Guildford and Waverley NHS
Primary Care Trust

Modernising your local healthcare

A Consultation On The Future Of Services Provided At Milford Hospital, Cranleigh Hospital, Haslemere Hospital, Farnham Hospital And Centre For Health And Proposed Service Developments At Godalming

01 December 2005 – 28 February 2006

FOREWORD

This Consultation document sets out Guildford and Waverley Primary Care Trust's (PCT) proposals for the future of locally based health services in Guildford and Waverley, including specific proposals relating to the way we wish to develop community services and hospitals. This Consultation builds on previous work carried out by the PCT, including a Public Listening Exercise held in 2004 and, more recently, a formal Consultation on the future of specialist rehabilitation and other services at Milford Hospital. We paused this Consultation in March 2005 to give us more time to consider the future for all of the community hospitals.

This is not just about hospitals and inpatient services, but about the range of care we propose to provide in future. We want to develop services nearer to people's homes. By making treatment and care easier to access and working with patients who, for example, have long term conditions we can bring about many improvements. We only have a limited amount of money to spend on healthcare and we need to make sure we use this to provide services in the most cost effective way. This document, therefore, sets out a number of options to improve care for local people and to develop services outside hospital. These proposals are about the different ways the PCT can provide healthcare, not about future management arrangements for the services.

Since March 2005 we have actively developed the proposals following extensive discussion with the public, patients who use the services, partners, our staff and local interest groups. You have all influenced the PCT's current thinking and helped us to develop further a 'vision' for care in this locality. The work we have been doing since March 2005 is described in this document.

We remain committed to ensuring that people have fast, fair and appropriate access to NHS services and to providing the best possible care to the local population. However, we are also required to ensure that we provide services that are both affordable and sustainable in the future. That is why we have worked hard over the last three years to modernise and invest in local health and social care services designed around patients' needs as outlined in 'The NHS Plan' (2000).

The PCT has also been influenced by developments taking place nationally in the NHS, and specifically by the publication of two key papers from the Department of Health: the Public Health White Paper, 'Choosing Health' (2004) and 'Creating a Patient-led NHS' (2005).

The Department of Health (DoH) Consultation 'Your Health, Your Care, Your Say', September – November 2005, was a major public engagement exercise which sought the views of the public on a wide range of services including community based health services and social care. The responses will help to shape the forthcoming DoH White Paper on 'Health Outside Hospitals'. Plans for the services will link to these findings. Early views suggest that people are keen to see changes made to their local health services and have enjoyed the opportunity to get involved in having a say on what those services might look like in the future.

We are committed to involving all stakeholders in planning the future services. With this in mind we would like you to consider this document, setting out specific proposals, but also describing the work we have been doing since March 2005 and the evidence we have been drawing upon. We want to hear your views on the proposals.

We will listen to everything you say and there will be plenty of opportunity for you to meet us during the next few months. We look forward to meeting, and hearing from as many of you as possible.

All written responses and feedback from formal and informal meetings will be recorded, analysed and summarised by an organisation external to the PCT. This information will then be independently validated before a new document is prepared providing details of the outcome, conclusions drawn and next steps. This information will then be formally considered at a meeting of the PCT Board in public on 23 March 2006.

CHRIS GRIMES
CHAIRMAN

JANE DALE
INTERIM CHIEF EXECUTIVE

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1 INTRODUCTION

1.1 This document seeks the views of local people about the way the PCT wishes to provide health care services in the future. The aim is to strike the right balance between hospital care and care provided in or near patients' own homes. In order to achieve this we need to change the way we provide services and reshape them to focus on services for patients with long term conditions, elderly patients who require rehabilitation services and those patients who need to access local diagnostic and treatment facilities.

1.2 Wherever possible this will mean patients being directed to a local community hospital for their treatment, thus avoiding a potentially inappropriate admission to an acute hospital. This will also enable people to receive a local service and return home from hospital sooner, with the right home based care and support. The PCT will put in place expanded community nursing and therapy teams to support care outside of an acute hospital. It will also mean that patients, wherever appropriate, can have their investigations and outpatient appointments in convenient local settings.

1.3 The PCT wants to provide sustainable local services for the future of the highest affordable quality. To this end the PCT brought together a group of interested local people and organisations who formed the *Clinical Services Development Programme Board.* A number of local clinicians, including local General Practitioners (GPs), took part in this work; providing clinical advice to the PCT. Members of this group looked at different ways of developing community services for the future. During this time the PCT also reviewed the overall capacity of local services throughout the health economy, looking at, for example, use of community hospital beds. Surrey and Sussex Strategic Health Authority (SHA) also recently commissioned work which looked at 'Sustainable Services for Surrey and Sussex' (July 2005).

1.4 We have taken into account the findings and recommendations from all of this work in defining the options for future local services for the population. When planning the future provision of health services, however, the PCT has also to bear in mind the financial resources available. We currently spend significantly more on healthcare than the funds made available and this must be taken into account as we plan for the future.

1.5 The PCT previously consulted on the future of Milford Hospital in isolation, 'Modernising Your Local Healthcare' (March 2005), and we are now widening this Consultation as a result of feedback received. The services on which we are seeking people's views are:

- Specialist consultant led rehabilitation services for older people with complex needs.
- Development of locally based facilities where patients can go, for example, for outpatient appointments or for investigations to aid in the diagnosis of a medical condition.
- Developing community services to care for people differently, offering inpatient services to people when they need them, for example, to people with long term conditions who may have previously had to go to an acute hospital for treatment.

1.6 The proposals in this document will create an opportunity to deliver real health improvements to the population, particularly the elderly and people with long term conditions; and ensure that services can be sustained within the PCT's limited financial resources.

1.7 Collecting a wide range of views is very important, so we want to hear from as many people as possible You can complete and return the Response Form at the back of this document (also available on the PCT's website at www.gwpct.nhs.uk), and we will be holding a number of meetings, both formal and informal, across Guildford and Waverley during the three month Consultation period. See page 34 for details of the formal public meetings.

2 BACKGROUND

2.1 The PCT was formed in 2002 to commission primary, acute and specialist health services for the local population. It also directly manages the community hospitals, community nursing, therapists and other community services provided to its population. Soon after its establishment the PCT began to review services, in line with the NHS modernisation agenda, with the aim of improving the quality of care that it provided. The PCT was also required to complete the review of Milford Hospital, begun by West Surrey Health Authority.

2.2 The PCT has, since its inception, invested heavily in access for patient services resulting in the reduction of waiting times for both inpatient and outpatient services and accident and emergency (A&E) care, for example:

- In April 2002 there were 1141 people who had been waiting between 17 and 26 weeks for an **outpatient** appointment and in April 2005 there was nobody waiting over 17 weeks and only 106 waiting between 13 and 17 weeks.
- In April 2002 there were 1542 people waiting over 6 months for an **inpatient** stay. In April 2005 the people waiting over 6 months had dropped to 102. The total waiting list has also fallen from 4718 in April 2002 to 3382 in April 2005.

2.3 Part of the investment has also been directed at modernising our services to reduce further waiting times and to improve access.

2.4 The PCT has been working with GPs and hospital consultants to establish a clinical assessment service (CAS) whose purpose is to review and sort through (triage) all referrals from primary care to the acute hospitals, using the best evidence of what is likely to work most effectively for that person. Referrals are then sent directly into secondary care or to a GP with a Special Interest. The PCT has initially put in place a CAS for ear, nose and throat (ENT) and orthopaedic referrals. The main advantage to patients is that they can be seen more quickly as the waiting times for these services are often less than for those in secondary care i.e. in an acute hospital. Furthermore, capacity will be created in acute hospitals for those patients whose condition must have the opinion of a consultant.

2.5 The PCT held a Public Listening Exercise in early 2004 to find out what the local population wanted from a modern health service. This informed the review of clinical services and a proposed change that was set out in the PCT's Consultation document entitled 'Modernising Your Local Healthcare – 'A Consultation on the Re-Provision of Specialist Rehabilitation Services Currently Based at Milford Hospital and the Closure of Milford Hospital.' (October 2004). This Consultation ran from 1 October 2004 – January 2005. The Consultation was an inclusive one and we received a wide variety of views and comments from the local population, interested stakeholders and Surrey County Council Health Scrutiny Committee (HSC). These views were given to us in the form of written feedback and verbally at locality meetings and formal public meetings.

