SUMMARY

This report describes the review of the Kingston Clinical Assessment Service by the Working Group appointed by this Panel and makes seven recommendations related to the following topics:

1. Publicity
2. Information Leaflets
3. Referrals
4. Public Health
5. Follow-up procedures
6. Clinical Governance
8. GPs Choose and Book limitations

ACTION BY THE PANEL

The Panel is asked to discuss this report and recommendations and request that Health Partners consider and respond to the recommendations.

REASON FOR ACTION PROPOSED

To make recommendations to the Panel related to this review.

BACKGROUND

1. This report summarises the work undertaken by the Working Group, including the findings and makes eight recommendations.
2. The decision to undertake a review of the new Kingston Clinical Assessment Service was taken by the Panel held on 24 July 2006 and a working group appointed with following membership:

Cllr Don Jordan, Chair
Cllr Geoff Austin
Cllr David Berry
Sandra Berry, Advisory Member to the Panel  ) Joint Project Officers.
Marian Morrison                                                )

3. The scope for this review was agreed by the Panel at its meeting on 7 December 2006 and an update report was received on 8 March 2007 which detailed the findings.

OBJECTIVES OF THE REVIEW

4. The agreed objectives of the review were to identify:
   - Possible delays to referrals
   - Appropriateness of referrals
   - Whether any groups are being disadvantaged
   - Overall effect on patients
   - Extent of the gains for the PCT and impact on the Hospitals
   - Effects on Kingston Hospital and the Foundation Status application
   - Possible confusion for patients between the locally operated services KCAS and the national internet service Choose & Book.

5. Possible outcomes which were hoped for included:
   - Ensuring that there is clarity about the new arrangements both for residents and patients.
   - Greater appreciation by KCI (and the PCT and KHT) about patients’ and residents’ perceptions about the new services.
   - Improvements to “patient focussed care” – more information, fewer delays, reduced waits for treatment.
   - Greater general emphasis on keeping patients informed about new ways of working and how to access appropriate treatment.
   - Raised awareness among patients of main conditions for which treatment is likely to be refused and reasons for this.
   - No reduction in patients’ clinical outcomes.
   - Greater local co-operation between professionals and health organisations.

KINGSTON CLINICAL ASSESSMENT SERVICE

6. Initial work by Kingston GPs on Practice Based Commissioning (PBC) in late 2005, (prior to the identification of KPCT financial problems) indicated that the introduction of a Clinical Assessment Service (see Annex 1) would be an important step in containing demand and improving the quality and appropriateness of referrals that would help practices to manage within PBC financial allocations. This approach was encouraged by the PCT as it was required, in common with all other PCTs, to develop and implement referral management plans and also to progress the Choose and Book system.
THE CHANGING HEALTH CARE ENVIRONMENT

7. It is important to recognise that this Review took place within the context of a changing NHS business environment and that KCAS itself was evolving. At the June 2006 meeting, the Panel was informed that KCAS was expected to help with KPCT’s financial deficit which then deteriorated considerably during the months that followed. However, many of the initial findings associated with shortcomings with KCAS that had been identified during the lead up to the review and at its earlier stages were quickly progressed and improvements made.

8. The NHS context behind KCAS is complex. The healthcare business environment has considerable pressures and is evolving in many ways. Some key factors include:
   • The serious on-going financial situation at KPCT whose prime role is to commission and fund health care for local people.
   • The inability of KPCT and Kingston Hospital to agree longer term activity levels due to KPCT’s financial deficit. This lack of agreement has delayed KHT’s Foundation Trust application.
   • The need to develop and progress new ways of working such as Practice Based Commissioning and a greater proportion of patient care being delivered outside of Acute Hospitals leading to inevitable reductions in work for hospitals.
   • Review of health care for London, currently underway.
   • The application of minimum waits for treatment to manage demand although these have been lifted from March 2007.
   • Work towards the achievement of 18 week wait (from referral to treatment) in March 2008 by the introduction of 4 quarterly incremental milestones reducing the minimum wait. For example, the wait for an outpatient appointment will reduce from 11 weeks by June, to 9 weeks by September, then 7 weeks by December and finally 5 weeks by March. Kingston Hospital will be working to achieve these targets within its current outpatient and operating sessions, but it is expected that service redesign and new care pathways will also help to ensure the target is reached.

