Guildford and Waverley Programme

Strategic Outline Business Case

Document Status: Draft
### Review

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### Approval

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### Document History

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<tr>
<th>Version</th>
<th>Summary of Changes</th>
<th>Document Status</th>
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<tr>
<td>0.1-0.9</td>
<td>Working drafts of document</td>
<td>Draft</td>
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<tr>
<td>1.0</td>
<td>Initial Draft</td>
<td>Draft</td>
<td>10/06/09</td>
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<td>1.3</td>
<td>Draft for Gateway</td>
<td>Draft</td>
<td>16/06/09</td>
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<tr>
<td>1.4</td>
<td>Internal review comments</td>
<td>Draft</td>
<td>18/06/09</td>
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<tr>
<td>1.5</td>
<td>Addition of appendices</td>
<td>Draft</td>
<td>22/06/09</td>
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<tr>
<td>1.6</td>
<td>Post co-design update</td>
<td>Draft</td>
<td>23/06/09</td>
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<tr>
<td>1.7</td>
<td>Updates pre distribution to Programme Board</td>
<td>Draft</td>
<td>25/06/09</td>
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<tr>
<td>1.8</td>
<td>Amendments following approval in principle by G&amp;W Board</td>
<td>Draft</td>
<td>03/07/09</td>
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<td>11/07/09</td>
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<td>1.10</td>
<td>Update following input from Finance</td>
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<td>15/07/09</td>
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<td>1.11</td>
<td>Update following discussion at programme board</td>
<td>Draft</td>
<td>22/07/09</td>
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<tr>
<td>1.12</td>
<td>Update following discussions with SRO</td>
<td>Draft</td>
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1 Executive Summary

Guildford and Waverley Programme
Strategic Outline Business Case
Executive overview

1.1 Background
Between 2002-2006, the former Guildford and Waverley Primary Care Trust (G&W PCT) embarked on a major modernisation programme to provide locally based healthcare services that were both affordable and sustainable in the future.

The consultation document, Modernising Your Local Healthcare (December 2005), outlined a vision for the future and set out five proposed options for change designed to improve care for people and to develop services outside hospital. All of the options considered the future of services provided at Milford Hospital, Cranleigh Hospital, Haslemere Hospital, and Farnham Hospital and Centre for Health. The options were consulted on from 1 December 2005 - 28 February 2006. The Public Consultation Outcome document provided information about the outcome of the public consultation.

In October 2006, Surrey Primary Care Trust (now known as NHS Surrey) was established and following the “Creating an NHS Fit for the Future Programme”, the Guildford and Waverley Programme was set up to take forward the actions from the former G&W PCT and Surrey and Sussex Strategic Health Authority.

The Programme Mandate was approved on 31 March 2008 and set out how the outcome of the consultation was to be tested. In July 2008, the evidence from the Test For Fitness was presented to an Independent Panel for assessment. The panel recommended that ‘Option 1’ (see Appendix A), previously agreed by the former G&W PCT, did not meet the requirements of the White Paper ‘Our health, our care, our say’ or other recent policies including the national stroke strategy.

The NHS Surrey Board on 29 July 2008 accepted the panel’s recommendation and approved further and urgent work on the emerging clinical model. The Programme Brief set out the revised scope and objectives for the G&W Programme.

1.2 Purpose and scope

This business case considers the implications of adopting a new clinical model of care for stroke rehabilitation, orthopaedic rehabilitation, and post-acute care for complex elderly who may have a co-morbidity of dementia in the south west locality of Surrey as set out in the Programme Brief. The full objectives, outputs and targets listed in the Programme Brief are:

- Ensure that the outcome will deliver clinically safe and sustainable services that demonstrate an improvement for patients in the Guildford and Waverley area
- Deliver service specifications for the specialities listed above
• Finance, activity and capacity modelling of current service provision and option(s) for service delivery
• Engagement with patients, public, carers, and third sector organisations
• Recommendations to the NHS Surrey Board around the services provided in the Guildford and Waverley area
• Commission an agreed service delivery model
• Deliver services that meet clinical governance and national quality standards
• Deliver services that offer value for money in Surrey
• Inform a Surrey-wide model of care

The Programme Brief specifically notes that fundamental to the Business Case is the wider consultation and consensus on a new integrated clinical model as the basis of care into the future that meets patient needs and focuses on patient outcomes. The agreed model of care would inform subsequent decisions about community services infrastructure and resourcing.

1.3 Developing the Model of Care

The new clinical model of care has been developed with stakeholders and clinicians, has been reviewed by the National Clinical Advisory Team (NCAT), and represents our desired patient care pathway – ‘right care, right staff, right place, right time’. This higher quality model has been developed by local clinicians based on national policy, best practice and local factors and validated in co-design events\(^1\).

Co-design enables clinicians, patients, carers, managers, local authorities, the third sector and local community representatives to consider the reasons for change and the opportunities for improvement ensuring that the evidence and assumptions that lie behind the evidence are clear and open.

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\(^1\) Co-design is a method of allowing everyone who provides or receives health care to work together as equals to achieve solutions to complex problems by consensus. Consensus is usually defined as meaning general agreement. Consensus decision-making refers to the process of getting an entire group of people to come to an agreement. However, most literature defines a consensual decision as an agreement that all participants are prepared to live with. It is a decision that, while perhaps not the preferred choice of each member is one that all members can accept, understands and publicly support. This often happens because, when it works, collective intelligence does come up with better solutions than could individuals - On Conflict and Consensus. A handbook on Formal Decision Making. CT Butler and Amy Rothstein. An in-depth and comprehensive account. [http://www.ic.org/pnp/ocac](http://www.ic.org/pnp/ocac)
### Building Blocks of Model*

<table>
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<th>Description</th>
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<tr>
<td>Acute hospital</td>
<td>An initial assessment led by a consultant clinician supported by a team of skilled health care professionals</td>
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<tr>
<td>Specialist rehabilitation unit</td>
<td>A stay in a main hospital such as Frimley Park or Royal Surrey County Hospitals under the care of a consultant clinician.</td>
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<tr>
<td>Usual or new residence with support if needed</td>
<td>A stay in a specialist rehabilitation unit under the care of a consultant clinician with care provided by a team of skilled health care professionals. This could be on the same site as a main hospital or in a stand alone unit.</td>
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<tr>
<td>Period of acute in-patient care (e.g. operation)</td>
<td>A period of time where additional care is provided by skilled health care professionals in someone’s place of residence</td>
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*This new clinical model of care includes Day Assessment and Rehabilitation services such as the Milford Assessment and Rehabilitation Centre (MARC), the Florence Desmond Day Hospital at the Royal Surrey County Hospital and the planned re-provision of the day hospital services in the redeveloped Cranleigh Hospital.*
The development of this new model of care has been centred on what will best deliver improved patient outcomes. It proposes that patients require access to consultant led multi-disciplinary assessment, and thereafter may access one or more of the other elements depending on their clinical need.

The following principles were developed in co-design and adopted in the service strategies to support the delivery of patient benefits:

**Focus on patient needs:**
- Rapid access to specialist therapy and diagnostic services
- Services that demonstrate clear and equitable access
- Optimise the number of patients receiving rehabilitation in a home setting
- Ensure patients and their families are fully involved and fully informed in all stages of care and care planning
- Services that provide quality and meet clinical governance standards
- Individual care plans which meet patient needs

**Join up care pathways:**
- Defined pathways across acute inpatient, specialist centres, community services and home/residential care that optimise both patient outcomes and use of scarce resources
- Quality specialist rehabilitation centres treating patients post discharge from an acute hospital into long term care and support, including social care
- Ensure GP, social care, primary care and wider community teams are actively involved in all stages of care
- Mental health assessment and access to appropriate services should be integrated into the service models
- Improve patient access to rehabilitation services through an integrated multidisciplinary team (MDT) service and improve patient experience and satisfaction
- Appropriate and timely specialist assessment and treatment within a comprehensive multidisciplinary rehabilitation service

In addition to the clinical requirements outlined above it is envisaged by clinicians, and supported through co-design, that the model could best be delivered through a lead provider as described in section 6.3 who would manage the whole patient pathway and subcontract services as necessary.

**Patient safety and critical mass**

Ensuring patient safety is paramount to NHS Surrey as the commissioner of health services in the county. Equitable access and affordable services that provide value for money must also be considered.

As the population of south west Surrey is 250,000 and the patient numbers in the three specialities considered in the new model of care are relatively low, we have considered the principles of critical mass (see section 5.2) to ensure patient safety and access is
protected and value for money maintained.

