Surrey Downs Clinical Commissioning Group

Title of paper:	**Draft Clinical Leadership Framework**
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Locality:	All
Meeting:	Executive Committee
Agenda item:	7
For:	Information / Discussion / Decision

Executive Summary:

This Clinical Leadership Framework confirms the clinical priorities and the process for securing clinical leadership at all levels to deliver SDCCG clinical strategy. There are two tasks in developing this framework:

1. Agree strategic and operational clinical leadership roles aligned to SDCCG commissioning intentions
2. Agree the Operational Plan to secure clinical leadership (End of August 2013)

Task 1 is complete with clinical leadership roles agreed by Executive Committee in July. This final draft paper reaffirms the alignment of Clinical Programme leads (GB members) and locality clinical leads to our emerging strategy. Clinical Remuneration has already been agreed by SDCCG Remuneration and Nomination Committee.

To Executive is asked to sign off this framework and the supporting operational plan. The executive committee members are particularly asked to note and agree:

- Clinical Programme and Delivery roles (Table 1)
- Draft Role Outline (Annex 1 & 2)
- Operational Process for securing clinical leadership

Patient and public engagement: Draft paper presented to Executive committee and comments encouraged from 2 Lay Members (Patient & Public). Will be fed into the next Patient Advisory Group as part of the update of Out of Hospital Strategy

Other key issues:

- Clinical leadership will enhance patient safety and quality issues but does incur costs against 2% transformational funding (already accounted for)

- Performance process will need to be considered in reviewing the impact on individual clinical leadership

Accompanying papers (please list):

Attachment 1: SDCCG: 13/14 Clinical Leadership Framework to support delivery

Attachment 2: Operational Process for securing clinical leadership

Surrey Downs Clinical Commissioning Group

CLINICAL LEADERSHIP FRAMEWORK 2013/14

Introduction

Clinical Leadership is central to everything we do. This Clinical Leadership Framework has been developed to underpin the values of Surrey Downs CCG (SDCCG) as a clinically led organisation. The objective is to build clinical credibility to ensure safe and effective delivery of services and enhance the development of robust relationships with our members, providers and stakeholders.

The framework is designed to confirm the strategic priorities and the process for securing clinical leadership at all levels to deliver SDCCG clinical strategy. There are two core elements of this framework:

1. Alignment of strategic and operational clinical leadership roles to support delivery of SDCCG 13/14 commissioning intentions (***Annex 1: SDCCG Key Priority Delivery Programmes 2013 – 2014)***
2. The Operational Plan to secure clinical leadership ***(Annex 2: SDCCG operational plan)***

1. Background

Surrey Downs CCG is a clinically led membership organisation of 4 localities, 33 Practices working as an associate commissioner with 3 main Acute Hospitals, lead commissioner for Central Surrey Health (Community Provider), associate commissioner of Surrey & Boarders Partnership (Mental health Trust), as well as lead commissioner for a range of Out-of-Hospital providers. The CCG also hosts significant services on behalf of other CCGs: Continuing Health Care; Medicines Management; Individual Funding Requests; and Safeguarding Adults.

SDCCG is overseen by a membership council represented by all 33 membership practices that have chosen to delegate the operations of their organisation through its Governing Body. The Clinical Leaders are responsible to the Governing Body for delivering the CCG's vision of commissioning high quality and safe services, by transforming the current model of care and ensuring it is financially sustainable.

There are **three key levels of clinical leadership**:

- ***Membership Practice level*:** Each membership practice has selected their own GP representative to be the designated CCG clinical commissioning lead to support the development and implementation of clinical commissioning. Each membership practice GP lead sits on one of the four Locality Sub Committee's

- ***Locality Sub Committee level***: Made up of 33 membership practice clinical leads and operates through four Locality Subcommittees: Dorking, East Elmbridge, Mid Surrey and Medlinc

- ***Governing Body Level***: GB leads are elected from localities to represent practices as part of the statutory function of the organisation. There is a CCG Constitution (revised in July), which all member Practices have signed up to and acts as a legal and statutory framework for the organisation. The governing body is represented by a clinical majority (12 clinical representatives, 4 Lay Panel members and 3 executive representatives)

2. Clinical Strategy

The CCG wishes to radically change the model of care to enable more people to be supported in the community and ensure continuous improvements in the quality of care. To achieve this SDCCG is involved in 'Better Services Better Value' consultation focusing on configuration of acute services.

Additionally, all 33 membership practices have been actively involved in developing SDCCG Out-of-Hospital Strategy to establish a sustainable model of care that will prioritise the commissioning of services over the next 5 years. This consists of four areas of care: admission prevention, early discharge, urgent care system and elective care. A key feature of the strategy is to expand the use of Community Hospitals for rehabilitation and therapies, as well as to prevent avoidable admissions, so that people can receive care closer to home

To achieve our strategic intentions we need to ensure clinical leadership is driving change with Governing Body members and Clinical Leads working together to redesign our local model of care.