METHODOLOGY REVIEW

9. The Working Group met on five occasions and other meetings were held with representatives of KCAS, Kingston Hospital, Kingston PCT and Kingston GP practices. A questionnaire was developed jointly between the Working Group and KCAS and was distributed widely via KCAS, GP Surgeries, Kingston Hospital and the RBK Website. Also, written comments were invited from GPs. Initial findings were made known in the report to the March Panel and were discussed with health partners. Draft recommendations were drawn up and discussed with representatives from Kingston Hospital and KCAS with further opportunity for all health partners to comment following that meeting.
FINDINGS

10. The main findings are grouped according to the evidence provided by each Health Partner and those leading to recommendations are identified separately.

11. KCAS FINDINGS

- The KCAS approach has received national attention, both by the Department of Health and by other PCTs.
- The King’s Fund has been commissioned to undertake an evaluation of demand management systems and KCI and KCAS are likely to be included in this. Clinically-led demand management systems are unusual.
- The teething problems of the early months which primarily prompted the review, and which included serious referral bottlenecks and communication difficulties with patients, have been resolved.
- Educating GPs about possible alternative clinical approaches to patients’ conditions has been successful.
- The appointment booking arrangements have been sub-contracted to Thamesdoc, a GP out-of-hours service which had capacity to take on this additional area of work effectively.
- The Call Service operates between 11am and 9pm, and more referrals are received on Mondays and Fridays. Urgent referrals are faxed to consultants and not dealt within the Choose and Book system. All local hospitals to which referrals are made are now on the C&B system (including Epsom and St. Helier and Queen Mary’s).
- The appointment of an Office Manager (with a background in Customer Service) has helped to develop closer working links with hospitals and GP surgeries to improve various operational aspects.
- Assurances have been given that the service does not place the patient at risk. Although referrals have reduced, this does not mean that patients are not getting the care that they clinically require.
- KCAS will be involved in non-urgent referrals to the new Rehabilitation Service at Tolworth Hospital and will begin to look at incorporating mental health referrals within the system.

12. KCAS Findings leading to Recommendations

- The IT system has bandwidth problems meaning that access is slow during the day and much of the clinical assessment of GP referrals by the Directors is completed on the system overnight.

13. KINGSTON HOSPITAL NHS TRUST FINDINGS

- Kingston Hospital had a number of concerns about the new arrangements. A fixed penalty of £40K had been applied by KPCT due to the KHT’s delayed implementation of the KCAS system that was due to KHT clinicians’ concerns.
- In order to comply with KCAS KHT has undertaken a considerable amount of work including a hospital-wide review of all patient booking processes, developing new guidance for ward receptionists and medical secretaries about
the management of consultant referrals. (Note: certain consultant referrals are included on an exemption list and do not need to follow the KCAS procedures).

- It is anticipated that the new booking processes will cost the Trust up to £100K to administer.
- Although regular review meetings had been taking place between KHT and KPCT there were still a number of areas that needed to be progressed and there has been little information identifying the impact of KCAS on referral patterns of Kingston GPs.
- KHT listed 10 concerns about KCAS and the Choose and Book system and most of these concerns had a common theme of communication between patients, KCAS and the Hospital.
- KCAS requirements apply to referrals from Kingston GPs, not other PCT areas.

14. **KHT Findings leading to Recommendations**

- The Working Group particularly formed the view that there was a lack of clarity about clinical responsibility once a patient leaves the hospital in cases where KCAS still needs to decide whether or not a consultant follow-up is required and also about ongoing communications between professionals, especially hospital clinicians who need to know about any on-going care arrangements.
- KCAS had developed a brief patient information leaflet about the new system but this had been withdrawn. Information did not go far enough in terms of what happens when a patient leaves hospital care and how follow up or a further referral is managed. This had been updated but this report makes some recommendations about this and other leaflets.