The principles are that the clinical model requires specialist consultant led multidisciplinary assessment including consultant-led rehabilitation units, which follow the principles of patient critical mass in making optimum use of facilities and resources:

- ensure patient safety, risk management and clinical governance
- safeguard continuity of service
- ensure economies of scale e.g. consolidating specialties and sharing staff
- recruitment and retention of high-calibre staff
- maximise opportunities for career progression
- ensure skill transfer and personal development
- provide adequate supervision
- provide contingency cover

The Department of Health specialised services national definition states:

- ‘Specialised services are those with low patient numbers but which need a critical mass of patients to make treatment centres cost effective’
- ‘In some areas of specialised services, the number of patients who need the services is relatively small and the clinical expertise is therefore concentrated in one location to ensure that there is a sufficient critical mass of work to meet clinical governance standards’.  

1.4 Current approach

The current model of consultant led services provides good care and is highly rated by users but could be improved. Particular short-comings identified from the clinical engagement event held on 24/25 March 2009 include:

- Pathways that are not driven by patient outcomes; choosing from what is available rather than what is best for the patient
- Inequitable patient access; not all patients have access to consultant led rehabilitation
- Variability of care planning; lack of early comprehensive assessment and early discharge planning from the point of the initial incident
- No clear pathway of care with patients referred to an available service rather than one that meets their individual clinical needs
- Difficulty in tracking a patient across a pathway
- Insufficient and inadequate integration, co-ordination and communication between acute, mental health, community, social and primary care
- Gaps, limited flexibility and availability of services

\(^2\) Department of Health Specialised Services Definition
• Lack of focus on prevention e.g. falls
• Inefficient use of specialist services and skills e.g. access to Early Discharge Team; mental health services

1.5 Adopting the new model of care

The new model is based on a menu of care options designed to deliver a consultant led multidisciplinary assessment and treatment either in an acute hospital, a specialist rehabilitation unit, or in the patient’s usual place of residence.

Location of specialist rehabilitation unit

The specialist consultant led rehabilitation units could either be co-located with an acute site or be a separate standalone unit provided it meets the principles of critical mass described in 5.2.

Frimley Park Hospital NHS Foundation Trust predominately uses the specialist consultant led facilities at Farnham Hospital and Centre for Health. This community hospital is a relatively new development which already houses primary, community, and social care services and meets the principles of critical mass.

The Royal Surrey County Hospital NHS Trust predominately uses the specialist consultant led rehabilitation unit at Milford Hospital which meets the principles of critical mass and this arrangement could continue to be provided at Milford.

Alternatively, this service currently delivered from Milford could be co-located as a new build at Royal Surrey County Hospital NHS Trust at Guildford. Or it could be provided as a standalone unit in a new build elsewhere in the Guildford and Waverley area, for example in Cranleigh.

The existing community hospital sites at Cranleigh and Haslemere are not suitable for the specialist rehabilitation unit due to constraints of size.

Therefore there are currently three scenarios for the Royal Surrey facing services to be evaluated for the location of the Specialist Rehabilitation Unit:

• Scenario 1 – Pathway from RSCH mainly utilises specialist consultant led beds at Milford
• Scenario 2 - Pathway from RSCH mainly utilises specialist consultant led beds at a new build site at Royal Surrey County Hospital NHS Trust in Guildford
• Scenario 3 - Pathway from RSCH mainly utilises specialist consultant led beds at a new build site at Cranleigh

Do nothing has not been considered further as Milford Hospital requires refurbishment/backlog maintenance to meet the needs of the clinical model. It is assumed that the clinical model could be implemented in any of the three scenarios to meet strategic fit and clinical quality.
What this means for Cranleigh

The model of care is to provide consultant led specialist rehabilitation in a dedicated unit and in patients own homes or at a day assessment and rehabilitation service. This means that the majority of the patients who previously received their care in the 14 GP beds at Cranleigh Village Hospital will now receive this care in the proposed specialist rehabilitation units and from the community services which are already in place as described in section 5.6.

Within the new clinical model of care NHS Surrey plans to provide a modern consultant led outreach day assessment and rehabilitation service in the redeveloped Cranleigh Hospital as described in section 7 as an outreach from MARC at Milford.

The analysis of the future needs of patients in the Cranleigh area indicates that approximately 6 – 8 NHS beds will be needed for continuing care (including dementia patients), palliative care and shorter stay beds to avoid hospitals admissions. For this kind of care, we need to buy between 6-8 NHS beds in the Cranleigh area as described in section 7.

Under all scenarios, a commitment has been made to a new build GP and Health Centre in Cranleigh and to commission six to eight NHS beds. There are various options which would enable this to happen and these are subject to more detailed discussions with local GPs and other partners.

1.6 Appraising the options

During the appraisal of the options (see section 6), it became clear that there was a preferred scenario of Milford Hospital continuing to be the site of the Specialist Rehabilitation Unit.

The redevelopment plans for the healthcare facilities in Cranleigh are subject to a planning consultation which will be taken forward separately by Waverley Borough Council.

1.7 Key Conclusions and Recommendations

Conclusion 1
That the proposed Model of Care and pathways within this document are clinically appropriate and represent best practice

Recommendation 1
That the proposed Model of Care be adopted within the Guildford and Waverley areas.

Conclusion 2
Farnham Hospital is fit for purpose as a Specialist Rehabilitation Unit defined within the model of care
Recommendation 2
That Farnham Hospital site be used as the Specialist Rehabilitation Unit predominantly facing the Frimley Park Hospital NHS Foundation Trust in Frimley

Conclusion 3
The analysis of the evidence demonstrates the need for a single viable scenario for the location of the Specialist Rehabilitation Unit facing Royal Surrey County Hospital NHS Trust

Recommendation 3
That Milford Hospital site be refurbished and used as the Specialist Rehabilitation Unit predominantly facing the Royal Surrey County Hospital NHS Trust in Guildford

Conclusion 4
The analysis of the evidence demonstrates that the majority of patients in the Cranleigh area would be treated within the new consultant led model of care and additional community services already in place. This analysis strongly suggests that the 14 GP beds at Cranleigh Village Hospital that were temporarily closed by G&W PCT are no longer required.

The analysis of the future needs of patients in the Cranleigh area indicates that approximately 6 – 8 NHS beds will be needed for conditions such as continuing care (including dementia patients), palliative care, and shorter stay beds to avoid hospital admission. For this kind of care, we need to buy between 6-8 NHS beds in the Cranleigh area. It would be inappropriate to accommodate these types of patients in a single small unit. It is more usual for this to be provided by specialist nursing home facilities.

Recommendation 4
A recommendation in this Business Case is therefore to consult on:
- The commissioning of six to eight NHS funded beds in the Cranleigh area.
- The establishment of a state of the art consultant led day assessment and rehabilitation service in the redeveloped Cranleigh Hospital
- The permanent closure of the 14 GP beds at Cranleigh Village Hospital.

Conclusion 5
The principle of joining up care pathways formed through the co-design process can best be delivered by a single lead provider.

Recommendation 5
NHS Surrey commissions lead providers within clearly set contractual arrangements.

Conclusion 6
Clinical opinion is to establish a range of beds to enable the system to flex to meet increased or decreased demand.

Recommendation 6
The principle of utilising a range of beds is approved.
2 Introduction

This document presents the business case in more detail based on proposals developed as part of the Guildford and Waverley (G&W) Programme, led by NHS Surrey. Over the last year, our G&W plans have developed through ongoing discussions and engagement with clinicians, local authorities, patient, carer and public representatives, and other partners (public sector, third sector, and private sector) with the aspiration to develop more integrated primary and community care services that are easily accessible and focused on patient needs.

The G&W Programme is a major review of community service configuration for older people in southwest Surrey. The programme is driven by the objectives of NHS Surrey’s Strategic Commissioning Plan and, recently published national and local policies, all of which frame the direction for the NHS for the next 10 years. It uses emerging Surrey wide strategic change work and will inform future Surrey wide work.

The Programme is focused on redesigning and shaping the way community services are delivered in the southwest Surrey, in more local and convenient settings of care, closer to home, and in patient’s usual place of residence. The programme originally included neuro-rehabilitation and end of life care however the initial work including co-design concluded that these should be reviewed on a Surrey wide basis. They were therefore excluded from the scope of this programme. The scope now covers stroke rehabilitation, orthopaedic rehabilitation, and rehabilitation of complex elderly who may have a co-morbidity of dementia. It involves services currently delivered from Royal Surrey County Hospital, Frimley Park Hospital, Milford Hospital, Farnham Hospital and Centre for Health, and Cranleigh Village Hospital (temporary closure of inpatients beds since September 2005). The beds in Haslemere are either neuro-rehabilitation or are not consultant led specialist beds and outside the model of care’.

NHS Surrey works towards ensuring high quality care is a consistent part of everyone’s experience of primary, community and acute care. Services need to evolve to reflect the changes in healthcare and society described in High Quality Care For All: NHS Next Stage Review Final Report.