3. Clinical programmes for 13/14

The clinical programmes summarised below form a significant part of SDCCG Clear and Credible Plan and mobilisation will be phased according to our emerging clinical strategy to enhance patient experience and QIPP delivery. The following **eleven programmes** have been prioritised for alignment of clinical leadership:

1. **Acute:** Improve the commissioning and provision of services and pathways and promote inter-organisational working. Responsibility for the reconfiguration of Acute Hospitals linked to the shift of acute provision. ***Anticipated Outcome:*** Transform the model of acute service provision.

2. **Community:** Responsibility for the reconfiguration of Community Hospitals linked to the shift of acute provision by developing a model of care that enables people with Long-Term Conditions to be supported in the community, develop new models of care such as Virtual Wards and adopt innovation such as Electronic Registers

3. **End of Life Care:** To implement a more effective planning tool through the procurement of 'coordinate my care' for patients. ***Anticipated Outcome*:**

clinicians and patients fully involved in choice and planning for end of life care. Reduced preventable admissions and earlier discharge from Hospital that enables people to remain independent and die in their preferred setting of care.

4. **Elective Care:** Build a referral support system to enable improved acuity of GPs referrals and promote patient choice. Ensure equity of care by implementing policies for clinical effectiveness and the substantial redesign of care pathways in line with best practice. This includes leading a review of the current model of care for stroke service and neuro-rehabilitation services. **Outcome:** Optimised referral processes, reduced duplication of services and improved quality of care

5. **Mental Health & Dementia (forms 2 programmes)**: Commission a range of services provision, from self-care, psychological therapies to community and in-patient care, including provision for people with Long-Term Conditions. Implement local whole system pilots for screening and diagnosis of dementia. The role will work closely with NW Hants CCG as the lead mental health commissioner. ***Anticipated Outcome:*** Improved mental health and wellbeing of our local communities and dignity of care for people with dementia.

6. **Quality:** Establish and implement a 13/14 programme of 'walk round' visits signed off by Quality Committee based on hard and soft intelligence to ensure that everything we do is patient focused and quality driven. ***Anticipated Outcome*:** Enhance and safeguard patient services and experience.

7. **Continuing Health Care (Funded Nursing Care) and Safeguarding Adults**: Commission a service review to redesign continuing health care, including improved access to continuing care assessments, which will involve working closely with the community programme. Ensure that Safeguarding Adults is aligned to service strategy. ***Anticipated Outcome*:** Improve patient experience of the continuing care process, reduce delays in the system and ensure appropriate provision of care.

8. **Childrens', Maternity and Children's Safeguarding:** Improving children's health and wellbeing by review opportunities of integrated commissioning through our joint health and wellbeing strategy. Focus on more babies born healthy and joined up services for children and young people with complex needs. ***Anticipated outcome:*** Improving children's health where more families, children and young people will have healthy behaviours

9. **Medicines Management**: Support Primary & Secondary Care prescribing and coordinate prescribing by clinicians across the whole system. Ensure compliance to prescribing protocols and the adoption of best practice. The programme will interface with all other programmes to ensure the optimisation of prescribing for patients across the care system. ***Anticipated Outcome***: Optimisation of

medicines management usage in Primary & Secondary Care, including joint prescribing.

10. **Information (Caldicott Guardian)**: Ensure the GB members are compliant with Information Governance (IG) and that all members are trained in IG. To ensure that governance of data is embedded within the organisation and enhanced through the protection, transfer and retrieval of appropriate clinical data. ***Anticipated Outcome***: Patient information is shared appropriately and kept safely to enhance patient experience and access to services

11. **Enhancement and standardisation of Clinical Standards:** This programme will be led by a Clinical Governing Body member to work with the emerging national, regional and local clinical networks to ensure benchmarking and standardisation of services. This programme will develop in year projects, the key agreed projects for 13/14 include:

- **COPD:** To develop an integrated model of care across Epsom & Ewell, working with Acute Consultants, Respiratory team, Voluntary Sector and Primary Care. This project will pilot tele-health to enable patients to self-manage their conditions and reduce the anxiety associated with respiratory exacerbations. If successful, the pilot may be of interest to other localities and acute hospitals. ***Anticipated Outcome*****:** Improved self-care for COPD and respiratory conditions, resulting in fewer admissions.

