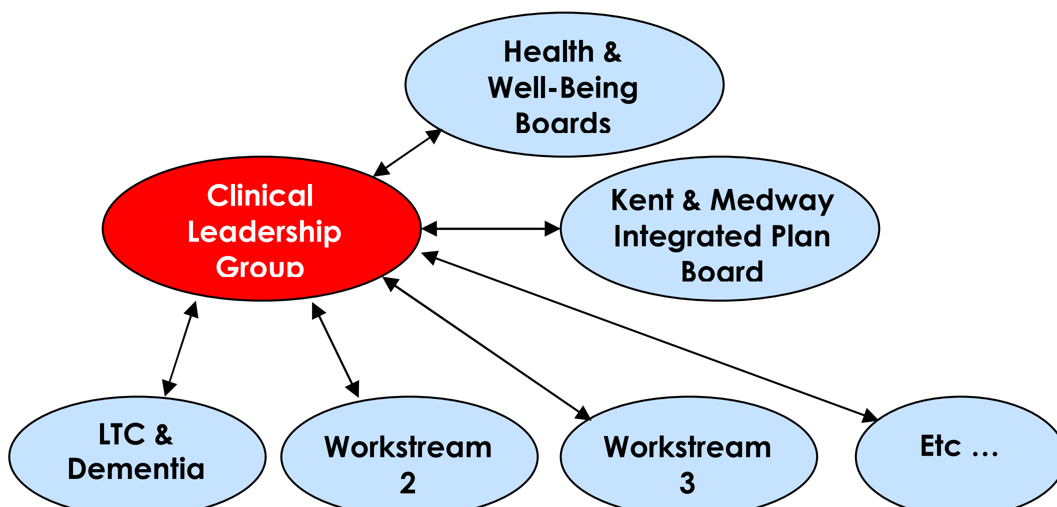
b) Is there a clear scope for the role of any proposed PAG under the HWB? It should be noted that existing groups are focussed on the improvement of clinical outcomes and patient experience, and the need to deliver best value for money. Increasingly, this will require a shift in spending from the acute sector and into the community sector.

c) Although the number of groups reviewing pathways in existence at any point in time will vary, the Board, at least whilst operating in shadow form, needs to be careful that it doesn't further confuse the landscape before details of how they might operate post April 2013 becomes clearer. Moreover, it should also be noted that neither KCC nor the HWB has a budget to support an extensive number of PAG.

3.2 On Wednesday 9th November clinical leads from commissioners and providers across Kent and Medway, including representatives of public health and social care, met to consider proposals for establishing a local clinical leadership group. There was strong support for such a group to be established, and to provide the leadership drive for service redesign, focusing in particular on those issues which are bigger than any one local system – for example major trauma, pathology and paediatric surgery – and on a significant shift in emphasis for services for people with long term conditions and dementia, such that the expectation for these large and growing groups of individuals is that their care is co-ordinated by the primary care team with specialist input, rather than the reverse, and a significant proportion of the 'care episode' shifts to the community.

3.3 The group felt strongly that membership of the clinical leadership group and any specific pathway review groups meeting under its aegis should be representative of the 'whole system' – health and social care commissioners and the full range of providers – and be multi-professional, involving nurses, allied health professionals and social care professionals in addition to doctors.

3.4 A diagram showing the potential relationship of this clinical leadership group, and the pathway review groups which it may set up, to the HWBs in both Kent and Medway is shown below:



4. Next Steps:

4.1 The HWB needs to be careful about how it progresses further on this agenda as it is likely to develop further as CCGs take over commissioning responsibilities from the PCT in April 2013 and the HWB moves out of shadow form. However, it would be unfortunate to miss the opportunity whilst in shadow form to shape how Kent HWB and CCG may engage with healthcare providers in Kent and feed this back through the national learning sets into the guidance likely to emerge from the Department for Health.

4.2 It is therefore suggested that the Board support the model proposed by local clinical leaders, and request feedback on progress throughout the period that the HWB is in shadow form. Given the pre-existing work that has been undertaken on dementia, and a clear appetite to improve outcomes for patients in this area, it is further suggested that a report on specific actions agreed to improve the pathways of care for people with dementia be requested from this group at the next HWB meeting.

5. Recommendations:

5.1 The Board is asked to:

a) Note the report.
b) Agree to the establishment of the Clinical Leadership Group to test the model of HWB/CCG engagement with providers to run alongside the shadow HWB.
c) Agree that an early focus of this group should be on Dementia or suggest suitable alternatives.

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