2.6 As a result of views received during this initial Consultation period, we concluded that none of the proposed options delivered the services required by the population of Guildford and Waverley. All of the community hospitals should be reviewed at the same time and we are therefore widening the Consultation. 'Modernising Your Local Healthcare' (March 2005) concluded that we needed to take more time to fully assess the impact on other services, including recommendations for the future of specialist rehabilitation and associated services.

2.7 The following table summarises the process to date:

Timeline Of Consultation	
Date	**Key To Events / Documents Around Consultation Process**
April 2002	The PCT was formed and asked by its predecessor West Surrey Health Authority to consider the role of Milford Hospital.
January 2004	A Public Listening Exercise was carried out by the PCT to find out the local views about the future for health and social care services.
April 2004	The outcome of the Public Listening Exercise was published. The PCT confirmed its intention to move toward a more community based service, with less emphasis on acute care
1 October 2004 – 4 January 2005	A formal public Consultation commenced on 'Modernising Your Local Healthcare ' – Re-provision Of Specialist Rehabilitation And Other Services Currently Based At Milford Hospital And The Closure Of Milford Hospital. This included 10 specialist orthopaedic beds used by the Royal Surrey County Hospital (RSCH)
December 2004	A Supplementary Information Document was issued with additional information for the public and extending the Consultation until the 27 May 2005
March 2005	A document was issued concluding Consultation on the re-provision of 10 specialist orthopaedic beds at Milford Hospital and explaining the next steps in the Consultation process.

2.8 A project to replace the existing hospital and health centre has been developed at Cranleigh, in discussion with the PCT and its predecessor, over the past five years. A new site has been donated, outline planning approval for a full locality care centre with up to 20 inpatient beds has been granted and the community has raised funds to support this development. A private finance partner has been identified and full funding is immediately available. The project can only be carried forward if an option to include beds is approved.

2.9 Throughout this document we refer to 'Step Up' and 'Step Down' beds. Step Down beds, as currently used in our community hospitals, admit patients who have been discharged from a District General Hospital following treatment for an acute phase of their illness. However, these patients still have a need for further rehabilitation prior to final discharge. The medical management of these patients is currently either GP or consultant led.

2.10 The establishment of Step Up beds is driven by both local and national policy to treat patients nearer to their homes. This requires a change in the patient journey, so that people who can safely be treated locally are admitted directly into a community hospital rather than a District General Hospital, as is usually the case now. As with Step Down beds the medical management of these patients will be determined locally, having regard to the resources and skills available in each community hospital.

2.11 We intend to be flexible about the use of all of these beds, dependent upon the needs of our population at any given time.

What Have We Been Doing?

2.12 We have spent the time since March 2005 undertaking several pieces of work which have influenced the direction we now wish to follow. This work encompassed reviews of services provided at Milford Hospital, Cranleigh Hospital, Haslemere Hospital, Farnham Hospital and Centre for Health (FHCFH) and a proposed development at Godalming. This Consultation document summarises this work, as follows:

Population Need for Specialist Rehabilitation

2.13 The work identified the population and assessed its need for specialist, consultant led rehabilitation services and then considered possible models of service across the PCT. The Clinical Services Development Programme Board used this analysis and reviewed a range of services.

2.14 The last few decades have seen significant changes in the presentation of some diseases, for example, we now regard coronary heart disease as a chronic disease that people live with. We have also seen changes in the approach to health and healthcare with the introduction of Government guidelines, called National Service Frameworks, which focus on the whole disease / illness experience from prevention to treatment, information and supportive care. The population of Guildford and Waverley has relatively more middle aged people than England. This population profile suggests the need for greater emphasis on prevention and the management of people living with long term conditions as they grow older. We gave more detailed information on the population in 'Modernising Your Local Healthcare' (March 2005).

2.15 As we looked closely at the use of specialist rehabilitation beds we found that they were not being used as effectively as they could be. Examining the bed use data, which included one or two people staying in a specialist consultant led rehabilitation ward for over a year, we identified opportunities to make much better use of these beds and hence offer a more patient focused service. This work suggested that the patients coming out of RSCH needing consultant led specialist rehabilitation could be treated effectively using between 35 and 42 beds. We found less evidence of the beneficial effects of rehabilitation after 42 days in terms of outcomes. We identified that each time a patient moves between hospitals or clinical teams there is a delay before they start to benefit from their treatment and care. This prolongs their stay in hospital. The needs assessment document can be found on the PCT's website.

What did this tell us?

- ***We should prevent lengthy inpatient stays where evidence would suggest there is no further benefit to the patient***
- ***We should seek to minimise the number of transfers between services and hospitals during an episode of care***
- ***The evidence in the literature supports inpatient specialist rehabilitation***

Reviewing the Service Pathway for Older People with Complex Needs Who Require Specialist Rehabilitation

2.16 We have also looked at the way in which an elderly person with complex needs receives care and treatment, from when they first need help, to when they require specialist rehabilitation, to when they are able to live independently again – *'the patient's journey'.* We began by looking at where and what type of rehabilitation is currently available for the elderly population. To support us in this work we actively involved Consultants in Elderly Care, GPs, Therapists and Matrons from the RSCH, Frimley Park Hospital (FPH), Milford Hospital and FHCFH. We also involved social care partners in Adults and Community Care, carers and patients. We wanted to hear from as many of those directly involved in providing or receiving specialist rehabilitative care as possible.

2.17 The outcome of this was the development of a rehabilitation pathway for patient care which evidence shows will ensure elderly patients benefit through appropriate care. A successful pilot of this work was carried out across Guildford and Waverley over a three month period and an operational group consisting of doctors, nurses, therapists and social care providers is now working to improve the service in the light of the findings. We expect clear benefits for the population who need to use the rehabilitation service.

What did this tell us?

- ***People need more help early on in their illness***
- ***There will be a continuing need for some consultant led specialist inpatient beds***
- ***We must work hard with partners to avoid duplication in services provided***

Clinical Services Development Programme Board

2.18 At the same time as rehabilitation services were being reviewed, the PCT established a group to look at the development of services in the community hospitals and Milford Hospital. Many members of this group were clinical staff, for example, senior nursing and therapy staff, and several GPs. The work focused on the localities of Cranleigh, Godalming, Guildford, Farnham and Haslemere. Members also made recommendations about diagnostic and outpatient facilities. The group met over a period of one year and during this time was able to build on the 'Public Listening Exercise' and shape options for services around localities. Its work and recommendations influence what we are saying in this Consultation, in particular:

- The Community hospital beds should be used to admit people directly from the community. This would help to avoid inappropriate acute hospital admissions. Using the beds in this way should better meet people's needs both in a planned way and when they need help 'out of hours'.
- Locality based services, including diagnostic facilities and access to outpatient clinics could be established in the Godalming locality.
- Services should be able to respond effectively to unplanned and emergency care – services available outside normal working hours – caring for people near to their homes.

What did this tell us?

- ***We should develop the valuable community services better, helping to prevent inappropriate acute admissions***
- ***We need to be able to respond more effectively to unplanned and emergency care meeting people's needs in the community where possible***
- ***Locality based services including access to diagnostics and outpatients should be developed***

Review by the Professional Executive Committee

2.19 The recommendation about the future role of community hospitals, and the proposals to develop services in Godalming, were supported by the PCT's Professional Executive Committee (PEC) and Board, (PEC members are mainly clinicians and provide clinical advice to the PCT's Board). The PEC made the following recommendations to the Board:

- *The PEC support the concept of local treatment centres.*
- *The PEC will not support the use of community hospital beds for Step Down unless purchased* by the acute hospital(s) as part of an episode of care.***
- *GPs will be the commissioners of services in the future as part of the arrangements for Practice Based / Locality Commissioning; should they wish to commission beds from community hospitals the financial risk will rest with them.*
- *The PEC feel that for inpatient services to be viable there should be a population base of 100,000 people, based on current evidence.*

* Purchasing services will be within 'Payment By Results' Guidance

** Where patients require specialist consultant led rehabilitation this will continue to be commissioned by the PCT

Capacity Management in the Local Health Community

2.20 The PCT commissioned an independent study, by a management and financial consultancy, to look at the overall number of hospitals and beds it currently manages. We wanted to establish what services could be provided locally that would offer patients the types of treatment they need. The findings from this work were that we cannot afford to continue to provide services from all of the current locations.

2.21 The study recommended that the PCT re-design services in the community to better support the management of unscheduled care i.e. unplanned or emergency care and individuals with long term conditions; as well as providing specialist rehabilitation for older people with complex needs. This would allow people to be admitted directly to the service and managed by GPs and other clinical staff locally. This would build on current services where some community hospital beds are already managed by GPs.