It is clear from national policy documents such as the White Paper ‘Our Health, Our Care, Our Say’ and the NHS Next Stage Review that there is a shared ambition for developing a greater range of services in GP practices, in other community-based settings, and in people’s usual place of residence. Crucially, this is matched by greater choice for patients so they can take advantage of the new range of services on offer.

For each of the services under review and developed in this Programme, NHS Surrey has established service strategies based on national guidance and best practice. They set out the clinical standards and quality requirements expected of the services to be commissioned. As the commissioner or ‘buyer’ of health services on behalf of Surrey residents, it is the responsibility of NHS Surrey to ensure effective care based on the best evidence available. A key principle in this role is to constantly review advice and guidance as it emerges to inform and develop our commissioning arrangements.
Adopting future changes when they occur will require clinical engagement and may require further consultation, but it is the only way to ensure that patients continue to receive high quality and effective care.

The health community within Surrey recognises the need for health services to adapt and change to meet these challenges. If we do nothing, healthcare in Surrey will be lagging behind national routine practice. Within NHS Surrey’s Strategic Commissioning Plan, we are addressing these challenges and will continue to work with provider organisations and patient and public representatives to design and deliver the necessary changes.

This document explains the new proposals for improvement under the G&W Programme. This document provides the strategic case for the work and sets out the service strategies for commissioning the services.

There are a range of factors that we considered when assessing current community services and making changes to ensure they are fit for the future. These include:

- Current performance
- The views of clinicians, patients, carers, managers, local authorities, the third sector and local community representatives and their changing needs and expectations
- Advances in clinical practice and healthcare technology
- Workforce constraints and developments
- National policy and system reform
- Value for money and financial sustainability

One of the major developments identified in the evidence base and confirmed in the work with our clinicians is the need to integrate services across pathways of care for example, stroke. This will produce significantly improve quality for patients in terms of better clinical outcomes, improved efficiency, and enable the patient pathways to be tracked throughout the system.
3 Background

Between 2002 and 2006, the former G&W PCT undertook a major modernisation programme to provide locally based healthcare services that were both affordable and sustainable in the future. In developing proposals for the future, G&W PCT was influenced by 4 key drivers:

- the needs and views of local people and staff
- changes taking place in the types of services prioritised nationally
- clinical support and evidence about clinical outcomes
- locally providing sustainable services within financial constraints

The consultation document, Modernising Your Local Healthcare (December 2005), outlined a vision for the future and set out five proposed options for change designed to improve care for people and to develop services outside hospital.

All of the options considered the future of services provided at Milford Hospital, Cranleigh Hospital, Haslemere Hospital, and Farnham Hospital and Centre for Health. The options were consulted on from 1 December 2005 – 28 February 2006. (The Public Consultation Outcome document provides information about the outcome of the public consultation.)

During the same period G & W PCT needed to implement a financial recovery plan in order to achieve financial balance. As part of this plan the G & W PCT took the decision in September 2005 to temporarily close the 14 beds at Cranleigh Village Hospital. The plan also included the closure of one day per week at Norman Day Hospital (Farnham) for one day per week and Milford Assessment and Rehabilitation Centre (MARC) for one day per week. In May 2006 G & W Professional Executive Committee reviewed the day hospitals and concludes that from the point of clinical effectiveness and health outcomes it would be better for patient care if the Cranleigh day hospital (currently three days per week) were closed as part of the urgent temporary measures and the Norman Day Hospital and MARC re-opened five days per week.

In January 2006, the Government White Paper ‘Our Health, Our Care, Our Say’ set out a new direction for health and social services. This paper reinforced the need for more community-focused services. In future, a greater proportion of care should be provided outside hospitals and more resources will be directed towards supporting people in their place of residence, in community venues and community hospitals, and in primary care.

On 27 April 2006, the G&W PCT Board discussed further the possibility of moving forward with option 1 from the consultation. Reports from Surrey’s Health Scrutiny Committee and the former Surrey and Sussex Strategic Health Authority were presented at the meeting. G&W PCT approved option 1 as recommended but agreed “that full implementation would rest with the PCT or any successor organisation and that implementation would be delayed until the decision had been tested against the Surrey wide review of settings of care.”
G&W PCT Board also agreed to undertake the 14 specific further actions set out in the public consultation outcome report, five additional actions set out in the former Surrey and Sussex Strategic Health Authority review, and the six actions set out by G&W Board meeting on 27th April 2006. This decision was taken in the context of the discussion document “Creating an NHS Fit for the Future” across Surrey and Sussex launched in June 2006.

In October 2006, NHS Surrey was established and following “Creating an NHS Fit for the Future Programme”, the G&W Programme was set to take forward the actions from the former G&W PCT.

The Programme Mandate was approved on 31 March 2008 and this document sets out the objectives. The Test for Fitness document set out how the outcome of the consultation was to be tested. In July 2008, the evidence from the Test for Fitness was presented to an Independent Panel for assessment and a recommendation on whether to implement Option 1. The panel recommended that ‘Option 1’, previously agreed by the former Guildford and Waverley Primary Care Trust, did not meet the requirements of the White Paper ‘Our health, our care, our say’ or other policies including the new national stroke strategy.

The panel reached a unanimous view that, as there were no compelling service or clinical reasons’ contained within the original proposals, NHS Surrey should consider a focused process to develop a model of care ‘consistent with best practice’. It is only with a strong model of care that the right decisions can be made.

In June 2008, the G&W Programme Board made a recommendation not to implement Option 1. The NHS Surrey Board on 29 July then accepted the recommendation and approved the End Stage Report to continue further and urgent work on the emerging clinical model. The Programme Brief sets out the revised scope and objectives for the G&W Programme.
4 Strategic fit

4.1 Business need

This community service reconfiguration programme fits with the objectives of NHS Surrey’s Strategic Commissioning Plan and recently published national and local policies, all of which frame the direction for the NHS for the next 10 years. It uses emerging Surrey wide strategic change work and will inform future Surrey wide work.

Business drivers for change:

- The goals of NHS Surrey’s Strategic Commissioning Plan
- The Department of Health World Class Commissioning Strategy that commissioners invest in local health services that bring the greatest health gains and reductions in health inequalities, which deliver sustainable services for the best value.
- Innovations in clinical pathways for stroke and cardiac care and the use of early discharge teams indicate that patients achieve better outcomes when treated in the community and in patient’s place of residence. The new consultant led multidisciplinary assessment service for stroke and orthopaedic rehabilitation has been developed pan Surrey and will deliver health improvements for patients with better clinical outcomes and provide value for money.
- The complex elderly pathway has also been developed across Surrey and while it is not anticipated for change in this pathway, it is anticipated that the consultant led multidisciplinary assessments will also deliver better outcomes for patients with a reduction on any requirement for the use of hospital beds. NHS Surrey Strategic Commissioning Plan stipulates that all patients with long term conditions have a personal care plan. It is forecast that these care plans will enable more patients to receive care in their own place of residence and enable patients and carers to feel part of their care decision planning.
- Lord Darzi’s mandate in the NHS Next Stage Review is a major focus within this programme

All national and local strategic frameworks are driven by a single vision for health care and services: to improve the quality of care, to improve the quality of patient experience and to increase the value and return on investment.

To achieve those three critical factors, NHS Surrey’s programme in Guildford and Waverley has been set up to review the clinical service for stroke and orthopaedic rehabilitation, as well as complex elderly including those with a co-morbidity of dementia, in the south west of Surrey. The Programme is designed to shape and re-design the way community services are delivered in Guildford and Waverley in line with national policy and clinical best practice and to ensure that investment in community hospitals in this area delivers best value. This work will inform other Surrey-wide commissioning plans and subsequent service specifications.


G&W Strategic Business Case
Author: NHS Surrey Programme Office
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Created: 27/07/2009
Printed: 29/07/2009
4.2 Organisational overview

Surrey Primary Care Trust (known as NHS Surrey) was formed on 1\textsuperscript{st} October 2006, bringing together the five former primary care trusts within Surrey namely:

1. North Surrey  
2. East Elmbridge and Mid-Surrey  
3. East Surrey  
4. Surrey Heath and Woking  
5. Guildford and Waverley

NHS Surrey now serves a population of 1.2 million people with a budget of around £1.6 billion to invest in local healthcare.

The main function of NHS Surrey is:

- Engaging with its local population to improve health and well-being and reduce health inequalities
- Commissioning a comprehensive and equitable range of high quality responsive and efficient services, within allocated resources
- Directly providing high quality responsive and efficient services where this gives best value

NHS Surrey works closely with GPs, dentists, opticians, social care services and pharmacists and currently provides many community services itself – e.g. district and school nursing, health visiting, therapy services and the running of our community hospitals – under the umbrella of Surrey Community Health. This is in the process of becoming a stand alone organisation that will have its services commissioned by NHS Surrey.