- **Diabetes: Diabetes:** To develop a 4-tier model of care, adopting best practice, with the provision of intermediate diabetes service, insulin initiation, across Acute, Primary and Community Acute. This project has started with Epsom Hospital and mirrors similar developments in Dorking. ***Anticipated Outcome:*** The improved self-management and coordination care of Type 1 & 2 Diabetes, with reduced admissions and surgery.

- **Urgent Care:** Ensure our local system is more navigable for patients and enable patients to make more informed choices about accessing care, with a focus on Out-of-Hours, 111, Primary Care Access and Urgent Care Centres. ***Anticipated Outcome*****:** Improved acuity of accessing services, leading to reduced dependence on A&E

- **Stroke:** Redesign of stroke pathway across 3 acute hospitals (Kingston, SASH and Epsom). ***Anticipated outcome***: New integrated stroke rehabilitation pathways for SDCCG

- **Heart Failure:** To lead the development of a new heart failure pathway including education to SDCCG member GPs – covering the use of BNP and

clinical assessment to define whether an echocardiogram and specialist assessment is required. ***Anticipated outcome*:** Heart failure pathway in place

Aligned Clinical Leadership to Clinical Programmes for 13/14

The **clinical programmes will be led by Governing Body members** as the ***'programme leads'*** of the projects, supported by operational Clinical Leads for delivery across the 4 localities. Clinical leads will be supported by the CCG and Commissioning Support Unit South (CSU) management teams to deliver the Clinical Programmes. All Clinical leadership roles will be underpinned by the following principles:

- All patients will have equitable access to services and be offered patient choice
- Continued improvement in patients' experience of the care they received and their journey through the care system
- Adopt the very best practice and clinical practice to ensure high quality clinical outcomes
- An absolute commitment to commissioning safe services and robust safe guarding processes

The Governing Body Programme Leads will take overall Clinical leadership, assurance and support and:

- be the accountable sponsor of the programme and accountable to the Executive
- assure the integrity of the clinical strategy, clinical quality standards and safety of services
- report to Governing Body, Localities and other stakeholders on progress, issues and risks
- share expertise with member practices and influence clinical practice in line with best practice, information and evidence
- manage senior clinical relationships with providers and working across organisational boundaries
- promote collaboration across Localities, to remove barriers to implementation and duplication of efforts
- communicate projects to stakeholders and the media, so that all our work is clinically led and explained.
- support and supervise Clinical Leads to deliver the programmes

Table 1 provides the alignment of the current clinical leadership team to lead and support programme delivery. It is intended that the Clinical Programme Leads

(Governing Body members) will continue in their leadership role for 13/14 but Locality Clinical Leads may **change**

Table 1: SDCCG CURRENT ALIGNMENT OF CLINICAL LEADERSHIP FOR 13/14

Clinical Programme	Clinical Programme Lead	Management Programme Lead	Locality Clinical Leads
Acute	Dr Mark Hamilton	Miles Freeman	Dr Simon Williams (MS) Dr Steve Loveless (D) Dr Claire Fuller (ML) Dr Jill Evans (EE)
Community	Dr Steve Loveless	Mark Needham	Kate Laws (MS) Rep for Medlinc Rep for EE
End of Life Care	Dr Kate Laws	Mark Needham	Dr Annette Monaco
Elective Care	Lay member – Peter Collis	Karen Parsons	Clinical leadership aligned to specific projects
Mental Health	Dr Jill Evans (EE)	Karen Parsons	Dr Joy Baldwin (MS) Dr Suzanne Sehnnan (ML)
Learning Disabilities	TBC	Karen Parsons	Diane Woods
Dementia	Dr Robin Gupta	Mark Needham	Dr Phil Gavins
Quality	Dr Suzanne Moore (MS/ML)	Eileen Clark	Dr Robin Gupta for Dorking Dr Phil Gavins (East Elmbridge)
Continuing Health Care and Safeguarding Adults	Dr Claire Fuller	Karen Parsons	Dr Phil Gavins
Childrens', Maternity and Childrens' Safeguarding	Dr Hazim Taki (EE) Dr Suzanne Moore (MS/ML)	Eileen Clark	Dr Robin Gupta

Medicines Management	Ibrahim Wali (ML)	Kevin Solomons	Dr Andreas Pitsiaeli (MS) Dr Richard Strickland (EE) ? Dorking Rep
Information (Caldecott Guardian)	Dr Andy Sharpe	Justin Dix	No locality representative required
Clinical Standards (projects): Programme Lead: Dr Jill Evans			
COPD/Telehealth	Dr Andy Sharpe	Mark Needham	
Diabetes	Gavin Cook Dr Andreas Pitsiaeli Dr John Lowes	Mark Needham	
Urgent Care	Dr Steve Loveless	Karen Parsons	
Stroke	Dr Steve Loveless	Mark Needham	
Heart Failure	TBC	Mark Needham	