2.22 This work supported the findings of the earlier needs assessment and recommended that resources should be re-directed from expensive acute inpatient care to more accessible, responsive and flexible community based care. The findings from the review of service sustainability by Surrey and Sussex SHA also concluded similarly.

2.23 The study reviewed findings of a Community and Specialist Bed Audit undertaken by the PCT in May 2005, which identified:

- If a patient's discharge or transfer between health care facilities is more efficiently planned and managed from the beginning of their stay this will impact directly on their overall length of stay in hospital. These recommendations are now being implemented.
- The majority of patient admissions were appropriate, following the hospital admissions criteria. Where this was found not to be the case the teams are working hard to improve this.
- Enabling patients to take their medication without prompting or assistance would be beneficial as this helps promote an individual's independence. Our national award winning prescribing team is now leading work to support and increase the number of patients who are independently taking their medication.

What did this tell us?

- ***Patients could be discharged or transferred earlier if planning was more effective***
- ***Carers and colleagues in social care need to be actively involved in planning people's discharges from when they are admitted***
- ***By reducing the time people stay in acute hospital beds we can decrease the burden on the acute sector and the need for social care following a lengthy admission***
- ***The PCT cannot continue to provide services in all current locations if it is to develop the quality of community based services across the whole PCT***

A Review of Service Sustainability by Surrey and Sussex Strategic Health Authority

2.24 During the time we were looking at needs of the population and the capacity in the local hospitals, the SHA was also reviewing services throughout Surrey and Sussex. It commissioned a major piece of work during summer 2005 to:

- Identify the extent of the financial problems and their root causes.
- Describe a clinically and financially sustainable health care system fit for the future.
- Identify the key areas of work to achieve this.

2.25 The benefits are being measured as:

- **Value for patients and carers.**
- **Value for staff.**
- **Value for money.**

2.26 The following table highlights some key findings and recommendations from this work.

The Findings and Recommendations from this Work	*Does this apply to this PCT?*
• *There is a recurring financial problem*	*Yes and the deficit at 01 04 2005 was £16.3 million*
• *Causes are a mixture of:* *a. Above average use of secondary care** *b. High investment in services and buildings outside acute hospitals which does not reduce the use of these hospitals* *c. A need for greater efficiency in the use of current resources*	*Yes The number of GPs within the Guildford and Waverley locality is high as are the number of beds in community hospitals*
• *A sustainable system is based on simplifying the way patients gain access to healthcare, and wherever possible providing treatment outside acute hospitals*	*Yes This supports the findings of the Public Listening Exercise*
• *There should be fewer sites, better used, for clinical and financial reasons*	*Yes Fewer, larger community facilities result in increased economies of scale and allow increased GP/Nurse specialisation*
• *To make this happen we need to focus on a few key areas, for example: increasing GP access to diagnostics e.g. x-ray and blood tests for their patients and reducing length of stay*	*Yes This supports the findings of the Public Listening Exercise*

*For example:

2.27 Figures from the Surrey and Sussex SHA Programme Budget Spend, 2003/04, show that SHA spends some 6% higher on all healthcare services, on a weighted population basis, than the England average and Guildford and Waverley PCT almost 6% above the SHA average.

2.28 Spend on primary and community care services in the PCT exceed the SHA average by over £2 million.

3 THE VISION FOR THE FUTURE

3.1 In developing a future vision of services for the people of Guildford and Waverley, the PCT has considered closely all of the Government's policies developed to secure better health and healthcare for the whole population. We have looked at these alongside local needs and aspirations. Our plans and specific proposals build on this vision.

3.2 In particular, the Wanless Report (2002) 'Securing Our Future Heath: Taking a Long Term View' gave a perspective on healthcare in 2022 which has been taken as the basis for defining an achievable model of health care in Guildford and Waverley. This was reflected in the PCT's four year strategy as follows:

3.3 "Patients and carers receive consistently high quality care wherever and whoever they are. It is appropriate, timely and in the right setting.

3.4 Patients and carers book appointments at a time that suits them not the service.

3.5 Choices are explained in a clear jargon-free way. Patients and carers seek more advice from pharmacists who handle routine prescribing and help patients and carers manage their medication effectively.

3.6 The majority of general and less specialised care has moved out of large hospitals. Hospitals focus mostly on specialist treatments.

3.7 Patients who need hospital care wait within reason, weeks not months, days not weeks and minutes not hours. They get the best treatments with minimum variability and supported by the latest technology.

3.8 There are no bottlenecks, no keeping people in hospital when they should be discharged with the support of social care. If needed, they are supported in the home by GPs. If necessary they move to a high quality residential or nursing home placement or another intermediate care setting'."

3.9 This vision aims to support people to make life-style choices that will improve their health and well being and also make good economic sense. We want to make access to healthcare easier and invest in new technologies.

For example, we will:

- Invest in community diagnostic and treatment services and enhance primary care to support the management of people with long term conditions, such as patients with diabetes, chronic respiratory diseases or heart conditions.
- Develop telemedicine, a new technology – using for example television equipment to enable a specialist to offer an opinion remotely, which will shortly be piloted and evaluated in the community, and be used to support patients with a long term condition at home, who would otherwise have needed a longer stay in hospital.

3.10 We cannot make these improvements in isolation and will continue to work ever closer with local health and social care organisations, including the voluntary sector.

3.11 The PCT want to be able to offer a range of services of high quality and locally based but not necessarily inpatient services. These are now described in more detail in the document.

Sustainable Services for the Future

3.12 In support of the services we have already described we are also looking at the way in which we provide care and treatment for people 'out of hours' including evenings, nights and weekends. We are working with health and social care partners to develop a joint / integrated approach which will mean people have better access to unplanned or emergency care. This includes a single access point for GPs to use when making patient referrals; an integrated Minor Injury and Walk in Centre at the RSCH which includes GPs and nurse practitioners. The PCT is also keen to promote and better use the skills of pharmacists to provide minor ailment services. By extending the opening hours of these services they would be more readily accessible. GPs themselves have also looked at how they can improve access for patients in their own surgeries.

3.13 Most people will remain independent for much of their life with the ***first level*** of care being accessed through ***primary care***, for example, seeing their GP, community pharmacist or the practice nurse. The PCT supports an emphasis on prevention, the promotion of health and wellbeing and self care. We have been successful, for example, in helping people to quit smoking which in itself really improves a person's health. We have also developed a successful 'Expert Patient' programme helping people who have long term conditions learn from others more effective ways of self caring. The Surrey and Sussex Transforming Chronic Care Programme (TCCP) is a local initiative aiming to improve the quality and consistency of care provided to people with long term conditions. The objective of the TCCP is to improve the health of patients and carers by enabling them to take more control of the management of their health.

3.14 The ***second level*** of care, termed ***intermediate care***, gives people a range of care in the community, often supported in their own homes by teams of therapists, nurses and other clinically trained professionals. This may include admission to a community hospital for support in a Step Up bed. In this service patients are cared for by locally based clinical teams. We will expand this level of service and develop specialist roles for clinicians. A further example of this would be a GP with a special interest in orthopaedics; we can improve access to high quality services by making them available outside of the acute hospital in a community setting.