In the boroughs of Epsom, Ewell and Mole Valley, community health services are provided by a social enterprise organisation, Central Surrey Health, who was previously part of the former East Elmbridge and Mid-Surrey Primary Care Trust.

NHS Surrey works closely with local GPs in ‘practice-based commissioning’ which means that GPs are helping to decide and plan what healthcare services are needed in their local areas.

In order to provide a complete service to our patients, NHS Surrey works with our partners in social care, the voluntary sector, local boroughs and hospital colleagues.

4.3 Contribution to key objectives

The Strategic Commissioning Plan sets out the NHS Surrey blueprint for health in Surrey up to 2013 by promoting better health, planning and commissioning (buying) the right health services to match the specific health needs of Surrey people.
The NHS Surrey vision signals a challenge for the organisation, not only transforming the health of the population and healthcare delivery but marking a fundamental shift in our relationship with Surrey’s population. This sets the standard for how NHS Surrey will go about its business and will govern the organisation’s culture and ethics.

**The NHS Surrey Vision Statement:**

We will work with you to improve your health and wellbeing and ensure everyone in Surrey gets healthier.
We will focus on preventing ill-health but when people are ill they will receive the very best quality healthcare with services designed around their needs and within our means.
NHS Surrey will earn a reputation for being innovative, a good place to work and trusted by the population it serves.

**The NHS Surrey Mission Statement:**

Over the next five years our investment strategy is to drive the best care and innovation through an open, competitive market to reinvest a greater reduction in health inequalities.

Equally, our engagement strategies will result in changed opinions and, ultimately behaviours, so Surrey people understand the impact of their choices

**Overarching Themes:**

- Clinical excellence – increasingly using international comparators
- Continually driving quality through assertive commissioning based on contestability through clinical quality.
- Maximising the market – driving investment and disinvestment to achieve improved value for money.
- Continually increasing the range and scope of services that are subject to contestability and outcome based specifications.
- Moving care into community settings wherever appropriate.
- High Impact Partnerships - to tackle health inequalities and the causes of health inequalities.
- Working for example with the county council, boroughs and districts, Police and voluntary sector to target ‘hot-spots’ where the added value of co-operation between partners will deliver enhanced results.
- Working through schools and school nursing to tackle causes of health inequalities.

The G&W Programme is entirely consistent with the vision statement, the mission statement and the overarching themes of the Strategic Commissioning Plan.
4.4 Stakeholders

Analysing stakeholder groups enables an understanding of their requirements, interest in, and impact on the G&W Programme so that communication and channels of communication can be based around their particular interests, issues and needs.

Initial analysis of stakeholders of the G&W Programme has been undertaken based on the following criteria:

- Interest of stakeholders in the Programme
- Influence of stakeholders on the Programme and its outcomes
- Communication needs of stakeholders

Based on this, the G&W Stakeholder management strategy and communication plan (APPENDIX B) has been devised to enable the Programme to communicate effective, relevant and timely information to stakeholders. A full stakeholder map is included within the Communication Plan, but key stakeholders are listed below:

- NHS Surrey (commissioning arm and community services)
- Royal Surrey County Hospital NHS Trust
- Frimley Park Hospital NHS Foundation Trust
- Practice based commissioning groups and GP practices
- South East Coast Ambulance Service NHS Trust
- Surrey and Borders Partnership NHS Foundation Trust
- NHS South East Coast
- NHS Hampshire
- NHS West Sussex
- Patients and patient representatives
- Carer groups
- Local residents and community interest groups
- Surrey Patients Forum (LINKS post 1/4/08)
- Surrey Health Scrutiny Committee
- Local Members of Parliament
- Guildford and Waverley borough councils
- Surrey County Council (councillors, Policy & Performance, Family Services)
- Hampshire County Council
- Local community interest groups
- Guildford and Waverley Parish and Town Councils
- Local voluntary organisations
- Local transport groups
- Local media
4.5 Constraints

Initial programme constraints include:
- The financial environment that NHS Surrey operates within
- Availability of capital funding, particularly time constraints
- Department of Health and NHS national policy
- NHS South East Coast Strategic and local policy and strategy
- Statutory and legal obligations, including estates.
- Practice based commissioning intentions
- Current contracts

4.6 Dependencies, interdependencies and interfaces

- Estates Programme
- NHS Surrey Strategic Commissioning Plan
- Assuring Access in Epsom and Ewell Programme
- NHS Surrey practice based commissioning initiatives
- NHS Surrey Productivity Plan
- Surrey County Council Transformational Change Programmes
- Strategic Programmes in neighbouring health communities
- Pilot integrated care organisations
5 The Clinical Model of Care

5.1 The model of care

The development of this new model of care has been centred on what will best deliver improved patient outcomes. It proposes that patients with post-acute stroke, those needing orthopaedic rehabilitation, and complex elderly with a co-morbidity of dementia require access to consultant led multi-disciplinary assessment, and thereafter may access one or more of the other elements depending on their clinical need.

<table>
<thead>
<tr>
<th>Building Blocks of Model*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to consultant led multi-disciplinary assessment</td>
<td>An initial assessment led by a consultant clinician supported by a team of skilled healthcare professionals</td>
</tr>
<tr>
<td>Period of acute in-patient care (e.g. operation)</td>
<td>A stay in a main hospital such as Frimley Park or Royal Surrey County Hospitals under the care of a consultant clinician.</td>
</tr>
<tr>
<td>Period of consultant led multi-disciplinary rehabilitation in a unit</td>
<td>A stay in a specialist rehabilitation unit under the care of a consultant clinician with care provided by a team of skilled healthcare professionals. This could be on the same site as a main hospital or in a standalone unit.</td>
</tr>
<tr>
<td>Period of supported multi-disciplinary care in the patient’s place of residence</td>
<td>A period of time where additional care is provided by skilled healthcare professionals in someone’s place of residence</td>
</tr>
</tbody>
</table>

*This new clinical model of care includes Day Assessment and Rehabilitation services such as the Milford Assessment and Rehabilitation Centre (MARC), the Florence Desmond Day Hospital at the Royal Surrey County Hospital and the planned reprovision of the day hospital services in the redeveloped Cranleigh Hospital.

The following principles were developed in co-design and adopted in the service strategies to support the delivery of patient benefits:

**Focus on patient needs:**
- Rapid access to specialist therapy and diagnostic services
- Services that demonstrate clear and equitable access
- Optimise the number of patients receiving rehabilitation in a home setting
- Ensure patients and their families are fully involved and fully informed in all stages of care and care planning
- Services that provide quality and meet clinical governance standards
• Individual care plans which meet patient needs

**Join up care pathways:**

- Defined pathways across acute inpatient, specialist centres, community services and home/residential care that optimise both patient outcomes and use of scarce resources
- Quality specialist rehabilitation centres treating patients post discharge from an acute hospital into long term care and support, including social care
- Ensure GP, social care, primary care and wider community teams are actively involved in all stages of care
- Mental health assessment and access to appropriate services should be integrated into the service models
- Improve patient access to rehabilitation services through an integrated multidisciplinary team (MDT) service and improve patient experience and satisfaction
- Appropriate and timely specialist assessment and treatment within a comprehensive multidisciplinary rehabilitation service

The service strategies for post-acute stroke, orthopaedic rehabilitation, and complex elderly with a co-morbidity of dementia are attached in APPENDICES C, D AND E.

Some of the key drivers of the service strategies developed under this Programme are to deliver improved patient outcomes via:

**Assessment;**

- Appropriate and timely specialist assessment and treatment within a comprehensive multidisciplinary rehabilitation service
- Individual care plans

**Discharge Planning and early supported discharge;**

- Discharge planning with the secondary care provider and social care at point of referral for intervention
- Improve patient access to rehabilitation services by establishing an integrated multidisciplinary team (MDT) service and improve patient experience and satisfaction
- Quality specialist rehabilitation services covering patients post discharge from an acute hospital into long term care and support
- Domiciliary rehabilitation services commissioned as part of an early supported discharge scheme to deliver specialist rehabilitation at the usual place of residence in liaison with inpatient services

**Discharge management;**

- Maximise the number of patients receiving rehabilitation in a home setting
- Rapid access to specialist therapy and diagnostic services
- Pathways that optimise both patient outcomes and use of scarce resources
• Services that demonstrate equity of access
• Patient/ carer information on conditions and local services

5.2 Principles of Critical Mass

Patient safety and critical mass
Ensuring patient safety is paramount to NHS Surrey as the commissioner of health services in the county. Equitable access and affordable services that provide value for money must also be considered.