15. **KINGSTON PRIMARY CARE TRUST FINDINGS**

- The PCT has a range of contractual quality and performance standards agreed with KCAS. These include:
  - Reduce GP referrals by 5%
  - Reduce consultant to consultant referrals by 10%
  - Ensure access to service every working day
  - Turnaround referrals within 10 working days moving to 5 working days by Dec 06
  - Manage routine bookings to a 10 week wait and urgent bookings to a 2-4 week wait
  - Numbers of referrals waiting for review and for booking
  - Number and nature of complaints and queries to the Patient Advisory & Liaison Service (PALS).
- Department of Health and NHS London Guidance introduced the requirement for referral management systems. Other Guidance on Practice Based Commissioning referred to the concept of consortia bodies as formal entities which can act on behalf of a body of GP practices. Locally this gave rise to the formation of Kingston Co-operative Initiative.
- The PCT has confirmed that the latest information (April 07) shows a reduction of 13.2% in new referrals across all the hospitals from which KPCT commissions hospital care for 2006/07 compared with 2005/06. However, it should be noted that KCAS did not commence until June 06 and the PCT is therefore expecting
further reductions during 2007/08. KPCT’s Operational Plan published in March 2007 indicates the targets for further reductions in outpatient appointments.

- Consultant-to-consultant referrals had reduced across all Trusts by 21.5% as at December 2006.
- Patterns of Hospital follow-up after discharge are changing and information recorded since August 2006 indicates that about 9% of follow-up care is now managed within GP practices.
- It is difficult for the PCT to give a definitive cost saving because of the delay between referrals and attendance, but this was estimated to be about £1M.
- The cost of KCAS to the PCT is £180K. (This does not include the Kingston Co-operative Initiative which is funded by individual GP practices - albeit from practice budgets which are funded by the PCT).
- Waiting times – KCAS met the booking targets for a first outpatient appointment of between a minimum wait of 10 weeks and a maximum wait of 13 weeks. All London PCTs were operating minimum waits with the exception of Wandsworth PCT. (These were removed at the end of March 2007.)
- A very few number of specialties are outside the Choose and Book system e.g. Audiology at Kingston Hospital and referrals are therefore sent to the provider outside of the Choose and Book system.
- There were 17 complaints about KCAS between June and December. Issues include:
  - patients being unable to contact the service
  - the service being unresponsive to a contact
  - delays in the processing of referrals in the earlier months of the service
  - patients not being notified of appointment cancellations
  - patients not being offered a choice of provider, date or time of appointment.
- The PAL Service received 169 queries about the service from July to December and the numbers are reducing. 134 occurred between July to September and 35 from October to December.
- 60% of patients who have made a booking over the phone provide positive feedback about the process.

16. **KPCT Findings leading to Recommendations**

- Turnaround referrals within 10 working days moving to 5 working days by Dec 06
- Requests by KCAS to the referring GP for additional information can add to the perceived waiting time if the referring GP does not respond immediately and GPs are being advised of the need of prompt action. KCAS believe that these types of requests will reduce as the educative approaches take effect.
- There have been several difficulties with the Choose and Book IT system being able to accommodate the more centralised approach of KCAS. (It was originally designed for individual practice use.)
  - Particular confusion has arisen for patients in relation to the national Choose and Book appointments line which has been contacting patients about their appointments and steps have been taken to stop this unnecessary contact with Kingston patients.
  - Another difficulty has occurred where providers reject a referral for various reasons. Due to the introduction of the additional KCAS steps,
the system does not allow the GP or KCAS or indeed the provider to see
the reason for the rejection. Again technical action is been taken to solve
this problem and in the meantime other less sophisticated methods are
being used e.g. faxes.

17. GP PRACTICES FINDINGS

18. Positive outcomes following the introduction of KCAS included:

- GPs do not have to spend consultation time on operating the Choose and
  Book system.
- Better management of demand that has made some savings and helped with
  the PCT’s financial situation.
- The reduction in consultant to consultant referrals made considerable
  savings to help the PCT deficit in the short term and for reinvestment in other
  PBC services in the longer term.
- Improved data collection systems were helping the development of PBC.
  This will lead eventually to greater health efficiencies in terms of locally
  provided services and savings on consultant referrals to secondary care.
- There had been a good level of consultation and discussion with GPs prior to
  the agreement to opt for the KCAS system and its introduction.
- The initiative had drawn GP practices together in much the same way as the
  old “Multifund” some years ago and this was felt to be beneficial. GPs found
  the regular meetings and discussions arranged by the Kingston Co-operative
  Initiative helpful.
- Although Public Health involvement in some excluded procedures such as
  Plastic surgery and Varicous Veins added a delay, this was no different to
  past arrangements.