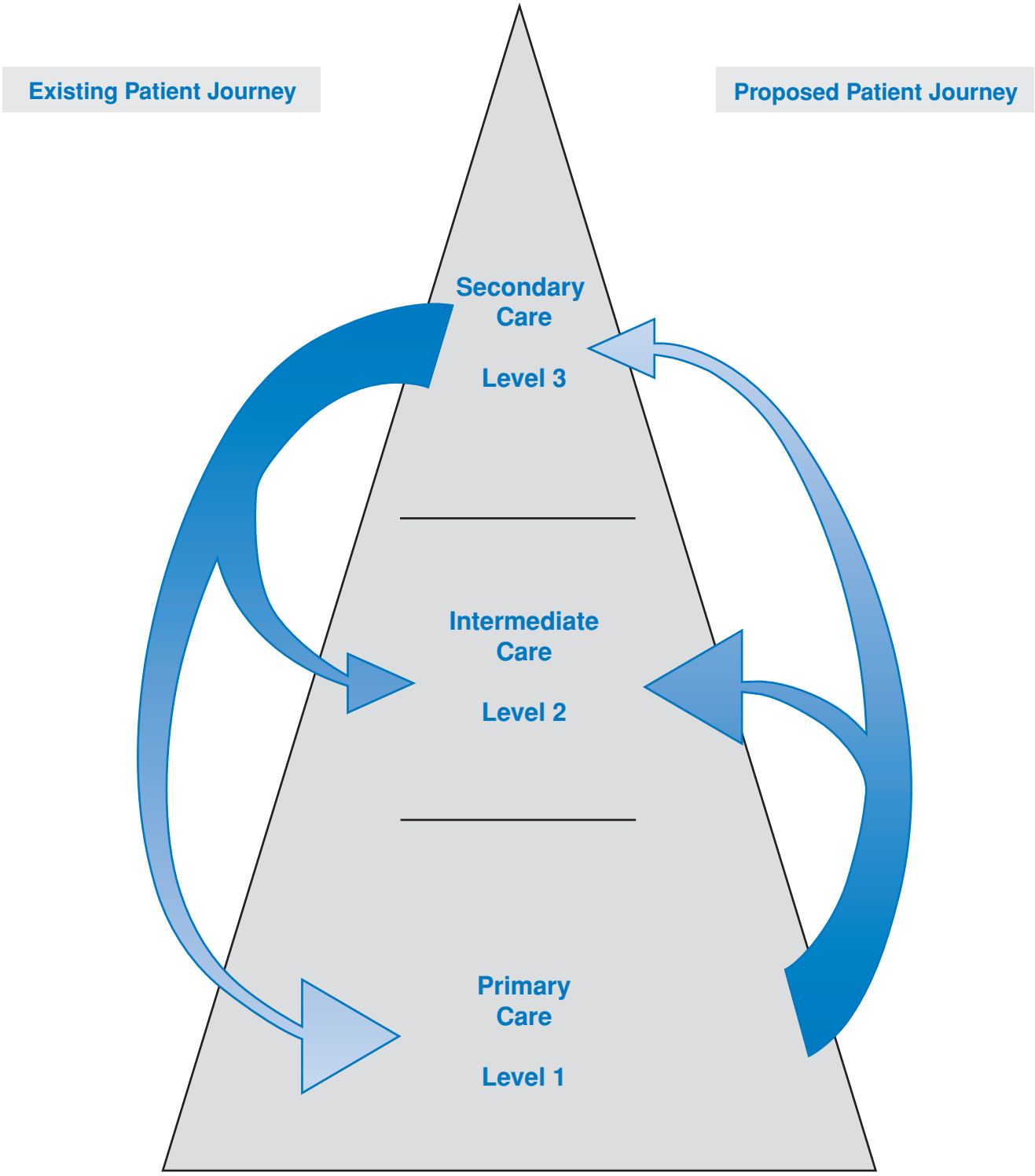
3.15 The ***third level*** of care is termed ***secondary care***, for example, admission to an acute hospital for diagnosis, treatment or care.

3.16 Over 90% of health care is currently provided outside the acute general hospital, secondary care setting. We want to make sure that as much care can continue to be supported in this way. To do this, and to support partners in secondary care, we want to be able to provide blood tests, x-ray and other scans in a community setting so that patients do not have to go into an acute hospital unless they need to. We can follow up people's care in community settings with a range of outpatient appointments and are already working with the RSCH to shift up to 40% of their current outpatient work into various community locations. Future plans must support this way of working and these aspirations.

3.17 This Consultation builds on what we are already starting to put in place but we need to move resources out of expensive inpatient care and provide care in the community. Huge advances in technology have made this type of service model possible meaning modern healthcare can be provided closer to people's homes.

3.18 The following diagram illustrates the various levels at which people can receive their healthcare with the emphasis in the future on levels one and two. The flow chart illustrates how patients will access services in the future and the benefits this will bring.

The Patients' Journey



This diagram illustrates the levels of care and how we would wish services to look in the future, with an emphasis on services to support people independently and in primary care with less dependence on acute and specialist care.

Patient Need		Where Would This Service Be Provided?		How Would This Benefit The Patient?
Minor illness or injury	➔	**Walk-in Centre / Minor Injuries Unit** These centres provide immediate access for patients with minor illnesses/injuries or who require health advice. (Additionally, these services will continue to be provided by GPs, practice nurses and community pharmacists)	➔	Both the Walk-in-Centre and the Minor Injuries Unit allow for immediate assessment and treatment of minor illness or injury without an appointment
Routine outpatient appointment – including specialties such as surgical pre assessment clinics, general surgery, ENT, general medicine, audiology, cardiology, medical oncology and rheumatology	➔	**Local Treatment Facility** These are facilities that provide a variety of services including access to routine tests and appointments that were previously only available in an acute hospital	➔	Local - patient does not have to travel to the acute hospital. Responsive service which will reduce waiting time and travel time
Investigations and Diagnostic tests, such as blood tests, x-rays, ultrasound and other scans, and possibly endoscopies	➔	**Local Treatment Centre** As above	➔	As above, and additionally this ensures an equitable service for all our patients – currently some of these services are available locally for some patients, while others have to travel to the acute hospital
Rapid assessment where hospital admission is threatened, but potentially avoidable	➔	**Day Hospital**	➔	Responsive service by Consultant Physicians in Care of the Elderly may prevent admission to hospital
Inpatient care other than acute illness	➔	**Step Up Facilities** Community hospital beds for patients who require inpatient care, but do not need all the services of an acute hospital	➔	Enables patients to be cared for in a community bed avoiding acute admission, quicker diagnosis and treatment closer to home
Home based Intermediate Care, Physiotherapy, Occupational therapy, Speech and Language Therapy	➔	**Inpatient, Outpatient and Community Based Rehabilitation Services** Ongoing medical and therapy input available from day hospitals and in the patients own home	➔	Therapy services help ensure patients gain maximum independence, avoid hospital admission and support early discharge
Specialist inpatient rehabilitation	➔	**Specialist Rehabilitation Beds** Available in some hospitals and community hospitals	➔	Comprehensive specialist rehabilitation led by a consultant

4 WHICH SERVICES DO WE NEED TO CHANGE?

4.1 To provide people with locally based services which are of the highest quality, affordable and meet national requirements we must decide what is the best option and where services should be located. ***The reality is that the PCT cannot afford to provide the current level of services from all of its hospitals and there will need to be some 'either / or' choices.*** The services we propose to provide are as follows:

- **Local treatment facilities offering investigations and outpatient treatment**
- **Inpatient, outpatient and community based specialist rehabilitation services**
- **Flexible use of community hospital beds, Step Up to provide local inpatient assessment and treatment and to avoid acute hospital admission, Step Down to support discharge**

4.2 Before considering the options for where these services could be located (as set out in section 5 of this document) we will outline the services to be provided.

Local Treatment Facilities Offering Investigations and Outpatient Treatment

4.3 Locally based treatment facilities are able to offer a range of services which would currently require a hospital visit. These include outpatient appointments, for example, assessments before or after an operation or other specialist services such as cardiology (heart problems). Investigative procedures including x-rays will be available. Some treatment facilities will offer slightly more specialised services such as endoscopy facilities, (an endoscopy is a test that looks inside the body), ultrasound, NHS dentistry, podiatry, physiotherapy, Minor injuries or minor surgery would also be provided from a local treatment facility but not necessarily in every location. All services would need to be cost effective and offer best value for money.

Inpatient, Outpatient and Community Based Rehabilitation Services

4.4 This service provides a range of therapeutic treatments geared towards the individual patient to allow them to reach the best possible level of independence in their lifestyle. The service would not be based just around inpatient beds but would include outpatients and day hospitals, attending for rehabilitation and treatment that best meets the patients' individual needs.

4.5 The specialist rehabilitation beds at Milford Hospital have been extensively studied. Initial analysis identified a few people being admitted from an acute bed for less than a week, while some people remained there for months. A thorough, multiagency working group, including patients and carers, developed a revised care pathway for these people over the 2004/05 winter. This was subsequently piloted. Key revisions to the pathway included identifying gaps in service and developing specific criteria for admission to exclude people who had stayed for only several days and a general maximum length of stay of 42 days. This enables the staff to fully assess individuals and their needs on a regular basis and supports the concept of a patient focussed rehabilitation service. The pilot identified that most people could be discharged home or to other planned care e.g. a nursing home within the 42 days and that this final discharge destination does not change for longer inpatient stays. This change in bed use has been modelled against the number of beds available. The result is that the service, for patients coming out of the RSCH, can be provided from 42 beds at the current time, while the care pathway is still being fully established, which suggests some potential flexibility for the future.

4.6 Day hospitals form part of the intermediate care services, and provide rehabilitation packages and comprehensive assessment to facilitate discharge. A review of day hospitals has been undertaken and the findings indicate the need for facilities at 3 locations in order to meet the needs of the population of Guildford and Waverley.