The services provided in south west Surrey for stroke and orthopaedic rehabilitation as well as caring for complex elderly cases affects a relatively small group of people. Consequently, we have adopted the principles of patient critical mass to ensure patient safety, appropriate environment, equitable access for patients and an affordable service for providers.

The principles are that the clinical model requires specialist consultant led multidisciplinary assessment including consultant-led rehabilitation units, which follow the principles of patient critical mass in making optimum use of facilities and resources:

• ensure patient safety, risk management and clinical governance
• safeguard continuity of service
• ensure economies of scale e.g. consolidating specialities and sharing staff
• recruitment and retention of high-calibre staff
• maximise opportunities for career progression
• ensure skill transfer and personal development
• provide adequate supervision
• provide contingency cover

The Department of Health specialised services national definition states:

• ‘Specialised services are those with low patient numbers but which need a critical mass of patients to make treatment centres cost effective’
• ‘In some areas of specialised services, the number of patients who need the services is relatively small and the clinical expertise is therefore concentrated in one location to ensure that there is a sufficient critical mass of work to meet clinical governance standards’. 4

4 Department of Health Specialised Services Definition
5.3 Principles of the clinical model

Menu of care options

Consultant-led multidisciplinary assessment

Acute hospital

Specialist rehabilitation unit

Usual or new residence with support if needed
Stroke pathway

Percentages within this and the following diagrams were derived from the clinical engagement event.
Orthopaedic pathway

Orthopaedic patient

Pathway A
Non-complex
25%

Pathway B
Pathways with LTC
50%

Pathway C1
Complex patient
20%

Pathway C2
Complex patient returning to nursing/residential home
5%

Acute
7-10 days

Acute
2 weeks

Acute
4 weeks

Acute
2 weeks

Outpatients and community therapy.

Community Hospital or Intermediate Care Team

Community hospital
Up to 3 months

Back to nursing / residential home

ICT – Intermediate Community Care Team
25%

Community Hospital
25%

Orthopaedic Rehabilitation in Community Hospital =
Pathway B – 25%
Pathway C – 20%
Older Person with Complex Needs Pathway

Older patient with complex needs

Consultant led Medical Assessment

Patient discharged & no care services required

Consultant led Medical Assessment

Patient admitted to Acute

Consultant led Medical Assessment

Patient admitted to Acute

Consultant led Medical Assessment

Specialist rehabilitation required (various locations)

Consultant led Medical Assessment

Further care & support provided (including rehabilitation in various locations)

Consultant led Medical Assessment

Patient discharged & no care services required

Patient discharged & no care services required
5.4 The new model of care – calculating future bed numbers

Taking each care pathway in turn, an assessment has been made of the likely impact of the new model on bed numbers using average length of stay (ALOS) estimated by local clinicians based on current conditions and bed availability (see APPENDIX F).

Local clinicians have indicated that the new model of care can be delivered without the need to increase bed numbers currently at Milford (40) and Farnham (53) and so the numbers represent no change. Currently 11 of the beds at Farnham are part of a Practice based Commissioning pilot project and four are dedicated continuing care beds.

Based on 2008/09 activity data and the health needs of the local population (see APPENDIX G for G & W Needs Assessment), the ALOS calculated are as follows:

**Local Clinician’s Estimated LOS for the New Pathway**

- Complex elderly pathway- ALOS 37 days (no change from 2008/09)
- Ortho rehab pathway - pathway B ALOS 21 days, pathway C ALOS 28 days (overall average 24 days)
- Stroke rehab pathway - ALOS 42 days
- Other - uncoded activity for other commissioners same as 2008/09

These assumptions lead to the following impact on bed numbers:

**Table 1**

<table>
<thead>
<tr>
<th></th>
<th>Farnham</th>
<th>Milford</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Available beds</td>
<td>No of patients</td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SW Surrey</td>
<td>56</td>
<td>2,039</td>
</tr>
<tr>
<td>Other Surrey</td>
<td>50</td>
<td>2,100</td>
</tr>
<tr>
<td>Out of Surrey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ortho</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SW Surrey</td>
<td>131</td>
<td>3,155</td>
</tr>
<tr>
<td>Other Surrey</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td>Out of Surrey</td>
<td>44</td>
<td>1,061</td>
</tr>
<tr>
<td>Complex elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SW Surrey</td>
<td>58</td>
<td>2,093</td>
</tr>
<tr>
<td>Other Surrey</td>
<td>12</td>
<td>288</td>
</tr>
<tr>
<td>Out of Surrey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unallocated</td>
<td>38</td>
<td>1,266</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>391</td>
</tr>
</tbody>
</table>
NB the 53 relates to the total beds at Farnham out of which 38 are currently consultant care within the model.

Due to the incompleteness of robust data, it should be noted that some assumptions have been made to complete the impact analysis.

This demonstrates that based on local clinicians current views of the average length of stay there would be a requirement for:
- 38 beds at Farnham
- 37 beds at Milford

We have done further sensitivity analysis based on implementation of the Community Hospital and Intermediate Care provision good practice guide\(^5\) which demonstrates that the length of stay could reduce further.

- Complex elderly 28 days,
- Orthopaedic rehabilitation 21 days
- Stroke rehabilitation 28 days.

These assumptions could lead to the following impact on bed numbers.

**Table 2**

|                | Available beds | No of patients | Total LOS | ALOS | Occupied beds | Required beds | Occupancy rate | Available beds | No of patients | Total LOS | ALOS | Occupied beds | Required beds | Occupancy rate |
|----------------|----------------|----------------|-----------|------|---------------|---------------|----------------|----------------|----------------|-----------|------|---------------|---------------|----------------|               |
| **Stroke**     |                |                |           |      |               |               |                |                |                |           |      |               |               |                |               |
| SW Surrey      | 56             | 1,566          | 28        | 4    | 5             | 90.0%         |                | 72             | 2,014          | 28        | 6    | 6             | 90.0%         |                |               |
| Other Surrey   | 50             | 1,400          | 29        | 4    | 4             | 90.0%         |                | 3              | 84             | 28        | 0    | 0             | 90.0%         |                |               |
| Out of Surrey  |                |                |           |      |               |               |                |                |                |           |      |               |               |                |               |
| **Ortho**      |                |                |           |      |               |               |                |                |                |           |      |               |               |                |               |
| SW Surrey      | 131            | 2,748          | 21        | 8    | 8             | 90.0%         |                | 60             | 1,269          | 21        | 3    | 4             | 90.0%         |                |               |
| Other Surrey   | 2              | 42             | 21        | 0    | 0             | 90.0%         |                | 2              | 42             | 21        | 0    | 0             | 90.0%         |                |               |
| Out of Surrey  | 44             | 924            | 21        | 3    | 3             | 90.0%         |                | 2              | 42             | 21        | 0    | 0             | 90.0%         |                |               |
| **Complex elderly** |          |                |           |      |               |               |                |                |                |           |      |               |               |                |               |
| SW Surrey      | 58             | 1,624          | 28        | 4    | 5             | 90.0%         |                | 146            | 4,088          | 28        | 11   | 12            | 90.0%         |                |               |
| Other Surrey   | 12             | 336            | 28        | 1    | 1             | 90.0%         |                | 5              | 140            | 28        | 0    | 0             | 90.0%         |                |               |
| Out of Surrey  |                |                |           |      |               |               |                |                |                |           |      |               |               |                |               |
| **Unallocated**|                |                |           |      |               |               |                |                |                |           |      |               |               |                |               |
|                | 38             | 1,266          | 33        | 3    | 4             | 90.0%         |                | 3              | 85             | 28        | 0    | 0             | 90.0%         |                |               |
| **Total**      | 53             | 391            | 9,906     | 25   | 27            | 30            | 51.2%          | 40             | 300            | 7,860     | 27   | 22            | 24            | 54.5%          |               |

NB the 53 relates to the total beds at Farnham out of which 38 are currently consultant care within the model.

This analysis demonstrates that based on 90% occupancy rates and reduced length of stay there would be a requirement for:
- 30 beds at Farnham,

\(^5\) Reviews of Community Hospital / Intermediate Care Provision, Good Practice Guide. Care Services Improvement Partnership
• 24 beds at Milford

However this may well be offset by the aging population and continuing changes in clinical best practice and international evidence. It will also be dependent on the level of community services available.

5.5 Other factors influencing the forecast bed capacity

These figures take into account the current situation however, other factors to be considered which may affect the forecast number of bed days required:

• Trend to repatriate inpatient care from acute hospitals to community settings which may indicate an upward trend in demand for community beds;
• Trend to transition care into patients’ place of residence, wherever clinically safe, which will indicate a trend downwards in demand for community beds;
• Forecast change in population, which may indicate an upward trend in demand for community beds;

It is difficult to accurately predict the impact of these changes on bed numbers, but the analysis leads to a consideration of a range of 54 to 75 beds required to deliver the model across the Farnham site and the other proposed Specialist Rehabilitation Unit (currently at Milford Hospital). This fits well with the number of beds currently available (78).