19. Concerns from GPs include:

- The vetting GPs at KCAS do not always understand the reasons for referral
  to a specialist.
- GPs do not like their colleagues intervening in their decision making.
- Vetting GPs may have less knowledge on certain topics.
- Consultants are having difficulty in arranging totally appropriate follow-up of
  their patients and consultant-to-consultant referrals are delayed, leading to
  additional work for the GP.
- Although it may be reasonable clinically in some cases for GPs to provide
  follow-up there is no extra time for this.
- GP follow up reduces the opportunity for surgeons to see any possible
  complications and to modify future practice if appropriate and also the
  experience for junior clinicians is reduced.
- The system is leading to a deterioration in relationships between hospital
  consultants and their GP colleagues which is not in the patient’s interest.
o On an individual basis, a GP sought help with a referral for plastic surgery requiring Public Health review which had apparently been delayed by the new system.

20. **GP Findings leading to Recommendations**

- The Choose and Book system had been designed for use by individual GP practices rather than a consortium body such as KCAS and this gave rise to certain informational interrogation and reporting difficulties.
- Elderly patients are baffled by the system and wonder what “passwords” are all about.
- Comprehensive information leaflet(s) for patients, especially about how future care is managed when leaving hospital, need to be provided.
- Reduced information from clinicians once a patient has completed secondary care.
- Major delays have occurred when Public Health Doctors (who may have even less breadth of clinical expertise) become involved in the process.

**THE QUESTIONNAIRE**

21. When the Working Group met with KCAS in November, it was identified that KCAS so far had not sought direct customer feedback. A simple questionnaire was then agreed with KCAS covering a number of questions and also to provide an opportunity for respondents to comment on their experiences. It was distributed to patients over a period of 6 weeks by KCAS along with letters about appointments, local GPs when seeing patients in their surgeries, by Kingston Hospital, Age Concern, via Councillors and was also on the RBK website. The purpose of using different distribution methods was to try and capture the views of patients at different stages of their treatment. 185 responses were received. Copies of all forms were shared with KCAS and KCAS kindly collated the information and performed a detailed analysis in mid February, updating this in mid April.

**QUESTIONNAIRE FINDINGS**

22. Analysis of the questionnaires indicated that 76% of patients had heard about KCAS. Of those who responded to the question about whether they felt the system worked smoothly, 57% said that it did and 43% said that it didn’t. Of those who responded about whether they found the KCAS staff helpful, 76% said that they did and 24% said that they did not. Themes and comments from the returned questionnaires include:

- Hospital name and phone number details given to patients need to be complete and accurate
- Various communication difficulties
- Various needs for prompt information where there are delays and especially progress of urgent referrals
- Concern about whether hospital has received referral
- What does URBN mean?
- View that KCAS is unnecessary and GP decision should be accepted
- Waited 3 weeks to be contacted for a specialist appointment, which was seeing a different GP at my surgery – not the outcome discussed with referring GP
- Confirmation letter should be addressed personally.

23. **Questionnaire Findings leading to Recommendations**

- Requests for more information about the system, especially in GP surgeries
- Leaflet needs KCAS address as well as phone number
- Reasons for needing a password
- Delays in receiving appointments
- Knowing more about excluded treatments & Public Health review.

**DISCUSSION**

24. The Working Group found this a very interesting area to explore and have widely increased their working knowledge about latest developments in health. The table below draws together the findings against the individual objectives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Findings and Outcomes</th>
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<tr>
<td>Identify possible delays to referrals</td>
<td>The bottlenecks of the very early days have been resolved and KCAS is now working to offering an appointment within 2 weeks of receipt of a referral i.e. 5 days for clinical assessment and 5 days to book an appointment.</td>
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<tr>
<td>Identify appropriateness of referrals</td>
<td>KCAS has helped to improve the quality of referrals and also provided an educative role for some referrals which could be more effectively managed by other routes. With the increasing work on care pathways between GPs and Kingston Hospital together with developments in practice based commissioning it is expected that there will be further refinement of this process.</td>
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<td>Whether any groups are being disadvantaged</td>
<td>Questionnaires raised concerns about lack of information about the new arrangements and difficulties with some patient groups understanding these, especially the elderly.</td>
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<tr>
<td>Overall effect on patients</td>
<td>Although there were teething problems initially, the wider benefits of the service are beginning realised.</td>
</tr>
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<td>Extent of gains for the PCT and impact on hospitals</td>
<td>There have been notable reductions in outpatient appointments together with financial savings and whilst this is particularly helpful in reducing the current KPCT financial deficit, it would have been more encouraging to see these savings</td>
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A10

| Effect on Kingston Hospital and the Foundation status application | Although KCAS has reduced referrals to KHT the inability to agree future activity has been the main delaying factor in KHT’s application for Foundation Status. |
| Possible confusion for patients between locally operated services i.e. KCAS and the national internet service Choose & Book | A small number of returned questionnaires identified some confusion about the two systems and recommendations about information leaflets have been made. |