4.7 Flexible use of community hospital beds, Step Up to provide local inpatient assessment and treatment and to avoid acute hospital admission, Step Down to support discharge

4.8 Currently people admitted to an acute hospital go through A&E or an Assessment Unit before they reach a ward where they stay for their treatment. The patient can then be transferred to a community hospital bed to complete their episode of care. We are proposing a direct admission to a Step Up bed as an alternative. Currently 61% of the community beds are used by elderly patients needing to complete their episode of care in a community hospital.

4.9 Step Up beds will enable patients to be cared for in a community hospital bed, thus avoiding an inappropriate admission to an acute hospital when needs could be better met nearer to people's homes. Currently, people may be admitted to an acute hospital unnecessarily, and the aim is to provide treatment in a community / local setting. This results in quicker diagnosis and/or treatment and shorter hospital stays. This reduces the need for prolonged periods of rehabilitation prior to discharge. By using the community hospital beds in this way we can also reduce the demand on social care services.

4.10 Older people particularly can benefit from direct admission to a community hospital as it avoids subsequent transfers. They could be admitted directly onto a ward with no further bed moves required during their stay, which can result in a shorter stay in hospital. They can then receive a diagnosis, further investigations and any further specialist input required.

4.11 A feasibility pilot was undertaken at Haslemere Hospital during the summer of 2005 to investigate the potential of using beds in the community hospitals as an alternative to an admission to an acute hospital for elderly people with complex health and social care needs. This pilot found that a third of the people assessed still needed to be admitted to an acute hospital. Another third were able to be helped while remaining at home or moving temporarily into residential care. The final third of people were admitted to a bed in a hospital in the community where their medical care was managed by a GP. They had an average length of stay of 10 days. More effective use of hospital beds will enable the PCT to increase the number of patients treated using a smaller number of beds. The results of the pilot suggest that up to 380 more patients per year could be treated in 27 Step Up beds than are currently being treated in the 51 Step Down beds.

4.12 This approach should deliver real benefit to our patients who are less likely to spend time in an acute hospital and will have far shorter overall stays in hospital. It is in the interests of the acute hospitals as it suggests that a number of current admissions of elderly patients may not be required. Consequently, fewer beds are required by acute and rehabilitation services for this population. The pilot has been extended to gather further evidence.

4.13 The following case studies illustrate the benefits of direct admission to a community bed:

Case Study 1

An 85 year old lady was admitted into a community hospital bed via her local Health Centre. The patient had been reluctant to go into an acute hospital as this was located away from her home. She was feeling 'unwell' and blood tests taken two days before had indicated underlying inflammation and infection. She had been given a chest x-ray en route to the ward. Further tests (diagnostics) were carried out in the community hospital over the next 36 hours. Once the diagnosis had been confirmed the patient was able to receive the appropriate treatment and care. Thus the patient had one admission point; she received the diagnostic intervention at the community hospital, close to her home. It was not necessary for her to move wards. She got to know all the staff and her individual needs were met.

Case Study 2

A 74 year old lady had been unable to cope at home for 4 days despite increased home care and nursing visits. Her presenting symptoms were: vomiting, incontinence of urine, and high temperature. Past medical history included: being a heavy cigarette smoker with a history of alcohol dependency. Admitted to a community bed for assessment and diagnosed with a urine infection after full blood tests had been done and a specimen of urine obtained for microbiology (testing). Tests showed some imbalance. An intravenous infusion (IV drip) was given over forty eight hours with intravenous antibiotics. Four hourly observations were maintained for forty eight hours. High temperature resolved and the patient was re-hydrated i.e. plenty of fluids given. Tests repeated daily for three days. Vomiting stopped and normal diet recommenced. Patient completed her course of antibiotics. Well enough to be discharged home on day six. On discharge the home care was reduced back to daily visits. Nurses continued to visit at home for two weeks post-discharge to monitor her progress. Did not require any further antibiotics. The patient has remained out of hospital since.

5 PROPOSED OPTIONS

5.1 Below you will find proposed options on the future of services provided at Milford Hospital, Cranleigh Hospital, Haslemere Hospital, FHCFH and the proposed locality development at Godalming. These options have been developed after consideration of evidence, as described earlier, from the following sources:

- Population need for specialist rehabilitation carried out by the PCT's Public Health Team.
- Development of a 'Service Pathway for Older People with Complex Needs Who Require Rehabilitation'.
- The work of the Clinical Services Development Programme Board.
- An analysis of 'Capacity Management in the Local Health Community' commissioned by the PCT.
- A review of 'Sustainable Services for Surrey and Sussex' commissioned by Surrey and Sussex SHA.
- PCT Financial Recovery Plan.
- DoH guidance and current thinking.
- The vision for the future.

5.2 The PCT is proposing several options which will support the development of locally based services, making available more diagnostics and access for people to 'planned' treatment. In these options the overall number of beds in community hospitals and Milford Hospital will be reduced from 172 to approximately 140. The options for consideration are as follows:

Current Position

5.3 The current position is used as the ***baseline*** against which all options can be compared. It shows services and beds as they currently are in each location. These comprise:

- 50 specialist consultant led rehabilitation beds located at Milford.
- 14 flexibly used, GP managed beds at Cranleigh.
- 16 flexibly used, GP managed beds at Haslemere and the 14 bedded Young Physically Disabled Unit, which is consultant led.
- 26 specialist consultant led rehabilitation beds and 21 Step Down beds at Farnham, also managed by the consultant led team.
- 6 GP managed beds and 4 continuing care beds at Farnham.
- 21 for older adult mental health beds at Farnham, managed by Surrey and Borders Partnership NHS Trust.
- Day hospitals located at Milford, Cranleigh, Farnham and Guildford.
- Direct access therapy services located at Milford, Haslemere, Cranleigh, Farnham and Guildford.

Options for Consultation

5.4 See page 7 for an explanation of the terms Step Up and Step Down.

Option 1

5.5 This option comprises the closure of Milford Hospital and the re-provision of 42 consultant led specialist rehabilitation beds at FHCFH. This is dependent upon the relocation, to a more appropriate setting, of 21 beds for older adult mental health, currently at FHCFH. In this option all 14 beds at Cranleigh Hospital would close. 4 continuing care beds would need to be commissioned from the private sector. Other services based at Milford would also be re-located; details regarding this were set out in the 'Supplementary Information Document' issued in December 2004.

5.6 This option includes the closure of the 51 Step Down beds currently at Cranleigh Hospital, Haslemere Hospital and FHCFH and the establishment of 27 Step Up beds. 16 beds would be located at Haslemere Hospital and 11 beds at FHCFH. This would result in a net closure of 24 Step Down beds.

5.7 Diagnostic facilities and access to outpatient facilities would be available at Cranleigh, Farnham, Haslemere, Godalming and Guildford. Day hospitals will be situated at Farnham, Haslemere and Guildford. Local treatment facilities for the population of Godalming would be developed. FHCFH would be used to capacity. Beds that are currently empty because they are un-commissioned would be filled.

5.8 Locality based services for the population of Guildford and Waverley, such as expanded community nursing and therapy teams, and additional medical support to the Step Up beds, would be developed in this option.

5.9 This option could be implemented by March 2008.

Option 2

5.10 This option comprises the closure of Milford Hospital and the re-provision of 42 consultant led specialist rehabilitation beds located at the RSCH. The capacity to provide these beds at the RSCH, either in an existing ward or a new build, and the future management arrangements of the specialist rehabilitation service would be agreed at a future date. Other services based at Milford would also be re-located; details regarding this were set out in the 'Supplementary Information Document' issued in December 2004. In this option all 14 beds at Cranleigh Hospital and 30 beds at Haslemere Hospital would close. 14 beds for young physically disabled people would either be commissioned elsewhere or re-located to FHCFH in which case the 21 mental health beds would be commissioned elsewhere. The service model for young physically disabled people is currently being reviewed across west Surrey, services are currently provided from The Godwin Unit in Haslemere Hospital and The Bradley Unit in Woking Community Hospital

5.11 This option includes the closure of the 51 Step Down beds currently at Cranleigh Hospital, Haslemere Hospital and FHCFH and the establishment of 27 Step Up beds. All 27 beds would be located at FHCFH. There would be a net closure of 24 Step Down beds.

5.12 Diagnostic facilities and access to outpatient facilities would be available at Cranleigh, Farnham, Haslemere, Godalming and Guildford. Day hospitals will be situated at Farnham, Haslemere and Guildford. Local treatment facilities for the population of Godalming would be developed.