The ability to use beds flexibly in response to need would be helpful in the delivery of the pathways. This would allow the beds to be opened and closed to cope with the demands on the system, and allow resources to be concentrated on the most appropriate areas of the pathways at any given time.

5.6 Existing arrangements

The current model of consultant led services provides good care and is highly rated by users but could be improved. A number of short comings were identified in the 24/25 March 2009 clinical engagement event, as follows:

• Pathways that are not driven by patient outcomes; choosing from what is available rather than what is best for the patient
• Inequitable patient access; not all patients have access to consultant led rehabilitation
• Variability of care planning; lack of early comprehensive assessment and early discharge planning from the point of the initial incident
• No clear pathway of care with patients referred to an available service rather than one that meets their individual clinical needs
• Difficulty in tracking a patient across a pathway
• Insufficient and inadequate integration, co-ordination and communication between acute, mental health, community, social and primary care
• Gaps, limited flexibility and availability of services
• Lack of focus on prevention e.g. falls
• Inefficient use of specialist services and skills e.g. access to Early Discharge Team; mental health services

The current services provided in Guildford and Waverley for stroke rehabilitation, orthopaedic rehabilitation, and post-acute care for complex elderly who may have a co-morbidity of dementia in the south west locality of Surrey patients within the scope of this business plan are as follows:

There are two acute hospitals that service south west Surrey:

• Frimley Park Hospital NHS Foundation Trust
• Royal Surrey County Hospital NHS Trust

In addition, there are four community hospitals in south west Surrey:

• Farnham hospital and Centre for Health is a relatively new development with;
  o primary, community (including day hospital) and social care services

• Milford hospital is used for specialist rehabilitation with;
  o two 20 bedded wards and one closed 20 bed ward
  o Milford Assessment and Rehabilitation Centre

• Haslemere hospital with;
  o two co-located wards, one with GP managed beds and one with specialist neuro-rehabilitation beds

• *Cranleigh hospital with;
  o temporarily closed standalone, GP managed 14 bed unit
  o closed day hospital service
  o outpatient, therapy and rehabilitation services

*Since the temporary closure of beds at Cranleigh hospital, additional services worth around £1m have been provided for these patients including:

- Outpatient services (general surgery, neurology, ophthalmology, pain management, dietetics)
- A Falls Service as set out in standard six of the national service framework for older people
- Single point of access for community assessment and rehabilitation
- Additional OT for the respiratory service
- Community midwife antenatal and prenatal clinics
- Diabetic retinopathy screening service
- Pulmonary rehabilitation service
- Community matron service
- Heart failure nurse service
NHS Surrey has requested the National Clinical Advisory Team assess these new services to ensure they are of sufficient clinical quality to meet national guidelines and best practice.

The programme commissioned an independent GP to audit the 184 in-patient admissions to Cranleigh Hospital in 2005/06 which identified the following categories of patients:-

<table>
<thead>
<tr>
<th>Inpatient Categories</th>
<th>184 inpatient admissions to Cranleigh Hospital in 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls 7%</td>
<td>Audit evidence:</td>
</tr>
<tr>
<td>Palliative 15%</td>
<td>• 142 of these were Cranleigh environ patients</td>
</tr>
<tr>
<td>Complex Elderly 27%</td>
<td>• The patients fell into the broad categories outlined to the left</td>
</tr>
<tr>
<td>Rehab 51%</td>
<td>• 78% (complex elderly and Rehab) would enter the new model of care</td>
</tr>
<tr>
<td></td>
<td>• 15% would enter the End of Life care pathway</td>
</tr>
<tr>
<td></td>
<td>• 7% would be dealt with by the Falls Service</td>
</tr>
</tbody>
</table>

NHS Surrey current contracts for these services are let to:

- Frimley Park Hospital NHS Foundation Trust
- Royal Surrey County Hospital NHS Trust
- Surrey Community Health
- Local GPs

5.7 Strategic benefits

The development of this new model of care has been centred on what will best deliver improved patient outcomes. It has been developed by clinicians, validated by stakeholder groups and represents NHS Surrey’s desired patient pathway – ‘right care, right staff, right place, right time’. The new care model is informed by national policy and evidence of best practice and fits with NHS Surrey’s strategic goals.
The strategic benefits from the new care model are as follows:

- Higher quality services with robust proactive care plans to meet patient’s needs delivered via consultant led multi-disciplinary assessment
- Rapid access to specialist therapy and diagnostic services
- Care plans allow patients and their carers to be fully involved and informed in their care decisions, which enables transition towards targeted self care
- Better co-ordinated care transcending organisational boundaries
- Optimises the number of patients able to receive rehabilitation in a home setting
- Equitable and accessible services for the population of Guildford and Waverley
- Well defined and integrated patient pathways
- Services that support the delivery of the overall NHS Surrey Strategic Commissioning Plan and the Fit for Future case for change
- Services that support national targets such as 18 weeks
- Meets the objectives of the White Paper ‘Our Health, Our Care, Our Say’ by shifting services from acute to community and primary settings of care
- Increased efficiency and capability of community services
- Increased opportunities for integrated health and social care
- Value for money services for NHS Surrey

5.8 Strategic risks

Initial high level risks include:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A change in government or national policy may change the scope and</td>
<td>All clinical models and decisions are made within latest best practice, policy and Royal College guidelines</td>
</tr>
<tr>
<td>outcomes of the programme</td>
<td></td>
</tr>
<tr>
<td>Focus on the SW Surrey may adversely affect pan Surrey plans</td>
<td>Ensure strategic programme and network managers are actively involved in the programme</td>
</tr>
<tr>
<td>Local population do not support the change</td>
<td>Ensure the decisions are clinically led and are validated with the local population through co-design</td>
</tr>
<tr>
<td>Lack of affordability of the new model, and productivity activities</td>
<td>Robust financial modelling is undertaken and take into account any scenarios decisions</td>
</tr>
<tr>
<td>Social care unable to support the outcome</td>
<td>Ability to meet the service demands will be managed through commissioning and procurement arrangements. Social Care involved in designing pathways</td>
</tr>
</tbody>
</table>
Estates considerations (including design of any new build, planning permission and construction costs and time) may prevent implementation of scenarios

| Estates considerations (including design of any new build, planning permission and construction costs and time) may prevent implementation of scenarios | Work closely with the estates to integrate programme timelines with existing estate timelines to ensure minimum delay |
| Lack of robust and reliable data to model volume of patient activity through the pathways. | Build in tolerance to create contingency in the figures. |

### 5.9 Critical success factors

The success for this programme will be measured in terms of the greatest health gains and reductions in health inequalities that ensure optimum effectiveness of revised community pathways for older people. Measurements of the success will be:

<table>
<thead>
<tr>
<th>Programme outcome</th>
<th>Critical Success Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinically and financially sustainable healthcare services in the Guildford and Waverley area that meet the health needs of the local population for the foreseeable future</td>
<td>The clinical models meets NHS Surrey’s commissioning intentions and quality criteria and take into account local population forecast changes.</td>
</tr>
<tr>
<td>Safe and affordable transition of services across Guildford and Waverley</td>
<td>Implementation plans will include evaluated pilots prior to full transition.</td>
</tr>
<tr>
<td>Delivery of services that meet national clinical best practice and improved clinical outcomes.</td>
<td>Clinical model meets national best practice and local requirements that demonstrate speedier rehabilitation with reduced re-admissions.</td>
</tr>
<tr>
<td>Local, convenient, and accessible services for the population of Guildford and Waverley</td>
<td>The clinical model allows for high quality patient care to be transitioned from acute to community and patient place of residence over a period of time.</td>
</tr>
<tr>
<td>Equity of services for all in Guildford and Waverley and in line with equity across NHS Surrey</td>
<td>Health equity and needs assessment carried out as part of initial assessment. Rehabilitation service providers routinely liaise with appropriate specialist teams e.g. for Learning difficulties, Hearing and Vision impairment, physical disabilities and cultural needs.</td>
</tr>
<tr>
<td>Systematically listen to patients and local communities and develop systems accordingly</td>
<td>Patients actively involved in co-design</td>
</tr>
</tbody>
</table>
6 Options appraisal

6.1 Scenarios for Specialist Consultant Led Rehabilitation Unit Provision

The new model of care proposes that patients with post-acute stroke, those needing orthopaedic rehabilitation, and complex elderly with a co-morbidity of dementia require access to consultant led multi-disciplinary assessment, and thereafter may access one or more of the other elements depending on their clinical need.