25. In relation to the possible outcomes which the Review hoped to realise (see para 5) the recommendations concerning the information leaflets and publicity should help provide more information about the system and also about the role of Public Health in reviewing some requests for treatment. The questionnaire has helped raise KCAS’s awareness of what people think about the system and enabled greater appreciation of their perceptions. Many of the questionnaire responses did comment on overall waiting times which in many cases were felt to be too long. The implementation of the 18 week wait will alleviate this concern in the coming months. From conversations with KCAS professionals it would seem that KCAS has not appeared to reduce patients’ clinical outcomes, however the Group has not attempted to look at this from a clinical audit perspective.

**FINAL RECOMMENDATIONS**

26. The final recommendations are listed below. There are a number of other learning points which it is hoped that health partners will draw out from the main body of the report such as accuracy of hospital details passed by KCAS to patients, possible junior doctor training issues which may emerge from the reduction in outpatient follow-up and GPs’ perceptions of interference by the KCAS system of reviewing referrals.

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<tr>
<th>No.</th>
<th>RECOMMENDATION</th>
<th>ACTION BY KPCT/KCAS/KCI/KHT</th>
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<tbody>
<tr>
<td>1.</td>
<td>Publicity</td>
<td>KPCT</td>
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<td></td>
<td>Extensive publicity, to educate the population about accessing specialist care, via local newspapers, radio station, RBK’s “Livin’ Kingston” and Hospital Radio.</td>
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<td>2.</td>
<td>Information Leaflets</td>
<td>KPCT/KCAS/KCI/KHT</td>
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<tr>
<td>A</td>
<td>KCAS Information leaflet and “Choosing your Hospital” booklet Both documents should not be circulated further until the Panel has had an opportunity to consider these recommendations.</td>
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The possibility of revising the December 06 issue of the “Choosing your Health” booklet be considered to ensure that the content fits better with the local KCAS arrangements or includes full details about KCAS.

The previous version of the KCAS leaflet be updated and include:

- How to contact KCAS i.e. address, phone and email details (and include this on all correspondence with patient)
- The role of Public Health in assessing specific referrals e.g. tonsillectomy, plastic surgery.
- Details about passwords.

KHT review and update the Discharge Information Pack and the Planning for Discharge Leaflets, particularly for advice about arrangements for follow-up appointments.

*Information needs to be given in a format that is simple and appropriate for patients, relatives and carers.*

Funding may need to be identified for issuing the revised leaflets.

### 3. Referrals

A Referrals, particularly those for review by Public Health, should include all relevant information to enable a clinically appropriate decision to be made.

B If there is likely to be a delay by the GP in making the referral to KCAS, then this should be explained to the patient by the GP or another member of the practice staff.

C Referrals should be turned around by KCAS within **5 working days** or earlier in accordance with the KPCT Performance Standard.

D Ensure all GPs within KPCT make referrals via KCAS (i.e. for those procedures which are not on the exclusion list) even if the GP considers the patient to be of greater priority than that determined by KCAS.