5.13 Locality based services for the population of Guildford and Waverley, such as expanded community nursing and therapy teams, and additional medical support to the Step Up beds, would be developed in this option.

5.14 This option could be implemented by December 2007.

Option 3

5.15 This option comprises the closure of Milford Hospital and the re-provision of 42 consultant led specialist rehabilitation beds split equally, with 21 beds based at FHCFH and 21 beds based at the RSCH. In this option the mental health beds currently sited at FHCFH would remain where they are. In this option all 14 beds at Cranleigh Hospital would close. 4 continuing care beds would need to be commissioned from the private sector. Other services based at Milford would also be re-located; details regarding this were set out in the 'Supplementary Information Document' issued in December 2004.

5.16 This option includes the closure of the 51 Step Down beds currently at Cranleigh Hospital, Haslemere Hospital and FHCFH and the establishment of 27 Step Up beds. 16 beds would be located at Haslemere Hospital and 11 beds at FHCFH. There would be a net closure of 24 Step Down beds.

5.17 Diagnostic facilities and access to outpatient facilities would be available at Cranleigh, Farnham, Haslemere, Godalming and Guildford. Day hospitals will be situated at Farnham, Haslemere and Guildford. Local treatment facilities for the population of Godalming would be developed.

5.18 Locality based services for the population of Guildford and Waverley, such as expanded community nursing and therapy teams, and additional medical support to the Step Up beds, would be developed in this option.

5.19 This option could be implemented by December 2007.

Option 4

5.20 This option comprises the closure of Milford Hospital and the re-provision of 42 consultant led specialist rehabilitation beds split equally with 21 beds based at FHCFH and 21 beds based at the RSCH. 4 continuing care beds would need to be commissioned from the private sector. Other services based at Milford would also be re-located; details regarding this were set out in the 'Supplementary Information Document' issued in December 2004. 14 beds for young physically disabled people would either be commissioned elsewhere or re-located to FHCFH in which case the 21 mental health beds would be commissioned elsewhere. The service model for young physically disabled people is currently being reviewed across west Surrey, services are currently provided from The Godwin Unit in Haslemere Hospital and The Bradley Unit in Woking Community Hospital

5.21 This option includes the closure of the 51 Step Down beds currently at Cranleigh Hospital, Haslemere Hospital and FHCFH and the establishment of 27 Step Up beds. 14 beds would be located at Cranleigh Hospital and 13 located at FHCFH. There would be a net closure of 24 Step Down beds.

5.22 Diagnostic facilities and access to outpatient facilities would be available at Cranleigh, Farnham, Haslemere, Godalming and Guildford. Day hospitals will be situated at Farnham, Haslemere and Guildford. Local treatment facilities for the population of Godalming would be developed.

5.23 Locality based services for the population of Guildford and Waverley, such as expanded community nursing and therapy teams, and additional medical support to the Step Up beds, would be developed in this option.

5.24 This option could be implemented by December 2007.

Option 5

5.25 This option comprises a split site for consultant led rehabilitation beds with 42 located at Milford Hospital and 26 located at FHCFH. As per Options 1 to 4 this also includes the move from Step Down to Step Up beds, but in this instance 16 beds would be located at Milford Hospital and 11 at FHCFH. There would be a net closure of 24 Step Down beds. There would be no beds located at Cranleigh or Haslemere Hospital. The 14 beds for young physically disabled people would be re-located at FHCFH. This would also leave 2 un-commissioned beds at FHCFH.

5.26 Diagnostic facilities and access to outpatient facilities would be available at Cranleigh, Farnham, Haslemere, Guildford and Milford. Day hospitals will be situated at Farnham, Guildford and Milford.

5.27 In this option local treatment facilities for the population of Godalming would be developed on the Milford Hospital site.

5.28 Locality based services for the population of Guildford and Waverley, such as expanded community nursing and therapy teams, and additional medical support to the Step Up beds, would be developed in this option.

5.29 This option could be implemented by December 2006.

General Comments

Where we are closing beds we intend to:

- ***Put in place a wider range of community based services that are able to respond to the needs of the individual more rapidly***
- ***Work with partners to tackle the problems of responding to unscheduled care by putting in place a single point of access - that is one point where people go to seek help or to access services***
- ***Make available locally a lot more diagnostics and 'planned' care for people***
- ***Use the Step Up beds more flexibly, across the area, rather than primarily for people who live in the locality of the hospital***
- ***Support patients in Step Up beds by ensuring they and their carers are involved in discharge planning as soon as possible after admission***
- ***Make available locally a range of services whereby people can receive a diagnosis and then go on to have treatment in one centre***
- ***Put patients at the centre of discharge planning and be actively involved in arrangements to support them when they are discharged***

Current Position

	Localities					
Service Provision	**Cranleigh**	**Farnham**	**Haslemere**	**Godalming**	**Guildford**	**Milford**
Consultant led Rehabilitation beds		26				50
Step Down beds	14	21	16			
Step Up beds						
Young Physically Disabled beds			14			
GP beds		6				
Continuing Care beds		4				
Un-commissioned beds		6				
Mental Health beds		21				
Diagnostics		✓	✓		✓	✓
Day Hospital	✓	✓			✓	✓
Local Treatment Facility at Godalming						
Access to outpatient services	✓	✓	✓		✓	✓
Total beds	**14**	**84**	**30**	**0**	**0**	**50**

Notes:

- There are 6 un-commissioned beds in total.
- Total number of beds in use is 172.
- The consultant led rehabilitation beds at Milford are for patients coming out of RSCH and at Farnham for patients predominantly from FPH.
- Rapid assessment and treatment services are provided from Farnham and Guildford day hospitals.

Options 1 – 5 are summarised in the following tables:

Option 1

	Localities					
Service Provision	**Cranleigh**	**Farnham**	**Haslemere**	**Godalming**	**Guildford**	**Milford**
Consultant led Rehabilitation beds		68				
Step Down beds						
Step Up beds		11	16			
Young Physically Disabled beds			14			
GP beds		5				
Continuing Care beds						
Un-commissioned beds						
Mental Health beds						
Diagnostics	✓	✓	✓	✓	✓	
Day Hospital		✓	✓		✓	
Local Treatment Facility at Godalming				✓		
Access to outpatient services	✓	✓	✓	✓	✓	
Total beds	**0**	**84**	**30**	**0**	**0**	**0**

Notes:

- 21 mental health beds would be commissioned elsewhere.
- 4 continuing care beds would be commissioned from the private sector.
- Total number of beds 139.
- Limited diagnostics at Cranleigh to support outpatient clinics but not inpatient beds.
- References to outpatient and day hospital facilities do not include services provided to people who have mental health problems.
- Services provided in day hospitals need to support Step Up beds with associated assessment and diagnostics and also support the specialist elderly rehabilitation service. Provision may not be on a 5 day a week basis.
- If there are no beds at Cranleigh the Cranleigh Project would close and non-inpatient services would be developed on the existing hospital or health centre sites. Where an option includes beds at Cranleigh the planned combined hospital and health centre on the new donated site could be built.

Option 2

	Localities					
Service Provision	**Cranleigh**	**Farnham**	**Haslemere**	**Godalming**	**Guildford**	**Milford**
Consultant led Rehabilitation beds		26			42	
Step Down beds						
Step Up beds		27				
Young Physically Disabled beds						
GP beds		6				
Continuing Care beds		4				
Un-commissioned beds						
Mental Health beds		21				
Diagnostics	✓	✓	✓	✓	✓	
Day Hospital		✓	✓		✓	
Local Treatment Facility at Godalming				✓		
Access to outpatient services	✓	✓	✓	✓	✓	
Total beds	**0**	**84**	**0**	**0**	**42**	**0**

Notes:

- Total number of beds is 140.
- 14 beds for young physically disabled people would either be commissioned elsewhere or re-located to Farnham in which case the 21 mental health beds would be commissioned elsewhere. The service model for young physically disabled people is currently being reviewed across west Surrey, services are currently provided from The Godwin Unit in Haslemere Hospital and The Bradley Unit in Woking Community Hospital.
- Limited diagnostics at Cranleigh to support outpatient clinics but not inpatient beds.
- References to outpatient and day hospital facilities do not include services provided to people who have mental health problems.
- Services provided in day hospitals need to support Step Up beds with associated assessment and diagnostics and also support the specialist elderly rehabilitation service. Provision may not be on a 5 day a week basis.
- If there are no beds at Cranleigh the Cranleigh Project would close and non-inpatient services would be developed on the existing hospital or health centre sites. Where an option includes beds at Cranleigh the planned combined hospital and health centre on the new donated site could be built.