<table>
<thead>
<tr>
<th>Building Blocks of Model*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to consultant led multi-disciplinary assessment</td>
<td>An initial assessment led by a consultant clinician supported by a team of skilled health care professionals</td>
</tr>
<tr>
<td>Period of acute in-patient care (e.g. operation)</td>
<td>A stay in a main hospital such as Frimley Park or Royal Surrey County Hospitals under the care of a consultant clinician.</td>
</tr>
<tr>
<td>Period of consultant led multi-disciplinary rehabilitation in a unit</td>
<td>A stay in a specialist rehabilitation unit under the care of a consultant clinician with care provided by a team of skilled health care professionals. This could be on the same site as a main hospital or in a standalone unit.</td>
</tr>
<tr>
<td>Period of supported multi-disciplinary care in the patient’s place of residence</td>
<td>A period of time where additional care is provided by skilled health care professionals in someone’s place of residence</td>
</tr>
</tbody>
</table>

*This new clinical model of care includes Day Assessment and Rehabilitation services such as the Milford Assessment and Rehabilitation Centre (MARC), the Florence Desmond Day Hospital at the Royal Surrey County Hospital and the planned reprovision of the day hospital services in the redeveloped Cranleigh Hospital.

The acute and community hospitals that service south west Surrey:

- **Frimley Park Hospital NHS Foundation Trust**
- **Royal Surrey County Hospital NHS Trust** (The Florence Desmond Day Hospital is on the Royal Surrey County Hospital site and will be retained within all scenarios)

- **Farnham hospital and Centre for Health** is a relatively new development with:
  - primary, community (including day hospital) and social care services and is fit for purpose
• this site is suitable for the location of the specialist rehabilitation unit

• **Milford hospital** is used for specialist rehabilitation with;
  - two 20 bedded wards and one closed 20 bed ward
  - Milford Assessment and Rehabilitation Centre
  - this site is suitable for the location of the specialist rehabilitation unit

• **Haslemere hospital** with;
  - two co-located wards, one with GP managed beds and one with specialist neuro-rehabilitation
  - this site is not suitable for the location of the specialist rehabilitation unit due to size restrictions

• **Cranleigh hospital** with;
  - *temporarily closed standalone, GP managed 14 bed unit
  - outpatient, therapy and rehabilitation services
  - this site is not suitable for the location of the specialist rehabilitation unit due to size restrictions
  - the site has been identified as unfit for purpose and in need of replacement (please see section 5.41)

Most patients who were previously treated within the 14 GP managed beds at Cranleigh would be treated within the proposed consultant led multidisciplinary assessment and treatment model or, within the additional services in Cranleigh outlined in section 5.6.

These additional services in the Cranleigh area evidence high patient satisfaction ratings.
6.2 Key Drivers

Some of the key drivers of the service strategies developed under this Programme are to deliver:

- Appropriate and timely specialist assessment and treatment within a comprehensive multidisciplinary rehabilitation service
- Improve patient access to rehabilitation services by establishing an integrated multidisciplinary team (MDT) service and improve patient experience and satisfaction
- Maximise the number of patients receiving rehabilitation in a home setting
- Quality specialist rehabilitation services covering patients post discharge from an acute hospital into long term care and support
- Rapid access to specialist therapy and diagnostic services
- Pathways that optimise both patient outcomes and use of scarce resources
- Services that demonstrate equity of access
- Individual care plans
- Patient/carer information on conditions and local services
- Discharge planning with the secondary care provider and social care at point of referral for intervention
- Domiciliary rehabilitation services commissioned as part of an early supported discharge scheme to deliver specialist rehabilitation at their usual place of residence in liaison with inpatient services

6.3 Service delivery scenarios

The principles developed in co-design and adopted in the service strategies to support the delivery of patient benefits were to focus on patient needs and join up the care pathway (please see page 20)

To ensure that these principles are firmly embedded and thus the envisaged patient benefits are fully realised, NHS Surrey wishes to implement the new clinical model using a lead provider arrangement across the Guildford and Waverley area.

This means commissioning a single organisation for each service strategy from each lead provider to provide the model of care who would then manage the whole patient pathway. The lead provider will manage all the services, but may not provide them all. The lead provider would benefit patients by having a single organisation ultimately responsible for all care delivery, but the care itself is still likely to be provided by the existing care providers.
The clinicians believe this would improve patient safety and co-design supported this principle to improve co-ordination of services for the patient. The chosen lead provider will be the one that can demonstrate they are best able to manage the overall pathway. This arrangement will have success criteria set, which will be monitored throughout the period of the contract. The success criteria will include optimal use of acute and community beds and effective use of all community services. This would involve flexible use of the existing bed stock, allowing the provider to expand and contract (within the existing bed stock envelope) to meet demands within the system.

The implementation of the clinical model under a lead provider arrangement will be monitored and if applicable the model may be repeated across the rest of Surrey.

### 6.4 Scenario Appraisal

Each of the available scenarios has been assessed against a standard set of objective criteria as part of the appraisal process. These preliminary ratings are shown below.

Do nothing is the fallback scenario if none of the described scenarios is successful, however, do nothing does not meet the needs of the clinical model. Therefore it has not been considered further.

It is assumed that the clinical model could be implemented in any of the three described scenarios to meet the strategic fit and clinical quality.
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Scenario 1 - Milford</th>
<th>Scenario 2 - Guildford</th>
<th>Scenario 3 - Cranleigh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic fit with clinical model, national policy and local strategy; world class commissioning</td>
<td><strong>3</strong> Specialist consultant led beds</td>
<td><strong>3</strong> Specialist consultant led beds</td>
<td><strong>3</strong> Specialist consultant led beds</td>
</tr>
<tr>
<td>Clinical quality and integrity</td>
<td><strong>3</strong> Clinically led model</td>
<td><strong>3</strong> Clinically led model</td>
<td><strong>3</strong> Clinically led model</td>
</tr>
<tr>
<td>Local access to community services</td>
<td><strong>2</strong> Station nearby, near A3, proposed new housing estate</td>
<td><strong>3</strong> Good transport infrastructure and serves a larger catchment area</td>
<td><strong>2</strong> Rural location. Inconvenient for Guildford residents.</td>
</tr>
<tr>
<td>Cost</td>
<td><strong>3</strong> Refurbishment</td>
<td><strong>1</strong> New building. NHS land</td>
<td><strong>0</strong> New building. Land ownership uncertain</td>
</tr>
<tr>
<td>Health gain and demographics</td>
<td><strong>2</strong> Service required for ageing population</td>
<td><strong>2</strong> Service required for ageing population</td>
<td><strong>2</strong> Service required for ageing population</td>
</tr>
<tr>
<td>Flexibility, capacity and continuity</td>
<td><strong>3</strong> Room to expand. Additional 20 bed ward currently closed</td>
<td><strong>2</strong> Expansion possible. Co-located with acute trust</td>
<td><strong>0</strong> Planning permissions and restrictions undefined</td>
</tr>
<tr>
<td>Patient experience</td>
<td><strong>2</strong> Not ideal for Guildford residents</td>
<td><strong>3</strong> Good transport infrastructure and serves a larger catchment area</td>
<td><strong>2</strong> Not ideal for Guildford residents</td>
</tr>
<tr>
<td>Workforce</td>
<td><strong>3</strong> Capacity and capability</td>
<td><strong>2</strong> Relocate/ recruit staff</td>
<td><strong>2</strong> Relocate/ recruit staff</td>
</tr>
<tr>
<td>Estate fitness for purpose</td>
<td><strong>3</strong> Require some refurbishment but space for expansion</td>
<td><strong>1</strong> Requires new building</td>
<td><strong>0</strong> Not established</td>
</tr>
<tr>
<td>Deliverability and achievability</td>
<td><strong>3</strong> Service already in place</td>
<td><strong>1</strong> Requires new building, Decommissioning at Milford financially prohibitive</td>
<td><strong>0</strong> Not established</td>
</tr>
<tr>
<td>Impact on partners</td>
<td><strong>3</strong> No change in current location</td>
<td><strong>3</strong> Co-located with acute trust</td>
<td><strong>2</strong> Not established. Rural location</td>
</tr>
</tbody>
</table>

**Key:**
- **3** Fully complies
- **2** Largely complies
- **1** Partly complies
- **0** Does not comply

**Scores:**
- Milford 30
- Guildford 24
- Cranleigh 16
6.5 Impact of the scenario appraisal

Milford is indicated as a best scenario under this analysis, however the other two scenarios achieve at least one score of zero. This would indicate at least one aspect of the scenario that is non-compliant, and therefore calls into question the viability of the scenario as a whole.