E The area of consultant to consultant referrals i.e. where a consultant needs to make a referral to another consultant (with the exception of referrals from A&E) requires further review.
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<th></th>
<th>Public Health</th>
<th>KPCT</th>
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<tr>
<td>A</td>
<td>Referrals requiring review by Public Health need to be progressed by KCAS as speedily as possible. Public Health should ensure that they complete the review within 3 weeks with the patient being kept informed by Public Health of developments (or delays).</td>
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<td>B</td>
<td>Any referral recommendations from Public Health need to be implemented by KCAS.</td>
<td>KCAS</td>
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<tr>
<td>C</td>
<td>KPCT needs to consider the impact that Review by Public Health will have on achieving the 18 week wait for these cases.</td>
<td>KPCT</td>
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<th>Follow up Procedures</th>
<th>KPCT/KAS</th>
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<tr>
<td>A</td>
<td>In cases where hospital follow-up is not automatic, and an appointment is not agreed by KCAS, prompt confirmation (within 2 working days) should be sent from KCAS to the hospital consultant about how patient follow-up will be managed after discharge.</td>
<td>KCAS</td>
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<tr>
<td>B</td>
<td>A Clinical Audit be undertaken to establish the proportion of consultant follow-up requests which are rejected by KCAS.</td>
<td>KPCT &amp; KHT clinical audit teams</td>
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<tr>
<td>C</td>
<td>Protocols be agreed with GPs about follow-up that can be performed in Primary Care (with KHT consultant input into discussions if required).</td>
<td>KPCT/KHT/KCAS</td>
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<th>Clinical Governance</th>
<th>KPCT/KAS</th>
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<td></td>
<td>KPCT &amp; KCAS provide evidence of the current Clinical Governance Framework which comprehensively covers the KCAS system especially for patients requiring follow-up in primary care or referral to another hospital.</td>
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<th>GPs</th>
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<td>A</td>
<td>Ensure GPs are clear about follow-up arrangements after hospital treatment and the process for consultant to consultant referrals.</td>
<td>KPCT/KAS/GPs</td>
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<tr>
<td>B</td>
<td>Ensure all GPs are kept up to date about any new and relevant developments e.g.</td>
<td>KPCT/KAS</td>
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<td>• latest DoH Choose and Book developments e.g. being able to choose any hospital for Orthopaedics from July 2008.</td>
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<td></td>
<td>• New waiting time milestones to attain 18 week target.</td>
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8. Choose and Book limitations

Ensure that further representations are made about the continuing technical limitations of Choose and Book e.g. ongoing messaging problems affecting booking (bandwidth), duplication, cancellation etc.

Note: Whilst many of the recommendations relate to relationships with KHT it is expected that some of these will be equally applicable to other Hospital Trusts.

ACTION BY THE PANEL

27. The Panel is requested to consider this report and recommendations and request that Health Partners consider and respond to the recommendations.

THANKS AND APPRECIATION

28. The Working Group would like to thank all those who have given their views and co-operated with the Review. These include senior officers at KPCT, KCAS, KHT and individual GPs. Thanks also go to patients and members of the public who have taken time to complete and return the questionnaire. We hope that this review will help improve aspects of the current KCAS service and influence the way future health service changes are communicated to patients and local residents.

Background papers – held by Marian Morrison, author of the report
0208 547 5062; e mail marian.morrison@rbk.kingston.gov.uk

Minutes and agendas of the Health Overview Panel held on 7 December 2006 and 8 March 2007.
Notes of Working Group meetings and those held with representatives of KCAS, Kingston Hospital, GPs and KPCT.
Papers and reports provided by Kingston Hospital and KPCT
ANNEX 1

TERMS & DESCRIPTIONS

Kingston Co-operative Initiative - is not for profit company set up by 27 of the 29 practices in the Kingston PCT representing 170,000 patients and 100 GPs. Its purpose is to aid in the commissioning and in the future in the provision of services for patients living within the boundaries of Kingston PCT.

KCI has 2 Medical Directors, 7 other Board members, an Office Manager, 28 Council Members (representing each of the 27 practices) and a significant backroom staff to enable KCI to function.

There are 2-weekly board meetings and 3-monthly Council meetings.

As a specialist PMS body, KCI will perform various functions and act as an agent for its constituent practices for Practice Based Commissioning. Functions include:

- Kingston Clinical Assessment Service
- Kingston Choose and Book Service
- Kingston Education and Support Service
- Kingston Provider and Treatment Service

Kingston Clinical Assessment Service - is the central system that collects the referrals from the GP practices electronically, assesses the referral for quality, to direct the referral to the appropriate department and pass the referral on to the Kingston Choose and Book Service for processing with the patient.

Source: KCI website  www.KCI-NHS.org.uk

Practice Based Commissioning – is a new approach to commissioning healthcare services whereby practices and primary care professionals are engaged in the commissioning process. It is envisaged that clinicians will have greater freedoms and flexibilities to tailor services to the needs of the local community.