Option 3

	Localities					
Service Provision	**Cranleigh**	**Farnham**	**Haslemere**	**Godalming**	**Guildford**	**Milford**
Consultant led Rehabilitation beds		47			21	
Step Down beds						
Step Up beds		11	16			
Young Physically Disabled beds			14			
GP beds		5				
Continuing Care beds						
Un-commissioned beds						
Mental Health beds		21				
Diagnostics	✓	✓	✓	✓	✓	
Day Hospital		✓	✓		✓	
Local Treatment Facility at Godalming				✓		
Access to outpatient services	✓	✓	✓	✓	✓	
Total beds	**0**	**84**	**30**	**0**	**21**	**0**

Notes:

- 4 continuing care beds would be commissioned from the private sector.
- Total number of beds 139.
- Limited diagnostics at Cranleigh to support outpatient clinics but not inpatient beds.
- References to outpatient and day hospital facilities do not include services provided to people who have mental health problems.
- Services provided in day hospitals need to support Step Up beds with associated assessment and diagnostics and also support the specialist elderly rehabilitation service. Provision may not be on a 5 day a week basis.
- If there are no beds at Cranleigh the Cranleigh Project would close and non-inpatient services would be developed on the existing hospital or health centre sites. Where an option includes beds at Cranleigh the planned combined hospital and health centre on the new donated site could be built.

Option 4

	Localities					
Service Provision	**Cranleigh**	**Farnham**	**Haslemere**	**Godalming**	**Guildford**	**Milford**
Consultant led Rehabilitation beds		47			21	
Step Down beds						
Step Up beds	14	13				
Young Physically Disabled beds						
GP beds		3				
Continuing Care beds						
Un-commissioned beds						
Mental Health beds		21				
Diagnostics	✓	✓	✓	✓	✓	
Day Hospital		✓	✓		✓	
Local Treatment Facility at Godalming				✓		
Access to outpatient services	✓	✓	✓	✓	✓	
Total beds	**14**	**84**	**0**	**0**	**21**	**0**

Notes:

- 4 continuing care beds would be commissioned from the private sector.
- 14 beds for young physically disabled people would either be commissioned elsewhere or re-located to Farnham in which case the 21 mental health beds would be commissioned elsewhere. The service model for young physically disabled people is currently being reviewed across west Surrey, services are currently provided from The Godwin Unit in Haslemere Hospital and The Bradley Unit in Woking Community Hospital.
- Total number of beds 137.
- References to outpatient and day hospital facilities do not include services provided to people who have mental health problems.
- Services provided in day hospitals need to support Step Up beds with associated assessment and diagnostics and also support the specialist elderly rehabilitation service. Provision may not be on a 5 day a week basis.
- If there are no beds at Cranleigh the Cranleigh Project would close and non-inpatient services would be developed on the existing hospital or health centre sites. Where an option includes beds at Cranleigh the planned combined hospital and health centre on the new donated site could be built.

Option 5

	Localities					
Service Provision	**Cranleigh**	**Farnham**	**Haslemere**	**Godalming**	**Guildford**	**Milford**
Consultant led Rehabilitation beds		26				42
Step Down beds						
Step Up beds		11				16
Young Physically Disabled beds		14				
GP beds		6				
Continuing Care beds		4				
Un-commissioned beds		2				
Mental Health beds		21				
Diagnostics	✓	✓	✓		✓	✓
Day Hospital		✓			✓	✓
Local Treatment Facilty at Godalming						✓
Access to outpatient services	✓	✓	✓		✓	✓
Total beds	**0**	**84**	**0**	**0**	**0**	**58**

Notes:

- There are 3 un-commissioned beds in total.
- Total number of beds 139.
- References to outpatient and day hospital facilities do not include services provided to people who have mental health problems.
- The consultant led rehabilitation beds at Milford are for patients coming out of RSCH and at Farnham for patients predominantly from FPH.
- Services provided in day hospitals need to support Step Up beds with associated assessment and diagnostics and also support the specialist elderly rehabilitation service. Provision may not be on a 5 day a week basis.
- This option looks at the development of the Milford Hospital site. The PCT explored a number of suggestions put forward by the 'cross community group' described in the previously published document 'Modernising Your Local Healthcare - Supplementary Information Document' - December 2004. In the concluding document 'Modernising Your Local Healthcare' March 2005, the PCT reported that services would cost significantly more to provide in this way.
- If there are no beds at Cranleigh the Cranleigh Project would close and non-inpatient services would be developed on the existing hospital or health centre sites. Where an option includes beds at Cranleigh the planned combined hospital and health centre on the new donated site could be built.

Non Financial Option Appraisal

A non-financial option appraisal was conducted by the PEC* as follows:

1. The criteria used in this non-financial option appraisal are a modified version of those used by Surrey and Sussex SHA to assess the merits of various proposals put forward to develop services.

2. The criteria were discussed and weighted against a standard of 100.

3. The criteria were then scored 0 to 10 (0 = does not meet criterion, 10 = fully meets criterion).

4. The average scores were then multiplied against the weighting to give a weighted average and summed to give a total weighted score for each option.

	Strategic Coherence	Health Gain	Access / transport parking	Impact on service performance	Clinical Governance	Patient Environment	Estate Optimisation	Staff Recruitment and Retention	Deliverability	TOTAL
Weighting	**15**	**15**	**10**	**15**	**15**	**8**	**5**	**8**	**9**	**100**
Current Position	60	75	40	75	45	40	10	40	90	**475**
Option 1	90	90	30	90	90	56	35	48	27	**556**
Option 2	45	90	20	75	105	56	35	32	27	**485**
Option 3	60	90	30	75	60	48	35	32	36	**466**
Option 4	60	90	30	60	45	56	25	32	36	**434**
Option 5	90	105	30	105	105	48	25	56	63	**627**

A Clinical Advisory Group comprising mainly medical, nursing and therapy staff will be providing clinical advice to the PCT during the Consultation process.

** The PEC which makes recommendations to the PCT Board on broad policy and on specific aspects of care and treatment to meet local needs and to achieve national standards and targets comprises mainly family doctors, nurses and other healthcare professionals.*

6 FINANCE

6.1 We have made no secret of the fact that the local health economy is facing significant financial problems. These proposals have been developed with the aim of modernising local healthcare services whilst ensuring services are affordable and that we do not continue to spend more than available budget. The proposed changes will help us work more efficiently and use resources more effectively. Patients will benefit by remaining independent for longer, avoiding unnecessary hospital admissions.

6.2 Figures from the SHA Programme Budget Spend, 2003/04, show that Surrey and Sussex SHA spends some 6% higher on all healthcare services, on a weighted population basis, than the England average and Guildford and Waverley PCT almost 6% above the SHA average.

6.3 We can work more efficiently by:

- Doing things differently, for example, making sure older people's care needs are assessed thoroughly and accurately, but without procedures being needlessly duplicated by different agencies.
- Making better use of the existing estate by reducing the number of buildings we use and using to maximum effect those buildings we retain.
- Enhancing primary care services, e.g. developing the role of community pharmacists, GPs with special interests and community nurse led care for people with long term conditions.

6.4 The PCT has a statutory duty to achieve financial balance each year. Currently we are spending more than we can afford and this has to be addressed. We have been proactive in managing financial difficulties by putting in place a plan to recover and redress this situation, but we need to do more.

6.5 We want to continue to provide services which are available locally, of the highest quality and offer appropriate treatment to the population. However, we cannot afford to financially support this on all of the current sites. This Consultation recognises the way forward is investing in more efficiently run and appropriate services which will be affordable and sustainable in the future.