Cost/Benefit options assessment

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Patient Safety</th>
<th>Patient Experience</th>
<th>Clinical Quality</th>
<th>Value for Money</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Milford</strong></td>
<td>Consultant led clinical model is already in place. Refurbishment of site will enable reduced risk of infection</td>
<td>The clinical model specifies MDT care plans which patients and carers are involved in. Milford is accessible by public transport and has car parking</td>
<td>The consultant led MDT managed service will ensure the right care at the right time by the right clinical people</td>
<td>Estimated £585-1,451k refurbishment costs (see Appendix H)</td>
</tr>
<tr>
<td><strong>2. Royal Surrey County Hospital</strong></td>
<td>Consultant led clinical model could be put into place. RSCH has a good record for management of MRSA and C Difficile</td>
<td>The clinical model specifies MDT care plans which patients and carers are involved in. RSCH is accessible by public transport and has car parking</td>
<td>The consultant led MDT managed service will ensure the right care at the right time by the right clinical people</td>
<td>New build - estimated £6M investment Decommissioning of existing beds at Milford – detailed costs to be established</td>
</tr>
<tr>
<td><strong>3. Cranleigh</strong></td>
<td>There needs to be confirmation that consultants would be available to manage the service. It is assumed that a new site would be easy to maintain and keep hygienically clean</td>
<td>The clinical model specifies MDT care plans which patients and carers are involved in. It is assumed that the proposed Cranleigh site will be accessible by public transport and will have car parking</td>
<td>The consultant led MDT managed service will ensure the right care at the right time by the right clinical people</td>
<td>New build - estimated £6M investment Decommissioning of existing beds at Milford – detailed costs to be established</td>
</tr>
</tbody>
</table>
7 What the model of care means for Cranleigh

As explained in the background NHS Surrey inherited the temporary and urgent decisions taken as part of the previous G & W financial recovery plan that closed the 14 GP led beds and the day assessment unit. NHS Surrey board gave a commitment to address the future of these facilities as a result of the model of care which is now set out within this business plan.

As detailed in the options appraisal in section 6, most patients would be treated within the new model of care or are cared for within the additional services described in section 5. This analysis strongly suggests that the 14 GP beds that were temporarily closed by G&W PCT are no longer required.

Within the new clinical model of care NHS Surrey plans to provide a modern consultant led outreach day assessment and rehabilitation service in the redeveloped Cranleigh Hospital as described in section 7 as an outreach from MARC at Milford. This will offer

- Rehabilitation during and after acute illness
- Post operative rehabilitation
- Supported early discharge from an acute hospital
- Post discharge assessment
- Chronic disease management for example, diabetes and chronic obstructive pulmonary disease (to include co-morbidity of dementia)
- Support for end stage chronic conditions with the palliative care team
- Support, information and education for patients, families and carers

However, additional work to identify the health needs of the local population, suggests that there is a need for between six to eight NHS beds for continuing care (including dementia patients), palliative care and short stay beds to avoid hospital admission.

These patients have very different health needs and it would be inappropriate to accommodate these types of patients in a single small unit. It is more usual for this to be provided by specialist nursing home facilities.

This has included the analysis of past, current and estimated future needs for continuing care beds including palliative care and dementia. Discussions have also taken place with local clinicians and social services colleagues in relation to the need for short-term beds to support community based care locally in Cranleigh.

This identified need sits outside of the proposed new clinical model of care (essentially stroke, orthopaedic rehabilitation and complex elderly). NHS Surrey will look to commission these beds from local private or third sector providers as a short term solution to ensure that patients are not disadvantaged. The longer term solution will require more detailed work and discussions with local GPs, Cranleigh Village Hospital Trust, Surrey County Council, Waverley Borough Council and other partners before a decision can be made.
A recommendation in this Business Case is therefore to consult on:

- The commissioning of six to eight NHS beds in the Cranleigh area.
- The establishment of a state of the art consultant led day assessment and rehabilitation service in the redeveloped Cranleigh Hospital
- The permanent closure of the 14 beds at Cranleigh Village Hospital.

Please see APPENDIX I for a full description of current arrangements.

In addition to the new investment detailed in section 5, NHS Surrey has set aside £4 million of capital funding in 2010/11 in addition to the £700k that has been agreed for this financial year (see Appendix H).

This enables NHS Surrey to progress the delayed redevelopment of the health centre and of the community hospital to provide outpatient treatment, including x-ray facilities, as well as creating space that can be used flexibly.

The Cranleigh Health Centre dates from the late 60s to early 70s and has been identified as unfit for purpose and in need of replacement. NHS Surrey approved the redevelopment case in December 2008 which explained the need for investment and outlined a number of building solutions to consider. The project has been delayed pending the outcome of the G&W Programme.

The Strategic Outline Case for the redevelopment work demonstrated that a new facility of up to 3000 m² was possible on land owned by NHS Surrey (the existing Health Centre and hospital sites) within the town and approved the production of an Outline Business Case to explore the way forward.

South East Coast Strategic Health Authority signed off the PCT capital work programme in May 2009. Strategic capital availability has only been guaranteed until 2011. The project has been altered to accommodate this new timeline which has a significant impact on the critical path and risks.

The availability of capital drives the urgency of this project and necessitates the condensed schedule that involves work at risk. The main activities in this project will need to run concurrently where possible to meet the required timescales (see APPENDIX J for full details of the planning and build programme).

In 2005 Cranleigh Hospital provided consultant outpatient services (paediatrics, cardiology, gynaecology, ENT, orthopaedics, elderly care, minor surgery, lymphoedema), Community Physiotherapy, Community Occupational Therapy and Primary care mental health counseling.

These have continued and the services provided to the Cranleigh population have been extended to include:

- Outpatient services (general surgery, neurology, ophthalmology, pain management, dietetics)
- Falls Service as set out in standard six of the national service framework for older people
- Single point of access for community assessment and rehabilitation
- Additional OT for the respiratory service
- Community midwife antenatal and prenatal clinics
- Diabetic retinopathy screening service
- Pulmonary rehabilitation service
- Community matron service
- Heart failure nurse service

It is proposed that the redeveloped hospital could provide diagnostics including x-ray, ultrasound and point of care testing and further consultant outpatient clinics including gastroenterology, respiratory, dermatology.

The redevelopment plans for Cranleigh hospital are subject to a planning consultation which will be taken forward separately by Waverley Borough Council.
8  Key Conclusions and Recommendations

Conclusion 1
That the proposed clinical model of care and pathways within this document are clinically appropriate and represent best practice.

Recommendation 1
That the proposed clinical model of care be adopted within the Guildford and Waverley areas.

Conclusion 2
Farnham Hospital is fit for purpose as a Specialist Rehabilitation Unit defined within the model of care.

Recommendation 2
That Farnham Hospital site be used as the Specialist Rehabilitation Unit predominantly facing the Frimley Park Hospital NHS Foundation Trust in Frimley.

Conclusion 3
The analysis of the evidence demonstrates the need for a single viable scenario for the location of the Specialist Rehabilitation Unit.

Recommendation 3
That Milford Hospital site be refurbished and used as the Specialist Rehabilitation Unit predominantly facing the Royal Surrey County Hospital NHS Trust in Guildford.

Conclusion 4
The analysis of the evidence demonstrates that the majority of patients in the Cranleigh area would be treated within the new consultant led model of care. This analysis strongly suggests that the 14 GP beds at Cranleigh Village Hospital that were temporarily closed by G&W PCT are no longer required.

The analysis of the future needs of patients in the Cranleigh area indicates that approximately 6 – 8 NHS beds will be needed for conditions such as continuing care (including dementia patients), palliative care and shorter stay beds to avoid hospital admission. For this kind of care, we think we need to buy approximately 6-8 NHS beds in the Cranleigh area.

It would be inappropriate to accommodate these types of patients in a single small unit. It is more usual for these to be provided by specialised nursing home facilities.

Recommendation 4
A recommendation in this Business Case is therefore to consult on:

- The commissioning of six to eight NHS beds in the Cranleigh area.
- The establishment of a modern consultant led outreach day assessment and rehabilitation service in the redeveloped Cranleigh Hospital
- The permanent closure of the 14 beds at Cranleigh Village Hospital.
Conclusion 5
The principle of joining up care pathways formed through the co-design process can best be delivered by a single lead provider.

Recommendation 5
NHS Surrey commissions lead providers within clearly set contractual arrangements.

Conclusion 6
Clinical opinion is to establish a range of beds to enable the system to flex to meet increased or decreased demand.

Recommendation 6
The principle of utilising a range of beds is approved.

Appendices

Please note all appendices are published at www.surreyhealth.nhs.uk/guildfordandwaverley

And also available on request by calling 0800 6525 297

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</tr>
<tr>
<td>Appendix C - Clinical strategy for specialist stroke rehabilitation services</td>
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<tr>
<td>Appendix D - Clinical strategy for community orthopaedic rehabilitation services</td>
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<td>Appendix E - Older people and complex needs – clinical strategy for a community assessment service</td>
</tr>
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</tbody>
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