Financial Option Appraisal

6.6 A financial appraisal of the current position and the 5 options was undertaken and is summarised as follows:

	Saving / (Cost) £'000	Loss of Income £'000	New Investment in Services £'000	Cost of Re-provision of services £'000	Reduced Acute Commissioning £'000	Net Saving / (Cost) £'000
Current Position	(5)	0	0	0	0	(5)
Option 1	2,521	(144)	692	166	559	2,078
Option 2	3,449	(658)	785	796	570	1,781
Option 3	2,382	(144)	692	166	559	1,939
Option 4	3,570	(649)	850	962	537	1,646
Option 5	1,654	(18)	375	0	570	1,831

Assumptions Used in the Financial Option Appraisal

Applicable Option	Assumption
All	Income and expenditure is at 2005/06 levels.
All	Backlog maintenance costs have not been taken into account.
All	Capital costs are indicative for the purpose of calculating capital charges. No detailed design work has been undertaken.
5	A one off capital cost of £45,000, revenue charge £5,000, for electrical work is required to keep Milford Hospital open.
4	Changes in the provision of services at a new Cranleigh Hospital would be cost neutral to the PCT.
All	No provision has been made for capital receipts relating to the sale of the Milford site or for costs relating to its disposal.
2, 4	At Haslemere Hospital one of the wards will be converted into a Day Hospital.
1, 2, 3, 4	Godalming treatment facility would be in leased accommodation. Costs relate to the community equipment room and therapy treatment rooms and a proportion of the shared areas. Other providers located in the building would meet their respective proportion of the revenue costs.
1,3,4	The estimated cost of re-providing the continuing care beds are £800 per patient per week.
1	The re-provision of the 21 older adult mental health beds will be cost neutral to the PCT.
2, 3, 4	Capital costs for beds based on the RSCH site have been taken from the work for the previous consultation and uplifted by 2.5% for 2005/06.
2, 4	9 Young Physically Disabled beds (i.e. those commissioned by the PCT) will be re-provided at a cost of £1,700 per patient per week.
5	Costs for the local treatment facility at Milford Hospital relate to the community treatment room and the therapy treatment rooms and a proportion of the shared areas. Other providers located in the building will meet their respective proportion of the revenue costs.
All	No non recurrent costs of change have been included.

6.7 The current position has not been included as an option for Consultation because it is not financially sustainable.

7 CONCLUSION

7.1 In order to meet the changing health care needs of the population and to enable people to benefit from new health care technologies we cannot continue to commission or provide services in the way we have. The PCT considers it important to focus its resources on health care that will improve people's health and quality of life. The PCT needs to have services that are sustainable and affordable locally while reflecting national policy.

7.2 This Consultation includes five options; however as this is a public Consultation the PCT is open to flexibilities regarding these options, including the proposed use of beds. The way forward must enable the following:

- Substantial recurrent financial savings.
- Services that can be used flexibly over time.
- A reduction in overall bed numbers in line with the options proposed.
- Implementation by no later than March 2008.
- Provision that is based on robust evidence of its effectiveness and gives optimal outcomes for individual people.

DECEMBER 2005

8 HAVING YOUR SAY

This Public Consultation starts on 1 December 2005 and will end on 28 February 2006.

Copies of the Consultation Document are being widely circulated and will also be available in libraries and other public places; it can also be read on the PCT website at: www.gwpct.nhs.uk. Previously published documents, referenced in this document, are also available on this website. Publicity for the Consultation is being sought in the local media.

Public meetings to present and discuss the options in this Document will be held as follows:

Monday	**5 December**	**6pm**	**Main Hall Rodborough School and Technology College Rake Lane, Milford**
Friday	**9 December**	**10.30am**	**Godalming Baptist Church Queen Street, Godalming**
Monday	**19 December**	**2pm**	**Great Hall Farnham Maltings, Farnham**
Monday	**16 January**	**6pm**	**Cranleigh Arts Centre High Street, Cranleigh**
Thursday	**19 January**	**2pm**	**Main Hall Haslemere Hall, Haslemere**
Tuesday	**24 January**	**10.30am**	**Coffee Lounge St Saviour's Church Woodbridge Road, Guildford**

If you have a local group and would like the opportunity for a PCT representative to come along and discuss the consultation, please phone Laura Dennett on 01252 305855

The outcome of the Consultation will be published and will be discussed at a meeting in public, of the Board of Guildford and Waverley PCT on **23 March 2006.** The venue and timing for this meeting will be advertised.

Comments on the recommendations in this Consultation document can be made by:

Sending the Response Form at the back of this document to Freepost RLXC-AXYC-RAAL 'Modernising Your Local Healthcare Consultation', Guildford and Waverley Primary Care Trust, Broadmede House, Farnham Business Park, Weydon Lane, Farnham, GU9 8QT

Telephone 01252 305700
Fax 01252 305701

E-mail to consultation@gwpct.nhs.uk

Please also contact the PCT using these details if you wish to make a complaint about this document. We undertake to read and record and to take into account all responses but will not be able to individually acknowledge receipt of them or any other correspondence relating to this Consultation. A summary of the analysis of responses will be published. The full set of responses will be filed and available for public inspection along with the full analysis. Please note that your response may be made public unless confidentiality is specifically asked for. We may also publish your response in a summary of responses to the Consultation unless you specifically include a request to the contrary.

9. GLOSSARY OF TERMS

A&E	Accident and Emergency
Capacity of local services	Total of all services provided
CAS	Clinical Assessment Service
Commissioned services	Funded services
Continuing Care Beds	Beds for patients needing long term care
Demography	Study of population
Diagnostic and treatment centre	Centre which provides access to investigative procedures and treatment
DoH	Department of Health
Domiciliary	Home based
ENT	Ear, nose and throat
FHCFH	Farnham Hospital and Centre For Health
FPH	Frimley Park Hospital
GP	General Practitioner
Hospital admissions criteria	Specific reasons for being admitted to hospital
HSC	Health Scrutiny Committee
Locality based services	Service available locally
Long term conditions	Chronic illnesses e.g. heart disease, bronchitis
Medical Assessment Unit	Unit in a hospital where a patient can have their medical condition investigated
Minor Injury Unit	Service provided to treat minor injuries
National Service Framework	Department Of Health long term strategy for treatment of specific conditions including standards for care
Older people with complex needs	Older people with multiple medical and/or social care problems
Primary Care	First contact for the patients who feel they need access to care or treatment, often their GP
PCT	Primary Care Trust
PEC (Professional Executive Committee)	PEC makes recommendations to the PCT Board on broad policy and on specific aspects of care and treatment, providing clinical advice
Practice Based Commissioning	Treatment and services funded by a GP practice
Rehabilitation services	Therapy and/or clinical services to support patients in achieving greatest independence
Rehabilitation pathway	Map of patient journey to access the most appropriate rehabilitation service
RSCH	Royal Surrey County Hospital
Secondary care	Care and treatment in an acute hospital
SHA	Strategic Health Authority
Specialist rehabilitation	Consultant led rehabilitation service
Step Up bed	Bed used for the facilitation of direct admissions from the community to avoid acute admission
Step Down bed	Bed used to complete episodes of care from the acute Trust
TCCP	Transforming Chronic Care Programme
Telemedicine	Tele-monitoring equipment which is used to transmit heart rate, blood pressure and other signs about a patient's condition to a medical team
Un-commissioned beds	Beds which are not funded
Unscheduled care	Non planned treatment episode
Voluntary Sector	Local and national charities that provide health and social care services
Walk-in-Centre	Patients can walk-in without an appointment and be treated for minor injuries or ailments

MODERNISING YOUR LOCAL HEALTHCARE RESPONSE FORM

Please complete and return to: **Freepost RLXC-AXYC-RAAL, 'Modernising Your Local Healthcare Consultation', Guildford and Waverley Primary Care Trust, Broadmede House, Farnham Business Park, Weydon Lane, Farnham, GU9 8QT**

Do you accept the need to make changes to community hospitals and services? ❑ **Yes** ❑ **No**

Do you support the plans to modernise services? ❑ **Yes** ❑ **No**

Do you have any general comments?

Option 1

Do you support this proposal? ❑ Yes ❑ No ❑ Don't Know

Why do you say that?

Option 2

Do you support this proposal? ❑ Yes ❑ No ❑ Don't Know

Why do you say that?

Option 3

Do you support this proposal? ❑ Yes ❑ No ❑ Don't Know

Why do you say that?

Option 4

Do you support this proposal? ❑ Yes ❑ No ❑ Don't Know

Why do you say that?

Option 5

Do you support this proposal? ❑ Yes ❑ No ❑ Don't Know

Why do you say that?

Thank you for taking the time to complete this response form. So that we can analyse all the responses and get an accurate picture, it is important that you complete your details clearly below:

Name	
Address	
Post Code	**Telephone**
E mail	

Do you work for Guildford & Waverley PCT? ❑ (Tick box if appropriate)

I wish my response to remain confidential ❑ (Tick box if appropriate)

Are you responding on behalf of an organisation? If so please provide details:

We will keep your details on the mailing list in order to update you on the Public Consultation and the work of Guildford and Waverley PCT. We will not share your details with any other organisation. If you do not wish to be on the mailing list please tick here ❑